Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Robert Reeder, M.D. and Reeder Medical Group, LLC,

(NPI: 124252469/ PTANs: 06473W and 06473)

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-17-627

Decision No. CR4958

Date: October 24, 2017

DECISION

The Medicare enrollment and billing privileges of Petitioner, Robert Reeder, M.D., and Reeder Medical Group, LLC, are revoked pursuant to 42 C.F.R. § 424.535(a)(8)(i),[1] effective December 15, 2016.

I. Background

The Centers for Medicare & Medicaid Services (CMS) notified Petitioner by letter dated November 15, 2016, that his Medicare billing number and billing privileges were revoked effective December 15, 2016. CMS cited 42 C.F.R. § 424.535(a)(8)(i) as the basis for the revocation. CMS further informed Petitioner that he was subject to a three-year bar to re-enrollment pursuant to 42 C.F.R. § 424.535(c) to begin 30 days after the date of CMS's letter. CMS Exhibit (Ex.) 1 at 11-12. On March 2, 2017, a CMS Hearing Officer upheld the revocation on reconsideration. CMS Ex. 1 at 1-7.

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[1] Citations are to the 2016 version of the Code of Federal Regulations (C.F.R.), unless otherwise stated.

Petitioner filed a request for hearing before an ALJ on April 26, 2017. On May 10, 2017, the case was assigned to me for hearing and decision and I issued an Acknowledgement and Prehearing Order (Prehearing Order).

On June 9, 2017, CMS filed a motion for summary judgment and brief in support of its motion (CMS Br.) and CMS Exs. 1 through 3. Petitioner filed a response on August 2, 2017 (P. Response). Petitioner did not submit any documentary evidence with his response. Petitioner did not object to my consideration of the CMS exhibits and they are admitted. CMS did not file a reply and I treat the failure as a waiver of the right to reply.

II. Discussion

A. Applicable Law

Section 1831 of the Social Security Act (the Act) (42 U.S.C. § 1395j) establishes the supplementary medical insurance benefits program for the aged and disabled known as Medicare Part B. Payment under the program for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of services and suppliers.[2] Act §§ 1835(a) (42 U.S.C. § 1395n(a)), 1842(h)(1) (42 U.S.C. § 1395u(h)(1)). Petitioner, a physician, is a supplier.

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, such as revocation of enrollment and billing privileges. Act § 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to 42 C.F.R. § 424.505, suppliers such as Petitioner must be enrolled in the Medicare program and be issued a billing number to have billing

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[2] 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) (42 U.S.C. § 1395f(g)) and 1835(e) (42 U.S.C. § 1395n(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.

privileges and to be eligible to receive payment for services rendered to a Medicare-eligible beneficiary.

The Secretary has delegated the authority to revoke enrollment and billing privileges to CMS. 42 C.F.R. § 424.535. CMS or its Medicare contractor may revoke an enrolled supplier's Medicare enrollment and billing privileges and supplier agreement for any of the reasons listed in 42 C.F.R. § 424.535. If CMS revokes a supplier's Medicare billing privileges, the revocation becomes effective 30 days after CMS or one of its contractors mails the revocation notice to the supplier, subject to some exceptions not applicable in this case. After a supplier's Medicare enrollment and billing privileges are revoked, the supplier is barred from re-enrolling in the Medicare program for a minimum of one year, but no more than three years. 42 C.F.R. § 424.535(c).

A supplier whose enrollment and billing privileges have been revoked may request reconsideration and review as provided by 42 C.F.R. pt. 498. 42 C.F.R. § 424.545(a). A supplier submits a written request for reconsideration to CMS or its contractor. 42 C.F.R. § 498.22(a). CMS or its contractor must give notice of its reconsidered determination to the supplier, giving the reasons for its determination and specifying the conditions or requirements the supplier failed to meet, and the right to an ALJ hearing. 42 C.F.R. § 498.25. If the decision on reconsideration is unfavorable to the supplier, the supplier has the right to request a hearing by an ALJ and further review by the Departmental Appeals Board (the Board). Act § 1866(j)(8) (42 U.S.C. § 1395cc(j)(8)); 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 unless waived. CMS is also granted the right to request ALJ review of a reconsidered determination with which it is dissatisfied. 42 C.F.R. § 498.5(*l*)(2). *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743, 748-51 (6th Cir. 2004). The supplier bears the burden to demonstrate that it meets enrollment requirements with documents and records. 42 C.F.R. § 424.545(c).

B. Issues

Whether summary judgment is appropriate;

Whether there was a basis for the 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 followed by the undisputed facts and analysis.

1. Summary judgment is appropriate.

CMS filed a motion for summary judgment. As noted above, a supplier whose enrollment has been revoked has a right to a hearing and judicial review, and a hearing on the record is required under the Act. Act §§ 205(b), 1866(h)(1), (j); 42 C.F.R. §§ 498.3(b)(5), (6), (8), (15), (17), 498.5; *Crestview*, 373 F.3d at 748-51. A party may waive appearance at an oral hearing but must do so affirmatively in writing. 42 C.F.R. § 498.66. In this case, Petitioner has not waived the right to oral hearing or otherwise consented to a decision based only upon the documentary evidence or pleadings. Accordingly, disposition on the written record alone is not permissible, unless summary judgment is appropriate.

Summary judgment is not automatic upon request but is limited to certain specific conditions. The Secretary's regulations at 42 C.F.R. pt. 498 that establish the procedures to be followed in adjudicating Petitioner's case do not establish a summary judgment procedure or recognize such a procedure. However, the Board has long accepted that summary judgment is an acceptable procedural device in cases adjudicated pursuant to 42 C.F.R. pt. 498. *See, e.g.*, *Ill. Knights Templar Home*, DAB No. 2274 at 3-4 (2009); *Garden City Med. Clinic*, DAB No. 1763 (2001); *Everett Rehab. & Med. Ctr.*, DAB No. 1628 at 3 (1997). The Board also has recognized that the Federal Rules of Civil Procedure do not apply in administrative adjudications such as this, but the Board has accepted that Fed. R. Civ. Pro. 56 and related cases provide useful guidance for determining whether summary judgment is appropriate. Furthermore, a summary judgment procedure was adopted as a matter of judicial economy within my authority to regulate the course of proceedings and made available to the parties in the litigation of this case by my Prehearing Order. The parties were given notice by the Prehearing Order that summary judgment is an available procedural device and that the law as it has developed related to Fed. R. Civ. Pro. 56 will be applied. Prehearing Order ¶ II.D and G.

Summary judgment is appropriate when there is no genuine dispute as to any issue of material fact for adjudication and/or the moving party is entitled to judgment as a matter of law. In determining whether there are genuine issues of material fact for trial, the ALJ must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. The party requesting summary judgment bears the burden of showing that there are no genuine issues of material fact for trial and/or that it is entitled to judgment as a matter of law. Generally, the non-movant may not defeat an adequately supported summary judgment motion by relying upon the denials in its pleadings or briefs but must furnish evidence of a dispute concerning a material fact, i.e., a fact that would affect the outcome of the case if proven. *Mission Hosp. Reg'l Med. Ctr.*, DAB No. 2459 at 4 (2012) (and cases cited therein); *Experts Are Us, Inc.*, DAB No. 2452 at 4 (2012) (and cases cited therein); *Senior Rehab. & Skilled*

Nursing Ctr., DAB No. 2300 at 3 (2010) (and cases cited therein); *see also Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986).

The standard for deciding a case on summary judgment and an ALJ's decision-making in deciding a summary judgment motion differ from that used in resolving a case after a hearing. On summary judgment, the ALJ does not make credibility determinations, weigh the evidence, or decide which inferences to draw from the evidence, as would be done when finding facts after a hearing on the record. Rather, on summary judgment, the ALJ construes the evidence in a light most favorable to the non-movant and avoids deciding which version of the facts is more likely true. *Holy Cross Vill. at Notre Dame, Inc.*, DAB No. 2291 at 5 (2009). The Board also has recognized that on summary judgment it is appropriate for the ALJ to consider whether a rational trier of fact could find that the party's evidence would be sufficient to meet that party's evidentiary burden. *Dumas Nursing & Rehab., L.P.*, DAB No. 2347 at 5 (2010). The Secretary has not provided in 42 C.F.R. pt. 498 for the allocation of the burden of persuasion or the quantum of evidence required to satisfy the burden of persuasion. However, the Board has provided some persuasive analysis regarding the allocation of the burden of persuasion in cases subject to 42 C.F.R. pt. 498. *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd*, *Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 Fed. App'x 181 (6th Cir. 2005).

Viewing the evidence before me in a light most favorable to Petitioner and drawing all inferences in Petitioner's favor, I conclude that there are no genuine disputes as to any material facts pertinent to revocation under 42 C.F.R. § 424.535(a)(8)(i) that require a hearing in this case. The issues in this case raised by Petitioner related to revocation under 42 C.F.R. § 424.535(a)(8)(i) must be resolved against him as a matter of law.

The undisputed evidence shows that there is a basis for revocation of Petitioner's Medicare enrollment and billing privileges and CMS is entitled to judgment as a matter of law. Accordingly, summary judgment is appropriate.

> **2. Billing privileges are abused, within the meaning of 42 C.F.R. § 424.535(a)(8)(i), when three or more claims are submitted to Medicare for services that could not have been furnished to the specific individuals identified in the claims on the dates the services were claimed to have been delivered.**
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> **3. Petitioner, or others on his behalf, submitted to Medicare 17 claims for payment between about June 27, 2014 and August 7, 2016, for services provided to 12 Medicare beneficiaries who were deceased on**

the claimed dates of service; the claims were, therefore, false and constituted an abuse of billing privileges under 42 C.F.R. § 424.535(a)(8)(i).

4. It is no defense to a revocation action for abuse of billing privileges under 42 C.F.R. § 424.535(a)(8)(i) that the false claims were due to inadvertent or unintentional errors of Petitioner's agents or employees or others.

5. There is a basis for revocation of Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(8)(i).

6. The effective date of revocation in this case was December 15, 2016, 30 days after the date of the notice of initial determination to revoke. 42 C.F.R. § 424.535(g).

The regulation provides:

> (8) *Abuse of billing privileges.* Abuse of billing privileges includes either of the following:
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> (i) 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 the following situations:
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> (A) Where the beneficiary is deceased.
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> (B) The directing physician or beneficiary is not in the state or country when services were furnished.
>
> (C) 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)(i) (italics in original).[3] The regulation provides Petitioner notice that billing privileges and Medicare enrollment may be revoked for an abuse of

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[3] The notice of the initial determination was issued on November 15, 2016, and the notice of the reconsidered determination was issued on March 2, 2017. CMS Ex. 1 at 1-7, 11-

(Footnote continued next page.)

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)(i) are: (1) the provider or supplier submitted one or more claims for services; and (2) the services for which a claim or claims were submitted could not have been delivered to the specific Medicare beneficiary on the date the service was claimed to have been delivered to him or her. *Realhab, Inc.*, DAB No. 2542 at 16-17 (2013). Although the plain language of the regulation seems clear enough at first blush, there have been several Board decisions that discussed the regulatory history of the regulation for clarification of what was intended to be a sufficient basis for revocation. *Proteam Healthcare, Inc.*, DAB No. 2658 (2015); *Ronald J. Grason, M.D.*, DAB No. 2592 at 8 (2014); *Realhab, Inc.*, DAB No. 2542 at 16; *Howard B. Reife, D.P.M.*, DAB No. 2527 at 1-2 (2013). CMS, the proponent of the regulation, explained in comments to the final rulemaking in 2008:

> CMS, not a Medicare contractor, will make the determination for revocation under the authority at § 424.535(a)(8). We will direct contractors to use this basis of revocation after identifying providers or suppliers that have these billing issues. We have found numerous examples of situations where a physician claims to have furnished a service to a beneficiary more than a month after their recorded death, or when the provider or supplier was out of State when the supposed services had been furnished. **In these instances, the provider has billed the Medicare program for services *which were not provided* and has submitted Medicare claims *for services to a beneficiary who could not have received the service which was billed*.** 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

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(Footnote continued.)

12. Therefore, 42 C.F.R. § 424.535(a)(8), as amended effective February 3, 2015, applies in this case. On December 5, 2014, 42 C.F.R. § 424.535(a)(8) was amended to re-number 42 C.F.R. § 424.535(a)(8) as 42 C.F.R. § 424.535(a)(8)(i) and to add subsection (8)(ii). The change was effective February 3, 2015. 79 Fed. Reg. 72,500, 72,513-521 (Dec. 5, 2014).

> 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 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) (emphasis added). Based on this regulatory history, I conclude that CMS must also show as part of its prima facie case that there were at least three claims for services that could not have been delivered to the Medicare beneficiary named in the claims. I note that the drafters of the regulation 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. at 36,455; 79 Fed. Reg. at 72,513-521.

a. Facts

CMS notified Petitioner on November 15, 2016, that his Medicare enrollment and billing privileges were revoked effective December 15, 2016. The notice alleged abuse of billing privileges and that the revocation was pursuant to 42 C.F.R. § 424.535(a)(8)(i). CMS Ex. 1 at 11. Specifically, CMS alleged that a data analysis of claims billed by Petitioner for dates of service from June 27, 2014 through August 7, 2016, revealed that Petitioner submitted 19 claims for reimbursement to Medicare for services provided to 13 Medicare beneficiaries who were deceased on the dates of service claimed. CMS Exs. 1 at 11, 13; 2; 3.

Petitioner does not deny that the claims cited by CMS (CMS Exs. 1 at 13; 2; 3) were filed by Petitioner or on his behalf. Petitioner does not deny that the 13 individuals named in the 19 claims were dead on the dates on which services were claimed to be delivered. Petitioner argues that all but two of the claims identified by CMS were the result of staff error and the other two were based on wrong information provided by a hospital. Petitioner alleges and I accept as true for purposes of summary judgment, that none of the claims were paid by Medicare. CMS Ex. 1 at 16-18, 21-22; Request for Hearing; P. Response. Petitioner does not address in his request for reconsideration Charles E. Johnson and Michael S. Baker, but he does discuss Victor Yee who was not listed in the notice of initial determination and is not currently alleged by CMS as one of the abusive claims. CMS Ex. 1 at 16-18, 21-23. In his response, Petitioner does not address Charles E. Johnson, but he does discuss Michael S. Baker and Victor Yee. For purposes of summary judgment, I do not treat Petitioner's failure to discuss Charles E. Johnson as an

admission by Petitioner. Rather, I do not consider the allegations related to Charles E. Johnson, concluding it is unnecessary to attempt to resolve the possible inconsistency as the remaining claims exceed three and constitute a sufficient basis for revocation. Therefore for purposes of summary judgment, I find and conclude that there is no material dispute of fact that 17 claims were submitted related to 12 beneficiaries who were deceased on the claimed dates of service. For purposes of summary judgment, I accept Petitioner's assertions that patients with the same or similar names were imported into his record system and staff did not carefully validate that the patient in the system was in fact the patient being treated. I also accept as true for summary judgment Petitioner's contention that since the last of these claims in issue were identified and reported by CMS, there has not been one single further incident and every staff member from the period in question is no longer with the practice. I accept as true for summary judgment that none of the claims involved were paid to Petitioner by CMS. P. Response at 2-3.

b. Analysis

I conclude that the undisputed facts establish a prima facie case of abuse of billing privileges under 42 C.F.R. § 424.535(a)(8)(i). The elements of the CMS prima facie case for revocation pursuant to 42 C.F.R. § 424.535(a)(8)(i) are met because it is undisputed that 17 claims were submitted by or on Petitioner's behalf, from June 27, 2014 through August 7, 2016, for services that could not have been furnished to 12 specific beneficiaries on the claimed date of service because each of the beneficiaries was dead.

I further conclude that Petitioner has neither rebutted the CMS prima facie case nor established any defense. CMS is not required to show that Petitioner intended to defraud or abuse billing privileges. The Board has upheld determinations that abuse in the context of 42 C.F.R. § 424.535(a)(8) occurs when a provider bills Medicare for services that could not have been provided to the Medicare beneficiary to whom the claim is related. *Realhab, Inc.*, DAB No. 2542 at 15. The Board has commented that a common definition of abuse is misuse, wrong, or improper use, and that the negligent submission of multiple erroneous claims for services that could not have been delivered to beneficiaries, amounts to abuse. *Louis J. Gaefke*, D.P.M., DAB No. 2554 at 9 (2013); *Howard B. Reife, D.P.M.*, DAB No. 2527 at 6. CMS is not required to show that Petitioner intended to defraud Medicare before it revokes his enrollment and billing privileges. The regulation only requires the existence of claims for services that could not have been delivered. 42 C.F.R. § 424.535(a)(8); *Louis J. Gaefke, D.P.M.*, DAB No. 2554 at 7 ("The plain language of the regulation contains no requirement that CMS establish that the supplier acted with fraudulent or dishonest intent. The regulatory language also does not provide any exception for inadvertent or accidental billing errors."). It is irrelevant whether or not the claims were actually paid by CMS. Petitioner's implied argument that he should not be held responsible for innocent staff or

clerical errors is also without merit. Petitioner is ultimately responsible as a matter of law for ensuring that his claims for Medicare reimbursement were accurate and for any errors in those claims. *Louis J. Gaefke*, *D.P.M.*, DAB No. 2554 at 5-6 (citing 73 Fed. Reg. at 36,455). Petitioner cannot avoid responsibility for his claims by the simple expedient of shifting responsibility and liability to staff or others. It is undisputed that Petitioner filed 17 claims for services to 12 former Medicare beneficiaries who were dead at the time the claimed services were supposed to be delivered. Petitioner, his staff, or his billing agent filed the claims. Petitioner, as the enrolled supplier, is responsible to ensure that he was in compliance with Medicare requirements. 42 C.F.R. §§ 424.510(d)(3), 424.516. As the drafters of 42 C.F.R. § 424.535(a)(8) stated:

> In conclusion, we believe that providers and suppliers are responsible for the claims they submit or the claims submitted on their behalf. We believe 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.

Under the regulations, the re-enrollment bar after a revocation is a minimum of one year and a maximum of three years. 42 C.F.R. § 424.535(c). There is no statutory or regulatory language establishing a right to review of the duration of the re-enrollment bar CMS imposes. Act § 1866(j)(8); 42 C.F.R. §§ 424.535(c), 424.545, 498.3(b), and 498.5. The Board has held that the duration of a revoked supplier's re-enrollment bar is not an appealable initial determination listed in 42 C.F.R. § 498.3(b), and thus, is not subject to ALJ review. *Vijendra Dave*, DAB No. 2672 at 11 (2016).

To the extent Petitioner's arguments may be construed as a request that I grant him equitable relief, I have no authority to do so. *US Ultrasound*, DAB No. 2302 at 8 (2010). I am required to follow the Act and regulations and have no authority to declare statutes or regulations invalid. *1866ICPayday.com, L.L.C.*, DAB No. 2289 at 14 (2009).

III. Conclusion

For the foregoing reasons, the Medicare enrollment and billing privileges of Petitioner are revoked pursuant to 42 C.F.R. § 424.535(a)(8)(i), effective December 15, 2016.

/s/
Keith W. Sickendick
Administrative Law Judge