Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Kermit E. White, M.D. &
Kermit E. White, M.D., P.C.
Docket No. A-16-95
Decision No. 2765
January 23, 2017

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Kermit E. White, M.D. and Kermit E. White, M.D., P.C. (Petitioner)[1] appeal the March 22, 2016 decision of an Administrative Law Judge (ALJ) sustaining the revocation of Petitioner's Medicare enrollment and billing privileges. *Kermit E. White, M.D. & Kermit E. White, M.D., P.C.*, DAB CR4553 (2016) (ALJ Decision). The Centers for Medicare & Medicaid Services (CMS), through its contractor, Wisconsin Physicians Service Insurance Corporation (WPS), revoked Petitioner's Medicare billing privileges based on its determination that Petitioner allowed another physician to submit claims under his billing number without entering into a valid reassignment of benefits, in violation of 42 C.F.R. § 424.535(a)(7).

For the reasons explained below, we affirm the ALJ's decision sustaining the revocation of Petitioner's Medicare enrollment and billing privileges.

Legal Background

A "supplier" of Medicare services – a term which includes a physician or a physician practice – must be enrolled in the Medicare program in order to receive payment for items and services covered by Medicare. 42 C.F.R. §§ 400.202, 424.505. "Enrollment" is the process that CMS uses to: (1) identify a prospective supplier; (2) validate the supplier's eligibility to provide items or services to Medicare beneficiaries; (3) identify and confirm a supplier's owners and "practice location"; and (4) grant the supplier "Medicare billing privileges." *Id.* § 424.502. A supplier "must submit enrollment information on the applicable enrollment application" and report changes in enrollment within 90 days (30 days for changes of ownership, any adverse legal action or change in

[1] Although the ALJ Decision refers to Kermit E. White, M.D. and Kermit E. White, M.D., P.C. as "Petitioners," we use only the term "Petitioner," meaning Dr. White, because he participated in Medicare using his professional corporation's billing number and the revocation notice was addressed to him.

practice location). *Id*. §§ 424.510(a), 424.516(d). An "enrollment application" is the CMS-approved paper enrollment application or an electronic Medicare enrollment process approved by the Office of Management and Budget. *Id.* § 424.502. The approved enrollment application for individual health care practitioners to reassign benefits to an organization is Form CMS-855R. 71 Fed. Reg. 20,754, 20,756 (2006) (preamble to final rule, 42 C.F.R. Part 424, subpart P, "Requirements for Establishing and Maintaining Medicare Billing Privileges").[2]

CMS is authorized to revoke a supplier's Medicare enrollment and billing privileges for any of the "reasons" specified in paragraphs (1) through (14) of section 424.535(a). Relevant here, paragraph (7), captioned "*Misuse of billing number*," permits CMS to revoke a supplier's enrollment and billing privileges if the supplier –

> knowingly sells to or allows another individual or entity to use its billing number. This does not include those . . . suppliers who enter into a valid reassignment of benefits as specified in § 424.80 or a change of ownership as outlined in § 489.18 of this chapter.

Section 424.80(a), captioned "*Basic prohibition*," states, in relevant part, that "[e]xcept as specified in paragraph (b) of this section, Medicare does not pay amounts that are due a supplier under an assignment to any other person under reassignment, power of attorney, or any other direct arrangement." Paragraph (b), captioned "*Exceptions to the basic rule*," states in relevant part:

> *Payment to employer*. Medicare may pay the supplier's employer if the supplier is required, as a condition of employment, to turn over to the employer the fees for his or her services.

42 C.F.R. § 424.80(b)(1). A supplier whose enrollment and billing privileges have been revoked under section 424.535 is "barred from participating in the Medicare program from the date of the revocation until the end of the re-enrollment bar." *Id.* § 424.535(c).

Case Background

Petitioner is a medical doctor who participated in the Medicare program as a "supplier" of services. In 2014, investigators for Cahaba Safeguard Administrators, LLC, a "Zone Program Integrity Contractor" working for CMS, observed that Petitioner had billed for types of services for which he had not previously billed, that there was a spike in his

[2] The version of the 855R dated 4/16 states that an "eligible organization/group may be an individual, a clinic/group practice or other health care organization." *See* http://www.cms.gov/MedicareProviderSupEnroll (last accessed 1/13/17). There is no 855R in the record for this case.

billed claims to Medicare, and that a significant number of the beneficiaries associated with the billed claims received services at a medical clinic owned by J.T., who was recently indicted in U.S. District Court. CMS Ex. 1, at 2. The investigators conducted both a telephone interview and an in-person interview with Dr. White and also interviewed the owner of Advanced Medical Billing Services, Inc. (AMBS), the billing agency that submitted the claims in question.[3] Based on the billing patterns and statements made at the interviews, Cahaba concluded that "Dr. White allowed Dr. [J.T.] to submit claims under his group PTAN [provider transaction access number]. . . – Kermit White MD PC." *Id*. at 1. Cahaba therefore recommended that CMS revoke Petitioner's billing privileges under section 424.535(a)(7). *Id*.

In an initial determination dated July 16, 2014, WPS notified Petitioner that it was revoking his Medicare enrollment and billing privileges effective August 15, 2014, pursuant to 42 C.F.R. § 424.535(a)(7), because Petitioner "allowed" another physician, J.T., "to submit claims under [Petitioner's] billing number for services rendered by" J.T. CMS Ex. 2, at 1.

On September 12, 2014, Petitioner requested reconsideration of WPS's revocation determination, stating in part that the revocation notice "fails to address or consider whether or not the purported improprieties noted therein were conducted with Dr. White's knowledge or consent, as opposed to surreptitiously." CMS Ex. 4, at 2. On October 20, 2014, CMS sustained the determination, concluding that Petitioner was out of compliance with section 424.535(a)(7) because Petitioner admitted to Cahaba "that he allowed Dr. [J.T.] to submit claims under his group Medicare billing number" and "[t]hese two providers did not enter into a valid reassignment of benefits." CMS Ex. 6, at 1.[4]

Petitioner timely requested a hearing before an ALJ. The parties filed pre-hearing briefs and submitted their proposed exhibits, including the declaration of A.B., a Cahaba investigator (CMS Ex. 9), and Petitioner's declaration (P. Ex. 2). CMS moved for summary judgment, arguing that "there is no dispute as to the material facts underlying the determination that Petitioner misused his Medicare billing privileges by allowing another physician, Dr. [J.T.], to knowingly use Petitioner's billing privileges." ALJ

[3] Petitioner and J.T. each signed an agreement with AMBS in December 2013 under which AMBS would "perform medical billing services" for him. CMS Ex. 1, at 21-25 (Petitioner's agreement dated 12/19/13); *id*. at 26-29 (J.T.'s agreement dated 12/13/13).

[4] Before requesting reconsideration, Petitioner submitted a Corrective Action Plan (CAP) in which he acknowledged his "[f]ailure to have appropriate compliance protocols in place to ensure the proper use of Medicare billing numbers by collaborating physicians." CMS Ex. 3, at 2. On November 6, 2014, CMS issued its decision on the CAP, stating that Petitioner "has not provided evidence to show that he has fully complied with the standards for which he was revoked" and CMS therefore cannot issue a Medicare number to him. CMS Ex. 7, at 1.

Order dated 4/15/15, at 1. The ALJ denied the motion, finding that "the essential questions of material fact, including whether Petitioner ever knowingly allowed Dr. [J.T.] to use Petitioner's Medicare billing information, or whether Dr. [J.T.] used that information without Petitioner's consent, remain contested." *Id*. At the hearing, Petitioner cross-examined A.B. and CMS cross-examined Petitioner.

The ALJ Decision

The ALJ made the following two findings of facts and conclusions of law (FFCLs):

> A. Dr. White knowingly allowed J.T. to submit claims using Dr. White's professional corporation's billing number for services that Dr. White did not provide.
> B. CMS was authorized to revoke Petitioners' Medicare enrollments and billing privileges pursuant to 42 C.F.R. § 424.535(a)(7).

ALJ Decision at 4, 8.

In his discussion of FFCL A, the ALJ relied primarily on the testimony of A.B., which he found "generally credible." *Id*. at 7. The ALJ stated that A.B.—

> ultimately did affirm . . . that based on his interview with Dr. White, he believed Dr. White knowingly authorized J.T. to bill for services J.T. provided using Dr. White's professional corporation's billing number. Tr. at 28. A.B. had no incentive to create a false report. He testified that he took notes during the interviews he had with Dr. White, prepared the reports found in CMS Ex. 1 at 51-52 based on those notes, and that the reports are a "true and accurate copy of the notes of [his] phone and in-person interviews with Dr. White." CMS Ex. 9 at 1-2.

Id. The ALJ also found that A.B.'s report and testimony were consistent with statements Petitioner made in his request for reconsideration and his CAP which the ALJ read as admissions that Petitioner had an improper arrangement whereby his billing number was used for services rendered by another physician. *Id*. In addition, the ALJ found that the statement made by the owner of the billing company in her interview with A.B., as reported by A.B., that Petitioner had knowingly allowed J.T. to submit claims under Petitioner's billing number was "worthy of some weight" since there was "no reason to doubt A.B.'s characterization of her statements," which A.B. testified he found credible. *Id*.

On the other hand, the ALJ found not "fully credible" Petitioner's (Dr. White's) testimony denying "that he knowingly allowed J.T. to bill for services J.T. provided using Dr. White's professional corporation's PTAN." *Id*. at 6. The ALJ noted that Petitioner relied primarily on a "purported written agreement between him and J.T." which

Petitioner claimed to have drafted to reduce to writing the agreement between him and J.T. *Id*. The agreement, which is signed only by Petitioner, states that in return for Petitioner's services "as 'Medical Director' to treat patients and to supervise the clinical and administrative personnel in Dr. [J.T.'s] clinics and to represent and market Dr. [J.T.'s] clinical enterprises," J.T. agrees to pay Petitioner $30,000 for services rendered as a physician from June 1, 2013 through the present, a monthly stipend of $1500 for each clinic under his supervision, and 6% of all collections for six months. P. Ex. 2. The ALJ found that Petitioner's reliance on this agreement was not justified, stating:

> Dr. White, however, did not sign the written agreement memorializing his understanding of his relationship with J.T. until January 31, 2014, six weeks after he signed a contract permitting J.T.'s biller to submit claims using his billing information and at least two months after he began working with J.T. . . . . Though he began providing services in one of J.T.'s clinics in November 2013, Dr. White inexplicably dated the agreement as beginning on June 1, 2013. . . . By the time Dr. White signed the agreement with J.T. on January 31, 2014, his professional corporation had already billed Medicare for 314 units of nerve block injections, 52 units of B12 injections, 562 units of CPT code 99215 and 121 units of CPT Code 96372. . . . . Dr. White does not claim that he actually provided these services. . . .

ALJ Decision at 6 (citations omitted).

The ALJ further found that "considering the overall evidence, Dr. White knowingly allowed J.T. to submit claims using Dr. White's professional corporation's billing number for services that Dr. White did not provide." *Id*. at 7.

In his discussion of FFCL B, the ALJ rejected Petitioner's argument that to meet its burden, CMS must put forward prima facie evidence that Petitioner knowingly "permitted the misuse of his billing number," stating:

> The plain language of section 424.535(a)(7), however, does not require a supplier to have knowingly permitted the *mis*use of his billing number; rather, it requires only that the [supplier] knowingly allowed another to use his billing number absent a valid reassignment or change of ownership.

Id. at 8 (italics in original), quoting P. Br. at 4. Noting that Petitioner does not "argue that a valid reassignment of benefits . . . or a transfer of ownership existed,"[5] the ALJ

[5] The ALJ Decision actually states that Petitioner did not argue "that a valid reassignment of benefits from J.T. to Dr. White's professional corporation" existed. ALJ Decision at 8. However, as discussed below, to fall under the exception in section 424.535(a)(7), Petitioner would have had to reassign his benefits to J.T. or his professional corporation.

concluded that since Petitioner "permitted J.T. to submit claims for services under Dr. White's professional corporation's billing number without a valid reassignment or change of ownership[,] . . . CMS had a legal basis to revoke Petitioners' Medicare enrollments and billing privileges." *Id*.

Standard of Review

We review a disputed finding of fact to determine whether the finding is supported by substantial evidence in the record as a whole and a disputed conclusion of law to determine whether it is erroneous. *See* Departmental Appeals Board, *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program (Guidelines)*. The *Guidelines* are available at http://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/index.html?language=en.

Analysis

In his request for review, Petitioner argues generally that the ALJ erred in finding that he knowingly allowed J.T. to submit claims using Petitioner's professional corporation's billing number for services Petitioner did not provide. Petitioner asserts that the ALJ should have credited his testimony that he gave J.T. permission to use his billing number only for claims for services Petitioner provided, believing that it was a condition of his employment to agree to such an arrangement. Petitioner takes the position that because he did not knowingly allow J.T. to use his billing number for other services, CMS had no legal basis for revoking his billing privileges.

As we explain below, although the ALJ found that Petitioner knowingly allowed J.T. to submit claims using Petitioner's professional corporation's billing number "for services that Dr. White did not provide," that finding was not necessary to the outcome of this case. Petitioner denies that he knew J.T. would use the number to bill for services that Petitioner did not provide (as an employee of J.T.), but Petitioner does not deny that he provided J.T. with access to his billing number. We conclude that revocation is authorized whenever a supplier permits another to use its billing number for any purpose, unless an exception applies. We need not, therefore, determine if the ALJ was correct in finding that Petitioner knew that J.T. would misuse the number to bill for J.T.'s own services. Moreover, the record shows that Petitioner did not fulfill the terms of the exception in section 424.80(b)(1) on which he relies.

1. The general rule prohibiting a supplier from knowingly allowing another individual or entity to use its billing number applies even if the supplier did not intend its billing number to be used to claim payment for services it did not provide.

The basis for revocation described in the first sentence of section 424.535(a)(7) – where a supplier "knowingly sells to or allows another individual or entity to use its billing number" – is very broad. Nothing in this language indicates that revocation is limited to situations in which the supplier knowingly allows another individual or entity to use its billing number for services not provided by the supplier. Thus, under the plain language of the first sentence, a basis for revocation exists whenever a supplier knowingly permits another individual or entity to use its billing number to claim payment for any services. Although the second sentence of section 424.535(a)(7) carves out an exception for "suppliers who enter into a valid reassignment of benefits as specified in section 424.80,"[6] the basic rule in section 424.80 is consistent with the first sentence of section 424.535(a)(7). Section 424.80(a) states: "Medicare does not pay amounts that are due a supplier under an assignment to any other person under reassignment, power of attorney, or any other direct arrangement." The phrase "amounts that are due a supplier under an assignment" refers to payments by Medicare for covered services that may be claimed by a supplier under an agreement by which the Medicare beneficiary who received the services from the supplier transfers his or her right to payment to the supplier, who must accept the amount allowable under Medicare as full payment for the services. *See, e.g.*, Social Security Act § 1842(b)(6) and (b)(3)(B)(ii); CMS's Medicare Claims Processing Manual, Ch. 1, 30.2.2, Para. C.[7] Accordingly, in stating that Medicare does not make payments due a supplier under such an arrangement, or assignment, "to any other person under reassignment, power of attorney, or any other direct arrangement," section 424.80(a) sets out a basic rule that a supplier may not reassign or otherwise transfer the right to receive payment for Medicare-covered services that has been assigned to that supplier by the beneficiary of the services. The regulatory history of section 424.80 confirms this interpretation as follows:

> The basic rule (established by section 1842(b)(6) of the [Social Security] Act) is that Medicare Part B payments may be made only to the beneficiary or to the physician or other supplier that furnished the service. That rule is set forth in paragraph (a); certain exceptions to the rule are specified in paragraph (b).

[6] As previously noted, section 424.535(a)(7) also states that it does not apply where there is "a change of ownership as outlined in § 489.18"; however, it is undisputed that no change of ownership was involved here.

[7] The Medicare Claims Processing Manual (Rev. 4/29/16) is available at https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms018912.html (last accessed 1/17/17).

53 Fed. Reg. 6629, 6631 (1988); *see also* Medicare Claims Processing Manual, Ch. 1, 30.2.2 (describing the law as "a prohibition against payment on a charge basis for covered services to anyone other than the patient, physician or other person who provided the services, with limited exceptions").[8]

Thus, like the first sentence of section 424.535(a)(7), the basic rule in section 424.80(a) prohibits Medicare from making payment to a physician for <u>any</u> services except those for which the beneficiary has assigned the right to payment. By allowing J.T. to use his professional corporation's billing number, Petitioner enabled J.T. to claim Medicare payments for services for which J.T. had not received assignment from the beneficiaries, contrary to this basic rule. Accordingly, unless one of the exceptions in section 424.80(b) applied, Petitioner was subject to revocation of his billing privileges under section 424.535(a)(7) even if he knowingly allowed J.T. access to his billing number only for services he, Petitioner, provided. Whether or not Petitioner was responsible for J.T.'s misuse of his billing number to claim Medicare payments for services J.T. provided, CMS could thus reasonably revoke Petitioner's billing privileges in order to protect the Medicare program from such misuse of billing privileges, absent proof that an exception applied.

2. <u>Petitioner failed to show that he qualified for the exception in section 424.80(b)(1) that allows a supplier to permit another supplier who is his employer to use his billing number under reassignment if this is required as a condition of employment.</u>

The only exception to the basic rule in section 424.80(b) on which Petitioner appears to rely (and the only one that arguably could apply to his situation) is the exception in section 424.80(b)(1), which provides that "Medicare may pay the supplier's employer if the supplier is required, as a condition of employment, to turn over to the employer the fees for his or her services." Petitioner in effect argues that this exception is applicable when he asserts that he was an employee of J.T. and was required as a condition of his employment to turn over to J.T. the fees for the services he provided or supervised at J.T.'s clinics. P. Ex. 1, at 2, Para. 8; P. Reply Br. at 8. This argument has no merit.

[8] The ALJ reached a similar conclusion about the applicable law, despite making the finding in FFCL A that Petitioner knowingly allowed J.T. to submit claims using Petitioner's professional corporation's billing number for services that Petitioner did not provide,. *See* ALJ Decision at 8 ("plain language of section 424.535(a)(7) . . . does not require a supplier to have knowingly permitted the *mis*use of his billing number; rather, it requires only that the provider knowingly allowed another to use his billing number absent a valid reassignment or change of ownership" (italics in original)).

As the ALJ noted, Petitioner did not submit a contemporaneous document setting out the terms of his employment by J.T. Instead, Petitioner proffers an agreement which he claims to have drafted and is signed only by him. The ALJ found that this document purports to confirm an agreement made between J.T. and Petitioner on June 1, 2013, but that Petitioner did not begin providing services at one of J.T.'s clinics until November 2013 and did not sign the agreement until January 31, 2014. ALJ Decision at 6. In light of these discrepancies, the ALJ did not accept this document as evidence that Petitioner did not knowingly permit J.T. to use Petitioner's professional corporation's billing number to bill for services J.T. provided. On appeal, Petitioner attempts to explain the discrepancies identified by the ALJ, citing his own testimony that he worked under the terms of the agreement before putting it in writing, and argues that the ALJ should have credited his testimony. RR at 5, citing P. Ex. 1 and Tr. at 56-58. The ALJ stated that "[a]fter weighing the direct testimony and testimony on cross-examination, as well as all the evidence in the case, I find Dr. White's explanation to not be fully credible." ALJ Decision at 6. The Board generally defers to an ALJ's findings on the weight and credibility to be given to a witness's testimony absent compelling reasons not to do so. *River City Care Ctr.*, DAB No. 2627, at 13 (2015), citing *Van Duyn Home & Hosp.*, DAB No. 2368, at 10-11 (2011); *Koester Pavilion*, DAB No. 1750, at 16, 21 (2000). Petitioner has given us no compelling reason not to defer to the ALJ's finding regarding his credibility.

Moreover, even if the evidence in the record had been sufficient to find that Petitioner was required to turn over to J.T. fees for his services as a condition of his employment (and we make no finding on this issue), we would conclude that the exception in section 424.80(b)(1) does not apply because Petitioner did not validly reassign to J.T. his right to Medicare payment for the services. Section 424.80 does not expressly require a reassignment in order for an exception in section 424.80(b) to apply; however, the second sentence of section 424.535(a)(7) states that the basis for revocation in the first sentence "does not include . . . suppliers who enter into a valid reassignment of benefits as specified in § 424.80." It follows that a reassignment is required in order for any of the exceptions in section 424.80(b) to apply. In addition, as noted above, the regulations governing supplier enrollment require that a supplier submit enrollment information on the applicable enrollment application, which includes Form CMS-855R. 42 C.F.R. § 424.510(a). That form, titled "Medicare Enrollment Application/Reassignment of Benefits," instructs the supplier to "[c]omplete this application if you are reassigning your right to bill the Medicare program and receive Medicare payments for some or all of the services you render to Medicare beneficiaries."

Petitioner does not allege that he submitted this form to WPS; indeed, Petitioner admits that he relied on the owner of AMBS to "properly effectuate the billing arrangement between Petitioner and [J.T.]." P. Reply at 5. We agree with the ALJ, however, that Petitioner "cannot avoid responsibility by deflecting blame to a biller." ALJ Decision at 8, citing *Louis J. Gaefke, DPM*, DAB No. 2554, at 5-6 (2013); 73 Fed. Reg. 36,448,

36,455 (June 27, 2008) ("[P]roviders and suppliers are responsible for the claims they submit or the claims submitted on their behalf."). Since there was no reassignment of Petitioner's billing privileges, the exception in section 424.80(b)(1) was not applicable here, even had Petitioner otherwise qualified for that exception.

Conclusion

For the foregoing reasons, we affirm the ALJ's decision sustaining the revocation of Petitioner's Medicare enrollment and billing privileges.

/s/
Constance B. Tobias

/s/
Susan S. Yim

/s/
Leslie A. Sussan
Presiding Board Member