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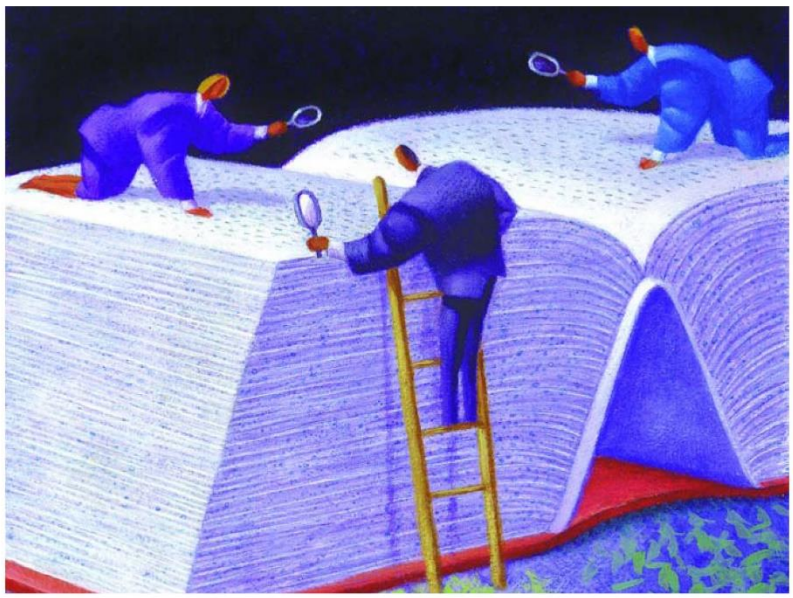
Risk Management

Due Diligence

By John P. Benson and Gary S. Goltz

What You Need to Know

In the healthcare market, performing due diligence on medical providers is a fact of life. The range of effort expended on due diligence, however, varies widely. Due diligence in healthcare generally involves the process of credentialing and re-credentialing medical providers.



The credentialing process is analogous to the prescreening of potential insurance applicants or, depending on the level of inquiry, the actual underwriting process. More important, and key to why I am using credentialing as an analogy here, is that there are key responsibilities that all insurers should be aware of, relative to their insureds' business practices.

The level of detail included in due diligence should correlate with the level of risk or exposure assumed in meeting a "best practices" standard. Sticking with a roster of minimal requirements set by some internally developed standard or a legal requirement may keep a company in compliance—but is that in the organization's best interest? Whatever definition or approach you take for achieving "best practices," the best result at the best price, it is ultimately about getting to the best possible outcome and continual improvement in outcomes (not unlike an ever-improving underwriting model).

The best possible outcome in due diligence is the discovery of everything you

John P. Benson, J.D., AFHI, CFE, CIFI, *is Chief Operating Officer of Government Management Services, Inc. (GMS) of Alexandria, Virginia, and* ***Gary S. Goltz, MBA,*** *is President of Goltz Healthcare Sales Strategies, Upland, California.*

would need to know to make a judicious and well-informed decision. The extent of effort expended during the investigative process is generally used as the gauge against which companies and individuals are measured, if issues arise in the wake of a bad outcome. Under modern-day standards, due diligence requires every reasonable effort to verify and validate information and uncover and confirm any misstatements or omissions.

Further, verification usually entails referencing information sources outside internal sources—for example, speaking with an applicant's employer and reviewing any news articles that relate to the applicant. Fortunately, there are plenty of sources that can help in finding good information about people, professionals, and businesses.

There are important incentives for compliance; the federal government is serious about due diligence.

Exclusion from participation in federal healthcare programs

In September 1999, the Department of Health and Human Services, Office of the Inspector General (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.

Within the Bulletin, it was made clear that not only were federal funds not to be used for individuals and entities directly involved with patient care, but that Civil Monetary Penalties (CMPs) could be imposed for using federal funds for excluded providers that were indirectly involved in patient care. In addition it stated that, "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 January 2005, the DHHS-OIG issued a supplement to its voluntary compliance program guidance for hospitals. The original guidance was issued in November 1998 for the purpose of assisting hospitals in complying with the rules and regulations for participation in Medicare, Medicaid, and other federal funded healthcare programs. In this update, among the factors a hospital may wish to consider when evaluating the manner in which it responds to detected deficiencies, the DHHS-OIG 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.

What to watch out for

Professionals who are under scrutiny, or subject to disciplinary actions of some sort, will probably try something to stay one step ahead of the consequences. Here are some examples.

"State hopping." Providers under scrutiny from a licensing or disciplinary board, before a final or reportable action is taken, may obtain a license in one or more jurisdictions outside their domicile, failing to report the action in process in their home state. Providers with multiple licenses may take advantage of the fact that states are not always diligent at cross-reporting actions and, even if they are, there may be a lag time before one state, or even the office of the inspector general (OIG), finds out about a disciplinary action in another jurisdiction. The best way to deal with state hoppers is to check for sanctions, at both the federal and state level, in all jurisdictions and for all provider types. One source for this sort of content is a database that compiles all of this information.

"Name changers." Providers can also change their names, or use variants in their legal name, to avoid detection. Making changes may be very easy for individuals who have culturally different naming conventions as to the number of names, the use of different names, or the order in which the names appear, depending on how the name is being used or the person being addressed. If the provider operates under a corporation or other business entity, he can file a "DBA" (doing business as) or create another new business entity to avoid detection (a "red flag" in this case would be multiple Federal Employment Identification Numbers—FEINs).[1] The outcome after a search that includes the possible variations of both personal and business names can sometimes end in "no results found," when, in fact, the provider has been sanctioned.

Searching databases that identify the relationships among people, professionals, and businesses can help overcome this tactic for avoiding detection. Sometimes, something as simple as a shared address can be sufficient to build an entity relationship that elucidates a sanction or other adverse action.

New profession. In the healthcare field, some providers start, for example, in nursing, and then at some later point move on to become a physician's assistant, or even a pharmacist. While most of this upward mobility is good, we have seen many examples where mobility, both upward and downward, is motivated by a desire to stay one step ahead of the "law." We have seen many instances of this strategy: a person is sanctioned, severely, and then goes back to school in some other location. Then, when he applies for his license in another field in another state (still within the general field of healthcare), once again fails to disclose his past. We have even seen sanctioned physicians, who have lost their license, turn up as pharmacists in another state.

Unfortunately for anyone who hires these people, if there is a federal sanction on the individual, regardless of his new profession, and if he goes to work for an entity that receives any federal money, the new employer

could be subject to CMPs.[2]

"Tainted providers." Many providers often have an ownership interest in some medical facility. The provider may have a "clean" record but the associated business entity may have a record of abuse or sanctions.

"Dirty hands, clean hands." A provider may have a financial interest—part ownership—in a business entity that has been sanctioned. Since he was not personally sanctioned, he can transfer ownership of the tainted entity, while retaining control, to a relative or friend, thereby providing the cover of plausible deniability when asked if he has been sanctioned. Inquiries about entities linked in some way with the applicant's relatives can be very enlightening, and may reveal information that would be missed during most due diligence efforts.

"Recidivists." Another issue that carriers should be aware of is the high correlation between an initial sanction event and the likelihood of subsequent sanctions: recidivism. One recent study found that the "most significant finding is that there is a very large number of repeat offenders among physicians who have received board sanctions, indicating a possible need for greater monitoring of disciplined physicians or less reliance upon rehabilitative sanctions."[3] Somewhat more concerning is that high-severity disciplinary actions were also correlated to a history of multiple disciplinary actions.[4]

The first evidence of trouble would usually be caught through an ongoing monitoring programming.

Best practices

The concept of "ongoing monitoring" requires that the status of a provider's credentials be reviewed according to a defined schedule (e.g., monthly), since re-credentialing is generally performed on a two-year or 36-month cycle.[5] Although no organization requires ongoing monitoring, the Joint Commission has implied that they are headed that way. John Herringer, associate director, Standards Interpretation Group, the Joint Commission said, "At this point, the idea is that it's supposed to be an ongoing review. We're not telling you it's going to be monthly or three months, six months, nine months. I personally think if you only looked at something every 12 months that's more of a period review than ongoing."[6]

Ongoing monitoring should include, where applicable, review of DEA, license and sanction status, at the lowest possible frequency, based on data-update schedules. Since many agencies may report the same event over time, the first evidence of trouble would usually be caught through an ongoing monitoring programming. Early detection lets the subscriber act proactively when an adverse event surfaces.

Another best practice would be to require insureds to engage in their own risk avoidance program. If you are insuring a professional association or corporation that comprises a sole practitioner or small-group practice, it is unlikely they have a credentialing program in place, unless they have sought accreditation. Large organizations, hospital systems, and large independent physician groups generally have compliance officers and programs in place to ascertain that they follow the published guidelines.[6] Because considerable government resources are focused on this and other issues in healthcare, these organizations generally try to follow the letter of the law relative to credentialing, compliance with The Health Care Quality Improvement Act of 1986,[7] and Medicare/Medicaid sanctions exclusions checking. The government is serious about this issue and is using its leverage by imposing civil monetary penalties on large healthcare organizations, as well as settlements that include corporate integrity agreements (a government-imposed best practices agreement), for organizations that violate guidelines and regulatory laws.

Independent physician practices, small groups, and professional associations generally do not have structures in place to create effective compliance policies and procedures. In an effort to manage your exposure and help your insureds reduce risk under your contract, inform them of their obligations under the law and as suggested in the published guidelines. Build into your contracts requirements that your insureds engage in due diligence (sanctions checking at a minimum) in checking on credentialing whenever they add a new staff member to their practice, whether it is another physician, a physician extender, or an allied health provider. This will likely improve your loss ratios. Guidance for the small-group provider may be found at http://oig.hhs.gov/authorities/docs/physician.pdf.[7]

An individual provider has just as much at risk, or more, relatively, as large institutional providers, because under the guidance, they have very similar obligations and duties. Individual and small group physician practices should have a compliance program in place, with the following seven key components:

1. Establishing compliance standards through the development of a code of conduct and written policies and procedures.
2. Assigning compliance monitoring efforts to a designated compliance officer or contact.
3. Conducting comprehensive training and education on practice ethics and policies and procedures.
4. Conducting internal monitoring and auditing focusing on high-risk billing and coding issues through performance of periodic audits.
5. Developing accessible lines of communication, such as discussions at staff meetings regarding fraudulent or erroneous conduct issues and community bulletin boards, to keep practice employees updated regarding compliance activities.
6. Enforcing disciplinary standards by making clear or ensuring employees are aware that compliance is treated seriously and that violations will be dealt with consistently and uniformly.
7. Responding appropriately to detected violations through the investigation of allegations and the disclosure of incidents to appropriate government entities.

Further, individual and small group physician practices, if the practice accepts any federal dollars, have the same obligation to ensure that the HHS-OIG List of Excluded

Individuals and Entities, and the General Services Administration's (GSA's) List of Parties Debarred from Federal Programs have been checked with respect to all employees, medical staff, and independent contractors. Failure to comply may be a violation of the Civil Monetary Penalties Law, which could result in a penalty of up to $10,000. In addition, the provider may be excluded from participation in federal healthcare programs.

An example from the *Federal Register:*

Dr. X hired Physician Assistant P to provide services to Medicare and Medicaid beneficiaries without conducting a background check on P. Had Dr. X performed a background check by reviewing the HHS–OIG List of Excluded Individuals/Entities, Dr. X would have discovered that he should not have hired Assistant P, because he is excluded from participation in federal health care programs for a period of five years.[7]

Overall, a best-practice due diligence program should be tailored to an organization's market and the products it offers. Thorough due diligence that can reveal as many possible risks prior to contracting offers an organization an opportunity to price effectively—or avoid the risk all together. If you take on an insured, why not help him reduce the risk to their patient, themselves, and your company by making them responsible for a reasonable tailored and required compliance program.

1. Federal Employer Identification Number, a businesses tax identification number issued by the IRS, commonly takes the form of xx-xxxxxxx. There are few external data sets that have aggregated this content effectively (if any) and the IRS will not release the content.
2. Civil Monetary Penalties Law ("CMPL"), 42 U.S.C. § 1320a-7a.
3. Grant, D, Alfred, KC, Sanctions and recidivism: an evaluation of physician discipline by state medical boards, J Health Polit Policy Law. 2007 Oct; 32(5):867-85.
4. Cardarelli R, Licciardone JC, Factors associated with high-severity disciplinary action by a state medical board: a Texas study of medical license revocation, J Am Osteopath Assoc. 2006 Mar; 106(3):153-6.
5. The Joint Commission and some States have a two-year requirement; the National Committee for Quality Assurance (NCQA) requirement is every 36 months.
6. The Joint Commission, 2007 Teleconference Calls, Monday, April 30, 2007, Topic: The Joint Commission's credentialing and privileging standards, O'Leary MD, J., Wise MD, R, Herringer, J and Barry-Ipema, C, see: http://www.jointcommission.org /NR/rdonlyres/8AB389E2-412D-49F0-BAC9-996D7EF098B1/0/audio_conference_043007.pdf (last viewed 11/12/2007).
7. Federal Register, Vol. 70, No. 19, January 31, 2005, Notices, 4858 – 4876, Department of Health and Human Services, Office of Inspector General, OIG Supplemental Compliance Program Guidance for Hospitals and Federal Register, Vol. 63, No. 35, February 23, 1998, Notices, 8987 – 8997, Department of Health and Human Services, Office of Inspector General, Publication of the OIG Compliance Program Guidance for Hospitals.

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BACKGROUND SCREENING IN THE HEALTHCARE INDUSTRY

(Reprinted from the Journal of the Association of Staff Physician Recruiters, Vol. 13, No. 4, Winter 2007)

By Gary Goltz

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

Lists of current CIAs by company as well as a sanctioned individuals are available to the public on the DHHS-OIG website.

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 with 12 years in prison, and civil penalties up to $275,000.00 per 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 - Link to current OIG Guidelines.

Gary Goltz is President of Goltz Business Development Group. He is among the founders of the home healthcare industry's giants, Apria and Coram. Mr. Goltz has a BA in Rhetoric from the University of Pittsburgh and an MBA from Pepperdine University's, President and Key Executive Program. He can be reached at 909-702-3250 or gary@goltzbdgroup.com.