Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Palmetto GBA,	)	Date: July 30, 2008
	)	
Petitioner,	)	
	)	
- v. -	)	Docket Nos. C-06-127
	)	C-06-128
Villages of Bentleyville, Moreland Hills, and South Russell,	)	C-06-129
	)	
	)	Decision No. CR1824
Respondents.	)	
	)	

DECISION

Palmetto GBA, Petitioner, appealed the decision by a carrier-hearing officer to allow the Villages of Bentleyville, Moreland Hills, and South Russell, Ohio, Respondents, to retain their Medicare Provider Identification Numbers (PINs). For the reasons discussed below, I reverse the decision of the carrier-hearing officer and find that Petitioner was entitled to revoke Respondents' Medicare PINs.

I. BACKGROUND

Petitioner, the Centers for Medicare & Medicaid Services (CMS) contractor for provider enrollments, is the Medicare carrier that processes, among other services, supplier enrollment applications for Ohio ambulance suppliers and determines whether claims for ambulance services meet Medicare requirements for payment. Each Respondent is a municipal corporation in the State of Ohio. Each of the Respondents entered into a Fire Protection and Emergency Medical Service Agreement with the Chagrin Falls Volunteer Firemen's Association (Association). *See, e.g.*, Respondents' Exhibit (R. Ex.) 1. Under these agreements the Association provides emergency medical services, with leased ambulance vehicles and EMS crew members employed by the Association, to Respondents for a fixed rate.

Each Respondent submitted a Medicare Federal Health Care Provider Enrollment Application to be an ambulance supplier to Petitioner. *See, e.g.*, R. Ex. 2.

Based on the information submitted by each Respondent, Petitioner determined that each Respondent was eligible as a Medicare ambulance supplier and issued a Medicare PIN to each Respondent. R. Ex. 6. On March 23, 2005, however, Petitioner revoked Respondents' Medicare PINs on the basis that Respondents failed to meet the conditions for coverage of ambulance services set forth at 42 C.F.R. § 410.41(c)(2). R. Ex. 7. Specifically, Petitioner stated that "Medicare has learned that licensure and ambulance information submitted by [Respondents] actually belongs to the Chagrin Falls Suburban Volunteer Fire Department." *Id*. On May 9, 2005, Respondents made a consolidated request for a hearing before a carrier-hearing officer. R. Ex. 8. On June 9, 2005, the carrier-hearing officer, finding that Respondents met the applicable Medicare requirements as ambulance suppliers, issued a decision reinstating Respondents' Medicare PINs. R. Ex. 9.

On August 4, 2005, Petitioner appealed the carrier-hearing officer's decision. The case was assigned to me for a hearing and a decision. On February 22, 2006, I conducted a telephone pre-hearing conference with the parties, wherein the parties agreed that this dispute involved purely legal issues which could be decided on the basis of written submissions without the need for an in-person hearing. Respondents then filed a motion to dismiss, accompanied by 13 exhibits (R. Exs. 1 - 13). Petitioner filed a reply to the motion to dismiss and a cross-motion for summary disposition, accompanied by nine exhibits (CMS Exs. 1 - 9). Respondents then filed a response to Petitioner's cross-motion.

As neither party objected to any of the opposing party's exhibits, I admit into the record Respondents' exhibits 1 - 13 and Petitioner's exhibits 1 - 9.

II. ISSUES

The issues presented in this case are:

1. Whether I have jurisdiction over this case.

2. Whether Petitioner's appeal was timely filed.

3. Whether Respondents are entitled to PINs because they have met the applicable legal standards to qualify as Medicare ambulance suppliers.

III. FINDINGS OF FACT AND CONCLUSIONS OF LAW

I make findings of fact and conclusion of law (Findings) to support my decision in this case. I set forth each Finding below in boldface italics as a separate heading and I discuss each finding in detail.

1. I have jurisdiction to resolve this dispute.

Part 498 of 42 C.F.R. sets out the appeals procedures for determinations that affect participation in the Medicare program. Subpart D of Part 498 further sets out the procedures for a hearing before an administrative law judge (ALJ). Respondents argue that I do not have jurisdiction to review this matter because Petitioner is not an affected party, under 42 C.F.R. § 498.40, that may request a hearing before an ALJ. An "affected party" is defined at 42 C.F.R. § 498.2 as "a provider, prospective provider, supplier, prospective supplier, or practitioner that is affected by an initial determination or by any subsequent determination or decision issued under this part, and 'party' means the affected party or CMS . . ., as appropriate." Respondents contend that Petitioner, as a CMS contractor, does not fall within this definition of an "affected party" with the consequence that I do not have the authority to resolve any dispute between Respondents and Petitioner.

In response, Petitioner correctly points out that I have jurisdiction over this matter not directly through Part 498, but rather pursuant to 42 C.F.R. § 405.874. This regulation sets out the procedures for the appeals of carrier decisions that Medicare supplier standards have not been met. Originally, jurisdiction over the supplier enrollment appeals resided with CMS, as detailed in 42 C.F.R. § 405.874(c). As to what party may initiate the appeals procedure, the regulations provide that after a hearing officer's decision, the notice of the hearing officer's decision --

> must include information about the supplier's further right to appeal, *the carrier's right to appeal*, the date by which the appeal must be filed . . . and the address to which the appeals must be sent in writing. Either *the carrier* or the entity may appeal the hearings officer's decision to CMS.

42 C.F.R. § 405.874(c) (emphasis added).

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), section 936 (Pub. L. No. 108-173) modified the process for appealing decisions by hearing officers involving the awarding of a Medicare PIN. The MMA transferred that jurisdiction from CMS to the Departmental Appeals Board and required that the appeals be governed by the procedures set forth in 42 C.F.R. Part 498.

This change in authority over the appeals process is detailed in the Medicare Program Integrity Manual, IOM 100-8. Discussing the appeals procedures for suppliers, this Manual provides:

> The appeals process can be found at 42 CFR § 405.874. The administrative appeals process includes the right to a Medicare contractor hearing before a hearing officer who was not involved with the original contractor determination, the right to seek a hearing before an Administrative Law Judge (ALJ), the right to review of the ALJ decision by the Departmental Appeals Board, and the right to judicial review.

Chapter 10, § 19.

Thus, Petitioner, as a carrier, had the right under 42 C.F.R. § 405.874 to appeal an adverse decision by a hearing officer, and, pursuant to the changes made by the MMA, that appeal will be heard by an ALJ under the procedures set forth in 42 C.F.R. Part 498. Accordingly, I find that I have jurisdiction over this matter.

2. Petitioner's appeal was timely filed.

Respondents contend that, even if I were to find that I had jurisdiction over this matter, Petitioner nevertheless filed its hearing request in an untimely manner under 42 C.F.R. Part 498. Respondents cite to 42 C.F.R. § 498.40(a)(2), which requires that a hearing request be filed within 60 days from receipt of an adverse determination. Indeed, the hearing officer's decision was dated June 9, 2005, and directed Petitioner that, if it wished to appeal the decision, it had to file its appeal within 60 days (by August 6, 2005). R. Ex. 9, at 3. Respondents argue that Petitioner, however, did not file a procedurally proper hearing request until December 1, 2005. R. Ex. 4. Respondents acknowledge that Petitioner did file an initial hearing request on August 4, 2005 (R. Ex. 10), but maintain that the request was rejected on procedural grounds (R. Ex. 11) and that Petitioner did not request an extension to file its appeal until October 27, 2005, 51 days after the rejection was sent. R. Ex. 12. According to Respondents, it was not until December 1, 2005, that Petitioner submitted a formal request for an ALJ review of the hearing officer's decision. P. Ex. 5.

Respondents' arguments are not persuasive. Petitioner did file a timely appeal on August 4, 2005. That letter identified the issues in the hearing officer's decision with which Petitioner disputed and specified the basis for its position, thereby conforming with the requirements set forth at 42 C.F.R. § 498.40(b). The September 6, 2005 letter from a Civil Remedies Division (CRD) staff paralegal, characterized by Respondents as a rejection of Petitioner's appeal request, was not, in fact, an explicit rejection of

Petitioner's hearing request, but rather constituted directions on how Petitioner could perfect its appeal in light of new procedures and guidelines for appeals in Medicare supplier enrollment cases instituted by the CRD. Upon receipt of this letter, Petitioner requested an extension of time in which to perfect its hearing request. This office, however, failed to respond to Petitioner's request. It was not until Petitioner re-filed its appeal, in accord with the new procedures, that the CRD subsequently docketed and formally acknowledged this matter on January 19, 2006. This delay in acknowledging Petitioner's appeal was due to circumstances beyond Petitioner's control and in no way was Petitioner's fault, and thus constitutes "good cause" under 42 C.F.R. § 498.40(c) for accepting Petitioner's hearing request. *Hillcrest Healthcare, LLC*, DAB CR976, at 6 (2002). I thus find that Petitioner's appeal was timely filed.

3. Respondents are not entitled to Medicare billing numbers because they failed to meet the applicable legal standards to qualify as Medicare ambulance suppliers.

Among the benefits provided under Medicare Part B are ambulance services. 42 C.F.R. § 410.10(i). Medicare Part B covers ambulance services provided that "[t]he supplier meets the applicable vehicle, staff, and billing and reporting requirements of § 410.41 . . ." 42 C.F.R. § 410.40(a)(1). The requirements for a supplier of ambulance services are accordingly set forth at 42 C.F.R. § 410.41. The vehicle used as an ambulance must meet certain requirements, as do the crew that staffs the ambulance. 42 C.F.R. § 410.41(a) and (b). Additionally, an ambulance supplier must comply with the following billing and reporting requirements:

> (2) Upon a carrier's request, complete and return the ambulance supplier form designated by CMS and provide the Medicare carrier with documentation of compliance with emergency vehicle and staff licensure and certification requirements in accordance with State and local laws.

42 C.F.R. § 410.41(c)(2). Most significant to this matter, the services must be furnished by the entity specified in 42 C.F.R. § 410.40. 42 C.F.R. § 410.12(a)(2).

CMS revoked Respondents' PINs because both the ambulance and pharmacy licenses involved in the delivery of the ambulance services at issue belonged to the Chagrin Falls Volunteer Firemen's Association and not to Respondents.

Respondents argue that they are entitled to Medicare PINs because they met all the legal and regulatory requirements for Medicare participation as an ambulance supplier and because Petitioner has provided no legal basis for the revocation of their Medicare PINs.

Respondents maintain that Petitioner has taken a position here that conflicts with the stated CMS intention to defer to state and local laws governing ambulance vehicles and their staffing. Respondents further argue that Petitioner's position thus raises federalism issues, as well as estoppel issues, as Petitioner was aware of the applicable license information when it first approved Respondents' PINs.

I find Respondents' arguments unavailing.

At the heart of Respondents' arguments is their belief that they have met all the regulatory requirements as ambulance services providers. Respondents maintain that it is undisputed that the emergency vehicles they used are registered in the State of Ohio and are designed and equipped to comply with state and local laws governing emergency vehicles. Furthermore, according to Respondents, it is likewise undisputed that the ambulance crews are properly certified by the State of Ohio and legally authorized to operate any and all lifesaving equipment onboard the ambulances. Therefore, in Respondents' view, there is no question that the ambulance services provided under their agreements with the Association qualified as ambulance services under 42 C.F.R. § 410.41, and thus eligible for Medicare reimbursement. Respondents contend that there is no requirement under the regulations that the supplier of ambulance services actually own the vehicles or actually employ the ambulance staff, but only that the supplier submit documentation showing compliance with vehicle and staff license and certification requirements. Respondents analogize their situation to Part A of Medicare, which allows hospitals to bill for ambulance services whether the hospitals themselves furnish the ambulances directly or use them under arrangements with other entities actually holding the relevant licenses. Respondents suggest that, since the regulations permit such arrangements under Part A, the same rules and benefits should equally be permitted under Part B.

In their arguments, however, Respondents overlook the connection in the regulations between the requirements of ambulance services stated in 42 C.F.R. § 410.41 and the regulatory requirement as to who must provide those ambulance services. Nowhere in their arguments do Respondents address 42 C.F.R. § 410.12, which requires, at subsection (a)(2), that the ambulance services must, in order to qualify as Medicare services, be furnished by the entity specified at 42 C.F.R. § 410.40, the entity that meets the requirements of section 410.41 and that actually furnishes the ambulance services. Therefore, when read as whole, the regulations clearly require that the *only* entity that qualifies as an ambulance supplier is the entity that meets the requirements of section 410.41 and that *actually* furnishes the ambulance services.

This interpretation is bolstered by the definition in the regulations of a "supplier" as an entity other than a provider that furnishes health care services under Medicare. 42 C.F.R. § 400.202. Thus, by definition, the supplier is the entity that furnishes the services, not the entity that contracts with another entity such as the Association to furnish the services. Furthermore, this interpretation is consistent with CMS's ambulance coverage policy set forth in Chapter 10 of the Medicare Benefit Policy Manual, which fortifies Petitioner's argument that Respondents do not qualify as Medicare Part B suppliers of ambulance services:

> The Medicare ambulance benefit is a transportation benefit and without a transport there is no payable service. When multiple ground and/or air ambulance providers/suppliers respond, payment may be made only to the ambulance provider/supplier that *actually furnishes* the transport.

CMS. Ex. 8 (emphasis added).

Thus, I find that under the regulations the Respondents did not furnish the ambulance services and accordingly are not entitled to Medicare PINs. It is in fact the Association that owned the vehicles, employed the ambulance crews, and actually furnished the ambulance services. Thus, only the Association, provided it has a Medicare PIN, may bill Medicare and receive Medicare payments for services it furnishes to Respondents' citizens.

Additionally in their motion to dismiss, Respondents advanced several arguments that I find that I am either without authority to address or are not relevant to the central issue before me. For example, Respondents put forth the argument that Petitioner's actions violate standards of federalism, in that the Medicare ambulance supplier standards set forth at 42 C.F.R. § 410.41 impose additional licensure and certification standards not required by Ohio state law, thereby violating Ohio's police powers. Petitioner, however, does not dispute that under section 410.41 Medicare does defer to state law in the determination whether a vehicle or staff members meet licensure standards. Rather, the issue, again, is *who can be paid* for those services. I thus find that Respondents' federalism argument is not relevant to this inquiry.

Respondents also raise arguments concerning the reassignment rights to Medicare payments. Once again, that is not the issue before me. The basis for the revocation of Respondents' PINs was the determination that Respondents were not the ambulance suppliers that actually provided services. Furthermore, any overpayment to Respondents that might have resulted from their claims for ambulance services is not before me.

Respondents further maintain that Petitioner should be estopped from now revoking Respondents' PINs since Petitioner initially determined that they were qualified to provide ambulance services and Respondents reasonably relied on that guidance. As Petitioner points out, the fact that Petitioner may have mistakenly granted PINs to Respondents does not mean that Respondents are entitled to continue using those PINs. The sole issue before me is whether Respondents are entitled to Medicare PINs. Furthermore, it is well settled that, while the Supreme Court has not ruled that estoppel will never lie against the government, the decisions of the Court make clear that equitable estoppel will not lie against the government, or here the government's contractor, in cases involving benefits to be paid from the Treasury, particularly in the complicated area of Medicare. *See Office of Personnel Management v. Richmond*, 496 U.S. 414 (1990); *Heckler v. Community Health Services of Crawford County, Inc.,* 467 U.S. 51 (1984).

IV. CONCLUSION

For the reasons discussed above, I reverse the decision of the carrier-hearing officer and find that Respondents are not entitled to Medicare PINs as suppliers of ambulance services.

/s/
Alfonso J. Montano
Administrative Law Judge