Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Howard B. Reife, D.P.M.
Docket No. A-13-69
Decision No. 2527
August 1, 2013

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Petitioner Howard B. Reife, D.P.M., requests review of the March 20, 2013 decision of an Administrative Law Judge (ALJ) sustaining the revocation of Petitioner's Medicare billing privileges. *Howard B. Reife, D.P.M.*, DAB CR2728 (2013) (ALJ Decision). The Center for Medicare & Medicaid Services (CMS), through its contractor, Wisconsin Physician Services Insurance Corporation (WPS), acted under regulations authorizing it to revoke the billing privileges of a Medicare supplier or provider who "submits a claim or claims for services that could not have been furnished to a specific individual on the date of service." 42 C.F.R. § 424.535(a)(8). Petitioner (both before the ALJ and on appeal to the Board) does not dispute submitting 35 claims for services that he could not have delivered to the beneficiaries named in the claims. For the reasons explained below, we sustain the ALJ Decision.

Applicable law

The regulation at 42 C.F.R. § 424.535(a)(8) states that CMS may revoke a provider or supplier's Medicare billing privileges and any corresponding provider or supplier agreement for the following reason:

> (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 preamble to the final rule publishing this section states:

> 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).

Revocation results in the termination of the provider's or supplier's agreement with Medicare as well as a ban on re-enrollment for at least one year, but no more than three years. 42 C.F.R. § 424.535(b)-(c).

A supplier whose Medicare enrollment has been revoked may request reconsideration by CMS, and then appeal CMS's reconsideration decision in accordance with the procedures at 42 C.F.R. Part 498. 42 C.F.R. §§ 424.545(a), 498.5(l)(1), 498.22(a).

Case background[1]

Petitioner is a podiatrist licensed to practice in Kansas and Missouri who participated in the Medicare program as a supplier of services.[2] WPS notified him in four letters dated May 18, 2012 (each for a different Provider Transaction Access Number assigned to Petitioner) that it was revoking his Medicare billing privileges for a period of two years effective May 16, 2012 on the basis of 42 C.F.R. § 424.535(a)(8). Petitioner submitted a corrective action plan, which WPS rejected, and also requested reconsideration of the determination to revoke his billing privileges. WPS upheld the revocation on August 27, 2012, stating that Petitioner "billed WPS for services that were not furnished to the specific beneficiaries indicated on the claims and has not reported any billing errors or submitted any voluntary refunds for these services." P. Ex. 12. Petitioner timely requested an ALJ hearing. ALJ Decision at 1-2; P. Exs. 8-12.

[1] The background information is drawn from the ALJ Decision and the record before him and is not intended to substitute for his findings.

[2] A "supplier" is "a physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare." 42 C.F.R. § 400.202.

The ALJ denied both parties' motions for summary judgment and decided the case based on the written record without an in-person hearing as neither party submitted direct written testimony that would require the opportunity for cross-examination. *Id*.

The ALJ found, and Petitioner did not dispute, that 35 Medicare claims were submitted on Petitioner's behalf for podiatric services that were claimed as either having been rendered to beneficiaries who had died before the dates of service or performed on both feet of beneficiaries who each had one leg amputated. ALJ Decision at 5-6; P. Amend. Br.; CMS Ex. 1, at 24-25. The ALJ concluded that Petitioner submitted a pattern of improper Medicare claims for services that could not have been furnished to specific individuals on the purported dates of service. He rejected Petitioner's explanations for the admittedly improper claims and concluded that CMS was authorized to revoke his billing privileges. The ALJ also rejected Petitioner's additional argument that the revocation should be reversed because CMS's May 18, 2012 notices revoked his billing privileges effective May 16, 2012, instead of "30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier" as required by 42 C.F.R. § 424.535(g) (with exceptions that the ALJ concluded were inapplicable). The ALJ determined that this defect in the notice was cured by his setting the effective date at June 17, 2012. ALJ Decision at 7.

Standard of Review

We review a disputed factual issue as to whether the ALJ's decision is supported by substantial evidence in the record as a whole. We review a disputed issue of law as to whether the ALJ's decision 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*, at http://www.hhs.gov/dab/divisions/appellate/guidelines/prosupenrolmen.html.

Analysis

Petitioner argues that the ALJ erred in concluding that Petitioner was not entitled to summary judgment, that he submitted a pattern of improper Medicare claims, and that CMS was authorized to revoke his Medicare billing privileges pursuant to section 424.535(a)(8). Petitioner's Request for Review of the ALJ Decision (RR) at 1. Petitioner however does not address the specifics of the ALJ's analysis but merely repeats the arguments he made to the ALJ and submits additional evidence that we are barred by regulation from admitting. We address those arguments and the ALJ's responses to them below and explain why Petitioner has identified no error in the ALJ's ultimate conclusion that CMS was authorized to revoke Petitioner's billing privileges.

Petitioner does not dispute that he was the Medicare supplier in 25 Medicare claims for services rendered to beneficiaries who had died before the dates of service, and 10 claims for toenail debridement services performed on "6-10 toes of beneficiaries" who each had one leg amputated. ALJ Decision at 5-6; RR at 7-14; CMS Ex. 1, at 24-25 (list of beneficiaries, services claimed, dates of services, and either date of death or amputation). Petitioner argues, as he did before the ALJ, that the improper claims were "accidental billing errors" committed by his billing agent, D.A.R.E. Foot Care, or his staff, that do not support revocation under the preamble to the regulation. RR at 5, 7, 12; P. Amend. Br. at 7; 73 Fed. Reg. at 36,455. He argues that he thus did not submit "a claim or claims for services that could not have been furnished to a specific individual on the date of service" authorizing CMS to revoke his billing privileges under 42 C.F.R. § 424.535(a)(8).

More specifically, Petitioner states that CMS identified 11 deceased patients for whom he submitted the 25 claims for services to patients who had died before the date of service of the claims. RR at 11, 12; P. Amend. Br. at 10, 11; CMS Ex. 1, at 22-25. Of those, he states that six deceased patients had similar or identical names and one deceased patient had a similar Medicare identification number as living patients who received the claimed services. For the remaining four deceased patients, Petitioner states that his "biller" or D.A.R.E. Foot Care "mistakenly submitted claims for reimbursement[.]"[3] RR at 11-13, citing P. Exs. 6-7a, 7c, 15.[4] Petitioner states that he often provided care "as a contracted provider through D.A.R.E." which "submitted claims for reimbursement to Medicare and was directly reimbursed by Medicare" as his payee and paid him a percentage of monthly reimbursements. RR at 2. He states that D.A.R.E. did not provide him with a breakdown of billings or reimbursements by patient, and that he "relied on D.A.R.E. to accurately submit claims to Medicare based on the documentation [he] provided." RR at 2-3.

Petitioner also states that CMS identified six patients for whom he submitted the 10 improper claims for debriding more than five toenails on one-legged patients. RR at 7; CMS Ex. 1, at 22-25. Petitioner states that each of the 10 improper claims was a

[3] Petitioner appears to use "biller" and D.A.R.E. Foot Care interchangeably. RR at 8-13.

[4] Petitioner's Exhibit 15, which he did not submit to the ALJ, comprises documentary evidence in support of Petitioner's assertions on appeal that one patient had a similar Medicare identification number, and two others had similar names, as living patients. RR at 12-13. Regarding the latter two deceased patients, Petitioner asserted before the ALJ only that the claims for services supplied to them were "accidental billing errors" caused when "D.A.R.E. mistakenly submitted claims for reimbursement[.]" P. Amend. Br. at 11-12. Because Petitioner did not submit this evidence to the ALJ, the regulations governing this appeal forbid us from considering it. 42 C.F.R. § 498.68(a) (emphasis added) ("Except for provider or supplier enrollment appeals the Board may admit evidence into the record in addition to the evidence introduced at the ALJ hearing [if] it is relevant and material to an issue before it hearing").

"procedure code typographical error" caused by D.A.R.E. Foot Care or Petitioner's assistant (in the case of one patient) mistakenly using the Medicare procedure code for debriding six or more toenails (11721) instead of the procedure code for debriding one to five toenails (11720). RR at 7; P. Amend. Br. at 7. Petitioner states that records he provided to D.A.R.E. Foot Care (or to his assistant) show in each case that the patient was an amputee and that Petitioner had debrided only one to five toenails. In each case, Petitioner states, he "did everything he could" or "provided ample documentation to D.A.R.E." or his assistant "to ensure that the billing was done appropriately" but they "mistakenly" billed Medicare using the incorrect procedure code "unbeknownst to him" (Petitioner). RR at 8-11, citing P. Exs. 1-7b, 14. For the reasons discussed below, we find that Petitioner's arguments are without merit.

1. **Petitioner's argument that the improper claims were all accidental is not supported and does not demonstrate any error in the ALJ Decision or warrant reversing the revocation.**

Petitioner's argument that he did not engage in "abusive billing" practices because the improper claims were all inadvertent and were accidental billing errors is not consistent with the undisputed facts or the plain language of the regulation and the preamble. RR at 7, 13. As the ALJ pointed out, the "operative language" of the regulation "does not require that CMS demonstrate that Petitioner intended to defraud Medicare before it may revoke Petitioner's billing privileges." ALJ Decision at 7. It simply authorizes revocation where the supplier submits "a claim or claims for services that could not have been furnished to a specific individual on the date of service," including, as is particularly applicable here, "where the beneficiary is deceased." The preamble language similarly does not state that CMS must establish, as a prerequisite to revocation, that a supplier who submits such claims intended to defraud Medicare.

Petitioner relies on statements in the preamble that the revocation authority "is not intended to be used for isolated occurrences or accidental billing errors" and "is directed at providers and suppliers who are engaging in a pattern of improper billing." 73 Fed. Reg. at 36,455. The preamble further stated that CMS would not exercise its revocation authority unless there were "multiple instances, at least three, where abusive billing practices have taken place." *Id*. Citing the preamble, the ALJ stated that "'accidental claims' may not be considered 'accidental' in nature after a supplier submits three improper claims." ALJ Decision at 6. Petitioner argues that his admittedly improper claims cannot establish a "pattern" of improper billing because they were all accidental errors.

Petitioner's argument is without merit. Petitioner's argument assumes that a pattern of abusive billing is required before CMS may revoke a Medicare supplier or provider's billing privileges even though the word "pattern" does not appear in the regulation. Citing to the preamble, the ALJ concluded that "CMS must demonstrate that Petitioner's billing practices showed a pattern of making claims that could not have been furnished to specific individuals on the dates of service." ALJ Decision at 7, citing 73 Fed. Reg. at 36,455. However, we do not need to reach this question because (as discussed below) substantial evidence in the record clearly demonstrates that a pattern of abusive billing practices exists in this case.

By any reasonable standard, Petitioner's improper claims, by their quantity and circumstances, constitute a pattern of abusive billing practices. Petitioner does not dispute that 35 improper claims were submitted for services he could not have delivered to two categories of beneficiaries over a period of three and a half years. *See* CMS Ex. 1, at 24-25. We agree with the ALJ's statement made in addressing the 25 claims submitted for services to deceased patients that "[r]epeatedly making those same errors [submission of at least 16 improper claims by 'the same entity' on behalf of 'the same supplier' making 'the same error'] reduces their credibility as 'accidental' and establishes a pattern of improper billing that suggests a lack of attention to detail considering Petitioner could have differentiated the patients through their birthdates or Medicare numbers." ALJ Decision at 5-6. Nothing in either the preamble language or the regulation requires CMS to establish that the improper claims were *not* accidental.

Petitioner also argues, with respect to the claims for debriding toenails on both feet of beneficiaries with only one foot, that "the difference in reimbursement between a claim for [procedure code] 11720 and a claim for [procedure code] 11721 is approximately $15," and argues that the improper claims were thus "clearly not made as part of a 'get rich quick' scheme." RR at 8. However, the regulation does not require CMS to establish 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. The underlying goal in implementing section 424.535(a)(8) of "protecting the expenditure of public monies" in the Medicare program would be significantly hindered if CMS were required to make such a showing.

Moreover, Petitioner's explanation for the claims for services to beneficiaries who were deceased by the date or dates of service – that the deceased beneficiaries had names similar to living patients – does not account for all of those undisputedly improper claims. The ALJ found that this explanation applied to only 16 of the 25 claims for services to deceased beneficiaries, and that for the remaining nine claims, filed on behalf of seven beneficiaries, Petitioner had offered "nothing substantive" to support his assertion that the claims were "accidental." ALJ Decision at 5, citing P. Amend. Br. at

10-12. For those claims, Petitioner alleged only that D.A.R.E. Foot Care "mistakenly submitted claims for reimbursement." P. Amend. Br. at 11-12. The ALJ further noted that seven of those nine improper claims were made within eight months of each other, between March 2008 and December 2008. ALJ Decision at 5. While Petitioner does not specifically dispute these findings, on appeal he alleges that two more of the deceased beneficiaries had similar names, and that one had a similar Medicare identification, as those belonging to living patients. RR at 12-13. Even accepting Petitioner's allegations on appeal, there were still more than three improper claims for services to deceased persons for which Petitioner offered no explanation, which clearly authorized CMS to revoke his billing privileges.

Petitioner also argues, as he did below, that the claims were accidental because CMS identified only 35 improper claims over a time period during which he "had in excess of 28,000 patient encounters with Medicare patients" and "submitted thousands of claims to Medicare for providing services to hundreds of patients." RR at 15, 7; P. Amend. Br. at 6, 12.

There is no indication in the record, nor does Petitioner assert, that CMS or WPS scrutinized all of the claims Petitioner submitted during the relevant time period. Thus, CMS's identification of the 35 improper claims does not constitute any determination of the propriety of all of Petitioner's remaining claims. There is also no requirement in the regulation (or the preamble) establishing a minimum claims error rate or dollar amount that must be exceeded before CMS may revoke billing privileges.

For these reasons, we conclude that there was no error in the ALJ's conclusion that CMS was authorized to revoke Petitioner's billing privileges under section 424.535(a)(8).

2. Petitioner's assertions that others were responsible for the improper claims does not demonstrate any error in the ALJ Decision or warrant reversing the revocation.

Petitioner's argument that the improper bills were the work of his billing agent does not shield his billing privileges from revocation. The ALJ properly rejected this argument, stating that Petitioner "is ultimately responsible for claims submitted to Medicare on his behalf" and "cannot shirk his responsibility through a faulty reliance on D.A.R.E.'s billing actions." ALJ Decision 6. The ALJ cited to the preamble where it stated that "[i]n conclusion, we believe that providers and suppliers are responsible for the claims they submit or the claims submitted on their behalf" and "[w]e 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. at 36,455. Additionally, as CMS noted, Medicare suppliers must certify on their claims that the "services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my

professional services by my employee under my immediate supervision" or, in the case of claims submitted electronically, that claims "are accurate, complete and truthful." CMS Exs. 2, 3. Those certifications are consistent with the preamble language emphasizing that suppliers are responsible for claims submitted on their behalf. Petitioner cites no legal authority relieving suppliers of responsibility for the claims for Medicare reimbursement submitted on their behalf and at their direction. Petitioner's efforts to assign blame for the improper billing to his billing agent or his assistant do not relieve him of his responsibility for the improper claims or bar CMS from revoking his billing privileges.

3. CMS's use in its notice letters of an incorrect effective date for the revocation did not entitle Petitioner to summary judgment in his favor.

Petitioner argues he was entitled to summary judgment because in issuing the notices of revocation, CMS "did not follow its own rules" as to the effective date of revocations and "did not properly exercise its authority to revoke Dr. Reife's Medicare billing privileges, and thus such revocation is invalid."[5] RR at 3. Here, CMS notified Petitioner in a letter dated May 18, 2012 that it was revoking Petitioner's Medicare billing privileges effective effective May 16, 2012. However, pursuant to section 424.535(g), the effective date of a revocation (except under circumstances not applicable here) is 30 days after CMS or its contractor issues the notice of revocation. Under the circumstances in this case, the effective date should have been June 17, 2012, and the ALJ cured the error by ordering CMS "to modify the effective date of [the] revocation of Petitioner's billing privileges to June 17, 2012." ALJ Decision at 7. While we, like the ALJ, agree with the general proposition Petitioner advanced, "that an agency must abide by its own regulations," we also agree with the ALJ that CMS's use of the incorrect effective date in its notice letter did not render the revocation invalid or otherwise entitle Petitioner to have the revocation reversed. RR at 4; ALJ Decision at 7. Petitioner cites to no legal authority that requires reversal of an entire administrative agency decision that may be modified or reversed during the course of subsequent administrative proceedings challenging that decision. Nor has Petitioner alleged that he was prejudiced by the contractor's error, which the ALJ corrected. Accordingly, we conclude that the ALJ did not err in denying Petitioner's request for summary judgment.

[5] Petitioner does not argue that there were any other grounds for summary judgment in his favor.

Conclusion

For all of the foregoing reasons, we affirm the ALJ Decision.

/s/
Judith A. Ballard

/s/
Sheila Ann Hegy

/s/
Stephen M. Godek
Presiding Board Member