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UPDATE
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CMS PROPOSES CHANGES TO INCENTIVE REWARD PROGRAM AND PROVIDER ENROLLMENT PROVISIONS

The Centers for Medicare & Medicaid Services (CMS) recently issued a proposed rule (Proposed Rule) significantly increasing the reward given to Medicare fraud whistleblowers and providing CMS with enhanced authority to deny enrollment privileges to providers posing a higher risk of fraud to the Medicare program. The Proposed Rule is available here.

Incentive Reward Program

The existing Incentive Reward Program (IRP) encourages the reporting of potential Medicare fraud. Individuals who provide CMS with specific information regarding fraudulent activities not already under review or investigation by CMS or another government agency receive a financial reward if the information leads to the recovery of Medicare funds. Currently, financial rewards to individuals under the IRP are capped at $1,000. CMS proposes to increase the potential reward to 15 percent of the final amount collected, up to the first $66 million recovered. The agency believes that the increased financial rewards will motivate more individuals to report suspicious activity, act as a deterrent to fraudulent conduct, and lead to higher recovered amounts by CMS.

CMS clarified in the Proposed Rule that individuals who file a claim under the federal or any state False Claims Act (FCA) are not eligible for an IRP reward. Additionally, individuals may not receive an IRP financial reward if they are eligible for a reward for furnishing similar information to the federal government under any other federal reward program or other federal law.

Provider Enrollment Provisions

Currently, CMS has the authority to deny or revoke Medicare enrollment for certain high-risk providers and suppliers. The agency proposes to revise Medicare provider enrollment provisions for certain providers posing a heightened risk of fraud. Some of the proposed changes include adding new provisions that allow it to do the following:

- Deny Medicare enrollment if a provider or supplier has a current Medicare debt or has a prior relationship with an entity that had an unpaid Medicare debt. Current regulations allow CMS to deny enrollment if the owner, physician, or nonphysician practitioner has an existing overpayment at the time of the application. To include all forms of debt to Medicare, CMS proposes to replace the term "overpayment" with "Medicare debt." In addition, CMS proposes to expand the regulation to apply to all providers and suppliers, regardless of type. A denial of enrollment may be avoided if the enrolling provider, supplier, or owner agrees to a repayment schedule or pays the debt in full.
- Deny or revoke enrollment or billing privileges if a provider, supplier, owner, or managing employee of the provider or supplier (for example, director or business manager) was convicted of certain felony offenses within the previous ten years.
- Revoke Medicare billing privileges from providers and suppliers that engage in a pattern or practice of improper billing for Medicare services, such as where a significant number of a provider's claims are denied for failing to meet medical necessity requirements. The current regulations limit CMS's right to revoke to situations involving improper billing for individual claims.

CMS is soliciting comments on the Proposed Rule, which must be submitted to CMS by 5:00 p.m. on June 28, 2013. Please contact a member of Robinson & Cole's Health Law Group if you would like assistance in preparing comments for submission to CMS or have any questions regarding the Proposed Rule.

OIG UPDATES SPECIAL ADVISORY BULLETIN REGARDING EFFECT OF EXCLUSION FROM PARTICIPATION IN FEDERAL HEALTH CARE PROGRAMS

The Department of Health and Human Services, Office of Inspector General (OIG), recently published an updated Special Advisory Bulletin (Updated Bulletin). The Updated Bulletin describes the scope and effect of OIG exclusion and provides guidance to health care providers regarding best practices for screening employees and contractors to determine whether they are excluded persons.

The Updated Bulletin replaces and supersedes the Special Advisory Bulletin originally issued by the OIG in 1999 (1999 Bulletin). Various statutory changes since the issuance of the 1999 Bulletin have strengthened and enhanced the OIG's authority concerning exclusions. The Updated Bulletin incorporates the statutory changes and provides clarification on a number of issues that have arisen since publication of the 1999 Bulletin.

Exclusion from Federal Health Care Programs

The Social Security Act (Act) authorizes the OIG to exclude individuals and entities from participation in federal health care programs where such individuals or entities have engaged

in certain forms of misconduct. The OIG has both mandatory and permissive exclusion authority, based on the nature of the offense.

Federally funded health care programs cannot pay for items or services (1) furnished by an excluded individual or entity (Excluded Person) or (2) directed or prescribed by an Excluded Person. The scope of the payment prohibition is very broad and includes activities outside of the direct provision of patient care, such as administrative and management services payable by federal health care programs and services performed by excluded individuals relating to treatment plan review.

Violation and Penalties

Any Excluded Person that submits a claim for payment to a federal health care program is subject to civil monetary penalties and may be held criminally liable. In addition, the OIG may impose civil monetary penalties on health care providers that employ or contract with Excluded Persons to provide items or services, directly or indirectly, payable by federal health care programs when such providers know or should know that the Excluded Persons have been excluded by the OIG. The OIG may impose civil monetary penalties of up to $10,000 for each item or service furnished by the Excluded Person, treble damages, and program exclusion. The Updated Bulletin provides that health care providers may be held liable when an Excluded Person participates in any way in furnishing items or services payable by a federal health care program, including where (1) an Excluded Person provides patient care or administrative or management services to the provider or (2) the provider furnishes items or services at the medical direction of, or on the prescription of, an Excluded Person. Liability may result even if the Excluded Person does not receive payment from the provider for services rendered (for example, where a nonemployed excluded physician volunteers at a hospital). Additionally, the OIG has permissive authority to exclude any health care provider owned in part (5 percent or more) by an Excluded Person.

The Updated Bulletin clarifies that a health care provider may employ or contract with an Excluded Person only if no federal health care program pays for the items or services provided by the Excluded Person or if the Excluded Person is hired or contracted solely to furnish items or services to nonfederal health care program beneficiaries.

Best Practices for Screening Employees and Contractors

Because of the potential ramifications of hiring or contracting with an Excluded Person, it is important that health care providers periodically screen potential and current employees and contractors to determine whether an individual or entity is excluded. Although providers may opt to check other databases, the OIG urges health care providers to use the OIG's List of Excluded Individuals and Entities (LEIE) as the primary source of information for purposes of exclusion screening for current and potential employees and contractors. The OIG recommends that providers (1) check the LEIE prior to employing or contracting with any individual or entity, and thereafter on a monthly basis, and (2) maintain some documentation regarding the provider's LEIE screening process. To determine which individuals and entities to screen, the OIG suggests that providers review each job category or contractual relationship to determine whether the item(s) or service(s) being provided is directly or indirectly payable by a federal health care program. If it is, the OIG recommends screening all individuals or entities that perform under that contract or are in that job category. While no requirement specifies that the LEIE be checked monthly, OIG encourages regularly checking the list, which is updated monthly.

The OIG further recommends that providers screen contractors, subcontractors, and employees of contractors, using the same analysis that they would for their own employees. Providers may, however, rely on screening conducted by a contractor. In such cases, the OIG recommends that the provider validate such screening. Providers should also obtain written verification of screening conducted by contractors. The OIG also suggests that providers screen more closely those persons involved with providing patient care. For example, the OIG specifically recommends screening nurses provided by staffing agencies, physician groups that contract with hospitals to provide emergency room coverage, and billing or coding contractors.

The Updated Bulletin states that health care providers that identify potential civil monetary penalty liability on the basis of employing or contracting with an Excluded Person may use the OIG's Provider Self-Disclosure Protocol to disclose and resolve the potential liability.

Health care providers are encouraged to properly screen potential and current employees and contractors for OIG exclusion; failure to do so can lead to significant fines, penalties, and program exclusion.

If you have any questions about either the CMS proposed changes or the OIG updates, please contact a member of Robinson & Cole's Health Law Group.

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