Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Access Foot Care, Inc./Robert Metnick, D.P.M.,
(PTAN Nos: K0540, 65246B),
(NPI: 1275579740),

Petitioners,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-2326

Decision No: CR4113

Date: August 11, 2015

DECISION

I grant summary judgment in favor of the Centers for Medicare & Medicaid Services (CMS), sustaining its determination to revoke the Medicare enrollment and billing privileges of Petitioners Access Foot Care, Inc. (Access) and Robert Metnick, D.P.M. CMS's determination is justified because Petitioner Metnick caused Petitioner Access to file claims with CMS for services allegedly provided to Medicare beneficiaries on service dates when these beneficiaries were deceased, in violation of the requirements of 42 C.F.R. § 424.535(a)(8).

I. Background

Petitioner Metnick is a podiatrist and he owns Petitioner Access. Petitioner Access files claims for Medicare reimbursement for podiatric services rendered by Petitioner Metnick. Petitioners requested a hearing to challenge a reconsideration determination affirming CMS's initial determination to revoke their Medicare enrollment and billing privileges. CMS moved for summary judgment and

Petitioners opposed it. CMS filed 12 exhibits, identified as CMS Ex. 1 – CMS Ex. 12 and Petitioners filed 17 exhibits, identified as P. Ex. 1 – P. Ex. 17. I receive these into the record for the purpose of deciding the motion.

II. Issue, Findings of Fact and Conclusions of Law

A. Issue

At issue is whether CMS is authorized to revoke Petitioners' Medicare participation and billing privileges.

B. Findings of Fact and Conclusions of Law

The central undisputed fact in this case is this: Petitioner Metnick caused Petitioner Access to submit 13 claims for podiatric services that he allegedly provided to Medicare beneficiaries who were, in fact, deceased at the times that the services allegedly were rendered. CMS Ex. 2 at ¶ 9; CMS Ex. 6; CMS Ex. 7.

These claims were not the first time that Petitioner Metnick had submitted claims for services allegedly rendered to beneficiaries who were deceased on the purported service dates. Petitioners previously had done the same thing and had filed a compliance plan that supposedly assured that they would not do so again. CMS Ex. 4 at 1; CMS Ex. 5 at 1.

Medicare regulations governing participation of suppliers like Petitioners authorize CMS to revoke the participation and billing privileges of any provider or supplier who: "submits a claim or claims for services that could not have been furnished to a specific individual on the date of service." 42 C.F.R. § 424.535(a)(8). The regulation specifically states that such instances include but are not limited to the situation or situations where the beneficiary or beneficiaries are deceased. *Id.*

The undisputed facts plainly establish a basis for revoking Petitioners' Medicare enrollment and billing privileges. They submitted or caused to be submitted Medicare reimbursement claims for beneficiaries who were deceased on the purported service dates. They did so not once, but on multiple occasions. And, they did so after having been caught doing the same thing previously.

Petitioners make several arguments to assert there is either no basis for revocation or that there are at least disputed issues of fact that prevent issuance of summary judgment. I find these arguments to be without merit.

Petitioners contend that the claims that they submitted for services purportedly rendered to beneficiaries who were deceased on the alleged service dates were accidental and thus, cannot be the basis for revocation. They assert that these claims were innocent billing errors and that they should not be penalized for such errors, which they contend comprise only a miniscule percentage of the claims filed by Petitioner Access. As support for this contention, Petitioners aver that the names of seven of the deceased beneficiaries whose purported services are at issue are identical or nearly identical to seven living beneficiaries who also receive care from Petitioners. Petitioners' brief at 3 – 4.

On its face 42 C.F.R. § 424.535(a)(8) does not distinguish between false claims that are filed accidentally and those that are fraudulent or filed with willful disregard of their truth. The regulation states only that the filing of claims on behalf of beneficiaries who are deceased on the purported service dates is grounds for revocation. The plain meaning of the regulation authorizes CMS to revoke Petitioners' participation whether or not they filed the claims at issue here accidentally.

However, the undisputed facts establish that Petitioners' claims were *not* mere "accidents," at least not in the sense that they comprised only one or two innocent mistakes. Petitioners filed multiple false claims. The claims that are the basis for CMS's revocation determination were not the first instances of false claims filed by Petitioners. There was a previous episode and, like the current episode, they involved claims filed on behalf of beneficiaries who were deceased on the dates of purported services.

The regulation does not require proof of intent to defraud or even negligence to justify revocation. *Howard B. Reife,* DAB No. 2527, at 4 (2013). The Secretary of Health and Human Services (Secretary) has, however, softened the potential impact of this regulation somewhat by conditioning revocation on at least a minimal pattern of claims abuse. In an interpretative statement the Secretary declared that revocations can be implemented where there are "multiple instances, at least three, where abusive billing practices have taken place." 73 Fed. Reg. 36,448, 36,455 (June 27, 2008).

That test is satisfied by the undisputed facts. The undisputed facts establish that Petitioners filed more than three claims for beneficiaries who were deceased on the purported service dates. CMS produced documentation establishing that Petitioners filed 13 claims on behalf of 11 beneficiaries who were deceased on the purported service dates. CMS Ex. 6; CMS Ex. 7. Petitioners concede that they submitted claims for eight beneficiaries who were deceased on the purported service dates. Petitioners' hearing request at 5 - 8. They do not deny that they

may have filed the other claims asserted by CMS, but state only that they have no records to show whether or not they filed them.

Petitioners argue that, at the very least, they should be given an in-person hearing in order to establish that their intent was benign. But, and as I have discussed, the regulation is not dependent on proving bad intentions. Even unintentionally filed false claims may be a basis for revocation where a pattern of such filings is present. *Louis J. Gaefke, D.P.M.*, DAB No. 2554, at 5 – 6 (2013). Petitioners have not offered any facts that refute the undisputed proof of a pattern of abusive claims.

Petitioners argue that recent changes to 42 C.F.R. § 484.538(a), published in December 2014, make it plain that providers who unintentionally file false claims due to clerical or billing errors should not be subject to revocation. This case predates the publication of that regulation and there is nothing in the letter of the regulation that suggests that it should be applied retroactively.

Furthermore, even if the amended regulation applies, there is nothing in its language that suggests that Petitioners should not have their participation and billing privileges revoked given the undisputed facts. If anything, the amended regulation reinforces the conclusion that CMS may revoke participation and billing privileges where a provider – even unintentionally – files claims for services for beneficiaries who are deceased on purported service dates.

The amended regulation leaves the original section 424.538(a) intact as 424.538(a)(i)(A) through (C). As with the original regulation, this subsection specifies that CMS may revoke a provider or supplier's participation and billing privileges where the beneficiary is deceased at the time of service. And, as with the original regulation, this subsection does not condition authority to revoke on proof of bad intent or even negligence by the provider or supplier.

The amended regulation adds a new subsection, 42 C.F.R. § 424.538(a)(ii). This new subsection authorizes revocation of participation and billing privileges for a reason that is additional to those stated at subsection (i). The additional ground for revocation consists of "a pattern or practice of submitting claims that fail to meet Medicare requirements." Thus, CMS may now revoke a provider or supplier's participation and billing privileges for the broadly stated reason that the provider or supplier has a pattern or practice of filing claims that fail to meet Medicare requirements. Unlike the specifically stated bases for revocation in subsection (i), the basis for revocation stated in subsection (ii) is general in nature. This potentially could sweep in a host of deficient claim filing practices in addition to those stated in subsection (i).

Subsection (ii) lists a number of factors that CMS will consider in determining whether a pattern of deficient claims exists. These factors apply *only* to the broad spectrum of deficient claims now covered by subsection (ii). They not only are not applicable to the claims covered by subsection (i), but their presence in subsection (ii) emphasizes that revocation may be imposed under subsection (i) without regard to any of the factors that should be considered for the broad spectrum of deficient claims described under subsection (ii).

Petitioners argue that their participation and billing privileges should not be revoked inasmuch as they gained no remuneration from the claims that are at issue. That is no defense. The authority to revoke arises from Petitioners' submission of false claims and not from whether or not Petitioners were remunerated for them. 42 C.F.R. § 424.535(a)(8).

Petitioners argue also that CMS failed to consider and accept a corrective action plan that they filed. They contend that CMS erred in not accepting the plan inasmuch as the plan addressed all of the problems identified by CMS.

There is nothing in the regulations that requires CMS to accept a corrective action plan. In this case CMS afforded Petitioners the opportunity to file a plan. But, determining not to accept it is entirely within CMS's discretion. Furthermore, there is no right to a hearing to challenge CMS's determination not to accept a corrective action plan. 42 C.F.R. § 498.3(b).

Finally, Petitioners argue that they should be permitted to apply for re-enrollment immediately. CMS determined to preclude Petitioners from applying for re-enrollment for a period of one year. Petitioners argue that the one-year re-enrollment bar is excessive and punitive. I have no authority to address this argument. First, applicable regulations specify that where participation and billing privileges are revoked, the period during which re-enrollment is prohibited must be a minimum of one year. 42 C.F.R. § 424.535(c). CMS imposed the minimum period allowed by law. Second, the length of the bar to re-enrollment is not an initial determination that may be appealed. 42 C.F.R. § 498.3(b).

/s/
Steven T. Kessel
Administrative Law Judge