

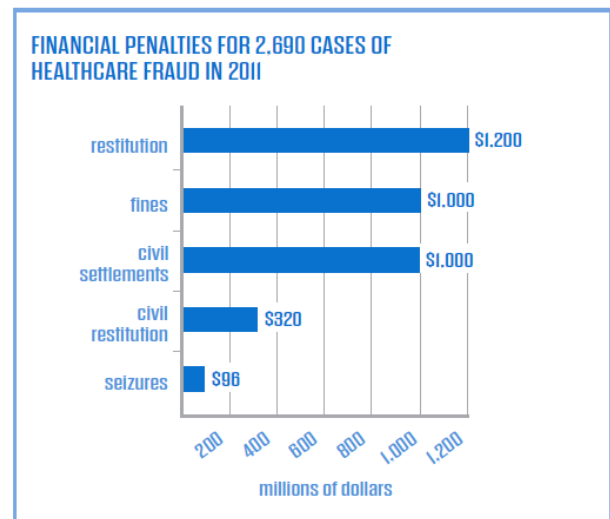
Medicare/Medicaid Sanctions Excluded Individuals and Entities

One pressing issue in the healthcare industry is the credibility and integrity of employees. Medicare/Medicaid Sanctions data provides information on any penalty or disciplinary action imposed on a medical professional or agency by the Office of the Inspector General (OIG). These regulations exclude individuals and entities from participating in federally funded healthcare programs such as Medicare and Medicaid.

OIG guidelines state that healthcare organizations cannot employ sanctioned or excluded individuals or vendors. By conducting a Medicare/Medicaid Sanctions search, organizations can identify individuals and entities that are excluded from Medicare, Medicaid and other federal healthcare programs.

Excluded individuals have a negative impact on these federally funded programs. The United States Office of Management and Budget (OMB) has estimated that fraud, waste, and abuse have cost Medicaid \$17 billion, just over 5 percent of the total program cost.

This sizable loss has resulted in the enactment of strict regulations and penalties for hiring, employing and working with sanctioned individuals. The OIG has stated that it may impose Civil Monetary Penalties (CMPs) and Affirmative Exclusions to employers or agencies that have employed or contracted with excluded individuals. Monetary penalties up to \$10,000 can be imposed for each item or service provided by the sanctioned individual, in addition to an assessment of up to three times the amount claimed. Further, programs may be subject to exclusion from federally funded programs. In extreme cases jail time can be incurred for the individual and/or the employer.



Key benefits of the Medicare/Medicaid Sanctions search:

- Preventative measure against losing federal funding
- Verify claims of program eligibility and prevent penalties for false claims
- Help ensure compliance with regulations and reduce potential risks and liabilities

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It's recommended to combine the Medicare/Medicaid Sanctions search with a criminal package and other products (such as Medical License Verifications, Government Sanctions, FACIS, Employment and Education searches). By doing so, it will help ensure compliance with Medicare/Medicaid regulations and promote healthcare industry best practices.

The legal landscape regarding healthcare providers and their employee background screening programs is ever changing. As a result, it is important understand the value of including Medical License Verifications (along with a Medicare/Medicaid Sanctions search) in a screening program. Learning that a medical professional lacks a valid license to practice can result in serious consequences. It can put an organization at risk for missing sanctions or vital information that could make an individual ineligible for employment. Medical License Verification searches provide a status if a license is expired, restricted, suspended or revoked. By combing both Medicare/Medicaid sanctions and Medical License Verifications in one search package, organizations can help ensure their staff is in good standing, have the required credentials and maintain high professional standards of conduct.

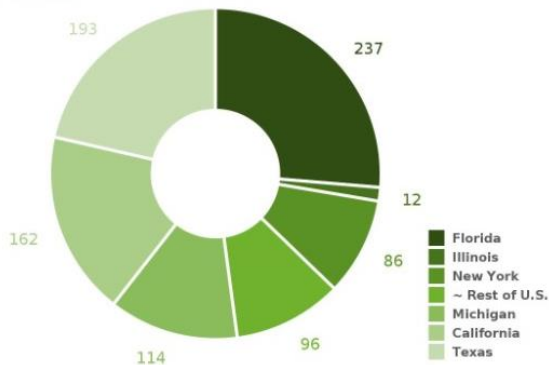
Key U.S. Statistics — Physician Discipline

State Medical Board Actions	2012
Total state medical board actions	9,219
Board actions by category*	
License restricted	1,480
Reprimand	1,224
Fine	995
Administrative action	949
Probation	913
License suspended	907
CME required	819
License surrendered	511
Conditions imposed	465
License revoked	299
License denied	170
Other	487
Reciprocal actions taken by state boards	1,306
Number of disciplinary alerts issued by the FSMB	14,487
Number of physicians disciplined	4,479
Physicians put on probation	857
Physicians with a license suspension	739
Physicians with a license revocation	275

Source: Federation of State Medical Boards
*The total number of board actions is higher than the total number of disciplined physicians because physicians may have had more than one action taken against them.

Where the fraud was allegedly committed

In millions of dollars



via U.S. Justice Department

Because the OIG updates their records monthly, it's suggested that employers and agencies rescreen employees and contractors at that interval to help make certain that anyone involved at a facility is compliant with Medicare and Medicaid standards. It's essential to be confident knowing that as much as possible is being done to promote the safety of a healthcare organization, its staff and patients.

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Even with all of the penalties and strict regulations, the problem surrounding these federally funded programs is not going away. In 2012, state boards and other entities received approximately 15,000 alerts from the Department of Administrative Services notifying them of issues surrounding healthcare fraud, malpractice, and abuse.

On June 23, 2016, the Justice Department announced the largest takedown of healthcare fraud in United States history (relating to the number of defendants charged and financial loss). More than 301 people were charged including doctors, skilled nurses, and home healthcare employees. Thus far, the financial loss has amounted to a staggering \$900 million (based on fraudulent billings to Medicare, Medicaid or both for treatments that were never provided). Crimes committed also include: health care fraud, violating anti-kickback statutes, money laundering, and identity theft.

What can employers do to protect themselves? The OIG is recommending that agencies working with federally funded healthcare programs expand the reporting and reviews of cases involving fraud, waste and abuse. A study done by the Centers for Medicare and Medicaid Services found that 3-22% of applicants were disqualified due to failing to pass a background check.

A comprehensive healthcare background screening policy that includes a Medicare/Medicaid Sanctions search is a preferred method to help ensure compliance with OIG regulations and federal healthcare program requirements. Learning if individuals appear on the OIG List of Excluded Individuals/Entities (LEIE) will help reduce risks and liabilities, and assist in complying with Medicare and Medicaid standards. Because the OIG updates records monthly, it is also recommended to rescreen individuals on a regular basis to increase program effectiveness and for ongoing compliance.

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