Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Rural Metro Corporation of Florida, Inc.
Docket No. A-19-92
Decision No. 2977
November 25, 2019

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Rural Metro Corporation of Florida, Inc. (Rural Metro, Petitioner) appeals the March 29, 2019 Administrative Law Judge (ALJ) decision affirming the Centers for Medicare & Medicaid Services (CMS) revocation of Rural Metro's Medicare enrollment and billing privileges, at *Rural Metro Corporation of Florida, Inc.*, DAB CR5279 (2019) (ALJ Decision). The revocation was based on allegations that Rural Metro submitted multiple Medicare claims that could not possibly have been provided as claimed because the named beneficiaries were deceased.

As explained below, we conclude that CMS did not demonstrate that it was authorized to revoke on the legal basis it cited. CMS provided no evidence that the named beneficiaries were actually deceased on the relevant dates or that the claims were otherwise "impossible." Rural Metro conceded that the claims contained errors as to names or dates. However, such errors alone do not suffice for revocation under the regulatory provision on which CMS relied.

We therefore reverse the ALJ Decision and overturn the revocation.

Applicable law

The Social Security Act (Act)[1] provides for CMS to regulate the enrollment of providers and suppliers in the Medicare program. Act § 1866(j)(1)(A) (42 U.S.C. § 1395cc(j)(1)(A)). The implementing regulations appear in 42 C.F.R. Part 424, subpart

[1] The current version of the Social Security Act can be found at https://www.ssa.gov/OP_Home/ssact/ssact-toc.htm. (Last visited November 22, 2019.) Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross-reference table for the Act and the United States Code can be found at https://www.ssa.gov/OP_Home/comp2/G-APP-H.html. (Last visited November 22, 2019.)

P. Section 424.535(a)[2] lists reasons for which enrollment may be revoked, including the following:

> (8) *Abuse of billing privileges.* Abuse of billing privileges includes either of the following:
>
> (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:
>
> (A) Where the beneficiary is deceased.
>
> (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.
>
> (ii) CMS determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements. In making this determination, CMS considers, as appropriate or applicable, the following:
>
> (A) The percentage of submitted claims that were denied.
>
> (B) The reason(s) for the claim denials.
>
> (C) Whether the provider or supplier has any history of final adverse actions . . . .
>
> (D) The length of time over which the pattern has continued.
>
> (E) How long the provider or supplier has been enrolled in Medicare.
>
> (F) Any other information regarding the provider or supplier's specific circumstances that CMS deems relevant . . . .

[2] This section was substantially revised effective February 3, 2015. 79 Fed. Reg. 72,500, 72,532 (Dec. 5, 2014). We apply the regulation as in effect at the time of the revocation (August 26, 2016). *See, e.g., John P. McDonough III, Ph.D., et al.*, DAB No. 2728, at 2 n.1 (2016).

The preamble to the final rule originally promulgating section 424.535(a)(8)[3] (before subsection ii was added) contained the following discussion of the intended application of the provision:

> 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 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 that 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).

Revocation results in the termination of the supplier agreement with Medicare; CMS will also impose a bar on re-enrollment which it may set from one to three years, depending on the severity of the basis for revocation. 42 C.F.R. § 424.535(b)-(c).

Case background

Rural Metro participated in Medicare as an ambulance transportation supplier. By letter dated August 26, 2016, CMS notified Rural Metro that its Medicare enrollment and billing privileges were revoked, effective September 25, 2016, for the following reason:

> **42 CFR §424.535(a)(8)(i) — Abuse of Billing Privileges**
> Data analysis conducted on claims by Rural Metro Corporation of Florida for the dates of service May 12, 2013 to August 02, 2015, revealed that

[3] The original section 424.535(a)(8) read as follows:

(8) *Abuse of billing privileges.* The provider or supplier submits a claim or claims for services that could not have been furnished to a specific individual on the date of service. These instances include but are not limited to situations where the beneficiary is deceased, the directing physician or beneficiary is not in the State or country when services were furnished, or when the equipment necessary for testing is not present where the testing is said to have occurred.

> Rural Metro Corporation of Florida billed nine (9) claims for services to seven (7) Medicare beneficiaries, who were deceased on the purported date of service.

CMS Ex. 3, at 1. CMS imposed a three-year reenrollment bar. *Id*. at 2. On reconsideration, CMS confirmed its initial determination that Rural Metro billed for nine claims for seven deceased beneficiaries as alleged, and concluded that these claims for services could not have been furnished to a specific individual on the date of service. CMS Ex. 1, at 1-3.

Rural Metro timely sought an ALJ hearing. The ALJ issued a decision on the written record because neither party offered any witness testimony so no in-person hearing was needed. ALJ Decision at 3. The ALJ upheld the revocation; Rural Metro timely sought review of the ALJ Decision from the Board.[4]

ALJ Decision

The claims at issue all involve ambulance transportation of specific beneficiaries during the time frame alleged. *See id.* at 5-8. CMS dropped one of the claims on appeal, leaving eight claims involving six beneficiaries which the ALJ listed in a table. *Id*. at 4. The ALJ noted "CMS did not submit evidence to support its revocation," other than an investigative report and the documents that Rural Metro submitted to CMS with its reconsideration request. *Id*. (citing CMS Exs. 4; 2, at 15-116). Moreover, the ALJ noted, in particular, that "CMS did not provide evidence that the beneficiaries that it identified as deceased on the relevant dates of service were in fact deceased." *Id*.

The ALJ concluded that CMS had failed to prove that any of the claims involved a deceased beneficiary:

> Petitioner is correct that the record in this case is relatively simple, and consists primarily of two charts, one attached to the initial determination and the other as part of Safeguard Services' data analysis document indicating the alleged dates of death for the beneficiaries in question. P. Br. at 10, 12; CMS Ex. 3 at 3; CMS Ex. 4 at 3; *see also* CMS Ex. 2 at 3. As Petitioner points out, Safeguard Services' report makes reference to supporting exhibits, but CMS did not submit them and they are not in the record in this case. P. Br. at 3, 9-11; CMS Ex. 4 at 3-5.

[4] In its reply brief, Rural Metro requested oral argument before the Board on the basis that the relevant facts and law are complex. Rural Metro Reply Br. at 3. Many of the issues to which Rural Metro alludes in its briefing are not material to the narrow basis on which we resolve this matter. We do not find any need for oral argument and decline to grant the request.

> Due to the lack of documentation submitted by CMS showing that the beneficiaries listed on Petitioner's claims were deceased, I have no factual basis for finding that those beneficiaries were deceased. Petitioner asserts that, without such evidence, CMS did not have a legitimate basis to revoke. P. Br. at 8-13.

Id. at 9.

Rural Metro, on the other hand, provided detailed factual information about each of the claims remaining at issue, which the ALJ found credible and largely adopted as his findings of fact. *Id*. at 4-5. Essentially, those factual summaries stated that Rural Metro provided transport on the dates in question to living beneficiaries but submitted bills containing errors. *Id*. at 5-8. The errors included using the Medicare Health Insurance Claim Numbers (HICNs) of other beneficiaries with identical or near identical names or transposing two numbers in a Social Security number. *Id.* In one case, a claim was first billed with the correct HICN but a coding error and was then resubmitted with the correct code but the wrong HICN; the resubmitted claim is listed. *Id.* at 5. Two beneficiaries (identified in the ALJ Decision as E.L. and J.N.) were listed with two claims each, but the second claim as to each beneficiary was for the same service on the same date for which a claim was resubmitted after a denial; for these, both the original and the resubmitted claim is listed. *Id.* at 7-8.

The ALJ held that, even though CMS failed to show that the beneficiaries named on the claims were deceased, CMS nevertheless had a legitimate basis to revoke under section 424.535(a)(8)(i). *Id*. at 9. The ALJ found "Petitioner's admissions" that it filed the identified claims and, as to each, failed to "properly identify the correct individuals to whom it provided services or the correct dates on which it provided services" were "sufficient to satisfy" the requirements of the regulatory provision. *Id*. at 10. He essentially read the regulation and earlier Board decisions as holding that the provider could only prevail if the services were provided to the specific individual claimed at the time claimed. *Id*. at 10-11 (citing *John P. McDonough III, Ph.D.,* DAB No. 2728, at 8 (2016); *Patrick Brueggeman, D.P.M.,* DAB No. 2725, at 11 (2016); *Louis J. Gaefke, D.P.M.,* DAB No. 2554, at 8 n.7 (2013); *John M. Shimko, D.P.M.,* DAB No. 2689, at 7 (2016)). The ALJ also noted that section 424.535(a)(8) does not contain an intent requirement and that prior Board decisions found that it is not a defense that the improper billing was caused by clerical error or occurred infrequently. *Id*. at 11-13.

He rejected Rural Metro's contention that he could review CMS's discretionary decision to revoke billing privileges where a legal basis for revocation has been established. *Id.* at 13-14 (citing *Access Footcare, Inc., & Robert Metnick, D.P.M.,* DAB No. 2752, at 9-10 (2016)). Finally, he concluded he had no authority to review the length of the re-enrollment bar imposed by CMS. *Id*. at 14 (citing *Vijendra Dave, M.D.,* DAB No. 2672, at 8-12 (2016)).

Standard of Review

The Board's standard of review on a disputed factual issue is whether the ALJ decision is supported by substantial evidence in the record as a whole. The Board's standard of review on a disputed issue of law is whether the ALJ decision is erroneous. Guidelines - Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program, available at https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/enrollment/index.html.

Analysis

Section 424.535(a)(8)(i) does not provide CMS authority to revoke in this case.

CMS did not provide any evidence that transport services could not have been provided to the named beneficiaries on the dates listed in the questioned claims because, as the ALJ found, CMS offered no evidence that the named beneficiaries were deceased as CMS had alleged. ALJ Decision at 9. We differ with the ALJ in that we conclude that it follows that CMS failed to make a prima facie case that the basis for revocation on which it relied was present. *See* Rural Metro Br. at 15-17.

The core error in this case arises from a misunderstanding of Board precedent. The Board has, indeed, as the ALJ notes, repeatedly held that section 424.535(a)(8)(i)[5] authorizes revocation whenever a provider submits "a claim for services that could not have been provided to the specific individual identified in the claim on the date of services." ALJ Decision at 10 (quoting *McDonough* at 8). Such claims (certainly if over three are involved) have indeed been held to constitute "an abuse of billing privileges." *Id*. Moreover, the ALJ correctly recognizes that, when such a provider has submitted claims for services that could not have been provided, assertions of accidental or clerical error, lack of intent, or infrequency of error cannot defeat CMS's authority to revoke. *See* ALJ Decision at 11-13 and Board cases cited therein; *see also Arriva Medical, LLC*, DAB No. 2934 (2019), appeal docketed, No. 9:19-CV-80685 (S.D. Fla. May 24, 2019). The Board rejected arguments that the absence of such defenses amounted to strict liability, explaining that the regulation on its face and as explained in the preamble defined the submission of such claims to be evidence of abusive billing --

[5] Earlier Board decisions refer to section 424.535(a)(8), which essentially became section 424.535(a)(8)(i) when subsection (ii) was added addressing patterns or practices of improper claims. The relevant regulatory language discussed in those decisions about claims for "impossible" services remained consistent in the current section 424.535(a)(8)(i).

> Neither the preamble to the Final Rule nor the plain language of the regulation establishes a strict liability standard for improper billing or creates an exception for accidental billing. To the contrary, the Final Rule establishes that CMS and its contractors will exercise discretion in determining whether revocation for improper billing is appropriate.
>
> The preamble to the Final Rule does provide guidance as to what may show a pattern of abusive billings by stating that CMS will *not* revoke Medicare billing privileges for improper billing *unless* the improper billing consists of "multiple instances" of abusive billing. The preamble further explains that improper billing is abusive if, for example (as is the case here), "a provider or supplier submits a claim or claims for services that could not have been furnished to a beneficiary." 73 Fed. Reg. at 35,455, 36,457. The preamble explains that this policy arises from CMS's experience with "numerous examples of situations where a physician or other practitioner has billed for services furnished to beneficiaries that are undeliverable, including but not limited to situations where the beneficiary was deceased." *Id.*

Access Foot Care, Inc., and Robert Metnick, D.P.M., DAB No. 2752, at 9 (2016).

The prerequisite, however, for these holdings is that the services for which the claims were submitted *could not*, in fact, have been provided *as claimed*. Board decisions sometimes have referred to this key component of section 424.535(a)(8)(i), by way of shorthand, as impossibility or "impossible" claims. *See, e.g., Blossomwood Medical, P.C.* and *Vytautas Pukis, M.D.*, DAB No. 2914, at 6-7 (2018). A claim may be impossible for reasons other than the named beneficiary being deceased, as the regulation makes clear. For example, in addition to the examples in the regulation (such as the absence of the physician or lack of equipment), the Board upheld revocation where claims were submitted for treatment of more than five toes of beneficiaries who had had one foot amputated because the services *could not* have been provided as claimed to the nonexistent foot. *Louis J. Gaefke, D.P.M.*, DAB No. 2554 (2013). However, if nothing about the claims as submitted was "impossible," as we have been using that term, then section 424.535(a)(8)(i) does not apply. In short, while it is no defense that the submission of impossible claims was "erroneous" or "accidental," a claim is not impossible merely because it is erroneous.

Situations involving claims that are improper for other reasons, such as not including a correct name and HICN, date of service, or code for services provided or otherwise failing to comply with Medicare billing requirements, may also establish abusive billing. Section 424.535(a)(8)(ii) provides the framework for determining when such "possible" but improper claims rise to the level of a pattern or practice of abusive billing. The

factors which CMS is to consider in evaluating that question include the very sort of factual matters which are irrelevant in the context of section 424.535(a)(8)(i), such as the reasons that the claims were flawed, the frequency of denials (in terms of percentage of submissions), and the persistence of the pattern of improper claiming. The ALJ's analysis, by contrast, would make section 424.535(a)(8)(i) superfluous once CMS added section 424.535(a)(8)(ii). If section 424.535(a)(8)(i) applied whenever an erroneous claim was submitted, rather than only when one or more impossible claims were submitted, providing examples of when services *could not* have been provided as claimed would be unnecessary. Moreover, the discussion and factors set out in section 424.535(a)(8)(ii) to determine if erroneous claiming showed a pattern or practice of abuse would be unnecessary. The main distinction between subsections (i) and (ii), as we have shown, is that revocation under the first depends on showing submission of impossible claims, while revocation under the second depends on showing a pattern or practice of claims that are not compliant with requirements. We interpret the language of a regulation in a manner that gives effect to all its terms. As the Board has held, "[i]t is a fundamental principle of statutory construction, equally applicable to regulatory construction, that every word and every phrase of the text must be given effect so that no word or phrase is rendered superfluous or to have no consequence." *Ridgeview Hosp.*, DAB No. 2593, at 7 (2014) (citing 2A Norman J. Singer and J.D. Shambie Singer, Sutherland Statutes and Statutory Construction § 46:6 (7th ed.); *Texas Office of the Att. Gen.*, DAB No. 2124, at 10 (2007); *North Ridge Care Ctr.*, DAB No. 1857 (2002) (noting that the Board generally strives to apply or interpret statutory or regulatory language in a way that does not render some provisions superfluous)).

We do not hold that CMS must always provide affirmative documentation of the basis for its claims of impossibility in a section 424.535(a)(8)(i) case. For example, in *Donald W. Hayes, D.P.M.*, DAB No. 2862 (2018), the parties filed cross motions for summary judgment. The ALJ concluded that the provider "had admitted that he, through his employees, had submitted Medicare claims for services purportedly rendered to beneficiaries who were deceased, and found immaterial Petitioner's explanations of human error and faulty billing technology for the claims at issue." *Hayes* at 6.[6] The Board upheld the ALJ and sustained the revocation because "CMS's prima facie showing of abusive billing is no less compelling in the face of Petitioner's claim that his billing errors lacked fraudulent or dishonest intent, and that they were in fact accidentally made." *Id.* at 9. Thus, where a provider does not contest CMS's allegation that the beneficiaries named in the claims were deceased, there is no factual issue to be resolved. Also, in some cases, the evidence for "impossibility" may be more available to the provider than to CMS, such as when the physician was allegedly not in the state or

[6] This is in contrast to Rural Metro's position: "Specifically, while CMS and the lower level tribunals in these appeal proceedings assert that Rural Metro admitted to erroneously submitting claims for beneficiaries that were deceased on the date of the transport, Rural Metro actually has done no such thing." Rural Metro Br. at 16.

country at the time of services. In the present case, however, Rural Metro not only did not concede that the named beneficiaries were deceased on the relevant dates but strongly questioned the reliability of the data used by the contractor and the lack of supporting documentation. *See, e.g.*, Rural Metro Br. at 17-21. Moreover, Rural Metro pointed to one claim on which CMS relied but later withdrew before the ALJ when it turned out that the beneficiary was actually alive on the date of service. *Id*. at 21-22. The ALJ found that claim was not at issue since CMS abandoned reliance on it. ALJ Decision at 4. We agree with Rural Metro, however, that the inclusion in the original list of deceased named beneficiaries of an individual apparently alive on the date of service casts further doubt on the reliability of the list absent supporting evidence. Rural Metro Br. at 21-22.[7]

Therefore, on the record in this case, CMS does not have authority under section 424.535(a)(8)(i) to revoke Rural Metro's Medicare billing privileges. We do not address whether CMS might have such authority under any other provisions, including section 424.535(a)(8)(ii), because CMS made no such claim and because the Board has long held that CMS is limited in revocation cases to the bases presented in the reconsideration decision. *Vijendra Dave, M.D.*, DAB No. 2672, at 8 n.10 (2016) and cases cited therein. Because CMS did not have a legal basis to revoke, we overturn the revocation.[8]

Conclusion

We reverse the ALJ Decision and overturn the revocation.

/s/
Christopher S. Randolph

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member

[7] Before the Board, CMS responds to the contentions that the named beneficiaries were not shown to be deceased merely by saying they are irrelevant because the ALJ relied on Rural Metro's admissions that it billed for services that were not provided to the six named beneficiaries. CMS Br. at 6.

[8] We note that, as mentioned in regard to the denial of oral argument, Rural Metro made a range of arguments as to the scope of the ALJ's review, the nature of CMS's discretion, the causes of its errors and potential mitigating circumstances, and other points. CMS responded to these points in its briefing. Because the reasoning in this decision suffices to resolve the issues before us, we do not comment on other arguments of the parties.