Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Medical and Foot Care Group, S.C.,[1]

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-2797

Decision No. CR4665

Date: July 28, 2016

DECISION

The Centers for Medicare & Medicaid Services (CMS), through its administrative contractor, National Government Services (NGS), revoked the Medicare enrollment and billing privileges of Medical and Foot Care Group, S.C. (Petitioner) because Petitioner filed multiple Medicare claims for services allegedly provided to deceased beneficiaries. Petitioner requested a hearing to dispute the revocation, arguing that Petitioner provided services to living beneficiaries each time it filed claims with Medicare; however, Petitioner admits that it unintentionally and erroneously filed a number of claims using Medicare numbers for deceased individuals. Because there is no dispute that Petitioner filed 17 claims related to 16 beneficiaries who were deceased on the date that Petitioner purportedly provided services to them, I grant CMS's motion for summary judgment and affirm CMS's revocation of Petitioner's Medicare billing privileges.

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[1] The Civil Remedies Division docketed this case with Petitioner's name as Medical and Foot Care Group, Inc. based on the reconsidered determination identifying Petitioner as such. Centers for Medicare & Medicare Services (CMS) Exhibit (Ex.) 10. However, the initial determination, and Petitioner's reconsideration and hearing requests indicate that Petitioner is a professional service corporation (i.e., an "S.C."). CMS Exs. 2, 14; Hearing Request at 1. Therefore, I modify the case caption to reflect that Petitioner is an "S.C."

I. Case Background and Procedural History

Petitioner was enrolled in the Medicare program as a Medicare Part B Group Practice. CMS Exhibit (Ex.) 3 at 1; CMS Ex. 7 at 2. In a December 10, 2014 initial determination, NGS revoked Petitioner's Medicare enrollment and billing privileges effective January 8, 2015, for the following reasons:

> **42 CFR § 424.535(a)(1) – Noncompliance**
>
> Medical and Foot Care Group's enrollment reflects Marwa Sayed as a 5% or more owner. Based on a notarized statement by Marwa Sayed, since 2013 she has had no affiliation with Medical and Foot Care Group. As of December 5, 2014, Medical and Foot Care Group has not reported any changes in ownership. Medical and Foot Care Group failed to report a change in ownership within 30 days as required by 42 CFR § 424.516(d) and is in noncompliance with Medicare enrollment requirements.
>
> **42 CFR §424.535(a)(8) – Abuse of Billing Privileges**
>
> Data analysis revealed that Medical and Foot Care Group SC submitted claims for services rendered to beneficiaries who were deceased on the purported date of service.

CMS Ex. 2 at 1 (emphasis in original). NGS attached a list of 34 claims filed between 2010 and 2014 involving 30 deceased beneficiaries. CMS Ex. 2 at 3. NGS also imposed a three-year re-enrollment bar in the Medicare program. CMS Ex. 2 at 2. NGS informed Petitioner that it could request reconsideration of the revocation. CMS Ex. 2 at 1.

Petitioner timely submitted two reconsideration requests. One request disputed that Petitioner violated 42 C.F.R. § 424.535(a)(1). In that request, Petitioner provided a detailed account of its dealings with Marwa Sayed, DPM, and its efforts to ensure that Dr. Sayed reported her divestiture of an ownership interest in Petitioner. CMS Ex. 12. The second reconsideration request disputed that Petitioner violated 42 C.F.R. § 424.535(a)(8). In that request, Petitioner provided extensive information about the claims referenced in the initial determination. Specifically, Petitioner indicated that it had provided services to living beneficiaries for all claims that it filed; however, Petitioner had mistakenly sought reimbursement from CMS using the names and Medicare numbers for deceased beneficiaries. CMS Exs. 14, 15.

On April 8, 2015, NGS issued a reconsidered determination upholding the initial determination to revoke Petitioner. CMS Ex. 10. Petitioner timely requested a hearing to dispute the revocation.

The case was originally assigned to Administrative Law Judge Joseph Grow. Judge Grow issued an Acknowledgment and Pre-hearing Order (Order) on June 15, 2015. In response to the Order, CMS filed a motion for summary judgment and prehearing brief (CMS Br.), and seventeen proposed exhibits (CMS Exs. 1-17), one of which was a notarized statement from Dr. Sayed (CMS Ex. 5). Petitioner filed a prehearing brief opposing summary judgment (P. Br.) and 24 proposed exhibits (P. Exs. 1-24).[2] On March 31, 2016, the parties were notified that Judge Grow transferred to another component in the Department of Health and Human Services and that this case was transferred to me.

II. Issues

1. Whether CMS is entitled to summary judgment; and

2. Whether CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges under 42 C.F.R. § 424.535(a)(8).[3]

III. Jurisdiction

I have jurisdiction to hear and decide this case. 42 C.F.R. §§ 498.3(b)(17), 498.5(*l*)(2); *see also* 42 U.S.C. § 1395cc(j)(8).

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

The Social Security Act (Act) authorizes the Secretary of Health and Human Services (Secretary) to issue regulations concerning the enrollment of providers and suppliers in the Medicare program. 42 U.S.C. § 1395cc(j)(1)(A). The Secretary has promulgated

[2] In its prehearing exchange, Petitioner objected to page 3 of CMS Ex. 2, and requested to cross-examine Dr. Sayed. P. Br. at 3, 23. I overrule this objection because CMS Ex. 2 is CMS's initial determination in this case and not a substantive exhibit. Exclusion of one page of the initial determination would make CMS Ex. 2 incomplete.

[3] As explained below, I grant summary judgment for CMS and affirm CMS's revocation of Petitioner's Medicare enrollment and billing privileges under 42 C.F.R. § 424.535(a)(8). Therefore, it is unnecessary for me to determine whether Petitioner violated 42 C.F.R. § 424.535(a)(9).

enrollment regulations in 42 C.F.R. part 424, subpart P. *See* 42 C.F.R. §§ 424.500 - 424.570. The regulations provide CMS with the authority to revoke the billing privileges of an enrolled provider or supplier if CMS determines that certain circumstances exist. *Id.* § 424.535(a). Relevant to this case, CMS may revoke a provider's or supplier's billing privileges if:

> 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.

Id. § 424.535(a)(8) (2014).[4] When CMS revokes a provider's or supplier's billing privileges, any provider agreement in effect at the time of revocation is terminated. *Id.* § 424.535(b). In addition, after revocation, CMS must impose a bar on re-enrollment for a minimum of one year, but no more than three years. *Id.* § 424.535(c).

A provider or supplier may request reconsideration of the initial determination to revoke his or her billing privileges. 42 C.F.R. §§ 498.5(*l*)(1), 498.22(a). If dissatisfied with the reconsidered determination, the supplier may request a hearing before an Administrative Law Judge (ALJ). *Id.* § 498.5(*l*)(2).

A. Summary judgment is appropriate in this case.

An ALJ may decide a case arising under 42 C.F.R. part 498 by summary judgment. *Livingston Care Ctr. v. U.S. Dep't of Health & Human Servs.*, 388 F.3d 168, 172 (6th Cir. 2004) (citing *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743 (6th Cir. 2004)). "Matters presented to the ALJ for summary judgment will follow Rule 56 of the Federal Rules of Civil Procedure and federal case law . . . ." Civil Remedies Division Procedures § 19(a)(iii).

As stated by the United States Supreme Court:

> Rule 56(c) of the Federal Rules of Civil Procedure provides that summary judgment 'shall be rendered forthwith if the

[4] CMS amended 42 C.F.R. § 424.535(a)(8) effective February 3, 2015. *See* 79 Fed. Reg. 72,500 (Dec. 5, 2014). However, in this case I will apply 42 C.F.R. § 424.535(a)(8) (2014) because the text reflected in that regulation was in effect on all the dates relevant to this case.

> pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.' By its very terms, this standard provides that the mere existence of *some* alleged factual dispute between the parties will not defeat an otherwise properly supported motion for summary judgment; the requirement is that there be no *genuine* issue of *material* fact.

Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 247-48 (1986) (emphasis in original). To determine whether there are genuine issues of material fact for an in-person hearing, 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. *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 at 3 (2010) (citations omitted). However, in order to defeat a well-pleaded motion for summary judgment, the non-moving party must come forward with some evidence of a dispute concerning a material fact; mere denials in its pleadings are not sufficient. *Id.*

In the present case, there are no material facts in dispute. Petitioner does not dispute that it filed 17 claims for services rendered to 16 of the beneficiaries identified in the list attached to the initial determination. Petitioner also does not dispute that the list attached to the initial determination provides accurate dates on which Petitioner claimed it provided services for the 16 named beneficiaries. Rather, Petitioner asserts that it provided services on the dates identified, except that Petitioner had sought Medicare reimbursement for services provided to beneficiaries who have similar names or Medicare numbers as the incorrectly identified beneficiaries (i.e., Petitioner mistakenly billed Medicare for services provided to beneficiaries other than the ones that Petitioner identified in the claims it filed).[5] CMS Exs. 14, 15. Although Petitioner "denies the Social Security death index" documentation CMS submitted in this case regarding the 16 beneficiaries at issue (P. Br. at 21), Petitioner only made this blanket denial and did not come forward with evidence to dispute the Social Security Administration's death records. Further, while Petitioner argues that "[a]ll of the practitioners including [Petitioner] had been told by Medicare to verify the coverage [of beneficiaries] by using C-Snap and not the Social Security death index" (P. Br. at 9), such an argument does not

[5] Of the 17 claims discussed below in this decision, two diverge from the general description just provided. In both of those claims, Petitioner provided a date of service that was after the beneficiaries died. Petitioner asserts that it actually provided the services to the beneficiaries named in those claims on different dates, which were both before the beneficiaries died, but that Petitioner had erroneously entered incorrect dates on the claims. For purposes of summary judgment, I accept these assertions as true.

dispute the fact that the 16 beneficiaries in question in this case were deceased on the dates Petitioner claimed it had provided services to them. Therefore, I do not consider Petitioner to have successfully disputed the dates of death for those beneficiaries.[6]

For purposes of summary judgment, I draw all inferences in favor of Petitioner. I accept as true that each instance where Petitioner billed for services purportedly provided to one of the 16 deceased beneficiaries, Petitioner had rendered those services to a different, living beneficiary and that Petitioner's staff had merely misidentified the deceased beneficiary on the Medicare claims it submitted to CMS. However, even accepting Petitioner's position as true, Petitioner has conceded that it claimed reimbursement for services that could not have been rendered to the beneficiaries it identified in the claims it submitted because the beneficiaries identified on the claims were deceased at the time Petitioner rendered the claimed services. These claims may form the basis for summary judgment.

B. Petitioner does not dispute that it filed 17 claims, related to 16 beneficiaries, for Medicare reimbursement for services purportedly provided on dates when the 16 beneficiaries were deceased.

As indicated above, for purposes of summary judgment, I accept as true Petitioner's position that it filed claims for reimbursement with the Medicare program for services that it provided to beneficiaries; however, Petitioner's staff erroneously identified the beneficiaries in question as ones who were deceased at the time that the services were rendered, or in two instances, incorrectly identified the dates of services for properly identified beneficiaries. Below are the specific factual positions that Petitioner takes with regard to each claim/beneficiary.

1) Brown

CMS asserted that Petitioner filed a claim for Medicare reimbursement for services provided on December 17, 2012, to a beneficiary with the surname of Brown and a Medicare number ending in 1423D, who had died on July 11, 2012. CMS Ex. 2 at 3; CMS Ex. 17 at 64. Petitioner responded that it had not provided the services to Brown, who Petitioner identified as Rose Brown, but to a living beneficiary with the similar name of Rosie Brown-Parker. CMS Ex. 14 at 10. Petitioner stated that the "incorrect patient . . . was unintentionally selected" for billing and that "[t]here was an unintentional human error from the billing clerk to select a similar but incorrect patient name."

[6] In light of Petitioner's concern about the dates of death for the beneficiaries identified in the attachment to the initial determination, for purposes of summary judgment, I limit my conclusions related to Petitioner's violation of 42 C.F.R. § 424.535(a)(8) to the 16 beneficiaries for whom CMS provided Social Security Administration death record documentation. *See* CMS Ex. 17.

CMS Ex. 14 at 10; *see also* P. Ex. 6 at 1; P. Ex. 9 at 3-4. Petitioner provided statements from Robyn Jackson, M.D., and Ms. Brown-Parker in which both individuals confirm that Dr. Jackson provided treatment to Ms. Brown-Parker on December 17, 2012. P. Ex. 7 at 11; P. Ex. 8 at 4. Petitioner also provided documentation from Ms. Brown-Parker's visit with Dr. Jackson. CMS Ex. 15 at 3, 6-10; P. Ex. 5 at 2; P. Ex. 7 at 13-16. Further, Petitioner submitted a document showing that Ms. Brown-Parker is a Medicare beneficiary (CMS Ex. 15 at 4-5; P. Ex. 7 at 12), and that Petitioner had claimed reimbursement for services provided to this beneficiary on multiple occasions from 2010 through 2014. P. Ex. 3 at 1-2; *see also* CMS Ex. 15 at 11-15. Petitioner provided documents to show that Rose Brown had previously been Petitioner's patient. CMS Ex. 15 at 16-21.

2) Ortega

CMS asserted that Petitioner filed a claim for Medicare reimbursement for services provided on March 27, 2014, to a beneficiary with the surname of Ortega and a Medicare number ending in 2125A, who had died on October 29, 2012. CMS Ex. 2 at 3; CMS Ex. 17 at 54. Petitioner responded that it had incorrectly billed for services provided to Ortega, who Petitioner identified as Maria Ortega, but actually provided those services to a living beneficiary with the similar name in its records of Maria Ortaga. CMS Ex. 14 at 12. Petitioner learned during its investigation of this matter that the beneficiary was incorrectly entered in its records as Maria Ortaga and that the beneficiary's real name is Maria Elena Uraga Olmedo, and it is for this beneficiary that Petitioner ought to have filed a claim related to services provided to her on March 27, 2014. CMS Ex. 14 at 12; *see also* P. Ex. 6 at 3-4; P. Ex. 9 at 3; P. Ex. 2 at 4. In its reconsideration request, Petitioner: asserted that both Maria Ortega and Maria Elena Uraga Olmedo were Petitioner's patients; confirmed that Maria Ortega died on October 29, 2012; and denied any accusation that Petitioner intentionally billed for a deceased patient. CMS Ex. 14 at 12-13. Petitioner provided statements from Neil Fried, DPM, and Ms. Uraga Olmedo in which both individuals confirm that Dr. Fried provided treatment to Ms. Uraga Olmedo on March 27, 2014. P. Ex. 7 at 57; P. Ex. 8 at 5. Petitioner also provided documentation from Ms. Uraga Olmedo's visit with Dr. Fried. CMS Ex. 15 at 40, 42-45; P. Ex. 5 at 4; P. Ex. 7 at 58-61. Further, Petitioner submitted a document showing that Ms. Uraga Olmedo is a Medicare beneficiary. CMS Ex. 15 at 46; P. Ex. 7 at 62. Petitioner also submitted documents showing that Maria Ortega had been Petitioner's patient. CMS Ex. 15 at 59-68.

3) Senda

CMS asserted that Petitioner filed a claim for Medicare reimbursement for services provided on February 4, 2013, to a beneficiary with the surname of Senda and a Medicare number ending in 2515A, who had died on January 10, 2013. CMS Ex. 2 at 3; CMS Ex. 17 at 29. Petitioner responded that it had provided services to Senda, who Petitioner

identified as Roberto Senda, but that the services had been provided on January 4, 2013, six days before Mr. Senda died. CMS Ex. 14 at 15. Petitioner asserts that a billing error resulted in the Medicare claim incorrectly identifying the date of services as February 4, 2013, rather than January 4, 2013. CMS Ex. 14 at 15; P. Ex. 6 at 6. Petitioner provided a statement from Mr. Senda's son and caregiver in which he confirmed that Dr. Robyn Jackson provided treatment to Mr. Senda on January 4, 2013. CMS Ex. 15 at 90; P. Ex. 8 at 6. Petitioner also provided documentation from Mr. Senda's January 4, 2013 visit. CMS Ex. 15 at 73, 77-79; P. Ex. 5 at 7. Petitioner further submitted documentation showing that Mr. Senda was a Medicare beneficiary. CMS Ex. 15 at 74-75, 81-83.

4) Williams

CMS asserted that Petitioner filed a claim for Medicare reimbursement for services provided on April 17, 2014, to a beneficiary with the surname of Williams and a Medicare number ending in 2994D, who had died on January 16, 2013. CMS Ex. 2 at 3; CMS Ex. 17 at 78. Petitioner responded that it had not provided the services to Williams, who Petitioner identified as Dorothy Williams, on April 17, 2014, but had provided services to a different Dorothy Williams (Medicare number ending in 3611D) on that date. CMS Ex. 14 at 20. Petitioner indicated that the deceased Dorothy Williams had been Petitioner's patient from 2009 to 2010, and that "unintentional human error at the time of billing" resulted in billing for the deceased Dorothy Williams rather than the living Dorothy Williams. CMS Ex. 14 at 20; *see also* P. Ex. 6 at 11; P. Ex. 9 at 4-5. Petitioner provided a statement from Dorothy Williams (Medicare number ending in 3611D) that Neil Fried, DPM, treated her on April 17, 2014. P. Ex. 8 at 1. Petitioner also submitted a statement from Dr. Fried indicating that he treated Dorothy Williams (Medicare number ending in 3611D) on April 27, 2014; however, Petitioner submitted treatment records from the April 17, 2017 visit with Dr. Fried. CMS Ex. 15 at 201-209. P. Ex. 7 at 75-78. Petitioner also submitted a document showing that Dorothy Williams (Medicare number ending in 3611D) is a Medicare beneficiary. CMS Ex. 15 at 214.

5) Hirsch

CMS asserted that Petitioner filed a claim for Medicare reimbursement for services provided on September 22, 2010, to a beneficiary with the surname of Hirsch and a Medicare number ending in 3635A, who had died on April 8, 2009. CMS Ex. 2 at 3; CMS Ex. 17 at 26. Petitioner responded that it had not provided the services to Harry Hirsch (Medicare number ending in 3635A), but rather provided them to his wife, Renee Hirsch (Medicare number ending in 6488A). CMS Ex. 14 at 21. Petitioner stated that both Harry Hirsch and Renee Hirsch had been Petitioner's patients and "[t]here was an unintentional human error on this date of service and her husband, Harry Hirsch, was incorrectly selected at the time of billing instead of Renee Hirsch, who is the actual patient who was seen on 9/22/2010." CMS Ex. 14 at 21; *see also* P. Ex. 6 at 12; P. Ex. 9 at 3. Petitioner provided documentation from the September 22, 2010 visit with Richard Committo, DPM. CMS Ex. 15 at 233-238; P. Ex. 5 at 18; P. Ex. 7 at 86-88.

Petitioner also submitted documents showing that Renee Hirsch was a Medicare beneficiary. CMS Ex. 15 at 227, 229-31; P. Ex. 7 at 84.

6) Smith

CMS asserted that Petitioner filed a claim for Medicare reimbursement for services provided on June 23, 2012, to a beneficiary with the surname of Smith and a Medicare number ending in 3635A, who had died on April 6, 2012. CMS Ex. 2 at 3; CMS Ex. 17 at 20. Petitioner responded that it had not provided the services to Smith, who Petitioner identified as Mary Smith, but to a living beneficiary with the similar name of Marie Smith. CMS Ex. 14 at 22. Petitioner stated that "[t]here was an unintentional human error of selecting the wrong patient name due to the similarity of the first name and the exact last name. CMS Ex. 14 at 22; *see also* P. Ex. 6 at 13; P. Ex. 9 at 5. Petitioner provided a statement from Keith Hopkins, M.D. confirming that Dr. Hopkins provided treatment to Marie Smith on June 23, 2012. P. Ex. 7 at 97. Petitioner also provided documentation from Marie Smith's visit with Dr. Hopkins. CMS Ex. 15 at 247, 251-55; P. Ex. 5 at 19; P. Ex. 7 at 99-103. Further, Petitioner submitted documents showing that Marie Smith is a Medicare beneficiary. CMS Ex. 15 at 249-250; P. Ex. 7 at 104.

7) Williams

CMS asserted that Petitioner filed a claim for Medicare reimbursement for services provided on July 24, 2013, to a beneficiary with the surname of Williams and a Medicare number ending in 3992A, who had died on July 23, 2013. CMS Ex. 2 at 3; CMS Ex. 17 at 44. Petitioner responded that it had not provided the services to Williams, who Petitioner identified as Frank Williams, but to a living beneficiary with the similar name of Frederick Williams. CMS Ex. 14 at 23. Petitioner stated that "the patient that was unintentionally billed had the same last name, Williams, with the first name 'Frank'. At the time of billing, Frank Williams was chosen instead of Frederick Williams due to the close similarity in names." CMS Ex. 14 at 23; *see also* P. Ex. 6 at 14; P. Ex. 9 at 5. Petitioner provided documentation from Frederick Williams' visit with Dr. Robert Bester. CMS Ex. 15 at 262, 266-69; P. Ex. 5 at 20. Petitioner also submitted a document showing that Frederick Williams is a Medicare beneficiary. CMS Ex. 15 at 264-65. Further, Petitioner submitted documents to show that Frank Williams had been Petitioner's patient. CMS Ex. 15 at 273-79

8) Hilliard

CMS asserted that Petitioner filed a claim for Medicare reimbursement for services provided on August 14, 2010, to a beneficiary with the surname of Hilliard and a Medicare number ending in 4326C, who had died on May 24, 2010. CMS Ex. 2 at 3; CMS Ex. 17 at 77. Petitioner responded that it had not provided the services to Hilliard, who Petitioner identified as Henrietta Hilliard, but to a living beneficiary with the same first name, Henrietta Patterson. CMS Ex. 14 at 24. Petitioner stated that "[t]here was

unintentional human error at the time of entering patients, when the name 'Henrietta' was entered as the last name for both patients." CMS Ex. 14 at 24; *see also* P. Ex. 6 at 15; P. Ex. 9 at 5. Petitioner provided documentation from Ms. Patterson's visit with Marwa Sayed, DPM. CMS Ex. 15 at 282, 288-92; P. Ex. 5 at 6. Petitioner also submitted a document showing that Ms. Patterson is eligible for Medicare. CMS Ex. 15 at 286. Finally, Petitioner provided documents showing that Henrietta Hilliard had been Petitioner's patient. CMS Ex. 15 at 293-300.

9) Moreno

CMS asserted that Petitioner filed a claim for Medicare reimbursement for services provided on April 24, 2014, to a beneficiary with the surname of Moreno and a Medicare number ending in 4538D, who had died on December 19, 2010. CMS Ex. 2 at 3; CMS Ex. 17 at 107. Petitioner responded that it had not provided the services to Moreno, who Petitioner identified as Guadalupe Moreno, but to a living beneficiary with the similar name of Ignacio Moreno. CMS Ex. 14 at 26. Petitioner stated that: "At the time of billing, Guadalupe Moreno . . . was incorrectly chosen due to the same last name as Ignacio Moreno." CMS Ex. 14 at 26; *see also* P. Ex. 6 at 17; P. Ex. 9 at 6. Petitioner provided a statement from Annell Tucker, DPM, confirming that Dr. Tucker provided treatment to Ignacio Moreno on April 24, 2014. P. Ex. 7 at 46. Petitioner also provided documents from Ignacio Moreno's visit with Dr. Tucker. CMS Ex. 15 at 320-23; P. Ex. 5 at 22; P. Ex. 7 at 47-49. Petitioner also submitted a document showing that Ignacio Moreno is a Medicare beneficiary. CMS Ex. 15 at 324. Further, Petitioner submitted documents showing Guadalupe Moreno was Petitioner's patient. CMS Ex. 15 at 331-35.

10) Charleston

CMS asserted that Petitioner filed a claim for Medicare reimbursement for services provided on January 26, 2013, to a beneficiary with the surname of Charleston and a Medicare number ending in 4928A, who had died on January 12, 2011. CMS Ex. 2 at 3; CMS Ex. 17 at 17. Petitioner responded that it had not provided the services to Charleston, who Petitioner identified as Charleston Levater,[7] but to a living beneficiary with the name of T. Charles Livingston. CMS Ex. 14 at 28. Petitioner stated that "due to an unintentional human error by the biller, the patient Charleston Levater . . . was selected at the time of billing, which is exactly listed in our computer database next to the

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[7] Though Petitioner identifies the deceased patient as Charleston Levater, both the Social Security Death Index (CMS Ex. 17 at 17) and Petitioner's own records, including the patient's signature (*e.g.*, CMS Ex. 15 at 367-69), identify the individual as Levater Charleston. Petitioner's explanation – that both patients were listed next to one another in its database – strains credulity, though for purposes of summary judgment I accept it as true, even if irrelevant. Petitioner subsequently correctly identified Ms. Charleston, but nevertheless offered the same explanation. P. Ex. 9 at 6.

intended patient who was seen and treated, T. Charles Livingston." CMS Ex. 14 at 28; *see also* P. Ex. 6 at 19; P. Ex. 9 at 6. Petitioner provided documentation from Ms. Livingston's visit with Marwa Sayed, DPM. CMS Ex. 15 at 349, 354-57; P. Ex. 5 at 24. Petitioner also submitted documents showing that Ms. Livingston is a Medicare beneficiary. CMS Ex. 15 at 350, 360. Further, Petitioner submitted documents showing that Levater Charleston was Petitioner's patient. CMS Ex. 15 at 367-69.

11) Emanuel

CMS asserted that Petitioner filed a claim for Medicare reimbursement for services provided on July 18, 2014, to a beneficiary with the surname of Emanuel and a Medicare number ending in 5690A, who had died on October 29, 2011. CMS Ex. 2 at 3; CMS Ex. 17 at 1. Petitioner responded that it had not provided the services to Emanuel, who Petitioner identified as Helen Emanuel, but to a living beneficiary with the name of Emanuel Klawir. CMS Ex. 14 at 29. Petitioner stated that "[a]t one point in time, we did have both patients in our database, Helen Emanuel and Emanuel Klawir, and apparently due to unintentional human error in entering patient name, the first and last name were inputted incorrectly and the first name was mismatched and switched with the last name. At the time of billing for the service date of 7/18/2014, the intended name was for Emanuel Klawir . . . but instead, due to this unintentional mistake, they clicked on the last name Emanuel with the different first name Helen." CMS Ex. 14 at 29; *see also* P. Ex. 6 at 20; P. Ex. 9 at 6. Petitioner provided statements from Annell Tucker, DPM, and Emanuel Klawir's daughter, Dolores Khuld (*see* CMS Ex. 15 at 379), in which both individuals confirm that Dr. Tucker provided treatment to Mr. Klawir on July 18, 2014. P. Ex. 7 at 51; P. Ex. 8 at 3. Petitioner also provided documentation regarding Mr. Klawir's visit with Dr. Tucker. CMS Ex. 15 at 372-78; P. Ex. 5 at 25; P. Ex. 7 at 52-55. Further, Petitioner provided documents showing that Helen Emanuel had been Petitioner's patient. CMS Ex. 15 at 382-85.

12) Williams

CMS asserted that Petitioner filed a claim for Medicare reimbursement for services provided on January 21, 2014, to a beneficiary with the surname of Williams and a Medicare number ending in 5866A, who had died on August 8, 2012. CMS Ex. 2 at 3; CMS Ex. 17 at 10. Petitioner responded that it had not provided the services to Williams, who Petitioner identified as Lionel Williams, but to a living beneficiary with the similar name of Lionel Wilson. CMS Ex. 14 at 30. Petitioner stated that "Lionel Wilson . . . was the intended patient and there was unintentional human error at the time of billing choosing a patient with the same first name and similar first letter of the last name. Both names are listed next to each other, therefore it was unintentional error to select Lionel Williams." CMS Ex. 14 at 30; *see also* P. Ex. 6 at 21; P. Ex. 9 at 6. Petitioner provided documentation related to Mr. Wilson's visit with Dr. Gatlin. CMS Ex. 15 at 388, 392-95; P. Ex. 5 at 26. Petitioner also submitted documentation showing that Mr. Wilson is a Medicare beneficiary. CMS Ex. 15 at 390-91. Further, Petitioner submitted

documentation showing that Mr. Williams was also Petitioner's patient. CMS Ex. 15 at 401-02.

13) Schramm

CMS asserted that Petitioner filed a claim for Medicare reimbursement for services provided on August 15, 2013, to a beneficiary with the surname of Schramm and a Medicare number ending in 7592C, who had died on March 28, 2013. CMS Ex. 2 at 3; CMS Ex. 17 at 23. Petitioner responded that it had not provided the services to Schramm, who Petitioner identified as Mary Schramm, but to a living beneficiary with the name of Mary Hilbert. CMS Ex. 14 at 34. Petitioner stated that:

> Both patients, Mary Schramm and Mary Hilbert, used to live in the same house, and when Mary Schramm died on 3/28/2013, Mary Hilbert was still living in the same house and same address.
>
> . . . .
>
> At the time of billing for this date of service, an unintentional human error was made. When the billing information was entered, the biller thought that because of the first name and the same address, patient Mary Schramm was selected and billed. Apparently the wrong patient name was selected instead of the intended and correct name Mary Hilbert . . . .

CMS Ex. 14 at 34; *see also* P. Ex. 6 at 25.

Petitioner provided documentation related to Ms. Hilbert's August 15, 2013 visit with Dr. Robert Bester, including a statement signed by Mary Hilbert that Dr. Bester treated her on August 15, 2013. CMS Ex. 15 at 455, 457-60, 463; P. Ex. 5 at 30. Petitioner also submitted documentation showing that Ms. Hilbert was a Medicare beneficiary. CMS Ex. 15 at 456. Further, Petitioner submitted documents showing that Mary Schramm had been Petitioner's patient. CMS Ex. 15 at 467-70.

14) Williams

CMS asserted that Petitioner filed a claim for Medicare reimbursement for services provided on May 1, 2013, to a beneficiary with the surname of Williams and a Medicare number ending in 8427M, who had died on March 11, 2011. CMS Ex. 2 at 3; CMS Ex. 17 at 96. Petitioner responded that it had not provided the services to Williams, who Petitioner identified as Clarice Williams, but to a living beneficiary with the similar name of Clarice Wells. CMS Ex. 14 at 36. Petitioner stated that it:

> intended to bill Clarice Wells . . . who was on schedule 5/1/2013 for Dr. Robyn Jackson and was seen and treated. The biller unintentionally made a human error in selecting the patient due to an exact first name and last names that begin with the letter "W" at the time of billing, which linked the wrong patient to the date of service.

CMS Ex. 14 at 36; *see also* P. Ex. 6 at 27; P. Ex. 9 at 7. Petitioner provided a statement from Robyn Jackson, M.D. confirming that Dr. Jackson provided treatment to Ms. Wells on May 1, 2013. P. Ex. 7 at 1. Petitioner also provided documentation from Ms. Wells' visit with Dr. Jackson. CMS Ex. 15 at 484, 486-90; P. Ex. 5 at 32; P. Ex. 7 at 2-5. Petitioner also submitted documentation showing that Ms. Wells was a Medicare beneficiary. CMS Ex. 15 at 485. Further, Petitioner provided documents showing that Ms. Williams was also one of Petitioner's patients. CMS Ex. 15 at 491-97.

15) Patel

CMS asserted that Petitioner filed claims for Medicare reimbursement for services provided on July 19, 2013, and January 4, 2014, to a beneficiary with the surname of Patel and a Medicare number ending in 8702M, who had died on October 20, 2012. CMS Ex. 2 at 3; CMS Ex. 17 at 6. Petitioner responded that it had not provided the services to the Laxmiben Patel with a Medicare number ending in 8702M, but had provided services to a Laxmiben Patel with a Medicare number ending in 3690M. CMS Ex. 14 at 38. Petitioner stated that "[a]pparently since there were exactly two similar patients with same first name and last name with an exact spelling, there was an unintentional human error in selecting the deceased patient as the patient who was seen." CMS Ex. 14 at 38. Petitioner provided documents to show that Laxmiben Patel (with the Medicare number ending in 3690M) was treated on both July 19, 2013, and January 4, 2014. CMS Ex. 15 at 526-29, 532; P. Ex. 7 at 30-31, 33-38. Petitioner provided statements from James Miller III, M.D. and Laxmiben Patel (with the Medicare number ending in 3690M) in which both individuals confirm that Dr. Miller provided treatment to Laxmiben Patel on January 4, 2014. P. Ex. 7 at 29; P. Ex. 8 at 2. Petitioner also submitted documentation that Laxmiben Patel (with the Medicare number ending in 3690M) was a Medicare beneficiary. CMS Ex. 15 at 524; P. Ex. 7 at 32.

16) Schuler

CMS asserted that Petitioner filed a claim for Medicare reimbursement for services provided on April 26, 2013, to a beneficiary with the surname of Schuler and a Medicare number ending in 9957D, who had died on June 15, 2011. CMS Ex. 2 at 3; CMS Ex. 17 at 32. Petitioner responded that it had not provided the services to Schuler, who Petitioner identified as Berdina Schuler, on April 26, 2013, but had provided the services to Ms. Schuler on April 26, 2011. CMS Ex. 14 at 42. Petitioner explained:

> Medicare rejected the claim for the date of service of 4/26/2011 . . . . Apparently, when reviewing the Medicare rejection folder, there was an unintentional human error where the rejected claim for 4/26/2011 was rebilled in the year 2013 with an incorrect year of service. This date of service of 4/26/2011 was for the exact procedures that were billed by mistake in the year 2013.

CMS Ex. 14 at 42. Petitioner provided a statement from Richard Committo, DPM, that confirms that Dr. Committo treated Ms. Schuler on April 26, 2011. P. Ex. 7 at 90. Petitioner also provided documentation from Ms. Schuler's visit with Dr. Committo. CMS Ex. 15 at 571-75; P. Ex. 5 at 37; P. Ex. 7 at 92-95. Petitioner also submitted a document showing that Ms. Schuler is a Medicare beneficiary. CMS Ex. 15 at 570.

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

Once CMS determined that Petitioner submitted a claim or claims that could not have been furnished to a specific individual on the dates of service, it was then authorized to revoke Petitioner's Medicare enrollment and billing privileges. 42 C.F.R. § 424.535(a)(8). Here, there are 17 undisputed instances where Petitioner submitted claims for services that could not have been and, in fact, were not furnished to specific individuals on the claimed dates of service.

Petitioner's argument in this case is that it unintentionally filed claims with incorrect information and had, in fact, provided the services claimed to Medicare beneficiaries, just that those services were provided to different beneficiaries than those listed in the claims or, in two instances, on dates that are different than those listed on the claims. Petitioner asserts that it has provided significant documentation to prove that services were provided to living beneficiaries. Petitioner concludes from this that its actions were not abusive under 42 C.F.R. § 424.535(a)(8), but simple errors in the claims it filed. Petitioner points out that it has merely had errors involving 16 beneficiaries among the 7,500 patients that Petitioner has served. Petitioner also avers that CMS failed to give it proper notice of the basis for the revocation in the initial determination. P. Br. at 18-24.

Although Petitioner's argument is understandable, the operative language of section 424.535(a)(8) does not require that CMS demonstrate Petitioner intended to defraud Medicare before it may revoke Petitioner's billing privileges. *See* 42 C.F.R. § 424.535(a)(8). Even an unintentional error with regard to claims may serve as a basis for revocation if the regulatory text does not require fraudulent or dishonest intent. *Louis J. Gaefke*, *D.P.M.*, DAB No. 2554 at 7 (2013).

The holdings in *Gaefke* are directly applicable to the case at hand. *Gaefke* involved a podiatrist who had sought Medicare reimbursement for services provided to certain

beneficiaries on dates that were after the beneficiaries had died. The podiatrist argued that his billing personnel had simply made errors in the claims they filed because he had provided the services claimed, just to different beneficiaries with similar names. *Gaefke*, DAB No. 2554 at 3. However, as stated above, the decision in *Gaefke* made it clear that unintentional errors in claims that were filed may serve as the basis for upholding a violation of 42 C.F.R. § 424.535(a)(8). As stated in the decision:

> Petitioner relies on CMS's preamble statements that the revocation authority is directed at providers and suppliers engaged in "a pattern of improper billing" and is not intended for "isolated occurrences" or "accidental billing errors," and that CMS would "not revoke billing privileges . . . unless there are multiple instances, at least three, where abusive billing practices have taken place." 73 Fed. Reg. [36,448,] 36,455 [June 27, 2008]. Petitioner argues that "[i]t is clear from the Federal Register excerpt . . . that 'abusive billing practices' must have taken place for the regulation to apply" and that "it absolutely cannot be applied in the area of accidental billing errors." [citation omitted]. Petitioner argues that the revocation is thus "clearly at odds with [section] 424.535(a)(8), which is intended to allow revocations only in instances where there is evidence that the provider has engaged in fraud or abuse." [citation omitted].
>
> The regulation, and the preamble when read in the context of the regulation, do not support Petitioner's argument that the revocation was unauthorized because his improper claims resulted from inadvertent errors. 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. As the Board stated in [*Howard B.*] *Reife* [, *D.P.M.*, DAB No. 2527 (2013)], the "operative language" of the regulation "does not require that CMS demonstrate that Petitioner intended to defraud Medicare before it may revoke Petitioner's billing privileges," but "simply authorizes revocation where the supplier submits 'a claim or claims for services that could not have been furnished to a specific individual on the date of service,'" including, as is particularly applicable here, "'where the beneficiary is deceased.'" *Reife* at 5. Petitioner's submission via his billing agent of multiple claims for services that could not have been provided as claimed falls squarely within the conduct the regulation prohibits.

Gaefke, DAB No. 2554 at 7-8 (footnote omitted).

Further, to the extent that Petitioner relies on the term "abuse" in the title to section 424.535(a)(8) to read a requirement into the regulation that Petitioner must have intended to file improper billing, this argument has previously been rejected. *Id.* at 8.

In addition, Petitioner's argument that its claim submission error rate is very low because it has only had problems with claims related to 16 beneficiaries out of the thousands of patients Petitioner has served, has also been previously been rejected. *Id*. at 10 (citing *Reife*, DAB No. 2527 at 7).

Petitioner also gains no benefit from blaming its employees who completed the erroneous claims that serve as the basis for revocation in this case. As stated in *Gaefke:*

> As discussed, Medicare suppliers and providers certify that they are responsible for the accuracy of their claims for reimbursement, and the regulation contains no exception for improper claims prepared and submitted by billing agents, which is consistent with the preamble stating that providers and suppliers are responsible for claims submitted on their behalf. As in *Reife*, Petitioner "cites no legal authority relieving suppliers of responsibility for the claims for Medicare reimbursement submitted on their behalf and at their direction." . . . Petitioner's position, if adopted, would effectively shield a supplier from any consequences for the submission of an unlimited number of improper claims on his behalf, so long as he could point to an agreement with a billing agent, who is not a party to the supplier's Medicare agreement, to submit the claims. Petitioner's efforts to assign blame for the improper billing to his billing agent or his assistant do not relieve him of his responsibility for the improper claims or bar CMS from revoking his billing privileges.

DAB No. 2554 at 6 (internal citation and footnote omitted).

Petitioner also asserts that the initial determination in this case violates the regulatory notice requirements. Petitioner argues that the list of claims and beneficiaries that served as the basis for Petitioner's revocation (CMS Ex. 2 at 3) only provided the surnames of the beneficiaries and the last four digits of the beneficiaries' Medicare numbers. Petitioner states that: "This was time consuming and [Petitioner] was not given adequate information to submit a 'corrective action plan' because the Petitioner could not correct a problem in which [it] was unaware of." P. Br at 22.

The regulations require that CMS's initial determination to revoke a provider or supplier must include:

> (i) The reason for the revocation in sufficient detail for the provider or supplier to understand the nature of its deficiencies.
>
> (ii) The right to appeal in accordance with part 498 of this chapter.

(iii) The address to which the written appeal must be mailed.

42 C.F.R. § 405.800(b); *see also* 42 C.F.R § 498.20(a)(1) (initial determination must set "forth the basis or reasons for the determination . . . .").

In the present case, the initial determination stated that one of the bases for revocation was that Petitioner "submitted claims for services rendered to beneficiaries who were deceased on the purported date of service." CMS Ex. 2 at 1. The initial determination then referenced "Attachment A," which provided a list with four columns for each claim in question: 1) "Beneficiary Claim HIC Num"; "Beneficiary [Surname]"; Beneficiary Death Date; and Claim Date of Service. CMS Ex. 2 at 3. The notice also included Petitioner's right to request reconsideration and the address where Petitioner should send such a request. CMS Ex. 2 at 1-2.

I conclude that the information provided to Petitioner in the initial determination was adequate to meet the regulatory requirement that CMS provide sufficient detail for Petitioner to understand the nature of its noncompliance. Although not having the full name or Medicare number for each patient made Petitioner's efforts to respond to the initial determination more challenging (P. Br. at 8), based on Petitioner's detailed reconsideration request, Petitioner was able to meaningfully respond to the allegations in the initial determination.

The 17 improper claims that are undisputed in this case are sufficient to show a section 424.535(a)(8) violation. Section 424.535(a)(8) only requires "a claim or claims" for services that could not have been rendered. Therefore, one claim for services that could not have been rendered is enough for revocation. Even CMS guidance on this subject requires no more than three claims. 73 Fed. Reg. at 36,455. Therefore, I conclude that CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(8).

V. Conclusion

I grant summary judgment in favor of CMS and affirm CMS's determination to revoke Petitioner's Medicare enrollment and billing privileges.

/s/
Scott Anderson
Administrative Law Judge