FEHB Program Carrier Letter
All Carriers

U.S. Office of Personnel Management
Insurance Services Programs

Letter No. 1993 - 20 **Date: July 16, 1993**

Fee-for-service [x] Experience-rated HMO [x] Community-rated HMO [x]

SUBJECT: Debarred Providers in the Federal Employees Health Benefits Program

This is in follow-up to Carrier Letter 93-01 of February 18, 1993, concerning the prohibition in OPM's appropriations bill on FEHB carriers from paying for care rendered by providers excluded under certain provisions of the Social Security Act.

As you may know, OPM has adopted the Nonprocurement Debarment and Suspension Common Rule as required by Executive Order 12549. Included under the Common Rule are debarments under the FEHBP for providers debarred by HHS on or after January 29, 1992. You will be hearing from OPM's Office of the Inspector General about those debarment actions.

We in the Office of Insurance programs will continue to meet our obligations under our appropriations by providing you with guidance on denying claims of providers debarred by HHS before January 29, 1992.

Enclosed are sample notices* for notifying members and providers. They are as follows:

A) Letter A In order to protect enrollees, whenever possible you should notify affected enrollees, via regular mail, that providers they have used in the past are on the debarred list. This prior notification effort should be undertaken only when existing systems allow for this procedure on an economical basis.

B) Letter B If the claim involves a debarred provider, a notice must be sent, via certified mail, to the enrollee stating that claims incurred after the date of the notice involving the debarred provider cannot be paid under the FEHBP.

C) Letter C A notice, via standard mail, must also be sent to the provider, if possible.

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* Use these notices for providers on the list whose sanction periods were effective before January 29, 1992, and are still in force at the time the claim is paid.

D) Letter D After an enrollee has been notified that a provider has been identified as being

debarred, claims incurred for services rendered by that provider to that enrollee may not be paid if the provider is still on the debarred list. You may pay claims for services rendered within 10 days of the date of the notice. If you get a claim for care rendered by the debarred provider after 10 days from the date of the notice, you must send the member a notice, via certified mail, stating that the claim cannot be paid. (No further notice is needed for the provider.)

Many of you have asked for clarification on your role; for instance, we were asked the following questions.

1. Q. Should carriers deny claims of all providers on the sanction list? Will Office of Insurance Programs update the sanction list?

   A. The appropriations language calls for denial of claims of only those providers which were debarred by HHS under section 1128 or section 1128A of the Social Security Act. (These sections also include subsections – such as 1128a1, 1128b4, and 1128Aa. Therefore, when the second column of the sanction list cites another section (e.g., 1862d1A, 1160, etc.), the HHS sanction is not applicable to FEHB and the claim for that provider would be paid.)

   Further, because the OIG has begun handling debarments under the common rule, we will not update the sanction list we sent you earlier. (You may assume that you will get further instructions from the OIG about providers on the sanction list that were debarred on January 29, 1992 or later.)

   For providers falling into the period covered by the appropriations and being handled by OIP, you should assure that the providers with pre-1/29/92 effective dates are dropped off the list when the suspension/debarment period expires.

2. Q. "In order to identify excluded providers from the HHS list of persons excluded from Medicare and Medicaid, the Plan must match this list against the Plan's provider file. The Medicare listing contains: the provider's name, the address, the person's date of birth, a code reference to the particular violation, and the time period of the debarment i.e. three years, ten years, etc. Medicare also publishes updates listing new debarments and reinstatements. The only items that can be cross indexed on our provider file are the names and addresses. The address provided by Medicare is the address that was current at the time of the sanction. HHS does not update addresses for sanctioned providers." Will OPM require the Plan to list a provider as debarred only if both the name and address match? What if, the name matches a provider on our file but the address is different?
   A. At this time, OPM will require the Plan to list a provider as debarred only if both the name and address match. If we obtain additional identifying information, we will notify you and allow a reasonable amount of time for you to set up procedures.

3. Q. Would it be possible to obtain any tax IDs or medical license numbers from HHS to provide better verification?
   A. At this time [July 16, 1993], no.

4. Q. "Many debarred providers will not be on our provider file. For example, the Plan provides benefits only to the enrollee for pharmacy charges. The Plan has no record of the name of the pharmacist at the pharmacy from which the claim is made. In addition a debarred provider who is employed with a corporation, i.e., nursing agency, etc. would not be on file – only the nursing agency will be listed. In these situations, will it be the Plan's obligation to notify the enrollee that an employee of a provider they have used in the past has been debarred?"
   A. Pharmacies are included on the list. However, the Plan is not obligated to deny payment when there is no match, including when the carrier cannot match the provider with the debarred list, e.g., a debarred pharmacist employed by a non-debarred pharmacy.

5. Q. "Our Plan has identified some providers on our file that were exact matches to the HHS list of names and addresses. Upon review of the claims history, we discovered the following situations:
   "Bills for two family members on the same day." Should we pay claims for both before refusing future payment?"
   "Office visits relatively close together i.e., two days apart. Clearly, the enrollee would never have received a letter in time to prevent the second visit – should the subsequent visits be paid if notification was not possible in the time frame?
   A. As noted above, you may pay claims for care rendered within 10 days after the date of the notice – including in situations such as those you describe.

6. Q. There are many providers on the Medicare lists whose sanctions have expired dates but have not been reinstated. Are these providers included in the FEHB debarment?
   A. For purposes of the appropriations language, include providers who, according to the list, were debarred before 1/29/92 and are debarred at the time the services are rendered. Therefore, if the time period shown in the sanction list for the debarment has expired, the claim may be paid.

7. Q. Can the enrollee appeal nonpayment of a claim for services provided by a debarred provider?
   A. Yes. For purposes of the appropriations language, the denial is <u>contractual</u>. The enrollee should be given the usual appeal process, ending in a request for review by OPM.

8. Q. "Several providers on our file practice under a group provider tax ID and can only be identified as part of the group. How should we match names with groups or professional associations?"
   A. If you do not have a contractual relationship with the group provider and therefore have no effective way of identifying the providers in the group, you need look no further than the group for which the claim is being made.

9. Q. "Ours is a prepaid plan, how does this apply to us?"
   A. For in-Plan claims, you should check your participating provider list against the debarred list. If a debarred provider is among the providers on your participating provider list, contact us for further guidance. For out-of-area and emergency claims, you should check the provider list before paying the claim, as the fee-for-service plans do. Although it is unlikely that a person will receive emergency care from the same provider again, the notice must be sent when appropriate and any future claims must be denied.

10. Q. What reports are required?
    A. Reports (see enclosure) will be required on the number and amounts of claims paid (or services provided) and denied involving debarred providers, i.e., claims incurred before notice and the number of claims denied.
    Semi-annual reports are required for 1993 and annual reports thereafter.
    The first of the two 1993 reports will be due September 30, 1993, for the period January 1 (or date your program was put in place) through June 30, 1993; the second 1993 report will be due March 31, 1994, for the period July 1 through December 31, 1993.
    The annual reports for 1994 and thereafter will be due each March 31st for the period January 1 through December 31 of the prior year.
    Reports will be required indefinitely. If the requirement for this process is lifted from our appropriations and, thus, reports are no longer necessary, we will notify you.
    Prepaid (HMO) plans will use the sanction less often (i.e., to periodically check the participating provider directory and to check out-of-Plan claims) than fee-for-service plans. For this reason, prepaid Plans may do reports manually.

We trust this information will be helpful. If you have further questions or concerns, you may write or call Agnes Kalland. Her telephone number is 202/606-0745.

Sincerely,

David Lewis, Chief
Program Planning
and Evaluation Division
Office of Insurance Programs

Enclosures:
Sample notices A – D
Exclusion Report

A – Sent by Regular Mail

Date of Notice:_____

Provider Name:_____

Provider Address:_____
_____
_____

Dear Federal Employees Health Benefits Program Member:

Your claims file indicates that you have filed claims for care rendered by the provider named above.

The provider has been identified as being excluded, pursuant to section 1128 or 1128A of the Social Security Act, from participation in a program under title XVIII of the Social Security Act.

You should know that we are prohibited from paying claims for the provider named above if the provider is identified as being excluded at the time services are rendered. If you use this provider in the future, you may not be reimbursed for the services provided.

Sincerely,

B – Sent by Certified Mail

Date of Claim:_____

Date of Notice:_____

Provider Name:_____

Provider Address:_____
_____
_____

Dear Federal Employees Health Benefits Program Member:

We received and processed claim(s) for care rendered by the provider named above.

The provider has been identified as having been excluded, pursuant to section 1128 or 1128A of the Social Security Act, from participation in a program under title XVIII of the Social Security Act at the time services were rendered.

We are prohibited from paying further claims for care rendered by such excluded providers. (See the exclusion on page [*fill in*] of your FEHB Plan brochure.)

As permitted by the Office of Personnel Management, we have processed the above claim(s). However, we will not pay future claims for care rendered by the provider named above if the provider is identified as being excluded at the time services are rendered.

Sincerely,

C – Sent by Regular Mail

Date of Claim:_____

FEHB Member:_____

Date of Notice:_____

Dear Provider:

We received and processed claim(s) for care rendered by you to the above Federal Employees Health Benefits (FEHB) member named above.

You have been identified as having been excluded, pursuant to section 1128 or 1128A of the Social Security Act, from participation in a program under title XVIII of the Social Security Act at the time services were rendered.

We are prohibited from paying claims for care rendered by such excluded providers.

As permitted by the Office of Personnel Management, we have processed the above claim(s) to allow a notice period for the member. However, you should know that we will not pay future claims for care rendered by you so long as you are identified as being excluded.

Sincerely,

D – Sent by Certified Mail

Date of Claim:_____

Date of Initial Notice:_____

Date of This Notice:_____

Provider Name:_____

Provider Address:_____
_____
_____

Dear Federal Employees Health Benefits Program Member:

We received a claim(s) for care rendered by the provider named above.

The provider has been identified as having been excluded, pursuant to section 1128 or 1128A of the Social Security Act, from participation in a program under title XVIII of the Social Security Act at the time services were rendered.

We are prohibited from paying claims for care rendered by such excluded providers. (See the exclusion on page [*fill in*] of your FEHB Plan brochure.) As permitted by the Office of Personnel Management, we processed your earlier claim(s) but notified you on the date shown above that we could not pay future claims for care rendered by the provider if the provider was identified as being excluded at the time services were rendered.

Therefore, your claim(s) for care rendered by the provider named above is denied.

[*Insert plan's reconsideration/disputed claims appeal procedure here*.]

Sincerely,

Debarment Actions under the FEHB Program
For mm/dy/yyyyy through mm/dy/yyyyy *

Plan_____ Code_____

A Before effective date of exclusion notice:

1. Initial notice *(Letter "A" to Enrollee)*

_____ a) Number of initial notices (i.e., no claim submitted yet) sent to enrollees

2. Exclusion Notice *(Letter "B" to Enrollee; Letter "C" to Provider)*

_____ a) Number of exclusion notices sent to enrollees

_____ b) Number of exclusion notices sent to providers

_____ c) Number of claims paid after debarred providers identified but before effective date of exclusion notices

$_____ d) Dollar amount of claims paid after debarred providers identified but before effective date of exclusion notices

B. After effective date of exclusion notice:

a) Claims denied *(Letter "D" to Enrollee)*

_____ 1) Number of non-payment notices sent to enrollees

_____ 2) Number of providers involved

_____ 3) Number of claims denied

$_____ 4) Dollar amount of claims denied

b) Claims paid after effective date of exclusion notice *(describe circumstances of payment separately)*

_____ 1) Number of enrollees receiving payment

_____ 2) Number of providers involved

_____ 3) Number of claims paid

$_____ 4) Dollar amount of claims paid

* Reporting periods:
Implementation date – 06/30/1993 (due 09/30/1993)
07/01/1993 – 12/31/1993
Thereafter: 01/01 – 12/31 (due 03/31)