Health Care Support Advisors Exclusion Check Service

What is the Exclusion Check Service?

The **Office of Medicaid Inspector General (OMIG) requires** that all providers who are billing Medicare and Medicaid for their services insure that their employees, contractors, and vendors are not barred from participation in these programs. The method that the OMIG demands that providers use to insure compliance is to check three lists that are maintained by separate entities each once per month.

Providers that don't have the time or the resources to conduct checks on all personnel, contractors and vendors on a monthly basis can provide HCSA with an electronic download of personnel and vendor information. HCSA will check the lists and return the provider a monthly report that states the date the check was done, the lists that were checked, and the date that the facility provided HCSA with their most current data.

How it works

We will become your partner in checking for excluded individuals, companies and contractors. The program is simple; participating facilities will send HCSA electronic files containing employee and vendor information. HCSA will check the three data bases cited by the OMIG as those that must be checked monthly. HCSA will e-mail a monthly report to the designated facility personnel stating the date that the check was run, the date of the most recent data that the facility provided, and if there was a match with information contained in the government exclusion data bases. The report will also state if there was no match.

Participating facilities that also use HCSA's Monroe County Criminal Background Check Program (CBC) will have all submissions to that program automatically checked against the three data bases. Those facilities will also enjoy preferred pricing for the monthly checking service.

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Why check for excluded individuals and companies?

New York State mandates that those involved in activities relating to furnishing medical care, services or supplies to recipients of medical assistance for which claims are submitted to the Medicare and/or Medicaid program, or relating to claiming or receiving payment for medical care, services or supplies *not be* ***excluded*** from participation during the period for which reimbursement is sought. If a provider of services is found to be on one of the exclusion lists, sanctions in effect that can affect providers include:

a No payments will be made to or on behalf of any person for the medical care, services or supplies **furnished by or under the supervision of the person** during a period of exclusion or in violation of any condition of participation in the program.

b No payment will be made for medical care, services or supplies o**rdered or prescribed by any person** while that person is excluded, nor for any medical care, services or supplies ordered or prescribed in violation of any condition of participation in the program.

c Providers reimbursed on a cost-related basis may not claim as allowable costs any amounts paid or credited to any person who is excluded from the program or who is in violation of any condition of participation in the program. In the case of a nursing assistant, this could jeopardize reimbursement for her assignment every day that she worked for the facility. In the case of an RN, it could mean reimbursement for the entire unit or the entire building.

d Providers reimbursed on a fee–for–services basis may not submit any claim and cannot be reimbursed for any medical care, services or supplies furnished by any person who is excluded from the program or which are furnished in violation of any condition of participation in the program. In addition to recovery by the OMIG of payments made, potential liability for employing or contracting with excluded individuals/entities include:

—$10,000 fine for each item/service claimed or caused to be claimed (i.e., by another entity)

—Plus treble damages based on the amount claimed for each item/service

—Extension of existing exclusion period

—There may also be a separate basis for administrative sanctions for filing such claims under the Federal False Claims Act

Excluded provider risks

When a provider is excluded, Federal health care programs (including Medicaid and SCHIP programs) are generally prohibited from paying for any items or services furnished, ordered, or prescribed by these individuals or entities, and extends to:

—All methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules, or a prospective payment system

—Payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to Medicaid recipients, when those payments are reported on a cost report or are otherwise payable by the Medicaid program

—Payment to cover an excluded individual's salary, expenses or fringe benefits, regardless of whether they provide direct patient care, when those payments are reported on a cost report or are otherwise payable by the Medicaid program.

In addition, no Medicaid payments can be made for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner or supplier that is not excluded.

Contact us today

Call or e-mail us to find out more and get started with the program. Signing up is easy. We will explain the program over the phone and in writing. Payments may be made by check or credit card.

Phone: **(585) 216-1095**
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Who is on the excluded lists and why?

Persons are not allowed to participate in the Medicaid program due to having committed a crime related to the provision of health care or having engaged in conduct characterized as unacceptable practices in the provision of health care. Persons may be excluded due to sexual assault, patient abuse, failure to repay HEAL loans, criminal convictions related to program, criminal convictions related to controlled substances as well as other reasons.

Who must comply with these guidelines?

Providers who bill the Medicaid program must comply with the OMIG guidance. These providers include:

—Hospitals and nursing facilities
—Home health and staffing agencies
—Physician practices
—Pharmacies
—Third party supplier and billers
—Ambulance companies

How often must the Exclusion List be checked?

According to the OMIG, searches of the exclusion data bases should be performed for each individual upon hire and all employees, vendors, and referral sources should be rescreened on a monthly basis, at a minimum.

Let us do it for you

Upon an organization submitting an updated electronic list of employees, vendors, and referral sources, we will check the three lists recommended by OMIG on a monthly basis and return a confirmation report to your organization each month.

Program cost

For smaller lists, prices start at as little as $100 a month.