Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Brajendra P. Singh, M.D.
(NPI: 1235122649),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-2637

Decision No. CR4477

Date: December 2, 2015

DECISION

Palmetto GBA (Palmetto), an administrative contractor for the Centers for Medicare & Medicaid Services (CMS), revoked the Medicare enrollment and billing privileges of Brajendra P. Singh, M.D. (Dr. Singh or Petitioner) based on Medicare claims Dr. Singh filed for services he allegedly provided to deceased beneficiaries. Dr. Singh requested that CMS reconsider Palmetto's determination; however, CMS upheld the revocation. Dr. Singh requested a hearing to dispute the revocation. Because there is no dispute that Petitioner erroneously filed 12 claims for services that were never provided because the beneficiaries in question were deceased, I grant CMS's motion for summary judgment and affirm the revocation of Petitioner's Medicare billing privileges.

I. Case Background and Procedural History

Dr. Singh has been a physician in North Carolina since 1986. Petitioner Exhibit (P. Ex.) 1 ¶ 4. As a physician, he is a "supplier" in the Medicare program. 42 U.S.C. § 1395x(d). In a September 5, 2014 letter, CMS zone protection integrity contractor AdvanceMed informed Dr. Singh that he may have violated 42 C.F.R. § 424.535(a)(8) based on filing claims for services allegedly provided to deceased beneficiaries from January 1, 2010,

through May 30, 2014. AdvanceMed included a list of the 35 claims in question and offered Dr. Singh an opportunity to respond to AdvanceMed's letter. CMS Ex. 1. Dr. Singh's office manager responded that Dr. Singh has not intentionally committed fraud and that their practice of billing at the end of each month might sometimes result in billing after Medicare beneficiaries have died. P. Ex. 2.

In a February 10, 2015 initial determination, Palmetto notified Dr. Singh that it was revoking his Medicare billing privileges effective March 12, 2015, for the following reason:

> **42 CFR §424.535(a)(8) – Abuse of Billing Privileges**
>
> Data analysis conducted on claims billed by Dr. Brajendra Singh, for dates of service between March 31, 2010 and May 30, 2014, revealed claims for services rendered to beneficiaries who were deceased on the purported date of service.

CMS Ex. 3 at 1 (emphasis in original). Palmetto attached a list of 26 claims involving 14 beneficiaries. CMS Ex. 3 at 3. Palmetto also imposed a three-year re-enrollment bar in the Medicare program. CMS Ex. 3 at 2. Palmetto informed Petitioner that he could request reconsideration by CMS's Center for Program Integrity. CMS Ex. 3 at 1.

Petitioner timely requested reconsideration and Petitioner's newly retained counsel filed a supplement to the reconsideration request. CMS Exs. 4-7. In his supplement to the request, Petitioner asserted that the billing problems primarily involved the way Petitioner billed for care plan oversight services. Specifically, Petitioner stated that care plan oversight for home health service patients only requires the physician to have had a face-to-face meeting within six months prior to billing for services. During each month, Petitioner would perform various care plan oversight functions for patients (e.g., review laboratory results, monitor medication changes, and monitor medical therapy), but would bill for those services at the end of each month with the date of service corresponding to the date of billing, even though the services were likely performed before that date. For seven of the beneficiaries identified in the initial determination to revoke, Petitioner asserted that the patients died in the same month for which Petitioner billed Medicare. Petitioner also acknowledged that he filed claims for five beneficiaries beyond the month in which the patients died. Petitioner admitted that this was because his office manager assumed that Petitioner was providing care plan oversight services during that time because Petitioner had never been informed that the patients were in fact deceased. Important to Petitioner's position was his assertion that home health agencies regularly failed to inform him timely of the death of patients and that Petitioner did not intend to bill Medicare abusively. CMS Ex. 7 at 2-4.

Petitioner also addressed claims involving care of nursing home residents. He asserted that claims involving four beneficiaries simply involved erroneous billing dates, i.e., Petitioner performed the services for those patients when they were alive, but Petitioner's office manager mistakenly indicated a service date after the date of death. However, Petitioner admitted that a few claims were improperly made because Petitioner's office manager did not actually confirm the services that she thought Petitioner had provided based on a list of residents he was supposed to see at nursing facilities. CMS Ex. 7 at 5.

Finally Petitioner's reconsideration request assured CMS that he had taken remedial action to make certain that there would only be proper billing in the future. Petitioner also indicated that he practices in a medically underserved area. CMS Ex. 7 at 6.

On April 10, 2015, CMS's Center for Program Integrity issued a reconsidered determination that upheld Palmetto's revocation. CMS Ex. 8. Petitioner timely requested a hearing before an administrative law judge (ALJ) to challenge the reconsidered determination. In the request for hearing (RFH), Petitioner argued that the initial determination to revoke his billing privileges was improperly issued by a CMS contractor rather than CMS itself. RFH at 1-2. Petitioner also argued that the revocation was improper because all of the billing issues identified by Palmetto were accidental or isolated problems. RFH at 2-3.

On June 17, 2015, I issued an Acknowledgment and Pre-hearing Order (Pre-hearing Order), which established general procedures for record development and permitted the parties to file for summary judgment if appropriate. *See* Pre-hearing Order ¶ 4. CMS timely filed a motion for summary judgment with a supporting brief (CMS Br.) along with eight proposed exhibits (CMS Exs. 1-8). In response, Petitioner requested that I issue a subpoena to compel CMS to produce documentation concerning its involvement in authorizing the initial determination to revoke. I denied the subpoena request because it failed to identify the specific documents sought. *See* 42 C.F.R. § 498.58(c)(1). Petitioner timely filed an opposition to CMS's motion for summary judgment as well as a cross-motion for summary judgment (P. Br.). Petitioner also submitted 17 proposed exhibits (P. Exs. 1-17), two of which were written direct testimony from witnesses (P. Exs. 1, 2). CMS filed a reply to Petitioner's cross-motion for summary judgment and requested that it be permitted to cross-examine Petitioner's witnesses if I denied CMS's motion for summary judgment (CMS Reply).

II. Issues

This case presents three issues:

1. Whether CMS is entitled to summary judgment;

2. Whether CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(8); and

3. Whether a CMS contractor can properly revoke Petitioner's Medicare billing privileges pursuant to 42 C.F.R. § 424.535(a)(8).

III. Jurisdiction

I have jurisdiction to decide the issues in this case. 42 C.F.R. §§ 498.3(b)(17), 498.5(*l*)(2); *see also* 42 U.S.C. § 1395cc(j)(8).

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

The Social Security Act (Act) authorizes the Secretary of Health and Human Services (Secretary) to establish by regulation procedures for enrolling providers and suppliers in the Medicare program. 42 U.S.C. § 1395cc(j)(1)(A). The Secretary has promulgated enrollment regulations in 42 C.F.R. part 424, subpart P. *See* 42 C.F.R. §§ 424.500 - .570. The regulations provide CMS with the authority to revoke the billing privileges of an enrolled provider or supplier if CMS determines that certain circumstances exist. *Id.* § 424.535(a). Relevant to this case, CMS may revoke a provider's or supplier's billing privileges if:

> 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.

Id. § 424.535(a)(8) (2014).[1] When CMS revokes a provider's or supplier's billing privileges, any provider agreement in effect at the time of revocation is terminated. *Id.* § 424.535(b). In addition, after revocation CMS must impose a bar on re-enrollment for a minimum of one year, but no more than three years. *Id.* § 424.535(c).

A provider or supplier may request reconsideration of the initial determination to revoke his or her billing privileges. 42 C.F.R. §§ 498.5(*l*)(1), 498.22(a). If dissatisfied with the

---

[1] CMS substantially amended 42 C.F.R. § 424.535(a)(8) effective February 3, 2015. *See* 79 Fed. Reg. 72,500 (Dec. 5, 2014). However, in this case I will apply 42 C.F.R. § 424.535(a)(8) (2014) because the text reflected in that regulation was in effect on the dates that Petitioner filed the claims on which Petitioner's revocation is based.

reconsidered determination, the supplier may request a hearing before an ALJ. *Id.* § 498.5(*l*)(2). When appropriate, ALJs may decide a case arising under 42 C.F.R. part 498 by summary judgment. *See* Civil Remedies Division Procedures § 19(a); *Livingston Care Ctr. v. U.S. Dep't of Health & Human Servs.*, 388 F.3d 168, 172 (6th Cir. 2004) (citing *Crestview Parke Care Ctr. v. Thomson*, 373 F.3d 743 (6th Cir. 2004)). Summary judgment is appropriate and an in-person hearing is not required if the record shows that there is no genuine dispute of any material fact and the moving party is entitled to judgment as a matter of law. *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 3 (2010) (citations omitted). To determine whether there are genuine issues of material fact for an in-person hearing, the ALJ must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. *Id.* (citation omitted).

1. Summary judgment is appropriate.

Although Petitioner disputes that some of the claims he submitted were not provided before the date that the beneficiaries died, others he acknowledges were improper claims. These latter claims provide a basis for summary judgment because Petitioner's arguments related to them are legal in nature.

As summarized above, a CMS contractor conducted an investigation and concluded that a number of Petitioner's claims for Medicare reimbursement indicated dates for services provided to beneficiaries who had already died. CMS provided that information to Petitioner and Petitioner responded. Palmetto later issued an initial determination to revoke Petitioner's billing privileges based on a shortened list of claims that Petitioner filed that indicated dates of services to beneficiaries who had already died.

In his reconsideration request, Petitioner responded to the claims listed in the initial determination to revoke and asserted that seven of the claims involved care plan oversight services where the dates of service on the claims did not actually reflect the date of service, but simply the date of submission at the end of each month. CMS Ex. 7 at 3. Petitioner also submitted records related to these claims. P. Exs. 3, 9, 11-12, 14-15. Petitioner asserted that due to his office manager's method of billing for monthly care plan oversight at the end of each month, it is likely that the services he provided earlier in the month occurred before the beneficiaries' deaths. CMS Ex. 7 at 4; P. Ex. 1 ¶¶ 7-9. For purposes of summary judgment, I accept as true that Petitioner provided the services in these claims while the beneficiaries were still alive.

Petitioner also addressed care plan oversight claims for services provided to deceased beneficiaries where the claims of services were more than month after the dates of death for the beneficiaries. Petitioner stated the following related to these claims:

> In another category of G0181 claims, however, [Petitioner's office manager] submitted claims for [care plan oversight] services with dates of service past the month in which the beneficiary died. These include beneficiaries ["C"] ([Date of Death] DOD 7-4-13; [Date of Service] DOS 8-30-13 and 9-30-13); ["P"] (DOD 5-2-12; DOS 6-29-12; 7-31-12; 8-31-12); ["J"] (DOD 5-3-12; DOS 6-29-12); ["F"] (DOD 8-13-11; DOS 9-30-11 and 10-31-11); and ["H"] (DOD 10-28-12; DOS 11-30-12). Because [Petitioner's office manager] did not have access to the home health agencies' medical records, she billed based on the plans of care, rather than what was documented in the patients' charts. And, because the home health agencies failed to properly notify Dr. Singh's office when patients died, [the office manager] mistakenly assumed that Dr. Singh had performed [care plan oversight] services for each month during which the patient's plan of care extended and billed for those services accordingly.
>
> . . . .
>
> With the benefit of hindsight, [the office manager] now understands that the [care plan oversight] services should have been billed based on documentation in the medical records and not simply on the assumption that Dr. Singh performed 30 minutes of [care plan oversight] services each month covered by the certification period. However, because neither she nor Dr Singh were ever advised by the home health agencies that these patients had died before the expiration of their plans of care, they could not have-and did not-knowingly or intentionally bill Medicare for services rendered to deceased beneficiaries.

CMS Ex. 7 at 4. Although Petitioner raises legal argument as to why the claims discussed above ought not to form a basis for revocation under 42 C.F.R. § 424.535(a)(8), for purposes of summary judgment, there is no dispute of fact that those claims involved services that could not have been provided to the named beneficiaries because those beneficiaries were deceased at the time the services were allegedly rendered.

Petitioner also responded to claims involving services rendered to nursing home residents. Petitioner asserts that a number of those claims simply involved clerical errors as to the dates the services to the deceased beneficiaries occurred. Petitioner argues that he provided the services claimed, but that the services were provided on an earlier date

when the beneficiary was still alive. CMS Ex. 7 at 5; P. Ex. 1 ¶ 10. For purposes of summary judgment, I accept as true that Petitioner provided the services for these claims, as detailed in his reconsideration request, while those beneficiaries were alive.

However, Petitioner conceded that other claims sought reimbursement for services that were not provided because the beneficiaries were deceased.

> Although most of the denied claims were the result of simple data entry errors as explained above, a few others were improperly billed due to a lack of communication between the nursing facilities and Dr. Singh's office. For example, a claim with a date of service of August 29, 2013, was submitted on behalf of beneficiary ["S"], who died July 31, 2013, and claims with dates of service of August 29, 2013, and September 26, 2013, were submitted on behalf of beneficiary ["E"], who died July 18, 2013. It is my understanding that the nursing facilities send to Dr. Singh, each month, a list of the patients to be seen by Dr. Singh that month. Dr. Singh makes rounds on these patients and documents his visits in the patients' charts, which belong to, and are kept at, the nursing facility. Until recently, [the office manager], who did not have access to the patient charts, would bill for these based on these lists received from the nursing facilities. Without access to the charts, she simply assumed that because the patient was on the list, Dr. Singh saw the patient. She billed the encounter accordingly, using code 99310, even though on some occasions the patient had, unbeknownst to her, died by the time Dr. Singh made his rounds at the facility.

CMS Ex. 7 at 5; *see also* P. Ex. 1 ¶¶ 11-12. Therefore, Petitioner concedes claiming reimbursement for services that could not have been rendered because the beneficiaries were deceased. These claims may form the basis for summary judgment.

For purposes of summary judgment, I draw all inferences in favor of Dr. Singh. I accept as true that the home health agencies that Dr. Singh worked with were often dilatory in informing him of the death of beneficiaries under Dr. Singh's care. P. Ex. 1 ¶ 9; P. Ex. 2 ¶ 6. I also accept as true that Petitioner's office manager did not intentionally file improper claims and that she considers them accidental. P. Ex. 1 ¶¶ 5-6. Further, I accept as true that Petitioner is located in a medically underserved area. P. Exs. 16-17. Finally, I accept as true that Petitioner has reformed his billing system to avoid new errors. P. Ex. 1 ¶ 13.

2. CMS was authorized to revoke Dr. Singh's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(8).

Once CMS determined that Dr. Singh submitted a claim or claims that could not have been furnished to a specific individual on the dates of service, it was then authorized to revoke Dr. Singh's Medicare enrollment and billing privileges. 42 C.F.R. § 424.535(a)(8). Here, there are 12 undisputed instances where Dr. Singh submitted claims for a service that could not have been and, in fact, were not furnished to a specific individual on the date of service. CMS Ex. 3 at 3; CMS Ex. 7 at 4-5.

Petitioner argues that despite the fact that 12 of his claims were for services he did not provide because the beneficiaries in question were deceased, CMS cannot revoke his Medicare enrollment and billing privileges because the claims were accidental or erroneous. Petitioner argues as follows:

> There is a genuine dispute as to whether CMS and its contractors have established a legitimate basis for revocation under § 424.535(a)(8). In its Final Rule, CMS specifically stated that the revocation authority found at § 424.535(a)(8) "is not intended to be used for isolated occurrences or *accidental billing errors*." 73 Fed. Reg. [36448], 36455 [(June 27, 2008)] (emphasis added). Petitioner has presented admissible evidence supporting his argument that the claims underlying this revocation were the result of accidental billing errors.

P. Br. at 6; *see also* RFH at 2; P. Ex. 1 ¶¶ 5-6. Petitioner blames many of the erroneous billings on poor communication from home health agencies and nursing homes as to when beneficiaries died. RFH at 2. Petitioner argues that simply submitting erroneous claims cannot serve to factually or legally prove abusive billing.

Although Petitioner quotes language from the preamble to the final rule publishing section 424.535(a)(8) to indicate that accidental abusive claims are not violations of section 424.535(a)(8), the preamble is not authoritative. The operative language of section 424.535(a)(8) does not require that CMS demonstrate Petitioner intended to defraud Medicare before it may revoke Petitioner's billing privileges. *See* 42 C.F.R. § 424.535(a)(8). Even an unintentional error with regard to claims may serve as a basis for revocation if the relevant regulation does not require fraudulent or dishonest intent. *See Louis J. Gaefke, D.P.M.*, DAB No. 2554, at 7 (2013); *cf. Proteam Healthcare Inc.*, DAB No. 2658, at 11 (2015).

As stated in *Gaefke:*

> Given the absence from the regulation of any requirement to show fraudulent intent, or exceptions for inadvertent error, the preamble cannot be read in a manner that would effectively bar CMS from taking action against providers or suppliers who submit multiple improper claims, even where the claims were the result of negligence or reckless indifference by the provider or supplier. We also agree with the ALJ that the preamble statements Petitioner cites do not bar CMS from revoking the enrollment of a supplier or provider whose incorrect billing falls within the plain language of the regulation.

DAB No. 2554, at 8. Further, to the extent that Petitioner relies on the term "abuse" in the title to section 424.535(a)(8) to read a requirement into the regulation that Petitioner must have intended to file improper billing, this argument has previously been rejected. *Id*.

The 12 improper claims that are undisputed in this case are more than sufficient to show a section 424.535(a)(8) violation. Section 424.535(a)(8) only requires "a claim or claims" for services that could not have been rendered. Therefore, one claim for services that could not have been rendered is enough for revocation. Even if the preamble to the final rule were controlling, the language there would require not more than three claims. 73 Fed. Reg. 36,448, 36,455 (June 27, 2008).

Petitioner also gains no benefit from blaming home health agencies and nursing homes for failing to inform him that beneficiaries for whom he was billing services had died. Although not directly argued, Petitioner clearly takes no personal responsibility for any of the claims because his office manager apparently prepared all of them. However, Petitioner cannot avoid revocation due to the actions of others. As stated in *Gaefke:*

> As discussed, Medicare suppliers and providers certify that they are responsible for the accuracy of their claims for reimbursement, and the regulation contains no exception for improper claims prepared and submitted by billing agents, which is consistent with the preamble stating that providers and suppliers are responsible for claims submitted on their behalf. As in [*Howard B.*] *Reife*, [*D.P.M.*, DAB No. 2527 (2013)], Petitioner "cites no legal authority relieving suppliers of responsibility for the claims for Medicare reimbursement submitted on their behalf and at their direction." . . . Petitioner's position, if adopted, would effectively shield a

> supplier from any consequences for the submission of an unlimited number of improper claims on his behalf, so long as he could point to an agreement with a billing agent, who is not a party to the supplier's Medicare agreement, to submit the claims. Petitioner's efforts to assign blame for the improper billing to his billing agent or his assistant do not relieve him of his responsibility for the improper claims or bar CMS from revoking his billing privileges.

DAB No. 2554, at 6 (internal citation omitted). Therefore, CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(8).[2]

3. The initial determination to revoke Petitioner's Medicare billing privileges in this case was properly issued by a CMS contractor and, even if CMS was required to revoke Petitioner itself without relying on a contractor, CMS's issuance of the reconsidered determination upholding the revocation was sufficient to meet such a requirement.

Petitioner argues that his revocation is procedurally defective and, therefore, I should reverse that revocation. Petitioner's basis for this argument is that there is no evidence that CMS was involved in the initial determination to revoke. Petitioner quotes from the preamble to the final rule establishing section 424.535(a)(8), which states that CMS, and not a Medicare contractor, will decide when to revoke billing privileges under that provision. P. Br. at 4 (citing 73 Fed. Reg. 36,448, 36,455 (June 27, 2008)). Respondent avers that CMS cannot violate its own procedural rules and cites *United States ex rel. Accardi v. Shaughnessy*, 347 U.S. 260 (1957) for support. P. Br. at 4.

CMS responded initially that Palmetto issued the initial determination revoking Petitioner at CMS's direction, and cited CMS Exhibits 1 and 3 for support. CMS Br. at 6. In response to Petitioner's cross-motion for summary judgment, CMS asserted that even if CMS did not direct the initial determination to revoke (a point that CMS did not concede), CMS issued the reconsidered determination upholding the revocation, and it is the reconsidered determination that is subject to review in this proceeding. CMS Reply at 3.

---

[2] Petitioner asserted that he practices in an underserved area and has changed his billing system. These were matters that CMS could consider when exercising its discretion as to whether to uphold the initial determination on reconsideration. I cannot consider those matters since my review is limited to deciding whether CMS had a legitimate basis to revoke Petitioner's billing privileges. *Letantia Bussell*, DAB No. 2196, at 13 (2008).

For purposes of summary judgment, I accept as true that Palmetto issued the initial determination to revoke Petitioner's billing privileges. Further, I accept as true that CMS did not direct Palmetto to issue the initial determination.

Petitioner's legal argument rests on a statement that CMS made in response to public comments in a final rule. However, the actual regulations do not prohibit a CMS contractor from issuing an initial determination to revoke a supplier under 42 C.F.R. § 424.535(a)(8). In fact, a regulation expressly authorizes Medicare contractors to revoke suppliers' billing privileges. 42 C.F.R. § 405.800(b). Further, this general authorization to CMS contractors has been upheld when challenged. *Fayad v. Sebelius*, 803 F.Supp. 2d. 699, 704-706 (E.D. Mich. 2011); *Douglas Bradley, M.D.*, DAB No. 2663, at 14-15 (2015). As discussed above, it is the regulatory language, and not the text to the preamble to the final rule, that is binding. Consistent with this, the case Petitioner cited to support the proposition that an agency cannot violate its own procedural rules involved an agency's failure to comply with duly promulgated regulations and not a statement made in a preamble to a final rule. *United States ex rel. Accardi v. Shaughnessy*, 347 U.S. 260, 266-67 (1957). Therefore, I cannot reverse a revocation because a Medicare contractor, and not CMS, issued that determination.

Even if a statement in the preamble to a final rule had legal affect, I agree with CMS that any defect in the issuance of the initial determination by Palmetto was cured by CMS's review of the case on reconsideration and its issuance of the reconsidered determination upholding the revocation. *See* CMS Ex. 8. At the reconsideration stage of the process, suppliers must provide the factual and legal reasons why they disagree with a revocation, and have the opportunity to submit evidence to show compliance with the regulations. 42 C.F.R. §§ 405.803(c), 498.22(c), 498.24(a). After receiving the reconsideration request, CMS:

> (b) Considers the initial determination, the findings on which the initial determination was based, the evidence considered in making the initial determination, and any other written evidence submitted [by the supplier] . . . .
>
> (c) Makes a reconsidered determination, affirming or modifying the initial determination and the findings on which it was based.

42 C.F.R. § 498.24(b)-(c). This process requires CMS to consider fully both the initial determination and a supplier's response to that determination, as well as all of the evidence in the case before deciding whether to affirm or modify the initial determination. Therefore, CMS affords suppliers with the same safeguards as envisioned by the preamble to the final rule.

V. Conclusion

For the reasons explained above, I grant summary judgment in favor of CMS and deny Petitioner's cross-motion for summary judgment. Consequently, I affirm CMS's determination to revoke Petitioner's Medicare enrollment and billing privileges.

/s/

Scott Anderson
Administrative Law Judge