Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

John DeCerce, M.D.,
(PTANs: 27276X, 27276Z),

Petitioner,

v.

Centers for Medicare & Medicaid Services

Docket No. C-16-236

Decision No. CR4568

Date: April 4, 2016

DECISION

I grant summary judgment in favor of the Centers for Medicare & Medicaid Services (CMS) sustaining the determination of its contractor to revoke the Medicare enrollment and billing privileges of Petitioner, John DeCerce, M.D., for a period of three years. The undisputed material facts establish that Petitioner submitted, or allowed to be submitted on his behalf, multiple claims for Medicare reimbursement for beneficiaries who were deceased on the dates for which services allegedly were performed. 42 C.F.R. § 424.535(a)(8).

I. Background

On August 24, 2015, a Medicare contractor notified Petitioner that his Medicare enrollment and billing privileges were being revoked for a three-year period. Petitioner requested reconsideration and, on November 23, 2015, CMS upheld the revocation determination. Petitioner then requested a hearing.[1]

[1] Petitioner contends that there were other actions by CMS or its contractor besides those that I have described which prejudiced him and interfered with his ability to practice. Petitioner describes these other actions as "due process violations." Petitioner's Pre-hearing brief at 2-3, 12-13. I do not address these arguments or the alleged actions by CMS or its contractor because I have no authority to address them. None of them appear

CMS moved for summary judgment. It filed 13 exhibits, identified as CMS Ex. 1-CMS Ex. 13, in support of its motion. Petitioner opposed the motion and also cross-moved for summary judgment. He filed five exhibits, identified as P. Ex. 1-P. Ex. 5, in support of his cross-motion and opposition to CMS's motion. I receive all of these exhibits into the record for purposes of deciding the parties' motions.

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 participation in Medicare and his Medicare billing privileges pursuant to the authority of 42 C.F.R. § 424.535(a)(8).

B. Findings of Fact and Conclusions of Law

CMS may revoke a provider or a supplier's Medicare enrollment and billing privileges where:

> 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 . . . .

42 C.F.R. § 424.535(a)(8).

The meaning of this regulation is plain and not susceptible to interpretation. CMS has the authority to revoke the Medicare participation and billing privileges of a provider or supplier who submits or causes to be submitted *any* claim for a service ostensibly provided to a beneficiary on a date when the beneficiary is deceased. The regulation does not distinguish between fraud and simple error; intent is not an element of the regulation's criteria for revocation. *Howard B. Reife*, DAB No. 2527 at 5 (2013), *Louis J. Gaefke*, DAB No. 2554 at 7-8 (2013).

Although the regulation could be applied strictly to authorize revocation for any claim filed for services allegedly rendered at the time that a beneficiary is deceased, the Secretary granted CMS discretion to exercise a small amount of leeway in order to forgive a possible random claims filing error. The preamble to the regulation suggests that revocation would be in order where the evidence "demonstrates multiple instances, at least three, where abusive billing practices have taken place." 73 Fed. Reg. 36,448,

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to rise to the level of a determination that gives hearing rights to Petitioner and Petitioner has cited to no authority that would empower me to address Petitioner's arguments.

36,455 (June 27, 2008). That language suggests that CMS *may* cut some slack to a provider or supplier where it determines that one or two claims are simple error. Nothing in the preamble, however, states that CMS *must* do so. The preamble doesn't undercut the plain language of the regulation. CMS always has the authority to revoke even if there is only one instance in which a provider or a supplier submits a claim for a service allegedly rendered to a beneficiary on a date when that beneficiary is deceased. It may do so without regard for the underlying reason for the false claim. Fraud is not a criterion of the regulatory authority to revoke.

The undisputed material facts establish that CMS has more than ample grounds to revoke Petitioner's participation and billing privileges. Petitioner submitted claims, or claims were submitted on Petitioner's behalf, for 35 services allegedly rendered to eight individual beneficiaries who were, in fact, deceased on the alleged service dates. CMS Ex. 4 at 1-3, 6-18, 21-24, 27-29, 32-33, 36-43, 46, 49, 52-53; CMS Ex. 12 at ¶¶ 6, 11, 14-15. As I discuss above, submitting or causing to be submitted any of these claims would be a sufficient basis for revocation. In this case, however, there were multiple instances of such claims submitted over a period of about two years and eight months, from July 2011 through April 2014. CMS Ex. 4 at 1-3. That is far more than is necessary to justify revocation, even if CMS exercises the discretionary leeway granted by the preamble to the regulation. There certainly are "three or more instances" present here of claims of services allegedly rendered to persons who were deceased on the service dates.

Petitioner does not assert that any of the claims were for services that were provided to beneficiaries who were alive on the alleged service dates. Rather, he makes a series of arguments that seek to hold him harmless despite the fact that he submitted or caused to be submitted claims for services allegedly provided to individuals who were, in fact, deceased. I find these arguments to be without merit.

First, Petitioner argues that there is a culpability standard in the regulation. He contends that the regulation is not aimed at mere mistakes but that it allows for revocation only where there is something more than that, consisting of "abusive claims." Petitioner never defines what he thinks is an "abusive claim" but it is apparent from his argument that he believes that it comprises more than simple negligence or human error.

Petitioner hinges his argument on the fact that the term "abusive claim" is used in the preamble to 42 C.F.R. § 424.535(a)(8) as a general descriptor of the types of claims for which revocation is justified. I disagree with Petitioner's assertion that CMS must look for something more than mistake in justifying revocation. The preamble doesn't define the term "abusive claim." More importantly, there is absolutely nothing in the preamble to suggest that something more than error is a *necessary* prerequisite for revocation. As I have stated, the preamble grants discretion to CMS not to revoke if CMS determines that a provider has committed only one or two mistakes in submitting claims. It does not mandate CMS to make culpability findings nor does it even require an extensive pattern

of false claims. Applying the preamble's language, at the least, CMS may revoke where there are more than two claims that are simply erroneous. Furthermore, CMS may rely on the plain regulatory language to justify its actions. And, that language allows for revocation if there is even a single claim for a service allegedly rendered to a beneficiary who is deceased on the alleged service date, without regard to the provider's intent.

Petitioner contends that certain of the claims were either the product of simple human error by Petitioner's staff or, perhaps, some strange byproduct of the operations of a computerized billing system. I find these arguments to be irrelevant. The regulation makes Petitioner as responsible for staff error or even computer error as he would be for his personal decisions. His motive for filing a claim is irrelevant here. CMS has to prove neither negligence nor fraud.[2]

Petitioner argues also that, with respect to four of the eight deceased beneficiaries, claims were submitted by a third party – a medical practice with which Petitioner was associated known as the "Sleep Medicine Center" – without Petitioner's authorization or even knowledge. He contends that he should be held harmless for any of these claims, even though they were false, inasmuch as he did not personally authorize that the individual claims be submitted. Petitioner acknowledges that he executed an assignment of benefits form 855R in which he reassigned his Medicare billing privileges to the third party. CMS Ex. 5 at 11-16. In Petitioner's eyes, reassigning benefits does not make him liable for actions by the third party. Thus, he contends, he did not authorize that entity to file any of the claims that were false.[3]

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[2] Petitioner seems to argue at times that he actually provided the services to the deceased beneficiaries. For example, he states: "It is not disputed that all services provided for . . . [a beneficiary] were covered services that were appropriately provided by . . . [Petitioner] to a live beneficiary." Petitioner's Pre-hearing brief at 6. However, he provides no citation for this assertion nor does he explain it. It is unclear to me whether Petitioner contends that he actually provided services to the beneficiary, but simply misstated the date of the services on his reimbursement claim. In any event, Petitioner has not offered proof for this assertion and, moreover, it is irrelevant, because the claim that he submitted was for a service that he did not perform – a service allegedly provided on a date when the beneficiary was deceased.

[3] Petitioner also contends that in two cases there is a genuine dispute as to whether there were billing errors. He asserts that in these instances, his own computer records show that services were billed appropriately even if CMS's records show otherwise. That may be true, but what matters for regulatory purposes is the claim that CMS receives from a provider or supplier. In this instance there is no dispute that CMS received claims for alleged services provided after the beneficiaries were deceased. But, even if that were not the case, Petitioner's argument applies to only a small subset of the total universe of claims that he submitted that did contravene the regulation.

I find that argument to be unpersuasive. It is not necessary that I find that Petitioner authorized the third party to file false claims or that he even knew that it was doing so. In executing an assignment of benefits Petitioner authorized the third party to collect payments for services that he performed as the third party's employee. He remained as responsible for the accuracy of any of the claims submitted by the third party as if he had personally submitted them. The preamble to the regulation makes it plain that a provider or a supplier is responsible for any claim that is submitted on his or her behalf. "[P]roviders and suppliers are responsible for the claims they submit or *claims submitted on their behalf*." 73 Fed. Reg. 36,448, 36,455 (June 27, 2008), (emphasis added).

Petitioner also characterizes the claims at issue as merely isolated events, not connected, and therefore, no basis for revocation. He asserts that no pattern can be found in these claims. I find this argument to be meritless for two reasons. First, there is a pattern to Petitioner's claims. He submitted or caused to be submitted multiple claims for individual beneficiaries who were deceased. There were a total of eight deceased beneficiaries on whose accounts Petitioner submitted or caused to be submitted 35 claims. Second, the regulation does not distinguish between isolated claims and claims that are linked by common factors. The preamble speaks of a pattern of abusive claims being a basis for revocation, but, and as I have explained, the preamble does not constrain CMS's authority or its discretion. Moreover, the use of the term "pattern" in the preamble is linked only to the quantity of claims that a provider submits that fall within regulatory criteria. Three or more of such claims is defined to be a pattern. The preamble doesn't require that the claims be linked by a plan or a conspiracy in order to comprise a pattern if there are three or more of them.

CMS imposed on Petitioner a three-year Medicare re-enrollment bar beginning on the effective date of the revocation. That is not a reviewable determination and I have no authority to decide whether a three-year bar is reasonable in this case. A determination to revoke a provider or a supplier's participation in Medicare is reviewable and there is a right to a hearing to challenge that determination. 42 C.F.R. § 498.3(b)(17). But, the regulations do not afford providers or suppliers the authority to challenge the length of a re-enrollment bar. *See id.* I note, however, that CMS is authorized to bar a provider or a supplier's participation and billing privileges for up to three years where grounds for revocation exist. 42 C.F.R. § 424.535(c).

/s/
Steven T. Kessel
Administrative Law Judge