Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Ronald J. Grason, M.D.,
(PTAN: 216496)
(NPI: 1801060538)

Petitioner,

v.

Centers for Medicare & Medicaid Services

Docket No. C-14-394

Decision No. CR3215

Date: May 2, 2014

DECISION

Petitioner, Ronald J. Grason, M.D., is a physician, practicing in Illinois, who, until recently, participated in the Medicare program. The Centers for Medicare & Medicaid Services (CMS) has revoked his billing privileges, citing abusive billing practices. Petitioner appeals.

For the reasons explained below, I find that Dr. Grason repeatedly billed the Medicare program for services he did not provide and that CMS properly revoked his billing privileges.

Background

By letter dated May 9, 2013, the Medicare contractor, Wisconsin Physicians Service Insurance Corporation, advised Dr. Grason that his Medicare billing privileges were revoked, effective June 8, 2013. The contractor took this action pursuant to 42 C.F.R. § 424.535(a)(8), because it found that Dr. Grason submitted multiple claims for services that he could not have furnished as billed. CMS Exhibit (Ex.) 1.

Petitioner requested reconsideration. In a reconsidered determination, dated August 29, 2013, the contractor upheld the revocation. CMS Ex. 4. Petitioner eventually appealed, and his appeal is now before me. CMS Ex. 5. CMS has filed a motion to dismiss, because Petitioner's hearing request was not timely filed. As alternatives, CMS asks that I enter summary judgment in its favor or that I issue a decision based on the written record.

I decline to rule on CMS's motion to dismiss and, for the reasons set forth below, deny its motion for summary judgment.[1] However, because CMS presents no witnesses and has not asked to cross-examine Petitioner's witnesses, this case is ready for a decision based on the written record.[2]

With its motions, CMS filed a brief (CMS Br.) and 14 exhibits (CMS Exs. 1-14). Petitioner objected to CMS's motions (P. Br.) and filed five exhibits (P. Exs. 1-5). I admit into evidence CMS Exs. 1-14 and P. Exs. 1-5. I discuss below Petitioner's objections to some of CMS's exhibits.

Discussion

CMS, acting on behalf of the Secretary of Health and Human Services, may revoke a supplier's billing privileges if he abuses them, specifically, if he submits a claim or claims for services that he could not have furnished to a specific individual on the date of service. 42 C.F.R. § 424.535(a)(8).

[1] Petitioner concedes that he did not appeal timely, but claims that his health issues constitute good cause for the late filing. His evidence suggests that for some – but not all – of the 60 days immediately prior to the appeal deadline, his health issues likely impeded his ability to file. Rather than address the difficult question of whether sporadic health issues constitute good cause for his failure to file timely, I move on to the more-easily-resolved merits.

[2] As I discuss below, CMS relies on documents that are not accompanied by testimony from those who created them. Had Petitioner asked that CMS produce the drafters of these documents (Agent Minden, Sullivan Apartments personnel) for cross-examination, I would have been compelled to order it. However, Petitioner made no such request.

1. CMS is not entitled to summary judgment, because Petitioner disputes a material fact.[3]

CMS has moved for summary judgment, arguing that no material facts are in dispute. Summary judgment is appropriate when a case presents no issue of material fact, and its resolution turns on questions of law. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-48 (1986); *1886ICPayday.com, L.L.C.*, DAB No. 2289 at 2-3 (2009); *Illinois Knights Templar Home*, DAB No. 2274 at 3-4 (2009), *citing Kingsville Nursing Ctr.*, DAB No. 2234 at 3-4 (2009); *Livingston Care Ctr. v. U.S. Dep't of Health & Human Servs.*, 388 F. 3d 168, 173 (6th Cir. 2004). The moving party may show the absence of a genuine factual dispute by presenting evidence so one-sided that it must prevail as a matter of law, or by showing that the non-moving party has presented no evidence "sufficient to establish the existence of an element essential to [that party's] case, and on which [the party] will bear the burden of proof at trial." *Livingston Care Ctr.*, 388 F.3d at 173 (*quoting Celotex Corp. v. Catrett*, 477 U.S. 317, 323-24 (1986)).

This case turns on questions of fact: whether, on December 23, 2011 and February 14, 2012, Dr. Grason provided the services – for which he billed the Medicare program – to five Medicare beneficiaries residing in a senior-citizen apartment complex. CMS points to the building's visitor sign-in sheets, which show that Dr. Grason was physically present for fifteen minutes or less on each of those days. CMS Exs. 7, 9. According to CMS, because Dr. Grason was in the building for such a short time, he could not possibly have provided the services for which he billed Medicare. For his part, Dr. Grason claims that he provided these services and more, and he attacks the reliability of the sign-in sheets. According to Dr. Grason, security staff did not ask him to produce identification, but just waved and buzzed him in. He did not generally check out at the security desk when he left the building, and "it [was] not uncommon" for building staff to sign him out five minutes after he arrived, even though he was there for more than three hours. P. Ex. 2 at 2; P. Br. at 1.[4]

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[3] My findings of fact/conclusions of law are set forth, in italics and bold, in the discussion captions of this decision.

[4] I recognize that Petitioner, who is not represented by counsel, did not submit a written declaration testifying to these facts. Instead, they are included in his objections to CMS's motions and in his correspondence to the Medicare contractor. As such, the statements could be considered arguments of counsel and hearsay, which, under the rules of evidence, might not be admissible to establish the truth of the underlying facts. However, the rules of evidence do not apply in these proceedings. 42 C.F.R. § 498.61. Moreover, the evidence upon which CMS relies – the investigator's report and the visitor sign-in sheets – could also be considered problematic, inasmuch as CMS did not provide

In ruling on a motion for summary judgment, I must draw all reasonable inferences in the light most favorable to the non-moving party. The sign-in sheets are evidence that Dr. Grason was not physically present in the building long enough to provide the services for which he billed Medicare. However, if I accepted as true Dr. Grason's statements as to the manner in which those documents were produced, I could reasonably infer that they are not reliable. Petitioner has therefore established a dispute of material fact, which precludes my entering summary judgment.

I therefore deny CMS's motion for summary judgment.

Nevertheless, because neither party justifies my convening an in-person hearing, I close the record and decide the case. My pre-hearing order directs the parties to file, among other submissions, a list of all proposed witnesses, and to include, as a proposed exhibit, the written direct testimony of any proposed witness. Acknowledgment and Pre-hearing Order (Order) at ¶¶ 4(c)(iv), 8. The order explains that an in-person hearing is necessary only if a party files a witness's admissible, written direct testimony, and the opposing party asks to cross-examine. Order ¶ 10. Because neither party asks to cross-examine any witness, the case can be decided based on the written record.

2. A preponderance of evidence establishes that, on December 23, 2011 and February 14, 2012, Dr. Grason could not have furnished the services – for which he submitted claims to the Medicare program – to five Medicare beneficiaries.

Burdens of proof. In supplier appeals brought under 42 C.F.R. Part 498, the parties' relative burdens of proof are well-established. CMS must come forward with evidence that establishes a prima facie case. Once CMS meets this burden, the provider must prove his case by a preponderance of the evidence. *MediSource Corp.*, DAB No. 2011 at 2-3 (2006), *citing Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, No. 04-3325 (6th Cir. 2005).

The CPT. The Current Procedural Terminology (CPT) is a set of codes used to describe medical, surgical, and diagnostic services. CPT Code 99349 describes a physician's "evaluation and management" of an established patient in the patient's home. It requires at least two of three key components: 1) detailed interval history; 2) detailed examination; and 3) medical decision-making of moderate complexity. CMS Ex. 13 at 2. According to CMS's claims processing manual, such a home visit should take forty minutes to complete. CMS Ex. 14 at 2-3.

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declarations from the investigator and security personnel establishing their authenticity. Under our more relaxed rules, however, all of the evidence comes in.

Facts. Dr. Grason is a physician who was living in Decatur, Illinois in 2011-2012, and participating in the Medicare program. He had no office and his practice was limited. Twice a week, every week, he made the three-hour drive from Decatur to Chicago. There, he purportedly visited the same 25-40 patients, who resided in senior-citizen retirement buildings. According to his billing records, all of his patients suffered from hypertension. He generally listed no other diagnoses. Virtually without exception, he billed the Medicare program for a "medium-high complexity home visit" (CPT Code 99349) for each patient. CMS Ex. 6 at 1. In the two and a half years immediately prior to the Inspector General's investigation of his billing practices, the Medicare program paid Dr. Grason approximately $730,000 for these types of claims. CMS Ex. 6 at 1; *see* CMS Ex. 13.

CMS limits this case to five Medicare beneficiaries, all residing in the Patrick Sullivan Apartments, a senior-retirement housing complex in Chicago. CMS Ex. 12 at 1. The complex consists of two towers, North and South, of at least 20 stories each. CMS Ex. 6 at 2. Three of the five beneficiaries resided in the north tower, each on a different floor. Two resided in the south tower, each on a different floor. CMS Ex. 12. Each tower has one elevator. To move from one tower to the other, a visitor must pass through the ground floor lobby. Visitors to either tower are signed in by an attendant at a common security access point. CMS Ex. 6 at 2.

Timothy Minden, a special agent with HHS's Office of Inspector General, interviewed about thirty of Dr. Grason's patients, along with staff from their building complex, and obtained the building's visitor sign-in sheets. CMS Ex. 6 at 1. According to the December 23, 2011 sheet, at 6:37 a.m., Ronald Grason arrived to see a building tenant named Monroe. Dr. Grason departed thirteen minutes later, at 6:50 a.m. CMS Ex. 7 at 1. He did not return. CMS Ex. 6 at 2; CMS Ex. 7. Agent Minden confirmed these entries with building staff. CMS Ex. 6 at 1.

CMS's record of Dr. Grason's billings for December 23, 2011 shows that he submitted claims for services he purportedly provided to 24 patients that day, including Mr. Monroe and the four other Sullivan Apartment residents on whom CMS has focused its attention. CMS Exs. 6, 8.

Similarly, on February 14, 2012, the visitor sign-in sheet shows that Dr. Grason arrived at the building at 6:33 a.m. and departed fifteen minutes later, at 6:48 a.m. CMS Ex. 9 at 1. For that day, he billed the Medicare program for services he purportedly provided to 25 patients, including the five residing at Patrick Sullivan Apartments. CMS Ex. 10.

Analysis. Petitioner objects to my admitting into evidence the visitor logs. He argues that they are inherently unreliable, factually untrue, and would not be admitted under the federal rules of evidence. I recognize that the foundation for these documents is a little weak; however, even under the rules of evidence they would likely be admissible as

business records, and, given the more relaxed rules that govern these proceedings, are certainly admissible.[5] The sign-in sheets, together with Special Agent Minden's report, establish a prima facie case that, on December 23 and February 14, Dr. Grason could not have furnished services to the five individuals as he claimed.

Dr. Grason offers no persuasive evidence to rebut CMS's case. He submits a written declaration signed by four of the five named patients. The declaration does nothing to counter CMS's prima facie case. The patients declare that Dr. Grason has been their attending physician for many years, that his services are necessary, that he visits twice a week at the patient's request. Otherwise, they say, they would have to go to the hospital. They would like the relationship to continue and "abhor any interference with [the] doctor-patient relationship." P. Ex. 3 at 4. The patients say nothing about Dr. Grason's visiting them on December 23, 2011 or February 14, 2012. They say nothing about the length of his visits. Nor do they specify what services he performs during those visits.

Nor does Dr. Grason offer any treatment notes, patient records, or other evidence showing that he performed the services for which he billed the Medicare program.

Dr. Grason challenges the CMS manual provision that a physician's home visit billed under CPT Code 99349 should take approximately 40 minutes. He argues that this is a guideline, "impractical in the medical realm," which fails to take into account the physician's experience and competence. P. Br. at 5. While I might accept the proposition that an experienced physician could perform the home visit – including the required two of three components (detailed interval history, detailed examination, moderately complex medical decision) – in less than forty minutes, I find that no one is capable of performing five such visits in less than fifteen minutes, particularly where, as here, doing so involves moving from floor to floor and even tower to tower.

Dr. Grason also argues that CMS has not proved its case, because it has not submitted evidence establishing a pattern of abuse. P. Br. at 6. First, the regulation does not require a "pattern" of abuse. It plainly authorizes CMS to act if the supplier "submits *a claim* . . . that could not have been furnished. . . ." 42 C.F.R. § 424.535(a)(8) (emphasis added). I recognize that language from the regulation's preamble suggests that CMS does not intend to revoke billing privileges in response to an isolated occurrence or an accidental billing error, but will generally act when it finds "multiple instances, at least three," abusive billing practices. 73 Fed. Reg. 36,448, 36,455 (June 27, 2008). Nevertheless, the language of the preamble should not preclude CMS from following the plain language of

[5] Moreover, his attacks on the records raise questions that he has not addressed. For example, if building staff only waved him in on the days in question, how would they know which tenant he was visiting?

the regulation. *See Louis J. Gaefke, D.P.M.*, DAB CR2785 at 7-8 (2013), *aff'd*, DAB No. 2554 (2013). In any event, ten incorrect billings submitted over two days constitutes a pattern within the meaning of the preamble.

Moreover, Dr. Grason's billing records for December 23 and February 14 establish billing practices that could not possibly reflect the services he actually rendered on those days. According to the billing records, Dr. Grason claimed to have provided services to 24 patients on one day (December 23, 2011) and 25 patients on another day (February 14, 2012). CMS Exs. 8, 10. At 40 minutes per visit, that means he would have spent 16 hours each of these days treating patients, plus the commute time – 3 hours to Chicago and 3 hours home – and the additional time required to move between patients. It seems there are not enough hours in the day to account for Dr. Grason's billings.

Petitioner also raises arguments that are irrelevant to the limited issue before me. He claims that he provides additional services for which he does not bill the Medicare program. He concedes that he listed the same diagnosis for each patient, but argues that they all had multiple diagnoses, for which he prescribes many drugs. These arguments do not establish that, on December 23 and February 14, he provided the services for which he billed Medicare.

Finally, I have no authority to consider Petitioner's due process arguments. Nor do I have jurisdiction over the significant overpayment that CMS is apparently demanding from Dr. Grason. *See* 42 C.F.R. § 498.3.

Conclusion

CMS has come forward with evidence that Petitioner Grason billed the Medicare program for services that he did not provide. Petitioner has not established that he provided those services. I therefore find that he billed the Medicare program for services he did not provide and that CMS properly revoked his billing privileges.

/s/
Carolyn Cozad Hughes
Administrative Law Judge