

**Department of Health and Human Services  
DEPARTMENTAL APPEALS BOARD  
Appellate Division**

Wassim Younes, M.D. and Wassim Younes, M.D., P.L.C.  
Docket No. A-18-2  
Decision No. 2861  
March 30, 2018

**FINAL DECISION ON REVIEW OF  
ADMINISTRATIVE LAW JUDGE DECISION**

Wassim Younes, M.D. (Dr. Younes) and Wassim Younes, M.D., P.L.C. (the practice), (collectively Petitioners) appeal the decision of an Administrative Law Judge (ALJ) affirming the determination of the Centers for Medicare & Medicaid Services (CMS) revoking Petitioner's Medicare enrollment and billing privileges for a period of three years. *Wassim Younes, M.D., P.L.C., and Wassim Younes, M.D.*, DAB No. CR4902 (2017). The revocation arose from a determination by a Medicare contractor (upheld on reconsideration) that Petitioners claimed Medicare payments for home health services (such as establishing, reviewing, and certifying home health plans of care and conducting face-to-face patient encounters) purportedly furnished to Medicare beneficiaries which could not have been provided to specific individuals on the claimed dates of service because the individuals were deceased.

As we explain below, we find no error in the ALJ Decision and therefore uphold the revocation.

**Applicable legal authorities**

The Social Security Act provides for CMS to regulate the enrollment of providers and suppliers in the Medicare program. Social Security Act § 1866(j)(1)(A); 42 U.S.C. § 1395cc(j)(1)(A). The implementing regulations appear in 42 C.F.R. Part 424, subpart P. Among the applicable provisions, section 424.535(a)<sup>1</sup> provides reasons for which enrollment may be revoked, including the following:

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<sup>1</sup> As the ALJ noted, this subsection was substantially revised effective February 3, 2015 (79 Fed. Reg. 72,500, 72,532 (Dec. 5, 2014) (ALJ Decision at 4 n.3)), and we also apply the regulation as in effect at the time of the revocation (April 2, 2015). The particular change to the regulation is not material to the outcome of this appeal.

(8) *Abuse of billing privileges*. Abuse of billing privileges includes either of the following:

(i) 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 the following situations:

(A) Where the beneficiary is deceased.

The preamble to the final rule originally promulgating section 424.535(a)(8)<sup>2</sup> provides the following guidance regarding its intended uses:

[CMS] will direct contractors to use this basis of revocation (the authority at § 424.535(a)(8)) after identifying providers or suppliers that have these billing issues. . . . 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 that 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).

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<sup>2</sup> The original section 424.535(a)(8) read as follows:

(8) *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.

The effect of revocation is to terminate any provider agreement and to bar the provider or supplier “from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar.” 42 C.F.R. § 424.535(b), (c). The re-enrollment bar lasts for at least one year but no more than three years. *Id.* at § 424.535(c).

A provider or supplier whose Medicare enrollment has been revoked may request reconsideration by CMS or its contractor, and then appeal the reconsideration decision, to an ALJ and then to the Board, in accordance with the procedures at 42 C.F.R. Part 498. 42 C.F.R. §§ 424.545(a), 498.3(b)(17), 498.5(1)(1)-(3), 498.22(a).

### **Factual and procedural background**<sup>3</sup>

Dr. Younes is a physician practicing in Michigan. He is the sole owner of his medical practice, Wassim Younes, M.D., P.L.C. ALJ Decision at 4. Wisconsin Physicians Service Insurance Corporation (WPS), the CMS Medicare contractor, notified Petitioners by letter dated March 2, 2015, that their Medicare billing numbers and billing privileges were revoked effective April 2, 2015. The revocations were based on 42 C.F.R. § 424.535(a)(8). P. Ex. 1, at 1-4. The letter, along with an attached chart, explained that data analysis showed that certain claims had been submitted under the providers’ billing numbers for services provided between February 27, 2012, and October 29, 2014, to beneficiaries who were deceased at the time the services were allegedly provided to them. *Id.* The chart identified each claim with the date(s) of service and the name, Medicare number and date of death of each beneficiary. *Id.* at 3-4. WPS also notified Petitioners that they were each subject to a three-year bar to re-enrollment pursuant to 42 C.F.R. § 424.535(c), that WPS would assess an overpayment pursuant to 42 C.F.R. § 424.565 for claims paid to Petitioners listed in an attached report, and that they had the right to seek reconsideration. *Id.* at 1-4.

Petitioners sent WPS a letter dated March 26, 2015, enclosing a request for reconsideration along with a position paper, and a corrective action plan (CAP). CMS Ex. 1, at 1-296.<sup>4</sup> On April 21, 2015, CMS upheld the revocations, citing section 424.535(a)(8)(i), on reconsideration. CMS Ex. 3. The reconsidered determination explained the basis for the revocation as follows:

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<sup>3</sup> Factual information in this section is drawn from the ALJ Decision and undisputed facts in the record before the ALJ and is not intended to add to or modify the ALJ’s findings.

<sup>4</sup> The reconsideration request named both Petitioners in the heading, although the text of the position paper sometimes refers to Dr. Younes in the first person singular. The reconsidered determination similarly identified both Petitioners in its heading and refers alternately to Dr. Younes and the practice, and only to Dr. Younes at times. It is not disputed that the reconsideration applied to both Petitioners.

All of the documentation in the file for Wassim Younes PLC/Wassim Younes, MD has been reviewed and the decision has been made in accordance with Medicare guidelines, as outlined in 42 CFR §424.535. Data analysis identified that Dr. Younes was billing from February 27, 2012 to October 29, 2014 for services that could not have been rendered due to the beneficiary being deceased when the service was alleged to have been rendered. The data analysis revealed 95 instances where claims were submitted for 31 different beneficiaries and inappropriate billing took place. These claims were submitted under the tax identification number of Wassim Younes M.D., PLC. . . . [Dr. Younes] alleges that 42 CFR §424.535(a)(8) is for isolated occurrences, [and he] additionally alleges that these were accidental mistakes and that the enrollment bar is excessive. Even accepting Dr. Younes defense as true, he is still held responsible for the accuracy of the claims submitted for Medicare reimbursement because Medicare suppliers and providers certify that they are responsible for the accuracy of their claims for reimbursement. *See Louis J Gaefke, D.P.M., DAB No. 2554 (2013).* . . . CMS concludes that there was no error made by WPS in the determination of a revocation. The CAP and reconsideration are denied and the revocation is upheld. Therefore, CMS cannot grant you access to the Medicare Trust Fund (by way or issuance) of a Medicare number.

Reconsidered Determination at 2.

Petitioners sought ALJ review. CMS submitted 43 exhibits and moved for summary judgment; Petitioners submitted eight exhibits and opposed CMS's summary judgment motion. ALJ Decision at 2. CMS objected to Petitioners' Exhibits 3, 4, 6 and 7. *Id.*

### **ALJ Decision**

The ALJ resolved pending evidentiary disputes, admitting CMS Exhibits 1- 43 and Petitioners' Exhibits 1, 2, 5 and 8. *Id.* at 2-3. In addition, the ALJ determined that she could properly proceed to decision on the written record. *Id.* at 3. She then made the following substantive finding of fact and conclusion of law:

***The undisputed evidence establishes that Petitioners billed the Medicare program for services that Dr. Younes could not have provided because the beneficiaries to whom the services were purportedly provided were no longer living. CMS therefore properly revoked Petitioners' Medicare enrollment pursuant to 42 C.F.R. § 424.535(a)(8).***

*Id.* at 3 (bold and italics in original; footnote omitted). The ALJ rejected Petitioners' contention that they had properly submitted nine out of the 55 claims CMS identified as abusive.<sup>5</sup> *Id.* at 4. In these nine instances, Dr. Younes contended that he had issued verbal orders for home health plans of care and certifications of the need for home health services while the beneficiaries were alive, but by the time he signed the patients' care plans/certification statements, the patients had died. *Id.*, citing Petitioner's ALJ Brief at 6-9. The ALJ rejected this contention, citing the lack of evidence in the administrative record that Dr. Younes issued any verbal orders. *Id.* at 4-5. Further, the ALJ reasoned that Dr. Younes did not state that he had read and countersigned the care plans (as is required by the applicable Medicare regulations) until "long after [the patients] had died." *Id.* at 5. However, the ALJ did not base her decision solely on her findings and conclusions as to these nine claims.

The ALJ further concluded that Petitioners had conceded that the remaining 46 claims were for services that Dr. Younes could not have provided. *Id.* She also found unpersuasive Petitioners' argument that significant mitigating circumstances excused the errors.<sup>6</sup> *Id.* at 5-6. She rejected Petitioners' argument that the regulations did not contemplate revocation for accidental, isolated mistakes or in cases where the rate of error was negligible. *Id.* at 6 (citations omitted). "The Board," the ALJ wrote, has "shown little patience with physicians who justify their erroneous billing by claiming that they 'misidentified' their patients" nor "any sympathy for physicians who blame their staff for coding or clerical errors." *Id.*, citing *John M. Shimko, D.P.M.*, DAB No. 2689, at 6, 7 (2016), quoting *Louis J. Gaefke, D.P.M.*, DAB No. 2554 (2013). "The efforts to assign the blame elsewhere (billing agents, assistants) 'do not relieve [them] of [their] responsibility for the improper claims or bar CMS from revoking [their] billing privileges.'" *Id.*, quoting *Howard B. Reife, D.P.M.*, DAB No. 2527, at 8 (2013).

Based on this finding and conclusion, the ALJ held that CMS properly revoked Petitioners' Medicare billing privileges. This appeal followed.

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<sup>5</sup> CMS originally alleged 56 improper claims but subsequently eliminated one claim from the list. ALJ Decision at 4, n.3.

<sup>6</sup> These errors are described as: a) misidentification of beneficiaries; b) miscoding by Petitioners' nurse practitioner; and c) clerical errors regarding the dates of service.

## **Standard of review**

The Board's standard of review on a disputed factual issue is whether the ALJ decision is supported by substantial evidence in the record as a whole. The Board's standard of review on a disputed issue of law is whether the ALJ decision is erroneous. *Guidelines—Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program*, available at <http://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/enrollment/index.html>.

## **Analysis**

On appeal, Petitioners contend that the ALJ erred by failing to apply CMS's policy that it does not intend to use its revocation authority in instances of accidental billing errors like those at issue in this appeal. Petitioners' Brief (P. Br.) at 3. Petitioners contend that Dr. Younes's staff member attempted to bill Medicare for preparing discharge summaries but instead mistakenly substituted the Current Procedural Terminology (CPT) code for a different service,<sup>7</sup> and that such a mistake does not warrant revocation. *Id.* at 10-12. Petitioner also contends that the ALJ erred when she found that another nine claims (eight claims for home health certifications and one claim for recertification) were not properly billed. *Id.* at 6-7.

We first address Petitioners' law and policy argument. Next we will discuss Petitioners' factual argument that not all of their claims were improperly submitted for payment and that the ALJ erred by failing to recognize this.

- A. *The ALJ correctly concluded that CMS policy provides for revocation where a provider or supplier mistakenly or unintentionally submits claims for Medicare payment for services which the provider or supplier could not have furnished on the date of service, even if the number of such claims constitutes a small fraction of the provider's or supplier's total claims.*

As noted above, CMS explained in the preamble to the final rule promulgating the regulation at 42 C.F.R. § 424.535(a)(8) that it would not exercise its revocation authority absent "sufficient evidence" of "abusive billing patterns," consisting of "multiple instances, at least three, where abusive billing practices have taken place[.]" 73 Fed. Reg. 36,488, 36,455 (2008). The ALJ correctly applied this policy. The ALJ found, and

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<sup>7</sup> Petitioner states that a nurse practitioner with his practice submitted claims mistakenly utilizing CPT Code 99315, which is the billing code for "in-person, beneficiary discharge day management services." See CMS Ex. 1, at 81-82; MLN Matters Number MM4246 (January 2006).

Petitioners concede, that Petitioners had submitted at least 46 claims<sup>8</sup> for Medicare reimbursement for services to beneficiaries who were deceased on the dates of service. We agree with the ALJ that this evidence is sufficient to show an abusive billing pattern. As the Board has said, the plain language of the regulation sufficed to notify Petitioners that the submission of a claim or claims for services that could not have been provided to the specific individual identified in the claim on the date of services could establish an abuse of billing privileges supporting revocation, and the preamble provided notice that the submission of at least three such claims would not be viewed as merely accidental. *John P. McDonough III, Ph.D.*, DAB No. 2728, at 8 (2016).

Before the Board, Petitioners argue that the ALJ failed to analyze whether Petitioners' accidental billing mistakes were the sort that should subject them to revocation under the regulation. P. Br. at 3. The ALJ Decision, they argue, fails to account for the severity of the offenses, mitigating circumstances, program and beneficiary risk from continued enrollment, beneficiary access to care and "other pertinent factors." *Id.* at 4 (citing the final rule publishing the Requirements for Providers and Suppliers To Establish and Maintain Medicare Enrollment at 71 Fed. Reg. 20,754, 20,761 (2006)). We disagree.

First, the ALJ did consider whether Petitioners' mistakes were the sort that should subject them to revocation. She reviewed the evidence underpinning CMS's revocation determination and concluded "the uncontroverted evidence supports CMS's position that these patients were already dead on the date Dr. Younes claims to have provided the billed services." ALJ Decision at 5. Section 424.535(a)(8) was promulgated to address, among others, exactly this kind of mistake. The language in the preamble to the final rule establishing the provider and supplier enrollment requirements offers no support for Petitioners' arguments. There, CMS listed some of the factors it would consider when deciding *whether* to use its revocation authority, not what would constitute a basis for revocation. However, Petitioners' billing privileges were revoked under section 424.535(a)(8), which had not yet been issued in 2006 when CMS issued the rule establishing the provider and supplier enrollment requirements. Thus, the language from the preamble to the 2006 enrollment rule does not necessarily inform CMS's consideration of whether a basis to revoke exists under the subsequently issued regulation at section 424.535(a)(8).

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<sup>8</sup> We discuss the other nine claims in the next section.

Section 424.535 of the subpart P regulations specifies the reasons for which CMS may legally revoke a provider or supplier's billing privileges. So long as CMS has shown that one of the regulatory bases for enrollment exists, the Board may not refuse to apply the regulation and must uphold the revocation. *Patrick Brueggeman, D.P.M.*, DAB No. 2725, at 15 (2016), and the cases cited therein. Therefore, we cannot consider as part of this appeal whether and to what extent CMS weighed offense severity, mitigating circumstances and other such factors when it determined to revoke Petitioners' billing privileges.

Second, the Board has repeatedly rejected the contention that a supplier who has submitted claims for "services that could not have been furnished to a specific individual on the date of service" under section 424.535(a)(8) must also be proven to have done so intentionally. *Brueggeman* at 8 (quoting *Reife* at 5); *see also Shimko* at 5-6, and cases cited therein. Nothing in either the preamble language or the regulation requires CMS to establish that the improper claims were *not* accidental. *Reife* at 6. The regulation's plain language does not require CMS to establish fraudulent or dishonest intent to revoke a supplier's billing privileges under this section. *Gaefke* at 7. The regulatory language also does not provide any exception for inadvertent or accidental billing errors. *Id.*

Petitioners attempt unsuccessfully to distinguish these binding precedents.<sup>9</sup> They contend that the ALJ's reliance on *Reife* and *Gaefke* is misplaced because neither petitioner in those cases argued that they had actually furnished the services in question. P. Br. at 5. This is incorrect. Dr. Reife argued that he had performed the services on living patients and mistakenly billed Medicare by incorrectly identifying deceased beneficiaries with similar or identical names and a similar Medicare identification number. *Reife* at 4. Dr. Gaefke also claimed to have furnished services to living patients but mistakenly submitted Medicare claims incorrectly identifying similarly named deceased beneficiaries. *Gaefke* at 3.

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<sup>9</sup> Petitioners cite a decision by another ALJ in a different matter in support of their argument in this case. ALJ decisions have no precedential weight and so are useful only to the extent their reasoning is on point and persuasive. *Shimko* at 10. We are not bound by the decisions of ALJs which were not appealed to the Board. *Avalon Place Trinity*, DAB No. 2819, at 13 (2017), citing *Shimko* at 5. Here, we do not find the case Petitioners cite to be on point or persuasive.



Petitioners also argue that their mistakes were not the sort CMS intended for revocation under section 424.535(a)(8) because they comprised too small a percentage of their overall claims, for too few dollars. *See* P. Br. at 5.<sup>10</sup> Here, the ALJ was also correct when, citing our decisions in *Shimko* at 10 (neither regulation nor preamble contemplate a minimum claims error rate or dollar amount), *Reife* at 7 (nothing in the regulation or preamble establishing a minimum claims error rate or dollar amount that must be exceeded before CMS may revoke billing privileges), and *Gaefke* at 10, quoting *Reife*, she rejected Petitioners' argument that CMS did not intend for revocation to apply to their mistakes. ALJ Decision at 6. Thus, Petitioners have shown no error of law in the ALJ Decision.

*B. Even if Petitioners could establish that the remaining nine claims were properly billed, Petitioners' arguments present no basis for overturning the ALJ's decision.*

Petitioners contend that eight of the home health service certifications and one recertification (for certification periods beginning in February and extending through November 2012) were properly submitted to Medicare for payment. P. Br. at 6. Specifically, Petitioners argue that "home health certifications and recertifications may be completed some days following a verbal order (or [ . . . ] may be completed after a patient's death)." *Id.* at 6-7, citing the regulation at 42 C.F.R. § 424.22. Petitioners also contend, under section 424.44 of the regulations, that providers and suppliers have 12 months after the date of service to submit a claim. *Id.* at 7. Petitioners further contend that the Medicare Benefits Policy Manual (MBPM) provides for a physician to issue verbal orders for home health care. *Id.* at 8, citing MBPM Ch. 7, § 30.2.5. In each instance, Petitioners argue, "the records support that Dr. Younes ordered services in the form of a verbal order for home health care prior to the beneficiary's death." *Id.*

Even if we concluded that Petitioners could properly submit the nine home health certification and recertification claims at issue (and we need not resolve questions surrounding the coding of the claims or the timing of their submission to resolve the issue presented), the ALJ correctly found that Petitioners failed to offer any evidence that Dr. Younes issued verbal orders certifying or recertifying the home health plans for these beneficiaries. ALJ Decision at 4-5. The ALJ found that "no evidence" supports Petitioners' contention that Dr. Younes issued verbal orders concerning the nine claims at issue, and that Petitioners "submit[ted] no underlying support for" the data underlying their claims. *Id.* at 4. The ALJ further noted that Dr. Younes did not testify to having

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<sup>10</sup> Petitioners argued:

- Had the claims identified in the Revocation Letter been paid, the total amount of the claims would have totaled *only* \$3,605.93.
- The 56 claims identified by WPS as the basis for the revocation constitute only 0.06% of the total claims Dr. Younes' practice billed to Medicare during the two and-a-half years in question. (Footnote omitted.)

“provided any of the services at any time” in the form of a written declaration. *Id.* at 5. Petitioners’ entire argument for the validity of these nine claims rests on the premise that the administrative record contains evidence that Dr. Younes issued such verbal orders. This argument is without support in the administrative record; therefore, we find no basis to reverse the ALJ Decision as to these claims.

Moreover, as we indicated above, the ALJ did not base her decision in this appeal on the validity of these nine claims. To the contrary, the ALJ clearly indicated that Petitioners’ 46 other improper claims constituted sufficient legal basis for CMS to revoke Petitioners’ Medicare enrollment and billing privileges. ALJ Decision at 5. Petitioners have failed to show, and we do not find, error in the ALJ’s legal conclusions as to those 46 claims, and the ALJ’s decision is supported by substantial evidence in the record as a whole.

### **Conclusion**

For the reasons set out above, the Board affirms the ALJ Decision upholding the revocation of Petitioner’s Medicare enrollment and billing privileges for a period of three years.

\_\_\_\_\_/s/  
Leslie A. Sussan

\_\_\_\_\_/s/  
Constance B. Tobias

\_\_\_\_\_/s/  
Christopher S. Randolph  
Presiding Board Member