Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Dumitru O. Sandulescu, M.D. and Dumitru Medical Center P.C.
(PTANs: 54760001; 0P54760),
(NPIs: 1104981695; 1770768879),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-537

Decision No. CR3891

Date: May 22, 2015

DECISION

The Centers for Medicare & Medicaid Services (CMS), through its administrative contractor, Wisconsin Physicians Service (WPS), revoked the Medicare billing privileges of Dr. Dumitru O. Sandulescu (Petitioner) and, separately, Dumitru Medical Center P.C. (Medical Center) based on a determination that Petitioner failed to comply with Medicare enrollment requirements and misused his Medicare billing number, and the Medical Center abused its Medicare billing privileges. Petitioner and the Medical Center jointly filed a request for hearing (RFH) to dispute the revocation. For the reasons stated below, I dismiss the RFH as it pertains to the Medical Center for lack of jurisdiction and affirm CMS's determination to revoke Petitioner's Medicare billing privileges.

I. Background

CMS first revoked Petitioner's Medicare billing privileges in an initial determination letter dated May 20, 2014. CMS Exhibit (Ex.) 1. Also on May 20, 2014, CMS revoked the Medical Center's Medicare billing privileges. RFH Ex. 1(B). On June 5, 2014, Petitioner and the Medical Center jointly requested reconsideration of the revocation and

submitted a corrective action plan (CAP). CMS Ex. 2; *see also* CMS Ex. 3. CMS revised the initial determination revoking Petitioner on June 27, 2014. CMS Ex. 4. Petitioner and the Medical Center again jointly requested reconsideration and submitted a CAP after the June 27, 2014 revision. CMS Ex. 5. On July 17, 2014, CMS revised the initial determination revoking Petitioner for the second time. CMS Ex. 6. On August 8, 2014, CMS revised the initial determination revoking Petitioner for the last time and this version of the initial determination superseded all prior versions. CMS Ex. 7.

In the August 8 initial determination, CMS revoked Petitioner's Medicare billing privileges and imposed a three year re-enrollment bar. The determination specified the Provider Transaction Access Number (PTAN) involved as P54760001 and the National Provider Identifier involved as 1104981695, numbers assigned to Dr. Sandulescu. RFH at 1. CMS revoked Petitioner's billing privileges because Petitioner failed to comply with Medicare requirements (42 C.F.R. § 424.535(a)(1)) and misused his Medicare billing number (42 C.F.R. § 424.535(a)(7)). The August 8 initial determination provided the following facts regarding Petitioner's alleged violation of 42 C.F.R. § 424.535(a)(1):

> With his signature on Medicare enrollment application 855, Dr. Dumitru Sandulescu, agreed to abide by Medicare laws, regulations, and program instructions. However, based on claims data with dates of service from January 1, 2013 through December 31, 2013, Dr. Dumitru Sandulescu did not abide by Medicare laws, regulations and program instructions when submitting claims when using the Q6 modifier, indicating that services were rendered by a locum tenens physician. Dr. Dumitru Sandulescu is in violation of the Section 125(b) of the Social Security Act Amendments of 1994, the regulatory definition of locum tenens physician at 42 CFR §411.351, and Chapter 1, Section 30.2.11 of the CMS Medicare Claims Processing Manual, Publication 100-04 that all relate to physician payment under locum tenens arrangements. These locum tenens laws, regulations, and program instructions require the regular physician be unavailable to provide the visit services. CMS has identified 237 dates of service in 2013 where Dr. Sandulescu billed for a service and on the same date services were billed under his provider number using the Q6 modifier indicating that locum tenens physician rendered services.

CMS Ex. 7 at 1.

Petitioner requested reconsideration and included the reconsideration requests and CAPs that he previously submitted. CMS Ex. 8; *see also* CMS Exs. 2, 5. In those documents,

Petitioner admitted that he submitted claims through the Medical Center, where he served as President, for the services of newly-hired physicians who did not yet have Medicare credentials using the Q6 (locum tenens) modifier. CMS Ex. 2 at 1; CMS Ex. 5 at 1-2.

A WPS hearing officer issued a reconsidered determination on October 13, 2014. The hearing officer upheld Petitioner's revocation pursuant to 42 C.F.R. § 424.535(a)(1) and (a)(7). CMS Ex. 10. The hearing officer determined that Petitioner admitted in his request for reconsideration that "the Medicare billing number for Dumitru O. Sandulescu, MD was misused and the Q6 modifier was used incorrectly . . . Dumitru O. Sandulescu, MD did submit these claims and the contractor correctly revoked the Medicare billing number." CMS Ex. 10 at 1. Therefore, the hearing officer found that "Dumitru O. Sandulescu, MD has not provided evidence to show [he has] fully compli[ed] with the standards for which [he was] revoked." CMS Ex. 10 at 1.

Petitioner and the Medical Center jointly requested a hearing to dispute the reconsidered determination. In response to my Acknowledgment and Pre-hearing Order (Order), CMS filed a motion for summary judgment and motion to dismiss the RFH with regard to the Medical Center, a brief (CMS Br.), and 14 exhibits (CMS Exs. 1-14) as its pre-hearing exchange. Petitioner and the Medical Center jointly filed a brief in opposition to the motion for summary judgment and motion to dismiss (P. Br.). Petitioner and the Medical Center also proposed to call 12 witnesses, but did not file written direct testimony for any of the witnesses.

II. Decision on the Record

In their prehearing exchange, Petitioner and the Medical Center did not object to any of CMS's proposed exhibits. Therefore, I admit CMS Exs. 1-14 into the record. *See* Order ¶ 7. Petitioner and the Medical Center did not submit any proposed exhibits.

My Order advised the parties that they must submit written direct testimony for each proposed witness and that an in-person hearing would only be necessary if the opposing party requested an opportunity to cross-examine a witness. Order ¶¶ 8-10. Because Petitioner and the Medical Center submitted a witness list and not written direct testimony for the proposed witnesses, on February 25, 2015, at my direction, the attorney-advisor assisting me with this case contacted counsel for the parties and advised them that Petitioner and the Medical Center failed to comply with the requirement to submit written direct testimony for their proposed witnesses. The attorney-advisor gave Petitioner and the Medical Center until March 4, 2015, to submit testimony for their proposed witnesses. *See Feb. 25 2015 email re omissions from Pet.'s prehearing exchange*. No response to this correspondence was received.

Because the parties did not submit written direct testimony, I will not hold an in-person hearing in this matter and I decide this matter based on the written record. Order ¶ 11.

III. Issues

1. Whether the Medical Center has a right to a hearing.

2. Whether CMS had a legitimate basis to revoke Petitioner's Medicare billing privileges.

IV. Jurisdiction

I have jurisdiction to hear and decide Petitioner's appeal of CMS's reconsidered determination (CMS Ex. 10) to revoke his Medicare billing privileges. 42 C.F.R. §§ 498.3(b)(17), 498.5(l)(2); *see also* 42 U.S.C. § 1395cc(j)(8). However, I do not have jurisdiction to hear and decide the Medical Center's appeal because CMS has not issued a reconsidered determination upholding the revocation of the Medical Center's Medicare billing privileges.

As mentioned above, CMS filed a motion to dismiss the hearing request as it pertains to the Medical Center. CMS argues in that motion that although Petitioner and the Medical Center requested reconsideration of CMS's separate initial determinations revoking the billing privileges of Petitioner and the Medical Center, CMS has only issued a reconsidered determination with respect to Petitioner. CMS Br. at 2 n.1, 22. Therefore, CMS argues, because there is no reconsidered determination for the Medical Center, I lack the jurisdiction to consider an appeal of the Medical Center's revocation. CMS Br. at 21-22.

Petitioner's prehearing brief did not address CMS's argument or present an opposition to CMS's motion. However, the joint RFH indicates that CMS has abandoned its revocation of the Medical Center, an assertion consistent with CMS's position that WPS has not yet issued a reconsidered determination for the Medical Center. RFH at 3. Further, the RFH only included a copy of the reconsidered determination for Petitioner and not one for the Medical Center. *See* RFH Ex. 8.

My jurisdiction is limited to those matters delegated to me by the Secretary of Health and Human Services (Secretary). Appeals from CMS's determination to revoke billing privileges are adjudicated under the provisions in 42 C.F.R. Part 498. 42 C.F.R. §§ 405.803(a); 424.545(a). As a general matter, only CMS decisions that are considered initial determinations are subject to further review. 42 C.F.R. § 498.3(a)(1). Decisions to revoke billing privileges are initial determinations. 42 C.F.R. § 498.3(b)(17). However, before a provider or supplier may seek administrative law judge (ALJ) review of a revocation, he must first request that CMS reconsider the initial determination to revoke billing privileges. 42 C.F.R. §§ 405.803(b), 498.5(*l*)(1), 498.20(b)(1). A provider or supplier dissatisfied with the reconsidered determination has a right to a hearing before an ALJ. 42 C.F.R. §§ 498.5(*l*)(2), 498.40(a)(2). Therefore, in provider and supplier

revocation cases, I only have jurisdiction to review CMS's actions following the issuance of a reconsidered determination. *See Ramaswamy v. Burwell*, 2015 Medicare & Medicaid Guide (CCH) ¶ 305,177, 2015 WL 75359, at *7-8 (E.D. Mo. Jan. 6, 2015).

I may dismiss the hearing request of a party that does not have a right to a hearing. 42 C.F.R. § 498.70(b). Because CMS has not issued a reconsidered determination related to its revocation of the Medical Center's billing privileges, the Medical Center does not have a right to a hearing. Accordingly, I dismiss, without prejudice, the hearing request as it relates to the Medical Center. When CMS issues a reconsidered determination in response to the Medical Center's reconsideration request, as it is obligated to do (42 C.F.R. § 498.24(c)), the Medical Center will have the right to request a hearing before an ALJ if the Medical Center is not satisfied with the reconsidered determination. 42 C.F.R. § 498.25(a)(3).

V. Findings of Fact, Conclusions of Law, and Analysis[1]

The Social Security Act (Act) authorizes the Secretary to promulgate regulations governing the enrollment process for providers and suppliers. 42 U.S.C. §§ 1302, 1395cc(j). Under the regulations, a provider or supplier that seeks billing privileges under the Medicare program must "submit enrollment information on the applicable enrollment application. Once the provider or supplier successfully completes the enrollment process . . . CMS enrolls the provider or supplier into the Medicare program." 42 C.F.R. § 424.510(a). CMS may revoke a provider or supplier's Medicare billing privileges for a variety of reasons, including if "[t]he provider or supplier is determined not to be in compliance with the enrollment requirements described in [section 424.535], or in the enrollment application applicable for its provider or supplier type . . . ." 42 C.F.R. § 424.535(a)(1).

Physicians are suppliers for Medicare purposes. 42 C.F.R. § 400.202 (definition of "*Supplier*"). Under the Act, the Medicare program may only pay either the beneficiary or treating physician for any services provided to a beneficiary; however, there is an exception to this requirement called the "locum tenens" exception:

> No payment under this part for a service provided to any individual shall . . . be made to anyone other than such individual or . . . the physician or other person who provided the service, except . . . (D) payment may be made to a physician for physicians' services (and services furnished incident to such services) furnished

[1] My numbered findings of fact and conclusions of law are set forth in italics and bold font.

> by a second physician to patients of the first physician if (i) the first physician is unavailable to provide the services; (ii) the services are furnished pursuant to an arrangement between the two physicians that (I) is informal and reciprocal, or (II) involves per diem or other fee-for-time compensation for such services; (iii) the services are not provided by the second physician over a continuous period of more than 60 days or are provided over a longer continuous period during all of which the first physician has been called or ordered to active duty as a member of a reserve component of the Armed Forces; and (iv) the claim form submitted to the carrier for such services includes the second physician's unique identifier (provided under the system established under subsection (r)) and indicates that the claim meets the requirements of this subparagraph for payment to the first physician.

42 U.S.C. § 1395u(b)(6)(D).

1. ***Petitioner submitted claims for Medicare reimbursement in which he billed, under his own billing number, for the services other physicians and non-physicians provided by using the Q6 billing modifier to indicate that these individuals had provided the services in locum tenens to Petitioner when, in actuality, the individuals were either newly-hired physicians who did not yet have Medicare billing privileges or ineligible non-physicians.***

Petitioner concedes the fundamental issue in this case: Petitioner, individually and as President of the Medical Center, submitted Medicare claims for services that newly-hired physician employees of the Medical Center and non-physicians provided using his billing number and the Q6 modifier. CMS Ex. 2 at 1, 6-9. Specifically, Petitioner submitted claims for services he performed on the same day that an alleged locum tenens physician also performed services, which he billed under his provider number using the Q6 modifier. CMS Ex. 2 at 5 ("This data is sorted by claim line from date and includes all dates of service where Dr. Dumitru Sandulescu submitted a claim with and without a Q6 modifier."). CMS identified 237 dates on which Petitioner billed for a service the same day as a service was billed under his billing number using the Q6 modifier. CMS Ex. 7 at 1, 4-5. Petitioner did not dispute the claims CMS identified. Instead, when seeking reconsideration of the revocation, Petitioner identified at least 32 claims that he submitted using his billing number and the Q6 modifier for services that physician assistants and nurse practitioners provided. CMS Ex. 2 at 6-9.

Petitioner concedes that the Medical Center "had hired new physician employees and began the credentialing process after the date of hire for each. Instead of holding the

billings until these physicians were credentialed as physicians of [the Medical Center, the Medical Center] billed the services of these physicians as locum tenens physicians." CMS Ex. 2 at 1. In requesting reconsideration of the first initial determination CMS issued, Petitioner explained that both his billing company and the Medical Center's administrative staff:

> made inquiry of the [Medicare Administrative Contractor] personnel to determine if and how physicians with pending credentials could be billed. The [Medicare Administrative Contractor] personnel advised that the services could be billed using the Q6 modifier. It is significant that [the Medical Center] did not attempt to conceal the nature of the billings as Dr. Sandulescu was identified on the claims together with the new physician. This was the result of an error in communication and poor judgment on the part of the [Medical Center] employees and agents responsible for billing matters.

CMS Ex. 2 at 1. Petitioner offers no explanation for why he submitted claims using the Q6 modifier for the services that physician assistants and nurse practitioners provided.

Therefore, I find that Petitioner submitted at least 237 Medicare claims in which he billed for services under the Q6 (locum tenens) modifier that newly-hired physicians provided.[2] I further find that Petitioner submitted at least 32 claims for services using the Q6 modifier that nurse practitioners and physician assistants provided.

2. ***CMS had a legitimate basis to revoke Petitioner's Medicare billing privileges because Petitioner's claims for reimbursement failed to comply with the requirements stated in the Social Security Act and the Medicare claims manual where Petitioner billed under his own Medicare billing number using the Q6 modifier to indicate that other physicians provided services in locum tenens to Petitioner when, in actuality, they were newly-hired physicians awaiting Medicare billing privileges and non-physician employees.***

CMS may revoke a provider or supplier who has failed to comply with enrollment requirements in section 424.535 of the regulations or in the supplier's enrollment

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[2] Because CMS identified only dates on which Petitioner both billed for a service and billed for a service using his billing number and the Q6 modifier, I assume that Petitioner and the newly-hired physician allegedly acting in locum tenens each billed for no more than one service per day on those dates. In actuality, both Petitioner and the alleged locum tenens physician could have billed for numerous services on each of the 237 dates CMS identified.

application. 42 C.F.R. § 424.535(a)(1). On the Medicare enrollment application that physicians must sign, Petitioner had to certify that he "meets, and continues to meet, and CMS verifies that it meets, and continues to meet, all of the following requirements: (1) Compliance with title XVIII of the Act and applicable Medicare regulations." 42 C.F.R. § 424.516(a)(1). Specifically, as part of the additional enrollment requirements in the certification statement section on the enrollment form, Petitioner had to certify that he:

> [A]gree[s] to abide by the Medicare laws, regulations and program instructions that apply to [physicians]. The Medicare laws, regulations, and program instructions are available through the fee-for-service contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the supplier's compliance with all applicable conditions of participation in Medicare.

Form CMS-855I at 25 *available at* http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855i.pdf.

The present matter involves the submission of Medicare claims billed under Petitioner's Medicare billing number for services provided by other physicians newly-employed by Petitioner's practice, nurse practitioners, and physician assistants. By using the Q6 modifier in the claims, Petitioner indicated that he could bill for the services provided by other physicians and medical professionals because those physicians were acting in locum tenens for Petitioner. However, the Q6 modifier is used to identify services that a locum tenens physician has provided in place of the billing physician. A locum tenens physician is "a physician who substitutes (that is, 'stands in the shoes') in exigent circumstances for a physician" in accordance with applicable rules. 42 C.F.R. § 411.351 (definition of *Locum tenens physician*). The Act sets forth the locum tenens exception to the general rule that Medicare may only pay the beneficiary who receives a medical service or the physician who performs the service. *See* 42 U.S.C. § 1395u(b)(6)(D). The Medicare Claims Processing Manual (MCPM), CMS Pub. 100-04, ch. 1, § 30.2.11, further clarifies the use of the locum tenens exception. Both state that the physician must be a substitute physician who is providing services because the treating physician is unavailable. The MCPM states that locum tenens is used "to retain substitute physicians to take over [a physician's] professional practices when the regular physicians are absent for reasons such as illness, pregnancy, vacation, or continuing medical education . . . ." MCPM, CMS Pub. 100-04, ch. 1, § 30.2.11(A.). WPS also provides clarifying guidance stating that a newly-hired physician who is in the process of enrolling in Medicare cannot be billed as a locum tenens physician. CMS Ex. 13 at 2. Finally, WPS provided notice

that the locum tenens modifier cannot be used at all to bill for services provided by nurse practitioners and physician assistants. CMS Ex. 14.

Petitioner does not dispute that he incorrectly billed for the services newly-hired physicians provided using the Q6 modifier, but he asserts that the billing company Petitioner hired and his administrative staff are to blame for the mistake in billing. CMS Ex. 2 at 1. Petitioner's explanation does not address why he used the Q6 modifier to bill for services that nurse practitioners and physician assistants provided. Petitioner states that the incorrect billing practices were "the result of [his] staff's misunderstanding of the Medicare rules." P. Br. at 2. However, even an unintentional error with regard to claims may serve as a basis for revocation if the relevant regulation does not require fraudulent or dishonest intent. *See Louis J. Gaefke*, *D.P.M.*, DAB No. 2554 at 7 (2013).

Further, Petitioner argues that CMS's administrative contractor told both the billing company and his staff that Petitioner could bill for the newly-hired physicians' services under his billing number using the Q6 modifier. CMS Ex. 2 at 1. Petitioner does not offer any evidence as to who his staff and billing company spoke with, on what dates, and at what times. Nevertheless, Petitioner's assertions amount to an argument that CMS should be equitably estopped from revoking his billing privileges based on the misinformation WPS allegedly provided his staff and billing company. However, even if I accept that WPS representatives misinformed Petitioner's staff and billing company regarding the use of the Q6 modifier, Petitioner does not allege that either WPS or its representatives engaged in affirmative misconduct. It is well-settled that:

> [T]he government cannot be estopped absent, at a minimum, a showing that the traditional requirements for estoppel are present (i.e., a factual misrepresentation by the government, reasonable reliance on the misrepresentation by the party seeking estoppel, and harm or detriment to that party as a result of the reliance) and that the government's employees or agents engaged in 'affirmative misconduct.'

Citadel Cmty. Dev. Corp., DAB No. 2596, at 7 (2014) (quoting *Oaks of Mid City Nursing & Rehab. Ctr.*, DAB No. 2375, at 31 (2011)); *Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414 (1990). Because Petitioner has not alleged that WPS engaged in affirmative misconduct, any misinformation that WPS or its representatives may have provided to Petitioner's staff or billing company cannot prevent CMS from exercising its authority to revoke his Medicare billing privileges.

Finally, Petitioner argues that because he submitted a CAP, CMS lacked the authority to revoke his billing privileges pursuant to 42 C.F.R. § 424.535(a)(1). P. Br. at 2. This argument is based on the text of section 424.535(a)(1) that makes it appear that revocation can only occur if a supplier fails to comply with enrollment requirements <u>and</u>

fails to submit a plan of correction. Petitioner's interpretation of this text means that a provider or supplier may avoid revocation under section 424.535(a)(1) by merely submitting a timely plan of correction. Such an interpretation fails to take into account the following additional text from section 424.535(a)(1): "All providers and suppliers are granted an opportunity to correct the deficient compliance requirement **before a final determination to revoke billing privileges** . . . ." 42 C.F.R. 424.535(a)(1) (emphasis added). Consistent with this is the following regulatory provision:

> If a provider or supplier completes a corrective action plan and provides sufficient evidence to the CMS contractor that it has complied fully with the Medicare requirements, the CMS contractor **may** reinstate the provider's or supplier's billing privileges . . . A CMS contractor's **refusal to reinstate** a supplier's billing privileges based on a corrective action plan is not an initial determination under Part 498 of this chapter.

42 C.F.R. § 405.809 (emphasis added). This regulation not only states that CMS has authority to accept or refuse to accept a supplier's CAP, but also that such a decision is not subject to further review. *See* 42 C.F.R. § 498.3(a)(1), (d) (indicating that only initial determinations are subject to additional review and that decisions that are not initial determinations are not subject to additional review).

In the present case, Petitioner was given the opportunity to submit a CAP, Petitioner submitted the CAP, and CMS declined to accept the CAP. CMS Ex. 1 at 2; CMS Ex. 2; CMS Ex. 7 at 2; CMS Ex. 8; RFH Exs. 3, 9. I have no authority to review that decision.

Therefore, based on the record in this case, I conclude that CMS had a legitimate basis to revoke Petitioner's Medicare billing privileges because Petitioner failed to comply with Medicare enrollment requirements.[3] 42 C.F.R. § 424.535(a)(1).

VI. Conclusion

For the reasons stated above, I affirm CMS's determination to revoke Petitioner's Medicare billing privileges.

/s/
Scott Anderson
Administrative Law Judge

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[3] Because I uphold CMS's revocation based on 42 C.F.R. § 424.535(a)(1), I need not consider the other basis for revocation that CMS relied on in its reconsidered determination.