Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Louis J. Gaefke, D.P.M.,
(NPI: 1629148648),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-145

Decision No. CR2785

Date: May 14, 2013

DECISION

Petitioner, Louis J. Gaefke, D.P.M., challenges the determination by Wisconsin Physician Services Insurance Corporation (WPS), an administrative contractor for the Centers for Medicare & Medicaid Services (CMS), to revoke Petitioner's Medicare billing privileges effective August 2, 2012, and to impose a three-year bar on re-enrollment. Both parties now move for summary judgment. For the reasons set forth below, I find that there is no genuine dispute of material facts and that CMS is entitled to judgment affirming its revocation of Petitioner's Medicare billing privileges. Accordingly, I grant summary judgment in favor of CMS. However, I also conclude that WPS erroneously set April 2, 2012, as the effective date of the revocation. Therefore, the effective date of Petitioner's revocation is modified to September 2, 2012.

I. Case Background and Procedural History

Petitioner is a podiatrist licensed to practice in Kansas and Missouri. He participated in the Medicare program as a supplier of services.[1] By five letters, all dated August 3, 2012,

[1] A "supplier" is a "physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare." 42 C.F.R. § 400.202.

WPS notified Petitioner that it was revoking his Medicare billing privileges. WPS sent Petitioner a separate letter for each of the provider transaction access numbers (PTANs) associated with his National Provider Identifier (NPI).[2] WPS stated that the revocation was effective retroactively to August 2, 2012. WPS did not allege specific facts in the letters, but rather quoted 42 C.F.R. § 424.535(a)(8), titled "Abuse of billing privileges," as its basis for revoking Petitioner's billing privileges. WPS also established a three-year bar on Petitioner's re-enrollment in the Medicare program. CMS Exhibit (Ex.) 2, at 4-13.

On August 28, 2012, Petitioner requested reconsideration. Petitioner asserted that the letters from WPS violated regulatory requirements for revocation notices and claimed that WPS refused to provide him with additional details about the revocation when he inquired. Petitioner stated that he did not submit a corrective action plan (CAP) because he cannot correct a problem about which he is unaware. He generally denied that the revocation authority stated in 42 C.F.R. § 424.535(a)(8) applied to him. Petitioner also noted that the revocation was imposed retroactively, which violated the applicable regulations. CMS Ex. 2, at 1-3.

After further efforts to obtain the documents that CMS and WPS relied on to revoke Petitioner's billing privileges, Petitioner received that material on October 2, 2012. Three days later, on October 5, 2012, Petitioner sent a second request for reconsideration that addressed the material CMS provided to Petitioner. CMS Ex. 3. He claimed that the instances of improper billing that CMS and WPS relied upon were "all the result of isolated billing errors and thus do not show that [Petitioner] in any way abused his Medicare billing privileges." CMS Ex. 3, at 1. On October 10, 2012, WPS issued its reconsidered determination. The WPS hearing officer stated that "[a]ccording to our records [Petitioner] has submitted claims for services that could not have been furnished." CMS Ex. 1, at 1. WPS therefore upheld the revocation of Petitioner's billing privileges.

On November 16, 2012, Petitioner timely requested a hearing. In response to my November 28, 2012 Acknowledgment and Pre-hearing Order (Order), CMS filed a motion for summary judgment and brief (CMS Br.) along with six proposed exhibits (CMS Exs. 1-6). Petitioner filed a response to CMS's motion for summary judgment, as well as his own motion for summary judgment and brief (P. Br.). Petitioner filed seven proposed exhibits, which he labeled alphabetically as Petitioner's Exhibits (P. Exs.) A through G. CMS did not file a response to Petitioner's motion for summary judgment.

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[2] While WPS sent five separate letters to Petitioner, the combined practical effect was the revocation of Petitioner's Medicare billing privileges and enrollment. Therefore, WPS made only one initial determination. *See* 42 C.F.R. § 498.3(b)(17) (explaining that an "initial determination" includes "whether to deny or revoke a . . . supplier's Medicare enrollment . . ."). Petitioner sent a single request for reconsideration and WPS issued a single reconsidered determination. CMS Exhibits (Exs). 1, 2.

Petitioner objects to the admission of a letter from "AdvanceMed" (presumably CMS Ex. 1, at 42-43), as well as the declaration of Megan Dimmock (CMS Ex. 6). P. Br. at 26 n.3. Petitioner argues that these exhibits should be excluded as a "reasonable sanction for the misconduct of CMS and WPS." P. Br. at 26 n.3. Petitioner posits that there is a conspiracy to force through the revocation of his billing privileges without providing him with specific information about why the revocation action was taken. However, aside from Petitioner's theory, Petitioner has not offered any direct evidence that CMS's investigation was improper or that these exhibits contain evidence unduly prejudicial to the presentation of Petitioner's case before me. Further, Petitioner has not argued that Ms. Dimmock's statement is not reliable or authentic; therefore, I find it admissible in these proceedings. *See* 42 C.F.R. § 498.61. I admit CMS Exs. 1-6 and P. Exs. A-G into the record.

II. Discussion

A. Issues

This case presents the following three issues:[3]

1. whether summary judgment is appropriate;

2. whether CMS has the authority to revoke Petitioner's billing privileges under 42 C.F.R. § 424.535(a)(8); and

3. if CMS has the authority to revoke Petitioner's billing privileges, whether CMS properly established the effective date of revocation.

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

The Social Security Act (Act) authorizes the Secretary of Health and Human Services (Secretary) to establish by regulation procedures for enrolling providers and suppliers in the Medicare program. 42 U.S.C. § 1395cc(j)(1)(A). The Secretary promulgated

[3] Petitioner argues that if I affirm the revocation of Petitioner's billing privileges, I should vacate the three-year re-enrollment bar that CMS imposed on Petitioner so that Petitioner is "free to apply for reenrollment in Medicare immediately." P. Br. at 23. The length of the re-enrollment bar CMS imposes is not a determination subject to review by an administrative law judge. *See Ravindra Patel, M.D.*, DAB CR2171, at 7 n.5 (2010); *Emmanuel Brown M.D. and Simeon K. Obeng, M.D.*, DAB CR2145, at 10 (2010); *see also* 42 C.F.R. § 498.3(b)(17) (establishing as an initial decision subject to review "[w]hether to deny or revoke a . . . supplier's Medicare enrollment . . . ," but not the length of reenrollment bar). Even if I had authority to review the length of the reenrollment bar, I could not reduce it to less than one year. 42 C.F.R. § 424.535(c).

enrollment regulations. *See* 42 C.F.R. § 424.500 *et seq*. 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 of 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). 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. *Id.* § 498.5(*l*)(2). When appropriate, administrative law judges may decide a case arising under 42 C.F.R. pt. 498 by summary judgment. *See* Civil Remedies Division Procedures § 7; *Livingston Care Center v. U.S. Dep't of Health & Human Services*, 388 F.3d 168, 172 (6th Cir. 2004) (citing *Crestview Parke Care Ctr. v. Thomson*, 373 F.3d 743 (6th Cir. 2004). Summary judgment is appropriate and an in-person hearing is not required if the record shows that there is no genuine dispute of any material fact and the moving party is entitled to judgment as a matter of law. *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 3 (2010) (citations omitted). To determine whether there are genuine issues of material fact for an in-person hearing, the administrative law judge must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. *Id.* (citation omitted).

1. *Summary judgment is appropriate.*

There is no genuine dispute of material facts in this case. CMS has presented evidence showing that Petitioner submitted claims for services that could not have been provided to a specific individual on the date of service. Petitioner does not dispute that his billing agent, D.A.R.E. Foot Care, submitted these claims on his behalf, but argues that the claims at issue contained clerical errors and did not support a "pattern of abusive billing." However, the nature of the billing errors is not material to the outcome of the case. The regulation applicable here does not require a "pattern of abusive billing" or expressly exclude clerical errors. 42 C.F.R. § 424.535(a)(8). Any evidence or factual inferences

that may be drawn showing that the claims submitted by Petitioner or his billing agent were clerical errors, accidental, or not a "pattern of abusive billing" do not alter the plain language of the regulation and do not impact the result here. Petitioner has not submitted any evidence that fairly detracts from CMS's evidence. This case turns on a matter of law, and is therefore appropriate for summary judgment.

For purposes of summary judgment, I draw all inferences in favor of Petitioner. Even though not material to the outcome, I accept as true, solely for purposes of summary judgment, that Petitioner did not intend to defraud Medicare and that all but one of the improper claims resulted from the clerical errors of Petitioner's billing agent.

2. *The undisputed facts show that Petitioner billed Medicare for services that could not have been provided to a specific beneficiary on the date of service.*

In support of its motion for summary judgment, CMS presented the results of an investigation that show Petitioner submitted Medicare claims for services that could not have been provided to the beneficiaries identified in the claims because either the beneficiaries were deceased on the dates of the claimed services or the claimed services involved medical care to six or more toes for beneficiaries who only had one foot. CMS Ex. 1, at 44-45. In response, Petitioner does not dispute that his billing agent, D.A.R.E. Foot Care, submitted the claims in question. P. Br. at 7-12. Petitioner concedes that one of the claims at issue was not the result of the billing agent, but Petitioner's "documentation oversight." P. Br. at 1, 10. However, with regard to all claims, Petitioner qualifies them as billing mistakes, accidental, and not rising to the level of abuse required by regulation. P. Br. at 6; P. Ex. A, at 9 ¶ 10.

The evidence shows that Petitioner or Petitioner's billing agent submitted 27 claims for services that Petitioner performed after the beneficiary indentified on the claim had died. CMS Ex. 1, at 44.[4] Petitioner argues that he provided care to beneficiaries with the same or similar names to the deceased beneficiaries identified on the submitted claims. Petitioner provided treatment sheets that support his argument. P. Ex. B. But Petitioner's exhibits also show that the treatment sheets and submitted claims identify two separate individuals. For example, Petitioner provided treatment to a living beneficiary, "C.B.," on September 16, 2011. P. Ex. B, at 1. C.B. was born January 6, 1944. P. Ex. B, at 1. However, the beneficiary identified on the claim sheet, also with the initials "C.B.," was born October 22, 1910. P. Ex. B, at 3. The "C.B." identified in the submitted claim died on April 8, 2011, and therefore could not have received treatment on September 16, 2011.

[4] Petitioner argues that four claims identified in CMS Ex. 1, at 44 were duplicates. P. Br. at 6. Therefore, while that exhibit shows that Petitioner submitted 31 improper claims, I accept as true for purposes of summary judgment that only 27 of those claims identified represent actual claims submitted to Medicare. *See* CMS Ex. 1, at 44.

Petitioner's evidence does not create a dispute about whether he or his agent submitted the claims at issue to Medicare, or about whether those claims identified deceased beneficiaries as receiving treatment. Therefore, Petitioner has not come forward with evidence to refute CMS's evidence that shows he submitted claims for services that could not have been provided to a specific beneficiary because that beneficiary was dead.

The evidence also shows that Petitioner or Petitioner's billing agent submitted eight claims for services that Petitioner performed on 6-10 toes even though the beneficiaries identified on the claims had one leg amputated. CMS Ex. 1, at 45. Petitioner provided treatment sheets for these claim. P. Exs. C, G. For example, Petitioner submitted treatment sheets supporting his argument that he provided treatment to the only foot that beneficiary "W.H." had. P. Ex. C. However, Petitioner's exhibits show that the treatment sheet and claim forms do not match. The claims that Petitioner submitted to Medicare for payment state that he provided care on 6-10 toes even though the treatment sheet has one foot with an "X" marked through it. P. Ex. C, at 1-2. Petitioner's evidence does not refute CMS's evidence establishing that he billed Medicare for services on 6-10 toes, which could not have been provided to the amputated beneficiaries identified in the claims.

3. *CMS has a sufficient basis to revoke Petitioner's Medicare billing privileges pursuant to 42 C.F.R. § 424.535(a)(8).*

CMS has the authority to revoke a supplier's Medicare billing privileges if that supplier "submits a claim or 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). As explained above, the facts in this case show that Petitioner or his billing representative, D.A.R.E. Foot Care, submitted claims for services that could not have been furnished to a specific individual on the date of service. It is undisputed that Petitioner ultimately billed Medicare for services when the patient named in the claim died before the date of service. P. Br. at 7-9. Petitioner also billed Medicare for services performed on 6-10 toes when the patient named in the claims had one leg amputated. P. Br. at 9-12. Therefore, the regulation authorizes CMS to decide whether to revoke Petitioner's Medicare billing privileges.

Petitioner attempts to shift blame for the improper claims onto the company acting as his billing representative. P. Br. at 6-12. However, Petitioner has voluntarily entered into a contractual relationship with D.A.R.E. Foot Care which, according to him, required him to yield to D.A.R.E. Foot Care his right to personally submit claims to CMS. P. Br at 18; P. Ex. A, at 1 ¶ 3. Petitioner asserts that suppliers today need to use third party billing agents and that Petitioner had no reason to question what claims were being submitted under his Medicare billing number. P. Br. at 18. Finally, Petitioner objects to a punitive penalty vicariously imposed on him. P. Br. at 19.

Revocation of billing privileges is remedial and not punitive in nature. If Petitioner's agent is improperly billing Medicare for services, this conduct is just as harmful as if Petitioner is doing so directly. Petitioner's failure to properly supervise the billing for services is not a defense because otherwise CMS would have no means to stop improper billing. In fact, suppliers would be protected when acting through an agent. Petitioner has not alleged that D.A.R.E. Foot Care falsely or fraudulently misused his supplier number to bill for services or that he did not authorize them to bill Medicare on his behalf. Therefore, Petitioner alone is responsible for the accurate billing of his services.

Petitioner also claims that CMS must show "patterns of abusive billing practices" before the regulation authorizes revocation. P. Br. at 17-22. Petitioner argues that accidental billing errors are not a basis for revocation because they are not "abusive." However, the elements that Petitioner cites as necessary for revocation are not regulatory requirements for revocation. The regulatory text does not mention, let alone require, a finding of "abusive billing practices" or a "pattern" of such practices. 42 C.F.R. § 424.535(a)(8). Further, the regulation does not expressly exclude accidental billing errors as a basis for revocation. *Id.*

Petitioner premises much of his legal theory on the preamble to the final rule establishing 42 C.F.R. § 424.535(a)(8). It states in relevant part:

> 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 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 . . . .

73 Fed. Reg. 36,448, 36,455 (June 27, 2008).

The statements in the preamble, however, are an articulation of enforcement policy rather than a rule establishing essential elements that must be proven to uphold a revocation under section 424.535(a)(8). The quotation above responded to concerns expressed by the public that there was "not enough guidance given to the contractors . . . which could cause overburdened contractors to implement this policy too widely." *Id.* CMS's decision to revoke billing privileges is, after all, discretionary. *See* 42 C.F.R. § 424.535(a) ("CMS *may* revoke a currently enrolled provider or supplier's Medicare

billing privileges . . . for the following reasons") (emphasis added). The context of the statement, therefore, shows that it is guidance to CMS contractors rather than a rule that is enforceable against CMS. *See CMS LCD Complaint; L29288*, DAB No. 2499, at 4 (2013) (stressing the importance of determining the context of a response to public comments in the preamble to a final rule).

This interpretation is supported by the fact that the text quoted from the preamble directly contradicts the plain language of the regulation. The regulation authorizes CMS to revoke a supplier's billing privileges after that supplier submits "*a claim* or claims" for services that could not have been provided. 42 C.F.R. § 424.535(a)(8) (emphasis added). One claim may trigger CMS's authority to revoke billing privileges. However, the preamble contradictorily states that CMS "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." 73 Fed. Reg. at 36,455.

If the language in a preamble conflicts with the plain language of the regulation, the regulatory language must prevail. *Cf. Ass'n of Am. R.R.s v. Costle*, 562 F.2d 1310, 1316 (D.C. Cir. 1977) ("Where the enacting or operative parts of a statute are unambiguous, the meaning of the statute cannot be controlled by language in the preamble."). Had a change to the basis for revocation under section 424.535(a)(8) been intended in the final rule, the regulatory text could have been modified to require a finding of three or more instances of abusive billing practices. *See CMS LCD Complaint: L29288*, DAB No. 2499, at 5 ("Had the intent been to exclude specialist physicians from certifying medical necessity, different wording could have easily accomplished that result."). No such change was made. Further, a duly promulgated regulation has the force and effect of federal law. *See Chrysler Corp. v. Brown*, 441 U.S. 281, 295-96 (1979). I am bound to apply the regulatory text even if it is more broadly worded than the statements in the preamble to the final rule. *Cf. CMS LCD Complaint; L29288*, DAB No. 2499, at 5. Therefore, a "pattern of abusive billing" need not be established for an administrative law judge to uphold the revocation of Medicare billing privileges.

Apart from the preamble to the final rule, Petitioner also relies on the title of section 424.535(a)(8), "Abuse of billing privileges," for his position that CMS must show Petitioner intended to submit improper claims. P. Br. at 17. However, the title to a section or subsection is not controlling, does not add elements to the operative language, and may only be used as an interpretative aid. *See Bhd. of R.R. Trainmen v. Balt. & Oh. R. Co.*, 331 U.S. 519, 528-29 (1947); *Ellen L. Morand*, DAB No. 2436, at 8 (2012) ("General principles of statutory construction provide that the title of a statutory provision should not be read in a manner that limits the plain meaning of the statutory text.") (citations omitted). Section 424.525(a)(8) does not mention the word "abuse." Accordingly, neither "abuse" nor "abusive billing practices" are required before CMS is authorized to revoke Petitioner's billing privileges pursuant to 42 C.F.R. § 424.535(a)(8).

Finally, Petitioner argues that the plain language of the regulation, "a specific individual," does not authorize revocation under the circumstances here. Petitioner asserts, and CMS does not dispute, that Petitioner provided services to some Medicare beneficiaries on the dates that he billed Medicare, albeit not to the beneficiaries named in the claims or the exact services stated in the claims. Petitioner states that:

> [i]f the regulation was intended to reach instances where the service was provided to a beneficiary but was mistakenly billed under the name of another, deceased beneficiary, it would not read "a specific beneficiary" [*sic*] but would read "*the* specific beneficiary[,]" expressly linking the identity of the person to whom the service was provided to the identity of the person for whom the claim was submitted.

P. Br. at 18 (emphasis in original). Petitioner's argument is unpersuasive.

Use of the article "a" does not warrant the broad reading Petitioner seeks; a claim containing a misidentified beneficiary is an acceptable practice so long as the underlying service was performed to some other beneficiary. Petitioner's argument overlooks that the regulation authorizing revocation requires that the improper claim be for services that Petitioner could not have provided to "a *specific* individual," not just "an individual." 42 C.F.R. § 424.535(a)(8) (emphasis added). Contrary to Petitioner's argument, the regulation requires specificity with reference to whom the services were allegedly provided, not a generic identification of any individual. The specific individual identified in a claim must be the specific individual who received the services claimed, otherwise the claim is for services that could not have been provided to "a specific individual," and revocation is permissible. *Id.* Petitioner admits that the specific individuals identified in the claims at issue were not the specific individuals receiving the services claimed. P. Br. at 7-9.[5]

[5] Even if Petitioner is correct in his interpretation of section 424.535(a)(8), this interpretation does not absolve him from having filed eight claims for debridements of six to ten toes for individuals who only had one foot. This is because the individuals on whom he claimed to have performed services were not in question, only whether the services claimed could have been performed. Petitioner admits that the individuals in each of these claims only had one foot. P. Br. at 9-12.

CMS need only show that Petitioner submitted a claim[6] or claims for services that could not have been provided to a specific individual on the date of service. CMS has made such a showing in this case.

4. *The effective date of the revocation of Petitioner's billing privileges is September 2, 2012.*

CMS notified Petitioner by notices, all dated August 3, 2012, that it was revoking his billing privileges effective August 2, 2012. CMS Ex. 2, at 4-13. Petitioner argued that CMS failed to properly set the effective date 30 days following notice. P. Br. at 28.

The revocation of Medicare billing privileges is effective 30 days after CMS or its contractor issues the notice of revocation, unless certain exceptions apply. 42 C.F.R. § 424.535(g). As Petitioner argues, none of the exceptions listed in section 424.535(g) apply to this case. Therefore, the effective date of Petitioner's revocation is September 2, 2012.

5. *Petitioner is not entitled to summary judgment based on his due process arguments.*

Petitioner argues that WPS and CMS violated his due process rights because the revocation notices did not comply with the regulatory requirement that the notice provide Petitioner with enough information to make an adequate response. P. Br. at 25-28. Petitioner claims the revocation is based on a "shocking disregard for the truth and essential principles of justice." P. Br. at 1-2.

The lack of specific factual allegations in the revocation notices (CMS Ex. 2, at 4-13) and CMS's unexplained reluctance to immediately provide Petitioner with specific information when requested is far from "good government." CMS Exs. 2, at 14; 3, at 64. However, CMS's actions or omissions do not justify granting Petitioner judgment. This is because Petitioner received timely notice of the action, received specific information about the revocation before CMS rendered the reconsidered determination, and has since had ample opportunity to defend himself at this level of appeal. For example, my Order in this case obliged CMS to submit its brief and all its exhibits first and allowed Petitioner to respond to these arguments and evidence. *See* Order ¶ 4. CMS submitted all of the documents from its investigation that it relied on to revoke Petitioner's billing

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[6] Petitioner admits fault for billing for the debridement of six or more toes to patient S.V. because Petitioner failed to include a notation in his records that S.V. is a partial amputee. P. Br. at 10. Despite Petitioner's characterization of his actions as a mistake, this admitted filing of a single claim for services that could not have been performed on S.V. is enough to compel me to affirm CMSs discretionary determination to revoke Petitioner's billing privileges under 42 C.F.R. § 424.535(a)(8).

privileges as well as a copy of documents Petitioner provided to CMS during the reconsideration stage. CMS Exs. 1, 3. Petitioner also filed nearly 70 pages of substantive exhibits and the written testimony of several witnesses. P. Exs. A-G. This evidence has been considered and entered into the record in this proceeding.

Due process is afforded when, such as here, Petitioner was given adequate notice and a reasonable opportunity to respond at the hearing level. *See Green Hills Enters., LLC*, DAB No. 2199, at 9 (2008). Further, Petitioner has not shown actual prejudice in his ability to defend his case before me; therefore, I cannot find a due process violation. *Id*. at 8. Accordingly, Petitioner has not shown that he is entitled to judgment in his favor.

III. Conclusion

For the reasons explained above, I grant summary judgment in favor of CMS. There is no genuine dispute of material facts and CMS is entitled to judgment affirming its revocation of Petitioner's Medicare billing privileges. However, I direct CMS to modify the effective date of the revocation of Petitioner's billing privileges to September 2, 2012.

/s/
Scott Anderson
Administrative Law Judge