Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Aleksandar Kondic, M.D.[1]
(NPI: 1265532766),

and

Aleksandar Kondic, Inc.
(NPI: 1235381906),

Petitioners,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-2933

Decision No. CR4487

Date: December 8, 2015

DECISION

The Centers for Medicare & Medicaid Services (CMS), through administrative contractor National Government Services (NGS), revoked the Medicare enrollment and billing

[1] The Civil Remedies Division originally captioned this case with Aleksandar Kondic, Inc., as the sole petitioner. Documents related to this case following the initial determinations to revoke both Dr. Kondic and his medical practice are ambiguous as to whether they apply to Dr. Kondic, his practice, or both. However, the basis for the revocation of Dr. Kondic and his practice were identical, and my analysis below applies equally to both Dr. Kondic and his practice. Further, the hearing request indicates the "Claimant Name" is "Alexandar K[o]ndic INC, and MD". Therefore, I correct the caption in this case to ensure that both Dr. Kondic and his practice receive the review they sought.

privileges of Aleksandar Kondic, M.D., and Aleksandar Kondic, Inc. (Petitioners) based on Medicare claims for services that Petitioners purportedly provided to deceased beneficiaries. Petitioners requested a hearing to dispute the revocations. Because there is no dispute that Petitioners erroneously filed 26 claims for services to deceased beneficiaries, I grant CMS's motion for summary judgment and affirm the revocations of Petitioners' Medicare enrollments and billing privileges.

I. Case Background and Procedural History

Dr. Kondic is a physician. Petitioners Exhibit (P. Ex.) A ¶ 1; CMS Ex. 31 at 15. On February 12, 2009, CMS separately enrolled Petitioners into the Medicare program with an effective date of September 1, 2008. CMS Ex. 5. As a physician, Dr. Kondic is a "supplier" in the Medicare program. 42 U.S.C. § 1395x(d).

In separate initial determinations dated March 4, 2015, NGS notified Petitioners that it was revoking their Medicare billing privileges effective April 3, 2015, for the following reason:

> **42 CFR §424.535(a)(8) – Abuse of Billing Privileges**
> Data analysis revealed that Alexandar Kondic submitted claims for services rendered to beneficiaries who were deceased on the purported date of service. Please see the attached claims data (Attachment A).[2]

CMS Ex. 30 (emphasis in original). NGS attached identical lists to each of the initial determinations. The lists showed 26 claims involving 24 beneficiaries with dates of service purportedly rendered later than the dates of death of the beneficiaries. CMS Ex. 30 at 3, 6. The claims in question ranged from June 2, 2012, through November 14, 2014. CMS Ex. 30 at 3, 6. NGS also barred Petitioners from re-enrollment in the Medicare program for three years. CMS Ex. 30 at 2, 5. Although the initial determinations advised Petitioners of their right to seek reconsideration of the revocations, they did not state that Petitioners could file corrective action plans (CAP). CMS Ex. 30.

Through counsel, Petitioners submitted a single document to request reconsideration of the revocations and to propose a CAP. CMS Ex. 31. In the reconsideration request portion of Petitioners' submission, Petitioners stated that they submitted erroneous claims to Medicare due to inexperience, poor documentation, and ineffective billing processes.

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[2] This quotation is from the initial determination to revoke Dr. Kondic. CMS Ex. 30 at 1. The initial determination concerning Dr. Kondic's practice stated the same reason for revocation, except that "Alexandar Kondic, Inc." appears in the quoted text instead of "Alexandar Kondic." CMS Ex. 30 at 4.

However, Petitioners asserted that they addressed the causes of the erroneous billing in the CAP. CMS Ex. 31 at 5.

On May 29, 2015, NGS issued a reconsidered determination upholding the revocations. CMS Ex. 32. Specifically, NGS stated as its decision: "Alexandar Kondic Inc has not *provided evidence to show full compliance with the standards for which you were revoked*." CMS Ex. 32 at 1 (emphasis in original).

Petitioners timely requested a hearing before an administrative law judge (ALJ) to challenge the reconsidered determination. On June 23, 2015, I issued an Acknowledgment and Pre-hearing Order (Pre-hearing Order), which established general procedures for record development and permitted the parties to file for summary judgment if appropriate. *See* Pre-hearing Order ¶ 4. CMS timely filed a motion for summary judgment with a supporting brief (CMS Br.) along with 32 proposed exhibits (CMS Exs. 1-32). In response, Petitioners filed a brief opposing summary judgment (P. Br.) along with one exhibit (P. Ex. A), which is Dr. Kondic's written direct testimony.

II. Issues

This case presents three issues:

1. Whether CMS is entitled to summary judgment;

2. Whether CMS had a legitimate basis to revoke Petitioners' Medicare enrollments and billing privileges pursuant to 42 C.F.R. § 424.535(a)(8); and

3. Whether CMS was obligated to review Petitioners' CAP.

III. Jurisdiction

I have jurisdiction to decide the issues in this case. 42 C.F.R. §§ 498.3(b)(17), 498.5(*l*)(2); *see also* 42 U.S.C. § 1395cc(j)(8).

IV. 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 has promulgated enrollment regulations in 42 C.F.R. part 424, subpart P. *See* 42 C.F.R. § 424.500-.570. 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 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 where the testing is said to have occurred.

Id. § 424.535(a)(8) (2014).[3] 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 ALJ. *Id.* § 498.5(*l*)(2). When appropriate, ALJs may decide a case arising under 42 C.F.R. part 498 by summary judgment. *See* Civil Remedies Division Procedures § 19(a); *Livingston Care Ctr. v. U.S. Dep't of Health & Human Servs.*, 388 F.3d 168, 172 (6th Cir. 2004) (citing *Crestview Parke Care Ctr. v. Thompson*, 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 ALJ 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.

As summarized above, a CMS contractor investigated Petitioners and concluded that they filed 26 claims for Medicare reimbursement for services provided to 24 beneficiaries who were deceased at the time that the services were purportedly provided. *See* CMS Ex. 30. CMS has provided documentation concerning the claims and the dates of death of the beneficiaries. CMS Exs. 8-29.

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[3] CMS substantially amended 42 C.F.R. § 424.535(a)(8) effective February 3, 2015. *See* 79 Fed. Reg. 72,500 (Dec. 5, 2014). However, in this case I will apply 42 C.F.R. § 424.535(a)(8) (2014) because the text reflected in that regulation was in effect on the dates that Petitioners filed the claims on which Petitioners' revocations are based. *See* CMS Ex. 30 at 3, 6.

Petitioners have never denied the allegations made in the initial determinations. In their reconsideration request/CAP, Petitioners admitted that they filed erroneous claims.

> As discussed above, neither Dr. Kondic nor his practice was abusing their Medicare billing privileges. Dr. Kondic's practice submitted erroneous claims to Medicare due to inexperience, poor documentation, and ineffective billing processes. We believe we have addressed the causes of the erroneous billing in the CAP and proposed new procedures that will eliminate the erroneous billing.

CMS Ex. 31 at 5.

Petitioners stated the following in the CAP portion of their submission related to the causes for the billing errors:

> Dr. Kondic and his billing staff have reviewed the claims identified by CMS in Attachment A to the Notice of Revocation, Enclosure '1.' These claims were submitted to Medicare erroneously due to defective processes for Dr. Kondic transmitting billing information to his billing staff.
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> . . .
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> Inadequate documentation and billing processes at Dr. Kondic's practice caused the erroneous billing to be submitted to Medicare. As stated above, Dr. Kondic provides geriatric psychiatric care to patients in several nursing homes. When Dr. Kondic visits a facility to see patients, the facility provides him with a list of all the patients that are on his service, or need to be added to his service. The list provided by the facility also includes the patients that were on Dr. Kondic's service, but who have died since his last visit to the facility.
>
> . . .
>
> When Dr. Kondic completes his examinations in the facility, he faxes the patient list with his notations to his billing staff. His billing staff then prepares and submits claims to Medicare and other payers electronically. We have examined this situation carefully with Dr. Kondic and his staff and

> identified multiple deficiencies in the documentation and billing practices.
>
> Dr. Kondic's handwriting and notations are not always clear to the billing staff, which resulted in some of the erroneous claims submitted to Medicare. In some instances, the facsimile transmission to the billing staff was of poor quality, which also resulted in erroneous claims to Medicare.

CMS Ex. 31 at 3-4.

Following an unfavorable reconsidered determination, Petitioners stated in their hearing request that they worked at seven nursing homes and focused on patient care rather than billing. Petitioners asserted that "Medicare has never paid for services I erroneously billed" and that Petitioners deserved probation or a fine instead of revocation. Petitioners admitted to making billing errors in their brief in this proceeding as well. P. Br. at 2. Rather than dispute the incorrect billing that forms the basis of the revocation, Petitioners argued that CMS's revocations were procedurally defective because CMS did not consider Petitioners' CAP and that it is against good public policy to revoke Petitioners' Medicare enrollments and billing privileges for merely filing erroneous claims. P. Br. at 4-7.

Because Petitioners concede that the claims identified in the initial determinations are ones that were not provided to the beneficiaries in question because those beneficiaries were deceased on the dates of the claimed services, these claims may form the basis for summary judgment.

For purposes of summary judgment, I draw all inferences in favor of Petitioners. I accept as true that prior to March 2015, Petitioners relied on a billing coordinator to provide billing services for their Medicare patients, and that Dr. Kondic would compile a list of patients seen each day and submit that list to the billing coordinator. P. Ex. A ¶ 4. I also accept as true that this practice resulted in billing errors related to beneficiary names and dates that services were provided. P. Ex. A ¶ 4. I further accept as true that Petitioners never attempted to intentionally submit a claim to Medicare that Petitioners knew was incorrect or inaccurate, and that all of the claims identified in the initial determination "represent unintentional billing submissions without any intent to deceive or defraud Medicare." P. Ex. A ¶ 5. Finally, I accept as true that Petitioners have identified the weaknesses in their internal processes that led to the erroneous Medicare claims at issue in this case and implemented, as part of their CAP, those changes to prevent the submission of erroneous claims in the future. P. Ex. A ¶ 6.

2. NGS was authorized to revoke Petitioners' Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(8).

Once NGS determined that Petitioners submitted a claim or claims that could not have been furnished to a specific individual on the dates of service, it was authorized to revoke Petitioners' Medicare enrollments and billing privileges. 42 C.F.R. § 424.535(a)(8). Here, there are 26 undisputed instances where Petitioners submitted claims for a service that could not have been furnished and, in fact, were not furnished to a specific individual on the date of service. CMS Exs. 8-31; *see also* P. Ex. A ¶¶ 4-6.

Petitioners explain in response that their inexperience, poor documentation, and ineffective billing processes are to blame for the erroneous claims that they filed. CMS Ex. 31 at 5; P. Ex. A ¶ 4. Petitioners assert that they never knowingly submitted erroneous or inaccurate claims and that they never had any intent to defraud Medicare. P. Ex. A ¶ 5. Petitioners argue that "it makes no sense" to restrict Dr. Kondic from providing much needed services to nursing home residents for three years "because of innocent billing mistakes." P. Br. at 6. Petitioners do not believe that a first offense involving claims that CMS never paid should result in punitive measures, especially when Petitioners have provided a CAP that will prevent errors from recurring in the future. P. Br at 7.

However, as Petitioners recognize (P. Br. at 6), even an unintentional error with regard to claims may serve as a basis for revocation because 42 C.F.R. § 424.535(a)(8) does not require fraudulent or dishonest intent to revoke. *See Louis J. Gaefke, D.P.M.*, DAB No. 2554, at 7 (2013); *cf. Proteam Healthcare Inc.*, DAB No. 2658, at 11 (2015).

As stated in *Gaefke:*

> Given the absence from the regulation of any requirement to show fraudulent intent, or exceptions for inadvertent error, the preamble cannot be read in a manner that would effectively bar CMS from taking action against providers or suppliers who submit multiple improper claims, even where the claims were the result of negligence or reckless indifference by the provider or supplier. We also agree with the ALJ that the preamble statements Petitioner cites do not bar CMS from revoking the enrollment of a supplier or provider whose incorrect billing falls within the plain language of the regulation.

The 26 improper claims that are undisputed in this case are more than sufficient to show a section 424.535(a)(8) violation. Section 424.535(a)(8) only requires "a claim or claims"

for services that could not have been rendered. Therefore, one claim for services that could not have been rendered is enough for revocation.

Although Petitioners do not directly blame the billing service they hired to file claims with Medicare (P. Ex. A ¶ 4), Petitioners cannot avoid revocation due to the errors or actions of others. As stated in *Gaefke:*

> As discussed, Medicare suppliers and providers certify that they are responsible for the accuracy of their claims for reimbursement, and the regulation contains no exception for improper claims prepared and submitted by billing agents, which is consistent with the preamble stating that providers and suppliers are responsible for claims submitted on their behalf. As in *Reife*, Petitioner "cites no legal authority relieving suppliers of responsibility for the claims for Medicare reimbursement submitted on their behalf and at their direction." *Id*. Petitioner's position, if adopted, would effectively shield a supplier from any consequences for the submission of an unlimited number of improper claims on his behalf, so long as he could point to an agreement with a billing agent, who is not a party to the supplier's Medicare agreement, to submit the claims. Petitioner's efforts to assign blame for the improper billing to his billing agent or his assistant do not relieve him of his responsibility for the improper claims or bar CMS from revoking his billing privileges.

DAB No. 2554, at 6.

Although Petitioners make public policy arguments against the interpretation of the regulations articulated above, I cannot consider those arguments since my review is limited to deciding whether CMS had a legitimate basis to revoke Petitioners' billing privileges. *Letantia Bussell*, DAB No. 2196, at 13 (2008).

Based on the foregoing, I conclude that CMS had a legitimate basis to revoke Petitioners' Medicare enrollments and billing privileges pursuant to 42 C.F.R. § 424.535(a)(8).

3. Petitioners did not have a right to file a CAP, but even if they did, NGS constructively rejected it in the reconsidered determination.

Petitioners argue that NGS did not consider their CAP and remedial efforts to correct their billing errors. Petitioners assert that, under the regulations prevailing at the time Petitioners filed the improper claims that form the basis for revocation, Petitioners had

the right to file a CAP and receive a decision from CMS on that CAP. P. Br. at 4-5; *see* 42 C.F.R. § 424.535(a)(1) (2014).

CMS's position is that Petitioners had no right to file a CAP under newly promulgated regulations that took effect on February 3, 2015, and that, in any event, "NGS's May 29, 2015 unfavorable decision on reconsideration constructively rejected [Petitioners'] CAP . . . ." CMS Br. at 4 n.3, 12 n.7.

I agree with CMS that Petitioners do not have the right to file a CAP for a revocation based on 42 C.F.R. § 424.535(a)(8). Although the regulations in effect before February 3, 2015, would have provided Petitioners a right to file a CAP (42 C.F.R. § 424.535(a)(1) (2014)), the Secretary modified the regulations to make it clear that providers or suppliers subject to revocation could only submit a CAP when CMS based revocation on non-compliance of enrollment requirements under 42 C.F.R. § 424.535(a)(1). 42 C.F.R. §§ 405.809(a), 424.535(a)(1) (2015); 79 Fed. Reg. 72,500 (Dec. 5, 2014).

NGS did not issue its initial determinations revoking Petitioners' billing privileges until March 4, 2015, which is after the modifications to the regulations took effect. CMS Ex. 30. As indicated in footnote 3 above, it is appropriate to apply the version of 42 C.F.R. § 424.535(a)(8) that was in effect from 2012 through 2014 because that was the substantive regulation under which Petitioners were operating as Medicare suppliers when Petitioners filed the claims at issue in this case. However, the provision governing CAPs is procedural; therefore, the modified version of the regulation applies to all cases where the initial determination was issued on or after February 3, 2015.

If Petitioners had a right to a CAP, I agree with CMS that NGS constructively rejected Petitioners' CAP in the reconsidered determination. In the reconsidered determination, NGS stated in the "Decision" section that: "Alexandar Kondic Inc has not *provided evidence to show full compliance with the standards for which you were revoked*." CMS Ex. 32 at 1 (emphasis in original). The standard that NGS applied, i.e., full compliance with standards, is the standard that it would apply when reviewing a CAP. *See* 42 C.F.R. § 405.809 (2014); 42 C.F.R. § 809(b)(1) (2015). Therefore, I conclude that even if NGS' reconsidered determination did not expressly deny the CAP, NGS's determination included a finding that would have resulted in the rejection of the CAP. Rejection of a CAP is not an initial determination and, therefore, not subject to further review. *See* 42 C.F.R. § 405.809 (2014); *DMS Imaging, Inc.*, DAB No. 2313, at 5 (2010).

V. Conclusion

For the reasons explained above, I grant summary judgment in favor of CMS. Consequently, I affirm CMS's determination to revoke Petitioners' Medicare enrollment and billing privileges.

/s/
Scott Anderson
Administrative Law Judge