Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Jessica S. Jackson, DPM
(NPI: 1912947631),

Jessica S. Jackson, DPM, PLLC
(NPI: 1558516054),

and

Special Care Podiatry of Kentucky, PLLC
(NPI: 1982036307),

Petitioners,

v.

Centers for Medicare & Medicaid Services.

Docket Nos. C-15-534, C-15-535

Decision No. CR4935

Date: September 6, 2017

DECISION

The Medicare enrollment and billing privileges of Petitioners, Jessica S. Jackson, DPM, Jessica S. Jackson, DPM, PLLC, and Special Care Podiatry of Kentucky, PLLC are revoked pursuant to 42 C.F.R. § 424.535(a)(8).[1] Dr. Jackson and Jessica S. Jackson, DPM, PLLC are revoked effective July 31, 2014, and Special Care Podiatry of Kentucky, PLLC is revoked effective July 25, 2014.

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[1] Citations are to the 2014 revision of the Code of Federal Regulations (C.F.R.) which was in effect at the time of the reconsideration determination, unless otherwise stated.

I. Background

Jessica Jackson, DPM was enrolled in Medicare as an individual supplier with National Provider Identifier (NPI) 1912947631. Dr. Jackson also enrolled in Medicare two professional limited liability corporations (PLLC), Jessica S. Jackson, DPM, PLLC (NPI: 1558516054) and Special Care Podiatry of Kentucky, PLLC (NPI: 1982036307). Dr. Jackson and the two business entities are referred to collectively as Petitioners. Petitioners had practice locations in Kentucky and Indiana and a contact and billing address in Ohio. C-15-534, Centers for Medicare & Medicaid Services (CMS) Exhibit (Ex.) 3; C-15-535, CMS Ex. 3-5. These cases were docketed separately due to the involvement of two different Medicare Administrative Contractors (MACs), Wisconsin Physician Service (WPS) with responsibility for Indiana and CGS which has responsibility for Kentucky. Docket Number 15-534 is the docket number for the case involving Petitioners Dr. Jackson and Jessica S. Jackson, DPM. Docket Number 15-535 relates to Petitioner Special Care Podiatry of Kentucky. The same alleged conduct, related to the same claims, is the basis for the adverse actions against all three Petitioners.

In Docket Number 15-534, WPS notified Petitioners Dr. Jackson and Jessica S. Jackson, DPM, PLLC by letter dated July 1, 2014, of the initial determination to revoke Petitioners' Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(8), effective July 31, 2014, for abuse of billing privileges. WPS included a list of 32 claims for services delivered to 17 allegedly deceased beneficiaries, 5 claims for services delivered to 4 beneficiaries who were alleged to be lower limb amputees, and 4 beneficiaries who were allegedly hospitalized on the dates on which Petitioners claimed to have provided services. C-15-534, CMS Ex. 1 at 19-22.

In Docket Number 15-535, CGS notified Petitioners Dr. Jackson and Special Care Podiatry of Kentucky, PLLC on June 25, 2014, of the initial determination to revoke Petitioners' enrollment and billing privileges, effective July 25, 2014. CGS alleged abuse of billing privileges and cited 42 C.F.R. § 424.535(a)(8) as the legal authority for revocation. CGS attached the same lists of beneficiaries and claims to its notice as were attached to the WPS notice. C-15-535, CMS Ex. 1 at 25-30.

Petitioners requested reconsideration of the initial determinations issued by the MACs. C-15-534, CMS Ex. 1 at 5-12; C-15-535, CMS Ex. 1 at 5-7. The WPS hearing officer issued a reconsidered determination on October 6, 2014. The CGS hearing officer issued a reconsidered determination on October 27, 2014. Revocation was upheld in both cases pursuant to 42 C.F.R. § 424.535(a)(8). The effective dates of the revocations were also upheld on reconsideration. C-15-534, CMS Ex. 1 at 1-3; C-15-535, CMS Ex. 1 at 1-3.

Petitioners requested hearings by letters dated November 20, 2014, and requested that the cases be consolidated. Case C-15-534 was initially docketed as Jessica Jackson, DPM, PLLC. Case C-15-535 was initially docketed as Dr. Jessica Jackson. However, the WPS

initial determination in C-15-534 was issued to Jessica S. Jackson, DPM, and Jessica S. Jackson, DPM, PLLC at 6200 Pleasant Avenue, Suite 3, Fairfield, Ohio. C-15-534, CMS Ex. 1 at 17. The initial determination of CGS in C-15-535 was issued to Jessica Jackson, DPM and Special Care Podiatry of Kentucky, PLLC at 12910 Shelbyville Road, Louisville, Kentucky. C-15-535, CMS Ex. 1 at 25. The evidence shows that Petitioner Dr. Jackson and both her PLLCs were enrolled in Medicare with the billing numbers reflected in the case caption above. Therefore, the caption of this decision was adopted to more accurately reflect the affected parties that have requested administrative law judge (ALJ) review. 42 C.F.R. § 498.2. The cases were assigned to me on December 3, 2014, and an Acknowledgement and Prehearing Order (Prehearing Order) was issued in each case. On December 16, 2014, I deferred ruling on Petitioners' request for consolidation (which was opposed by CMS) pending further case development. The parties filed cross-motions for summary judgment in both cases. On June 1, 2015, I denied the parties' cross-motions for summary judgment and consolidated the cases for hearing and decision.

I convened a hearing on September 10 and 11, 2015, and a transcript (Tr.) was prepared. CMS offered CMS Exs. 1 through 8 related to C-15-534 and all were admitted as evidence. Tr. 39-59. CMS offered CMS Exs. 1 through 11 in C-15-535 and CMS Ex. 1 through 10 were admitted as evidence. Tr. 41, 59-71.[2] I admitted P. Exs. 1 through 3 in C-15-534, and admitted P. Exs. 1 and 2 in C-15-535. Tr. 72-81.

On November 6, 2015, CMS filed its post-hearing brief and other post-hearing submissions. On November 9, 2015, Petitioners filed their post-hearing brief (P. Br.) and other post-hearing submissions. Both parties filed a post-hearing reply brief on December 8, 2015 (P. Reply and CMS Reply, respectively). CMS filed a motion to supplement its post-hearing brief on May 26, 2016, and Petitioners responded on May 31, 2016.[3]

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[2] The parties agreed during the hearing that CMS Exs. 5 through 8 in C-15-534 and CMS Exs. 7 through 10 in C-15-535 are the same documents and list the same claims. Tr. 60-66. The parties also agreed at hearing that C-15-534 P. Ex. 1 and C-15-535 P. Ex. 1 are copies of the same document.

[3] The parties made duplicate post-hearing filings in C-15-534 and C-15-535. On May 26, 2016, CMS moved for leave to supplement its post-hearing briefing to address a new Board decision, *John Shimko, D.P.M.*, DAB No. 2689 (2016). On May 31, 2016, Petitioner opposed the CMS motion for leave to supplement its post-hearing brief. Petitioner also addressed the CMS supplemental argument. It is necessary for me to consider the *Shimko* decision and the party's arguments for how the decision may apply

(Footnote continued next page.)

II. Discussion

A. Applicable Law

Section 1831 of the Social Security Act (the Act) (42 U.S.C. § 1395j) establishes the supplementary medical insurance benefits program for the aged and disabled known as Medicare Part B. Administration of the Part B program is through contractors, such as WPS and CGS. Act § 1842(a) (42 U.S.C. § 1395u(a)). Payment under the program for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of services and suppliers.[4] Act §§ 1835(a) (42 U.S.C. § 1395n(a)), 1842(h)(1) (42 U.S.C. § 1395u(h)(1)). Dr. Jackson, a podiatric physician, is a supplier as are her two medical practices.

The Act requires the Secretary of Health and Human Services (Secretary) to issue regulations that establish a process for the enrollment in Medicare of providers and suppliers, including the right to a hearing and judicial review of certain enrollment determinations, such as revocation of enrollment and billing privileges. Act § 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to 42 C.F.R. § 424.505, suppliers such as Petitioners must be enrolled in the Medicare program and be issued a billing number to have billing privileges and to be eligible to receive payment for services rendered to a Medicare-eligible beneficiary.

The Secretary has delegated the authority to revoke enrollment and billing privileges to CMS. 42 C.F.R. § 424.535. CMS may revoke an enrolled supplier's Medicare enrollment and billing privileges and supplier agreement for any of the reasons listed in 42 C.F.R. § 424.535. If CMS revokes a supplier's Medicare billing privileges, the

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(Footnote continued.)

in this case are helpful. Accordingly, the supplemental post-hearing briefings filed by both parties are accepted.

[4] A "supplier" furnishes services under Medicare and includes physicians or other practitioners and facilities that are not included within the definition of the phrase "provider of services." Act § 1861(d) (42 U.S.C. § 1395x(d)). A "provider of services," commonly shortened to "provider," includes hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, hospice programs, and a fund as described in sections 1814(g) (42 U.S.C. § 1395f(g)) and 1835(e) (42 U.S.C. § 1395n(e)) of the Act. Act § 1861(u) (42 U.S.C. § 1395x(u)). The distinction between providers and suppliers is important because they are treated differently under the Act for some purposes.

revocation becomes effective 30 days after CMS or one of its contractors mails the revocation notice to the supplier, subject to some exceptions not applicable in this case. After a supplier's Medicare enrollment and billing privileges are revoked, the supplier is barred from re-enrolling in the Medicare program for a minimum of one year, but no more than three years. 42 C.F.R. § 424.535(c).

A supplier whose enrollment and billing privileges have been revoked may request reconsideration and review as provided by 42 C.F.R. pt. 498. 42 C.F.R. § 424.545(a). A supplier submits a written request for reconsideration to CMS or its contractor. 42 C.F.R. § 498.22(a). CMS or its contractor must give notice of its reconsidered determination to the supplier, giving the reasons for its determination and specifying the conditions or requirements the supplier failed to meet, and of the right to an ALJ hearing. 42 C.F.R. § 498.25. If the decision on reconsideration is unfavorable to the supplier, the supplier has the right to request a hearing by an ALJ and further review by the Departmental Appeals Board (the Board). Act § 1866(j)(8) (42 U.S.C. § 1395cc(j)(8)); 42 C.F.R. §§ 424.545, 498.3(b)(17), 498.5. A hearing on the record, also known as an oral hearing, is required under the Act unless waived. *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743, 748-51 (6th Cir. 2004). The supplier bears the burden to demonstrate that it meets enrollment requirements with documents and records. 42 C.F.R. § 424.545(c).

B. Issue

Whether there was a basis for the revocation of Petitioners' billing privileges and enrollment in Medicare pursuant to 42 C.F.R. § 424.535(a)(8).

C. Findings of Fact, Conclusions of Law, and Analysis

My conclusions of law are set forth in bold text followed by my findings of fact and analysis. I have carefully considered all the evidence and the arguments of both parties, though not all may be specifically discussed in this decision. I discuss in this decision the credible evidence given the greatest weight in my decision-making.[5] I also discuss any evidence that I find is not credible or worthy of weight. The fact that evidence is not specifically discussed should not be considered sufficient to rebut the presumption that I considered all the evidence and assigned such weight or probative value to the credible evidence that I determined appropriate within my discretion as an ALJ. There is no

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[5] "Credible evidence" is evidence that is worthy of belief. *Black's Law Dictionary* 596 (8th ed. 2004). The "weight of evidence" is the persuasiveness of some evidence compared to other evidence. *Id*. at 1625.

requirement for me to discuss the weight given to every piece of evidence considered in this case, nor would it be consistent with notions of judicial economy to do so. Charles H. Koch, Jr., *Admin. L. and Prac.* § 5:64 (3d ed. 2013).

> **1. Billing privileges are abused, within the meaning of 42 C.F.R. § 424.535(a)(8), when three or more claims are submitted to Medicare for services that could not have been furnished to the specific individuals identified in the claims on the dates the services were claimed to be delivered.**
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> **2. Petitioners abused billing privileges within the meaning of 42 C.F.R. § 424.535(a)(8) because Petitioners submitted 38 claims for payment to Medicare for services purportedly delivered to Medicare beneficiaries; but the claims were for services that could not have been delivered because 29 claims were for services to dead beneficiaries, 5 claims were for the debridement of 6 or more toenails on beneficiaries who had a lower limb amputation and did not have more than 5 toenails, and 4 claims were for services for beneficiaries who were not present in the nursing homes at the time the services were purportedly rendered.**
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> **3. It is no defense to a revocation action for abuse of billing privileges under 42 C.F.R. § 424.535(a)(8) that the false claims were due to accidental, inadvertent, or unintentional errors of Petitioners' agents, employees, or others.**
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> **4. There is a basis for revocation of Petitioners' Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(8).**
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> **5. The effective dates of the revocations in this case are July 31, 2014, for Petitioners Dr. Jackson and Jessica S. Jackson, DPM, LLC, and July 25, 2014, for Petitioner Special Care Podiatry of Kentucky, PLLC, 30 days after the dates of the notices of initial determination to revoke. 42 C.F.R. § 424.535(g).**

Petitioners' enrollment and billing privileges were revoked pursuant to 42 C.F.R. § 424.535(a)(8). The regulation in effect at the time of the reconsidered determinations provided:

> *Abuse of billing privileges.* **The provider or supplier submits a claim or claims for services that could not have been furnished to a specific individual on the date of service.** These instances include but are not limited to situations where the beneficiary is deceased, the directing

> physician or beneficiary is not in the State or country when services were furnished, or when the equipment necessary for testing is not present where the testing is said to have occurred.

42 C.F.R. § 424.535(a)(8) (emphasis added). This regulation provides Petitioner notice that billing privileges and Medicare enrollment may be revoked for an abuse of billing privileges. 5 U.S.C. §§ 551(4), 552(a)(1). The elements of the CMS prima facie case for revocation pursuant to 42 C.F.R. § 424.535(a)(8) are: (1) the provider or supplier submits one or more claims for services; and (2) the services for which a claim or claims were submitted could not have been delivered to a Medicare beneficiary on the date the service was claimed to have been delivered. *Realhab, Inc.*, DAB No. 2542 at 16-17 (2013). Although the plain language of the regulation seems clear enough at first blush, there have been several Board decisions that turned to the regulatory history of the regulation for clarification of what was intended to be a sufficient basis for revocation under the regulation. *Proteam Healthcare, Inc.*, DAB No. 2658 (2015); *Ronald J. Grason, M.D.*, DAB No. 2592 at 7 (2014); *Realhab, Inc.*, DAB No. 2542 at 16; *Howard B. Reife, D.P.M.*, DAB No. 2527 at 1 (2013). CMS, the proponent of the regulation, explained in comments to the final rule making in 2008:

> CMS, not a Medicare contractor, will make the determination for revocation under the authority at § 424.535(a)(8). We will direct contractors to use this basis of revocation after identifying providers or suppliers that have these billing issues. We have found numerous examples of situations where a physician claims to have furnished a service to a beneficiary more than a month after their recorded death, or when the provider or supplier was out of State when the supposed services had been furnished. **In these instances, the provider has billed the Medicare program for services *which were not provided* and has submitted Medicare claims for services to a beneficiary who could not have received the service which was billed.** This revocation authority is not intended to be used for isolated occurrences or accidental billing errors. Rather, this basis for revocation is directed at providers and suppliers who are engaging in a pattern of improper billing . . . . We believe that it is both appropriate and necessary that we have the ability to revoke billing privileges when services could not have been furnished by a provider or supplier. We recognize the impact that this revocation has, and a revocation will not be issued unless sufficient evidence demonstrates abusive billing patterns. **Accordingly, we will not revoke billing privileges**

> **under § 424.535(a)(8)** ***unless there are multiple instances, at least three,*** **where abusive billing practices have taken place** . . . . **In conclusion,** ***we believe that providers and suppliers are responsible for the claims they submit or the claims submitted on their behalf.*** We believe it is essential that providers and suppliers take the necessary steps to ensure they are billing appropriately for services furnished to Medicare beneficiaries.

73 Fed. Reg. 36,448, 36,455 (June 27, 2008) (emphasis added). Based on this regulatory history, I conclude that CMS must also show as part of its prima facie case that there were more than one and at least three claims for services that could not have been delivered. I note that the drafters of the regulation also state that only CMS and not a Medicare contractor will make the determination to revoke pursuant to 42 C.F.R. § 424.535(a)(8). 73 Fed. Reg. at 36,455.[6] As discussed more fully hereafter, CMS did make the revocation determination in these cases and directed the issuance of the initial determinations and the period of the bar to re-enrollment. C-15-534 CMS Ex. 1 at 47;C-15-535 CMS Ex. 1 at 39.

Because I conclude that CMS did make a prima facie showing of a basis for revocation pursuant to 42 C.F.R. § 424.535(a)(8), it is necessary in this case to consider whether or not Petitioner either rebutted the prima facie case or established a defense. The Secretary's regulations at 42 C.F.R. pt. 498 do not address the allocation of the burden of proof or the standard of proof. However, the Board has addressed the allocation of the burden of proof in cases subject to 42 C.F.R. pt. 498 in many decisions. According to the Board, the standard of proof is a preponderance of the evidence. CMS has the burden of coming forward with the evidence and making a prima facie showing of a basis for revocation of Petitioner's enrollment. Petitioner bears the burden of persuasion to rebut the CMS prima facie showing by a preponderance of the evidence or to establish any affirmative defense. *Batavia Nursing & Convalescent Inn*, DAB No. 1911 (2004); *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd*, 129 F. App'x 181 (6th Cir. 2005); *Emerald Oaks*, DAB No. 1800 (2001); *Cross Creek Health Care Ctr.*, DAB No. 1665 (1998); *Hillman Rehab. Ctr.*, DAB No. 1611 (1997) (*remand*), DAB No. 1663 (1998) (*aft. remand*), *aff'd*, *Hillman Rehab. Ctr. v. United States*, No. 98-3789 (GEB), 1999 WL 34813783 (D.N.J. May 13, 1999).

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[6] On December 5, 2014, 42 C.F.R. § 424.535(a)(8) was amended to add 42 C.F.R. § 424.535(a)(8)(ii) effective February 3, 2015. 79 Fed. Reg. 72,500 (Dec. 5, 2014). The amendment of 42 C.F.R. § 424.535(a)(8) does not impact the outcome in this case.

a. Facts

On April 29, 2014, the Zone Program Integrity Contractor (ZPIC) Cahaba Safeguard Administrators notified CMS, WPS, and CGS that it had identified possible abuse of billing privileges by Petitioner Jackson. The ZPIC allegations were based, at least in part, on Petitioners' claims history records obtained from Petitioners. ZPIC alleged that Petitioners filed claims for: services delivered to Medicare-eligible beneficiaries after their date of death; debridement services for more toe nails than beneficiaries had due to lower limb amputations; and for services delivered to Medicare-eligible beneficiaries in skilled nursing facilities when they were actually in inpatient status in a hospital. C-15-534 CMS Ex. 1 at 49-70; C-15-535 CMS Ex. 1 at 41-62; Tr. 98-99.

On June 23, 2014, CMS directed WPS and CGS to revoke Petitioners' enrollment pursuant to 42 C.F.R. § 424.535(a)(8) based on the ZPIC report, with a three-year re-enrollment bar. C-15-534 CMS Ex. 1 at 47; C-15-535 CMS Ex. 1 at 39. The WPS notice of initial determination to revoke was reviewed and approved by the "CMS Provider Enrollment Revocations Office" on June 20, 2014. C-15-534 CMS Ex. 1 at 23. CMS also provided specific guidance to CGS for preparing the notice of the initial determination to revoke on June 24 and 25, 2014. C-15-535 CMS Ex. 1 at 37-38.

CGS issued notices of the initial determination to revoke on June 25, 2014, to Petitioner Jackson and Petitioner Special Care Podiatry of Kentucky, PLLC (C-15-535 CMS Ex. 1 at 25-26) and to Petitioner Jackson and Jessica S. Jackson, DPM, PLLC (C-15-535 at 31-32). WPS issued its notice of the initial determination to revoke to Petitioner Jackson and Jessica S. Jackson, DPM, PLLC, on July 1, 2014. C-15-534 CMS Ex. 1 at 17-18. The MACs attached the same lists of claims and beneficiaries to their initial determinations. The deceased Medicare beneficiaries list consists of 32 claims for services delivered to 17 beneficiaries on dates of service after their dates of death. The amputee list consists of five claims for services delivered to four Medicare beneficiaries for service for more toes than they had on the dates of service. The inpatient billings list consists of four claims for four beneficiaries for services rendered in a nursing facility on dates of service when they were inpatients in the hospital. C-15-534 CMS Ex. 1 at 19-22; C-15-535 CMS Ex. 1 at 27-30, 33-36. Records of the individual claims have been admitted as C-15-534 CMS Exs. 5, 6, and 7 and C-15-535 CMS Exs. 7, 8, and 9; and Social Security Death Index information for the deceased beneficiaries was admitted as C-15-534 CMS Ex. 8 and C-15-535 CMS Ex. 10.

Petitioner does not deny that all claims listed in the attachments to the notice of initial determination were erroneous claims, except those related to three beneficiaries for which Petitioners deny having any records and for which Dr. Jackson denied having provided any services. Tr. 201-08. But Petitioners assert that the errors are inadvertent and involve services actually delivered by Petitioner Jackson but to the wrong person due to misidentification of the person to whom services were rendered; coding error by

Petitioner Jackson; and unintentional billing errors by Petitioners billing service. C-15-534 CMS Ex. 1 at 5-15; C-15-535 CMS Ex. 1 at 5-22; Tr. 100-117, 126-29; C-15-534 P. Exs. 1-3; C-15-535 P. Exs. 1-2.

Petitioner Jackson testified the erroneous claims involved in this case were due to coding and other errors by her billing company, incorrect identifying information provided by facilities where beneficiaries received services, inability of beneficiaries to correctly identify themselves, and her confusion about the identity of a beneficiary. Tr. 176-92. Petitioner Jackson testified that she was not paid for any of the claims related to deceased beneficiaries except a payment of $41.60, which she immediately returned. Tr. 187, 209. She testified that, subsequent to being informed of the ZPIC audit findings, she engaged an expert to help her avoid similar issues in the future. Tr. 192-94. Dr. Jackson testified that she never knowingly incorrectly billed for services. She also testified to changes in the billing process to avoid similar errors in the future. Tr. 197-98. Dr. Jackson denied submitting claims for R.S., W.K, and M.C. who were listed on the deceased beneficiary list. Tr. 203; P. Br. Ex. A at 1-3. Dr. Jackson's testimony is unrebutted and fully credible.

Natalie Thomas was called as a witness by Petitioner. Ms. Thomas was employed by Petitioners' billing company and reviewed the claims identified in the initial determinations. She confirmed that errors occurred at the billing company or erroneous information was provided by the nursing facilities where services were delivered. She testified that Petitioners' billing company has no record of any claims submitted on behalf of Petitioners for R.S., W.K., or M.C., all of whom were listed on the deceased beneficiary list. Tr. 226-27; P. Br. Ex. A at 1-3. She also testified to changes made in the Petitioners billing process to avoid similar errors in the future. Tr. 218-32. On cross-examination she clarified that she did not process any of the claims in question, but she investigated the circumstances of each. Tr. 234. Ms. Thomas' testimony is unrebutted and fully credible.

Petitioner also called Robert Weatherford. Mr. Weatherford is president and owner of Medical Compliance Associates, Incorporated and specializes in helping providers and suppliers ensure they are complying with Medicare requirements. Mr. Weatherford was qualified and accepted as an expert in billing and coding under Medicare. He opined that Petitioners' records are some of the best he has seen; the errors are common errors; any loss by Medicare was minimal; and he opined that the billing errors in these cases do not reflect abusive billing or fraud but are innocent mistakes. Tr. 261-85. Mr. Weatherford's testimony was unrebutted and fully credible.

b. Analysis[7]

The elements of the CMS prima facie case for revocation pursuant to 42 C.F.R. § 424.535(a)(8) are: (1) the provider or supplier submitted more than one and at least three claims for services; and (2) the services for which claims were submitted could not have been delivered to a Medicare beneficiary on the dates the services were claimed to have been delivered. There is no dispute that the following claims identified by CMS and its MACs and included with the notices of initial determination were submitted on behalf of Petitioners and were erroneous claims:

- 29 claims for services delivered to 14 beneficiaries on dates of service after their dates of death;

- 5 claims for services delivered to 4 Medicare beneficiaries for service for more toes than they had on the dates of service; and

- 4 claims for 4 beneficiaries for services rendered in a nursing facility on dates of service when they were inpatients in the hospital.

C-15-534 CMS Ex. 1 at 19-22; C-15-535 CMS Ex. 1 at 27-30, 33-36; C-15-534 CMS Exs. 5, 6, and 7; C-15-535 CMS Exs. 7, 8, and 9; C-15-534 CMS Ex. 8; C-15-535 CMS Ex. 10; P. Br. Ex. A. I find that Petitioners rebutted the CMS prima facie showing as to claims related to deceased beneficiaries, R.S., W.K., and M.C., based on the unrebutted testimony of Dr. Jackson and Ms. Thomas that they reviewed Petitioners' claims records and found no evidence that any claim was submitted for these three deceased beneficiaries. Tr. 203, 226-27. There is no question that more than three claims were submitted by Petitioners for services delivered to Medicare eligible beneficiaries for dates of service when the claimed services could not have been delivered to the specific Medicare beneficiary. Accordingly, I conclude that CMS has made a prima facie showing of a basis for revocation of Petitioners' Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(8).

I further conclude, contrary to the arguments of Petitioners (P. Br. at 29), that the evidence shows that CMS did make the revocation determination in these cases and directed the issuance of the initial determinations, including the period of the bar to re-enrollment. C-15-534 CMS Ex. 1 at 47; C-15-535 CMS Ex. 1 at 39. The CMS action

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[7] At the conclusion of the government case-in-chief, counsel for Petitioners requested a judgment on partial findings in favor of Petitioners. *See* Fed. R. Civ. Pro. 52(c). The motion is denied for the reasons addressed in this decision. Tr. 166-70.

satisfies the intention of the drafters of 42 C.F.R. § 424.535(a)(8) that only CMS and not a Medicare contractor make the determination to revoke pursuant to 42 C.F.R. § 424.535(a)(8). 73 Fed. Reg. at 36,455. The regulatory history of 42 C.F.R. § 424.535(a)(8) reflects the intention that there be a consultation between the MAC and CMS with direction by CMS to the MAC for revocations pursuant to the regulation. *John M. Shimko, D.P.M.*, DAB No. 2689 at 11. In this case, WPS, CGS, and Cahaba did not make the decision to revoke, they simply executed the decision of CMS.

The issue remaining for examination is whether Petitioners met their burden to establish a defense. Petitioners agree that the facts are largely undisputed in this case. P. Br. at 1. Petitioner asserts that in 2014, CMS reviewed Petitioner's Medicare billing for four years and identified only 38 errors out of 45,000 claims. P. Br. at 1, 8-10. CMS does not concede that only 38 erroneous claims were discovered out of 45,000 claims. CMS offered evidence that it has declared 100 percent of Petitioner's claims to be overpayments. CMS Ex. 11. But there is no evidence those alleged overpayments have been adjudicated and no evidence related to those claims has been presented to me. The CMS witness, Adam Barnett, testified credibly and consistent with Petitioners' position that the number of erroneous claims he found was a small percentage of the group of Petitioners' claims he reviewed. Tr. 155. Before me, CMS is only proceeding upon the claims listed in the attachments to the initial determinations which total 41 claims related to 25 beneficiaries. C-15-535 CMS Ex. 1 at 27-30. Petitioners have presented credible testimony that their records are actually very good and the errors reflected in the claims presented to me were innocent and unintentional and involved the actual delivery of service, albeit to the wrong patient. Petitioners also point out that there has been no financial loss to the government on account of any of the claims involved. P. Br. at 2; P. Reply at 3-10. Petitioners characterize the issues for resolution as follows:

> [W]hether the law requires absolute perfection in Medicare billing and coding such that CMS may adopt a zero-tolerance policy for unintentional billing errors;
>
> [T]he impact of regulatory history and CMS's own statements on judicial interpretation of Medicare regulations and whether providers [or suppliers], like Dr. Jackson, may rely on CMS's public representations concerning the scope and intended use of its revocation authority;
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> [W]hether the few isolated and accidental billing errors identified by CMS in this case constitute an "abuse of billing privileges" sufficient to exclude Dr. Jackson from Medicare; and

> [W]hether CMS contractors have authority to revoke a provider's [or supplier's] billing privileges under 42 C.F.R. § 424.535(a)(8).

P. Br. at 2. The gist of Petitioner's argument is that the drafters of 42 C.F.R. § 424.535(a)(8) clearly expressed that revocation was not intended for isolated occurrences or accidental billing errors, and they strongly suggested that revocation should be limited to those cases where a provider or supplier is engaging in improper billing. P. Br. at 3. Petitioners argue that it was the intent of the drafters that innocent and unintentional errors should not be the bases for revocation. P. Br. at 3, 11-16; P. Reply at 3-10. In other words, Petitioner's position is that a showing that errors in claims are innocent or accidental should be a defense to revocation under 42 C.F.R. § 424.535(a)(8).

Petitioners argue that in *Proteam Healthcare, Inc.*, DAB No. 2658, an appellate panel of the Board held that CMS does not have "absolute and unfettered discretion to revoke billing privileges for innocent billing errors." P. Br. at 16-22. However, Petitioners reliance on *Proteam* is misplaced as the Board clearly limited the scope of that decision to the application of 42 C.F.R. § 424.535(a)(1) and specifically declined to address the application of other revocation authorities. The Board found in *Proteam* "that CMS has consistently treated section 424.535(a)(1) as inapplicable to mere errors in claiming and has stated that its authority to revoke for inaccurate billing is set out in other provisions." *Proteam*, DAB No. 2659 at 7. The Board also concluded that "erroneous billing does not constitute noncompliance with enrollment requirements" for purposes of revocation pursuant to 42 C.F.R. § 424.535(a)(1). *Id.* Although the Board specifically did not apply 42 C.F.R. § 424.535(a)(8) in *Proteam*, the Board relied on the adoption of that provision as a basis for its limitation on the application of 42 C.F.R. § 424.535(a)(1). The Board also cited extensively to the regulatory history of 42 C.F.R. § 424.535(a)(8) and the purported limitations the drafters intended to apply to its application. *Proteam*, DAB No. 2658 at 8-10. I conclude Petitioners' reliance on *Proteam* is misplaced and their effort to extrapolate from that case to the interpretation and application of 42 C.F.R. § 424.535(a)(8) fails.

Petitioners discussed other decisions of the Board upholding revocation pursuant to 42 C.F.R. § 424.535(a)(8) and argue all represent more egregious facts than presented in this case. P. Br. at 22-24. While I recognize that there are different facts, I also find no decision of the Board where a defense of innocent or accidental error has been recognized or accepted by the Board when revocation is based on 42 C.F.R. § 424.535(a)(8). Appellate panels of the Board have addressed revocation pursuant to 42 C.F.R. § 424.535(a)(8) in several cases. The Board's analysis and interpretation of 42 C.F.R. § 424.535(a)(8) and its regulatory history can be summarized as follows:

Abuse within the meaning of 42 C.F.R. § 424.535(a)(8) occurs when a provider or supplier bills Medicare for services that could not have been provided to the specific Medicare beneficiary to whom the claim related. *Realhab, Inc.*, DAB No. 2542 at 14.

The Board has said that the common definition of abuse is misuse, wrong, or improper use, and negligent submission of multiple erroneous claims for services that could not have been delivered to beneficiaries satisfies the common definition of abuse. *Louis J. Gaefke, D.P.M.*, DAB No. 2554 at 9 (2013); *Howard B. Reife, D.P.M.*, DAB No. 2527 at 6.

A pattern of improper billing occurs when there are three or more instances of improper billing. *John P. McDonough, III, Ph.D, Geriatric Psychological Specialists, and GPS II, LLC,* DAB No. 2728 at 7-8 (2016).

CMS is not required to show that a provider or supplier intended to defraud Medicare before it revokes their billing privileges as the regulation only requires the existence of claims for services that could not have been delivered. 42 C.F.R. § 424.535(a)(8); *Gaefke*, DAB No. 2554 at 7; *Patrick Brueggeman, D.P.M.*, DAB No. 2725 at 8 (2016); *John M. Shimko, D.P.M.*, DAB No. 2689 at 11; *McDonough*, DAB No. 2728 at 7.

CMS is not required to show that improper claims were not accidental. *Brueggeman*, DAB No. 2725 at 11; *McDonough*, DAB No. 2728 at 8.

The regulation does not provide any exception for inadvertent or accidental billing errors. Providers and suppliers may not avoid responsibility for their claims by shifting responsibility and liability to their billing agent. A provider or supplier is ultimately responsible, both as a matter of law and under the terms of their participation agreements, for ensuring that their claims are accurate and for any errors in their claims. *Gaefke*, DAB No. 2554 at 5-6 (citing 73 Fed. Reg. at 36,455).

The plain language of the regulation is sufficient to place providers and suppliers on notice that the submission of a claim for a specific individual on a specific date for services that could not have been provided to the specific individual is an abuse of billing privilege that could result in revocation and three such claims shows that the submission of the claims is not merely accidental. *McDonough*, DAB No. 2728 at 8. The Board's decision seems to indicate that three erroneous claims triggers a presumption that the submission of the claims was not accidental and sufficient to justify revocation pursuant to 42 C.F.R. § 424.535(a)(8), though the Board has not specifically used the term "presumption." The Board has also not held nor suggested that if a presumption is triggered, that it is rebuttable.

> The Board has not recognized a defense based on accidental or unintentional error in the submission of claims. Indeed, in *Gaefke*, the Board stated that "[t]he regulatory language also does not provide any exception for inadvertent or accidental billing errors." DAB No. 2554 at 7. The Board stated in *McDonough* that "Petitioners overlook CMS's further elucidation in the preamble that, for this purpose, submission of three or more improper claims would not be considered accidental but rather evidence of a pattern of abusive billing. DAB No. 2728 at 7-8 (citing 73 Fed. Reg. at 36,455). The Board has stated that "the Secretary stated a policy of not initiating revocation based on accidental claims but also warned that the submission of three or more improper claims would not be considered accidental." *Gaefke*, DAB No. 2554 at 8.
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> CMS is not required to establish an error rate or percentage of improper claims submitted by a provider or supplier in order to revoke Medicare enrollment and billing privileges under 42 C.F.R. § 424.535(a)(8). *McDonough*, DAB No. 2728 at 8. The Board has not recognized a low error rate as a defense to revocation pursuant to 42 C.F.R. § 424.535(a)(8).

Petitioner argues that CMS has recognized that billing errors are inevitable and CMS has adopted policies and procedures to assist providers and suppliers to identify and address erroneous claims. Citing the regulatory history of 42 C.F.R. § 424.535(a)(8), Petitioner asserts that revocation is not intended to be the response to unintentional and innocent billing errors such as those of Petitioners. P. Reply at 9-10. The Board has rejected similar arguments, concluding in past cases that three erroneous claims constitute abusive billing and a basis for revocation. The Board has recognized no defense to a revocation pursuant to 42 C.F.R. § 424.535(a)(8). In this case, the testimony of Petitioners' witnesses is fully credible that the claims listed on the enclosures to the notice of initial determination were accidental and unintentional errors. Petitioners make a strong argument that the regulatory history of 42 C.F.R. § 424.535(a)(8) indicates that the drafters intended for innocent or accidental claims to be a defense to their consideration as a basis for revocation under 42 C.F.R. § 424.535(a). Petitioners also advance a strong policy argument that the CMS policy of strict application of 42 C.F.R. § 424.535(a)(8) is unwarranted, unreasonable, and unjust. There is evidence that it is not uncommon for innocent and accidental errors in claims to occur and if every provider or supplier was held to no more than three erroneous claims, few if any providers or suppliers could survive CMS review and revocation pursuant to 42 C.F.R. § 424.535(a)(8). But neither the plain language of the regulation nor the Board's various decisions interpreting the regulation in light of its regulatory history recognize any defense to the submission of three or more claims of the type that are described by the regulation. I have no policy making role or authority to consider Petitioners' policy argument but merely conduct a de novo review. My jurisdiction is limited to determining whether, consistent with the Act and regulations, CMS has a basis to revoke Petitioners' Medicare enrollment and billing privileges. I have no authority to review the exercise of discretion by CMS to revoke

where there is a basis for revocation. *Abdul Razzaque Ahmed, M.D.*, DAB No. 2261 at 19 (2009). If either of the parties are dissatisfied with my decision they may seek review by the Board pursuant to 42 C.F.R. § 498.80. The Board's decision is the final action on behalf of the Secretary and is only subject to further review by the federal courts under the Act. 42 C.F.R. §§ 498.5, 498.90. Whether as the final decision-maker on behalf of the Secretary the Board finds that it has authority to consider policy arguments and make policy is for the Board to decide.[8] I clearly do not have such authority. Accordingly, I conclude Petitioners have established no defense to revocation pursuant to 42 C.F.R. § 424.535(a)(8).

The effective dates of the revocations in this case are July 31, 2014, for Petitioners Dr. Jackson and Jessica S. Jackson, DPM, LLC, and July 25, 2014 for Petitioner Special Care Podiatry of Kentucky, PLLC; 30 days after the dates of the notices of initial determination to revoke. 42 C.F.R. § 424.535(g).

III. Conclusion

For the foregoing reasons, the Medicare enrollment and billing privileges of Petitioners are revoked pursuant to 42 C.F.R. § 424.535(a)(8). Dr. Jackson and Jessica S. Jackson, DPM, PLLC are revoked effective July 31, 2014, and Special Care Podiatry of Kentucky, PLLC is revoked effective July 25, 2014

_____/s/_____
Keith W. Sickendick
Administrative Law Judge

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[8] It could be concluded that the Board's interpretation of the regulatory history and strict application of 42 C.F.R. § 424.535(a)(8) reflects a policy judgment. Certainly, the Board's authority to make interpretative rules, which are for all practical purposes agency policy, has been recognized by the federal courts. *See, e.g., Crestview Parke Care Ctr. v. Thompson*, 373 F.3d at 750. I note, however, that the Board's prior decisions related to 42 C.F.R. § 424.535(a)(8) involved cases decided on summary judgment and addressed the government's burden and not after a full hearing, so the Board did not specifically address the issue of whether there are any defenses available to revocation pursuant to 42 C.F.R. § 424.535(a)(8) as a matter of law or policy.