Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD
Civil Remedies Division

John P. McDonough III, Ph.D.,[1] (NPI: 1831244714; PTAN: 54217A),

Geriatric Psychological Specialists, (NPI: 1346280161; PTAN: K0175), and

GPS II, LLC (NPI: 1922411263; PTAN: HD970A),

Petitioners,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-2101

Decision No. CR4494

Date: December 18, 2015

DECISION

The Medicare enrollment and billing privileges of John P. McDonough, III, Ph.D. (Petitioner McDonough), GPS II, and Geriatric Psychological Specialists (GPS) (collectively Petitioners) are revoked pursuant to 42 C.F.R. § 424.535(a)(8).[2]

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[1] This case was originally docketed listing only John P. McDonough III, Ph.D. The caption of this decision more accurately reflects that there are three suppliers who are affected parties in this case. The reconsideration determination affected all three suppliers (Centers for Medicare & Medicaid Services (CMS) Exhibit (Ex.) 1) and the request for hearing specifically requests a hearing on behalf of all three. Joint proceedings are permitted by 42 C.F.R. § 498.54. Modification of the caption to reflect each of the three affected parties satisfies the regulatory requirement that I issue a separate decision with respect to each. *Id.*

[2] Citations are to the 2014 revision of the Code of Federal Regulations (C.F.R.), unless otherwise stated.

I. Background

First Coast Service Options, Inc. (FCSO), the CMS Medicare contractor, notified Petitioners by letters dated October 28, 2014, that their Medicare billing numbers and billing privileges were revoked effective November 27, 2014. FCSO cited 42 C.F.R. § 424.535(a)(8) as the basis for the revocations. CMS Ex. 1 at 4-20. FCSO also notified Petitioners that they were subject to a three-year bars to re-enrollment pursuant to 42 C.F.R. § 424.535(c). CMS Ex. 1 at 5, 8, 12.

On January 2, 2015, Petitioners requested reconsideration. CMS Ex. 1 at 46-50. On February 25, 2015, CMS upheld the revocations on reconsideration. CMS Ex. 1 at 1-3.

Petitioners filed a combined request for hearing (RFH) before an administrative law judge (ALJ) on April 16, 2015. On May 12, 2015, the case was assigned to me for hearing and decision and I issued an Acknowledgement and Prehearing Order (Prehearing Order).

On June 11, 2015, CMS filed a motion for summary judgment (CMS Br.) with CMS Exs. 1 through 5. On July 13, 2015, Petitioners filed their opposition to CMS's motion; a cross-motion for summary judgment; objections to CMS Exs. 2, 3 and 4; and a waiver of oral hearing (P. Br.). Petitioners also filed Petitioners' exhibits (P. Exs.) 1 through 7.[3] On July 27, 2015, CMS filed its reply (CMS Reply). On October 5, 2015, I directed the parties to provide supplemental briefing on the impact in this case, if any, of the decision of an appellate panel of the Departmental Appeals Board (the Board) in *Proteam Healthcare, Inc.*, DAB No. 2658 (2015). The parties filed their supplemental briefs on October 26, 2015 (CMS Supp. Br. and P. Supp. Br.). CMS did not object to P. Exs. 1 through 7 and they are admitted as evidence.

Petitioners did not object to my consideration of CMS Exs. 1 and 5 and they are admitted. Petitioners objected to my consideration of CMS Exs. 2, 3, and 4. P. Br. at 10-11. CMS Exs. 2, 3, and 4 are screen shots from the Health Insurance Master Record and Multi-Carrier Systems (HIMR) for claims submitted by the Petitioners. CMS Ex. 2 includes claims submitted by Petitioner McDonough. CMS Ex. 3 includes claims submitted by

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[3] On July 27, 2015, I ordered Petitioners to refile their exhibits correctly marked. Petitioner's filed their corrected exhibits on August 5, 2015, and it is only the corrected exhibits that are considered, specifically those in the Departmental Appeals Board Electronic Filing System (DAB E-File) under this docket as items #8, #8a-f ,#9, and #9a-f.

Petitioner GPS. CMS Ex. 4 includes claims submitted by Petitioner GPSII. Maureen Pickering states in her declaration that she personally accessed the HIMR and printed the screenshots which comprise CMS Exs. 2, 3, and 4. She further testified that she selected the particular beneficiaries and claims to which the screenshots relate because they are the particular claims and beneficiaries listed on the spreadsheets attached to the October 28, 2014 notices of revocation from FCSO to Petitioners, i.e., the claims are the claims for which the Petitioners' enrollments and billing privileges were revoked. CMS Ex. 5. Comparing the October 28, 2014 notices to Petitioner McDonough, Petitioner GPS, and Petitioner GPSII and their attached spreadsheets (CMS Ex. 1 at 4-20) with CMS Exs. 2, 3, and 4, I find that Ms. Pickering has accurately identified the documents in CMS 2, 3, and 4 as being related to the claims cited as the basis for the October 28, 2014 decisions to revoke Petitioners' enrollments. Based on my review of CMS Exs. 2, 3, and 4, and considering the testimony of Ms. Pickering (CMS Ex. 5) and the notices in CMS Ex. 1, I conclude that CMS Exs. 2, 3, and 4 are relevant. Petitioner does not specifically dispute the authenticity of CMS Exs. 2, 3, and 4, and based on the testimony of Ms. Pickering and my review of CMS Ex. 2, 3, and 4, I conclude that the documents are what they are purported to be and they are authentic. CMS Exs. 2, 3, and 4 are offered for the truth of the matter asserted therein and they are hearsay evidence. Petitioner has not objected to CMS Exs. 2, 3, and 4 on grounds that they are hearsay. Even though hearsay is generally subject to exclusion in the civil and the criminal courts (Fed. R. Evid. 803), the documents are admissible in this administrative proceeding as the hearsay nature of the documents does not preclude their admission as evidence, but rather, must be considered when deciding the weight to be accorded the evidence. 42 C.F.R. § 498.61. CMS Exs. 2, 3, and 4 also arguably fit within the public records exception to the rule against admitting hearsay in criminal and civil court proceedings (Fed. R. Evid. 803(8)). Petitioners have waived the right to cross-examine Ms. Pickering or the custodian of the documents included in CMS Exs. 2, 3, and 4 by waiving their right to appear at an oral hearing.

Petitioner argues that CMS Exs. 2, 3, and 4 should not be admitted as evidence because they were compiled by Ms. Pickering after the reconsideration decision and, therefore, CMS has conceded that the documents were not considered on reconsideration. Petitioner argues that CMS Exs. 2, 3, and 4 were not provided to Petitioners with the October 28, 2014 revocation notices or with the notice of the reconsidered determination. Petitioner points-out that CMS Exs. 2, 3, and 4 were actually printed just days before being filed as proposed exhibits in this case. Petitioner argues that Ms. Pickering does not state in her declaration that she has personal knowledge as to the accuracy of the information contained in CMS Exs. 2, 3, and 4 or that those exhibits were prepared by someone with knowledge of the facts asserted. P. Br. at 10-11. Petitioner's objections are not evidentiary objections but are rather arguments about the weight I should accord to the information in CMS Exs. 2, 3, and 4. Furthermore, Civil Remedies Division

Procedure (CRDP)[4] § 15, adopts Fed. R. Evid. 1006 and provides that "unless permitted by the ALJ to do otherwise, a party that wants the ALJ to consider the contents of voluminous records should offer that evidence as an exhibit in the form of a chart or summary." In this case, the spreadsheets listing claims included with the October 24, 2014 revocation notices are offered as exhibits by CMS (CMS Ex. 1 at 4-20). The spreadsheets are consistent with the requirements of CRDP §15a. Pursuant to CRDP §15b, CMS was required to file with its prehearing exchange the documents upon which the spreadsheets are based, specifically, I conclude, those documents marked as CMS Exs. 2, 3, and 4.

I am also not persuaded by Petitioners' arguments that CMS Exs. 2, 3, and 4 were not considered by the official that conducted the reconsidered determination. My review is de novo as to the issue of whether or not CMS has a basis to revoke Petitioners' enrollment and billing privileges. Therefore, the fact that CMS Exs. 2, 3, and 4 may not have been considered on reconsideration is no bar to their admission in this proceeding. Similarly the fact Petitioner may not have received CMS Exs. 2, 3, and 4 prior to the exchange of exhibits in this case is also not grounds for excluding those documents in this proceeding. Pursuant to my Prehearing Order paragraph II.D.1, CMS was required to provide Petitioner copies of the exhibits on which CMS relies as a basis for revocation of Petitioners' enrollment and billing privileges. CMS has complied.

I conclude that CMS Exs. 2, 3, and 4 are admissible and will be considered as evidence, and they are admitted. The weight accorded the exhibits is discussed in greater detail in my analysis.

II. Discussion

A. Applicable Law

Section 1831 of the Social Security Act (the Act) (42 U.S.C. § 1395j) establishes the supplementary medical insurance benefits program for the aged and disabled known as Medicare Part B. Administration of the Part B program is through contractors, such as FCSO. Act § 1842(a) (42 U.S.C. § 1395u(a)). Payment under the program for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of services and suppliers.[5] Act §§ 1835(a) (42 U.S.C. § 1395n(a)), 1842(h)(1) (42 U.S.C.

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[4] The CRDP was provided to the parties with the Prehearing Order on May 12, 2015. DAB E-File #2b.

[5] A "supplier" furnishes services under Medicare and includes physicians or other practitioners and facilities that are not included within the definition of the phrase

(Footnote continued next page.)

§ 1395u(h)(1)). Petitioner McDonough is a psychologist and he and his two affiliated medical practices, Petitioner GPS and Petitioner GPS II, were suppliers enrolled in Medicare.

The Act requires the Secretary of Health and Human Services (Secretary) to issue regulations that establish a process for the enrollment in Medicare of providers and suppliers, including the right to a hearing and judicial review of certain enrollment determinations, such as revocation of enrollment and billing privileges. Act § 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to 42 C.F.R. § 424.505, suppliers such as Petitioners must be enrolled in the Medicare program and be issued a billing number to have billing privileges and to be eligible to receive payment for services rendered to a Medicare-eligible beneficiary.

The Secretary has delegated the authority to revoke enrollment and billing privileges to CMS. 42 C.F.R. § 424.535. CMS or its Medicare contractor may revoke an enrolled supplier's Medicare enrollment and billing privileges and supplier agreement for any of the reasons listed in 42 C.F.R. § 424.535. If CMS revokes a supplier's Medicare billing privileges, the revocation becomes effective 30 days after CMS or one of its contractors mails the revocation notice to the supplier, subject to some exceptions not applicable in this case. After a supplier's Medicare enrollment and billing privileges are revoked, the supplier is barred from reenrolling in the Medicare program for a minimum of one year, but no more than three years. 42 C.F.R. § 424.535(c).

A supplier whose enrollment and billing privileges have been revoked may request reconsideration and review as provided by 42 C.F.R. pt. 498. 42 C.F.R. § 424.545(a). A supplier submits a written request for reconsideration to CMS or its contractor. 42 C.F.R. § 498.22(a). CMS or its contractor must give notice of its reconsidered determination to the supplier, giving the reasons for its determination and specifying the conditions or requirements the supplier failed to meet, and the right to an ALJ hearing. 42 C.F.R. § 498.25. If the decision on reconsideration is unfavorable to the supplier, the supplier has the right to request a hearing by an ALJ and further review by the Departmental

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(Footnote Continued.)

"provider of services." Act § 1861(d) (42 U.S.C. § 1395x(d)). A "provider of services," commonly shortened to "provider," includes hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, hospice programs, and a fund as described in sections 1814(g) (42 U.S.C. § 1395f(g)) and 1835(e) (42 U.S.C. § 1395n(e)) of the Act. Act § 1861(u) (42 U.S.C. § 1395x(u)). The distinction between providers and suppliers is important because they are treated differently under the Act for some purposes.

Appeals Board (the Board). Act § 1866(j)(8) (42 U.S.C. § 1395cc(j)(8)); 42 C.F.R. §§ 424.545, 498.3(b)(17), 498.5. A hearing on the record, also known as an oral hearing, is required under the Act unless waived. *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743, 748-51 (6th Cir. 2004). The supplier bears the burden to demonstrate that it meets enrollment requirements with documents and records. 42 C.F.R. § 424.545(c).

B. Issue

Whether there was a basis for the revocation of Petitioner's billing privileges and enrollment in Medicare.

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

My conclusions of law are set forth in bold followed by my findings of fact and analysis. The findings of fact are based on the documents admitted as exhibits. I have carefully considered all the evidence and the arguments of both parties, though not all may be specifically discussed in this decision. I discuss in this decision the credible evidence given the greatest weight in my decision-making. I also discuss any evidence that I find is not credible or worthy of weight. The fact that evidence is not specifically discussed should not be considered sufficient to rebut the presumption that I considered all the evidence and assigned such weight or probative value to the credible evidence that I determined appropriate within my discretion as an ALJ. There is no requirement for me to discuss the weight given every piece of evidence considered in this case, nor would it be consistent with notions of judicial economy to do so. Charles H. Kock, Jr., *Admin L. and Prac*. § 5:64 (3d ed. 2013).

1. Decision on the documents and briefs is permissible in this case and no oral hearing is required.

Pursuant to 42 C.F.R. § 498.66(a), an affected party, such as Petitioners, may waive the right to appear and present evidence at an oral hearing by filing a written waiver. When a written waiver is filed by a petitioner, an ALJ need not conduct an oral hearing except in two circumstances: the ALJ concludes witness testimony is necessary to clarify facts at issue; or CMS shows good cause for presenting oral testimony. 42 C.F.R. § 498.66(b).

Petitioners waived their right to appear and present evidence at an oral hearing and cross examine witnesses. Petitioners agreed to receive a decision upon the documentary evidence and briefs, citing 42 C.F.R. § 498.66. P. Br. at 1-2. CMS has not shown good cause to require the presentation of oral evidence and I do not find that the presentation of oral testimony is necessary to clarify any facts. Accordingly, I conclude it is not necessary to conduct an oral hearing. Rather, I decide the case on the documentary evidence and the written arguments of the parties. 42 C.F.R. § 498.66(b). I further conclude that it is not necessary to decide this case by applying the standards applicable

to summary judgment. *See, e.g.*, Fed. R. Civ. Pro. 56. Rather, I decide this case on the merits, including assessing the weight and credibility of the evidence. The parties are both represented by counsel, who I presume understand that by waiving an oral hearing they have also waived cross-examination of adverse witnesses.

> **2. Billing privileges are abused, within the meaning of 42 C.F.R. § 424.535(a)(8), when three or more claims are submitted to Medicare for services that could not have been furnished to the specific individuals identified on the claims on the dates of the claimed services.**
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> **3. The 243 claims submitted by Petitioners or on their behalf that were false because they were for services not delivered to the beneficiaries listed on the claims constituted an abuse of billing privileges under 42 C.F.R. § 424.535(a)(8).**
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> **4. It is no defense to a revocation action for abuse of billing privileges under 42 C.F.R. § 424.535(a)(8) that the false claims were due to errors of Petitioners' agents.**
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> **5. There is a basis for revocation of Petitioners' Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(8).**

Petitioners' enrollment and billing privileges were revoked pursuant to 42 C.F.R. § 424.535(a)(8). The regulation provides:

> *Abuse of billing privileges*. **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.

42 C.F.R. § 424.535(a)(8) (emphasis added). This regulation provides Petitioner notice that billing privileges and Medicare enrollment may be revoked for an abuse of billing privileges. 5 U.S.C. §§ 551(4), 552(a)(1). The elements of the CMS prima facie case for revocation based on the language of 42 C.F.R. § 424.535(a)(8) are: (1) the provider or supplier submits one or more claims for services; and (2) the services for which a claim or claims were submitted could not have been delivered to a Medicare beneficiary on the date the service was claimed to have been delivered. *Realhab, Inc.*, DAB No. 2542 at 16-17 (2013). Although the plain language of the regulation seems clear enough at first

blush, there have been several Board decisions that turned to the legislative history of the regulations for clarification of what was intended to be a sufficient basis for revocation under the regulation. *Proteam Healthcare, Inc.*, DAB No. 2658; *Ronald J. Grason, M.D.*, DAB No. 2592 at 7 (2014); *Realhab, Inc.*, DAB No. 2542 at 16; *Howard B. Reife, D.P.M.*, DAB No. 2527 at 1 (2013). CMS, the proponent of the regulation, explained in comments to the final rule making in 2008:

> CMS, not a Medicare contractor, will make the determination for revocation under the authority at § 424.535(a)(8). We will direct contractors to use this basis of revocation after identifying providers or suppliers that have these billing issues. We have found numerous examples of situations where a physician claims to have furnished a service to a beneficiary more than a month after their recorded death, or when the provider or supplier was out of State when the supposed services had been furnished. **In these instances, the provider has billed the Medicare program for services *which were not provided* and has submitted Medicare claims for services to a beneficiary who could not have received the service which was billed.** 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 believe that it is both appropriate and necessary that we have the ability to revoke billing privileges when services could not have been furnished by a provider or supplier. 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** . . . . **In conclusion*, we believe that providers and suppliers are responsible for the claims they submit or the claims submitted on their behalf*.** We believe it is essential that providers and suppliers take the necessary steps to ensure they are billing appropriately for services furnished to Medicare beneficiaries.

73 Fed. Reg. 36,448, 36,455 (June 27, 2008) (emphases added). Based on this regulatory history, I conclude that CMS must also show as part of its prima facie case that there were more than one and at least three claims for services that could not have been

delivered. I note that the drafters of the regulation also state that only CMS and not a Medicare contractor will make the determination to revoke pursuant to 42 C.F.R. § 424.535(a)(8). 73 Fed. Reg. at 36,455.[6]

Petitioners pursue two primary theories in this case:

> 1. CMS failed to make a prima facie showing of a basis for revocation pursuant to 42 C.F.R. § 424.535(a)(8); and
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> 2. If CMS made a prima facie showing, Petitioners have shown by a preponderance of the evidence that they did not abuse billing privileges.

P. Br. at 2, 9-16.

a. Prima Facie Showing by CMS

Petitioners' argument that CMS has failed to make a prima facie showing is without merit. The Secretary's regulations at 42 C.F.R. pts. 424 and 498 do not address the allocation of the burden of proof or the standard of proof in cases subject to those regulations. However, the Board has addressed the allocation of the burden of proof in many decisions applying 42 C.F.R. pt. 498. The standard of proof is a preponderance of the evidence. CMS has the burden of coming forward with the evidence sufficient to make a prima facie showing of a basis for the enforcement action. The quantum of evidence necessary for a prima facie showing is not specified in the regulations or specifically resolved by prior decisions of the Board. But, the Board has stated that CMS must come forward with "evidence related to disputed findings that is sufficient (together with any undisputed findings and relevant legal authority) to establish a prima facie case of noncompliance with a regulatory requirement." *Evergreene Nursing Care Ctr.*, DAB No. 2069 at 7 (2007); *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004). "Prima facie" means generally that the evidence is "[s]ufficient to establish a fact or raise a presumption unless disproved or rebutted." *Black's Law Dictionary* 1228 (18th ed. 2004). I conclude that the CMS evidence is sufficient to establish a prima facie case of a basis for revocation pursuant to 42 C.F.R. § 424.535(a)(8). CMS relies upon evidence derived from its database of claims information, specifically claims filed by Petitioners. CMS also relies upon information derived from the Social Security Administration (SSA) database.

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[6] On December 5, 2014, 42 C.F.R. § 424.535(a)(8) was amended to add 42 C.F.R. § 424.535(a)(8)(ii) effective February 3, 2015. 79 Fed. Reg. 72500 (Dec. 5, 2014). The amendment of 42 C.F.R. § 424.535(a)(8) does not impact the outcome in this case.

FCSO notified Petitioner McDonough on October 28, 2014, that his enrollment and billing privileges were revoked effective November 27, 2014. The notice alleged abuse of billing privileges and that revocation was pursuant to 42 C.F.R. § 424.535(a)(8). CMS Ex. 1 at 4-5. Attached to the FCSO notice was a list of 27 claims for 24 beneficiaries, with dates of service beginning in April 2012 and running through May 2014. CMS Ex. 1 at 6.

FCSO notified Petitioner GPSII on October 28, 2014, that its enrollment and billing privileges were revoked effective November 27, 2014. The notice alleged abuse of billing privileges and that revocation was pursuant to 42 C.F.R. § 424.535(a)(8). CMS Ex. 1 at 7-8. Attached to the FCSO notice was a list of 68 claims for 52 beneficiaries, with dates of service beginning in May 2013 and continuing through June 2014. CMS Ex. 1 at 9-10.

FCSO notified Petitioner McDonough on behalf of GPS on October 28, 2014, that its enrollment and billing privileges were revoked effective November 27, 2014. The notice alleged abuse of billing privileges and that revocation was pursuant to 42 C.F.R. § 424.535(a)(8). CMS Ex. 1 at 11-12. Attached to the FCSO notice was a list of 325 claims for 207 beneficiaries, with dates of service beginning in January 2012 and continuing through February 2014. CMS Ex. 13-20.

The reconsidered determination was issued by the CMS Provider Enrollment Oversight Group on February 25, 2015. The reconsidered determination upheld revocation for all three Petitioners concluding that Petitioners failed to disprove that an abuse of billing privileges occurred. CMS Ex. 1 at 1-2. Petitioners argue that CMS failed to meet its burden to make a prima facie showing of a basis for revocation because "[t]here is no evidence that CMS, rather than its contractor . . . made the decision to revoke Petitioners' Medical (sic) billing privileges as required by law." P. Br. at 2, 9-11. Petitioners are in error both legally and factually. No provision of the Act or the regulations require that CMS make the decision to revoke for abuse of billing privileges under 42 C.F.R. § 424.535(a)(8). Rather, CMS stated as part of the regulatory history for 42 C.F.R. § 424.535(a)(8) that CMS would make the determination to revoke for abuse of billing privileges rather than relying upon its contractors for that determination. At most, the statement in the regulatory history is evidence of a CMS policy not a statement of law. CMS did not violate its policy in this case. Pursuant to 42 C.F.R. § 498.5(*l*)(1) a supplier dissatisfied with an initial determination to revoke its Medicare enrollment is entitled to request reconsideration. If a supplier is dissatisfied with the reconsidered determination that upholds revocation, the supplier has the right to request a hearing before an ALJ. 42 C.F.R. § 498.5(*l*)(2). Therefore, it is the reconsidered determination that is before me for hearing and decision. In this case the reconsidered determination reflects on its face that it was made by the CMS Provider Enrollment Oversight Group not FCSO. Accordingly, I conclude that CMS complied with its policy to make the revocation determination rather than have FCSO make that decision. Even if the fact that FCSO made the initial

determination was considered a violation of the CMS policy, that policy was clearly remedied by the reconsidered determination made by CMS. I also reject Petitioners' suggestion that the reconsidered determination was no more than a stamp of the initial determination by FCSO. The reconsidered determination reflects that the contents of the record were reviewed and includes a discussion of the basis for the decision to uphold the revocation of Petitioners' enrollment and billing privileges. CMS Ex. 1 at 1-2.

CMS submitted the declaration of Maureen Pickering. CMS Ex. 5. Petitioners waived the right to cross-examine Ms. Pickering by waiving an oral hearing. I have no reason to question the credibility of Ms. Pickering's testimony. Ms. Pickering established her knowledge of CMS and SSA databases and how to extract information from those databases. Ms. Pickering credibly testified as to the source of the claims related evidence in CMS Exs. 2, 3, and 4. CMS Ex. 5. The evidence is authentic and relevant.

Based on my review of the CMS evidence, I conclude it is sufficient to show that Petitioner filed claims for Medicare beneficiaries for dates of service after the dates of death of those beneficiaries. Therefore, the issue is whether or not Petitioner has presented sufficient evidence to rebut the prima facie showing or establish an affirmative defense.

b. Petitioners' Case

Petitioners submitted for my consideration the July 13, 2015 declaration of Petitioner McDonough. P. Ex. 1. Petitioner McDonough attests that he examined the books, records and documents maintained by Petitioners. Petitioner McDonough prepared or had prepared P. Ex. 2, a list of claims of GPS cited by CMS as a basis for revocation. He collected or had collected the documents in P. Ex. 3 in support of the summary regarding the claim in P. Ex. 2. P. Ex. 4 is a summary chart for the claims of GPSII cited by CMS and P. Ex. 5 includes the supporting documents. P. Ex. 6 is the summary chart of claims of Petitioner McDonough cited by CMS and P. Ex. 7 includes the supporting documents. Petitioner McDonough attests that the summary charts admitted as P. Exs. 2, 4, and 6 contain an explanation for each billing discrepancy raised by CMS, listed by beneficiary name, Medicare number, date of service, and purported dates of death. Petitioner McDonough states that the billing discrepancies were identified by Petitioners' billing companies after review of the lists of claims submitted by CMS.

Petitioners waived their right to appear and present evidence at an oral hearing and cross examine witnesses. 42 C.F.R. § 498.66. P. Br. at 1-2. CMS did not request an oral hearing to cross-examine Petitioner McDonough or show good cause to require the presentation of oral testimony to rebut the declaration of Petitioner McDonough. I conclude that CMS waived cross-examination of Petitioner McDonough. Other than his own self-interest in the outcome of this case, I see no basis to discount the credibility of Petitioner McDonough. There is nothing to suggest that Petitioner McDonough's self-

interest is sufficient to cause him to risk punishment for commission of perjury. Furthermore, Petitioner McDonough's testimony is narrowly limited to describing the compilation and contents of P. Exs. 2 through 7. Indeed his credibility is bolstered by the fact that not all the explanations provided in P. Exs. 2, 4, and 6 are in Petitioners' best interest. I conclude that Petitioner McDonough's declaration and P. Exs. 2 through 7 are fully credible.

My analysis focuses upon P. Exs. 2, 4, and 6, and Petitioners' admissions with respect to the claims listed in those exhibits. P. Ex. 2 lists the 207 beneficiaries for whom Petitioners admit 299 Medicare claims were filed by Petitioner GPS.[7] Petitioners note in P. Ex. 2 that not all claims were actually paid by Medicare. However, whether or not claims were paid is not relevant to whether there was a basis for revocation under 42 C.F.R. § 424.535(a)(8). The issue is whether or not Petitioners submitted claims for services that could not have been furnished to a specific individual on the claimed date of service. 42 C.F.R. § 424.535(a)(8). Whether or not any of the claims were paid is not a defense. P. Ex. 4 lists 52 beneficiaries for whom Petitioners admit Petitioner GPSII submitted 66 claims.[8] Petitioners' note in P. Ex. 4 that not all claims were paid, but that is not relevant as previously explained. P. Ex. 6 lists 24 beneficiaries for whom Petitioners admit Petitioner McDonough submitted 25 claims.[9]

P. Ex. 2, 4, and 6 list the Medicare beneficiaries cited by CMS, the specific claims cited by CMS as abusive, and Petitioners' explanations for each claim. Petitioners' explanations are admissions, and as already noted, considered to be reliable. Petitioners' explanations can be divided into three groups for ease of discussion: (1) claims for services billed when services, including reports were complete, consistent with

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[7] The October 28, 2014, FCSO notice of revocation listed 207 beneficiaries, the same listing of beneficiaries as P. Ex. 2, but 325 claims, 26 more than P. Ex. 2. CMS Ex. 1 at 11-20. Given my decision in this case, I conclude in the interest of judicial economy, it is not necessary to attempt to determine the reason for the discrepancy.

[8] The October 28, 2014, FCSO notice of revocation listed 52 beneficiaries, the same listing of beneficiaries as P. Ex.4, but 68 claims, 2 more than P. Ex. 4. CMS Ex. 1 at 9-10. Given my decision in this case, I conclude in the interest of judicial economy, it is not necessary to attempt to determine the reason for the discrepancy.

[9] The October 28, 2014, FCSO notice of revocation listed 24 beneficiaries, the same listing of beneficiaries as P. Ex.6, but 27 claims, 2 more than P. Ex. 6. CMS Ex. 1 at 6. Given my decision in this case, I conclude in the interest of judicial economy, it is not necessary to attempt to determine the reason for the discrepancy.

Petitioners' interpretation of a Local Coverage Determination (LCD); (2) claims that were the result of data input errors by Petitioners' billing services (billing errors); and (3) claims for services provided by therapists to the wrong person (misidentifications). Petitioners' admit that Petitioner GPS had 12 claims billed based on misidentification by therapists, 93 claims billed according to the LCD, and 191 billing errors.[10] P. Ex. 2. Petitioners admit that GPSII submitted 30 claims billed in accordance with the LCD and 36 billing errors. P. Ex. 4. Petitioners admit that Petitioner McDonough submitted 2 claims billed in accordance with the LCD; 2 claims involving misidentification; and 21 billing errors. P. Ex. 6.

I conclude that Petitioners reliance upon an LCD is reasonable and the claims billed in accordance with Petitioners' interpretation of the LCD did not amount to an abuse of billing privileges on the facts of this case. The Petitioners had a combined total of 125 claims that were billed in accordance with Petitioners interpretation of the LCD. Petitioners explain in their brief that the LCD claims were for psychological services, evaluation and testing, done for beneficiaries while they were alive. However, pursuant to LCD L33688, Medicare claims could not be filed until reports related to those services were completed and those reports were not complete and claims filed until after the beneficiaries death. The gist of Petitioners' argument is that the date on which reports were prepared was treated as a date of service just like the days on which actual evaluations and testing were done, which explains how some dates of service were after the date of death of the beneficiaries. P. Br. at 5, 12, 16; CMS Ex. 1 at 76.

Petitioners are located in Florida and the claims in issue were for services between January 2012 and June 2014. CMS Ex. 1 at 4-20; P. Exs. 2, 4, 6. LCD L33688, titled Psychological and Neuropsychological Tests, was issued by FCSO in 2013, and subsequently revised several times.[11] The various revisions of LCD L33688 included under "General Information" "Utilization Guidelines" the following instructions:

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[10] Petitioners provided explanations for three claims that I cannot decipher. I conclude it is not necessary to develop further evidence as to those three claims.

[11] Current and retired LCDs are available at https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. The earliest version of LCD L33688 available online is a draft from May 2013. Whether or not there was an earlier edition of LCD L33688 dating to January 2012 or before is not reflected in online materials. LCD L33688 has been retired as of September 30, 2015. LCD L34520 was issued effective October 1, 2015 with the title "Psychological and Neuropsychological Tests. LCD L34520 also includes the same guidance as quoted from LCD L33688.

> Typically, psychological testing/neuropsychological testing may require four (4) to six (6) hours to perform (including administration, scoring, and interpretation). If the testing is done over several days, the testing time should be combined and reported all on the last date of service. Supporting documentation in the medical record must be present to justify the medical necessity and hours tested per patient per evaluation. If the testing time exceeds eight (8) hours, medical necessity for the extended testing should be documented in the report.

The LCD clearly recognizes that psychological and neuropsychological testing may be performed over several days. The LCD instructs that when testing is done over several days it should all be combined and reported on the last day of service. Petitioners interpreted the plain language to mean that the date on which reports of testing and evaluation were prepared was the last day of service and all hours involved in testing and reporting were to be combined and reported on that last day. Petitioners' interpretation of the LCD provision is reasonable. Petitioners' assertions that 2 claims filed by Petitioner McDonough, 93 claims filed by GPS, and 30 filed by GPSII reflect dates of service after the date of death of the beneficiary is consistent with Petitioners' interpretation of the application of the LCD. CMS presented no evidence or legal authority to show that Petitioner McDonough's interpretation of the LCD provision was in error. CMS also waived cross-examination of Petitioner McDonough and failed to present any evidence to rebut his declaration and the assertions in P. Exs. 2, 4, and 6, that claims were for services provided while the beneficiaries were alive and billed as services for a date after their date of death due to Petitioner McDonough's interpretation of the LCD. The drafters of 42 C.F.R. § 424.535(a)(8) specifically recognized that in some instances a claim for services after the date of death may be appropriate:

> We understand that there are certain situations when the date of service may legitimately be the day after the date of death of the beneficiary. Accordingly, Medicare contractors and CMS will review the specific details associated with each claim before taking any revocation action.

73 Fed. Reg. at 36,455.

Based upon my review of the specific details, I conclude that the claims billed in accordance with Petitioners' interpretation of the LCD do not reflect an abuse of billing privileges.

However, I conclude that an abuse of billing privileges occurred based on Petitioners' admissions that:

1. Petitioner GPS had 12 claims billed based on misidentification by therapists and 191 billing errors (P. Ex. 2);

2. Petitioner GPSII had 36 billing errors (P. Ex. 4); and

3. Petitioner McDonough had 2 claims involving misidentification and 21 billing errors (P. Ex. 6).

Petitioners have not presented evidence or argued that any of the beneficiaries identified with these 243 claims actually received services for which the claims were filed or that they were not dead prior to the date of service for each claim.

The gist of Petitioners' defense is that misidentifications by therapists and billing errors are not an abuse of billing privileges and should be excused. Petitioners also assert that they have developed procedures to avoid similar errors in the future. Petitioners argue that the errors were accidental or unintentional and, therefore, do not constitute an abuse of billing. Petitioners attribute their improper claims and billing errors to: incorrect billing entries due to similar beneficiary names or Medicare numbers, and inadvertent typing errors by billing service representatives. P. Br. at 5; CMS Ex. 1 at 75-76.

The Board has upheld determinations that abuse in the context of 42 C.F.R. § 424.535(a)(8) occurs when a provider bills Medicare for services that could not have been provided to the Medicare beneficiary to whom the claim is related. *Realhab, Inc.*, DAB No. 2542 at 15. The Board has commented that a common definition of abuse is misuse, wrong, or improper use, and that the negligent submission of multiple erroneous claims for services that could not have been delivered to beneficiaries, amounts to abuse. *Louis J. Gaefke*, D.P.M., DAB No. 2554 at 9 (2013); *Howard B. Reife, D.P.M.*, DAB No. 2527 at 6. CMS is not required to show that Petitioners intended to defraud Medicare before it revokes their billing privileged. The regulation only requires the existence of claims for services that could not have been delivered. 42 C.F.R. § 424.535(a)(8); *Louis J. Gaefke, D.P.M.*, DAB No. 2554 at 7 ("[T]he plain language of the regulation contains no requirement that CMS establish that the supplier acted with fraudulent or dishonest intent. The regulatory language also does not provide any exception for inadvertent or accidental billing errors."). Petitioners are ultimately responsible, both as a matter of law and under the terms of their participation agreements, for ensuring that their claims for Medicare reimbursement were accurate and for any errors in those claims. *Louis J. Gaefke, D.P.M.*, DAB No. 2554 at 5-6 (citing 73 Fed. Reg. at 36,455). Petitioners cannot avoid responsibility for their claims by the simple expedient of shifting responsibility and liability by contracting with a billing agent. While the language of the regulation does not require a pattern of improper billing, the preamble states that a "pattern of improper billing" occurs when there are three or more instances of improper billing. 73 Fed Reg. at 36,455. Petitioners have admitted that the 243 claims were in error. The claims were

for services delivered on dates after the dates of death of the beneficiaries listed in the claims. Petitioner has not shown that the beneficiaries involved in the claims were not dead, that the services claimed were delivered on a different date, or that it was otherwise possible that services claimed were delivered. The number of claims exceeds three and shows a pattern of improper false claims. Whether or not the 243 false claims were false due to the intention of Petitioners or the neglect of Petitioners' billing agents are not issues under 42 C.F.R. § 424.535(a)(8). Petitioners are responsible to ensure claims are correct and they are responsible for the conduct of their billing agents. As the drafters of the regulation stated:

> In conclusion, *we believe that providers and suppliers are responsible for the claims they submit or the claims submitted on their behalf.* We believe it is essential that providers and suppliers take the necessary steps to ensure they are billing appropriately for services furnished to Medicare beneficiaries.

73 Fed. Reg. at 36,455 (emphasis added).

I conclude that there is a basis to revoke Petitioners' Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(8).

Petitioners submitted a corrective action plan. P. Br. at 3-6; CMS Ex. 1 at 74-81. Petitioners note they received no decision on the corrective action plan but assume it was not accepted by CMS. P. Br. at 6, n.3. Petitioner has no right to request a hearing based on the denial of a corrective action plan and I have no authority to review such a denial. 42 C.F.R. §§ 405.809(b)(2), 424.545(a), 498.3(b); *Conchita Jackson, M.D.*, DAB No. 2495 at 6-7 (2013); *DMS Imaging, Inc.*, DAB No. 2313 at 5-8 (2010).

I have no authority to review the exercise of discretion by CMS to revoke where there is a basis for revocation. *Abdul Razzaque Ahmed, M.D.*, DAB No. 2261 at 19 (2009). To the extent Petitioners' arguments are construed as a request for equitable relief, I have no authority to grant equitable relief. *US Ultrasound*, DAB No. 2302 at 8 (2010) ("[n]either the ALJ nor the Board is authorized to provide equitable relief by reimbursing or enrolling a supplier who does not meet statutory or regulatory requirements."). I am also required to follow the Act and regulations and have no authority to declare statutes or regulations invalid. *1866ICPayday.com, L.L.C.*, DAB No. 2289 at 14 (2009) ("[a]n ALJ is bound by applicable laws and regulations and may not invalidate either a law or regulation on any ground.").

III. Conclusion

For the foregoing reasons, the Medicare enrollment and billing privileges of Petitioners are revoked pursuant to 42 C.F.R. § 424.535(a)(8).

/s/
Keith W. Sickendick
Administrative Law Judge