DON'T FORGET TO CHECK (AND RE-CHECK)

THE MEDICARE EXCLUSION STATUS OF EMPLOYEES AND CONTRACTORS

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THERE IS ONE mandatory element of a medical practice's compliance program that is easily done but that can also be easily missed: checking the Medicare exclusionary status of employees and contractors. Federal health care programs may not pay, directly or indirectly, for items or services that are furnished, ordered or prescribed by individuals or entities that have been excluded from participation in Medicare.

As part of the enactment of the HIPAA statute in 1996 and the Balanced Budget Act of 1997, penalties and assessments may be imposed against a health care provider that employs or enters into a contract with a person or entity that is excluded from Medicare to provide items or services for which payment is made under a Federal health care program. Individual and entity names can be checked on the Office of Inspector General's (OIG) Medicare Exclusions Database at https://exclusions.oig.hhs.gov.

This compliance risk is real and is a well-defined area of health care law. A person either is or is not excluded from Medicare. If the person is excluded, a provider cannot employ (or if the exclusion happens post-employment, continue to employ) that person to provide items or services for which Medicare makes a payment.

This prohibition goes beyond direct patient care services. For example, indirect patient care services, such as preparation of surgical trays or review of treatment plans, are also prohibited regardless of whether the service is separately billed or reimbursed in a bundled payment. Additionally, excluded persons cannot provide management services such as being an officer, director or manager, nor can they provide administrative services such as health information technology, billing and accounting, staff training, and human resources.

If a provider discovers that one of its employees or contractors is excluded from Medicare, it needs to self-disclose to the OIG within 60 days using the OIG's Provider Self-Disclosure Protocol. If the excluded person is a direct provider (such as a physician) and the items or services by said person were separately billed to a Federal health care program, then repayment will consist of the total amounts that were paid for those items or services. For items or services not separately billed, the OIG uses a formula to determine the amount to be returned. The formula considers the disclosing party's total cost of employment or contracting related to the excluded party multiplied by the Federal health care program payor mix for the relevant time period.

Timely disclosure is important. Failure to do so subjects the provider to False Claims Act liability and imposition of a Civil Monetary Penalty of more than $20,000 for each Medicare item or service furnished by an excluded individual, plus an assessment of three times the amount claimed, and program exclusion.

An effective compliance plan should address the process and frequency of checking the Medicare exclusion status of employees and contractors. A provider should review each job category and contractual relationship to determine if the item or service being provided is reimbursed, directly or indirectly, in whole or in part, by a Federal health care program. Best practice is to simply check all new employees and contractors. Also, each employee and contractor needs to be periodically re-checked for any changes to their exclusionary status, which CMS recommends be done on a monthly basis.

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