Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Carlos G. Sanchez, M.D.
(NPI: 1225069776),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-431

Decision No. CR3827

Date: May 1, 2015

DECISION

The Centers for Medicare & Medicaid Services (CMS), through its administrative contractor, First Coast Service Options, Inc. (First Coast), revoked the Medicare billing privileges of Carlos G. Sanchez, M.D. (Petitioner), because Petitioner failed to comply with Medicare enrollment requirements, misused his Medicare billing number, and engaged in abusive Medicare billing practices. Petitioner requested a hearing to dispute the revocation. For the reasons stated below, I affirm CMS's determination to revoke Petitioner's billing privileges.

I. Background

In five initial determinations, all nearly identical, dated May 20, 2014, First Coast revoked Petitioner's Medicare billing privileges effective June 19, 2014. The determinations specified the Provider Transaction Access Numbers (PTANs) involved as 42360V, 42360W, 42360X, and 42360Y. First Coast stated that the revocation was based on Petitioner's failure to comply with Medicare requirements (42 C.F.R. § 424.535(a)(1)), Petitioner's misuse of Medicare billing numbers (42 C.F.R.

§ 424.535(a)(7), and Petitioner's abuse of his Medicare billing number (42 C.F.R. § 424.535(a)(8). In regard to the alleged violation of 42 C.F.R. § 424.535(a)(1), First Coast provided the following facts:

> With his signature on Medicare enrollment application 855, [Petitioner], 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, [Petitioner] 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. [Petitioner] is in violation of . . . Section 125(b) of the Social Security Act Amendments 1994, the regulatory definition of locum tenens physician at 42 C.F.R. § 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 programs instructions require the regular physician be unavailable to provide the visit services. CMS has identified 445 dates of service in 2013, where [Petitioner] 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 Exs. 1-5.

In response, Petitioner filed a corrective action plan (CAP) and a request for reconsideration. CMS Exs. 6, 9. In those documents, Petitioner admitted that his billing company had used the Q6 (locum tenens) modifier to bill for services provided by radiologists who were temporarily working with Petitioner's practice and that this had been incorrect. CMS Ex. 6 at 2; CMS Ex. 9 at 3. However, Petitioner disputed that he engaged in abuse of his Medicare billing number by billing Medicare for beneficiaries who had been deceased at the time of the alleged services and provided documentation that a billing error occurred in which the dates of services, which were actually prior to the beneficiaries' deaths, were incorrectly modified to later dates. CMS Ex. 9 at 3-4. Petitioner also disputed that he abused his Medicare billing number by providing services from a location CMS already deemed to be non-operational and revoked. CMS Ex. 9 at 4-5. In July and August 2014, respectively, First Coast denied Petitioner's CAP and reconsideration request. CMS Exs. 7, 10.

Petitioner filed a request for hearing (RFH) to dispute the revocation determination. In response to my Acknowledgment and Pre-hearing Order (Order), CMS filed a brief

(CMS Br.) and 15 exhibits (CMS Exs. 1-15) as its pre-hearing exchange. Petitioner filed a brief (P. Br.) and one exhibit (P. Ex. 1) as its pre-hearing exchange.

II. Decision on the Record

Neither CMS nor Petitioner objected to any of the proposed exhibits that the parties submitted in this case. *See* Order ¶ 7. Therefore, I admit CMS Exs. 1-15 and P. Ex. 1 into the record.

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. CMS and Petitioner each submitted written direct testimony from a witness. CMS Ex. 15; P. Ex. 1. However, neither CMS nor Petitioner requested to cross-examine each other's witness. Consequently, I will not hold an in-person hearing in this matter and I will decide this matter based on the written record. Order ¶ 11.

III. Issue

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

IV. Jurisdiction

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

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

The Social Security Act (Act) authorizes the Secretary of Health and Human Services 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 it 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).

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

Physicians are suppliers for Medicare purposes. 42 C.F.R. § 400.202 (definition of "*Supplier*"). The Act requires that payment under the Medicare program may only be made to the beneficiary or the treating physician; however, there is a locum tenens exception to this:

> 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 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 hundreds of claims for Medicare reimbursement in which he billed, under his own billing number, for the services provided by other physicians by using the Q6 billing modifier to indicate that these physicians had provided the services in locum tenens to Petitioner when, in actuality, the physicians were temporarily working for Petitioner.***

Petitioner testified that he is a radiologist who provides diagnostic and interventional radiology services to Medicare beneficiaries at hospitals and out-patient imaging centers. Petitioner employs and contracts with other radiologists. Petitioner further testified that he hired a billing company that:

> recommended that [Petitioner] use the Q6 modifier [locum tenens] for billing the services of radiologists who were

> temporarily working for one of [Petitioner's] Medicare-enrolled group practices to fill a gap in coverage.
>
> These physicians who worked temporarily in [Petitioner's] group practices occasionally performed services on days [Petitioner] also performed services. Further, in limited instances those physicians performed radiology services on the same beneficiary for whom [Petitioner] also provided services on the same day . . . . these physicians and [Petitioner] performed independent radiology services otherwise payable by Medicare if the billing company had not inappropriately recommended the use of the Q6 modifier.

P. Ex. 1 at 1-2. Petitioner also stated in an affidavit: "As soon as [Petitioner] learned that [Petitioner] had been using the Q6 modifier incorrectly, [Petitioner] immediately stopped using it." CMS Ex. 9 at 15.

CMS conducted an inquiry into Petitioner's Medicare billing practices. The CMS analyst testified as follows regarding the outcome of the investigation:

> [Petitioner] billed 445 dates of service from November 1, 2012 to March 23, 2014 reflecting both [Petitioner] and the locum tenens supplier rendering services on the same day under [Petitioner's] provider number. Accordingly, on those days [Petitioner] was available to render services and did not require the services of a substitute physician.
>
> . . . .
>
> [Petitioner] submitted also 671 claims for dates of service from November 1, 2012 to March 23, 2014 that reflect [Petitioner] rendering a service and a locum tenens physician also rendering a service for the same Medicare beneficiary on the same day. Accordingly, on those days [Petitioner] was available to render services and did not require the services of a substitute physician.

CMS Ex. 15 at 2-3. The CMS analyst investigating this matter generated a spreadsheet of the claims Petitioner filed using the Q6 modifier. CMS Ex. 11; *see also* CMS Ex. 15 at 2-3.

Therefore, I find that Petitioner submitted hundreds of Medicare claims in which he billed for services provided by physicians temporarily working with his practice under the Q6 (locum tenens) modifier.

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 because Petitioner billed under his own Medicare billing number using the Q6 modifier to indicate that services were provided by other physicians in locum tenens to Petitioner when, in actuality, they were working for Petitioner temporarily.

CMS may revoke a supplier who has failed to comply with enrollment requirements in section 424.535 of the regulations or in the supplier's enrollment 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 list 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 hundreds of Medicare claims billed under Petitioner's Medicare billing number for services provided by other physicians temporarily working for Petitioner's practice. By using the Q6 modifier in the claims, Petitioner indicated that he could bill for the services provided by other physicians 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.).

Petitioner does not dispute that he incorrectly billed using the Q6 modifier, rather, he asserts that the billing company Petitioner hired is to blame for the mistake in billing. 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).

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.[2] 42 C.F.R. § 424.535(a)(1).

3. I do not have jurisdiction over the other issues raised by Petitioner.

Petitioner argues that First Coast improperly revoked Petitioner's Medicare billing privileges because it did so before First Coast gave Petitioner an opportunity to correct, thereby revoking billing privileges without considering a CAP from Petitioner. P. Br. at 8. Petitioner also argues that, although First Coast later issued a decision based on the CAP Petitioner submitted (CMS Ex. 7), First Coast applied the standard used to consider a request for reconsideration rather than the standard used for assessing CAPs (i.e., whether Petitioner had been in compliance with Medicare rules, not whether Petitioner had come into compliance with Medicare rules). P. Br. at 9; CMS Ex. 8. Petitioner concludes that a lack of meaningful review of his CAP entitles him to reversal of the revocation. P. Br. at 10. However, it is not disputed that First Coast issued a decision on Petitioner's CAP. Because a CMS contractor's refusal to reinstate a supplier's billing privileges based on a CAP is not an initial determination under 42 C.F.R. Part 498, I have no jurisdiction to review that decision. 42 C.F.R. § 405.803(b)(2); *see also* 42 C.F.R. § 498.3(a)(1), 498.3(d) ("Administrative actions that are not initial determinations (and therefore not subject to appeal under this part) include but are not limited to the following"). Therefore, I do not have the authority to review the contents of a

[2] Because CMS's revocation can be upheld based on 42 C.F.R. § 424.535(a)(1), I need not decide the other bases for revocation listed in the CMS determination.

contractor's decision regarding a CAP in order to determine whether First Coast applied a correct or incorrect standard.

Further, Petitioner argues that CMS's decision to impose a three-year re-enrollment bar is arbitrary and capricious, and is disproportionate when considering the severity of Petitioner's conduct in this matter. P. Br. at 11-13. Petitioner cites the Medicare Program Integrity Manual and notes that it only establishes set lengths for re-enrollment bars for certain specified offenses, such as for being non-operational, and that in other cases, the length of the re-enrollment bar is left entirely to CMS's discretion. P. Br at 11-12. Petitioner urges me to reduce the length of the re-enrollment bar to one year. P. Br. at 13. However, I do not have jurisdiction to consider this issue.[3] *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).

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

[3] If I had jurisdiction to review the re-enrollment bar in this case, I would have to conclude that CMS's decision to apply a three-year re-enrollment bar was supported by the record given the hundreds of improper Medicare claims that Petitioner filed in relation to his revocation under 42 C.F.R. § 424.535(a)(1). *See Gaefke*, DAB No. 2554 at 10 n.9.