Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Zille Shah, M.D. and Zille Huma Zaim, M.D., PA
(PTAN: 1497957773, 195262269),

Petitioner,

v.

Centers for Medicare & Medicaid Services,

Respondent.

Docket No. C-15-2436

Decision No. CR4243

Date: September 22, 2015

DECISION

I grant summary judgment in favor of the Centers for Medicare & Medicaid Services (CMS) sustaining the determination to revoke the Medicare enrollment and billing privileges of Zille Shah, M.D. and Zille Huma Zaim, M.D., Professional Association for a period of three years.[1] Revocation is justified pursuant to 42 C.F.R. § 424.535(a)(8) (2015) because Petitioner submitted or caused to be submitted Medicare reimbursement claims that she could not have furnished on the claimed service dates.

[1] These two names in fact identify one individual who enrolled in Medicare using two different identities, one as an individual physician and the other as a professional association. I refer to her as "Petitioner" for the remainder of this decision.

I. Background

Petitioner, a physician, filed her hearing request in order to challenge a reconsidered determination that affirmed the initial determination to revoke her enrollment and billing privileges. The parties cross-moved for summary judgment. Each party filed a brief supporting its respective position and each party replied to its adversary's brief.[2]

CMS filed 11 exhibits supporting its motion. These are identified as CMS Ex. 1 – CMS Ex. 11. Petitioner filed exhibits supporting its cross-motion. Petitioner used an idiosyncratic method of identifying her exhibits even though I issued specific instructions to the parties explaining that each exhibit should be numbered separately and that letter prefixes should not be used. Petitioner's identified her exhibits as P. Ex. 1 – P. Ex. 9; P. Ex. 10a – P. Ex. 10o; P. Ex. 11a – P. Ex. 11e; P. Ex. 12 – P. Ex. 20; and P. Ex. 20a.

Petitioner objected to my receiving certain of CMS's exhibits on the grounds that they are "incomprehensible" or not credible and reliable. Petitioner's Resp. to CMS's Mot. for Summ. J. at 2. Although she does not state her objections specifically, Petitioner seems to be objecting to CMS Ex. 8, which contains the declaration of Matthew Kirk and records of claims that Petitioner filed. I overrule the objection. Petitioner asserts -- without explanation -- that the declaration of Matthew Kirk is not credible. I need not address that argument in order to issue summary judgment favorable to CMS because CMS does not rely on anything in the affidavit to establish facts that are in dispute. As I will explain, Petitioner admits that she was out of the country during periods of time when she claimed reimbursement for services that she ostensibly provided to Medicare beneficiaries. Additionally, the claims are not incomprehensible. I note, additionally, that Petitioner does not deny filing, or causing to be filed, any of the claims that are identified in the exhibit. Petitioner has not explained its credibility and reliability objections and I overrule them for that reason. I receive CMS Ex. 1 – CMS Ex. 11.

CMS objected to my receiving P. Exs. 8-15, P. Exs. 18 - 19, and P. Ex. 20a on the ground that these comprise new evidence that Petitioner did not file at reconsideration and did not make a showing of good cause for its failure to do so. I sustain CMS's objections to these exhibits. I receive P. Exs. 1 - 7; P. Ex. 16 – P. Ex. 17; and P. Ex. 20. I exclude the remainder of Petitioner's exhibits.

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[2] Petitioner also filed documents that she styled as "amended" briefs addressing the issues of whether CMS should be granted summary judgment and Petitioner's own motion for summary judgment. She filed these briefs without seeking my permission to file them. They are not in compliance with the pre-hearing order that I issued in this case because in total, Petitioner's arguments on both CMS's motion and its own motion exceed 25 pages. However, I have elected to read these briefs and to consider all of Petitioner's arguments.

I must exclude documents that Petitioner failed to submit at reconsideration absent a showing of good cause by Petitioner for its failure to do so. 42 C.F.R. § 498.56(e)(1). Petitioner failed to submit the challenged exhibits at reconsideration and she has not established good cause for her failure. Petitioner argues that the notice that she received of her right to seek reconsideration was ambiguous, stating only that it "may" submit additional evidence at reconsideration and not advising Petitioner that the requirement to do so is mandatory. I agree that the notice is ambiguous. But, here, Petitioner was represented by counsel at reconsideration and counsel is charged with the responsibility of reading and understanding governing regulations. 42 C.F.R. § 498.56(e)(1) is unambiguous. Counsel should have known what her responsibilities were.

Moreover, none of the exhibits that Petitioner offers – including those that I exclude – establishes facts that contradict the undisputed facts upon which I base this decision.

II. Issue, Findings of Fact and Conclusions of Law

A. Issue

The issue is whether the undisputed material facts establish that CMS is authorized to revoke Petitioner's Medicare participation and billing privileges due to her having submitted or causing to be submitted Medicare reimbursement claims for items or services that could not have been provided on the claimed service dates.

B. Findings of Fact and Conclusions of Law

CMS argues that revocation of Petitioner's Medicare participation and billing privileges is authorized by 42 C.F.R. § 424.535(a)(8). The version of that regulation in effect on October 30, 2014, the effective date of the revocation determination, provides in relevant part that CMS may revoke a provider or a supplier's participation where the provider or supplier submits a claim or claims for services that could not have been furnished to a specific individual on the alleged date or dates of services. The regulation specifically lists the circumstance where the provider or supplier is out of the country on the alleged service date as one of the events where revocation is justified.[3]

On its face the regulation gives CMS authority to revoke participation where there is even one instance in which a provider or supplier files even a single claim for services that he or she could not have provided on the alleged service date. CMS has chosen, in its

[3] The regulation was amended in February 2015 to add additional circumstances in which revocation is justified. The amendments do not change the language that is the basis for the revocation determination in this case.

discretion, to give some leeway to providers. The preamble to the regulation states that there will be at least three instances of abusive billing practices before CMS exercises its discretion to revoke. 73 Fed. Reg. 36,448, 36,455 (June 27, 2008).

CMS contends that Petitioner was out of the country on dates for which she submitted multiple claims for items or services that were allegedly provided on those dates. It asserts that these multiple instances of false claims establish a pattern of such claims that justify its determination to revoke. I find these assertions to be amply supported by the undisputed material facts. CMS's revocation determination plainly is justified by these undisputed facts.

The undisputed facts establish that Petitioner was out of the country on dates that included June 18 – June 20, 2011; September 27 – October 2, 2011; May 2 – May 4, 2012; and May 20 – June 4, 2013. CMS Ex. 1 at 2-5; CMS Ex. 6 at 1-2; CMS Ex. 8 at 68-72. She submitted reimbursement claims – more than 90 in total – for services that she allegedly provided on these dates when she was not in the United States. CMS Ex. 1 at 1-5; CMS Ex. 8 at 6-72. Petitioner admits being out of the country on the dates that are at issue and she admits additionally that she submitted or caused to be submitted claims for services that were ostensibly provided by her on these dates. CMS Ex. 5 at 5.

Petitioner has thrown up a barrage of arguments challenging the revocation determination but she has not denied any of the facts alleged and demonstrated by CMS. Her attacks, essentially, are collateral attacks on CMS's determination and I find them to be without merit.

Essentially, Petitioner argues that what she characterizes as billing mistakes are not her fault. The gist of her argument is that, while she may have made mistakes, she made them in good faith and they were not so egregious as CMS contends them to be.

Petitioner asserts that she found CMS's reimbursement criteria to be confusing and difficult to understand and that she relied on the advice of a billing expert. She asserts that she relied on CMS's "incident to" billing policies. She contends that when she was out of the country her patients were seen by a nurse practitioner who functioned under Petitioner's authority. Section 1861(s)(2)(A) of the Social Security Act and 42 C.F.R. § 410.26(b) (2011-2013) allow a physician to bill for services performed by auxiliary personnel incident to the physician's services if certain requirements are met. Among other things, the services must be furnished under the direct supervision of a physician. 42 C.F.R. § 410.26(b)(5). A CMS Medicare Learning Network notice about "incident to" services posted in 2004 clearly explains that, "Physicians do not have to be physically present in the patient's treatment room while these services are provided, but must provide direct supervision, that is, the physician must be present in the office suite to render assistance, if necessary." Medicare Learning Network Matters Article #: SE0441, *"Incident to" Services*, available at https://www.cms.gov/site-search/search-

results.html?q =SE0441%202004. Thus, Petitioner could not have met the "incident to" billing requirements if she was out of the country at the time the services were furnished.

She also argues that the total number of false claims that she submitted is not 90 – but does not deny that she submitted some unspecified number of claims for services that she could not have provided on the claimed service dates. She makes other assertions as well, all of which are intended to deflect blame for the false claims that she submitted or caused to be submitted.

But, what Petitioner *does not deny* is that she was out of the country for periods of time and that she submitted or caused to be submitted claims for services that she allegedly provided on dates when she was not in the United States. That concession is all that CMS needs in order to authorize revocation of Petitioner's participation.

A basic misconception that underlies Petitioner's arguments is that there must be proof of culpability to justify revocation pursuant to 42 C.F.R. § 424.535(a)(8). That is simply not so. *Louis J. Gaefke, D.P.M.*, DAB No. 2554 at 5-6 (2013). The regulation is not an anti-fraud regulation so much as it is intended to allow CMS to disassociate itself from providers and suppliers who are not rigorous in assuring that their claims are accurate. The Medicare program receives millions of reimbursement claims every year. It does not have the resources to audit every claim for accuracy. Rather, it relies on providers and suppliers to state their claims accurately. CMS is not required to do business with any provider or supplier who fails to fulfill this basic obligation.

The regulation, as I have stated, permits revocation where there is any instance of a claim for which the provider or supplier could not have provided the claimed service. CMS, in its discretion, has cut some slack for providers or suppliers by stating that it will not revoke absent at least three instances of such claims. But, that is not a legal requirement and, moreover, whether Petitioner submitted at least 90 false claims or somewhat fewer than that number, there is no doubt that she submitted or caused to be submitted more than three of them.

/s/
Steven T. Kessel
Administrative Law Judge