OIG Issues Updated Advisory Bulletin on Excluded Persons

By Ruth E. Granfors

On May 8, 2013 the Office of Inspector General for the United States Health and Human Services Department (“OIG”) issued an updated Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs (“Updated Bulletin”), which replaces the September 1999 Special Advisory Bulletin (the “1999 Bulletin”) on the same topic. The Updated Bulletin addresses certain questions and provides some clarification based on the more than 10 year experience since the 1999 Bulletin was issued.

The 1999 Bulletin

The 1999 Bulletin addressed the statutory evolution of the prohibition on submission of claims to a Federal health care program for services or items provided by an individual or entity that has been excluded from a Federal health care program as defined in the Social Security Act. It explained the impact on the excluded individual or entity, the impact on health care providers who employ or contract with such excluded individuals and entities, and the related penalties and liabilities for billing for services provided by such individuals and entities. It also provided guidance on how providers should determine if an individual or entity is excluded through the OIG’s List of Excluded Individuals/Entities (“LEIE”). In addition to nonpayment of claims, an excluded individual or entity and a provider who employs or contracts with an excluded individual or entity are subject to civil monetary penalties for violation of the prohibition.

The Updated Bulletin

The Updated Bulletin provides guidance based on the experience of implementing the 1999 Bulletin over the past 14 years. Since the 1999 Bulletin, the OIG has operated under expanded statutory authority for mandatory and permissive exclusions and waiver exclusion authority. The Updated Bulletin addresses, among other things: (1) the breadth of the nonpayment prohibition, (2) limitations on allowable activities of an excluded individual, and (3) the obligation of providers to screen for excluded individuals and entities.

The Breadth of the Nonpayment Prohibition

The Updated Bulletin reiterates the basic prohibition that no Federal health care payment may be made, directly or indirectly, for an item or service provided by an excluded individual or entity or at the direction or under the prescription of an excluded individual. That includes services or items provided by a licensed health care practitioner who after exclusion provides services in a different capacity or under a separate license or certification. For example, an excluded nurse may not be

1 42 U.S.C. § 1320a-7c. The primary affected programs are Medicare, Medicaid, Tricare and Veterans health care programs. The federal employee benefit program is not within the definition of Federal health care program.

2 The Updated Bulletin explains that the term “provider” is used broadly to include “providers, suppliers, manufacturers, and any other individual or entity, including a drug plan sponsor or managed care entity, that directly or indirectly furnishes, arranges or pays for items or services.”
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employed or under contract or subcontract as a nursing aide in a facility that provides services or items reimbursable by a Federal health care program.

In addition, an excluded individual may not provide management or administrative services for a provider that furnishes items or services payable by a Federal health care program. This prohibition applies even when the item or service payment does not take into account the cost of such administrative services, e.g., through submission of a cost report. A provider that bills for services based on a fee schedule may not employ an excluded individual in an executive or leadership role, or in an administrative role, such as in health information technology, strategic planning, billing and accounting or human resources, if such services are reimbursed indirectly through a Federal health care program.

Limitations on Allowable Activities by an Excluded Individual or Entity

The Updated Bulletin also provides guidance “regarding the circumstances under which an excluded person may be employed by, or contract with, a provider that receives payments from Federal health care programs.” The clarification states that an excluded individual may be employed or under contract to provide items and services not paid, directly or indirectly, by a Federal health care program. In other words, if the services are provided for a person who is not a Federal health care program beneficiary, then the payment prohibition is not applicable. The Updated Bulletin states that in this situation, “A provider need not maintain a separate account from which to pay an excluded person, as long as no claims are submitted to or payment is received from Federal health care programs for items or services that the excluded person provides and such items and services relate solely to non-Federal health care program patients.”

The OIG clarifies that although there is no statutory prohibition against ownership of a provider by an excluded person, “there are several risks to such ownership.” In essence, ownership of a provider by an excluded individual should be less than a five percent interest, and the excluded owner should have no involvement in administration or management of the provider. Otherwise, both the provider and the owner risk liability for claims submitted by the provider.

Provider’s Obligation to Screen Employees, Contractors and Subcontractors

The Updated Bulletin suggests that in addition to screening all new employees, contractors and subcontractors, providers should perform monthly screening of all subject individuals and entities, as the LEIE is updated.

The OIG takes the position that providers are obligated to screen not only their own employees and the entities with which they contract and subcontract, but also employees of contractors and subcontractors. The Updated Bulletin states:

OIG recommends that to determine which persons should be screened against the LEIE, the provider 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. If the answer is yes, then the best mechanism for limiting CMP [Civil Monetary Penalty] liability is to screen all persons that perform under that contract or that are in that job category.
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Providers should determine whether or not to screen contractors, subcontractors and the employees of contractors using the same analysis that they would for their own employees.

If the screening function is performed by a third party, the provider retains liability to the government for ensuring that no excluded individuals or entities provide services or items that are directly or indirectly payable by a Federal health care program.

**Conclusion**

The “devil is in the details” is an apt expression here. Since the OIG applies the Updated Bulletin to all health care providers, as well as suppliers, manufacturers and health plans, what is expected and what is permissible will depend on the facts, the type of provider, and the items, services and programs in which the provider is engaged. While the Updated Bulletin provides some greater detail on the OIG’s analysis and recommendations related to the exclusion rules, there are still gray areas. For example, may an excluded individual hold any administrative position, regardless of level of responsibility, in a health care provider that submits claims to Federal health care programs? Recognizing that there remain areas of uncertainty, the Updated Bulletin indicates that a question about employing or entering into a contract with an excluded person in a specific capacity may be submitted to the OIG using the Advisory Opinion Process. Unfortunately, this process is not set up to provide a timely answer. Additionally, although the Updated Bulletin purports to answer the question on how to disclose a violation, there is no nuance in the answer, distinguishing, for example, between a major screening failure involving thousands of submitted claims and a discovery that a contracted nurse was recently excluded, involving a minimal amount of claims. No doubt additional interpretation will be revealed over the next ten years.

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3. See, e.g., OIG Advisory Opinion 03-1 (January 13, 2003), involving the proposed employment of an excluded physician by a data service company that sells products to hospitals and radiology clinics that are reimbursable by Federal health care programs.

4. The answer is that providers should use the April 2013 OIG Provider Self-Disclosure Protocol, at 9-10.
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Author:
Ruth E. Granfors
ruth.granfors@klgates.com
+1.717.231.5835

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