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SUBJECT Provider Screening of Employees and Contractors for Exclusion from Participation in Federal Health Care Programs and the Effect of Exclusion on Participation		BY  Izanne Leonard-Haak, Acting Deputy Secretary Office of Medical Assistance Programs

PURPOSE:

The purpose of this bulletin is to:

1. Remind providers who participate in the Medical Assistance (MA) Program to screen their employees and contractors, both individuals and entities, to determine if they have been excluded from participation in Medicare, Medicaid or any other federal health care program.
2. Remind providers of the consequences for failure to prevent payments for items or services furnished or ordered by excluded individuals or entities.
3. Advise providers to conduct self audits to determine compliance with this requirement and report any discovered exclusion of an employee or contractor, either an individual or entity, to the Department of Public Welfare’s Bureau of Program Integrity (BPI).
4. Provide information to assist providers with compliance with regulatory requirements.

SCOPE:

This bulletin applies to all providers enrolled in the MA Program’s Fee-for-Service (FFS) and the managed care delivery systems.

BACKGROUND:

The Department of Health and Human Services’ Office of Inspector General (HHS-OIG) excludes individuals and entities from participation in Medicare, Medicaid, the State Children’s Health Insurance Program (SCHIP), and all Federal health care programs (as defined in Section 1128B(f) of the Social Security Act (the Act)) based on the authority contained in various sections of the Act, including Sections 1128, 1128A, and 1156.

<p>COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO: Bureau of Program Integrity P.O. Box 2675 Harrisburg, PA 17105-2675 (717) 705-6872 Visit the Office of Medical Assistance Programs Web site at http://www.dpw.state.pa.us/provider/healthcaremedicalassistance/index.htm</p>
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When the HHS-OIG excludes a provider, Federal health care programs (including Medicaid and SCHIP programs) are generally prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. Section 1903(i)(2)(A),(B) of the Act (42 U.S.C.A. § 1396b(i)(2)(A),(B))¹; and 42 Code of Federal Regulation (CFR) Section 1001.1901(b).² This payment ban applies to any items or services payable under a Medicaid program that are furnished by an excluded individual or entity, and extends to:

- all methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules, or a prospective payment system;
- payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to Medicaid recipients, when those payments are reported on a cost report or are otherwise payable by the Medicaid program; and
- payment to cover an excluded individual's salary, expenses or fringe benefits, regardless of whether they provide direct patient care, when those payments are reported on a cost report or are otherwise payable by the Medicaid program.

In addition, no Medicaid payments can be made for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner or supplier that is not excluded. 42 CFR § 1001.1901(b).

Similarly, Pennsylvania law provides that the Department of Public Welfare does not pay for services or items rendered, prescribed or ordered on and after the effective date of a provider's termination from the MA Program. 55 Pa. Code §§ 1101.66(e). See also 55 Pa.Code § 1101.77(c): (i) a provider is not paid for services or items rendered on and after the effective date of his termination from the program; (ii) a participating provider is not paid for

¹ 42 U.S.C.A. § 1396b(i) provides:

Payment ...shall not be made—

....

(2) with respect to any amount expended for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished--

(A) under the plan by any individual or entity during any period when the individual or entity is excluded from participation under subchapter V, XVIII, or XX of this chapter or under this subchapter [XIX] pursuant to section 1320a-7, 1320a-7a, 1320c-5, or 1395u(j)(2) of this title [42 U.S.C.A.],

(B) at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under subchapter V, XVIII, or XX of this chapter or under this subchapter [XIX] pursuant to section 1320a-7, 1320a-7a, 1320c-5, or 1395u(j)(2) of this title [42 U.S.C.A.] and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person);

² 42 CFR § 1001.1901(b) provides, in pertinent part, that "no payment will be made by Medicare, Medicaid or any of the other Federal health care programs for any item or service furnished, on or after the effective date [of an exclusion], 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."

services, including inpatient hospital care and nursing home care, or items prescribed or ordered by a provider who has been terminated from the program; (iii) a participating provider is paid for services or items prescribed or ordered by a provider who voluntarily withdraws from the program. Furthermore, a provider whose enrollment in the program has been terminated may not, during the period of termination: (i) own, render, order or arrange for a service for a recipient; or (ii) receive direct or indirect payments from the Department in the form of salary, equity, dividends, shared fees, contracts, kickbacks or rebates from or through a participating provider or related entity. 55 Pa. Code § 1101.77(c). See also 55 Pa. Code § 1101.42(c).

The listing below sets forth some examples of types of items or services that are reimbursed by Medicaid which, when provided by excluded parties, are not payable:

- Services performed by excluded nurses, technicians, or other excluded individuals who work for a hospital, nursing home, home health agency or physician practice, where such services are related to administrative duties, preparation of surgical trays or review of treatment plans if such services are paid directly or indirectly (such as through a pay per service or a bundled payment) by a Medicaid program, even if the individuals do not furnish direct care to Medicaid recipients;
- Services performed by excluded pharmacists or other excluded individuals who input prescription information for pharmacy billing or who are involved in any way in filling prescriptions for drugs paid, directly or indirectly, by a Medicaid program;
- Services performed by excluded ambulance drivers, dispatchers and other employees involved in providing transportation paid by a Medicaid program, to hospital patients or nursing home residents;
- Services performed for program recipients by excluded individuals who sell, deliver or refill orders for medical devices or equipment paid by a Medicaid program;
- Services performed by excluded social workers who are employed by health care entities to provide services to Medicaid recipients, and whose services are paid, directly or indirectly, by a Medicaid program;
- Services performed by an excluded administrator, billing agent, accountant, claims processor or utilization reviewer that are related to and paid, directly or indirectly, by a Medicaid program;
- Items or services provided to a Medicaid recipient by an excluded individual who works for an entity that has a contractual agreement with, and is paid by, a Medicaid program; and
- Items or equipment sold by an excluded manufacturer or supplier, used in the care or treatment of recipients and paid, directly or indirectly, by a Medicaid program.

See 1999 HHS-OIG Special Advisory Bulletin: The Effect of Exclusion From Participation in Federal Health Care Programs: <http://oig.hhs.gov/fraud/docs/alertsandbulletins/effected.htm>

Civil monetary penalties may be imposed against Medicaid providers and managed care entities (including managed care organizations (MCOs), prepaid inpatient health plans, prepaid ambulatory health plans, and primary care case management (PCCM) plans) that employ or enter into contracts with excluded individuals or entities to provide items or services

to Medicaid recipients. Section 1128A(a)(6) of the Act [42 U.S.C.A. § 1320a-7a(a)(6)]³; and 42 CFR Section 1003.102(a)(2)⁴. The Federal civil monetary penalty is up to \$10,000 for each item or service. In addition, an assessment may be imposed of not more than three times the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim. Moreover, the person may be excluded from participation in Federal health care programs, including Pennsylvania's MA Program.

The HHS-OIG imposes exclusions under the authority of Sections 1128 and 1156 of the Social Security Act. The OIG maintains a list of all currently excluded parties called the List of Excluded Individuals/Entities (LEIE). The LEIE database, which is accessible to the general public and can be searched by the names of any individual or entity, provides information to the health care industry, patients and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid and all other Federal health care programs. Individuals and entities who have been reinstated are removed from the LEIE. The LEIE website is located at <http://www.oig.hhs.gov/fraud/exclusions.asp> and is available in two formats. The on-line search engine identifies currently excluded individuals or entities. When a match is identified, it is possible for the searcher to verify the accuracy of the match using a Social Security Number ("SSN") or Employer Identification Number ("EIN"). The downloadable version of the database may be compared against an existing database maintained by a provider. However, unlike the on-line format, the downloadable database does not contain SSNs or EINs.

Whereas the LEIE contains only exclusion actions taken by the HHS-OIG, the General Services Administration's ("GSA") Excluded Parties List System ("EPLS") contains debarment actions taken by various Federal agencies, including exclusion actions taken by the HHS-OIG. The EPLS may be accessed at: <http://epls.arnet.gov>

The Department also maintains an on-line listing called the "Medicheck List" that identifies providers, individuals, and other entities who are precluded from participation in the MA Program. The Medicheck List may be searched by provider name, license number,

³ Any person (including an organization, agency, or other entity...) that-- ... (6) arranges or contracts (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from participation in a Federal health care program (as defined in [42 U.S.C.A. § 1320a-7b(f)], for the provision of items or services for which payment may be made under such a program ... shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than \$10,000 for each item or service.... In addition, such a person shall be subject to an assessment of not more than 3 times the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim.... In addition the Secretary may make a determination in the same proceeding to exclude the person from participation in the Federal health care programs [] and to direct the appropriate State agency to exclude the person from participation in any State health care program.

⁴ (a) The OIG may impose a penalty and assessment against any person whom it determines in accordance with this part has knowingly presented, or caused to be presented, a claim which is for—

....
(2) An item or service for which the person knew, or should have known, that the claim was false or fraudulent, including a claim for any item or service furnished by an excluded individual employed by or otherwise under contract with that person;

business name, or by using the "Search by" pull-down menu; also available is a complete Medichcek List, sorted by provider last name. The Medichcek List may be accessed at: http://www.dpw.state.pa.us/learnaboutdpw/fraudandabuse/medichcekprecludedproviderslist/S_001152

DISCUSSION:

Under both State and Federal law, the Department and its MA MCOs are generally prohibited from paying for any items or services furnished, ordered, or prescribed by individuals or entities excluded from the MA Program as well as other Federal health care programs. Medicaid providers and managed care entities who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid recipients when those individuals or entities are excluded from participation in any Medicare, Medicaid, or other Federal health care programs are subject to termination of their enrollment in and exclusion from participation in the MA Program and all Federal health care programs, recoupment of overpayments, and imposition of civil monetary penalties.

The amount of the Medicaid overpayment for such items or services is the actual amount of Medicaid dollars that were expended for those items or services. When Medicaid funds have been expended to pay an excluded individual's salary, expenses, or fringe benefits, the amount of the overpayment is the amount of those expended Medicaid funds.

All employees, vendors, contractors, service providers, and referral sources whose functions are a necessary component of providing items and services to MA recipients, and who are involved in generating a claim to bill for services, or are paid by Medicaid (including salaries that are included on a cost report submitted to the Department), should be screened for exclusion before employing and/or contracting with them and, if hired, should be rescreened on an ongoing monthly basis to capture exclusions and reinstatements that have occurred since the last search. Examples of individuals or entities that providers should screen for exclusion include, but are not limited to:

- Individual or entity who provides a service for which a claim is submitted to Medicaid;
- Individual or entity who causes a claim to be generated to Medicaid;
- Individual or entity whose income derives all, or in part, directly or indirectly, from Medicaid funds;
- Independent contractors if they are billing for Medicaid services;
- Referral sources, such as providers who send a Medicaid recipient to another provider for additional services or second opinion related to medical condition.

PROCEDURE:

In order to protect the MA Program against payments for items or services furnished, ordered, or prescribed by excluded individuals or entities; to establish sound compliance practices, and to prevent potential monetary and other sanctions, providers should:

1. Develop policies and procedures for screening of all employees and contractors (both individuals and entities), at time of hire or contracting; and, thereafter, on an ongoing monthly basis to determine if they have been excluded from participation in federal health care programs;
2. Use the following databases to determine exclusion status;
 - a. ***Pennsylvania Mediceck List***: a data base maintained by the Department that identifies providers, individuals, and other entities that are precluded from participation in Pennsylvania's MA Program:
http://www.dpw.state.pa.us/learnaboutdpw/fraudandabuse/mediceckprecludedproviderslist/S_001152

If an individual's resume indicates that he/she has worked in another state, providers should also check that state's individual list.

- b. ***List of Excluded Individuals/Entities (LEIE)***: data base maintained by HHS-OIG that identifies individuals or entities that have been excluded nationwide from participation in any federal health care program. An individual or entity included on the LEIE is ineligible to participate, either directly or indirectly, in the MA Program. Although the Department makes best efforts to include on the Mediceck List all federally excluded individuals/entities that practice in Pennsylvania, providers must also use the LEIE to ensure that the individual/entity is eligible to participate in the MA Program:
<http://oig.hhs.gov/fraud/exclusions.asp>.
 - c. ***Excluded Parties List System (EPLS)***: World wide data base maintained by the General Services Administration (GSA) that provides information about parties that are excluded from receiving Federal contracts, certain subcontracts, and certain Federal financial and nonfinancial assistance and benefits:
<https://www.epls.gov/>.
3. Immediately self report any discovered exclusion of an employee or contractor, either an individual or entity, to the Bureau of Program Integrity;
 - via e-mail through the MA Provider Compliance form at the following link:
<http://www.dpw.state.pa.us/learnaboutdpw/fraudandabuse/maprovidercompliancehotlinerresponseform/index.htm>.

- by U.S. mail at the following address:

Bureau of Program Integrity
Commonwealth of Pennsylvania
P.O. Box 2675
Harrisburg, PA 17105-2675

or

- by fax at: 1-717-772-4655 or 1-717-772-4638
4. Develop and maintain auditable documentation of screening efforts, including dates the screenings were performed and the source data checked and its date of most recent update; and
 5. Periodically conduct self-audits to determine compliance with this requirement.