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President Donald J. Trump
The White House
1600 Pennsylvania Avenue NW
Washington, DC 20500

Dear President Trump,

This letter is to express concern over the termination of Bryan Merrick, M.D., and to urge his immediate restatement. The letter is to also address concerns about CMS's application of 42 CFR 424.535(a)(8) in revocation of Medicare billing privileges.

CMS failed to perform the appropriate analysis of this matter under 42 CFR 424.535(a)(8). CMS focused excessively on the fact that the isolated billing errors involved deceased patients, rather than whether there had in fact been "abuse" of billing, such as a pattern or fraudulent behavior, and failing to perform the review of the situation specified in part (ii) of the Rule to assess whether there is a "pattern of abusive billing".

CMS should review this case again in light of the factors listed in 42 CFR 424.535(a)(8), as well as a review of how the revocation consideration process is performed at CMS.

1. **Dr. Merrick's revocation indicates that CMS is revoking Medicare billing privileges for "Abuse of billing privileges" under 424.535(a)(8)** [1] **without performing a proper**

[1] (a) Reasons for revocation. CMS may revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement or supplier agreement for the following reasons:

(8) Abuse of billing privileges. Abuse of billing privileges includes either of the following:

(i) 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 the following situations:

(A) Where the beneficiary is deceased.

(B) The directing physician or beneficiary is not in the state or country when services were furnished.

(C) When the equipment necessary for testing is not present where the testing is said to have occurred.

(ii) CMS determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements. In making this determination, CMS considers, as appropriate or applicable, the following:

(A) The percentage of submitted claims that were denied.

(B) The reason(s) for the claim denials.

(C) Whether the provider or supplier has any history of final adverse actions (as that term is defined under § 424.502) and the nature of any such actions.

(D) The length of time over which the pattern has continued.

(E) How long the provider or supplier has been enrolled in Medicare.

(F) Any other information regarding the provider or supplier's specific circumstances that CMS deems relevant to its determination as to whether the provider or supplier has or has not engaged in the pattern or practice described in this paragraph.

analysis required by the rule; it is not considering the factors in (ii), and is misapplying the Federal Register "floor" requiring three (3) instances of non-accidental, non-isolated abusive billing practices (and is instead considering three instances as conclusive evidence of "abusive billing", even if isolated or accidental).

a. Revocation is not appropriate for accidental or isolated billing errors:
    i. "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 . . . . Accordingly, [CMS] will not revoke billing privileges under [section] 424.535(a)(8) unless there are multiple instances, at least three, where abusive billing practices have taken place." 73 Fed. Reg. at 36,455.
    ii. In other words, there has to be a ***pattern***, and more than isolated occurrences or accidental billing errors.
    iii. This assessment of whether the situation was "isolated or accidental" cannot be determined without considering the factors listed in 424.535(a)(8)(ii), which CMS is not doing.
    iv. This does not mean that three isolated or accidental billing errors merit revocation just because the claims involved deceased patients.
b. Revocation 42 CFR 424.535(a) is not mandatory, but must fall within one of the categories of reasons listed:
    i. "(a) Reasons for revocation. CMS ***may*** revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement or supplier agreement ***for the following reasons***:"
    ii. The cited reason, 42 CFR 424.535(a)(8), requires the exercise of discretion to take into account the factors listed in 42 CFR 424.535(a)(8)(ii).
c. CMS failed to do type of analysis required under 424.535(a)(8)(ii):
    i. "In making this determination, *CMS* ***considers,*** as appropriate or applicable, the following:"
    ii. The "determination" is whether the situation is one of "isolated or accidental" billing errors (i.e., not "abusive"), or "a ***pattern*** of ***abusive billing***"; which is required by the Federal Register comment above, and the title of the rule.
    iii. P. 5 of the decision says that the conclusion was based upon a finding of a ***"pattern"*** due to three (3) or more claims submitted to Medicare.
    iv. You can't base the termination on a "pattern" unless you do the analysis in section (ii), relating to a pattern, including the consideration of stated factors.
    v. The addition of Part (ii) demonstrates the intent that the factor in Part (ii) also requires a pattern, as determined by the analysis.
d. Use of part (i) is only for situations where services could not possibly have been performed, and with no explanation for the errors; not for services that were in fact performed, or inadvertently billed incorrectly by accident;

i. …"that ***could not have been furnished to a specific individual*** on the date of service".

1. In all but three instances, Dr. Merrick services could were in fact furnished to a specific individual; were just inadvertently billed incorrectly, or, in the case of records reviews, done prior to notice that the patient had died.
2. Even the three where services were billed but not performed, they were "isolated and accidental", not "abusive billing".
    a. Dr. Merrick was given a list of patients who were all to be billed for the same service; nursing home list still included patients who had died, resulting in accidental billing.
3. See p. 4; "Although Dr. Merrick ***may have rendered services to beneficiaries who received services from him on the listed dates of service***, the claims submitted to CMS for payment were submitted using HICNs for deceased beneficiaries and not the beneficiaries which Dr. Merrick alleges that he treated."
    a. So revocation should not have been based upon (i) exclusively without a consideration of the factors in (ii).
    b. Policy: If conclusively didn't provide any services but billed, on a basis that was not isolated or accidental, that's a different problem; no explanation other than "abuse". That is not this case.
    c. "Abuse": Use (something) to bad effect or for a bad purpose; misuse:
        i. This is more than situations that are isolated or accidental.
    d. These services could have provided to "a" specific individual, but the appeal stated they were not provided to "the" specific individual. One poses a loss to the program and ill-gotten gains to the physician, the other doesn't. They should not be confused.

2. The flawed analysis is apparent from the appeal decision:
    a. The Reconsideration decision demonstrates that CMS is considering "3" incidents as conclusive proof of "abusive billing", rather than as a ***floor*** before even considering revocation. (The Reconsideration decision does not identify where ***"Medicare has stated…"*** this is presumably 73 Fed. Reg. at 36,455, above.)
        i. "Three instances" is an overly simplistic and improper standard for "pattern"; the Rule contains considerations for determining whether there is a "pattern" in part (ii).
        ii. The decision failed to address the argument that there should be a review of reasons, which even felons get prior to revocation.
    b. No support in decision for assertion that there will not be access problem;
        i. How can there not be access problems with only one other internist??
    c. There were not in fact thirty instances; 13? were resubmissions due to CMS error in the denial reason.

3. 42 CFR 424.535(a)(8) requires consideration of the following factors, all of which mandate that Dr. Merrick's privileges should not have been terminated:
    a. In making this determination, CMS considers, as appropriate or applicable, the following:
        (A) The percentage of submitted claims that were denied.
            i. ***The errors comprised less than .1% of claims filed, a negligible amount of claim dollars and zero dollars ($0) of payments;***
        (B) The reason(s) for the claim denials.
            i. ***The reasons are understandable due to staff confusion of patients with the same or similar names, or the fact that chart reviews were requested, but no notification was given of the death of the patients***;
        (C) Whether the provider or supplier has any history of final adverse actions (as that term is defined under § 424.502) and the nature of any such actions.
            i. There is no history of adverse actions. There is a history of decades of good service.
        (D) The length of time over which the pattern has continued.
            i. The only events occurred over a two year period, but not before.
        (E) How long the provider or supplier has been enrolled in Medicare.
            i. ***Dr. Merrick has been enrolled in Medicare for decades, and throughout that time has provided selfless care to an aging population in his rural West Tennessee community***;
        (F) Any other information regarding the provider or supplier's specific circumstances that CMS deems relevant to its determination as to whether the provider or supplier has or has not engaged in the pattern or practice described in this paragraph.
            i. The errors were made by billing staff, not Dr. Merrick. Procedures have been put in place to prevent similar future errors. There will be an access problem for the Medicare population if Dr. Merrick is terminated.
4. The termination must not take effect until there has been a reconsideration with a proper application of the rule, or the ALJ appeal has occurred, in light of the significant issues raised.
5. Is there an ALJ hearing/decision backlog?
    a. That may not be a problem with revocation hearings, only overpayment hearings?
    b. ALJ review is reportedly a "rubber stamp" for CMS action.

Respectfully Yours,

Dr. George Flinn