Do Your Monthly Checks to Avoid Fines and Risk of Exclusion from Federal Health Care Programs

Client Advisories

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Healthcare facilities are urged to remember to perform regular checks of both state and federal lists of excluded individuals and entities – i.e. persons or organizations who are prohibited from participating in federal and state health care programs – to ensure that their employees, independent contractors and vendors are not on such lists. As a general rule, federal health care programs such as Medicare will not pay for items or services which are furnished, ordered, prescribed, or supplied, whether directly or indirectly, by an individual or entity (i.e. a "Person") who has been excluded from participation in that federal health care program. If a healthcare entity employs or engages an excluded Person and then bills a federal health care program for any items or services the excluded Person directly or indirectly furnished, ordered, or prescribed, it may also be subject to Civil Monetary Penalties ("CMP") liability under the False Claims Act ("FCA").

It is important to note that the prohibition on services is broadly defined so as to include not only direct care, but also indirect services such as filling prescriptions, providing transportation services, and performing administrative and management services that are not separately billable. While OIG guidance does permit entities to employ/engage an excluded Person who does not provide any items or services paid for, directly or indirectly, by federal health care programs, doing so requires significant caution and a strict curtailing of their roles and responsibilities to ensure protection from future liabilities. While the regulations concerning exclusions have existed for almost fifty years, it is clear that they remain an important area of enforcement. Since 2023, the federal Office of Inspector General has issued over $2.5 million in CMPs to healthcare entities who have employed an excluded individual.

In addition to the federal requirements surrounding excluded individuals, many states have not only adopted versions of the federal exclusion requirements, but have created their own exclusion criteria and penalties

associated with employing an excluded individual. For this reason, participating providers should consult not only the federal guidance on exclusion checks, but also their state requirements.

Best Practices to Ensure Compliance

The responsibility of remaining compliant with state and federal exclusion provisions falls to the billing healthcare provider/ facility. The easiest method to ensure compliance is to maintain a robust compliance program within the entity through the development of policies and procedures that mandate routine checks of all employees and vendors against state and federal exclusion lists. Entities should also maintain records of these completed checks. Because the applicable lists are generally updated every thirty (30) days, it is recommended that entities perform checks upon engagement or employment, as well as every thirty (30) days thereafter.

For healthcare providers in New Jersey, we recommend a monthly review of the following databases:

1. Federal exclusions database
https://exclusions.oig.hhs.gov/

2. Federal exclusions and licensure database
https://www.npdb.hrsa.gov/hcorg/pds.jsp

3. Federal List of Excluded Individuals/ Entities (LEIE)
http://exclusions.oig.hhs.gov/

4. Federal System for Award Management
https://www.sam.gov/

5. N.J. Treasurer's exclusions database
http://www.state.nj.us/treasury/revenue/debarment/debarsearch.shtml

6. N.J. Division of Consumer Affairs licensure databases (if applicable)
http://www.njconsumeraffairs.gov/Pages/verification.aspx2

7. State of New Jersey debarment list
https://nj.gov/comptroller/doc/nj_debarment_list.pdf

8. N.J. Department of Health licensure and certification database, including: Nursing Home Administrators, Certified Assisted Living Administrators, Certified Nurse Aides/Personal Care Assistants, and Certified Medication Aides (mandatory, if applicable)
https://njna.psiexams.com/

Healthcare providers who are enrolled in the Medicaid program in New Jersey and have received over five million dollars ($5,000,000) in annual Medicaid payments from New Jersey are also subject to the requirements of Section 6032 of the Federal Deficit Reduction Act of 2005, which requires providers to take steps to prevent and detect fraud, waste, and abuse in the Medicaid program. Under Section 6032, providers are required to maintain a compliance program and educate their employees, contractors, and subcontractors on how to detect and prevent fraud, waste, and abuse. Routine exclusion checks of employees, contractors, and subcontractors is also required. The New Jersey Office of the State Comptroller requires all providers subject to these requirements to submit annual certifications of compliance, and in some circumstances, may require the submission of supporting documentation.

For additional guidance related to your entity's compliance program, the implementation of routine exclusion checks, and how to manage results of an exclusion check or related state or federal action, please contact Lisa Albright at lalbright@archerlaw.com or 609-580-3710 or Shloka Joshi at sjoshi@archerlaw.com or 267-817-9248.

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