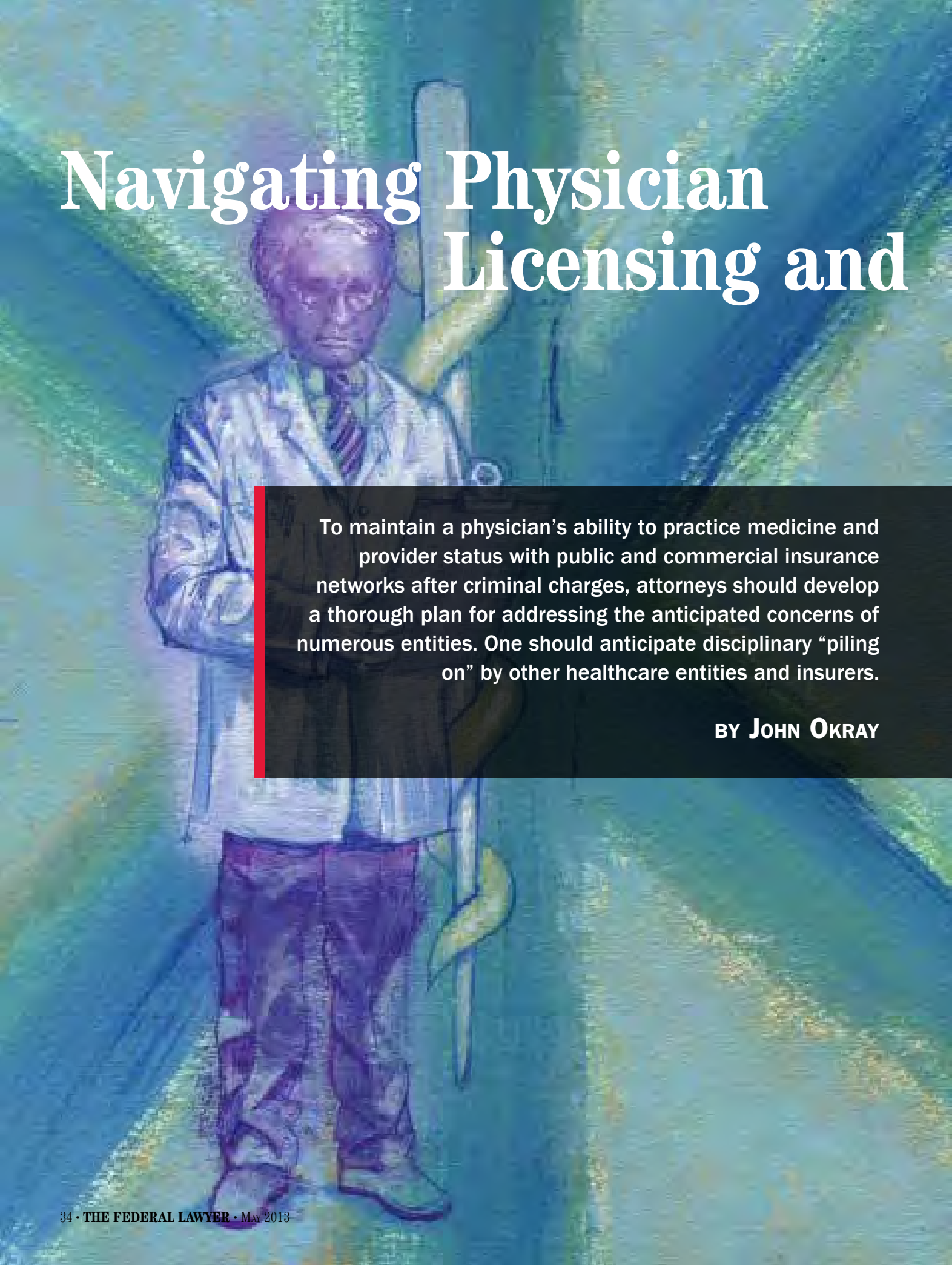

Navigating Physician Licensing and

To maintain a physician's ability to practice medicine and provider status with public and commercial insurance networks after criminal charges, attorneys should develop a thorough plan for addressing the anticipated concerns of numerous entities. One should anticipate disciplinary "piling on" by other healthcare entities and insurers.

BY JOHN OKRAY

Insurance Credentialing

Legal Issues After Criminal Charges

When a physician has been charged with any crime, there are a number of critical steps to take to avoid an avalanche of disciplinary actions and terminations of participation in public and commercial insurance programs. If the alleged crime is arguably related to the practice of medicine, controlled substances, or insurance billing practices, or if it could reasonably imply that the physician might not meet the professional and ethical qualifications required by credentialing entities, the physician will face an uphill battle to maintain his/her license, certifications, and insurance provider contracts. Moreover, if there is a highly prejudicial disciplinary action (e.g., any loss of license or material restriction on practice, etc.) reported against a physician, one should anticipate disciplinary "piling on" by other healthcare entities and insurers.

In modern medicine, physicians increasingly practice in multiple states. Federal laws and regulations governing the Medicare and Medicaid programs and the national practitioner data banks are of paramount importance in the insurance and credentialing contexts for the medical profession. Nevertheless, in order to develop an effective strategy for defending the physician's ability to practice medicine and participate as a provider in government and commercial insurance networks, it is necessary to understand the entire physician licensing and credentialing framework and the relationship between federal, state, and commercial healthcare programs.

Resolving the Criminal Complaint

The manner in which criminal charges against a physician are resolved will have a profound impact on what actions, if any, healthcare credentialing entities will take. The criminal defense attorney and physician should consider the likely ramifications of each proposed disposition of the case. Depending on what state(s) the physician is licensed in, a felony conviction for any crime could cause the automatic revocation of the physician's medical license.[1] Even if the license revocation is not automatic, the physician will very likely face a disciplinary inquiry from the medical board(s). Entering a plea of no contest where adjudication is withheld may afford little benefit since healthcare credentialing entities will often treat this disposition the same as a conviction.[2]

Depending on the nature of the alleged crime, the physician may be able to enter into a treatment plan with a state physician health program. These programs are typically designed to promote the treatment, documentation, and monitoring of physicians to prevent their illnesses from impacting the care they render to patients. The Federation of State Physician Health Programs maintains a directory of physician health programs on its website.[3] A criminal court, state medical board, or insurance network may get some level of comfort from a physician's participation and monitoring in such a diversion program which might help avoid the harshest disciplinary options or terminations of provider contracts.

National Data Banks

The primary healthcare provider disciplinary action reporting regimes are the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB). These federally mandated[4] clearinghouses are maintained by the U.S. Department of Health and Human Services' (HHS) Health Resources and Services Administration and are widely used by public and commercial healthcare entities to protect the public and reduce healthcare fraud. Federal and state government agencies and health plans report to the HIPDB while state medical boards, hospitals, peer review organizations, medical malpractice payers, and other private accreditation organizations report to the

NPDB. Considerations related to these reports may include:

1. When a physician has been charged with a crime, he or she should promptly request a combined NPDB/HIPDB self-query report. Counsel cannot request the report on behalf of the physician.
2. Review whether there have been any previous adverse actions reported against the physician, and if so, confirm their accuracy. If an adverse action is reported incorrectly, the physician must notify the reporting entity to request that they submit a correction. If the reporting entity does not make the requested correction, the physician may initiate a dispute, which can include requesting the secretary of HHS to intervene.
3. Add a statement, if appropriate, of up to 2,000 characters to any adverse action report, which would be provided to any entities that receive the report in the future.
4. Review which entities have received copies of the physician's previous NPDB and/or HIPDB reports, which may help identify to whom the physician may have self-reporting obligations or with whom the physician may face future credentialing challenges.

The NPDB and HIPDB guidebooks describe when an entity is required to report an adverse action to one of the data banks.[5] These will be important to take into consideration when negotiating any settlement agreement since there may be reasonable actions that credentialing entities could take which would not require reporting to one of these data banks.

On April 5, 2013, a final rule was published in the Federal Register announcing the consolidation of the HIPDB into the NPDB. Effective May 6, 2013, all information previously contained in the HIPDB will be contained, collected, and disclosed through the NPDB.

State Medical Boards

A physician and his or her attorney should conduct an assessment of the disciplinary laws and self-reporting procedures for each state where a physician holds a medical license. For example, if a physician's principal office is located in state A, but he/she also maintains medical licenses in states B and C, the physician should determine the necessity for continuing to hold licenses in all of these jurisdictions. If the physician has no plans to practice medicine in state C in the future, he or she might consider whether to relinquish this license before having to face another potential disciplinary investigation. From a credentialing perspective, entities will often ask physicians if they have ever surrendered any medical license under threat of a disciplinary action, and if so, to provide a full explanation. So, even if state A reviewed the criminal matter and declined to revoke the license or materially restrict the physician's medical practice, state B or state C could still impose a harsher penalty. Various types of disciplinary actions by a state medical board are reportable to the NPDB. Additionally, states typically have their own online physician databases that include disciplinary information. Remember that even if a settlement with a medical licensing board is not reportable to the NPDB, the adverse action and settlement agreement may be publicly available from the state medical board's own physician credentialing website. The Federation of State Medical Boards (FSMB) publishes an annual summary of board actions for each state showing the level of prejudicial versus non-prejudicial actions.[6] The data from the *FSMB Summary of 2011 Board Actions* by medical and osteopathic boards in Table 1 illustrates that prejudicial actions accounted for 83 percent of board actions, versus only 17 percent for non-prejudicial board actions.

The FSMB also maintains the Federation Physician Data Center which makes board actions against physicians available to the public via the FSMB Physician Profile[7] for a nominal fee. Again, certain disciplinary actions that are not reportable to the NPDB might be reportable to the FSMB Physician Profile. If one state reports a disciplinary action against a physician related to a criminal matter on one of these reporting systems, anticipate all other states where the physician is licensed to eventually launch their own disciplinary investigations.

HHS Office of Inspector General

The Office of the Inspector General of HHS (OIG) is authorized under the Social Security Act to exclude professionals from participation in federal health programs including Medicare and Medicaid. Tables 2 and 3 summarize the OIG's mandatory and permissive exclusion categories, corresponding minimum exclusion periods, and statutory authorities.

If the OIG is contemplating excluding a physician, they will send a Notice of Intent to Exclude, including the basis for the proposed exclusion.[8] The physician then has 30 days to respond in writing with any evidence or rationale as to why they should not be excluded. If the physician is excluded by the OIG, appeals may be made to an HHS Administrative Law Judge, then to the HHS Department Appeals Board, and finally through judicial review in federal court.

Table 1: Actions Taken by NPDB in 2011

Action Taken	Number of Actions	Percent of Total
Loss of License or Licensed Privilege Actions (includes revocations, suspensions, surrender or mandatory retirement of licenses, or loss of privileges afforded by those licenses)	1,905	32%
Restriction of License or Licensed Privilege Actions (includes probations, limitations, or restrictions of license or licensed privileges)	1,323	22%
Other Prejudicial Actions (includes modifications of a license or the privileges granted by that license that results in a penalty or reprimand, etc., to the licensee)	1,768	29%
Non-Prejudicial Actions (actions that do not result in modification or termination of a license or licensed privileges; these actions are often administrative in nature (e.g., the reinstatement of a license after a disciplinary action))	1,038	17%
Total	6,034	

Table 2: Mandatory Exclusions

Description	Minimum Period	42 U.S.C. §
Conviction of program-related crimes	5 years	1320a-7(a)(1)
Conviction relating to patient abuse or neglect	5 years	1230a-7(a)(2)
Felony conviction related to healthcare fraud	5 years	1320-7a(a)(3)
Felony conviction related to controlled substance	5 years	1320-7(a)(4)
Conviction of two mandatory exclusion offenses	10 years	1320a-7(c)(3)(G)(i)

Table 3: Permissive Exclusions

Description	Minimum Period	42 U.S.C. §
Misdemeanor conviction relating to healthcare fraud	3 years	1320a-7(b)(1)(A)
Conviction relating to fraud in non-healthcare programs	3 years	1320a-7(b)(1)(B)
Conviction relating to obstruction of an investigation	3 years	1320-7(b)(2)
Misdemeanor conviction relating to controlled substance	3 years	1320-7(b)(3)
License revocation or suspension	No less than state licensing authority	1320-7(b)(4)
Exclusion or suspension under federal or state healthcare program	No less than healthcare program	1320-7(b)(5)
Claims for excessive charges, unnecessary services, or services which fail to meet professionally recognized standards of healthcare	1 year	1320-7(b)(6)
Fraud, kickbacks, and other prohibited activities	None	1320-7(b)(7)
Failure to take corrective action	None	1320-7(b)(13)
Default on health education loan or scholarship obligations	Until cured	1320-7(b)(14)
Making false statement or misrepresentations of material fact	None	1320a-7(b)(16)
Failure to meet statutory obligations of practitioners and providers to provide medically necessary services meeting professionally recognized standards of healthcare (peer review organization findings)	1 year	1320c-5

The OIG maintains the searchable List of Excluded Individuals/Entities on its website.[9]

The Medicare Enrollment Application, CMS-855I, requires participating physicians to notify Medicare of a final adverse action within 30 days of the reportable event. Below are certain reportable events (regardless of whether an appeal is pending):

Exclusions, Revocations, or Suspensions

- Any revocation or suspension of a license to provide healthcare by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority.
- Any revocation or suspension of accreditation.
- Any suspension or exclusion from participation in, or any sanction imposed by, a federal or state healthcare program, or any debarment from participation in any federal Executive Branch procurement or non-procurement program.
- Any current Medicare payment suspension under any Medicare billing number.
- Any Medicare revocation of any Medicare billing number.

Convictions

The provider within the last 10 years preceding enrollment or revalidation of enrollment was convicted of a federal or state felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include:

- Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; any felony that placed the Medicare program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under § 1128(a) of the Social Security Act.
- Any misdemeanor conviction, under federal or state law, related to: (a) the delivery of an item or service under Medicare or a state healthcare program; or (b) the abuse or neglect of a patient in connection with the delivery of a healthcare item or service.
- Any misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a healthcare item or service.
- Any felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. §§1001.101 or 1001.201.
- Any felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Since Medicare and Medicaid are federal programs, exclusion by the OIG would impact the physician's participation

nationally, ultimately terminating all state Medicare and Medicaid provider contracts. It should be noted that even if the OIG does not exclude a physician at the national level, an individual state's Medicaid credentialing authority may restrict a physician from participation within the state.

State Medicaid and Medicare Programs

Physicians licensed in a particular state are often providers in that state's Medicaid and/or Medicare programs. The physician should thus consider any need to maintain provider contracts with these programs. Depending on the nature of the crime or action taken by a state medical board, a state Medicaid credentialing authority or state Medicare administrative contractor could revoke or restrict the physician's provider status. Even if a state medical board chooses not to discipline a physician's license, the state Medicaid and/or Medicare program may still revoke or restrict the physician's provider status. Similarly, the reinstatement of a state medical license also does not guarantee the reinstatement of a physician's provider status with these programs in that state. If a state Medicaid or Medicare program reports a disciplinary action to the HIPDB, anticipate investigations by other governmental insurance programs and commercial insurance companies.

Hospitals, physician practice groups, or commercial insurance networks may require that a physician be certified (or eligible to be certified) by a particular medical specialty board to maintain their affiliations or provider status. Therefore, the loss of certification or diplomate status with a medical specialty board may have other ramifications.

U.S. Drug Enforcement Agency and State Pharmacy Boards

Physicians that require the ability to prescribe certain controlled substances must be registered with the U.S. Department of Justices' Drug Enforcement Agency (DEA) Office of Diversion Control. A state may also require licensing by its pharmacy board. The DEA assigns registered physicians a federal DEA number. Under the Controlled Substances Act (CSA), the attorney general has the authority to deny, suspend, or revoke a DEA registration upon the finding that a registrant has (1) materially falsified any application filed, (2) been convicted of a felony relating to a controlled substance or certain chemicals, (3) had his or her state license or registration suspended, revoked, or denied, (4) committed an act which would render the DEA registration inconsistent with the public interest, or (5) been excluded from participation in a Medicaid or Medicare program.[10] The liability section of the DEA registration renewal application will ask the physician questions pertaining to these types of disciplinary actions. Under the CSA, factors to be taken into consideration for a registration revocation include (1) the recommendation of the appropriate state licensing board or professional disciplinary authority, (2) the applicant's experience in dispensing or conducting research with respect to controlled substances, (3) the applicant's conviction record under federal or state laws relating to the manufacture, distribution, or dispensing of controlled substances, (4) compliance with applicable state, federal, or local laws relating to controlled substances, and (5) such other conduct which may threaten the public health and safety.[11] It should be expected that the loss of a DEA registration would ultimately result in the loss of a state pharmacy board license.

Peer Review Organizations and Medical Specialty Boards

Physicians are often credentialed by medical specialty boards. The three umbrella medical specialty organizations are the American Board of Medical Specialties (ABMS), American Board of Physician Specialties (ABPS), and American Osteopathic Association Bureau of Osteopathic Specialties. Each has several subspecialty boards where a physician can be certified, such as the American Board of Radiology, Board of Certification in Diagnostic Radiology, and American Osteopathic Board of Radiology, respectively. These peer review organizations may impose self-reporting obligations on their members. If a criminal matter did not reasonably relate to the practice of medicine it should be emphasized in explanatory documentation since it will be reviewed by credentialing staff and/or a governing body made up of physicians from their particular discipline. Disciplinary actions by a peer review organization may be reportable on the NPDB. Additionally an umbrella specialty organization may maintain its own credential verification system.[12] Hospitals, physician practice groups, or commercial insurance networks may require that a physician be certified (or eligible to be certified) by a particular medical specialty board to maintain their affiliations or provider status. Therefore, the loss of certification or diplomate status with a medical specialty board may have other ramifications.

Hospitals

Hospitals are the only entities required to query the NPDB, for the granting, maintenance, or expansion of a physician's clinical privileges, including temporary *locum tenens* privileges. Therefore, any adverse actions reported on the NPDB will be scrutinized by a prospective hospital employer. Additionally, hospitals must report to the NPDB and applicable state licensing board, any professional review actions reasonably related to professional competence or conduct adversely affecting clinical privileges for a period longer than 30 days. Therefore, should a hospital revoke a physician's clinical privileges based on a criminal matter, its report to the NPDB will likely trigger disciplinary inquiries by other entities.

Commercial Insurance Networks and Accountable Care Organizations

An inventory of all commercial insurance companies with whom the physician's practice is credentialed should be reviewed. A contract with an insurance company may impose certain reporting requirements related to criminal matters and/or disciplinary actions by other healthcare entities. If the insurer becomes aware of a criminal matter from the NPDB/HIPDB report or other source and the physician did not meet any contractual self-reporting require-

ment, the insurer may choose to terminate the physician's contract. Many national insurance networks have robust credentialing staff, committees, and even appellate bodies that include physicians, nurses, attorneys, and others. When arguing that a physician should continue to be a provider in their network, needing to explain why the physician did not meet a contractual reporting requirement is an unnecessary strike against the physician.

The ability for a physician to maintain his/her provider status with a commercial insurance network may be highly impacted by the type of discipline imposed by state medical boards, governmental insurance programs, hospitals, or peer review organizations. However, the insurance company possesses complete discretion over whether to continue to allow a physician in their provider network. As previously noted, depending on the nature of the criminal matter, participation in a state physician treatment program might prove helpful. If necessary, a physician can seek to enter into an agreement stipulating enhanced reporting requirements or other undertakings to maintain their participation in the insurance network.

A new type of healthcare entity gaining traction is the accountable care organization (ACO). ACOs are generally groups of doctors, hospitals, and other healthcare providers who work together to provide healthcare services to a particular Medicare patient population. ACO performance is evaluated by HHS' Centers for Medicare and Medicaid Services (CMS) on a number of criteria, one of which is patient safety. If a physician is disciplined or terminated by any Medicare related program, his or her participation in an ACO may also be jeopardized.

Medical Malpractice Insurance Coverage and Other Contracts

Besides healthcare licensing and insurance entities, physicians should determine if they have other contractual reporting obligations. For example, does their individual or group medical malpractice insurance carrier require the reporting of criminal actions and/or disciplinary actions? A physician's employment, partnership, or membership agreement with the practice group may impose certain reporting or professional standing requirements. If a physician utilizes third-party billing and/or credentialing services, these service providers should be apprised of any disciplinary issues so that careful attention is paid to insurance billing/reimbursement issues and the legal or compliance staff has the opportunity to review responses to insurance network credentialing questions about disciplinary actions.

Settlement amd Other Considerations

There are a number of things for physicians and their attorneys to take into consideration when negotiating any settlement, whether it is with a prosecutor, licensing board, peer review organization, hospital, or public or commercial insurance program.

- In any settlement agreement, to the extent appropriate, try to avoid any statement or admission that the crime relates to the practice of medicine, patients, controlled substances, or involves insurance billing, moral turpitude, fraud, deceit, or other dispositions that could be highly prejudicial to credentialing bodies.
- Carefully review what types of actions are reportable on the NPDB/HIPDB and other applicable reporting regimes. Certain actions do not require reporting and therefore may avoid "piling on" disciplinary actions by other entities.
- Focus on the positive when talking to credentialing bodies. Has the physician avoided medical malpractice claims? Demonstrate, if possible, that the physician has accepted full responsibility for his/her actions and taken meaningful steps to ensure there will be no recidivism. Show that the physician has been fully rehabilitated from any temporary illness. Does the physician volunteer or work in medically underserved areas? Obtain written professional and personal reference letters that speak to the continued confidence in the physician.
- While the typical patient might not have access to NPDB/HIPDB reports or conduct due diligence on state medical board websites, physicians should be cognizant that the reporting of disciplinary actions or public commentary from patients are more prevalent through consumer focused websites such as such as healthgrades.com, Angie's List, etc.
- Once a physician has been convicted or pleads guilty to a crime, it will be important to pay careful attention to how all future credentialing documentation is completed and to keep track of any ongoing reporting obligations and other undertakings.

The portability of physician medical practices, telemedicine, expansion of federal health programs and commercial insurers, physician review internet sites, and increased information sharing and sophistication of credentialing bodies will continue to increase the level of scrutiny on physicians. Early intervention and advocacy after a physician has been charged with a crime can often have a dramatic impact on maintaining a physician's practice and on the rest of her/his future career in the medical field. ⊙

John Okray has appeared before state medical boards, peer review organizations, and insurance carrier provider credentialing committees to maintain or restore physician licenses or insurance provider participation. He can be reached at johnokray@gmail.com.

Endnotes

[1]*See, e.g.*, Mo. Rev. Stat. § 334.103.

[2]*See, e.g.*, Fla. Stat. ch. 458.331(1)(c) (2012).

[3]Federation of State Physician Health Programs, *About*, www.fsphp.org.

[4]Originally established by Title IV of Public Law Number 99-660, the Health Care Quality Improvement Act of 1986, as amended.

[5]Available at www.npdb-hipdb.hrsa.gov.

[6]Available at www.fsmb.org/pub_basummary.html.

[7]Available at www.docinfo.org.

[8]42 U.S.C. § 1320a-7(f).

[9]Available at exclusions.oig.hhs.gov.

[10]21 U.S.C. § 824.

[11]*Id.* § 823.

[12]Such as the ABMS' at www.certificationmatters.org.