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Exclusion checks: Making the search

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Management, Legal, and Compliance review many issues when a healthcare provider plans to enter into an agreement. When the other party is another healthcare provider, one important consideration is whether the Department of Health and Human Services Office of Inspector General (OIG) has excluded that other party from federal programs. Such an exclusion is a penalty imposed by the government on those who have engaged in fraud, abuse, or other misconduct related to a federal healthcare program, not a voluntary decision by individuals who have decided not to enroll or to participate in federal programs.

The OIG has the authority to exclude individuals or entities under Title XI of the Social Security Act.[1] That exclusion applies to all federal healthcare programs, including Medicare, Medicaid, and other programs that provide health benefits that the United States funds either directly or indirectly.[2] If a healthcare provider enters into an agreement with or employs another who has been excluded from a federal healthcare program, the OIG may impose significant civil monetary penalties or even exclude that healthcare provider from future participation. The standard is whether the healthcare provider knew or should have known that the party it contracted with was excluded.

Under the exclusion power, the OIG can mandate that no payment will be made by any federal healthcare program for any items or services furnished, ordered, or prescribed by an excluded individual or entity. This prohibition covers the excluded party along with any entity that employs the excluded party, any hospital at which the excluded party provides services, or anyone else with whom the excluded party contracts. Further, the exclusion applies regardless of how the claim is submitted or who submits it, and it applies to all administrative and management services as well.