Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Jaimy H. Bensimon, M.D., P.A.,
(PTANs: K6871, 61229U, and 61229T;
NPIs: 1932110897, 1497726962),

Petitioner,

v.

Centers for Medicare & Medicaid Services,
Respondent

Docket No. C-14-254

Decision No. CR3236

Date: May 20, 2014

DECISION

There is no basis for the revocation of the Medicare enrollment and billing privileges of Petitioner, Jaimy H. Bensimon, M.D., P.A.

I. Procedural Background

The Medicare contractor, First Coast Service Options (FCSO), notified Petitioner[1] by letter dated August 9, 2013, that his Medicare billing privileges and enrollment were being revoked effective September 8, 2013. FCSO cited 42 C.F.R. § 424.535(a)(8)[2] as

---

[1] The billing privileges of both Dr. Bensimon and his practice are involved in this case.

[2] Citations are to the revision of the Code of Federal Regulations (C.F.R.) in effect at the time of the revocation, unless otherwise stated.

the basis for revocation. FCSO also notified Petitioner that he was subject to a three-year bar to reenrollment in Medicare pursuant to 42 C.F.R. § 424.535(c). Centers for Medicare & Medicaid Services (CMS) Exhibit (Ex.) 5.

Petitioner requested a Corrective Action Plan by letter dated August 26, 2013, which was denied by FCSO on October 28, 2012.[3] CMS Exs. 2, 3. Petitioner requested reconsideration of the initial determination to revoke by letter dated August 28, 2013. CMS Ex. 4. FCSO notified Petitioner by letter dated October 31, 2013, that revocation was upheld on reconsideration. CMS Ex. 1.

Petitioner requested review by an administrative law judge (ALJ) by letter dated November 13, 2013. The case was assigned to me for hearing and decision on November 21, 2013, and an Acknowledgement and Prehearing Order (Prehearing Order) was issued at my direction. On December 20, 2013, CMS filed a motion for summary judgment, a memorandum in support of the motion, and CMS Exs. 1 through 10. On January 15, 2014, Petitioner filed his prehearing brief and a cross-motion for summary judgment, with Petitioner's exhibits (P. Exs.) 1 through 5. On February 5, 2014, Petitioner filed a memorandum of law in support of his prehearing brief and cross-motion for summary judgment. On February 10, 2014, CMS filed its reply to Petitioner's prehearing brief. Also on February 10, 2014, Petitioner filed a motion to strike CMS's reply for late filing. On March 6, 2014, Petitioner filed a sixth exhibit, P. Ex. 6. On March 18, 2014, Petitioner filed a supplement to his prehearing brief. On March 27, 2014, I issued a ruling denying the cross-motions for summary judgment and I ordered that the parties file a joint status report advising me when the parties would be available to participate in a two-day hearing to be conducted by video teleconference (VTC). The parties filed a joint status report on April 10, 2014. On April 17, 2014, Petitioner filed a waiver of his right to an oral hearing requesting a judgment upon the pleadings and documentary evidence previously filed. Petitioner represented that CMS counsel had no objection to the waiver of oral hearing. Petitioner's counsel advised me by email dated April 17, 2014, that he did not intend to submit any further briefs or documents. CMS did not request an opportunity to file further submissions. By Order dated May 2, 2014, I accepted the waiver of oral hearing and closed the record. I proceed to a decision based on written submissions and the documentary evidence. No objections were made to my consideration of the offered exhibits and CMS Exs. 1 through10 and P. Exs. 1 through 6 are admitted and considered as evidence.

---

[3] Action by CMS on a corrective action plan is not an initial determination and, therefore, not subject to my review. 42 C.F.R. §§ 405.809, 424.545(a), 498.3(b)(17); *Conchita Jackson, M.D.*, DAB No. 2495 at 5-7 (2013); *Pepper Hill Nursing & Rehab. Ctr., LLC*, DAB No. 2395 at 8 (2011); *DMS Imaging, Inc.*, DAB No. 2313 at 5-8 (2010).

II. Discussion

A. Statutory and Regulatory Program Requirements

Section 1831 of the Social Security Act (42 U.S.C. § 1395j) establishes the supplementary medical insurance benefits program for the aged and disabled known as Medicare Part B. Administration of the Part B program is through contractors such as FCSO. Act § 1842(a) (42 U.S.C. § 1395u(a)). Payment under the program for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of services and suppliers.[4] Act §§ 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395(u)(h)(1)). Petitioner is a physician and a supplier. Subject to some limitations, qualified physician services are covered by Medicare Part B for those physicians enrolled in Medicare. Act §§ 1832(a) (42 U.S.C. § 1395k(a)), 1861(s)(1) (42 U.S.C. § 1395x(s)(1)); 42 C.F.R. § 410.20. "Physician's services" are professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls also subject to some exceptions. Act § 1861(q) (42 U.S.C. § 1395x(q)); 42 C.F.R. § 410.20.

The Act requires the Secretary of Health and Human Services (Secretary) to issue regulations that establish a process for the enrollment in Medicare of providers and suppliers, including the right to a hearing and judicial review of certain enrollment determinations, including revocation of enrollment and billing privileges. Act § 1866(j) (42 U.S.C. § 1395cc(j)).

Pursuant to 42 C.F.R. § 424.505, a supplier such as Petitioner must be enrolled in the Medicare program to be reimbursed for services provided to Medicare beneficiaries. Participation in Medicare imposes obligations upon a supplier. Suppliers must submit complete, accurate and truthful responses to all information requested in the enrollment

---

[4] A "supplier" furnishes services under Medicare and includes physicians or other practitioners and facilities that are not included within the definition of the phrase "provider of services." Act § 1861(d) (42 U.S.C. § 1395x(d)). A "provider of services," commonly shortened to "provider," includes hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, hospice programs, and a fund as described in sections 1814(g) and 1835(e) of the Act. Act § 1861(u) (42 U.S.C. § 1395x(u)). The distinction between providers and suppliers is important because they are treated differently under the Act for some purposes.

application. 42 C.F.R. § 424.510(d)(2). Pursuant to 42 C.F.R. §§ 424.502 and 424.510(d)(3), a supplier's application to enroll in Medicare must be signed by an authorized official, that is, one with authority to bind the supplier both legally and financially. The regulation provides that the signature attests to the accuracy of information provided in the application. The signature also attests to the fact that the supplier is aware of and agrees to abide by all applicable statutes, regulations, and program instructions. 42 C.F.R. § 424.510(d)(3). Suppliers must meet basic requirements depending on their type of service. 42 C.F.R. §§ 424.505, .516, .517. Suppliers are also subject to additional screening requirements depending upon the type of service they provide. 42 C.F.R. § 424.518.

Once enrolled, the supplier receives billing privileges and is issued a billing number that is required to receive payment for services rendered to a Medicare beneficiary. 42 C.F.R. § 424.505. The supplier is subject to a five-year revalidation of enrollment cycle and CMS is authorized to perform off-cycle revalidations for a number of reasons. CMS has the right to perform on-site inspections to verify that the information CMS receives is correct. CMS contacts the supplier directly when it is time to revalidate enrollment information. A supplier must submit the applicable enrollment information, with complete and accurate information and supporting documentation, within 60 calendar days of CMS's notification. 42 C.F.R. § 424.515.

CMS or its Medicare contractor has been delegated authority to revoke an enrolled provider or supplier's Medicare enrollment and billing privileges and any provider or supplier agreement for any of the reasons listed in 42 C.F.R. § 424.535(a). In this case, Petitioner was notified that his enrollment and billing privileges were being revoked pursuant to 42 C.F.R. § 424.535(a)(8), which authorizes revocation if a 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." The regulation provides examples to clarify its application as follows: "[t]hese 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).

A supplier who has been denied enrollment or whose enrollment and billing privileges have been revoked has a right to request a hearing by an ALJ and further review by the Departmental Appeals Board (the Board). 42 C.F.R. §§ 424.545, 498.3(b)(17), 498.5. A hearing on the record, also known as an oral hearing, is required under the Act. *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743, 748-51 (6th Cir. 2004).

B. Issue

Whether there was a basis for revocation of Petitioner's billing privileges and enrollment in Medicare.

C. Findings of Fact, Conclusions of Law, and Analysis

My conclusions of law are set forth in bold text followed by my findings of fact and analysis. The findings of fact are based upon the exhibits admitted. I have carefully considered all the evidence and the arguments of both parties, though not all may be specifically discussed in this decision. I discuss in this decision the credible evidence given the greatest weight in my decision-making.[5] I also discuss any evidence that I find is not credible or worthy of weight. The fact that evidence is not specifically discussed should not be considered sufficient to rebut the presumption that I considered all the evidence and assigned such weight or probative value to the credible evidence that I determined appropriate within my discretion as an ALJ. There is no requirement for me to discuss the weight given every piece of evidence considered in this case, nor would it be consistent with notions of judicial economy to do so. Charles H. Koch, Jr., *Admin. L. and Prac.* § 5:64 (3d ed. 2013).

1. Judgment on the written pleadings and documentary evidence is permissible in this case.

Pursuant to 42 C.F.R. § 498.66(a), an affected party, such as Petitioner, may waive its right to appear and present evidence at an oral hearing by filing a written waiver. When a written waiver is filed by a petitioner, an ALJ need not conduct an oral hearing except in two circumstances: the ALJ concludes witness testimony is necessary to clarify facts at issue; or CMS shows good cause for presenting oral testimony. 42 C.F.R. § 498.66(b). Petitioner waived his right to an oral hearing consistent with the requirements of 42 C.F.R. § 498.66(a). After review of the evidence and pleadings of the parties, I conclude that oral testimony is not necessary for clarification of the facts at issue. CMS has not argued that oral testimony is necessary or otherwise shown good cause to convene an oral hearing. In fact, in completing its prehearing exchanges as required by the Prehearing Order ¶ II.D, CMS identified no witnesses it proposed to call at an oral hearing.

---

[5] "Credible evidence" is evidence that is worthy of belief. *Black's Law Dictionary* 596 (18th ed. 2004). The "weight of evidence" is the persuasiveness of some evidence compared to other evidence. *Id*. at 1625.

In accordance with 42 C.F.R. § 498.66, the record of the hearing in this case without oral testimony consists of the documentary evidence admitted and the parties' pleadings. The parties also had a reasonable opportunity for rebuttal as reflected by their various filings.

Accordingly, this decision is on the merits and not based on summary judgment.

2. The evidence does not establish an abuse of billing privileges within the meaning of 42 C.F.R. § 424.535(a)(8).

3. CMS made a prima facie showing of a basis for the revocation of Petitioner's billing privileged and Medicare enrollment but Petitioner rebutted the prima facie showing.

a. CMS's Evidence

CMS revoked Petitioner's Medicare enrollment and billing privileges effective September 8, 2013, pursuant to 42 C.F.R. § 424.535(a)(8) based on an alleged abuse of billing privileges. Petitioner was barred from re-enrolling in Medicare for three years. CMS Ex. 5. According to the August 9, 2013 FCSO notice, the initial determination that there was abuse of billing privileges was based on data analysis of claimed services furnished to Medicare beneficiaries by Petitioner on 93 dates of service between January 2011 and August 2012. FSCO concluded that Petitioner billed from 16 to 62 hours of services per day. The initial determination states that it was calculated that Petitioner billed for 16 to 62 hours of services per day based on "time estimates per procedure." CMS Ex. 5 at 2. The initial determination states that Petitioner claimed to have delivered the excessive hours of services in multiple locations including his office, assisted living facilities (ALFs), skilled nursing facilities (SNFs) or nursing homes (NFs), and in private homes. CMS Ex. 5 at 2-3. The initial determination also states that Petitioner provided a statement that he was the only member of his practice who billed Medicare for services. FSCO concluded that it was impossible for Petitioner to have furnished the claimed services to specific individuals on the 93 dates of service for which the claims were submitted. CMS Ex. 5. The reconsideration hearing officer upheld the revocation pursuant to 42 C.F.R. § 424.535(a)(8), with no discussion of the evidence upon which she relied. CMS Ex. 1.

The evidence shows that this case was triggered by a probe medical review, the results of which are reported in a March 25, 2013 Probe Medical Review Summary. CMS Ex. 9. The review considered 55 claims for evaluation and management services billed to Medicare by Petitioner for a 24 hour period, specifically April 4, 2012. The claims included 58 services for 55 beneficiaries at four places of service: home, SNFs/NFs, ALFs, and Petitioner's office. The purpose of the review was to determine if services billed were documented as performed, appropriately coded, medically necessary, and

covered by Medicare. The probe considered select Current Procedural Terminology (CPT) codes each of which lists the time physicians typically spend face-to-face with the patient or family or caregiver; or at bedside on the patient's floor or unit. The CPT codes and usual times were: 99213, 15 minutes face-to-face with the patient and/or family; 99214, 25 minutes face-to-face with the patient and/or family; 99305, 35 minutes at the bedside and on patient's facility floor or unit; 99308, 15 minutes at the bedside and on patient's facility floor or unit; 99309, 25 minutes at the bedside and on patient's facility floor or unit; 99335, 25 minutes with the patient and/or family or caregiver; 99336, 40 minutes with the patient and/or family or caregiver; 99348, 25 minutes face-to-face with the patient and/or family; 99354, prolonged service beyond usual first hour; and 99406, 3 to 10 minutes. CMS Ex. 9 at 1-3, 13. The Probe Medical Review Summary states, citing the 2012 CPT Professional Edition, that:

> It should be recognized that the specific times expressed in the visit code descriptors are averages, and, therefore, represent a range of times that may be higher or lower depending upon actual clinical circumstances.

CMS Ex. 9 at 3. The Probe Medical Review Summary also sets forth provisions of the Medicare Claims Processing Manual CMS Pub. 100-04, ch. 12, § 30.6B, which show that physicians are instructed to select the CPT code for evaluation and management services (CPT codes 99201-99499) based on the content of the service and that duration is an ancillary factor, except in cases when more than 50 percent of face-to-face time or more than 50 percent of floor time is spent counseling or coordinating care. CMS Ex. 9 at 5. The Probe Medical Review Summary lists several findings. The most pertinent to the case before me is that Petitioner billed evaluation and management services in the office, SNF/NF, ALF, and home "which amounted to 1600 minutes" which is 24 hours and 20 minutes. CMS Ex. 9 at 15. Other findings of the probe are not the bases for the allegation of abuse of billing privileges and are, therefore, not relevant. The Probe Medical Review Summary concluded that Petitioner had a 17.8 percent error rate for the claims examined and remedial action was imposed including an overpayment and prepayment review for CPT codes 99213, 99214, 99308, and 99309. CMS Ex. 9 at 18-19.

On July 29, 2013, SafeGuard Services, LLC (SGS), a Zone Program Integrity Contractor (ZPIC), requested that Petitioner's Medicare enrollment and billing privileges be revoked based on 42 C.F.R. § 424.535(a)(8) for abuse of billing privileges. CMS Ex. 10. The July 29 ZPIC Revocation Request refers to a Timed Code Report (CMS Ex. 8) for the period January 2011 through August 2012, which purports to list those 93 days on which Petitioner's Medicare claims were for 16 or more hours of service. The ZPIC Revocation Request notes that 28 of the days with hours amounting to 16 to 62.83 hours per day were Sundays; that there were four "most egregious days" during which claimed services amounted to 47.17 to 62.83 hours of services delivered in locations including ALFs and

homes: specifically, on Sunday, June 19, 2011 Petitioner billed for services to 99 beneficiaries in ALFs amounting to 62.83 hours; on May 5, 2013 Petitioner billed Medicare for home and office visits for 104 unique beneficiaries amounting to 49.08 hours; on Sunday, November 20, 2011, Petitioner billed Medicare for home visit to 73 beneficiaries in ALF and private homes amounting to 47.67 hours; and on Sunday, December 18, 2011, Petitioner billed Medicare for home visits to 72 unique beneficiaries in ALFs and private homes amounting to 47.17 hours. CMS Ex. 10 at 1-3. The ZPIC Revocation Request states that Petitioner told investigators that he was the only member of his practice that billed Medicare and that the services billed were delivered by him. CMS Exs. 6; 7 at 2; 10 at 3-4. The ZPIC Revocation Request concludes that revocation is appropriate for the following reasons: Petitioner told investigators that he was the only supplier who billed Medicare using his Medicare numbers; data analysis for dates of service between January 2011 and August 2012 revealed that on 93 dates of service Petitioner "billed for 16 to 62 hours of service per day based on time estimates per procedure;" Petitioner delivered services in ALFs, SNFs/NFs, private homes, and his office; and "it was impossible for him to have rendered the services billed on these 93 dates of service." CMS Ex. 10 at 4.

Petitioner told investigators during his interview on December 5, 2012, that he worked from 8:30 a.m. to 9:00 p.m. Sunday through Friday, seeing approximately 55 patients per day but, he did not normally work on Saturdays. He told investigators that he had 35 appointments per day with an average of 20 walk-ins. He told investigators that he has thousands of patients, the majority of whom are Medicare beneficiaries. Petitioner stated that the services billed to Medicare were only for patients that he had seen himself. CMS Exs. 6, 7 at 2. Petitioner told the investigators that he treats patients in his office, ALFs, SNFs/NFs, and in private homes. He has a staff of seven to eight. Petitioner gave the investigators a list of 13 ALFs, and SNFs/NFs where he provides services to patients. Petitioner is also the Medical Director at Edward J. Heely Nursing Home. CMS Ex. 7 at 2-4. CMS presented no evidence that rebuts Petitioner's assertions to the investigators.

b. Petitioner's Evidence

Petitioner filed his affidavit as P. Ex. 2. He testifies that he is able to provide the services claimed because of: the nature of his practice, which is mostly geriatric and he sees the same patients and problems repeatedly; the close proximity of a number of ALFs and SNFs/NFs to his office and home so that he generally sees a significant number of ALF and SNF/NF patients each day both before and after his regular office hours; his 33 years of medical experience; he states that he does his consultations more quickly than the average time listed in the CPT codes; he is a medical director at three of the nearby facilities; he works all day Sunday; and spends about 15 minutes with new patients and five minutes with established patients. Petitioner states that he typically sees 55 patients in office each day, 80 percent are follow-ups and 20 percent are initial visits. He does not generally work sundown Friday to sundown on Saturday. He works Sunday, 7:00 a.m. to

8:30 p.m., and generally sees 60 to 70 ALF patients on Sundays. Petitioner states that he is:

> able to see this volume of patients each day, in part because my office staff are able to handle preliminary work (i.e. reception, paper work, take vital signs, discuss chief complaint, take EKGs and ultrasounds, blood work and urine samples as needed), thereby limiting time for diagnosis, treatment and counseling and allowing me to focus on each patient I see.

P. Ex. 2. Petitioner states that medical assistants and nurse practitioners in the ALF are well trained and handle much of the preliminary work so that he can get right to the patient's complaint. He states often he merely needs to confirm the diagnosis suggested by the nurse practitioner. He states that the design of ALFs and SNFs/NFs are such that he can see a large number of patients in a short-time. Also, he can see multiple patients in each room at ALFs and SNFs/NFs reducing the time significantly when he is at an ALF or a nursing home. Petitioner testified that he works long-hours and can provide consultations quickly and efficiently without sacrificing the quality of his work. P. Ex. 2. CMS offered no evidence to rebut Petitioner's affidavit.

Petitioner filed the affidavit of Lorraine Molinari, her curriculum vitae, and her report as P. Ex. 3. Ms. Molinari is a consultant with LMA, Inc., a consulting firm that specializes in Medicare coding, billing, and documentation requirements. She states that her company conducts seminars for physicians, office managers, and practice management professionals regarding Medicare national and local coverage determination requirements for Medicare Part B, including proper billing of evaluation and management codes under the CPT. Ms. Molinari started her company in 1991. Ms. Molinari formerly worked for FCSO as a Professional Relations Representative, in which capacity she provided much the same kind of advice as her company currently provides. She states that she has been qualified and testified as an expert witness in administrative and judicial cases involving Medicare coding and reimbursement. Ms. Molinari states that she was retained by Petitioner to review the billing records for Petitioner for the days CMS alleges abusive billing occurred. She states that she did not review every day but rather three days on which Petitioner saw the greatest number of patients, June 19, 2011, March 5, 2012, and August 28, 2011. P. Ex. 3 at 1. Ms. Molinari testified she determined, based on Petitioners billing records, that on Sunday June 19, 2011, Petitioner saw 106 patients and if he spent the average time estimate of the CPT manual he would have worked 67.42 hours, which was impossible. But by seeing new patients only 15 minutes and established patients for only 5 minutes he worked only 15.83 hours, which is neither impossible nor unreasonable. P. Ex. 3 at 2-3. She determined that on March 5, 2012, Petitioner saw 119 patients and if he spent the average time under the CPT manual he would have worked 56.52 hours but, by averaging only 15 minutes with new patients and

5 minutes with established patients he worked only 9.38 hours, which is not impossible or unreasonable. P. Ex. 3 at 3. She determined that on August 28, 2011, Petitioner saw 108 patients and if he spent the average time under the CPT manual he would have worked 45.5 hours but by seeing new patients only 15 minutes and established patients for 5 minutes he worked only 9.33 hours, which is not impossible or unreasonable. P. Ex. 3 at 3. She testified that typical times for evaluation and management services in the CPT manual are averages and actual times may vary significantly depending on circumstances. Time is only one of the components to be considered for billing evaluation and management services and not one of the key components. She opined that it would be reasonable for Petitioner to spend 15 minutes with new patients and five minutes with established patients. She opined based on her review that it was not impossible or unreasonable for Petitioner to see the number of patients on each day listed in the Timed Code Report. P. Ex. 3 at 3. CMS presented no evidence to rebut the affidavit of Ms. Molinari and the CMS argument intended to discredit her testimony is ineffective. CMS Reply at 3 n.1.

SGS informed Dr. Bensimon by letter dated May 23, 2013, that he was removed from prepayment review effective May 15, 2013, due "to the high percentage of claims allowed." P. Ex. 5 at 2.

c. Analysis

CMS is delegated authority to revoke Medicare enrollment and billing privileges for abuse of billing privileges 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.

42 C.F.R. § 424.535(a)(8) (emphasis added).

This regulation provides Petitioner notice that billing privileges and Medicare enrollment may be revoked for an abuse of billing privileges. 5 U.S.C. §§ 551(4), 552(a)(1). The elements of the CMS prima facie case for revocation based on the language of 42 C.F.R. § 424.535(a)(8) are: (1) the provider or supplier submits one or more claims for services; and (2) the services for which a claim or claims were submitted could not have been delivered to a Medicare beneficiary on the date the service was claimed to have been delivered. *Realhab, Inc.*, DAB No. 2542 at 16-17 (2013). Subsection 424.535(a)(8) was

added to Title 42 as a basis for revocation of billing privileges by a final rule issued on June 27, 2008, with an effective date of August 26, 2008. 73 Fed. Reg. 36,448 (June 27, 2008). The regulatory history states that the subsection was proposed to permit Medicare contractors to revoke billing privileges when "a provider or supplier submits a claim or claims for services that **could not** have been furnished to a beneficiary." *Id*. at 36,450 (emphasis added). The drafters state that it is "both appropriate and necessary that [CMS] have the ability to revoke billing privileges when services could not have been furnished by a provider or supplier." *Id*. at 36,455. "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." *Id*. The drafters state that revocation on this basis will not be issued absent sufficient evidence of abusive billing patterns and that billing privileges will not be revoked unless there are at least three instances where billings privileges have been abused. *Id*. The regulation does not specifically state that revocation is limited to cases where the evidence is sufficient to show a pattern of abusive billing. However, the regulatory history strongly states that that limitation was intended by the drafters. Therefore, I conclude that it is necessary for CMS to show as part of its prima facie case that there was more than one claim for a service that could not have been delivered.[6]

CMS has the burden of coming forward with evidence sufficient to make a prima facie showing of a basis for the enforcement action. The quantum of evidence necessary for a prima facie showing is not specified in the regulations or specifically resolved by prior decisions of the Board. But, the Board has stated that CMS must come forward with "evidence related to disputed findings that is sufficient (together with any undisputed findings and relevant legal authority) to establish a prima facie case of noncompliance with a regulatory requirement." *Evergreene Nursing Care Ctr.*, DAB No. 2069 at 7 (2007); *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004). "Prima facie" means generally that the evidence is "[s]ufficient to establish a fact or raise a presumption unless disproved or rebutted." *Black's Law Dictionary* 1228 (18th ed. 2004). In *Hillman Rehab. Ctr.*, the Board described the elements of the CMS prima facie case in general terms as follows:

---

[6] The drafters also state that only CMS and not a Medicare contractor will make the determination to revoke pursuant to 42 C.F.R. § 424.535(a)(8). 73 Fed. Reg. 36,448, 36,455. Both the initial and reconsideration determinations in this case were issued by the contractor, not CMS. The evidence does not show that CMS initiated or reviewed either action prior to issuance. Therefore, the CMS action in this case is inconsistent with its clearly articulated policy in the regulatory history of 42 C.F.R. § 424.535(a)(8).

> HCFA [now known as CMS] must identify the legal criteria to which it seeks to hold a provider. Moreover, to the extent that a provider challenges HCFA's findings, HCFA must come forward with evidence of the basis for its determination, including the factual findings on which HCFA is relying and, if HCFA has determined that a condition of participation was not met, HCFA's evaluation that the deficiencies found meet the regulatory standard for a condition-level deficiency.

DAB No. 1611 at 8. Thus, CMS has the initial burden of coming forward with sufficient evidence to show that its decision to impose an enforcement remedy is legally sufficient under the statute and regulations. To make a prima facie case that its decision was legally sufficient, CMS must: (1) identify the statute, regulation or other legal criteria to which it seeks to hold the provider; (2) come forward with evidence upon which it relies for its factual conclusions that are disputed by the petitioner. In *Evergreene Nursing Care Center*, the Board explained its "well-established framework for allocating the burden of proof on the issue of whether the SNF was out of substantial compliance" as follows:

> CMS has the burden of coming forward with evidence related to disputed findings that is sufficient (together with any undisputed findings and relevant legal authority) to establish a prima facie case of noncompliance with a regulatory requirement. If CMS makes this prima facie showing, then the SNF must carry its ultimate burden of persuasion by showing, by a preponderance of the evidence, on the record as a whole, that it was in substantial compliance during the relevant period.

Evergreene at 7. CMS makes a prima facie showing of noncompliance if the credible evidence CMS relies on is sufficient to support a decision in its favor absent an effective rebuttal.

In this case, CMS made a prima facie showing of a basis for revocation under 42 C.F.R. § 424.535(a)(8). As to the first element and third elements, it is undisputed that Petitioner submitted multiple claims for Medicare payment for services to Medicare beneficiaries on dates of service as alleged by CMS. The second element is that the services for which claims were submitted could not have been provided to a Medicare

beneficiary on the date of service claimed.[7] SGS and FSCO determined and CMS argued before me that it was impossible for Petitioner to deliver the services claimed on the dates of service. The SGS, FSCO, and CMS determinations were made by multiplying the number of services claimed under evaluation and management CPT codes, by the average times listed in the CPT codes, resulting in hours that exceeded 24 hours, which is of course, impossible. Considering only the CMS evidence, CMS made a prima facie showing that Petitioner submitted claims for services on dates of services that it was impossible for him to deliver. Petitioner argued in his supplemental brief that CMS failed to make a prima facie showing of noncompliance citing in support of its argument *D & G Holdings, LLC d/b/a Doctor's Lab*, DAB CR3120 (2014). The present case is unlike *D & G* in which I concluded that CMS's failure to present evidence such as "actual claim forms, requests for reimbursement, death certificates, or other evidence . . . to show that claims were actually filed" prevented CMS from meeting its burden to establish a prima facie case. In this case, I note that CMS Exs. 9 and 10 were neither signed nor sworn to by the authors of these exhibits. Normally this failure might have influenced my conclusion whether or not CMS had made a prima facie case. CMS also did not request an opportunity to present either author as a witness at hearing to support these exhibits. However, unlike in *D&G*, Petitioner in this case does not dispute that he submitted the claims for services on the dates of service alleged. The issue in this case is whether CMS can make a prima facie showing by simply multiplying the average times for evaluation and management CPT codes by the services claimed to have been delivered on certain dates of service. I conclude that the CMS reliance on CPT code time averages is a sufficient basis to establish a prima facie case. The CPT codes are maintained, developed, and updated annually by the American Medical Association. The CPT codes are regularly used by CMS in their normal course of business to evaluate claims for reimbursement. The Board has accepted the use by CMS of CPT codes. *Realhab, Inc.*, DAB No. 2542 (2013). Petitioner also does not allege that the average times stated in the CPT codes in issue are in error or otherwise unreliable.

---

[7] CMS makes allegations regarding findings contained in the Probe Review Summary that have no bearing upon revocation pursuant to 42 C.F.R. § 424.535(a)(8). CMS Br. at 4. CMS also mischaracterized the evidence by asserting that Petitioner claimed to provide a certain number of hours of treatment on July 19 and July 24, 2011 and that Petitioner told investigators that he did not work on Sunday. CMS Br. at 5. CMS argues that if Petitioner routinely provided services in less than the average time listed in the CPT codes he should have submitted documentation to FSCO, but CMS cites no authority for such a requirement. CMS also mischaracterized Petitioner's argument alleging that Petitioner does not dispute that he "submitted claims to Medicare for 16 to 62 hours of services on each of 93 dates of service." CMS Reply at 1.

However, Petitioner has rebutted the CMS prima facie case by a preponderance of the evidence with his unrebutted evidence. Both the CMS evidence and Petitioner's evidence shows that the times listed in the CPT codes are averages that may be higher or lower depending upon actual clinical circumstances. The CMS evidence clearly shows that the times listed in the CPT codes are not minimum times required for billing using a particular evaluation and management CPT code, but are included to assist the physician in selecting the appropriate level of evaluation and management services for which to bill. The Probe Medical Review Summary includes the following:

> The inclusion of time in the definitions of levels of E/M [Evaluation and Management] services has been implicit in prior editions of the CPT codebook. The inclusion of time as an explicit factor beginning in CPT 1992 is done to assist physicians in selecting the most appropriate level of E/M services. It should be recognized that the **specific times expressed in the visit code descriptors are averages and, therefore, represent a range of times that may be higher or lower depending on actual clinical circumstances.**

CMS Ex. 9 at 3. (Emphasis added.).

Petitioner's affidavit and that of his expert are credible and unrebutted. Petitioner's unrebutted evidence clearly establishes that it was possible for him to see the numbers of patients he claimed to see on the dates of service he claimed to see them. The proximity of Petitioner's office to the multiple SNFs/NFs and ALFs, his long work hours six days per week, his ability to rely upon staff to minimize his time with each patient, his significant years of experience, and the fact that the majority of his patients are geriatric, all support the credibility of his testimony that he can generally see a new patient in 15 minutes and an established patient in 5 minutes. Although, I certainly do not intend to endorse such brief periods of physician-patient interaction, the Act, regulations, and CMS policy do not appear to establish minimum interaction times for evaluation and management services.

Petitioner has successfully rebutted CMS's prima facie showing of abusive billing under 42 C.F.R. § 424.535(a)(8). Accordingly, I conclude that there is no basis for revocation of Petitioner's Medicare enrollment and billing privileges pursuant to the authority of 42 C.F.R. § 424.535(a).

III. Conclusion

For the foregoing reasons, I conclude that there is no basis for the revocation of Petitioner's Medicare enrollment and billing privileges.

/s/
Keith W. Sickendick
Administrative Law Judge