



TENNCARE POLICY MANUAL

Policy No: PI 11-003 (Rev. 2)	
Subject: Federal Provider Terminations and Exclusions	
Approval: <i>D. J. Harvey</i>	Date: 5-29-12

BACKGROUND:

Federal law and regulations require that State Medicaid agencies terminate any provider who has been terminated on or after January 1, 2011, under Medicare or under the Medicaid or CHIP program of any state.¹

According to CMS, "termination" occurs when:

- The Medicare program, a State Medicaid program, or CHIP has taken an action to revoke a provider's billing privileges, and
- A provider has exhausted all applicable appeal rights or the timeframe for appeal has expired, and
- There is no expectation on the part of a provider or supplier or the Medicare program, State Medicaid program, or CHIP that the revocation is temporary.²

CMS differentiates "termination" from "exclusion." "Exclusion" refers to a penalty imposed on providers by the Department of Health and Human Services' Office of General Counsel (HHS-OIG) for misconduct ranging from patient abuse to defaulting on student loans.³ "Termination" refers to actions related to fraud and program integrity. However, CMS recognizes that many states use these terms interchangeably.⁴ The net result of either action is that the provider is unable to participate in the State's Medicaid program.

¹ Section 6501 of the Affordable Care Act; 42 C.F.R. § 455.416(c).

² CPI-CMCS Informational Bulletin (CPI-B 11-05), May 31, 2011.

³ "Frequently Asked Questions, Section 6501 of the Affordable Care Act," CPI-CMCS Informational Bulletin (CPI-B 11-05), May 31, 2011.

⁴ Ibid.

POLICY:

It is the policy of the Bureau of TennCare to terminate any providers who have been determined by the Department of Health and Human Services (HHS) or the Centers for Medicare and Medicaid Services (CMS) to meet termination or exclusion criteria.⁵ The effective date of the provider's termination from TennCare can be no later than the date of the provider's termination or exclusion by HHS-OIG or CMS.

No State appeals are permitted for providers that have been terminated or excluded by HHS-OIG or CMS. Those appeals would have occurred at the federal level prior to termination or exclusion. State appeal processes, which are discussed in TennCare Rule 1200-13-18, are applicable only to providers against which the State has initiated an action.

PROCEDURES:

The Bureau of TennCare and its Managed Care Contractors (MCCs) conduct regular activities to make certain that federally terminated and excluded providers do not receive payments under the TennCare program.

The procedures used by the Bureau of TennCare are listed below.

1. On a monthly basis, the Office of Provider Integrity (OPI) conducts a match of TennCare provider data with two federal databases: the List of Excluded Individuals and Entities (LEIE) and the Medicare Exclusion Database (MED). The source of both databases is the Office of Inspector General (OIG) in HHS.
 - a. The LEIE is downloaded from the OIG's website.⁶
 - b. The MED is made available by the Centers for Medicare and Medicaid Services (CMS) via its contractor CORMAC. CORMAC places the updated MED file on the State of Tennessee's Secure File Transfer Protocol (SFTP) server monthly.
 - c. Each month OPI creates a new Excel file identifying matches between the TennCare provider database and the federal databases. Matched providers are reviewed and verified against InterChange provider enrollment information. The matched

⁵ It should be noted that there may be exceptions to this requirement for a particular provider if the State requests and receives approval of a waiver from the CMS Regional Office in Atlanta.

⁶ <http://www.oig.hhs.gov/fraud/exclusions.asp>

providers are compared against the Monthly Exclusion reports received from the individual MCCs identifying sanctioned providers.

2. OPI regularly checks the web-based portal established by CMS to identify providers that have had their billing privileges revoked by Medicare or that have been terminated by other State Medicaid or CHIP programs as of January 1, 2011.⁷
3. OPI also conducts matches with the Excluded Parties List System (EPLS) on a monthly basis.
4. OPI maintains a TennCare Provider Ownership file, which is updated regularly by the MCCs' weekly provider enrollment files. OPI extracts current ownership data for comparison against the LEIE, EPLS, and MED files.
5. The Office of Provider Services (OPS) maintains an MCC Provider file in interChange, which is updated regularly by OPS. This file includes information about all providers that have been registered by TennCare. OPI extracts current provider enrollment data for comparison against the LEIE, EPLS, and MED files.
6. MCCs do their own data matches and forward names of excluded providers to OPS so that OPS can terminate those providers' Medicaid identification numbers.
7. If OPI, through the matching activities discussed above, identifies a provider that should have been excluded by an MCC but has not been excluded, OPI forwards the name to the MCC, along with an On-Request Report (ORR) for enrollment identification and an analysis of any claims paid after the federal termination date. When the response to the ORR is received by OPI, OPI reviews the response and forwards it to OPS for termination of the provider's Medicaid identification number. The effective date of the provider's termination from TennCare is the date of his federal termination.
8. OPI maintains a Program Integrity (PI) Provider Information System to keep track of providers that have been excluded. OPI uses this system to verify that providers that have been excluded on one of the federal databases have been terminated from TennCare. In addition, OPI reviews data in interChange to ensure that no payments have been made to excluded providers after the termination date.

⁷ Access to the CMS web-based portal is limited to users approved by CMS.

9. Funds that were inappropriately paid to excluded providers for services delivered after their federal termination date are considered “overpayments.” For example, a payment to an excluded pharmacy by the Pharmacy Benefits Manager would be considered an overpayment by the PBM and would be recovered by TennCare in accordance with the procedures outlined in Policy PI 11-001 on overpayments.
10. In addition to notifying the HHS-OIG under 42 CFR 1002.3(b)(3) of actions the State takes to limit a provider’s participation in TennCare, OPI reports terminations to the CMS web-based portal established under section 6501 of the Affordable Care Act.

OFFICES OF PRIMARY RESPONSIBILITY:

Office of Program Integrity
Office of Provider Services

REFERENCES:

Section 6501 of the Affordable Care Act

<http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>

42 C.F.R. § 455.416(c)

<http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=%2Findex.tpl>

CPI-CMCS Informational Bulletin (CPI-B 11-05), May 31, 2011

<http://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/6501-Term.pdf>

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