Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Jason E. Brunt, D.O.,
(PTAN: P44690001; NPI: 1619979713),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-1700

Decision No. CR3457

Date: November 13, 2014

DECISION

I. Introduction

I sustain the determination of a Medicare contractor, as ratified by the Centers for Medicare & Medicaid Services (CMS), to revoke the Medicare billing privileges of Petitioner, Jason E. Brunt, D.O., and to bar him from re-enrolling in Medicare for a period of two years. CMS contends, and the uncontroverted evidence establishes, that Petitioner abused his Medicare billing privileges as is described at 42 C.F.R. § 424.535(a)(8).

Neither party requested that I conduct a hearing in person. Consequently, I decide this case based on the parties' written exchanges of briefs and proposed exhibits. CMS filed 19 proposed exhibits that it identified as CMS Ex. 1 – CMS Ex. 19. Petitioner filed five proposed exhibits that it identified as P. Ex. 1 – P. Ex. 5. I receive the parties' exhibits into the record.[*]

II. Issues, Findings of Fact and Conclusions of Law

A. Issues

The issues are: whether CMS is authorized to revoke Petitioner's Medicare billing privileges; and, whether the remedies CMS imposed are authorized.

B. Findings of Fact and Conclusions of Law

The essence of CMS's case against Petitioner is that it is authorized to revoke his Medicare billing privileges and to bar him from re-applying for a two-year period because Petitioner, on at least ten dates, filed Medicare reimbursement claims for services that he could not possibly have provided to Medicare beneficiaries. CMS's assertions about Petitioner's claims are true. They are supported by overwhelming, uncontroverted proof.

The evidence shows that, between December 2011 and November 2012, Petitioner submitted reimbursement claims for comprehensive home visits to Medicare beneficiaries and for prolonged services to these beneficiaries in their homes. The "Current Procedural Terminology" (CPT) codes that Petitioner used in making these claims are codes, which when used in conjunction with claims, signify that the practitioner expended substantial amounts of time to provide services to beneficiaries. Petitioner misused these codes in a way that maximized his reimbursement but which also claimed – impossibly – that he expended more hours per day providing services to beneficiaries than there are in a day.

From the face of Petitioner's reimbursement claims Petitioner was able to defy the laws of physics in that on numerous days he worked more than 24 hours – sometimes more than 40 hours – to provide services to Medicare beneficiaries in their homes. And, if

[*] CMS did not object to my receiving Petitioner's exhibits. P. Exs. 1 – 4 are procedural documents that do not address the substantive issues of this case. P. Ex. 5 is a treatment record. It is unclear from what the parties submitted to me whether Petitioner offered any of his exhibits in connection with his request for reconsideration of CMS's adverse initial determination. *See* 42 C.F.R. § 498.56(e). I am assuming that Petitioner did offer these exhibits at reconsideration solely because CMS did not object to my receiving them.

Petitioner's claims are accepted on their face, he was able to warp space and time so as to be able to travel from patient to patient, in addition to providing more than 24 hours' service, all within the limits of a single 24-hour day.

Petitioner used three CPT codes in conjunction with his reimbursement claims: CPT codes 99350, 99354, and 99355. Code 99350 is used to claim reimbursement when a physician makes a home visit to a beneficiary, which includes two of the following three elements: a comprehensive examination; a comprehensive interval history; or a medical decision of moderate to high complexity. CMS Ex. 16 at 1, 6, 8. CPT 99354 and 99355 are used to claim reimbursement for prolonged services requiring direct face-to-face patient contact. CPT Code 99354 covers the first hour of prolonged service in the office or in another outpatient setting requiring direct patient contact beyond the usual service. CMS Ex. 17 at 1, 5. CPT code 99355 is used to claim reimbursement for each additional time period in increments of 30 minutes beyond the services claimed under CPT Code 99354. CMS Ex. 18 at 1, 5, 9; CMS Ex. 19 at 15-16.

An audit conducted of claims submitted by Petitioner established that he made claims for services pursuant to CPT codes 99350, 99354, and 99355 which included numerous instances in which Petitioner claimed to have worked more than 30 hours during a single day. CMS Ex. 1 at 25, 26-27. On ten separate dates between December 2011 and November 2012, Petitioner billed for and was reimbursed for services provided to as many as sixteen Medicare beneficiaries in one day pursuant to the three codes, at the rate of 2.5 hours of service for each patient. *Id.* As an example, on November 15, 2012, Petitioner filed claims for sixteen beneficiaries using the three codes that added up to over 40 hours of service on that date. *Id.* at 26.

The absurdity of Petitioner's claims becomes even more evident when one considers that they do not even factor in the travel time that Petitioner would have had to incur between patient visits. Adding likely travel time to the time that Petitioner alleged to have spent with his patients meant that on some days, he was by some feat of legerdemain able to work well over 40 hours.

Petitioner's claims obviously were false and an abuse of his billing privileges. CMS certainly had the authority to revoke his billing privileges based on the evidence that I have just described. Claims abuse is an explicit reason for revoking a provider or supplier's Medicare 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 when the testing is said to have occurred.

42 C.F.R. § 424.535(a)(8).

CMS not only revoked Petitioner's billing privileges, it barred him from re-enrolling as a Medicare participant for a period of two years. It is within CMS's discretion to impose a two-year bar on re-enrollment. CMS must impose a re-enrollment bar of at least one year where it exercises its authority to revoke a participant's billing privileges and may increase the bar to as long as three years depending on the severity of the misconduct that justifies revocation. 42 C.F.R. § 424.535(c). Although the determination to impose a bar of more than a year is within CMS's discretion, it is evident in this case that Petitioner's abuse of his billing privileges was egregious and therefore easily justified a bar of two years, if not longer. It is impossible to explain Petitioner's patently false claims as simple error on his part, particularly in light of the fact that he filed such claims on multiple occasions.

Petitioner made several arguments to contest CMS's determination. I find all of them to be without merit.

However, prior to addressing these arguments I note that Petitioner's arguments are significant for what they do *not* challenge. Petitioner does not contest the accuracy of CMS's assertions concerning his Medicare reimbursement claims. Fundamentally, Petitioner concedes that he filed the claims that are at issue and he concedes that these claims grossly misstated the time that he spent providing services to beneficiaries.

Petitioner argues that there would be minimal risk to Medicare and its beneficiaries if he were to continue participating in the program. Petitioner's Memorandum of Law in Support of Summary Disposition and Pre-Hearing Brief (Petitioner's Brief) at 3 – 4. He contends that he was placed on prepayment review after his billing misadventures were discovered and that the vast majority of his claims subsequently were approved. I find this argument to be without merit for two reasons. First, CMS's determination is authorized by regulation. My authority in this case is limited to deciding whether CMS is authorized to act. I do not have the authority to question CMS's exercise of the discretion that is conferred on it by regulation if, in fact, CMS's action is authorized. Second, the fact that Petitioner's claims have been approved *while he is under close scrutiny* is no basis in any event for invalidating CMS's exercise of its authority. CMS should not be required to ensure the accuracy of a practitioner's claims through reviews and close scrutiny if other, more efficient means to protect the program and its beneficiaries are available to it, such as revocation of billing privileges and a bar to re-enrollment.

Next, Petitioner contends that revocation of his billing privileges is unwarranted due to alleged "mitigating circumstances." Petitioner's Brief at 4 – 5. The gravamen of Petitioner's argument is that he has been assessed an overpayment totaling more than $1.1 million for the false claims that he filed. This, he contends, together with the suspension of his Medicare payments and prepayment review, is more than enough remedy in his case. He asserts that as a matter of fairness he should not have to repay this overpayment *and* have his billing privileges revoked.

I disagree. The size of the overpayment is a striking measure of the extent to which Petitioner disregarded Medicare billing requirements during a short period of time and it is also a measure of his untrustworthiness to deal with Medicare trust fund money as well as with beneficiaries. As I have stated, it is within CMS's discretion to determine whether Petitioner's billing privileges ought to be revoked. But, the dollar amount of Petitioner's false claims is more than enough justification for CMS to take the action that it has taken in this case.

Then, Petitioner argues that his false claims are not an abuse of his billing privileges within the meaning of 42 C.F.R. § 424.535(a)(8). Petitioner's Brief at 5 – 10. Essentially, Petitioner premises his argument on the fact that the specific claims that he filed are not listed in the examples of claims abuse described by the regulation. He concedes that the regulation's reach is not limited to those precise examples, but he argues that anything included within the regulation's reach must be similar to those examples. Other types of billing misconduct, he reasons, are beyond the regulation's reach. The distinction that Petitioner attempts to draw is that, according to him, each of the three examples listed under the regulation is an instance where claims were filed for services that were not provided at all. Thus, for example, claiming reimbursement for a service that allegedly was provided to a deceased individual obviously is a claim for a service that wasn't provided. Petitioner reasons that the claims for the services that he provided aren't covered by the regulation because he provided *something* on the dates in question even if what he provided wasn't the "something" contemplated by CPT codes 99350, 99354, and 99355.

Petitioner's asserted distinction is invalid. The regulation explicitly applies to all 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). On its face it applies equally to claims where no services were provided and to claims where something may have been provided but where what was claimed could not possibly have been provided.

Petitioner could not possibly have provided the services to the beneficiaries that he claimed to have provided on the dates in question. It is no defense that he may have seen these beneficiaries or provided something to them in the nature of services on the dates in

question (although Petitioner has not provided proof that he actually saw or provided services to all of the beneficiaries on these dates). Petitioner did not provide prolonged and comprehensive care to these beneficiaries as he claimed.

So, Petitioner's assertions notwithstanding, his false claims are claims "that could not have been furnished to a specific individual on the date(s) of service" and, hence, they fall exactly within the reach of 42 C.F.R. § 424.535(a)(8).

Finally, Petitioner argues that to the extent that he may have improperly filed claims under the three CPT codes that are at issue, those false claims were a "mistake" and not intentional. I am skeptical that the false claims that Petitioner filed were good faith errors as he contends. However, and even if they were, it is no excuse that Petitioner may have filed these claims through ignorance or misunderstanding on his part.

Petitioner was obligated to know and to understand how the CPT codes functioned as a condition for using them to claim reimbursement from the Medicare program. CMS points out, and I agree, that the Medicare Claims Processing Manual (MCPM), a document that Petitioner certainly had access to, explains in detail the circumstances under which a practitioner may claim reimbursement under the three codes. CMS Ex. 19 at 15 – 18. The explanations offered by the MCPM are unambiguous. For example, in explaining the use of CPT code 99355, the MCPM states:

> Code 99355 . . . may be used to report each additional 30 minutes beyond the first hour of prolonged services, based on the place of service . . . .

CMS Ex. 19, at 16. Petitioner was therefore on explicit notice about what he could and could not claim reimbursement for.

There is no language in 42 C.F.R. § 424.535(a)(8) that suggests that the regulation only applies to practitioners who file false claims with the intent to defraud. The regulation sweeps in the negligent along with the knowing. Petitioner, as a participant in Medicare, owed the program the duty of being diligent in complying with billing requirements. CMS is fully justified in revoking Petitioner's billing privileges and imposing a two-year re-enrollment bar based on his misfeasance as much as it would be justified in taking the same action based on malfeasance.

/s/
Steven T. Kessel
Administrative Law Judge