Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Proteam Healthcare, Inc.
(PTAN: 45-7916),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-398

Decision No. CR3246

Date: May 29, 2014

DECISION

Palmetto GBA (Palmetto), an administrative contractor acting on behalf of the Centers for Medicare & Medicaid Services (CMS), revoked the Medicare billing privileges of Petitioner, Proteam Healthcare, Inc., because Petitioner failed to comply with Medicare enrollment requirements. Petitioner disputed the revocation and requested a hearing. For the reasons stated below, I affirm CMS's determination to revoke Petitioner's billing privileges.

I. Background

In 2004, Petitioner filed an application (Form CMS-855A) for enrollment in the Medicare program as a home health agency (HHA). *See* CMS Exhibit (Ex.) 20, at 3-4. Karibi Briggs, Petitioner's Chief Financial Officer, signed the Certification Statement on the application agreeing to the following "Additional Requirements for Medicare Enrollment":

> I agree to abide by the Medicare laws, regulations and program instructions that apply to [HHAs]. The Medicare laws, regulations, and program instructions are available through the Medicare 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.

CMS Ex. 20, at 3-4. On December 22, 2005, CMS enrolled Petitioner as a Medicare provider. CMS Ex. 20, at 1-2.

On June 24, 2013, Palmetto issued an initial determination revoking Petitioner's Medicare billing number and provider agreement "for noncompliance with enrollment requirements." CMS Ex. 1, at 1. Specifically, Palmetto alleged that Petitioner:

> failed to abide by Medicare laws, regulations, and program instructions by failing to obtain valid physician orders when it submitted claims using Dr. Bernadette Iguh's NPI [National Provider Identifier] for Medicare patients from November 1, 2009 through October 12, 2012. Dr. Iguh signed an attestation indicating that she neither provided any Part B services to or [sic] referred these beneficiaries for home health services provided by [Petitioner]. In addition, [Petitioner] provided Medical records for 12 beneficiaries. A review of the 12 records delivered by [Petitioner] showed some of the records listed Dr. Lguh [sic] as the patient's physician. Often, the records included an additional physician with Dr. Iguh. Two records included Dr. Iguh with Drs. Albert Chen and Mario Bertoni, and one set of the records showed Dr. Iguh and Dr. Bertoni. Several sets of records did not mention Dr. Iguh's name at all, instead listing Drs. Mario Bertoni, Albert Chen, and Augustine Egbunike, either all together or in pairs.

CMS Ex. 1, at 1. Palmetto notified Petitioner it could file a corrective action plan (CAP) and/or reconsideration request. CMS Ex. 1, at 2.

Petitioner submitted a CAP in which it stated that it "completed a review of the billing records for all patients billed with Dr. Iguh's NPI number and cancelled the RAP [Request for Anticipated Payment] and reimbursed the final claims for all beneficiaries

without valid physician orders." CMS Ex. 2, at 3. Petitioner indicated the action it intended to take in the future to ensure that it would have physician orders for each patient. On August 28, 2013, Palmetto denied Petitioner's CAP stating that Palmetto was not satisfied that it "has corrected or established prospective compliance with Medicare home health referral laws, regulations, and program instructions." CMS Ex. 3, at 2.

On September 30, 2013, Petitioner filed a timely request for reconsideration in which Petitioner argued that: the initial determination failed to specify the specific legal basis for revocation; the factual basis for revocation, i.e., failure to obtain valid orders from physicians, is a condition for Medicare payment and not enrollment as a Medicare provider; and that, despite what Petitioner admitted in its CAP, Petitioner had physician orders for all of its patients, although "[s]ome of these patients were never seen by Dr. Iguh, while others were originally seen by Dr. Iguh before she stopped seeing home health patients. Those patients who were seen by Dr. Iguh before she decided to stop seeing home health patients were seen by other physicians after that point, and their orders were signed by their new physician." CMS Ex. 3, at 3-6. Petitioner submitted documentation in support of the latter argument.

On October 9, 2013, CMS's Center for Program Integrity issued a reconsideration determination in which it upheld the initial determination stating that:

> Dr. Iguh reviewed the Plans of Care, Verbal Face-To-Face forms and prescriptions provided to CMS by [Petitioner] and she stated that the signatures on the Plans of Care , Face-To-Face, Prescriptions and Verbals Orders were not her signatures. Dr. Iguh also attested that on these documents the signature was not hers and signed an attestation to that effect for each patient's documentation.
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> . . . .
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> She indicated, for [Petitioner], the beneficiaries she has neither seen nor referred by placing her initials beside the names of 12 beneficiaries on the attestation forms identifying fraudulent activity. Petitioner has argued against these allegations but with no proof that combat's such allegations.

CMS Ex. 3, at 9-10.

Petitioner filed a timely request for hearing (RFH) with the Departmental Appeals Board (DAB), Civil Remedies Division (CRD) on December 9, 2013. In its RFH, Petitioner asserts that CMS failed to provide sufficient notice of the basis for revocation because it did not cite to the law, rule, or program instruction involving enrollment that Petitioner

violated. RFH at 3-4. Further, Petitioner argues that CMS's basis for revocation, i.e., indicating on claims that Dr. Iguh ordered HHA services for Petitioner's patients, when she did not, is a condition for Medicare payment and not an enrollment requirement. RFH at 4-5. Finally, Petitioner asserts that while it did not have an order from Dr. Iguh for the patients in question, Petitioner did have an order from other physicians for each of these patients. RFH at 5-6.

The director of CRD administratively assigned this case to me for hearing and decision. In response to my Acknowledgment and Pre-hearing Order (Order), CMS filed a brief (CMS Br.) and 21 exhibits (CMS Exs. 1-21) as its pre-hearing exchange. Petitioner filed a brief (P. Br.) and two exhibits (P. Exs. 1-2) as its pre-hearing exchange.

II. Decision on the Record

Petitioner did not object to any of CMS's proposed exhibits. *See* Order ¶ 7. Therefore, I admit CMS Exs. 1-21 into the record. CMS did not object to Petitioner's proposed exhibits; however, because those exhibits duplicate CMS's exhibits (*compare* CMS Ex. 3, at 3-11 *with* P. Exs. 1 and 2), I will not admit them 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; *Vandalia Park*, DAB No. 1940, at 28-30 (2004); *Pacific Regency Arvin*, DAB No. 1823, at 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).[1] Neither CMS nor Petitioner offered any proposed witnesses or written direct testimony. 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 based on Petitioner's failure to comply with Medicare enrollment requirements under 42 C.F.R. § 424.535(a)(1).

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).

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[1] Administrative decisions cited in this decision are accessible on the internet at: http://www.hhs.gov/dab/decisions/index.html.

V. Findings of Fact, Conclusions of Law, and Analysis[2]

The Social Security Act (Act) authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations governing the enrollment process for providers and suppliers. 42 U.S.C. §§ 1302, 1395cc(j). Under the Secretary's 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 . . . ." *Id*. § 424.535(a)(1).

HHAs are providers for Medicare purposes. 42 U.S.C. § 1395x(u). The term "home health services" is defined as "items and services furnished to an individual, who is under the care of a physician . . . under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician . . ." *Id*. § 1395x(m). Home health services are covered by Medicare only if "a physician . . . certifies . . . that . . . home health services . . . are or were required because the individual is or was confined to his home . . . and needs or needed skilled nursing care . . . ." *Id*. § 1395f(a)(2)(C); *see also* 42 U.S.C. § 1395n(a)(2)(A). The certifying physician is required to know the Medicare beneficiary's medical status and, therefore, there must be a face-to-face encounter with the individual. 42 C.F.R. § 424.22(a); Medicare Benefit Policy Manual, CMS Pub. 100-102, Ch. 7 (Home Health Services), § 30.5.1.1. The face-to-face encounter must be "related to the primary reason the patient requires home health services . . . ." 42 C.F.R. § 424.22(a)(1)(v).

Home health services must be furnished while the individual is under the care of a physician, and a physician must establish and periodically review a plan of care for furnishing the services. *Id*. § 424.22(a)(iii), (iv). A physician and HHA must review a Medicare beneficiary's plan of care at regular intervals. *Id*. § 484.18(b). Also, HHAs are required to "promptly alert the physician" to significant changes that suggest a need to alter the plan of care. *Id*. HHAs consults with the individual's physician to obtain approval of any "additions or modifications to the original plan" of care. *Id.* § 484.18(a).

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

1. ***Petitioner submitted claims for Medicare reimbursement in which it incorrectly indicated that Dr. Iguh ordered home health services for 12 Medicare beneficiaries.***

From 2009 to 2012, Petitioner submitted claims for home health services for 12 beneficiaries indicating Dr. Iguh's NPI as the physician who ordered home health services for those beneficiaries. CMS Ex. 1; 3; 4; 7. During an inquiry into those claims, Dr. Iguh attested that she never provided orders for those 12 beneficiaries. CMS Exs. 1; 3; 5; 6. Petitioner at first agreed that it did not have any physician orders for home health services for the 12 beneficiaries. CMS Ex. 2. However, Petitioner later submitted documentation that physicians other than Dr. Iguh had ordered the home health services. CMS Exs. 7-19. CMS Exs. 3; 8-19.

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 Petitioner's Medicare enrollment application, thus causing Petitioner to be non-compliant with provider enrollment requirements.***

Petitioner asserts that CMS erroneously accuses Petitioner of failing to obtain a physician's order for the home health services that it provided to the 12 beneficiaries CMS has identified. Petitioner avers instead that it made a "scrivener's error" on the claims it filed for reimbursement when it indicated Dr. Iguh's NPI as the ordering physician when, in fact, other physicians actually ordered the home health services. Petitioner argues that its error in misidentifying the NPI of the physicians who actually ordered the home health services is not a basis for the revocation of billing privileges because the requirement that HHAs provide the NPI of the physician who ordered the home health services is a "condition for payment" under the regulations and not an enrollment requirement. Petitioner indicates that to allow CMS to consider non-compliance with any Medicare law, rule, or program instruction as a basis for revocation renders pointless the enumerated grounds for revocation in 42 C.F.R. § 424.535(a) because all of these grounds would be subsumed under the enrollment requirements. Further, Petitioner believes that CMS's position impermissibly blurs Medicare enrollment requirements and billing requirements. P. Br. at 5-6, 8-10.

I disagree with Petitioner. CMS may "revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement or supplier agreement" for reasons including, as relevant here:

> (1) *Noncompliance*. The provider or supplier is determined not to be in compliance with the enrollment requirements described in this section, or <u>in the enrollment application</u> applicable for its provider or supplier type . . . .

42 C.F.R. § 424.535(a) (emphasis added).

The Certification Statement on Petitioner's Medicare enrollment application provides "Additional Requirements for Medicare Enrollment," one of which requires compliance with Medicare laws, regulations and program instructions that apply to HHAs. CMS Ex. 20, at 3-4. Although Petitioner believes that this requirement is too broad and would allow revocation for any violation of applicable laws, rules, and program instructions, the Secretary acted within her authority to impose such requirements. 42 U.S.C. § 1395x(o)(8) (authorizing the Secretary to establish requirements for HHA participation "as the Secretary finds necessary for the effective and efficient operation of [the Medicare] program."). Petitioner's belief that there are too many requirements for HHAs is not a defense.

Further, Petitioner cannot claim that it was not on notice of the additional enrollment requirements in the enrollment application because CMS placed those requirements on the Certification Statement above the place for the signature of Petitioner's authorized official. In fact, the first sentence on the Certification Statement states that "[t]his section is used to officially notify the provider of additional requirements that must be met and maintained in order for the provider to be enrolled in the Medicare program." CMS Ex. 20, at 3-4 (emphasis added). In the portion of the Certification Statement for the authorized official's signature, it states: "I have read the contents of this application. My signature legally and financially binds this provider to the laws, regulations, and program instructions of the Medicare program." CMS Ex. 20, at 3-4. Petitioner was on notice that its continued right to be an enrolled provider was subject to its full compliance with all Medicare laws, regulations, and program instructions.

Although Petitioner believes that there is a strict separation of enrollment requirements and billing requirements, this is not so with regard to revocation of Medicare billing privileges. In the provision on the Certification Statement imposing compliance with Medicare laws, regulations, and program instructions as an enrollment requirement, it states as the second sentence in that provision that: "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 . . . and on the provider's compliance with all applicable conditions of participation in Medicare." CMS Ex. 20, at 3-4. Therefore, the provision in the enrollment application that is at the center of this case expressly binds the participation and payment requirements together.[3]

Petitioner also contends that it never received appropriate notice of the specific legal basis for revocation and that CMS's factual basis (i.e., that Petitioner did not have

[3] This holding is implicit in *Improving Life Home Care, LLC*, DAB No. CR3076 (2014), *Universal Health Provider Corp.*, DAB CR2747 (2013), *Hoyos Home Health Care Inc.*, DAB CR2746 (2013), and *IFA Universal Home Care, Inc.*, DAB CR2745 (2013).

physicians' orders for the 12 beneficiaries identified by CMS) is erroneous. Palmetto and Petitioner both initially believed that Petitioner did not have any physician orders for the claims it filed. CMS Exs. 1, at 1; 2, at 2. However, Petitioner changed its position in its reconsideration request and provided evidence that physicians other than Dr. Iguh ordered the home health services for the beneficiaries in question. Based on this information, CMS slightly adjusted its factual basis for the revocation to Petitioner's failure to obtain a valid physician order "when it submitted claims using Dr. Bernadette Iguh's NPI for Medicare patients." CMS Ex. 3, at 9. I interpret CMS's statement to be that CMS's revocation of Petitioner's enrollment was now based on Petitioner providing the NPI of a physician who did not order the home health services in question. CMS's position appears to be that it is not dispositive that physicians ordered the home health services to the 12 beneficiaries in question, but rather that Petitioner filed claims with the NPI of a physician who did not order the home health services in question.[4]

As Petitioner points out, the regulations expressly require that "[t]he claim for a provider of home health services must contain the legal name and the National Provider Identifier (NPI) of the ordering physician." 42 C.F.R. § 424.507(b)(ii). Petitioner failed to provide this information on its claim and, in fact, provided incorrect information in its place. Petitioner claims that this was merely a mistake; 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).

In *Gaefke*, a supplier billed Medicare for beneficiaries who were deceased at the time services were alleged to have been rendered and billed for services that could not have been physically rendered to the identified beneficiaries. The supplier's primary defense was that it provided all of the services in question to Medicare beneficiaries; however, it misidentified the real beneficiaries with deceased ones and simply made other errors. *Gaefke*, DAB No. 2554 at 3. However, even accepting the supplier's defense as true, the supplier was still held "responsible for the accuracy of his claims for Medicare reimbursement" because "Medicare suppliers and providers certify that they are

[4] In a provider or supplier enrollment case, it is the reconsidered determination upon which administrative law judge review is predicated. *See Hiva Vakil, M.D.*, DAB No. 2460, at 4-5 (2012) (holding that a supplier cannot obtain administrative law judge review of the initial determination; the supplier may only obtain administrative law judge review when there is a reconsidered determination); *see also* 42 C.F.R. §§ 498.5(*l*), 498.20(b)(1), 498.24(c), 498.25(b)(2). So long as an issue was considered in a reconsidered determination, it is an issue that can be considered by an administrative law judge in a provider or supplier enrollment case. *See* 42 C.F.R. § 498.56(a)(2); *see also Neb Group of Ariz., LLC*, DAB No. 2573, at 7 (2014) (stating that a petitioner's right to appeal is "from the reconsidered determination, not the initial determination").

responsible for the accuracy of their claims for reimbursement. . . ." *Id.* at 6.[5] This reasoning applies to Petitioner because it needed to make such a certification on the claims it filed. CMS Ex. 21, at 2.

Although CMS need not assert or prove that Petitioner's actions in the 12 claims in question involve fraud, CMS indicated that it identified Petitioner's errors due to a "questionable or suspicious pattern[] that could indicate fraudulent activity." CMS Ex. 3, at 10. Whether CMS believes that the number of claims submitted in this matter with incorrect information is of sufficient concern to revoke Petitioner's billing privileges is not an issue for review. However, "[r]epeatedly making those same errors reduces their credibility as 'accidental' and establishes a pattern of improper billing that suggests a lack of attention to detail." *Howard B. Reife, D.P.M.*, DAB No. 2527, at 6 (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, as stated in the enrollment application Petitioner signed, when it incorrectly indicated on claims for reimbursement that Dr. Iguh had ordered home health services for 12 beneficiaries when Dr. Iguh had not done so.

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

[5] Although the *Gaefke* case involved a different legal basis for revocation (i.e., 42 C.F.R. § 424.535(a)(8)), elements of its reasoning are sufficiently analogous to this case.