Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

John P. McDonough III, Ph.D.,
Geriatric Psychological Specialists, and GPS II, LLC
Docket No. A-16-45
Decision No. 2728
August 16, 2016

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

John P. McDonough III, Ph.D. (McDonough), Geriatric Psychological Specialists (GPS), and GPS II, LLC, (collectively Petitioners) appeal the decision of an Administrative Law Judge (ALJ) granting summary judgment and affirming the determination of the Centers for Medicare & Medicaid Services (CMS) revoking Petitioners' Medicare enrollment and billing privileges for a period of three years. The revocation arose from a determination by a Medicare contractor (upheld on reconsideration) that Petitioners claimed Medicare payments for psychological testing services that could not have been provided to specific individuals on the claimed dates of service because they were deceased.

As explained below, we find no error in the ALJ Decision and consequently 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) provides reasons for which enrollment may be revoked, including the following:

> (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.

42 C.F.R. § 424.535(a)(8) (Oct. 1, 2014).[1] The preamble to the final rule provides the following guidance regarding its intended uses:

> CMS, not a Medicare contractor, will make the determination for revocation under the authority at § 424.535(a)(8). We will direct contractors to use this basis of revocation 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).

The regulations provide that 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.* § 424.535(c).

[1] 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 1 n. 2), but we too apply the regulation as in effect at the time of the revocation.

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(l)(1)-(3), 498.22(a).

Factual and procedural background[2]

First Coast Service Options, Inc. (FCSO), the CMS Medicare contractor, notified Petitioners by separate letters dated October 28, 2014, that their Medicare billing numbers and billing privileges were revoked effective November 27, 2014. CMS Ex. 1, at 4-20. All three revocations were based on 42 C.F.R. § 424.535(a)(8). *Id*. Each letter explained that a data analysis showed that a specific number of claims had been submitted under that provider's billing numbers for services provided between January 1, 2012 and August 31, 2014 to beneficiaries who were deceased at the time the services were allegedly provided to them. *Id*. at 4, 7, 11. Attached to each letter was a chart identifying each claim with the date(s) of service and the name, Medicare number and date of death of each beneficiary. *Id*. at 6, 9-10, 13-20. FCSO 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) and that they had the right to seek reconsideration. *Id*. at 5, 8, 12.

Petitioners sent FCSO a letter dated January 2, 2015, enclosing a request for reconsideration and a corrective action plan (CAP). CMS Ex. 1, at 45.[3] On February 25, 2015, CMS upheld the revocations on reconsideration. CMS Ex. 1, at 1-3. The reconsideration explained the basis for the revocation as follows:

> All of the documentation in the file for this case has been reviewed and the decision has been made in accordance with Medicare guidelines. Specifically, John P. McDonough III Ph.D has provided no new evidence to disprove the errors resulting in over 23 claims for deceased beneficiaries to Medicare over a 2 year period that shows you have not fully complied with the standards for which you were revoked. John P. McDonough III submitted a detailed plan, including statements of unintentional clerical errors, increased training, and the hiring compliance officer. There was no evidence that disproves that abuse of billing occurred in this case. Alleging no deliberate wrong doing doesn't establish prospective compliance with

[2] 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.

[3] The reconsideration request named all three Petitioners in the heading, although the text refers to McDonough in the first person singular. The reconsideration determination similarly identified the three Petitioners in its heading even though the discussion, as quoted in the text, refers only to McDonough by name. It is not disputed that the reconsideration applied to all three Petitioners and the ALJ expressly treated the proceedings as joint and issued his decision as to all three. ALJ Decision at 1 n.1.

> Medicare regulations, and program instructions. Therefore, CMS does not find that its contractors erred in determining to revoke your billing privileges based on billing for deceased beneficiaries; after all, billing for deceased beneficiaries is exactly the kind of objectively impossible service for which the regulation accounts. We are not satisfied that the reconsideration corrects the deficiencies identified in our October 28, 2014 correspondence regarding the revocation of your Medicare billing privileges. For this reason, your proposed reconsideration is hereby denied. Therefore, we cannot grant you access to the Medicare Trust Fund (by way or issuance) of a Medicare number.

Petitioners sought ALJ review. The parties filed cross-motions for summary judgment and Petitioners waived their right to oral hearing. ALJ Decision at 2.

ALJ Decision

The ALJ, having resolved pending evidentiary disputes, determined that he could properly proceed to decision on the written record. *Id*. at 6-7. He then made the following substantive findings of fact and conclusions of law:

> **Billing privileges are abused, within the meaning of 42 C.F.R. § 424.535(a)(8), when three or more claims are submitted to Medicare for services that could not have been furnished to the specific individuals identified on the claims on the dates of the claimed services.**
>
> **The 243 claims submitted by Petitioners or on their behalf that were false because they were for services not delivered to the beneficiaries listed on the claims constituted an abuse of billing privileges under 42 C.F.R. § 424.535(a)(8).**
>
> **It is no defense to a revocation action for abuse of billing privileges under 42 C.F.R. § 424.535(a)(8) that the false claims were due to errors of Petitioners' agents.**
>
> **There is a basis for revocation of Petitioners' Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(8).**

Id. at 7 (bold in original, numbering omitted). The ALJ rejected Petitioners' claim that CMS failed to establish a prima facie case. *Id*. at 9-11. That claim was based on the issuance of the initial revocation notice by the Medicare contractor instead of CMS itself, which Petitioners said violated CMS's assurance in the preamble that CMS, not its contractors, would "make the determination for revocation" under the abuse-of-billing-privileges regulation. *Id*. at 10, citing argument in P. Br. in C-15-2101, at 2, 9-11; *see*

also 73 Fed. Reg. at 36,455. The ALJ concluded that the preamble statement at most expressed CMS policy intentions, but did not create a legal requirement. *Id*. at 10. Furthermore, the ALJ concluded, CMS's own Provider Enrollment Oversight Group issued the reconsidered determination, which either constituted compliance with the policy or cured any defect in compliance. *Id*. at 10-11.

The ALJ then turned to Petitioners' argument that they had shown by the preponderance of the evidence that no abuse of billing privileges occurred. *Id*. at 11. The ALJ stated Petitioners' position as follows:

> Petitioners' explanations can be divided into three groups for ease of discussion: (1) claims for services billed when services, including reports were complete, consistent with Petitioners' interpretation of a Local Coverage Determination (LCD); (2) claims that were the result of data input errors by Petitioners' billing services (billing errors); and (3) claims for services provided by therapists to the wrong person (misidentifications). Petitioners' admit that Petitioner GPS had 12 claims billed based on misidentification by therapists, 93 claims billed according to the LCD, and 191 billing errors. P. Ex. 2. Petitioners admit that GPSII submitted 30 claims billed in accordance with the LCD and 36 billing errors. P. Ex. 4. Petitioners admit that Petitioner McDonough submitted 2 claims billed in accordance with the LCD; 2 claims involving misidentification; and 21 billing errors. P. Ex. 6.

Id. at 12-13 (footnote omitted). The first category involved claims in which the date of service was identified as the date on which the final interpretive report of testing was completed (based on Petitioners' reading of the LCD instructions about how to identify dates of services) but the relevant beneficiary had died between the date the test was performed and the date the report was completed. The ALJ accepted that the claims in that category were not abusive but were based on a reasonable interpretation of the LCD. *Id*. at 13-14.[4]

The ALJ concluded, however, that the claims in the other two categories (billing errors and misidentifications) did constitute abuse of billing privileges. *Id*. at 14-16. The ALJ concluded that attributing the admitted submission of repeated claims for services to deceased beneficiaries to "incorrect billing entries due to similar beneficiary names or Medicare numbers, and inadvertent typing errors by billing service representatives" does not establish that the Petitioners did not abuse their billing privileges. *Id*. at 15. The ALJ explained his reasoning as follows:

[4] CMS has not challenged this conclusion so the claims in this category are not at issue before us.

> The Board has upheld determinations that abuse in the context of 42 C.F.R. § 424.535(a)(8) occurs when a provider bills Medicare for services that could not have been provided to the Medicare beneficiary to whom the claim is related. *Realhab, Inc.*, DAB No. 2542 at 15. The Board has commented that a common definition of abuse is misuse, wrong, or improper use, and that the negligent submission of multiple erroneous claims for services that could not have been delivered to beneficiaries, amounts to abuse. *Louis J. Gaefke*, D.P.M., DAB No. 2554 at 9 (2013); *Howard B. Reife, D.P.M.*, DAB No. 2527 at 6. CMS is not required to show that Petitioners intended to defraud Medicare before it revokes their billing privilege[s]. The regulation only requires the existence of claims for services that could not have been delivered. 42 C.F.R. § 424.535(a)(8); *Louis J. Gaefke, D.P.M.*, DAB No. 2554 at 7 ("[T]he plain language of the regulation contains no requirement that CMS establish that the supplier acted with fraudulent or dishonest intent. The regulatory language also does not provide any exception for inadvertent or accidental billing errors."). Petitioners are ultimately responsible, both as a matter of law and under the terms of their participation agreements, for ensuring that their claims for Medicare reimbursement were accurate and for any errors in those claims. *Louis J. Gaefke, D.P.M.*, DAB No. 2554 at 5-6 (citing 73 Fed. Reg. at 36,455). Petitioners cannot avoid responsibility for their claims by the simple expedient of shifting responsibility and liability by contracting with a billing agent. While the language of the regulation does not require a pattern of improper billing, the preamble states that a "pattern of improper billing" occurs when there are three or more instances of improper billing. 73 Fed Reg. at 36,455. Petitioners have admitted that the 243 claims were in error. The claims were for services delivered on dates after the dates of death of the beneficiaries listed in the claims. Petitioner has not shown that the beneficiaries involved in the claims were not dead, that the services claimed were delivered on a different date, or that it was otherwise possible that services claimed were delivered. The number of claims exceeds three and shows a pattern of improper false claims. Whether or not the 243 false claims were false due to the intention of Petitioners or the neglect of Petitioners' billing agents are not issues under 42 C.F.R. § 424.535(a)(8). Petitioners are responsible to ensure claims are correct and they are responsible for the conduct of their billing agents.

Id. at 15-16. Based on these findings and conclusions, the ALJ held that CMS was authorized to revoke Petitioners' enrollment. This appeal ensued.

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/dab/divisions/appellate/guidelines/prosupenrolmen.html.

Analysis

On appeal, Petitioners reiterate their argument that their revocations are improper because they were issued initially by FSCO and not by CMS itself. Request for Review (RR) at 1-2. The Board has held that the preamble discussion does not assert that contractors will play no role in section 424.535(a)(8) revocations but rather "contemplates consultation by contractors with CMS and direction by CMS to contractors" with contractors then issuing the revocations. *John M. Shimko, D.P.M.*, DAB No. 2689, at 11 (2016), quoting 73 Fed. Reg. at 36,455 (responding to question of whether contractors would issue revocations if they found claims for "services that could not have been delivered," that CMS "will instruct Medicare contractors to issue a revocation under § 424.535(a)(8)"). In any case, as the ALJ pointed out, the action on appeal here, the reconsidered determination, was actually issued by CMS. ALJ Decision at 10-11. We thus find no merit to Petitioners' argument.

Petitioners next contend that the ALJ erred in finding abuse of billing privileges in the absence of proof of "any *intent* on the part of Petitioners to submit false claims . . . ." RR at 3 (italics in original). As the ALJ recognized, 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. *Patrick Brueggeman, D.P.M.*, DAB No. 2725, at 8 (2016); *see also Shimko* at 5-6 (2016), and cases cited therein. The Board has long held that 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 and that "[t]he regulatory language also does not provide any exception for inadvertent or accidental billing errors." *Louis J. Gaefke, D.P.M.*, DAB No. 2554, at 7 (2013). Even though the ALJ cited these binding precedents (as quoted above), Petitioners fail to address them and give us no reason that we should not apply them here.

Petitioner relies only on the statement in the preamble that this basis for revocation "'is not intended to be used for *isolated occurrences or accidental billing errors*.'" RR at 3 (italics in RR), quoting 73 Fed. Reg. at 36,455. Petitioners overlook CMS's further elucidation in the preamble that, for this purpose, submission of three or more improper claims would not be considered accidental but rather evidence of a pattern of abusive

billing. 73 Fed. Reg. at 36,455. Although Petitioners claim that the record does not show that they were "negligent" or that they "submitted multiple 'erroneous claims,'" the ALJ did not err in reaching contrary conclusions, because the submission of 243 claims that Petitioners admit could not have been provided as claimed, as with the claims in *Gaefke*, "by their sheer number, fall within the preamble language, in which the Secretary stated a policy of not initiating revocation based on accidental claims but also warned that the submission of three or more improper claims would not be considered accidental." DAB No. 2554, at 8.

As the Board recently stated in *Brueggeman*, "'[n]othing in either the preamble language or the regulation requires CMS to establish that the improper claims were not accidental' or 'that a supplier's explanation for the improper claims (i.e., similarities among patient names or between the incorrect procedure code used in the claims and the correct code that would have yielded lower reimbursement) was the result of a carefully concocted story or scheme to cover improper behavior by a supplier acting to defraud Medicare.'" DAB No. 2725, at 11, quoting *Gaefke* at 9-10 and *Howard B. Reife, D.P.M.*, DAB No. 2527, at 6 (2013). We conclude that the plain language of the regulation sufficed to notify Petitioners that the submission of a claim for services that could not have been provided to the specific individual identified in the claim on the date of services was an abuse of billing privileges that could lead to revocation, and the preamble provided notice that the submission of at least three such claims would not be viewed as merely accidental.

Petitioners also argue that their CAP demonstrated that they were making "diligent strides" to avoid further billing errors. RR at 2. A plan to reduce improper billing in the future does not preclude CMS from taking action about improper claims already submitted. Moreover, as the ALJ noted, the denial of a CAP is not subject to review. ALJ Decision at 16, citing *DMS Imaging, Inc.*, DAB No. 2313, at 5-8 (2010).

Finally, Petitioners briefly assert that the improper claims at issue are a "very small percentage" of "tens of thousands" of claims during the same period. RR at 3 n.2. Petitioners present no evidence of how many claims they submitted or of whether all other claims have been found free of errors. In any case, in *Brueggeman* and prior cases, the Board has made clear that section 424.535(a)(8) does not require CMS to establish an error rate or percentage of improper claims. DAB No. 2725, at 11-12, and cases cited therein.

Conclusion

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

/s/
Christopher S. Randolph

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member