Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Oakwest Healthcare Services, Inc.,
(NPI: 1285642223; PTAN: 45-3105),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-408

Decision No. CR3658

Date: February 20, 2015

DECISION

Petitioner, Oakwest Healthcare Services, Inc., a home health agency, appeals a reconsideration decision, dated October 17, 2013, upholding the revocation of Petitioner's Medicare enrollment and billing privileges. The undisputed evidence establishes that Petitioner was not in compliance with Medicare program requirements for home health care certification. Consequently, I find the Centers for Medicare & Medicaid Services (CMS) had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges and impose a three-year re-enrollment bar.

Background

Petitioner is a home health agency located in Houston, Texas. CMS Exhibit (Ex.) 3. By letter dated June 24, 2013, Palmetto GBA (Palmetto) notified Petitioner that it was revoking Petitioner's provider transaction access number (PTAN) and terminating Petitioner's provider agreement. CMS Ex. 8. Palmetto stated it was taking this action under 42 C.F.R. § 424.535(a)(1), which provides CMS with the authority to revoke billing privileges and any corresponding provider or supplier agreement for noncompliance with enrollment requirements. Palmetto noted that the form CMS 855A

enrollment application (CMS 855A) for home health agencies contains a certification statement requiring the appropriate agency official to certify:

> I agree to abide by the Medicare laws, regulations and program instructions that apply to this provider. 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 . . . and on the provider's compliance with all applicable conditions of participation in Medicare.

CMS Ex. 8, at 2. Palmetto determined that Petitioner failed to abide by Medicare laws, regulations, and program instructions because Petitioner did not obtain valid physician orders when submitting claims using the NPI (national provider identifier) for Dr. B.I.,[1] for seven Medicare beneficiaries from November 1, 2009 through October 21, 2012. Palmetto stated that Dr. B.I. provided a CMS contractor, Health Integrity (HI), with a statement in which she attested that she neither provided Part B services to these Medicare beneficiaries nor referred them to Petitioner for home health services. Palmetto stated that its review of the medical records for these beneficiaries (provided to HI by Petitioner) showed:

> . . . most records listed Dr. [B.I.] as the patient's physician. Often, the records included an additional physician with Dr. [B.I.]. One record included . . . Drs. [P.O.] and [O.D.], two records showed Dr. [B.I.] with Dr. [R.K.], one record showed Dr. [B.I.] and Dr. [J.R.], another with Dr. [J.G.], another with Dr. [P.O.], and another with Dr. [D.M.] . . . One record didn't mention Dr. [B.I.] at all and instead listed Dr. [M.C.].

CMS Ex. 8, at 2. Palmetto gave Petitioner the opportunity both to file a corrective action plan (CAP) and to request reconsideration. CMS Ex. 8, at 2-4; *see* CMS Ex. 6. Petitioner requested reconsideration on August 20, 2013.[2] CMS Ex. 6. In its reconsideration request, Petitioner asserted that Palmetto's revocation notice letter was vague and did not reference the seven beneficiaries by name. However, Petitioner "assume[d]" they were the seven beneficiary claims Petitioner had previously provided to HI. Petitioner noted that it had not been provided a copy of Dr. B.I.'s statement. Petitioner stated that Dr. B.I. referred and provided services to three of the beneficiaries in question. Petitioner also noted that according to Petitioner's owner, Obinna Ujari

---

[1] I refer to some individuals by their initials.

[2] The reconsideration decision explains that Petitioner submitted a CAP to Palmetto on July 18, 2013, and provides reasons for rejecting it. CMS Ex. 2. I do not have authority to review those reasons.

(whose affidavit Petitioner attached), Dr. B.I. provided services to and referred over 130 patients to Petitioner since 2008. CMS Exs. 6, at 2; 16, at 7-8; Petitioner Exhibits (P. Exs.) 1, 12.

On October 17, 2013, CMS's Center for Program Integrity (CPI) issued a decision in response to Petitioner's reconsideration request. CPI stated that it had reviewed the evidence and determined that Petitioner did not abide by Medicare law, regulations, and program instructions in submitting claims for Medicare beneficiaries without a valid certification or plan of care. Specifically, Petitioner failed to obtain a valid order from a physician when submitting claims using Dr. B.I.'s NPI for Medicare beneficiaries when Dr. B.I. had not seen or referred the beneficiaries for home health services. CMS Ex. 2, at 2-3.

Petitioner filed a timely request for an administrative law judge hearing. The case was assigned to me for hearing and decision. I ordered the parties to file pre-hearing exchanges including all of their arguments and evidence. CMS filed a motion for summary judgment (CMS Br.), accompanied by 17 exhibits. Petitioner did not file a responsive brief or any exhibits by the deadline I ordered. I ordered Petitioner to show good cause for its omission, and then I granted its request for extension. Petitioner eventually filed 11 exhibits, P. Exs. 1-4 and 6-12, including the affidavits of Petitioner's owner Obinna Ujari (filed twice, once as P. Ex. 1 and a second time as P. Ex. 12) and the affidavit of Petitioner's Director of Nursing, Helen Ujari (P. Ex. 11).

My pre-hearing order advised the parties that they must submit written direct testimony for each proposed witness and that an in-person hearing is only necessary when the opposing party affirmatively requests an opportunity to cross-examine a witness. Acknowledgment and Pre-Hearing Order (Order) ¶¶ 8, 9; *see Vandalia Park*, DAB No. 1940 (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). Considering neither party requested the opportunity to cross-examine any witnesses, I find that an in-person hearing in this case is unnecessary and issue this decision on the full merits of the written record. Order ¶¶ 10, 11.

Issue

Whether CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges.

Findings of Fact and Conclusions of Law

1. CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges because Petitioner filed Medicare reimbursement claims containing improper physician certifications for at least three beneficiaries.

CMS's authority to revoke a provider or supplier's enrollment and billing privileges is codified at 42 C.F.R. § 424.535. The pertinent subsection of the regulation states:

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

The Medicare statute defines "home health services" 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 . . ." 42 U.S.C. § 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 . . . ." 42 U.S.C. § 1395f(a)(2)(C); 42 U.S.C. § 1395n(a)(2)(A). Thus, a home health agency may receive Medicare payment for home health services for individuals only after the home health agency has obtained a valid certification from a physician that the individual is homebound and requires home health services. 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. 42 C.F.R. § 424.22(a)(1)(iii), (iv). Also, 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).

To enroll in Medicare, a home health agency must complete an enrollment application, the CMS 855A. The CMS 855A requires a home health agency, through an authorized official, to sign a certification statement at Section 15 of the enrollment application. Obinna Ujari signed such a statement, acknowledging that his signature, "binds this provider to the laws, regulations, and program instructions of the Medicare program." CMS Ex. 3, at 3; *see* CMS Ex. 3, at 4-5. The certification statement he signed also

required him to certify that Petitioner would "not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity." CMS Ex. 3, at 3; *see* CMS Ex. 3, at 4-5.

Petitioner's owner, Obinna Ujari, testified that of the seven beneficiaries CMS cited, and for whom Petitioner claimed payment, Dr. B.I. actually treated only three of them. P. Exs. 1, 12. Petitioner's Director of Nursing, Helen Ujari, testified that three of the seven beneficiaries in question "were seen by a different doctor." P. Ex. 11. Combined, I find their testimony establishes that, for at least three Medicare beneficiaries for whom Petitioner claimed payment, Dr. B.I. was not the treating physician or involved in their care or monitoring, and thus Dr. B.I. could not be the certifying physician. It is unnecessary for me to find that Petitioner improperly claimed payment for all seven beneficiaries to uphold the revocation.

2. Petitioner may not avoid revocation by assigning blame to a third party biller for its improper certifications to CMS's contractor.

Obinna Ujari and Helen Ujari both testified that Dr. B.I. was not the treating physician for at least three beneficiaries (Obinna Ujari testifying that Dr. B.I. only treated three of the beneficiaries and Helen Ujari testifying that three beneficiaries for whom Petitioner claimed payment were actually seen by a physician other than Dr. B.I., identifying those beneficiaries as L.W., W.H., and M.S.). P. Ex. 11, at 1; P. Exs. 1, 12; CMS Ex. 9 (Home Health Certification and Plan of Treatment for L.W.); CMS Ex. 10 (Home Health Certification and Plan of Treatment for W.H.); and CMS Ex. 12 (Home Health Certification and Plan of Treatment for M.S.); CMS Ex. 16. The only evidence Petitioner offers as to why it claimed that Dr. B.I. was the certifying physician for these three beneficiaries is that:

> The independent biller hired by [Petitioner] billed under the wrong [NPI] for [three beneficiaries]. . . . The independent biller made errors in the billing by confusing some of the other doctor's patients with [Dr. B.I.].

P. Ex. 11, at 1 (Director of Nursing's affidavit).

It is a supplier or provider's responsibility to "take the necessary steps to ensure that they are billing appropriately for services furnished to Medicare beneficiaries." *See* 73 Fed. Reg. 36,448, 36,455 (June 27, 2008).[3] The Departmental Appeals Board has held:

[3] At least three instances of filing a claim for services that could not have been furnished to a specific individual on the date of service may constitute a "pattern of improper billing," which could have constituted a separate basis for revocation. 42 C.F.R. § 424.535(a)(8); 73 Fed. Reg. 36,448, 36,455 (June 27, 2008).

> Medicare suppliers and providers certify that they are responsible for the accuracy of their claims for reimbursement, and the regulation contains no exception for improper claims prepared and submitted by billing agents, which is consistent with the preamble stating that providers and suppliers are responsible for claims submitted on their behalf. . . . Petitioner's position, if adopted, would effectively shield a supplier from any consequences for the submission of an unlimited number of improper claims on his behalf, so long as he could point to an agreement with a billing agent, who is not a party to the supplier's Medicare agreement, to submit the claims. Petitioner's efforts to assign blame for the improper billing to his billing agent . . . do not relieve him of his responsibility for the improper claims or bar CMS from revoking his billing privileges.

Louis J. Gaefke, D.P.M., DAB No. 2554, at 6 (2013).

The CMS 855A application that Obinna Ujari signed on behalf of Petitioner placed Petitioner on notice that submitting claims with reckless disregard for their truth or falsity could lead to revocation of its enrollment and billing privileges. Simply relying on a billing agent without checking that the claims filed are correct could clearly lead to the submission of incorrect and invalid claims. Petitioner's failure to assure that the claims it submitted were correct persuades me that Petitioner submitted claims with reckless disregard for the truth or falsity of the physician certification in at least three cases.[4]

Accordingly, I find that Petitioner's evidence showing that it submitted invalid claims due to invalid physician certifications for at least three Medicare beneficiaries, whether or not due to its billing agent's error, supports CMS's revocation of its enrollment and billing privileges.

/s/
Joseph Grow
Administrative Law Judge

[4] In a separate and independent decision issued on the same date as this decision, I upheld CMS's revocation of another home health agency also finding its owner, Obinna Ujari, filed improper claims based on Dr. B.I.'s physician certifications which undisputedly never occurred. *See CJN Enterprises, Inc.*, DAB CR3859 (2015).