Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Kermit E. White, M.D. &
Kermit E. White, M.D., P.C.

Petitioners,

v.

Respondent.

Docket No. C-15-735

Decision No. CR4553

Date: March 22, 2016

DECISION

Wisconsin Physician Services (WPS), an administrative contractor for the Centers for Medicare & Medicaid Services (CMS), revoked the Medicare enrollment and billing privileges of Kermit E. White, M.D. and his professional corporation, Kermit E. White M.D., P.C. (Petitioners, collectively), pursuant to 42 C.F.R. § 424.535(a)(7). WPS determined that Dr. White knowingly allowed another to use the billing number assigned to Kermit E. White, M.D., P.C. WPS upheld the revocation on reconsideration. Petitioners now appeal to challenge the reconsidered determination. For the reasons set forth below, I find that CMS had a legal basis to revoke Petitioners' Medicare enrollments and billing privileges because Dr. White knowingly allowed another doctor to use his professional corporation's billing number without executing a valid reassignment.

I. Case Background and Procedural History

Dr. Kermit White is a medical doctor who practices in Michigan. Petitioner's Exhibit (P. Ex.) 1 at 1. He participated in the Medicare program as a "supplier" of services.[1] In an initial determination dated July 16, 2014, WPS notified Petitioners that it was revoking their Medicare enrollments and billing privileges effective August 15, 2014, pursuant to 42 C.F.R. § 424.535(a)(7), because Dr. White permitted another doctor (hereinafter "J.T.") to submit claims under Dr. White's professional corporation's billing number for services J.T. performed. CMS Exhibit (CMS Ex.) 2 at 1. WPS imposed three year re-enrollment bars on Petitioners' re-enrollments in the Medicare program. CMS Ex. 2 at 2.

On August 26, 2014, Petitioners submitted a Corrective Action Plan (CAP) in response to the initial determination. In their CAP, Petitioners acknowledged that Dr. White "fail[ed] to have appropriate compliance protocols in place" and that he did not provide "adequate care and supervision to ensure all professional relationships were properly structured" in his "effort to engage in collaborative practice with another physician . . . ." CMS Ex. 3 at 1.

On September 12, 2014, Petitioners also requested reconsideration of the initial determination. Petitioners suggested that there were "any number of plausible and appropriate reasons why Dr. White may have altered or amended the nature of the services he provided . . . ." CMS Ex. 4 at 1. They alluded to the possibility that Dr. White "may have had an appropriate business relationship . . . that would have supported the use of Dr. White's billing number for services rendered by another licensed provider . . . ." CMS Ex. 4 at 1-2. Petitioners did not actually argue or otherwise provide support for the propositions that Dr. White *had* amended the nature of his practice or that he *did* have an appropriate business relationship with J.T. Petitioners also criticized WPS for failing to "address or consider whether or not the purported improprieties . . . were conducted with Dr. White's knowledge or consent, as opposed to surreptitiously." CMS Ex. 4 at 2.

WPS issued a reconsidered determination on October 20, 2014. WPS upheld the revocations because it found "Dr. White admitted that he allowed [J.T.] to submit claims under his group Medicare billing number," and Dr. White instructed J.T. that "all transactions using [his] name or credentials must stop immediately." CMS Ex. 6 at 1. Further, the hearing officer observed that the doctors did not enter into a valid reassignment of benefits and therefore were not compliant with 42 C.F.R. § 424.535(a)(7). CMS Ex. 6 at 1.

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[1] A "supplier" is defined as "a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under [Title XVIII of the Social Security Act]." 42 U.S.C. § 1395x(d); *see also* 42 C.F.R. § 400.202.

Petitioners timely requested a hearing before an administrative law judge (ALJ). I was assigned to hear and decide this case. I issued a prehearing order on December 22, 2014. The parties filed prehearing briefs (CMS PH Br. and P. PH Br.) and proposed exhibits, CMS Exs. 1-9 and P. Exs. 1-2.

As part of its prehearing exchange, CMS moved for summary judgment. Petitioner opposed the motion. I determined that the parties' prehearing exchanges presented disputes of material fact and denied CMS's motion for summary judgment on April 15, 2015. Order Denying Summary Judgment and Establishing Procedures for Hearing by Video Teleconference at 1-2.

On September 21, 2015, I conducted a hearing by video teleconference to permit Petitioners to cross-examine A.B., who at all relevant times was an investigator for Cahaba Safeguard Administrators LLC (Cahaba), and to permit CMS to cross-examine Dr. White. [2] At the hearing, I received both parties' exhibits (CMS Exs. 1-9 and P. Exs. 1-2) into evidence. Transcript (Tr.) at 8. I scheduled posthearing briefing at the hearing's conclusion. Tr. at 70-71. CMS filed a posthearing brief and reply (CMS Br. and CMS Reply), and Petitioners filed a posthearing brief and reply (P. Br. and P. Reply).

II. Issue Presented

> Whether CMS had a basis to revoke Petitioners' Medicare enrollments and billing privileges pursuant to 42 C.F.R. § 424.535(a)(7).

III. Statutory and Regulatory Framework

The Social Security 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 for providers and suppliers in 42 C.F.R. Part 424, Subpart P. *See* 42 C.F.R. §§ 424.500 – 424.570 (2014). CMS may revoke the billing privileges of an enrolled provider or supplier if it 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:

> *Misuse of billing number*. The provider or supplier knowingly sells to or allows another individual or entity to use its billing number. This does not include those

[2] A.B. was the lead investigator who prepared the report recommending that CMS revoke Petitioners' Medicare enrollments and billing privileges. Tr. at 15. He is identified by name at CMS Ex. 1 at 1.

> providers or 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.

Id. § 424.535(a)(7) (italics in original).

When CMS revokes a provider's or supplier's billing privileges, any provider agreement in effect at the time of revocation is terminated. 42 C.F.R. § 424.535(b). After revoking a provider's or supplier's billing privileges, CMS must impose a re-enrollment bar of between one and three years on the entity or individual. *Id.* § 424.535(c). Once the re-enrollment bar has expired, the supplier must submit a new enrollment application to re-enroll in the Medicare program. *Id.* § 424.535(d).

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 reconsidered determination, the supplier may request a hearing before an ALJ. *Id.* § 498.5(*l*)(2).

IV. Findings of Fact and Conclusions of Law

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.

Petitioners first came to CMS's attention due to unusual claims Dr. White's professional corporation submitted for reimbursement from Medicare for services Dr. White apparently provided to Medicare beneficiaries. A.B. began to investigate Petitioners after Cahaba identified an unusual pattern of claims that Kermit White M.D., P.C. submitted in December 2013 and January 2014. CMS Ex. 9 at 2; Tr. at 17. Dr. White had historically billed CMS for services provided during nursing home visits and had never billed for either nerve block injections or B12 injections. In December 2013 and January 2014, he apparently billed for 314 nerve block injections and 52 B12 injections. Also, his billing for two specific Current Procedural Terminology (CPT) codes ballooned from 13 and 3 over a nearly four year period to 562 and 121 from December 2013 to January 2014. CMS Exs. 1 at 3; 9 at 1-2. A new billing agency submitted these unusual claims on Dr. White's behalf. Finally, the claims related to Medicare beneficiaries for whom Dr. White had never before submitted claims, but for whom an entity J.T. controlled *had* submitted claims. CMS Ex. 9 at 1-2.

In response to these anomalies, A.B. interviewed Dr. White for an explanation of the unusual claims. During their March 25 and March 26, 2014 interviews, Dr. White reportedly told A.B. that he understood J.T. could not submit claims to Medicare because J.T. had failed to respond to or follow-up with a letter from Medicare. CMS Ex. 1 at 51. When A.B. asked Dr. White "why the claims for [J.T] were billed under his PTAN," Dr.

White reportedly responded that J.T. and another individual, P.F., "convinced him to bill under his number," and P.F. "asked [Dr. White] if they could bill under his provider number to help expedite the payment to [J.T.]."[3] CMS Ex. 1 at 52; CMS Ex. 9 at 2. A.B. reported that according to Dr. White, "Medicare and Medicaid" assured P.F. that "there were no issues with billing under [Dr. White's] PTAN." CMS Ex. 1 at 52. A.B. understood that part of the agreement between Dr. White, J.T. and P.F. was that they would reportedly use J.T.'s biller to submit the claims. Toward the end of January 2014, Dr. White reportedly explained his relationship with J.T. came to a conclusion. The day before A.B. interviewed Dr. White in person, Dr. White reportedly stated that J.T. approached Dr. White, demanded $100,000, and had to be escorted from the premises. CMS Ex. 1 at 52.

When A.B. later interviewed the biller J.T. and Dr. White shared, she reportedly confirmed that she met with Dr. White and J.T. From that meeting, she reportedly understood that J.T. "was going to submit claims from his clinics under [Dr.] White's provider number while [J.T.] receives a new number from Medicare." CMS Ex. 1 at 53. She reportedly agreed to submit the claims on the condition that both J.T. and Dr. White sign a contract permitting her to submit claims on their behalves. Dr. White signed the requested contract on December 19, 2014, while J.T. signed it on December 13, 2014. CMS Ex. 1 at 21-29. The biller reportedly never received an enrollment application from J.T. to formalize his relationship with Dr. White. CMS Ex. 1 at 53.

Dr. White has a very different explanation for his relationship with J.T. and denies making most of the statements A.B. attributed to him. Dr. White explains that he agreed to serve as Medical Director of J.T.'s clinics. His responsibilities were to "treat patients, supervise clinical and administrative staff, and assist in marketing" the clinics. P. Ex. 1 at 2. He created a written agreement detailing his arrangement with J.T., signed it on January 31, 2014. He testifies that he then forwarded it to J.T. for his signature. P. Ex. 1 at 2; P. Ex. 2. He specifically disavowed ever "authoriz[ing] [J.T.] or anyone else to submit claims under [his] Provider Transaction Access Number ("PTAN") other than those claims for services [he] performed or supervised." P. Ex. 1 at 2.

According to Dr. White, he had an employer-employee relationship with J.T., and he believed he "would be paid a set fee plus a percentage of services [he] personally rendered or supervised." P. Ex. 1 at 2. Further, he believed that permitting "[J.T.]'s practice(s) to bill for those services was a condition of [his] employment." P. Ex. 1 at 2. Dr. White confirms A.B.'s report that Dr. White believed, based on conversations with P.F. and the biller, that his arrangement with J.T. "was appropriate." P. Ex. 1 at 2. He repudiates his reported admission to A.B. that he allowed J.T. to submit claims under his

[3] "P.F." is the individual identified in CMS Ex. 1 at 51, with those initials. I identify her by her initials because she is not a party to this proceeding.

professional corporation's PTAN and characterizes the quoted statement in the report as "not an accurate representation of [their] conversation(s) . . . ." P. Ex. 1 at 2. Dr. White unequivocally testifies that he "had no knowledge of the fact that [J.T.] was apparently submitting claims to CMS with [his] billing or other identifying information for services [he] did not perform or supervise, and [he] certainly did not authorize [J.T.] or anyone else" to do so. P. Ex. 1 at 3. Finally, Dr. White testifies that "[a]s soon as [he] became aware of [J.T.'s] misappropriation of [his] billing information, [he] immediately contacted him and demanded that he cease and desist from any such activity." P. Ex. 1 at 3.

After 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. I find that A.B.'s testimony, including that his interview reports were generally consistent with other evidence, such as the unusual billing data the contractor originally discovered and Petitioner's reconsideration and CAP requests, to be more credible. *See* CMS Ex. 9 at 1-2; Tr. at 19. Dr. White denies the essential accusation in this case: that he knowingly allowed J.T. to bill for services J.T. provided using Dr. White's professional corporation's PTAN. In order to support his denials, Dr. White primarily points to the purported written agreement between him and J.T. P. Ex. 1 at 2.

Petitioners argue that Dr. White, "viewing himself as an employee of J.T.'s clinics, drafted and signed an agreement reducing to writing the agreement of the parties." P. PH Br. at 2. 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. CMS Ex. 1 at 25, 51; P. Ex. 2. 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. CMS Ex. 1 at 51; P. Ex. 2. 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. CMS Exs. 9 at 2; 1 at 3. Dr. White does not claim that he actually provided these services. He told A.B. that he "did not know about the nerve block injections until after they were submitted and agents had visited the billing agency." CMS Ex. 1 at 52.

Petitioners urge that "the most crucial analysis . . . is an evaluation of the credibility of the witnesses" and argue that neither A.B. nor the biller Dr. White shared with J.T. is credible. P. Br. at 4: P. PH Br. at 8. A.B. reported Dr. White's admission to agreeing that J.T. would submit claims using Dr. White's professional corporation's billing number. A.B. also reported that the biller Dr. White shared with J.T. told A.B. that she was aware of the illicit arrangement between Dr. White and J.T. as a result of the meeting she had with the two of them. CMS Ex. 1 at 51-54.

Petitioners argue that A.B. was evasive on cross-examination and failed to directly answer yes-or-no questions. P. Br. at 6; Tr. at 25-26. While I agree that A.B. could have been more direct at hearing when originally answering whether Dr. White explicitly reported in their interview that he allowed J.T. to use his billing number, I find his testimony generally credible. He ultimately did affirm, after refreshing his recollection of his investigative report, 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. A.B.'s report and testimony is also consistent with Petitioners' request for reconsideration in which they alluded to the possibility that Dr. White "may have had an appropriate business relationship . . . that would have supported the use of Dr. White's billing number for services rendered by another licensed provider," even though there was never ultimately any proof of the appropriateness of the arrangement. *See* CMS Ex. 4 at 1-2. Similarly, A.B.'s testimony is consistent with Petitioners' CAP that acknowledged that Dr. White "fail[ed] to have appropriate compliance protocols in place" and that he did not provide "adequate care and supervision to ensure all professional relationships were properly structured" in his "effort to engage in collaborative practice with another physician . . . ." CMS Ex. 3 at 1.

With respect to the biller that Dr. White shared with J.T., I have no reason to doubt A.B.'s characterization of her statements. Petitioners characterize her testimony as "unreliable hearsay" emanating from "a complaining witness in the underlying dispute and subsequent indictment of [J.T.] . . . and a potential *qui tam* plaintiff . . . ." P. PH Br. at 8. If Petitioners wished to examine the biller's reported position, they could have requested a subpoena to compel her testimony at the hearing. 42 C.F.R. § 498.58. They did not do so. Further, A.B. testified that he found the biller credible. Tr. at 33. I also find her statements as described in A.B.'s report of contact to be consistent with Petitioners' statements during the reconsideration process regarding a lack of a proper reassignment and worthy of some weight.

CMS has presented compelling evidence demonstrating that Dr. White knowingly allowed J.T. to submit claims using Dr. White's professional corporation's billing number. CMS has presented evidence that J.T. did submit such claims, and Petitioners never acted at the relevant time to contact CMS or its agents to ascertain the gross discrepancy between Dr. White's historical billing and the sudden uptick in certain procedures during the period in which he worked with J.T. Therefore, I find that, when 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.

B. *CMS was authorized to revoke Petitioners' Medicare enrollments and billing privileges pursuant to 42 C.F.R. § 424.535(a)(7).*

Once CMS determined that Dr. White knowingly allowed another to use his professional corporation's billing number, and that neither a valid reassignment of benefits nor a change of ownership existed, it was authorized to revoke Petitioners' Medicare billing privileges. 42 C.F.R. § 424.535(a)(7). Here, CMS has offered credible evidence that Dr. White's professional corporation submitted claims in a volume and of a kind that Dr. White had never previously performed or had only performed in much smaller volumes. CMS Ex. 9 at 1-2; CMS Ex. 1 at 3. Dr. White does not argue that he actually performed these services. Indeed, he essentially concedes that he did not. P. Ex. 1 at 3. Nor do Petitioners argue that a valid reassignment of benefits from J.T. to Dr. White's professional corporation or a transfer of ownership existed. At most, they suggested in a request for reconsideration that there might be a plausible explanation or an appropriate relationship without ever arguing or submitting evidence to establish as much. CMS Ex. 4 at 1-2.

Dr. White testified that he believed CMS had approved his arrangement with J.T., consistent with his statement during his interview with A.B. P. Ex. 1 at 2; CMS Ex. 1 at 52. Petitioners argue that "to meet its burden, CMS must put forward prima facie evidence that [Dr. White] ***knowingly*** permitted the misuse of his billing number." P. Br. at 4 (emphasis in original). 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 provider knowingly allowed another to use his billing number absent a valid reassignment or change of ownership. Whether Dr. White understood his actions to have justified revocation or constitute misuse is of no import under the plain language of the regulation. Moreover, Dr. White is ultimately and always responsible for the accuracy of his claims. He cannot avoid responsibility by deflecting blame to a biller. *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."). I have found Dr. White 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. For that reason, CMS had a legal basis to revoke Petitioners' Medicare enrollments and billing privileges.

V. Conclusion

CMS was authorized to revoke the Medicare enrollments and billing privileges of Petitioners, Kermit E. White, M.D. and Kermit E. White M.D., P.C., effective August 15, 2014, because CMS has proven Petitioners knowingly allowed another doctor to directly bill the Medicare program using their Medicare billing number.

/s/
Joseph Grow
Administrative Law Judge