Screening Against Government Exclusions Lists
Overview Guidance for Health Care Providers and Business Partners

Screening Sources

- Office of the Inspector General Exclusion Database (OIG)
- System for Award Management (SAM) (fka GSA)

The General Services Administration's https://www.sam.gov/portal/SAM/#1 site and the Office of Inspector General's https://oig.hhs.gov/exclusions/exclusions_list.asp site are external sites and are subject to changes without corresponding changes in this document.

What Screening Determines, Who to Screen and Frequency

What Screening Determines: Whether anyone supporting your organization's contract has been excluded from participation in Medicare, Medicaid, and all other Federal health care programs

Who to Screen: Your organization's employees and subcontractors

When to Conduct:

- Upon hire of an employee
- Upon signing of a contract with a subcontractor
- On a monthly basis thereafter for both of the above segments

Who Conducts the Screening

Of Your Organization's Employees, Board of Directors, and Subcontractors

Either someone Medicare payment may not be made for items or services furnished or prescribed by an excluded provider or entity.

Sponsors shall not use federal funds to pay for services, equipment or drugs prescribed or provided by a provider, supplier, employee or FDR excluded by the DHHS OIG or GSA within your organization or an entity or individual contracted by your organization.

Of Those Tasked by Entities Your Organization's Contracts, including Their Supporting Entities

It is your organization's responsibility to assure that its contracted entities are routinely and properly conducting screening of their employees, temporary and contract workers, as well the entities that assist them in supporting business; the screening requirement persists at every downstream level of the ultimate provider of both health and administrative services.

- **Downstream Entity** is any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit or Part D benefit, below the level of the arrangement between an MAO or applicant or a Part D plan sponsor or applicant and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. (See, 42 C.F.R. §, 423.501).

Record Retention

Health care providers and business partners must maintain documentation and records for requirements and activities outlined in Network Medical Management *Compliance Policy for Contracted Health Care Providers and Business Partners* for a minimum of 10 years.

This document is for guidance only. Your organization may not distribute or publish it outside of your organization or allow any third party to distribute or publish it. Network Medical Management is not liable for any issues arising out of interpretation or use of this guidance; your organization is responsible for consulting with its designated compliance resource and/or legal counsel regarding how to comply with the requirements of *Network Medical Management Compliance Policy For Health Care Providers and Business Partners*.

Your organization is responsible for complying with any applicable changes, including changes to the exclusion screening requirement issued by the Centers for Medicare & Medicaid Services.