Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Ronald J. Grason, M.D.
Docket No. A-14-84
Decision No. 2592
September 15, 2014

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Petitioner, Ronald J. Grason, M.D., requests review of the May 2, 2014 decision of an Administrative Law Judge (ALJ) sustaining the revocation of his Medicare billing privileges. *Ronald J. Grason, M.D.*, DAB CR3215 (2014) (ALJ Decision). The ALJ concluded that Petitioner abused his billing privileges within the meaning of 42 C.F.R. § 424.535(a)(8) by billing the Medicare program for services he could not have provided to five beneficiaries on two days. For the reasons explained below, we sustain the ALJ Decision.

Applicable law

The regulation at 42 C.F.R. § 424.535(a)(8), "Abuse of billing privileges," states that CMS may revoke a provider's or supplier's Medicare billing privileges and any corresponding provider or supplier agreement for the following reason:[1]

> (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.

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

[1] 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; *see also* Social Security Act § 1861(d) (42 U.S.C. § 1395x(d) ("The term 'supplier' means, unless the context otherwise requires, a physician or other practitioner . . . that furnishes items or services under this title.").

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[2]

Petitioner is a physician whose practice during the period 2011-2012 consisted of traveling three hours from his home in Decatur, Illinois to Chicago, twice a week, to visit the same 25 to 40 patients who resided in senior-citizen retirement buildings. ALJ Decision at 5, citing CMS Ex. 6. He generally billed the Medicare program for "a physician's home visit for the evaluation and management of an established patient" under "CPT Code 99349" for each patient.[3] *Id*. CPT Code 99349 requires at least two of these three key components: detailed interval history, detailed examination and medical decision making of moderate complexity. ALJ Decision at 4, citing CMS Ex. 13 at 2. CMS's claims processing manual states a "typical time" of 40 minutes for CPT Code 99349. *Id*. citing CMS Ex. 14, at 2-3.

Wisconsin Physician Services Insurance Corporation (WPS), a CMS Medicare contractor, notified Petitioner in a letter dated May 9, 2013 that his Medicare billing privileges were being revoked for three years effective June 8, 2013 under 42 C.F.R. § 424.535(a)(8). CMS Ex. 1. WPS determined that Petitioner could not have furnished the physician services he claimed to have provided to five patients on December 23, 2011 and February 14, 2012 "[g]iven the CPT code you billed to Medicare, the number of beneficiaries you billed for and the total time spent in the apartment complex" where the patients lived. CMS Ex. 1. It is not disputed that Petitioner billed Medicare for CPT Code 99349 for each of the five patients for services he claimed to have rendered on those two days. CMS Exs. 6, 8, 10.

WPS based the revocation on evidence indicating that Petitioner was in the apartment complex where the five patients lived for 15 minutes or less on each of the two days for which Petitioner billed Medicare for the five home visit examinations, which CMS estimates should take 40 minutes each to complete. The evidence consists of reports of a special agent with HHS's Office of Inspector General (OIG) and the apartment complex's

[2] The information in this section is drawn from undisputed findings in the ALJ Decision and the record exhibits and is presented to provide a context for the discussion of the issues raised on appeal. Nothing in this section is intended to replace, modify, or supplement the ALJ's findings of fact or conclusions of law.

[3] CPT (Current Procedural Terminology) codes are numeric codes maintained by the American Medical Association that are used to describe medical, surgical, and diagnostic services and procedures furnished by physicians and other health care professionals. ALJ Decision at 4; *Realhab, Inc.*, DAB No. 2542, at 6 (2014).

visitor logs or sign-in sheets for December 23, 2011 and February 14, 2012, the two days on which Petitioner claimed to have provided the services to the five patients. CMS Exs. 6, 7, 11, 12. The OIG agent interviewed 30 of Petitioner's patients, reviewed billing records, and visited the apartment complex. *Id*.

The OIG agent reported that the apartment complex consisted of a north and a south tower, each with at least 20 stories and one elevator. ALJ Decision at 5, citing CMS Exs. 6, at 2; 12. The towers were connected by a ground-floor lobby through which anyone proceeding from one tower to the other would have to pass; visitors to either tower are signed in by an attendant at a common security access point. *Id*. Three of the five beneficiaries resided in the north tower, each on a different floor, and two resided in the south tower, each on a different floor. *Id*. The visitor logs indicate that on December 23, 2011, Petitioner entered the building at 6:37 a.m. and departed at 6:50 a.m. and did not return, and that on February 14, 2012 Petitioner arrived at 6:33 a.m. and departed at 6:48 a.m. *Id*. citing CMS Ex. 9, at 1.

WPS upheld the revocation in a reconsideration decision on August 29, 2013, and Petitioner on November 29, 2013 requested an ALJ hearing. CMS Exs. 4, 5. CMS moved for summary disposition and for dismissal of the hearing request as untimely and filed 14 exhibits. Petitioner objected to CMS's motions and filed five exhibits. The ALJ admitted the parties' exhibits into evidence.

The ALJ denied CMS's motion for summary judgment on the ground that the case presented a material issue of fact concerning whether Petitioner was in the apartment complex long enough to have performed the claimed services. The ALJ decided the case based on the written record as neither party asked to cross-examine witnesses. ALJ Decision at 2. The ALJ found and concluded that "[a] preponderance of evidence establishes that, on December 23, 2011 and February 14, 2012, [Petitioner] could not have furnished the services – for which he submitted claims to the Medicare program – to five Medicare beneficiaries." [4] ALJ Decision at 4. Petitioner timely requested review of the ALJ Decision.

Standard of Review

Our standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. Our standard of review on a disputed finding of fact is whether the ALJ decision is supported by substantial evidence on the record as a whole. *See Guidelines — Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's*

[4] The ALJ did not rule on CMS's motion to dismiss, or Petitioner's argument that his health issues constituted good cause for the untimeliness, in favor of addressing "the more-easily-resolved merits" of the case. ALJ Decision at 2 n.1.

Participation in the Medicare and Medicaid Programs, http://www.hhs.gov/dab/divisions/appellate/guidelines/prov.html. The Board may modify, affirm, or reverse an ALJ Decision. 42 C.F.R. § 498.88(f)(1)(3).

Analysis

A. Petitioner's criticisms of CMS's evidence demonstrate no error in the ALJ Decision.

Petitioner primarily argues that the ALJ improperly relied on hearsay evidence that was inadmissible under the Federal Rules of Evidence. P. Request for Review of ALJ Decision (RR) at 2. Petitioner argues that the visitor logs showing that he was in the apartment complex for less than 15 minutes on the two days he claimed to have provided the services to the five patients were "not signed, [not] under oath, and [were] unreliable." RR at 2-3. The OIG agent's reports, Petitioner argues, were "not based on his own observations or witnessing, but attributed to conversations he conducted at the building site." RR at 2-3.

Petitioner's argument that some of CMS's evidence was not admissible under federal rules does not furnish a basis to reverse the ALJ Decision. As the ALJ correctly pointed out, "the rules of evidence do not apply in these proceedings." ALJ Decision at 3 n.4, citing 42 C.F.R. § 498.61 ("Evidence may be received at the hearing even though inadmissible under the rules of evidence applicable to court procedure. The ALJ rules on the admissibility of evidence."). Indeed, the ALJ in his prehearing order setting the procedures for the appeal did not adopt the Federal Rules of Evidence and cited only the regulations at Part 498 and the Civil Remedies Division's Procedures which, like Part 498, state that the ALJ is not bound by the Federal Rules of Evidence.

The ALJ also noted that Petitioner could have, but did not, request that the ALJ order CMS to produce the OIG agent and personnel of the apartment complex for cross-examination. ALJ Decision at 2 n.2. Petitioner does not identify any statements in the OIG agent's report that Petitioner alleges are false. Petitioner does not, for example, dispute the OIG agent's description of the apartment complex or the locations of the patients' apartments.

Petitioner questions the accuracy of the visitor logs, asserting that he is hardly ever requested to show a photo ID when entering the apartment complex, that the guards "wave at me and buzz me in," and that "I never checkout at the security desk when I exit the building [so that] anytime recorded as to the length of time spent in the building is

merely guess work."[5] P. Ex. 2, at 2; ALJ Decision at 3. Petitioner has also questioned the accuracy of visitor logs in general, asserting that "it is not uncommon for me to be present in a senior residential building for more than three hours and discover that someone at the security desk signed me out five minutes after I had arrived." CMS Ex. 2, at 3.

Petitioner's general criticisms of the reliability of visitor logs include no allegation that he was in the apartment complex on December 23, 2011 or February 14, 2012 for longer than the visitor logs indicate. Contemporaneous treatment notes or patient records showing the specific services Petitioner rendered to the five patients on those days, if sufficiently reliable, might have called into question the accuracy of the visitor logs. As the ALJ noted, and as we discuss in the next section, Petitioner provided no such evidence. ALJ Decision at 6. Thus, Petitioner's arguments regarding the Federal Rules of Evidence and the reliability of CMS's evidence in general do not show that the ALJ erred in considering that evidence, especially given Petitioner's failure to provide evidence of the specific services he provided to the five patients on the two days at issue.

B. Petitioner failed to demonstrate that he provided services under CPT Code 99349 to the five patients on December 23, 2011 or February 14, 2012.

The ALJ concluded that the visitor logs together with the OIG agent's report "establish a prima facie case that, on December 23 and February 14, [Petitioner] could not have furnished services to the five individuals as he claimed" and that "CMS has come forward with evidence that Petitioner . . . billed the Medicare program for services that he did not provide." ALJ Decision at 6-7. The ALJ further concluded that Petitioner "offers no persuasive evidence to rebut CMS's case" and "has not established that he provided those services." *Id*. In reaching those conclusions, the ALJ applied the "well-established" "relative burdens of proof" the Board has applied in appeals under 42 C.F.R. Part 498: "CMS must come forward with evidence that establishes a prima facie case. Once CMS meets this burden, the provider must prove his case by a preponderance of the evidence." *Id*. at 4, citing *MediSource Corp.*, DAB No. 2011, at 2-3 (2006), citing *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 F. App'x 181 (6th Cir. 2005).

Petitioner "object[s] to the finding that CPT 99349 (home visit) requires at least 40 minutes face to face with the patient." RR at 2. Petitioner argued below that his experience practicing medicine for 44 years enables him to quickly diagnose the ailments of his elderly patients and that he need not spend 40 minutes with each patient on each

[5] The ALJ treated Petitioner's factual assertions in his request for reconsideration and his opposition to CMS's motions for dismissal or summary disposition as declaration testimony, although they were not in the form of declarations. ALJ Decision at 4-5 n.4. The ALJ noted that rules of evidence for court proceedings do not apply in proceedings under Part 498. *Id*.

visit in order to render appropriate care, because of his experience and because he sees patients twice each week. *See, e.g.*, P. Opposition to CMS Motions (P. Br.) at 5 ("40 minutes in the 99349 code . . . fails to take into account the experience and competence of the provider."). On appeal, Petitioner states that he provides many services to his patients for which he does not bill Medicare, and that after he has visited his patients he performs various tasks such as "making appointments, ordering medicines or tests and completing my progress notes." RR at 5; *see also* P. Br. at 4, 6 ("Petitioner provides comprehensive care by necessity to patients [who] have a multitude of complex medical problems I need to address each visit time . . . Besides the home visit I am required to spend additional time phoning in prescriptions ordering tests, making consultations, medical research").

We first note, as did the ALJ, that to have provided the services claimed under CPT Code 99349, Petitioner would have had to have performed two of the three components – detailed interval history, detailed examination, moderately complex medical decision – for each of five patients who resided on different floors and in two different towers. The ALJ found, even accepting "that an experienced physician could perform the home visit – including the required two of three components . . . in less than forty minutes . . . that no one is capable of performing five such visits in less than fifteen minutes," the approximate times Petitioner was in the building according to the visitor logs, "particularly where, as here, doing so involves moving from floor to floor and even tower to tower." ALJ Decision at 6.

Nothing in the record undermines the ALJ's finding. Significantly, Petitioner has offered no evidence, or even alleged, that on December 23, 2011 and February 14, 2012 he provided to the five patients the procedures required to claim Medicare reimbursement for physician's home visits under Code 99349. As the ALJ stated, Petitioner did not "offer any treatment notes, patient records, or other evidence showing that he performed the services for which he billed the Medicare program" on the days in question. *Id*. Petitioner does not dispute that finding. Indeed, the only evidence Petitioner produced relating specifically to the five patients who resided in the apartment complex was a joint affidavit of four patients expressing their general satisfaction with Petitioner's services. P. Ex. 3, at 4. That affidavit, as the ALJ stated, "say[s] nothing about [Petitioner]'s visiting them on December 23, 2011 or February 14, 2012 [and] nothing about the length of his visits" and did not "specify what services he performed during those visits." ALJ Decision at 6.[6]

[6] Petitioner's request for review includes 11 exhibits, some of which duplicate materials in the parties' exhibits before the ALJ. The regulations forbid us from considering evidence not provided on reconsideration or before the ALJ. Section 498.86(a) of 42 C.F.R. provides for the admission of additional evidence before the Board "except for provider and supplier enrollment appeals." This is a provider appeal, and our review is thus limited to the evidence the ALJ admitted into the record. In any event, none of the additional exhibits indicate that Petitioner provided the Code 99349 services to the five patients on the two days at issue.

Similarly, Petitioner's general descriptions of how he practices medicine and serves patients include no specific allegation, let alone any documentary evidence, that he rendered to the five patients the services required for a physician's home visits under Code 99349 on the days at issue.

Absent evidence of what services Petitioner actually provided to the five patients on December 23, 2011 or February 14, 2012, the ALJ correctly found that Petitioner failed to rebut CMS's evidence that he was not in the apartment complex long enough to have provided the claimed services. *See* 73 Fed. Reg. 36,448, 36,452 (June 27, 2008) ("a provider or supplier is required to furnish the evidence that demonstrates that the Medicare contractor made an error at the time an adverse determination was made, not that the provider or supplier is now in compliance . . . it is essential that providers and suppliers submit documentation that supports their eligibility to participate in the Medicare program during the reconsideration step of the provider enrollment appeals process") (emphasis added).

C. Petitioner's other arguments demonstrate no error in the ALJ Decision.

Petitioner "objects to the lengthy process for appeals (twenty months thus far) as a violation of procedural due process, specifically denying him an opportunity for an immediate unbiased hearing and final determination." RR at 2. Petitioner does not cite any provision in the law or regulations, nor are we aware of any, requiring an "immediate" hearing and determination following the revocation of billing privileges under 42 C.F.R. § 424.535(a)(8). The Board has held, in the context of revocations based on other provisions of Part 424, that providers or suppliers are not entitled to pre-revocation hearings. *1866ICPayday.com, L.L.C.*, DAB No. 2289, at 14-15 (2009) (nothing in the law granting hearing rights for suppliers requires that the hearing be a pre-revocation hearing); *see also Fady Fayad, M.D.*, DAB No. 2266, at 14 (2009) (regulations authorizing revocations under section 424.535(a)(3) based on felony convictions "afford affected suppliers only a post-revocation hearing"), *aff'd*, *Fayad v. Sebelius*, 803 F. Supp. 2d 699, 707 (E.D. Mich. 2011) ("due process did not entitle Plaintiff to a prerevocation hearing"). In addition, "[n]othing in the regulations authorizes the ALJ to reverse a revocation to sanction CMS for alleged due process violations where CMS had a basis for the revocation under section 424.535(a)." *Louis J. Gaefke, D.P.M*, DAB No. 2554, at 11 n.10 (2013); *see also Mission Home Health, et al.*, DAB No. 2310, at 8-9 (2011) (facility's "argument that its constitutional rights were violated . . . provides no basis to reverse a denial of enrollment that is fully supported by the applicable laws and regulations."). Thus, any delay in acting on Petitioner's challenges to the revocation of his billing privileges would not provide the Board with a basis to reverse the ALJ Decision and the revocation.

Petitioner on appeal does not dispute the ALJ's finding that the "ten incorrect billings submitted over two days constitutes a pattern within the meaning of the preamble" to the final rule including 42 C.F.R. § 424.535(a)(8). ALJ Decision at 6-7, citing 73 Fed. Reg. 36,448, 36,455 (June 27, 2008) ("this basis for revocation is directed at providers and suppliers who are engaging in a pattern of improper billing . . . 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"). We accordingly do not address the ALJ's finding of a pattern of improper billing, or the ALJ's observation that a showing of a pattern of improper billing is not required by "the plain language of the regulation" authorizing revocation when the supplier "submits a claim or claims for services that could not have been furnished to a specific individual on the date of service." ALJ Decision at 6-7; 42 C.F.R. § 424.535(a)(8) (emphasis added).

Petitioner also seeks review of CMS's determination seeking recoupment of Medicare payments for claims that, he reports, CMS has determined were unsupported. *See* P. Ex. 4 (first page of CMS November 8, 2013 letter to Petitioner seeking repayment of "an overpayment in the amount of $684,068.98"). Petitioner "has asked for a hearing adjudication on his denied Medicare claims and overpayments demands [which] was not addressed" by the ALJ. RR at 1. Neither the ALJ nor the Board have authority to review CMS's overpayment determination. The initial determinations specified at 42 C.F.R. § 498.13(b) that the Board and its ALJs are authorized to review do not include CMS denials of individual Medicare payment claims. A supplier or provider may appeal claim denials to a CMS contractor in accordance with procedures set out in 42 C.F.R. Part 405, subpart I, and claim denials may be further appealed, in appropriate circumstances, to the ALJs in the Office of Medicare Hearings and Appeals and then to the Medicare Appeals Council. *See* 42 C.F.R. Part 405, Subparts G, H, I; 74 Fed. Reg. 65,295 (Dec. 9, 2009).

Accordingly, we conclude that the ALJ's determination that Petitioner could not have furnished Medicare services as claimed to five Medicare beneficiaries on December 23, 2011 and February 14, 2012 was supported by substantial evidence and free of legal error.

Conclusion

For the reasons explained above, we affirm the ALJ Decision sustaining the revocation of Petitioner's Medicare billing privileges under 42 C.F.R. § 424.535(a)(8).

/s/
Constance B. Tobias

/s/
Leslie A. Sussan

/s/
Stephen M. Godek
Presiding Board Member