



SANCTION SCREENING: OIG HIGH RISK PRIORITY

Overview

Healthcare organizations and entities have as a Condition of Participation the affirmative duty to screen all those with whom they have a business relationship against published sanction data. This includes but is not limited to employees, physicians given staff privileges, vendors, and contractors. As such, individuals being considered for employment by human resource management represent only a small part of the whole equation. The Department of Health and Human Services (DHHS) Office of Inspector General (OIG) has as their mission to root out fraud, waste, and abuse in the Department programs. In furtherance of this, they investigate violations of law and regulation that are presented for prosecution through the Department of Justice (DOJ). They also have seventeen separate sanction authorities for administrative prosecution and action. Under the Title 42 USC section 1128 of the Social Security Act, the OIG has mandatory and permissible sanction authority to exclude individuals and entities from participation in federally financed health care programs, including Medicare, Medicaid, and Child Maternal Care for various types of misconduct, such as:

- Conviction for program-related crimes;
- Felony conviction for health care fraud;
- Conviction related to patient abuse and/or neglect;
- Failure to repay Health Education Assistance Loans;
- Conviction related to fraud against non-health care programs;
- Misdemeanor conviction for controlled substances;
- License revocation or suspension; and
- Misdemeanor health fraud conviction.

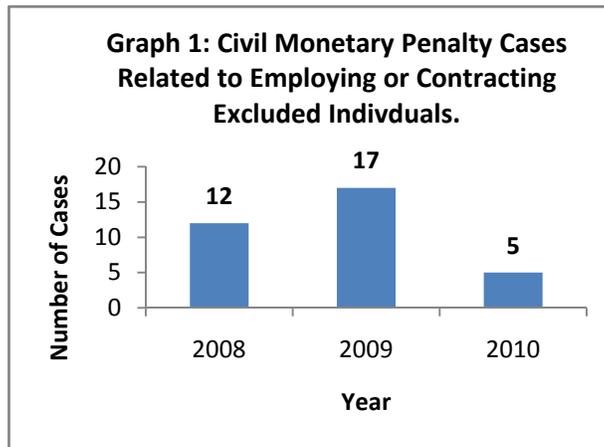
It is important to underscore the fact that no payment will be made for any items or services furnished by an excluded provider under the Medicare and Medicaid programs. Submitting such claims wherein any portion is attributable to an excluded individual or entity can be considered false and potentially fraudulent. In addition to facing the DOJ initiated actions, the OIG has independent authorities to seek civil monetary penalty action through the administrative processes of DHHS. Penalties for violating the Federal False Claims Act can be up to three times the value of the false claim, plus \$5,500 to \$11,000 in fines, per claim and program exclusion.

During 2008 through 2009 the OIG have settled 29 civil monetary penalty cases, majority are self-disclosures, related to employing or contracting of excluded individuals. See Graph 1. Among these

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cases, the OIG collected over \$5 million in settlements. These settlements illustrate the OIG's continued effort to ensure compliance with sanctions screening.¹



The Impact of Not Complying

Chapter 42, section 1001.1901(b) of the Code of Federal Regulations states that:

[N]o payment will be made by Medicare, Medicaid, or any of the other federal health care programs for any items or service furnished by an excluded individual or entity, or at the medical direction or on the prescription of a physician or other authorized individual who is excluded when the person furnishing such item or service knew or had reason to know of the exclusion.²

This payment ban applies to all methods of Federal program reimbursements including claims, cost reports, fee schedules, and prospective payment systems. Further, the payment restriction can affect any payment used to cover an excluded individual's salary, expenses, or fringe benefits regardless if he/she provides direct patient care. Additionally, any payment for administrative and management services not directly related to patient care but necessary to provide an item and/or service to beneficiaries is affected by this restriction.

To comply with these provisions, hospitals are strongly discouraged from employing or contracting with excluded individuals or entities to reduce potential liability. Hospitals should conduct sanction screenings prior to hiring or contracting with an individual or entity and periodically thereafter for all affected parties. Generally, sanctions screening for new employee hires is conducted by human resource management as part of the background check. In addition, similar checks should be made for physicians applying for staff privileges by the credentialing committee, as well as those responsible for

¹ Figures based on data provided on OIG's website: http://oig.hhs.gov/fraud/enforcement/cmp/false_claims.asp. Accessed on 15 Jul. 2010.

² 42 CFR § 1001.1901(b).

contracting for services and products. Failure to conduct a thorough review by all these parties can have a negative impact on the whole organization; including potentially having CMS revoking an organization's billing privileges. As such, it is imperative that all hospitals fully understand the implications of not complying with these provisions.

Can't Afford Failure to Check Sanction Data

The OIG has in all their compliance guidance documents noted that one of the compliance officer's primary responsibilities is ensuring that the OIG List of Excluded Individuals and Entities (LEIE)³ has been checked with respect to all employees, medical staff, and independent contractors. They have been increasing their focus on taking action against those that bill for items and/or services furnished by excluded providers. As a result, the OIG's position is that when a health care entity has billed for services rendered by an excluded individual or entity, it is an actionable offense. Thus, the burden is squarely upon hospitals and other health care entities to ensure that claims submitted to Medicare or Medicaid are not related to items and/or services provided by excluded individuals or entities. There are several enforcement initiatives underway to ensure compliance with sanctions screening. For example, the OIG "is considering a national initiative to identify and recover payments to entities that collected reimbursement from [excluded] employees."⁴ Moreover, there are a number of projects at both the federal and state level focusing on this, including the following:

- **Where Are They Now?** This is a new data-mining project that is managed by New York's Office of Medicaid Inspector General (OMIG). Under this project, the OMIG will use search programs to identify excluded providers and contractors (e.g. doctors, nurses, pharmacists, etc.) through the medical billing system. Specifically, this project will identify excluded providers who are submitting false claims. This project will begin in the next six months.
- **Excluded Provider Project.** This project started in 2008 and is a joint effort between the OIG and the U.S. attorneys' offices in New England. Similar to the project above, the OIG and U.S. attorneys' offices identify entities submitting claims for items and/or services rendered by excluded providers. According to a press release, more than \$1 million of improper payments have been recovered in the New England region under this project.
- **Patient Affordable Care Act (PPACA).** Section 6401(b)(d) of the PPACA requires CMS to establish a process to inform state Medicaid and Children's Health Insurance Program (CHIP) plans of providers terminated from the Medicare program. CMS is currently developing an automated system to alert states about terminated providers. Thus, CMS will provide the information concerning terminated providers via email and a secure website. The PPACA also

³ The DHHS Office of Inspector General List of Excluded Individuals and Entities can be found on their website at http://oig.hhs.gov/fraud/exclusions/exclusions_list.asp

⁴ "OIG Weighs Probe of Entities That Bill for Excluded Providers." Report on Medicare Compliance Vol. 19, No.10, 15 Mar. 2010; 4-5.

mandates states to terminate providers participating in their Medicaid plans if the providers have been excluded from Medicare or another state Medicaid plan. Although, this requirement is not effective until January 1, 2011, CMS advises state Medicaid offices to review its list of terminated providers. In addition, CMS states that “if there are providers currently participating in the Medicaid or CHIP program that have been previously terminated from Medicare... [CMS] also encourage[s] [state Medicaid offices] to evaluate the provider to determine if it is appropriate to initiate termination action at this time, or if additional oversight and scrutiny of the provider is warranted.”⁵

Given the high level of enforcement emphasis on this issue, hospitals need to make it a high priority to screen all affected parties with whom they are involved against the OIG LEIE. In addition, CMS has been urging states to require separate screening of Medicaid sanction data maintained at the state level.

Hospitals should not solely rely on federal lists of excluded providers because not all state enforcement actions are reported and/or included in the OIG’s LEIE. Further, according to New York State’s Medicaid Inspector General, James G. Sheehan, “[s]tate exclusions are not reciprocal.”⁶ Thus, hospitals are encouraged to review multiple states to improve completeness of their sanction screening. For example, Sheehan recommends New York providers to not only review New York’s exclusion lists but also New Jersey and Connecticut. Moreover, if a hospital intends to hire an individual who worked in a different state, e.g. the potential new hire worked in Virginia and the hospital (employer) is located in California, the hospital should review the individual’s previous state of employment.

Overall, hospitals must review the exclusion lists prior to hiring or contracting an individual or entity. Additionally, hospitals should periodically review the lists to determine the exclusion status of current employees and contractors.

Frequently Asked Questions

Hospitals may have a number of questions concerning sanctions screening. The following table outlines and provides responses to frequently asked questions.

⁵ Budetti, Peter and Mann, Cindy. “Implementation of Process to Provide States with Information on Providers and Suppliers that have been Terminated from the Medicare Program or Children’s Health Insurance Programs.” CPI-CMCS Informational Bulletin. 21 Jun. 2010. Access on 8 Jul. 2010 [http://op.bna.com/hl.nsf/id/sfak-86nseb/\\$File/CPIbulletin.pdf](http://op.bna.com/hl.nsf/id/sfak-86nseb/$File/CPIbulletin.pdf).

⁶ “OMIG Compliance Webinar #1-Addressing Excluded Persons in Medicaid Employment and Contracting-New York June 2010.” Office of Medicaid Inspector General. 8 Jun. 2010. Accessed on 7 Jul. 2010 http://www.omig.ny.gov/data/images/stories/Webinar/6-8-10_exclusion_webinar_final.pdf.

Table 1: Frequently Asked Questions Concerning Sanctions Screening.

Question	Response
When should sanctions screening take place?	Sanctions screening should be conducted prior to hiring and/or contracting with an individual or entity. In addition, hospitals should conduct periodic reviews on current employees and contractors to verify exclusion status.
How often should screening of individuals and entities take place during the course of a year?	Both the OIG and CMS recommend periodic screenings of sanctioned individuals. The OIG suggests that providers conduct reviews on a quarterly basis. However, in CMS’ letter to State Medicaid Directors, issued June 12, 2008, states are advised to conduct monthly screenings. Overall, hospitals should conduct at least quarterly reviews but monthly reviews are strongly recommended.
Who should be responsible for screening?	Generally, human resource management, credentialing, and contracting are responsible for the screening sanctioned individuals and entities. More specifically, (1) human resource management should screen individuals and entities prior to hiring and periodically thereafter; (2) credentialing committees should screen physicians before granting staff privileges and periodically thereafter; and (3) the Procurement Department screen contractors and vendors prior to contracting. The Compliance Office, as part of ongoing auditing and monitoring should ensure that this screening is taking place.
Who should be responsible for overseeing the sanction screening?	The compliance officer should be responsible for ensuring that the OIG List of Excluded Individuals and Entities have been checked with respect to all employees, medical staff and independent contractors.
What should you do, if you find an excluded individual or entity in the screening process?	<p>If a provider identifies an excluded individual or entity prior to hiring or contracting, the provider should not move forward with the engagement. However, if a provider identifies that a current employee or contractor’s exclusion status has changed, i.e. the employee or contractor is sanctioned, the provider should:</p> <ul style="list-style-type: none"> • Step 1: Terminate the engagement with the employee or contractor. • Step 2: Identify potential overpayments due to claims submitted for federal reimbursement that are related to the

Question	Response
Are there state requirements for sanction screening frequency?	excluded employee or contractor. <ul style="list-style-type: none">• Step 3: Self-disclose overpayment to the OIG within 60 days of discovery as required under the False Claims Act. Sanction screening requirements at the state level for Medicaid varies and should be checked. Some states have moved to follow the CMS guidance for monthly screening, but to date only a few have implemented such requirements.

Take Home Message

Sanction screening requirements are a high priority for both the OIG and CMS and should not be taken lightly. According to the Inspector General, Daniel Levinson, “Medicare and Medicaid provider enrollment standards and screening should be strengthened [to make] participation in Federal health care programs as a provider or supplier a privilege, not a right.”⁷ The OIG and CMS are developing and implementing a number of initiatives to combat fraud and abuse related to providers billing for items and/or services render by excluded individuals. Hospitals may wish to keep the following in mind about sanctioned individuals or entities:

- Failure to conduct accurate, thorough, and regular reviews of excluded providers can not only result in millions of dollars of liability but have negatives implications on the *whole* organization;
- Reinstatement does not occur automatically. An excluded individual or entity must apply for reinstatement with the OIG. As such, if the individual or entity is on the OIG’s List of Excluded Individuals/Entities, the individual or entity is excluded regardless if exclusion term has expired; and
- The payment ban for sanctioned individuals or entities applies to *all* methods of the Federal program reimbursement. This includes claims, cost reports, fee schedules, and prospective payment system.

Resources:

Regulatory Authority

- Patient Protection and Affordable Care Act, Pub.L.no.111-148, 658 Stat. 6501 (2010).
- Social Security Act § 1128.
- 42 CFR § 1001.1901.

⁷ <http://aging.senate.gov/events/hr208dl.pdf>

Federal and State Guidance

- “OMIG Compliance Webinar #1-Addressing Excluded Persons in Medicaid Employment and Contracting-New York June 2010.” Office of Medicaid Inspector General. 8 Jun. 2010. Accessed on 7 Jul. 2010 http://www.omig.ny.gov/data/images/stories/Webinar/6-8-10_exclusion_webinar_final.pdf.
- “What Should I Know About Sanctions/Exclusions.” Centers for Medicare & Medicaid Fact Sheet. 26 Sept. 2003. Access on 7 Jul. 2010 <http://www.lamsmedicare.com/factsheets/Sanctions.pdf>.
- “The Effect of Exclusion From Participation in Federal Health Care Programs.”1999. Department of Health and Human Service Office of Inspector General. Accessed on 7 Jul. 2010. http://oig.hhs.gov/fraud/alerts/effect_of_exclusion.asp.

Informative Articles on Sanction Screening

- Kusserow, Richard. “Clarifying Sanction Screening: OIG LEIE and Entities versus GSA EPLS.” Journal of Health Care Compliance. Jan. and Feb. 2010. Accessed on 8 Jul. 2010 www.strategiccm.com/articles/JHCC_Kusserow_January%202010.pdf.
- Budetti, Peter and Mann, Cindy. “Implementation of Process to Provide States with Information on Providers and Suppliers that have been Terminated from the Medicare Program or Children’s Health Insurance Programs.” CPI-CMCS Informational Bulletin. 21 Jun. 2010. Access on 8 Jul. 2010 [http://op.bna.com/hl.nsf/id/sfak-86nseb/\\$File/CPIbulletin.pdf](http://op.bna.com/hl.nsf/id/sfak-86nseb/$File/CPIbulletin.pdf).
- “Official Urges Providers to Prepare For New ‘Excluded Persons’ Listings.” BNA’s Health Care Daily Report Vol. 15, No.110. 10 Jun. 2010.
- “OIG Weighs Probe of Entities That Bill for Excluded Providers.” Report on Medicare Compliance Vol. 19, No.10, 15 Mar. 2010; 4-5.
- “Questions Raised About Necessity, Utility of Debarment Screening.” Report on Medicare Compliance Vol. 19, No. 4, 1 Feb. 2010; 4-6. Accessed on 14 Jul. 2010.