Exclusion Screening Basics for Providers

By Paul Weidenfeld[1]

Providers of medical services that participate in Federal or State Health Care Programs are required to screen all of their employees, vendors, and contractors monthly to ensure that none have been excluded from either the Medicare or Medicaid programs. Practices that fail to meet this requirement risk Civil Monetary Penalties (CMPs) and overpayments because Federal and State regulations prohibit payment for any item or service that was provided, directly or indirectly, by an excluded person.

Enforcement cases involving the employment of excluded persons are increasing dramatically, the imposition of CMPs more than doubled from 2013 to 2014, and recent cases investigations have been supported by data analysis projects by the Office of Audit Services and the Office of Evaluation and Inspections. In light of the increasing enforcement efforts and the potential consequences, it is critical that providers gain a basic understanding of the issues relating to Exclusion Screening and how they can be addressed.

What is an Exclusion?

HHS/OIG has the authority (by delegation from the Secretary) to deny persons and entities the ability to participate in federal healthcare programs. When such an action is taken by the OIG, that person or entity is said to be "excluded" and placed on the List of Excluded Individuals and Entities (commonly abbreviated "LEIE") and they become "excluded."

Federal exclusions can be either mandatory or permissive, but both have the effect of barring participation in all federal healthcare programs until such time, if ever, that the government agrees to reinstatement. Mandatory exclusions last a minimum of 5 years and generally involve felony convictions for defrauding health care programs, felony drug offenses and convictions for patient abuse or neglect. Permissive exclusions implicate a wider range of conduct and most often involve misdemeanor health care fraud, misdemeanor drug offenses and licensing issues.

States also have the authority to exclude individuals and entities from participating in their own programs, such as Medicaid, and currently, 37 states maintain their own exclusion lists that are separate from the OIG's LEIE. States will generally add OIG Exclusions to their own list, but they are also free to adopt their own exclusion criteria. It is important to note that states also often fail to report their own exclusions to CMS or the OIG such that it is not uncommon for an individual to end up on a state exclusion list and not the LEIE.

Federal and State Regulations Prohibit Payment for any Item or Service Performed by an Excluded Person

Neither Medicare or Medicaid will pay for any item or service that results in a claim for reimbursement if an excluded individual contributed to it in any way — either directly or

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indirectly. The so-called "payment prohibition" is broadly interpreted by the OIG. For instance, in it's May, 2013 "Special Advisory on the Effect of Exclusions," the expressed the view that the preparation of a surgical tray individual or the inputting of information by an excluded person or vendor could taint a claim. Even volunteer work by an excluded person could trigger the prohibition according to the OIG unless the volunteer activities were "wholly unrelated to federal health care programs."

Thus, if a practice that hires an excluded person or does business with an excluded vendor or contractor could find that every billable service he or it contributes to is tainted and a potential overpayment. Most states have also adopted this rationale and apply it to their Medicaid claims.

Don't Risk Civil Money Penalties, Overpayments and Potential Actions under the False Claims Act

Civil Money Penalties are often employed by the OIG as an enforcement tool when it discovers that claims have been made for an item or service that was provided, or contributed to, by an excluded employee. CMPs are very difficult to defend since the OIG has interpreted the relevant federal regulations to mean that the entity either "knew" of the exclusion and still submitted the claim, or that the entity "should have known," but failed to properly screen the employee. Either way, penalties are appropriate, according to the OIG.

It should also be noted that Section 6501 of the Affordable Care Act (ACA) which requires "State Medicaid Agencies to terminate the participation of any individual or entity if such individual or entity is terminated under Medicare or any other State Medicaid plan." As such, any person terminated under any federal or state authority is subject to exclusion by all federal or state authorities, and, therefore, claims by them are potentially problematic.

The failure to screen also creates a risk for providers of being sued under the False Claims Act. The theory behind FCA claims, which is employed with increasing frequency, asserts simply that since providers know that Medicare will not pay for a claim by an excluded person, a provider that fails to screen has constructive knowledge of the persons status or is acting in deliberate ignorance.

Federal and State Screening Requirements

Federal screening requirements, as contained in the May, 2013 Special Advisory Bulletin, requires providers to check the LEIE for employees and contractors. According to the Bulletin's guidance, providers should "review each job category or contractual relationship to determine whether the item or service being provided is directly or indirectly, in whole or in part, payable by a Federal health care program," and then "screen everyone that perform[s] under that contract or in that job category" on a regular (read monthly) basis. If only it was that simple.

It is important to remember that the OIG's guidance addresses only federal concerns. State Medicaid programs also have screening requirements that generally require, at a minimum, that providers screen their own State Exclusion List (38 States have them) in addition to the LEIE, and many also require screening of the System for Award Management list ("SAM"), and/or other State specific exclusions lists (such as sex

offender lists, elder abuse lists, etc.). Further still, it is not uncommon for States to add onerous screening requirements in enrollment or reenrollment applications and provider agreements. For example, a number of states require a certification that it has no employees that are suspended or excluded from **any** Federal or State Health Care Program, and some even require certification that their employees have never been excluded or suspended from any Federal or State exclusion list.

The Difficulty in Meeting Federal and State Exclusion Screening Requirements

OIG suggestions to the contrary notwithstanding, the ability of individual practices to meet their federal screening requirements is a difficult for a provider of any size. The current web-based LEIE interface allows only five employees to be screened at a time, each of which must be entered manually, and potential matches must be verified individually by entering the Social Security Number. While this might work for a provider who only has to screen a handful of employees or contractors, but for a provider with a large number of employees, this would be a long and difficult undertaking. The alternative OIG suggestion is to download the entire LEIE database and compare it to an employee list, but his is equally problematic – if not more so. The LEIE currently contains almost 60,000 names and few providers have the ability to compare that to their own employee database in any reliable or economically viable way.

But even if a provider has the ability to meet the OIG's screening obligation, State exclusion lists must also be checked and they present additional problems. To start, State lists come in a variety of formats (Word, Excel, or PDF) with different data fields – indeed, some State lists have little more than a name and an address. Many states also have additional state-specific screening requirements such as for lists of sex offenders, elder abuse lists, etc. Finally, as indicated previously, practices need to be aware that a number of States have enrollment applications and provider agreements that require providers to certify that they have screened all employees and contractors with **all** federal and state exclusion lists.

Outsourcing is the Solution that makes Sense

In addition to the logistical problems associated with screening federal and state exclusion lists, there are the practical concerns associated with ensuring compliance with a repetitive and difficult task that may be viewed as "unnecessary" by the person tasked with the job. The best solution all around is to find a vendor who will perform the task for you for a reasonable fee – one which will probably considerably less than the cost of doing the screening by oneself.

When a provider is choosing a company price is an obvious concern, but there are other important factors to consider. For instance, a provider should ask: What is the company's background in healthcare? Does it have an understanding of exclusion related issues? Does it have a willingness and ability to assist the provider in determining vendor related issues (such as who to screen and vendor certifications)? Will it provide support as needed? Does it have complimentary products such as hotline services that it can provide at little or no cost?