Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Howard B. Reife, D.P.M.,
(NPI: 1801901343),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-36

Decision No. CR2728

Date: March 20, 2013

DECISION

Petitioner, Howard B. Riefe, D.P.M., appeals the reconsidered determination of Wisconsin Physician Services Insurance Corporation (WPS), a contractor for the Centers for Medicare & Medicaid Services (CMS), which revoked Petitioner's Medicare billing privileges. WPS revoked Petitioner's billing privileges pursuant to 42 C.F.R. § 424.535(a)(8) because it determined that Petitioner submitted Medicare claims for services that could not have been provided to specific individuals on the dates of service. Both parties now move for summary judgment. For the reasons set forth below, I deny the parties' motions for summary judgment and find that CMS was authorized to revoke Petitioner's Medicare billing privileges effective 30 days after the date of the revocation notice.

I. Case Background and Procedural History

Petitioner is a podiatrist currently licensed to practice in Kansas and Missouri. Petitioner participated in the Medicare program as a "supplier" of services.[1] While he participated

[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.

in Medicare, Petitioner acquired four Provider Transaction Access Numbers (PTANs) associated with his National Provider Identifier (NPI).[2] By four separate letters, each dated May 18, 2012, WPS notified Petitioner that it was revoking each of Petitioner's four PTANs and thus revoking his Medicare billing privileges. WPS stated that it had revoked Petitioner's billing privileges effective May 16, 2012. WPS did not identify specific facts upon which it relied to revoke Petitioner's billing privileges, but it recited the language of 42 C.F.R. § 424.535(a)(8) in each letter as its authority for the revocation. WPS imposed a two-year bar on Petitioner's reenrollment in the Medicare program.

Petitioner submitted a corrective action plan, which WPS rejected.[3] Petitioner also requested reconsideration of the initial determination to revoke his billing privileges. On August 27, 2012, WPS issued a reconsidered determination that upheld the revocation. The WPS hearing officer stated that Petitioner "billed WPS for services that were not furnished to the specific beneficiaries indicated on the claims and has not reported any billing errors or submitted any voluntary refunds for these services." P. Ex. 12.

By letter dated October 3, 2012, Petitioner requested a hearing before an administrative law judge (ALJ) to challenge the initial and reconsidered determinations.[4] This case was assigned to me for a hearing, if necessary, and decision. On October 22, 2012, I issued an Acknowledgment and Pre-Hearing Order (Pre-Hearing Order), which established general procedures for record development in this case. CMS filed a motion for summary judgment with a supporting brief (CMS Br.) along with three supporting exhibits (CMS Exs. 1-3). Petitioner opposed CMS's motion for summary judgment and also filed his own motion for summary judgment with supporting brief and 13 proposed exhibits (P. Exs. 1-13). Petitioner subsequently filed a motion to amend his supporting brief and one additional exhibit (P. Ex. 14). In the absence of objections from either party, I admit CMS Exs. 1-3, P. Exs. 1-14, and Petitioner's amended brief (P. Amend. Br.) into the record.

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[2] In 1988, the Inspector General for the Department of Health and Human Services excluded Petitioner from participating in all federal health care programs for five years based on his conviction for submitting false Medicare claims. That exclusion was upheld on an appeal to this forum. *Howard B. Reife, D.P.M.*, DAB CR25 (1989). Nothing in this decision is based on Petitioner's prior exclusion.

[3] I do not have authority to review the denial of a corrective action plan. 42 C.F.R. §§ 424.545(a), 498.3(b)(17); *DMS Imaging, Inc.*, DAB No. 2313, at 5-8 (2010).

[4] My review is limited to CMS's reconsidered determination. 42 C.F.R. § 498.5(l)(2).

II. Applicable Law

CMS, acting on behalf of the Secretary of Health and Human Services, may revoke an enrolled provider's or supplier's Medicare billing privileges if, among other things, 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." 42 C.F.R. § 424.535(a)(8). The regulation provides a non-exhaustive list of examples of services that could not have been furnished to a specific individual on the date of service: "situations where the beneficiary is deceased, the directing physician 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." *Id.*; *see also* 73 Fed. Reg. 36, 448 at 36,455 (June 27, 2008) ("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.").

The regulatory drafters explained in the preamble to section 424.535(a)(8):

> 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 . . . . Accordingly, [CMS] will not revoke billing privileges under [section] 424.535(a)(8) unless there are multiple instances, at least three, where abusive billing practices have taken place.

73 Fed. Reg. at 36,455.

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, unless certain exceptions apply. 42 C.F.R. § 424.535(g). The exceptions include instances where CMS has revoked a supplier's billing privileges based on an exclusion from Federal health care programs, felony conviction, license suspension or revocation, or CMS determines the supplier's practice location is not operational. *Id.* Under these exceptions, the revocation of billing privileges is effective retroactively to the date of the supplier's exclusion, conviction, license suspension or revocation, or the date CMS determines non-operational status began. *Id.*

A supplier whose billing privileges have been revoked is barred from reenrollment for a minimum of one year, though CMS may increase the reenrollment bar to a maximum of three years. 42 C.F.R. § 424.535(c). Once the reenrollment bar has expired, the supplier must submit a new enrollment application to reenroll in the Medicare program. *Id.* § 424.535(d).

III. Analysis

A. Issue

This case presents three issues:

1. whether either party is entitled to summary judgment;

2. whether CMS was authorized to revoke Petitioner's Medicare billing privileges pursuant to 42 C.F.R. § 424.535(a)(8); and

2. if CMS was authorized to revoke Petitioner's billing privileges, whether the effective date of the revocation, May 16, 2012, was appropriate.

B. Findings of Fact and Conclusions of Law

1. *Neither party is entitled to summary judgment.*

Summary judgment is appropriate if there is no genuine dispute as to any material fact, and the moving party is entitled to judgment as a matter of law. *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 3 (2010) (citations omitted). When evaluating the appropriateness of summary judgment, the adjudicator must "view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor." *Id.* For the purposes of motions for summary judgment, the ALJ should not assess credibility or evaluate the weight of conflicting evidence. *Holy Cross Vill. at Notre Dame, Inc.*, DAB No. 2291, at 5 (2009).

Here, there are material facts in dispute regarding whether Petitioner submitted claims that showed a "pattern of improper billing" that would result in revocation of his billing privileges. While Petitioner does not dispute the existence of improper claims, he argues that certain billing practices were "accidental." Therefore, summary judgment is not appropriate as there are questions of material fact that require a credibility determination.

I decide this case on the merits of the complete written record by fully evaluating the evidence and applying it to the applicable legal standards. An in-person hearing is not necessary considering neither party submitted direct written testimony that would require the opportunity for cross-examination. Pre-Hearing Order at 4-5, ¶¶ 8-11.

2. *Petitioner submitted a pattern of improper Medicare claims for services that could not have been furnished to specific individuals on the purported dates of services.*

CMS identified two types of improper billing from Petitioner: (a) claims where the named beneficiary had died before the date of service; and (b) claims for procedures performed on 6-10 toes where the named beneficiary had one leg amputated.

a. *Petitioner submitted claims for payment where the named beneficiaries predeceased the purported dates of service.*

CMS presented evidence showing that Petitioner, or Petitioner's agent for billing purposes, D.A.R.E. Foot Care, submitted claims for services that Petitioner could not have furnished to specific individuals on the purported dates of services because the beneficiaries named in the claims predeceased those dates of service. CMS Ex. 1, at 24. Petitioner does not dispute that D.A.R.E. Foot Care submitted 25 such claims on his behalf, but he argues that the beneficiaries named in the claims were the result of "accidental billing errors." P. Amend. Br. 10-11. Petitioner explains that 16 of the 25 improper claims were for services rendered to beneficiaries with the same or similar names to those of the deceased beneficiaries named. P. Amend. Br. 10-11; P Exs. 6-7.

However, for nine claims that D.A.R.E. Foot Care submitted on Petitioner's behalf, where the named beneficiary was deceased at the time of service, Petitioner simply asserts that these were "accidental" claims but offers nothing substantive to support that assertion. P. Amend. Br. 11-12; *see* CMS Ex. 1, at 24. Petitioner made seven of these nine undisputed claims within eight months of each other, between March 2008 and December 2008. The regulatory drafters explained that CMS "will not revoke billing privileges under [section] 424.535(a)(8) unless there are multiple instances, *at least three*, where abusive billing practices have taken place." 73 Fed. Reg. at 36,455 (emphasis added). Here, Petitioner's billing practices, which resulted in seven improper claims in eight months, demonstrate a pattern of improper billing under the standard announced in the preamble because there were more than three instances of improper claims in less than eight months.[5]

Moreover, Petitioner's argument that 16 claims naming beneficiaries who predeceased the date of service were "accidental" based on beneficiaries with similar names to other patients is not persuasive. Submitting 16 improper claims cannot be overlooked or mitigated as merely being "accidental" when done by the same entity (D.A.R.E. Foot

[5] This finding does not suggest that there is a defined timeframe within which three instances of improper billing practices must occur for a "pattern" to emerge. Neither the regulation nor the preamble suggests that there is such a timeframe. *See* 42 C.F.R. § 424.535(a)(8), 73 Fed. Reg. at 36,455.

Care), on behalf of the same supplier (Petitioner), making the same error (naming beneficiaries that predeceased the date of service). Repeatedly making those same errors reduces their credibility as "accidental" and establishes a pattern of improper billing that suggests a lack of attention to detail considering Petitioner could have differentiated the patients through their birthdates or Medicare numbers.

b. *Petitioner submitted Medicare reimbursement claims for procedures on beneficiaries involving 6-10 toes where the beneficiaries had one leg amputated.*

CMS identified 10 claims that Petitioner submitted for services performed on 6-10 toes of beneficiaries even though the named beneficiaries had one leg amputated. CMS Ex. 1, at 25. Petitioner does not dispute D.A.R.E. Foot Care improperly submitted these claims on his behalf, other than to assert that Petitioner documented the patients' statuses as amputees correctly on patient evaluation forms, but the "biller inadvertently submitted claims using the incorrect procedure code." P. Amend. Br. 7; P. Exs. 1-5, 7b, 14. As explained, for purposes of revocation under 42 C.F.R. § 424.535(a)(8), "accidental claims" may not be considered "accidental" in nature after a supplier submits three improper claims. *See* 73 Fed. Reg. at 36,455. Therefore, even if D.A.R.E. Foot Care submitted claims using the incorrect codes, it did so 10 times on Petitioner's behalf, which supports a pattern of improper claims.

Petitioner argues that he did "everything he could to ensure that the billing was done appropriately, *but unbeknownst to him*, D.A.R.E. Foot Care mistakenly billed Medicare for a Debridement of 6[-10] nails." P. Amend Br. 8-10 (emphasis added). However, Petitioner is ultimately responsible for claims submitted to Medicare on his behalf. Petitioner cannot shirk his responsibility through a faulty reliance on D.A.R.E.'s billing actions. *See* 73 Fed. Reg. at 36,455 ("In conclusion, we believe that providers and suppliers are responsible for the claims they submit or the claims submitted on their behalf.").

3. *CMS was authorized to revoke Petitioner's Medicare billing privileges pursuant to 42 C.F.R. § 424.535(a)(8).*

Once CMS establishes that Petitioner's billing practices constituted a pattern of claims for services that could not have been furnished to specific individuals on the dates of service, it is authorized to revoke Petitioner's Medicare billing privileges. 42 C.F.R. § 424.535(a)(8). Here, Petitioner provided statistical estimates of his Medicare claims for payment, arguing that the instances of billing issues leading to revocation were so minor that he was clearly not attempting to defraud Medicare or otherwise have some type of improper pecuniary gain. P. Amend. Br. at 6-7. Petitioner also claimed that all of the identified billing errors were "accidental," that CMS's position regarding Petitioner's claims as "abuse" was "flawed," and that the preamble does not support revocation for

"accidental" claims that are a result of human error. *See* P. Amend. Br. at 9-13 (citing 73 Fed. Reg. at 36,455).

The operative language of the revocation provision does not require that CMS demonstrate that Petitioner intended to defraud Medicare before it may revoke Petitioner's billing privileges. *See* 42 C.F.R. § 424.535(a)(8). In addition, the regulation does not suggest that a certain minimum percentage of total improper claims be tolerable. *Id.* CMS must demonstrate that Petitioner's billing practices showed a pattern of making claims that could not have been furnished to specific individuals on the dates of service. *Id.*; *see also* 73 Fed. Reg. at 36,455 ("[T]his basis for revocation is directed at providers and suppliers who are engaging in a pattern of improper billing."). As explained above, CMS demonstrated, in 35 instances, that Petitioner engaged in a "pattern of improper billing" for services that could not have been furnished to specific individuals on the dates of service. Therefore, CMS had a legitimate basis to revoke Petitioner's billing privileges.

4. *The proper effective date of revocation is June 17, 2012.*

The revocation of billing privileges is effective 30 days after CMS or its contractor issues the notice of revocation, unless certain exceptions apply. *See* 42 C.F.R. § 424.535(g). It is undisputed that none of the exceptions listed in section 424.535(g) apply to this case. CMS notified Petitioner by letter, dated May 18, 2012, that it was revoking Petitioner's billing privileges effective May 16, 2012. The date of Petitioner's revocation, therefore, should have been effective on June 17, 2012, which is 30 days after the date on the notice of revocation. 42 C.F.R. § 424.535(g). Accordingly, CMS must modify the effective date of revocation of Petitioner's billing privileges to June 17, 2012.

Petitioner argues that the revocation must be reversed because "CMS did not follow its own rules and did not properly exercise its authority to revoke [Petitioner's] Medicare billing privileges, and thus such revocation is invalid." P. Amend. Br. 4. For support, Petitioner cites *Fort Steward Schools v. Federal Labor Relations Authority*, 495 U.S. 641, 654 (1990), for the general proposition that it is a "familiar rule of administrative law that an agency must abide by its own regulations." P. Amend. Br. 4. While I agree that an agency must abide by its own regulations, that proposition does not support the relief that Petitioner seeks -- reversal of an otherwise duly authorized act. Petitioner cites no authority that requires reversal of an entire administrative action when it may be modified or reversed in part. Here, modifying the effective date of revocation to June 17, 2012 is enough to ensure that CMS has complied fully with applicable regulations in revoking Petitioner's billing privileges.

IV. Conclusion

For the foregoing reasons, I find CMS was authorized to revoke Petitioner's Medicare billing privileges under 42 C.F.R. § 424.535(a)(8) because he submitted 35 claims for services that were not furnished to those individuals. CMS must modify the effective date of Petitioner's revocation to June 17, 2012, in accordance with 42 C.F.R. § 424.535(g).

/s/
Joseph Grow
Administrative Law Judge