Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

George M. Young, M.D.
(CCN: 371506869540-001; PTAN: 11906P; NPI: 1245265677),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-3553

Decision No. CR4539

Date: March 1, 2016

DECISION

Petitioner, George M. Young, M.D., challenges the reconsidered determination by First Coast Service Options, Inc. (First Coast), an administrative contractor of the Centers for Medicare & Medicaid Services (CMS), to revoke his Medicare enrollment and billing privileges. First Coast took this action pursuant to 42 C.F.R. § 424.535(a)(10) because Petitioner did not provide CMS access to medical documentation for durable medical equipment that he ordered for his Medicare patients. As explained below, I uphold CMS's revocation determination.

I. Background and Procedural History

Petitioner is a physician practicing in Florida. *See* CMS Exhibit (Ex.) 2 at 1. He participated in the Medicare program as a "supplier" of services.[1] On January 6, 2015, CMS wrote to Petitioner requesting medical documentation supporting the ordered equipment for fourteen Medicare beneficiaries, including documentation related to

[1] A "supplier" is defined as "a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under [Title XVIII of the Social Security Act]." 42 U.S.C. § 1395x(d); *see also* 42 C.F.R. § 400.202.

written orders, and certification or requests for payments for items of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS). CMS Ex. 2. Specifically, CMS requested the physician's orders, prescriptions, progress notes, and patient information sheets. *Id*. CMS stated that Petitioner must provide the requested documents by January 13, 2015. *Id*. On January 13, 2015, Petitioner's counsel wrote to CMS stating that Petitioner "tried to locate these records, however, the facility at which he was employed which has possession of the records cannot be located. I will be happy to further explain the situation if need be or furnish any other explanation that you seek." CMS Ex. 3.

By letter dated February 19, 2015, First Coast notified Petitioner that it was revoking Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(10) because Petitioner failed to submit the physician's orders, prescriptions, progress notes, and patient information sheets that CMS requested for the fourteen beneficiaries. CMS Ex. 1 at 4-5. First Coast established a one-year re-enrollment bar effective from March 21, 2015. *Id.* at 5.

On March 9, 2015, First Coast received Petitioner's request for reconsideration. CMS Ex. 1 at 1. Petitioner stated in his request that he acquired the requested medical records and was now producing them. CMS Ex. 4 at 3. Petitioner explained that the delay in producing the records occurred because the records related to beneficiaries he treated while previously employed at the Sleep Medicine Center. *Id*. Petitioner further explained that its owner had "full and sole possession" of those records and was unavailable in early January 2015 to provide them. *Id*. Petitioner stated that either the owner's counsel or a third party holder of the records provided the records supplied with the request for reconsideration. *Id*. On May 27, 2015, First Coast issued a reconsidered determination that upheld the revocation pursuant to 42 C.F.R. § 424.535(a)(10). Petitioner Exhibit (P. Ex.) 4 at 1-2. On July 21, 2015, First Coast issued a reconsidered determination that corrected administrative errors in the May 27, 2015 determination. CMS Ex. 1 at 1-2.

Petitioner then timely requested a hearing with the Civil Remedies Division of the Departmental Appeals Board. On August 7, 2015, I issued an Acknowledgment and Pre-Hearing Order (Order), which established general procedures for record development and permitted the parties to file motions for summary judgment, if appropriate. CMS timely filed its pre-hearing brief and motion for summary judgment (CMS Br.), along with four exhibits (CMS Exs. 1-4). On November 23, 2015, Petitioner timely filed its pre-hearing brief and opposition to CMS's motion for summary judgment (P. Br.), along with five exhibits (P. Exs. 1-5), one of which was the written direct testimony of the Petitioner. On December 14, 2015, CMS filed a reply to Petitioner's pre-hearing brief and response to CMS's motion for summary judgment.

My Order advised the parties that they must submit written direct testimony for each proposed witness and that an in-person hearing would be necessary only if the opposing party affirmatively requested an opportunity to cross-examine a witness. Pre-Hearing Order ¶¶ 8, 9; *see Vandalia Park*, DAB No. 1940 (2004); *Pacific Regency Arvin*, DAB No. 1823, at 7-8 (2002) (holding that the use of written direct testimony for witnesses is permissible so long as the opposing party has the opportunity to cross-examine those witnesses). CMS did not propose any witnesses, nor did it request to cross-examine Petitioner's sole witness. Therefore, an in-person hearing in this case is unnecessary, and I issue this decision on the full merits of the written record.

II. Evidentiary Ruling

CMS objects to the admission of two documents in P. Ex. 3 because "[t]hese documents were not submitted to the hearing officer during the proceedings below." CMS Reply Br. at 4. The two documents at issue are prescriptions for two of the beneficiaries (Beneficiary A.D. and Beneficiary J.A.) for whom CMS had requested medical records.

My pre-hearing order advised the parties that I must exclude any new evidence that Petitioner offers where Petitioner does not show good cause for not previously submitting the evidence. Pre-Hearing Order ¶ 6; *see* 42 C.F.R. § 498.56(e). Petitioner asserts that he did include the documents at issue with his request for reconsideration. On review of the record, including the documents Petitioner submitted that represented his reconsideration request and accompanying documents, it appears Petitioner did not submit the prescription for Beneficiary A.D. with his request for reconsideration. Further, while the request for reconsideration contained a prescription for Beneficiary J.A., the prescription that Petitioner submitted with his pre-hearing exchange is different from that submitted with Petitioner's request for reconsideration. Therefore, both documents may constitute new evidence. Nevertheless, I am unable to ascertain definitively what was presented to the hearing officer without a certified record from the CMS contractor, and I find CMS is not prejudiced by the inclusion of the documents in my review here. Accordingly, I overrule CMS's objections. In the absence of other objections, I also admit CMS Exs. 1-4, as well as P. Exs. 1-5, into the record.

III. Discussion

A. Issue

The issue in this case is whether the evidence establishes that CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(10) because Petitioner did not provide the required beneficiary care documentation to CMS and its contractors.

B. Findings of Fact and Conclusions of Law

CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges because Petitioner violated 42 C.F.R. § 424.535(a)(10).

1. Petitioner did not provide the documentation to CMS or its contractor at the time of the original request.

The Social Security 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 for providers and suppliers in 42 C.F.R. pt. 424, Subpart P. *See* 42 C.F.R. §§ 424.500 – 424.545 (2014). The regulations authorize CMS to revoke the direct Medicare 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 and any corresponding provider or supplier agreement if:

> (i) The provider or supplier did not comply with the documentation or CMS access requirements specified in § 424.516(f) of this subpart.
> (ii) A provider or supplier that meets the revocation criteria specified in paragraph (a)(10)(i) of this section, is subject to revocation for a period of not more than 1 year for each act of noncompliance.

42 C.F.R. § 424.535(a)(10). A physician who orders DMEPOS must maintain documentation relating to the written orders or certifications or requests for payments for those items or services for 7 years from the date of the service. 42 C.F.R. § 424.516(f)(2). A physician must also provide access to the documentation upon request by CMS or a Medicare contractor. *Id.*

Here, the evidence shows that Petitioner did not timely provide any of the medical records CMS requested relating to the orders of fourteen of Petitioner's patients for durable medical equipment. Instead, Petitioner responded that he was unable to produce the requested documentation because his former employer was in sole possession of the documents. CMS Ex. 3. Considering Petitioner did not provide the documentation that CMS originally requested, CMS had a legitimate basis to revoke Petitioner's Medicare enrollment due to a violation of 42 C.F.R. § 424.535(a)(10).

2. The records Petitioner provided later with his request for reconsideration still did not fully respond to CMS's request for required documentation.

Petitioner concedes that there was a delay in providing any of the requested documentation to CMS but argues that Petitioner ultimately provided "voluminous records" with the request for reconsideration. P. Br. at 8, 10-11. Petitioner asserts that the documents provided were "exactly" the documents that CMS requested, and CMS now attempts to "nit pick" because some of the records were not detailed enough or because Petitioner did not produce his own records. *Id*. at 9.

However, I find those documents were still not fully responsive to CMS's request. CMS's January 6, 2015 request for documents asked Petitioner to provide "written and electronic documents relating to written orders, certifications or requests for payments for items of DMEPOS," specifically requesting the physician's orders, prescriptions, progress notes and patient information sheets. CMS Ex. 2. Petitioner provided numerous pages of medical documentation with his request for reconsideration. Petitioner did not sign the vast majority of these records. Most of the records were either signed by another physician or were forms filled out by the patients. *See, e.g.,* CMS Ex. 4 at 62, 68-89. The documentation Petitioner submitted includes 14 prescriptions with Petitioner's signature, six written detailed orders that Petitioner signed and one clinical note that Petitioner signed. CMS Ex. 4 at 90, 137, 160, 201, 271-74, 373, 427-28, 431, 501-02, 583, 617, 714, 750, 752, 795-96, 854; P. Ex. 3 at 11. While Petitioner provided 14 prescriptions, he did not provide all the related orders, progress notes and patient information sheets as CMS requested.

Petitioner asserts that CMS was too exacting in its requirement for "detailed written orders." P. Br. at 9. Petitioner argues that determining whether documentation is "detailed" is subjective and that CMS's Medicare Program Integrity Manual refers only to documentation "being sufficiently detailed." *Id*. The Medicare Program Integrity Manual, however, describes a "Detailed written order," in part, as:

> The written order must be sufficiently detailed, including all options or additional features that will be separately billed or that will require an upgraded code. The description can be either a narrative description (e.g., lightweight wheelchair base) or a brand name/model number. All orders must clearly specify the start date of the order. . . .
>
> Someone other than the physician may complete the detailed description of the item. However, the treating physician/practitioner must review the detailed description and personally sign and date the order to indicate agreement.

> The supplier must have a detailed written order prior to submitting a claim. If a supplier does not have a faxed, photocopied, electronic or pen and ink detailed written order signed and dated by the treating physician/practitioner in their records before they submit a claim to Medicare (i.e., if there is no order or only a verbal order), the claim will be denied. . . .

Medicare Program Integrity Manual (MPIM), chapter 5, section 5.2.3. The record shows that Petitioner did not submit detailed written orders for eight of the beneficiaries (S.B., J.G., B.B., S.H., E.B., C.J., L.H., and M.E.) and was therefore not fully responsive to CMS's request for required documentation.

3. CMS was not required to make an exception because Petitioner did not maintain the patient documentation for reasons beyond his ability to control.

Petitioner further asserts it is not practical to require him to maintain a separate copy of the records, and even if he were required to maintain separate copies, an exception should be made in his case. P. Br. at 7-8, 11. Petitioner states that the delay in producing the records was beyond his control because he did not have an ownership interest in the Sleep Medicine Center, and he was not a custodian of the records. *Id*. at 11. Further, the Sleep Medicine Center had since closed, and Petitioner explained the owner of the facility "had absconded with the records." *Id*. Petitioner argues that CMS incorrectly "seeks to require a physician to keep his own separate copy of patient records anytime he works at a facility, and maintain that separate copy either at his home or somewhere else." *Id*.

However, Petitioner was legally responsible for maintaining and producing the requested records. A physician must maintain, and retain for 7 years, documentation pertaining to ordered and certified services for durable medical equipment. *See* 42 C.F.R. § 424.516(f)(2). The April 27, 2012, CMS final rule implementing these requirements stated that the "rule places the responsibility for the maintenance of records on both the ordering and certifying physician and the provider and supplier." 77 Fed. Reg. 25284, 25310 (April 27, 2012). Further, CMS clarified that even in the case of a physician referral for DMEPOS at a hospital or nursing home discharge, "[t]he physician or other eligible profession who signed the order or certification is responsible for maintaining and disclosing the documentation." *Id*.

Petitioner references the preamble to the final rule to support his assertion that he should be excused from the document retention and production requirements because the delay in producing the records was outside of his control. P. Br. at 7-8. However, that full discussion describes situations where, despite good faith efforts, documentation was lost or destroyed due to circumstances beyond the supplier's control during the seven year

retention period. The discussion describes two examples of such circumstances: a systems malfunction or a natural disaster. The comment states that suppliers who demonstrate good faith efforts to maintain the documentation should not receive the same penalty as a supplier that "intentionally or carelessly disregards the documentation requirements." 77 Fed. Reg. 25284, 25310 (April 27, 2012). Here I do not find Petitioner's lack of maintaining documents out of his control but rather a function of disregarding the documentation requirements, which provides CMS a legitimate basis for not granting an exception. I am not authorized to review whether CMS exercised its discretion wisely, merely whether CMS acted permissibly based on the law and facts in a case. *Latantia Bussell, M.D.*, DAB No. 2196, at 13 (2008) ("[T]he right to review of CMS's determination by an ALJ serves to determine whether CMS had the authority to revoke . . . not to substitute the ALJ's discretion about whether to revoke.").

IV. Conclusion

I sustain the revocation of Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(10) because CMS has shown that Petitioner did not provide the required documentation CMS requested relating to Petitioner's orders of durable medical equipment for his Medicare patients. Petitioner is barred from re-enrolling in Medicare for one year from the March 21, 2015 revocation date.

/s/
Joseph Grow
Administrative Law Judge