

BACKGROUND SCREENING IN THE HEALTHCARE INDUSTRY

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Introduction:

Healthcare organizations such as hospitals, nursing homes, medical equipment suppliers, lab services, staffing companies, pharmacies, and any business that interacts with Medicare and Medicaid have particular concerns when conducting background screening of its providers, employees, and vendors. This is due to regulations that when not strictly adhered to can result in fines, withholding of payments, and suspension of licenses, and negative press.

The Health Insurance Portability and Accountability Act:

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) required the Secretary of the Department of Health and Human (DHHS), acting through the Office of Inspector General (OIG) and the United States Attorney General to establish a new program to combat healthcare fraud and abuse. Among the major steps in this program was the establishment of a national data bank referred to as the Healthcare Integrity and Protection Data Bank (HIPDB) to receive and disclose certain final adverse actions against healthcare providers, employees and vendors.

The HIPDB helped the DHHS-OIG ensure that healthcare organizations not employ or contract with excluded individual or entities. It gave the DHHS-OIG a software tool and the option to enforcement authority. In July of 1999 the Federal Register detailed the Civil Monetary Penalties (CMP's) for those healthcare organizations that fail to disclose adverse actions against providers, employees, and vendors to the HIPDB.

Specifically, the Federal Register indicated that the DHHS-OIG has authority to impose CMP's against entities that submit, or cause to be submitted, claims for healthcare services rendered by employees or other individuals under contract whom they know, or should know, have been excluded from participation in the federal healthcare programs. These penalties can potentially amount to as much as \$10,000 per infraction.

Three infractions of the proposed rule can also lead to permanent exclusion from the Medicare and Medicaid programs. In addition, the DHHS-OIG may impose an assessment of not more than three times the amount claimed for each item or service, which was the basis for the penalty.

HIPPA also enacted standards for electronic health information transactions, including claims, enrollment, eligibility, payment, and coordination of benefits. These standards address security of the systems and place a heavy emphasis on protecting a patient's right to privacy.

Exclusion from Participation in Federal Healthcare Programs:

In September of 1999 the DHHS-OIG released a Special Advisory Bulletin concerning "The Effect of Exclusion from Participation in Federal Healthcare Programs". This document provided a more detailed explanation of when services rendered by an excluded provider are not reimbursable.

The Bulletin made clear that federal funds were not to be paid to excluded individuals and entities directly involved with patient care and that Civil Monetary Penalties (CMPs) could be imposed for using federal funds for excluded providers that were *indirectly* involved in patient care. It further stated, "*No federal program payment may be made to cover an excluded individual's salary, expenses or fringe benefits, regardless of whether they provide direct patient care.*"

In November of 1998 the DHHS-OIG outlined the basis for compliance in terms of the rules and regulations for participation in Medicare, Medicaid and other federal funded healthcare programs.

In January of 2005 the DHHS-OIG issued a supplement to its voluntary compliance program guidance for hospitals noting among the factors a hospital may wish to consider when evaluating the manner it responds to detected deficiencies and recommended addressing the question:

“Are employees, contractors, medical and clinical staff members checked routinely (e.g., at least annually) against government sanctions lists, including the Office of Inspector General’s, (OIG), List of Excluded Individuals/Entities (LEIE) and the General Services Administration’s, (GSA), Excluded Parties Listing System (EPLS)?”

This clearly put the burden on healthcare organizations to be aware of excluded providers among its providers, employees and vendors due to potential CMPs as well as the possibility of the organization being excluded from participation in federal healthcare programs.

In addition healthcare organizations may be the subject of adverse actions not taken by the federal government but by state licensing agencies only. In these instances the adverse actions could cause an organization to suffer monetary penalties as well, not necessarily from the federal government but from criminal and civil suits.

Corporate Integrity Agreements:

Corporate Integrity Agreements (CIAs) is the process by which an organization settles allegations of fraud and abuse with the federal government. CIA’s are extremely costly usually in terms of millions of dollars as well as very time consuming. During the settlement process an organization must take steps to proactively address the components which caused them to get a CIA such as:

- Hiring a compliance officer and appointing a compliance committee
- Developing strict written standards and policies
- Implementing a comprehensive employee-training program
- Establishing a federal claims review process
- Installing an employee confidential disclosure hotline
- Restricting the employment of ineligible persons
- Submitting a variety of detailed regular reports to the DHHS-OIG

A list of current CIAs listed by company is available to the public on the DHHS-OIG’s website at <http://oig.hhs.gov/fraud/cia/index.html>.

What a Healthcare Background Check Should Include:

1. Criminal Record Searches, (Identity, Verification, SSN, and Address History)

This should encompass a search of federal, state, and county criminal records as well as the sexual offender registry. Verifying that the Social Security Number (SSN) is validly issued, to whom does the SSN belong, in which year and state the SSN was issued, and the current and other known or previous addresses to that SSN is key. The SSN verification process can reveal that the number belongs to another individual, has more than one name associated therewith, produces other aliases, including maiden and divorced names, is associated with fraud, is not a validly issued SSN, belongs to a deceased person, produces additional addresses not stated by the application/request form, or has other SSNs associated with that individual.

2. Federal Civil Records Search

This will apply to individuals sued in federal civil court may be involved in disputes with considerations greater than \$50,000, suits filed between parties residing in different states or an individual in violation of federal law such as Title VII, the Americans with Disabilities Act or the Fair Labor Standards Act.

3. State and County Civil Suits and Judgments and DMV Records

All records pertaining to civil suits filed by or against the individual and department of motor vehicle report should be reviewed. These records can be obtained through county and state clerks of court.

4. Consumer Credit Report

A thorough analysis of an individual's credit history should be conducted. This written history may provide information such as places of employment or prior addresses, credit account types, terms, amounts past due, loan types, balances, public records, high credit, dates opened and closed, payment patterns, credit limits, and modes of payment.

5. Federal District Bankruptcy Records Search

These searches are conducted by review of U.S. District Bankruptcy Courts. Findings may include Chapter 7, 11, and 13 filings. Bankruptcy records may reveal assets and liability amounts, as well as additional debtors.

6. Media Search

This should include a compilation of major newspapers, news wires, magazines, trade journals and other publications nationwide and will determine if the subject has made headlines in business or personal dealings.

7. OFAC-SDN Search

The express OFAC-SDN Requirement prohibits insurers from engaging in transactions with individuals or entities on the OFAC-SDN (Office of Foreign Assets and Control – Specially Designated Nationals) List. If an individual's or entity's name appears on the OFAC-SDN List, the insurer must immediately block them and notify OFAC within 10 days. Criminal penalties for violation can reach \$1 million and 12 years in prison, and civil penalties can reach up to \$275,000.00 per each occurrence.

8. Healthcare Exclusions and Sanctions Search

A healthcare licensing sanctions search should be performed at both the federal and state levels. A sanctions search at the federal level includes a search against the DHHS. Office of Inspector General List of Excluded Individuals/Entities list and the General Services Administration Excluded Parties List System. A search for sanctions at the state level can vary and is determined by the types of healthcare providers and vendors employed by a healthcare facility.

Summary:

In this article, I have attempted to simplify what could fill an encyclopedia. Therefore please consider this a primer when it comes to the regulations within the healthcare industry. Remember, the rules governing healthcare are subject to frequent changes and are almost always in flux.

About the Author:

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