Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Robert Lifson, M.D.,	)	Date: June 11, 2008
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-08-209
	)	Decision No. CR1802
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

Petitioner, Robert Lifson, M.D., is a physician who participated in the Medicare program as a provider of services. The Centers for Medicare & Medicaid Services (CMS) has revoked his Medicare billing privileges because he allegedly submitted false claims to the Medicare program. Petitioner appeals. CMS has moved for summary judgment, arguing that no material facts are in dispute and that it is entitled to judgment as a matter of law. I agree and affirm CMS's revocation of Petitioner's Medicare billing privileges.

> ***CMS is entitled to summary judgment because it has brought forth evidence that Petitioner submitted false claims to the Medicare program, in contravention of the Social Security Act, regulations, and the terms of his provider agreement, and Petitioner has not brought forth evidence sufficient to establish a genuine factual dispute on that issue.***[*]

"To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact . . . ." *Livingston Care Center*, DAB No. 1871 (2003). The moving party may show the absence of a genuine factual dispute by showing that the non-moving party has presented no evidence "sufficient to establish the existence of an

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

element essential to that party's case, and on which that party will bear the burden of proof at trial." *Livingston Care Center v. Dep't of Health and Human Services*, 388 F.3d 168, 173 (6th Cir. 2004). To avoid summary judgment, the non-moving party must then act affirmatively by tendering evidence of specific facts showing that a dispute exists. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 n.11 (1986). *See also Vandalia Park*, DAB No. 1939 (2004); *Lebanon Nursing and Rehabilitation Center*, DAB No. 1918 (2004).

In this case, CMS alleges that, from January 2005 through August 2006, Petitioner Lifson billed the Medicare program for services that he did not provide. In some cases, the beneficiaries were dead at the time he claimed to have provided the services. He also billed for office visits that he could not have provided because the beneficiaries were hospitalized at the time. In other instances, beneficiaries denied receiving the services for which he billed. CMS Exhibits (Exs.) 5, 6, 7.

Billing Medicare for services not provided justifies termination of a provider agreement. Social Security Act (Act), section 1866(b)(2); 42 C.F.R. § 424.535(a)(1). When Petitioner entered into his provider agreement, he acknowledged that "any deliberate omission, misrepresentation or falsification of any information . . . in any communication supplying information to Medicare . . . may be punished by [among other penalties] denial or revocation of Medicare identification number(s) . . . ." CMS Ex. 4, at 1. Petitioner explicitly agreed to abide by Medicare laws, regulations and program instructions, and acknowledged that payment of a Medicare claim is conditioned on compliance with the law, regulations, and program instructions. CMS Ex. 4, at 1.

For his part, Petitioner Lifson does not deny the allegations of false claims, but asserts that he was not responsible for erroneous billing done in his name. In his written declaration he characterizes himself as the too-trusting victim of clinic staff. According to Petitioner, through an internet employment company, he was hired to "open, supervise, and manage a general medical clinic." Petitioner (P.) Ex. 2, at 1. His job was to insure quality, but physicians assistants generally provided the services to beneficiaries. P. Ex. 2, at 2 (Lifson Decl. ¶¶ 6, 8, 9). For his part, Petitioner was available for telephone consultations, and made weekly visits to the clinic where he reviewed approximately 10% of the medical charts. In his view, this is all that was required of him. P. Ex. 2, at 2, 3 (Lifson Decl. ¶¶ 9, 10, 16). Clinic staff helped Petitioner fill out his Medicare application. P. Ex. 2, at 2 (Lifson Decl. ¶ 4). He denies ever submitting a superbill to Medicare, and asserts that he would not even know how to do so. Instead that responsibility was delegated to untrustworthy individuals who "misused [Petitioner's] license." P. Ex. 2, at 2, 3 (Lifson Decl. ¶¶ 13, 15, 17).

For summary judgment purposes, I accept all of Petitioner's factual allegations. However, based upon these facts, CMS is entitled to judgment as a matter of law. Petitioner Lifson admits that he knowingly allowed clinic staff to use his billing number and he is therefore responsible for the claims submitted in his name. As the Departmental Appeals Board observed in a related context, an employee's knowledge of the submission of a false Medicare claim is imputed to the employer "even absent actual knowledge because self-imposed ignorance of the subordinate's actions is not a shield." *Thomas M. Horras and Christine Richards,* DAB No. 2015, at 15 (2006), *citing United States v. Cabrera-Diaz*, 106 F. Supp. 2d 234, 239 (D.P.R. 2000).

Because Petitioner has "conceded all of the material facts" and "proffered testimonial evidence only on facts which, even if proved, clearly would not make any substantive difference in the result," CMS is entitled to summary judgment (*see Michael J. Rosen, M.D.*, DAB No. 2096, at 4 (2007)), and I affirm CMS's revocation of his Medicare billing privileges.

/s/
Carolyn Cozad Hughes
Administrative Law Judge