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Final Medicare Exclusion Rules

Much attention has focused on the recent "safe harbor" Medicare fraud and abuse regulations issued by the Office Inspector General (OIG) of the Department of Health and Human Services (HHS). Equally important are the final rules which implement the amendments to the Medicare and Medicaid Patient and Program Protection Act (MMPPPA) of 1987. The amendments gave authority to the department of HHS to disqualify physicians and other providers from the Medicare program for a variety of reasons, including but not limited to violations of the federal anti-kickback law, and permitted HHS to seek civil money penalties against "unfit healthcare practitioners."

The final rules, effective Jan. 29, 1992, enable the federal government to move more quickly and effectively in its concerted effort to cut Medicare costs by pursuing civil exclusion, civil reimbursement, and money penalty measures. It is important that physicians be aware of the key provisions of the final rules. The highlights of the new regulations are as follows:

Exclusion for License Revocation or Suspension

Pursuant to the MMPPPA, any physician who has his or her license to provide healthcare revoked or suspended by any state licensing authority, or has otherwise lost such a

proceeding pending, may be excluded as a provider to the Medicare and Medicaid programs for the period of time that the license is revoked, suspended or otherwise is not in effect. The new regulations make it clear that the exclusion will never be for a period of time less than the time for which the provider loses the state license.

Further, the new regulations set forth aggravating circumstances which may lengthen the period of exclusion. These include the following: if the acts which resulted in the revocation or suspension or loss of license could have had a significantly adverse physical, emotional, or financial impact on any individual; if the individual whose license has been revoked has a prior criminal, civil, or administrative sanction; or if the acts could have had a significantly adverse impact on the financial integrity of the programs.

Mitigating circumstances that can counteract aggravating circumstances are as follows: cooperation with a state licensing authority resulting in the sanctioning of other individuals or entities; if alternative sources of the same type of healthcare provided are not available in the area; or if the individual entity obtained a valid license in the

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license for reasons bearing on the individual's professional competence, professional performance, or financial integrity, or has surrendered such a license with a formal disciplinary

when he or she was not; where a physician has presented a request for payment to a person in violation of an agreement to accept payments on the basis of an assignment or an agreement with a state Medicaid plan not to charge persons for an item or service in excess of the amount permitted to be charged, or in violation of a participating physician agreement. In determining the amount of the penalty and assessments under the regulations the OIG takes into account the nature of the request for payments, the circumstances under which it was presented, the degree of culpability of the person submitting the claim, the history of prior offenses and the financial condition of the person presenting the claim.

Appeals of Exclusions and Penalties

A provider may appeal the imposition of an exclusion or the imposition of an assessment or penalty and is entitled to an administrative hearing. The issues on appeal are whether the basis for the imposition of the sanction exists and whether the length of the exclusion is unreasonable. At these hearings the provider is entitled to be represented by an attorney and to present evidence and examine and cross-examine witnesses. With respect to penalties and assessments, the provider will receive notice of any such assessment and a description of the incident with respect to which the penalty, assessment and exclusion are proposed; the reasons for the penalty, assessment, or exclusion; the amount of the proposed penalty assessment and period of exclusion (where applicable); and the circumstances which were considered in determining the amount of the proposed penalty assessment and the period of exclusion if any.

The notice will also advise the provider of the right to appeal. The appeal process gives the right to call and subpoena witnesses, to examine and cross-examine witnesses and ultimately, to obtain judicial review of any penalties, assessments or exclusions that become final. In addition, there is a limited right of discovery and there is a right to be represented by counsel.

The hearings will be conducted before an administrative law judge. Following the administrative law judge's decision, there is a right to appeal to the HHS departmental appeals board and ultimately to the courts.

Conclusion

To a large extent, the financial problems of our national healthcare

system are being blamed on provider fraud and abuse. As a result, the government's enforcement apparatus is increasingly focusing on physicians and other healthcare providers. For this reason it is important that physicians remain vigilant in their adherence to the law and that they be aware of the possible consequences of practices that the federal government considers fraudulent or abusive. **LF**



■ CALL TO ACTION ■

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Send to CALPAC, PO Box 7690, San Francisco, CA 94120-7690

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state where the license was originally revoked, suspended, surrendered, or otherwise lost. If a license is obtained in some other state, that also could fall within an exception and be a basis for a shorter period of exclusion. Physicians faced with disciplinary action as a result of problems that they had years earlier sometimes choose to voluntarily resign their medical license in their home state. They should be aware that this will have profound impact in terms of their ability to see Medicare or Medicaid patients in the future even if they subsequently obtain a license elsewhere.

Exclusion for Furnishing Unnecessary or Substandard Services

The submission of requests for payment under Medicare or Medicaid that are substantially in excess of the provider's usual charges or costs are also a permissible basis for exclusion from Medicare. Similarly, if patients are furnished services or items substantially in excess of their needs or of a quality "that fails to meet professionally recognized standards of healthcare," the Inspector General is empowered to exclude that provider from the Medicare and Medicaid programs. In the event of an exclusion on these bases, the exclusion will be for a three-year period unless aggravating or mitigating factors form a basis for lengthening or shortening the period.

Aggravating circumstances listed include the following: if the violations were serious and occurred over a period of one year or more; if the violations had a significantly adverse physical, mental, or financial impact on any individual; if the violation resulted in financial loss to the Medicare or Medicaid programs of \$1,500 or more. The only mitigating circumstances are if there were few violations and they occurred over a short period of time or if alternative sources of the same type are not available in the area in which the provider would be excluded.

Exclusion for Engaging in a Kickback

There is a wide variety of conduct that could technically violate the

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in the Medicare and Medicaid programs. The fraud and abuse regulations discussed in the Sept. 9, 1991, issue of *LACMA Physician* described the business and payment practices that are considered by the OIG to technically violate the anti-kickback statute, but which will not be treated as criminal offenses nor serve as a basis for program exclusion.

Exclusion for Commission of a Criminal Offense Related to the Delivery of an Item of Service

Pursuant to the 1987 MMPPPA, any physician convicted of a criminal offense related to the delivery of an item of service under Medicare or a state healthcare program, or convicted under federal or state law of a criminal offense related to the neglect or abuse of a patient is subject to a minimum exclusion from the Medicare and Medicaid system for five years. This applies to situations where there has been a trial or where the physician has pleaded guilty or no contest.

Exclusions, until now, for this reason have generally been for five years. The new regulations set forth factors which may be considered to be aggravating and are a basis for lengthening the period of exclusion beyond five years. Those factors consist of the following: if there was a financial loss to the program of \$1,500 or more; if the conviction had a significantly adverse physical, mental, or

financial loss to the program; if the sentence included incarceration; if the convicted party had a prior criminal, civil, or administrative sanction record; or if the party had at any time been overpaid a total of \$1,500 or more by Medicare or Medicaid as a result of improper billings.

It is quite apparent that under this new regulation in the majority of cases where someone is convicted, one or more of these aggravating factors will be present. In contrast, the mitigating circumstances, which are a basis of counteracting the aggravating circumstances, are very limited. The mitigating circumstances are as follows: that the party was convicted of three or fewer misdemeanor offenses and the entire amount of financial loss to Medicare or Medicaid was less than \$1,500; that the sentencing documents show that the court determined that the individual had a mental, emotional, or physical condition that reduced the individual's capability; or that the individual's cooperation resulted in others being convicted or excluded from Medicare or Medicaid. Hence, the new regulations will result in exclusions of more than five years in most cases when physicians are convicted of applicable criminal offenses.

Civil Money Penalties and Assessments

The regulations provide that a penalty and assessment may be imposed upon any person who has submitted a claim for an item or service that the person knew or should have known was not provided as claimed, or for any false or fraudulent claims. Hence, under this standard even negligently made claims that were paid by Medicare or Medicaid can be the subject of a penalty proceeding. In addition to reimbursement of the monies paid for such claims, a monetary penalty of up to \$2,000 for each item or service may be imposed by the OIG.

Additionally, penalties may be imposed under the following circumstances: if the physician represented that he or she was certified in a