Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Wassim Younes, M.D., P.L.C.,
Wassim Younes, M.D.
(PTANs: 0P32730/P32730001)
(NPIs: 1578518304/1386610764)

Petitioners,

v.

Centers for Medicare & Medicaid Services

Docket No. C-15-2934

Decision No. CR4902

Date: August 1, 2017

DECISION

Petitioner, Wassim Younes, M.D., is a physician, practicing in Michigan. "Wassim Younes, M.D., PLC" is the corporation through which he bills. Until recently, Dr. Younes and his corporation participated in the Medicare program. The Centers for Medicare & Medicaid Services (CMS) has revoked their billing privileges, citing abusive billing practices, specifically, CMS charges that Dr. Younes billed for services to Medicare beneficiaries who were dead at the time those services were ostensibly provided.

Petitioners appeal. CMS has moved for summary judgment, which Petitioners oppose. Because an in-person hearing would serve no purpose (see below), I decide this case based on the written record rather than on summary judgment.

The evidence establishes that, through his corporation, Dr. Younes repeatedly billed the Medicare program for services he could not have provided and, in fact, did not provide. CMS therefore properly revoked his and his corporation's billing privileges.

Background

By letter dated March 2, 2015, the Medicare contractor, Wisconsin Physician Service Insurance Corporation, advised Dr. Younes and his corporation that their Medicare billing privileges were revoked, effective April 2, 2015. The contractor took this action pursuant to 42 C.F.R. § 424.535(a)(8) because it found that Dr. Younes submitted multiple claims for services rendered to beneficiaries who were deceased on the purported dates of service. Petitioner (P.) Exhibit (Ex.) 1.

Petitioners requested reconsideration and submitted a corrective action plan. CMS Exs. 1 and 2. In a reconsidered determination, dated April 21, 2015, the contractor upheld the revocation. The contractor also explained that it could not consider Petitioners' corrective action plan. Suppliers may submit corrective action plans only for revocations brought under 42 C.F.R. § 424.535(a)(1), which authorizes revocation based on the supplier's noncompliance with enrollment requirements. 42 C.F.R. § 405.809(a)(1); CMS Ex. 3 at 2.

Petitioners appealed, and their appeal is now before me. CMS has filed a pre-hearing brief and motion for summary judgment (CMS Br.). With its motion and brief, CMS submits 43 exhibits. Petitioners have submitted a pre-hearing brief and response to CMS's motion for summary judgment (P. Br.), accompanied by eight exhibits (P. Exs. 1-8).

In the absence of any objection, I admit into evidence CMS Exs. 1-43.

CMS objects to my admitting P. Exs. 3, 4, 6, and 7. P. Exs. 3, 4, and 7 are documents that Petitioner did not submit at the reconsideration level. *See* CMS Ex. 1 (Petitioners' reconsideration submissions). Under 42 C.F.R. § 498.56(e), I may admit new documentary evidence if I find good cause for Petitioners' failing to admit it at reconsideration. Petitioner has offered no reasons for failing to submit these documents earlier, much less established good cause.[1] I therefore decline to admit them.

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[1] The first page of P. Ex. 3 was generated after the reconsideration determination. That it did not exist at the time of reconsideration would have constituted good cause and justified its admission, if it were otherwise admissible. But the document – correspondence from the contractor confirming receipt of Petitioners' check to cover an overpayment – is not relevant and should not be admitted. 42 C.F.R. § 498.60(b)(1).

P. Ex. 6 is a written declaration from Therese M. Boka, operations manager for Physician Billing Solutions. She indicates that Petitioners have retained her company and promises to review all of Dr. Younes's Medicare claims in order to "identify and fix" potential billing errors. P. Ex. 6 at 1 (Boka Decl. ¶ 9). CMS objects, arguing that the testimony is irrelevant. I agree. The witness was not involved in the billing practices that are the subject of this appeal; her testimony contributes nothing to the issues before me. I therefore decline to admit it. 42 C.F.R. § 498.60(b)(1).

I admit P. Exs. 1, 2, 5, and 8.

CMS is more than likely entitled to summary judgment because the parties agree that Petitioners billed Medicare for services that Dr. Younes could not have provided inasmuch as the beneficiaries died before the service dates. CMS is therefore entitled to judgment as a matter of law. But I need not consider whether the standards for summary judgment are met here. Neither party has asked to cross-examine the other's witness as required by my prehearing order. Acknowledgment and Pre-hearing Order at 3, 5-6 (¶¶ 4(c)(iv), 8-10) (June 26, 2015)). In compliance with that order, CMS listed one witness and provided his written direct testimony, CMS Ex. 4. My order directs Petitioners to state affirmatively whether they want to cross-examine CMS's witness, and they have not done so. Petitioners have therefore waived cross-examination. Acknowledgment at 5-6 (¶¶ 9, 10).

For their part, Petitioners listed Dr. Younes as a witness but did not provide his written testimony – as my order requires – so Petitioners have waived their right to present his testimony. Acknowledgment at 3, 5 (¶¶ 4(c)(iv), 8). Petitioners provided the written direct testimony of two other individuals (P. Exs. 6, 8), one of which I have excluded (P. Ex. 6). CMS has not asked to cross-examine the remaining witnesses.

Thus, an in-person hearing would serve no purpose, and the case may be decided based on the written record.

Discussion

> ***The undisputed evidence establishes that Petitioners billed the Medicare program for services that Dr. Younes could not have provided because the beneficiaries to whom the services were purportedly provided were no longer living. CMS therefore properly revoked Petitioners' Medicare enrollment pursuant to 42 C.F.R. § 424.535(a)(8).*** [2]

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[2] I make this one finding of fact/conclusion of law.

Program rules. CMS regulates the Medicare enrollment of providers and suppliers. Social Security Act (Act) § 1866(j)(1)(A). It may revoke a supplier's billing privileges if he abuses them by submitting a claim or claims for services that he could not have furnished to a specific individual on the date of service, such as "where the beneficiary is deceased." 42 C.F.R. § 424.535(a)(8).[3]

Undisputed facts. Dr. Younes is a physician practicing in Dearborn, Michigan. He is the sole owner of Wassim Younes, PLC, and billed the Medicare program through that corporation. CMS Ex. 4 at 3 (Neubert Decl. ¶ 11); P. Br. at 1.

The parties agree that Dr. Younes billed the Medicare program for services he could not have provided because the beneficiaries were dead on the billed dates of service. CMS compared Dr. Younes's billing records with the Social Security Administration's "death master file" and found 56 such posthumous dates of service between February 27, 2012, and October 29, 2014. During this time, Petitioners submitted 60 unique claims for 31 deceased beneficiaries. CMS Ex. 4 at 3 (Neubert Decl. ¶¶ 13, 15, 16); CMS Ex. 36. CMS subsequently eliminated one claim from its list of improper claims. CMS Br. at 3; *see* CMS Ex. 36 at 1; P. Br. at 6.

The erroneous claims. Of the 55 claims remaining, Petitioners argue that nine were billed properly. P. Br. at 5-9. They assert that these claims represent Dr. Younes's verbal orders for home health services, issued before the residents' deaths.

"Home health services" are particular items and services furnished to an individual who is under the care of a physician; the services must be provided under a plan "established and periodically reviewed by a physician." With limited exceptions, the services are provided in the individual's home. Act § 1861(m). Medicare pays for home health services if, among other requirements, a *physician certifies* that the home health services are/were required because the individual is/was confined to his/her home and needs/needed skilled nursing care or similar services. Act § 1814(a)(2)(C); 42 C.F.R. § 424.22(a). The physician must periodically review the care plan. Act § 1835(a)(2)(A); 42 C.F.R. § 424.22(a)(1)(iii). The physician must document that a "face-to-face patient encounter" occurred no more than 90 days before or within 30 days of the start of service delivery. 42 C.F.R. § 424.22(a)(v).

According to Petitioners, although Dr. Younes issued the orders (verbally) while the patients were living, by the time he signed the patients' care plans/certification statements, the patients had died. P. Br. at 6-9. The major problem with this argument is that no evidence supports it. Petitioners offer a summary table, which lists patients and dates, but they submit no underlying support for that data. P. Br. at 6-7. They provide no

[3] Currently 42 C.F.R. § 424.535(a)(8)(i)(A). *See* 79 Fed. Reg. 72532 (December 5, 2014).

medical documentation. Dr. Younes has not testified (in the form of a written declaration) that he provided any of these services at any time. I therefore find that the uncontroverted evidence supports CMS's position that these patients were already dead on the date Dr. Younes claims to have provided the billed services.

Moreover, as CMS points out, the physician is supposed to read and countersign the care plans. For at least some of these patients, Dr. Younes does not purport to have read and countersigned their care plans until long after they had died, which made his doing so (even assuming he did it) a pointless exercise.

- For one patient (DW), Petitioners indicate that the date of Dr. Younes's verbal order is "not applicable." Dr. Younes's "claim date" – the date he supposedly reviewed and certified the written care plan – is November 10, 2012, which would have been the last day of the 60-day period he certified for home health services (9/12-11/10). But the patient died on September 23, seven weeks earlier. P. Br. at 7.

- For a second patient (RS), Petitioners claim that Dr. Younes issued his verbal order on April 18, 2012, certifying the need for services from April 21 through June 19, 2012. The patient died on June 22, 2012. Yet, Dr. Younes' claim date is July 23, 2012, more than three months after he purportedly authorized the services, and a full month after the patient's death. P. Br. at 6.

- Dr. Younes apparently signed two care plans, a certification and then a recertification, for a third patient (CL). Petitioners claim that he issued his first verbal order on June 24, 2012, for services from June 24 through July 22, 2012. On July 22, 2012, he issued the verbal order recertifying the services from July 23 through September 20, 2012 – apparently without having reviewed and signed the original care plan. His claim date for the first certification was October 29, 2012, and for the second, it was November 8, 2012. But the patient died on September 6, 2012, well before Dr. Younes reviewed and approved even the first plan. P. Br. at 7.

- Finally, for a fourth patient (EM), Petitioners claim that Dr. Younes issued a verbal order on March 15, 2012, for services from March 19 through May 17, 2012. The claim date is September 26, 2012, but the patient died almost five months earlier, on May 2, 2012. P. Br. at 7.

But even discounting those nine claims (which I do not), for the remaining 46, Petitioners concede that Dr. Younes billed the Medicare program for services that he could not have provided. They argue that significant mitigating circumstances excuse the errors and that Dr. Younes's continuing enrollment poses no risk to the Medicare program or any of its beneficiaries. P. Br. at 2. Specifically, Petitioners attribute the errors to: beneficiary

misidentification (14 claims); miscoding by Dr. Younes's nurse practitioner (15 claims); and clerical errors regarding the dates of service (15 claims). They admit that they cannot explain one of the claims. P. Br. at 21.

Referring to language in the regulation's preamble, Petitioners suggest that these "accidental mistakes" and "isolated occurrences" do not show a pattern of improper billing, which, in Petitioners' view, is required for revocation under section 424.535(a)(8). P. Br. at 2-3, *citing* 71 Fed. Reg. 20754, 20761. But nothing in the language of the regulation or its preamble suggests that CMS must "find 'a minimum claims error rate or dollar amount' before revoking billing privileges under section 424.535(a)(8)." *John M. Shimko, D.P.M.*, DAB No. 2689 at 10 (2016), *quoting Howard B. Reife*, D.P.M., DAB No. 2527 at 7 (2013). Indeed, the Departmental Appeals Board has affirmed revocations in cases involving far fewer errors and lower errors rates than presented here. *Shimko*, DAB No. 2689 (19 claims over 3 years); *Louis J. Gaefke, D.P.M.*, DAB No. 2554 (2013) (35 claims over 4 years); *Reife*, DAB No. 2527 (35 claims over an unspecified period of time). Moreover, the plain language of the regulation authorizes CMS to revoke billing privileges based on a single claim. 42 C.F.R. § 424.535(a)(8) (authorizing revocation if the supplier submits "*a claim* or claims for services that could not have been furnished . . .").

The Board has understandably shown little patience with physicians who justify their erroneous billing by claiming that they "misidentified" their patients, mistaking a living patient for a dead one. A physician is expected to know whom he is treating. "Surely, repeatedly mistaking the identity of the individual being treated and failing to confirm identifiers . . . raise[s] questions of lack of attention and *a pattern of unreliable or abusive billing*." *Shimko* at 7 (emphasis added).

Nor has the Board shown any sympathy for physicians who blame their staff for coding or clerical errors, finding, repeatedly, that the regulation provides no exceptions "for inadvertent or accidental billing errors." *Shimko* at 6, *quoting Gaefke* at 7. Nothing in the regulation or its preamble requires CMS to establish that the improper claims were not accidental. *Reife* at 6. Physicians are responsible for Medicare claims submitted on their behalf and at their direction. Their efforts to assign the blame elsewhere (billing agent, assistants) "do not relieve [them] of [their] responsibility for the improper claims or bar CMS from revoking [their] billing privileges." *Reife* at 8.

I have no authority to consider the contractor's refusal to accept Petitioners' corrective action plan. 42 C.F.R. § 405.809.

Conclusion

The evidence establishes that Petitioner Wassim Younes, M.D., through his corporation, repeatedly billed the Medicare program for services that he could not have provided because the beneficiaries were dead on the purported dates of service. CMS therefore properly revoked his and his corporation's billing privileges.

/s/
Carolyn Cozad Hughes
Administrative Law Judge