Advisory
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Billing Federal Health Care Programs for Excluded Individuals and Entities is a Government Enforcement Priority

At a recent Health Care Roundtable sponsored by Wiggin and Dana LLP, Assistant United States Attorney Richard M. Molot advised attendees that "exclusion billing" is now a government enforcement priority. Exclusion billing is the unlawful practice of billing Medicare, Medicaid, and other federal health care programs for services provided by individuals or entities, including employees or contractors, that are excluded from participation in federal health care programs.

The Balanced Budget Act of 1997 authorized the OIG to impose civil monetary penalties on anyone that employs or contracts with excluded individuals or entities to provide services or supplies that are reimbursed by federal health care programs. Penalties for exclusion billing can include fines of up to $10,000 for each billed item or service furnished by the excluded individual or entity, recoupment of reimbursement received for such services, civil monetary penalties of up to three times the amount of the claims submitted, and program exclusion. AUSA Molot announced that there has been an uptick in such investigations, many of which are brought to the government's attention by whistleblowers.

This advisory explains the legal requirements pertaining to exclusion and discusses recent examples of government investigations and civil settlements. Finally, it presents practical tips for avoiding compliance problems.

WHO ARE EXCLUDED INDIVIDUALS AND ENTITIES?

Under federal law, no payment under any federal health care program may be made for items or services furnished by an excluded individual or entity.[1] Individuals and entities may become excluded from participation in federal health care programs for a variety of reasons, including fraud, theft, embezzlement, breach of fiduciary responsibility, financial misconduct, unlawful kickbacks, or interference or obstruction of a criminal investigation.[2] Exclusion is mandatory under certain circumstances, such as upon conviction of a criminal offense related to the delivery of an item or service under Medicare or of a felony relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance.[3] In addition to those circumstances where exclusion is mandated, the OIG has sweeping authority to order permissive exclusion in a variety of circumstances.[4]

While a common basis for exclusion is the submission of false or improper claims to Medicare or Medicaid, exclusion need not result from billing misconduct or even from misconduct in the health care setting. For example, the OIG has the permissive power to exclude any individual or entity upon the suspension or revocation of a license to provide health care for reasons bearing on the individual's or the entity's professional competence, professional performance or financial integrity.[5] Additionally, exclusion can be imposed when an individual or entity is

sanctioned by a federal or state health care program.[6] Even maintaining certain types of direct or indirect ownership or control interests of excluded entities may provide a basis for exclusion.[7] These few examples illustrate the diverse grounds for exclusions and the concomitant difficulty a health care provider may encounter in discovering that it employs or contracts with an excluded party.

HOW CAN EXCLUDED INDIVIDUALS AND ENTITIES AFFECT YOU?

You should not employ or contract with excluded individuals and entities, since they are prohibited from participating in federal health care programs, and doing so violates Medicare and Medicaid provider agreements. In addition, you cannot submit claims for any items or services furnished by excluded individuals and entities to federal health care programs.[8]

This prohibition applies to all methods of federal health care program reimbursement, including fee for service claims, prospective payment system (PPS) payments, and the submission of costs on Medicare and Medicaid cost reports. Moreover, the prohibition extends beyond direct patient care services to include administrative, clerical, and management services. Any individual or entity submitting claims or reporting costs to any federal health care program has an affirmative duty to ensure that all employees or contractors providing services encompassed in those claims or costs are not excluded.[9]

RECENT ENFORCEMENT

In order to assess civil monetary penalties, the government must find that the billing party knew, or should have known, about the exclusion.[10] In addition to using the OIG's civil monetary penalty authority as a basis for enforcement, the government also investigates exclusion billing for potential False Claims Act liability, which would follow a similar analysis.[11]

At the Wiggin and Dana Health Care Roundtable, AUSA Molot discussed a recent False Claims Act settlement for exclusion billing. The settlement involved Walnut Hill Care Center, a skilled nursing facility based in New Britain, Connecticut. In 2005, Walnut Hill had hired a nursing supervisor without first ensuring that she was not excluded. The facility later learned that she had been excluded from Medicare and Medicaid after her license was revoked in Florida. Although Walnut Hill terminated the nursing supervisor as soon as it learned that her license in Connecticut was being revoked, the facility had already received reimbursement covering services that the she had provided. After a lengthy government investigation conducted by the United States Attorneys Office for the District of Connecticut in conjunction with the OIG, Walnut Hill entered into a civil settlement with the government on November 7, 2008. Under the settlement agreement, Walnut Hill agreed to pay $222,419 without admitting liability to settle alleged False Claims Act violations. This amount was calculated by doubling damages based on the portion of the nursing supervisor's salary attributable to federal health care programs. In addition, Walnut Hill entered into a Certification of Compliance Agreement ("CCA") with the OIG, which contains provisions regarding screening for excluded individuals and entities.

More recently, on January 8, 2009, the United States Attorneys Office for the District of Connecticut announced

another exclusion-related settlement with Silver Hill Hospital, a psychiatric hospital in New Canaan, Connecticut. In 2004, Silver Hill hired a full-time registered nurse whose license to practice in Connecticut had recently been reinstated. However, the nurse had neglected to be reinstated to the Medicare and Medicaid programs, and Silver Hill allegedly failed to check the OIG's exclusion database, where she was still listed as an excluded provider. Silver Hill employed her for four years before the facility learned that she was excluded. Without admitting liability, Silver Hill agreed to settle False Claims Act allegations and to pay $60,338.49, including double damages, and similarly agreed to enter into a CCA. As with in the Walnut Hill matter, the base damages amount was based on the portion of the nurse's salary attributable to federal health care programs.

WHAT CAN YOU DO?

Although anyone that submits claims to federal health care programs is at risk of mistakenly billing for services or supplies furnished by excluded individuals or entities, there are simple compliance steps that you can take to mitigate this risk:

- **Check government exclusion data bases for all prospective employees and contractors.** Your organization's corporate compliance program should contain a policy and procedures addressing exclusion. The policy should require that all prospective employees and outside contractors be screened against the OIG's List of Excluded Individuals or Entities, (LEIE), available at http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp and the U.S. General Services Administration's Excluded Parties List System, available at https://www.epls.gov/. The Connecticut Department of Social Services also requires that prospective employees and outside contractors be screened against the state Administrative Action List, available at http://www.ct.gov/dss/cwp/view.asp?a=2349&q=310706.
- **Develop a policy and practice for regular exclusion updates.** In addition to checking these databases upon hire or prior to entering into a contract, providers should check the databases on a regular basis to determine whether current employees or contractors have been excluded. These checks are important because the databases are continually updated and because employees may be excluded for reasons that would not be obvious to an employer. The OIG has not made any formal recommendation regarding how frequently providers should conduct these checks. Government officials have indicated informally that screening should occur systematically at least annually, although some providers conduct checks more frequently than once a year. Regardless of whether you choose to conduct checks annually or more frequently, you should decide on a time frame, incorporate it into policy and make sure that you follow the policy.
- **Train human resources personnel.** The OIG recommends implementation of written policies and procedures for training human resources personnel on exclusion regulations.[12]
- **Address exclusion in contracts.** We think it is also prudent to include the following provisions in all agreements with outside contractors: (1) contractor's representation that neither the entity nor any of its employees are excluded and that periodic exclusion checks are performed to ensure continued compliance; (2) contractor's responsibility to notify you if the contractor or any of its employees are excluded; and (3) your right to immediate termination in the event the contracting entity is excluded.
- **Take immediate corrective action if an employee or contractor appears on the exclusion list.** Once an individual or entity appears on these public lists, the government imputes knowledge of that individual's or entity's excluded status to anyone submitting claims to a federal health care program. In other words, providers will be considered to have known that the individual or entity was excluded, and, therefore, could be found liable for civil monetary penalties, treble damages, and even exclusion. While the compliance steps outlined above should help you screen out most excluded individuals, situations can arise where an individual's exclusion appears in the databases between periodic checks, or claims for services by the individual or entity are submitted before the exclusion is discovered. If you discover an excluded individual or entity, do not panic. There are many complex rules regarding calculating when exclusion takes effect and how long after that date claims may still be processed. It is best to consult with counsel in these cases. In most circumstances, an internal investigation followed by self-disclosure to the government is the recommended course. Presenting the government with documentation of employee and contractor screens and periodic checks will be extremely valuable when alerting and negotiating with the government.

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Although there are many risks associated with exclusion billing, it is an area where achieving and documenting compliance is relatively simple and inexpensive. If you have further questions or would like additional information, please contact Maureen Weaver, at 203.468.4384 or mweaver@wiggin.com; James Glasser, at 203.498.4313 or jglasser@wiggin.com, or Joseph Martini, at 203.498.4310 or jmartini@wiggin.com, or Patrick Egan, at 215.988.8315, or pegan@wiggin.com.

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[1] 42 CFR §1001.1901. 42 CFR § 1001.2 states that:

> Exclusion means that items or services furnished, ordered or prescribed by a specified individual or entity will not be reimbursed under Medicare, Medicaid and all other Federal health care programs until the individual or entity is reinstated by the OIG.
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> Federal health care program means any plan or program providing health care benefits, whether directly through insurance or otherwise, that is funded, directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program), or any State health care program as defined in this section.
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> . . . State health care program means: (a) A state plan approved under title XIX of the Act (Medicaid), (b) Any program receiving funds under title V of the Act or from an allotment to a State under such title (Maternal and Child Health Services Block Grant Program), or (c) Any program receiving funds under title XX of the Act or from any allotment to a State under such title (Block Grants to States for Social Services).

[2] 42 USC §1320a-7; 42 CFR §1001.101 et seq. See also, http://www.oig.hhs.gov/fraud/exclusions/authorities.asp.

[3] 42 USC §1320a-7(a)(4); 42 CFR §1001.101(d). The OIG has permissive authority to exclude these individuals for a misdemeanor conviction relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance. 42 USC §1320a-7(b)(3); 42 CFR §1001.401.

[4] 42 USC §1320a-7(b); 42 CFR §1001.201 et seq.

[5] 42 USC §1320a-7(b)(4); 42 CFR §1001.501(a).

[6] 42 USC §1320a-7(b)(5); 42 CFR §1001.601(a).

[7] 42 USC §1320a-7(b)(8); 42 USC §1320a-7(b)(15); 42 CFR §1001.1001(a); 42 CFR §101.1051(a).

[8] 42 CFR §1001.1901(b).

[9] See the OIG's Special Advisory Bulletin, "The Effect of Exclusion from Participation in Federal Health Care Programs," available at http://oig.hhs.gov/fraud/docs/alertsandbulletins/effected.htm.

[10] 42 USC §1320a-7a(a)(6).

[11] 31 USC §3129 et seq.

[12] OIG Supplemental Compliance Program Guidance for Nursing Facilties, September 30, 2008, at 73 Fed. Reg. 56832, 56840 (September 30, 2008).