From: Gruttadauria, Sharon E.
To: Eileen.Turner@cms.hhs.gov
Cc: Thorpe, Lisa (CMS/CM); Terry Fortin; Eidex, Brian (RIS-HBE)
Subject: NCPDP Follow-Up to CMS Questions Re: Precluded Provider
Date: Friday, December 9, 2016 5:25:21 PM

Good Afternoon Eileen,

The NCPDP Definition of a Valid Prescriber Task Group appreciates the opportunity to provide you a summary of their concerns and recommendations to the CMS Precluded Prescriber requirements so that you may use this as reference material for ongoing discussions and implementation planning. As you may already know, this detail was also shared with PCMA to ensure the NCPDP comments aligned with PCMA, specifically as they related to the technical claims processing questions. Please let me know if you have any questions on the below details. The task group looks forward to collaborating with CMS in ensuring a smooth implementation for these interim phased-in and the final prescriber enrollment requirements.

Thank you,
Sharon Gruttadauria, NCPDP Task Group Leader
Brian Eidex, NCPDP Task Group Leader
Terry Fortin, NCPDP Staff Liaison

CPI Questions/ NCPDP Task Group Feedback:

1. Please identify and provide the specific existing fields in the MED file that are recommended and required for the Preclusion List.
2. Please explain the general process your plan/PBM uses to obtain the current MED file.
3. Can your plan/PBM use a similar process to obtain the Preclusion List? If not, please explain and provide a recommendation for an alternative approach to obtaining the Preclusion List.
4. CMS is asking for plan/PBM comments and recommendations on including the prescriber in only one of the two files.
   - Refer to #5
5. What problems will be caused if there is a duplication and providers are on both files?
   - The NCPDP TG will be reviewing the previously defined/published order of edits for prescriber enrollment to include the precluded provider check. It appears that this would occur post the OIG excluded provider check therefore there is minimal risk if the provider is duplicated on the excluded and precluded provider files. While the duplication of the provider on the files may not be a risk for validation, the pharmacy receiving the reject code of A1 (ID Submitted is associated with a Sanctioned Prescriber) cannot determine whether the conflict is OIG exclusion or CMS Preclusion. This is based on CMS indicating that the current reject code of A1 may be used (refer to #3) below).
   - The TG is seeking additional information and examples based on the OIG excluded provider look back period of 5 years and the CMS precluded provider look back period of 10 years, to determine if there may be a conflict in rules when the provider is listed on both files. Need to ensure a consistent process is in place between point of service and CMS PDE claims processing rules.
6. To assist CMS, we ask that plans/PBMs provide CMS with examples of existing MED file providers who meet the criteria and their corresponding state waivers. We also ask for a description of how plans/PBMs handle these providers and their waivers from an operational processing prospective.
7. CMS asks for plan/PBM input on what the date(s) are to represent, i.e. should the date represent the beginning and end dates of the revocation period or something else? Under what circumstances should each field be populated given that the Preclusion List is under development as a monthly prospective replacement file?

8. Date of service and date of prescription: For the MED file prescribers, is the point of service (POS) denial based on the date the prescription was written by the prescriber or is the POS denial based on the date the beneficiary presents the prescription to the pharmacy?
    - The NCPDP TG does not recommend using either the RX Written Date or the Date or the date the patient presents the prescription to the pharmacy (i.e. claim submission date) to determine if the claim is payable under Part D based on the effective and termination dates of a precluded provider. The Task Group believes the claim Date of Service (DOS) should be used to make that determination. For example: If the claim DOS is equal to or greater than the preclusion effective date and less than the preclusion termination date, the claim will reject. If the claim is being reprocessed after the claim DOS (e.g. Reverse and Reprocess) and the claim DOS is less than the preclusion effective date, then the preclusion edit will not apply. This is how the OIG Excluded Provider edits (MED) work today.
    - This recommendation is predicated on the fact that all records added to the preclusion file must be post-dated and incorporate a file extraction and load period.
    - The TG also recommends that a preclusion termination date apply to the file, versus the record dropping off the file once the preclusion when the preclusion no longer applies. The preclusion termination date is needed in order to support claims that are reversed and reprocessed, i.e. the claim DOS is less than the claim transaction submitted/received date.

Additional Comments/Questions from the NCPDP Task Group:

1) Once the enrollment requirement is in place, will the precluded prescriber list go away where the enrollment process will incorporate precluded providers by applying an enrollment end date?
2) If the precluded prescriber file process will remain in place post the 1/1/2019 prescriber enrollment requirement, is the intent to specifically identify the difference between a non-enrolled provider and a precluded provider?
3) In order to ensure the appropriate message is returned to the pharmacy, the Task Group is recommending that the description for reject code of A1 *(ID Submitted is associated with a Sanctioned Prescriber)* used for OIG excluded providers be updated to use the term "Excluded" versus "Sanctioned" so that this reject code can apply to OIG Exclusions, Medicaid Exclusions and CMS Preclusions. NCPDP guidance would also recommend that the processor reference the specific file in which the exclusion was determined with the response message field. NCPDP requests CMS review this recommendation and provide any concerns they may have to this approach.
4) Can CMS provide further clarification on the below language that was in the 11/09/2016 communication? The task group is seeking clarification on what "non-enrolled" provider is referring to. For example:
    - How is CMS determining non-enrolled prescribers, specifically as it relates to OAPs?
    - If a prescriber is currently enrolled and is subsequently determined to be precluded, will that prescriber appear on the preclusion file and an end date apply to the enrollment record?

CMS Clarification: As requested by the Industry, the Preclusion List will be a separate file that will include prescribers who have been revoked from the Medicare program and those **non-enrolled prescribers** with felony conviction(s) within the past ten years.

Sharon Gruttadauria | CVS Pharmacy | Payer Relations | Director Industry Standards | Phone: 401-770-5945 | Fax: 401-652-9955 | One CVS Drive, Mail Code 1090, Woonsocket, RI 02895 | e-mail: | E-mail: Sharon.Gruttadauria@CVSCaremark.com