Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Accuread Quality Mobile X-Rays, LLC
(NPI: 1124218045;
PTAN: 45-9912),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-3862

ALJ Ruling No. 2016-7

Date: January 8, 2015

ORDER OF REMAND AND DISMISSAL

The Centers for Medicare & Medicaid Services (CMS) revoked the Medicare enrollment and billing privileges of Accuread Quality Mobile X-Rays, LLC (herein "Petitioner") after it concluded that Petitioner was not operational at the practice location on file with CMS and the Medicare contractor, Novitas Solutions (herein "Novitas"). On August 10, 2015, Petitioner requested a hearing to dispute the revocation. Because evidence submitted by CMS has raised a new issue related to Petitioner's compliance with Medicare enrollment requirements, I remand this case to CMS to render a new determination and provide Petitioner with an opportunity to respond to the new issue. If Petitioner is dissatisfied with the new determination, Petitioner may request reconsideration and, if dissatisfied with the reconsidered determination, may file a new request for an administrative law judge hearing.

Petitioner is a portable X-ray supplier that was enrolled as a supplier of services in the Medicare program.[1] CMS Exhibit (Ex.) 4 at 1. Novitas, in a July 7, 2015 letter, informed Petitioner that its Medicare billing privileges were being revoked retroactively to March 9, 2015. CMS Ex. 4. Novitas explained in its letter that it performed a site verification visit at Petitioner's location of record at 105 N. Lopez St. in Rio Grande City, Texas on March 9, 2015, and at that time, it discovered that Petitioner was no longer located at that address. *Id*. at 1. Novitas further reported that a second site visit on March 19, 2015 confirmed the original findings. *Id.* at 2. In its July 7, 2015 letter, Novitas explained that Petitioner did not notify CMS of its change in practice location as is required pursuant to 42 C.F.R. § 424.516. As a result, Novitas informed Petitioner that it would revoke its Medicare privileges and terminate its enrollment agreement, effective March 9, 2015. *Id*. at 1-2.

On July 14, 2015, Petitioner submitted a response to the July 7, 2015 letter which was construed as a request for reconsideration of the revocation. CMS Exs. 2, 3. In its construed reconsideration request, Petitioner conceded that it relocated from its office at 105 N. Lopez St. on January 20, 2015. CMS Ex. 3 at 1. Petitioner explained that the "[d]elegated parties for updating and renewing license have been removed from our office due to theft," and that these same individuals did not "complete their jobs as well." *Id.*

CMS's Provider Enrollment Oversight Group (PEOG) issued a reconsidered determination on August 3, 2015, that determined that the 105 N. Lopez St. location was not operational at the time of a site visit on March 9, 2015, and that Petitioner failed to report a change of practice location within 30 days of its relocation. CMS Ex. 2 at 2. CMS explained, in the case analysis section of the determination, that "[Petitioner] did not notify CMS of a change in practice location as required under 42 C.F.R. § 424.516(d)(1)(i) whereby physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations must report reportable events to their Medicare contractor within 30 days for a change in practice location." *Id*. The determination informed Petitioner that it "did not comply with the reporting requirements specified in § 424.516(d)(1)(ii) and (iii) of this subpart," and as a result, its Medicare billing privileges and supplier agreement were revoked under 42 C.F.R. § 425.535(a)(9). CMS further determined that based on Petitioner's failure to timely report its relocation, it was not operational at the 105 N. Lopez St. location pursuant to 42 C.F.R. § 424.535(a)(5) at the time of the March 9, 2015 site visit.

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[1] Under Medicare statutes and regulations, a "supplier," such as Petitioner, means a physician or other practitioner, or a facility or entity other than a provider of services. 42 U.S.C. § 1395x(d); 42 C.F.R. § 400.202. "Providers of services," or "providers," include hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, and hospice programs. 42 U.S.C. § 1395x(u); 42 C.F.R. § 400.202.

As noted, Petitioner filed a request for an administrative law judge hearing to contest the reconsidered determination. CMS contended in its pre-hearing brief (CMS Br.) that "[w]hile comprehensible, Petitioner is not excused from its obligation to report to CMS any changes in information supplied on its application within 30 days of the change. 42 C.F.R. § 424.516(d)(1)(iii)." CMS Br. at 2. CMS first argued that Petitioner was not operational at the time of the March 2015 site visits and therefore in violation of 42 C.F.R. § 424.535(a)(5). CMS also argued that Petitioner failed to meet reporting requirements, stating the following in its second argument heading: "CMS could not conduct an on-site review because Petitioner did not comply with the reporting requirement specified in §424.516(d)(1)(ii) and (iii) of this subpart, hence CMS's subsequent revocation was appropriate." CMS Br. at 7. In the closing sentence of that section, CMS gave the following summation of its argument: "Petitioner did not comply with the § 424.516(d)(1)(iii) and CMS appropriately revoked it [in] accordance with 42 C.F.R. § 424.535(a)(9)." CMS Br. at 8.

CMS submitted eleven proposed exhibits as part of its pre-hearing exchange.[2] Three of those exhibits consist of declarations by CMS and CMS-contractor employees. CMS Ex. 10 is a declaration from S.K., a Provider Relations Hearing Specialist for Novitas, and CMS Ex. 11 is a declaration from E.L., a Health Insurance Specialist who is employed by the PEOG. Declarant E.L. is the author of the aforementioned reconsidered determination. CMS Ex. 2 at 4.

In her declaration, S.K. stated the following, in pertinent part:

> [W]hen a portable x-ray supplier such as Accuread changes its practice location, the provider must notify the [Medicare Administrative Contractor]. 42 C.F.R. §516(e).[3] This also is done by filing a Form CMS-855B to update the practice location address. In the case of a change to its practice address, a medical supplier such as Accuread must file the updated Form CMS-855-B within ninety (90) days. *Id.* *See also* Medicare Program Integrity Manual, CMS Pub. 100-08, Chapter 15 ("Provider Enrollment"), §15.10.1

CMS Ex. 10 at 1-2. With striking similarity, E.L. stated the following in her declaration:

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[2] Petitioner submitted a pre-hearing exchange consisting of a brief and twelve unmarked exhibits.

[3] The reference to "§516(e)," when read in context, is clearly an incomplete reference to 42 C.F.R. § 424.516(e).

> [W]hen a portable x-ray provider such as Accuread changes its practice location, the provider must notify the [Medicare Administrative Contractor]. 42 C.F.R. §516(e).[4] This also is done by filing a Form 855B to update the practice location address. In the case of a change to its practice address, a medical supplier such as Accuread must file the updated Form 855B within ninety (90) days. *Id See also* Medicare Program Integrity Manual, CMS Pub. 100-08, Chapter 15 ("Provider Enrollment"), §15.10.1.

CMS Ex. 11 at 1. While CMS does not make any reference to or discuss S.K and E.L.'s declarations in its brief, both declarations identify a new issue in this case. Specifically, both declarants posit, for the first time, that Petitioner was obligated to report its change of address within 90 days, rather than 30 days, pursuant to 42 C.F.R. § 424.516(e) ("Reporting requirements for all other providers and suppliers"), as opposed to 42 C.F.R. §424.516(d) (Reporting requirements for physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations), which is the authority that was relied upon in both the reconsidered determination and CMS's pre-hearing brief. The obvious discrepancy in the authorities cited by E.L., in her reconsidered determination and subsequent declaration, and the newly cited authority in both declarations supporting revocation, go to the underpinnings of the entire basis for revoking Petitioner's enrollment and Medicare billing privileges.

As noted, the reconsidered determination informed Petitioner that its Medicare enrollment and billing privileges were revoked because it did not notify CMS of its move within 30 days of January 20, 2015, and because of such a failure to timely report its relocation, it was non-operational at the location where the two March 2015 site visits were performed.[5] If 42 C.F.R. § 424.516(e), rather than 42 C.F.R. § 424.516(d), dictates the time period for which notice of the relocation must have been provided, Petitioner would have been well within its 90-day grace period for reporting its relocation at the time of the site visits on March 9 and 19, 2015. Thus, *at the time* of the two verification site visits in March 2015, assuming that 42 C.F.R. § 424.516(e) is the applicable regulation, no violations of sections 424.535(a)(5) and (a)(9) could have yet been conclusively found. Furthermore, even if a violation of the supplier standards had occurred, it is possible that the CMS contractor, based on this much expanded reporting window and the application of the correct legal authority, may have imposed a different effective date of revocation or a reenrollment bar of a duration other than the two-year

[4] As previously stated, the reference to "§516(e)," when read in context, is clearly an incomplete reference to 42 C.F.R. § 424.516(e).

[5] The January 20, 2015 date of relocation is not disputed by the parties.

period that was imposed.[6] Thus, not only does this new issue raise a question as to whether a violation of the supplier standards in fact occurred, but also raises potential questions regarding the appropriate effective date and the duration of any reenrollment bar. Remand is therefore warranted, as explained more fully below, so that these questions can be resolved through the issuance of a new initial determination that is premised on the correct legal authorities.

The failure to report, and in turn the determination that Petitioner was non-operational, was initially based on the requirements listed in 42 C.F.R. § 424.516(d), which pertains to physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations. CMS has not explained why section 424.516(d) is applicable or explained how it considers Petitioner, a portable X-ray supplier, to be a physician, nonphysician practitioner, or physician/nonphysician practitioner organization.

The regulations distinguish physicians and nonphysician practitioners from other suppliers, defining a supplier as a "physician or other practitioner, *or* an entity other than a provider, that furnishes health care services under Medicare." 42 C.F.R. § 400.202 (emphasis added). Additionally, Medicare Pub. No. CMS-11048 (Medicare Enrollment for Physicians, Non-Physician Practitioners and Other Health Care Suppliers) lists portable X-ray facilities in the category of "[s]uppliers, other than Durable Medical Equipment Prosthetics, Orthotics and Supplier (DMEPOS)." That publication instructs that, for the aforementioned category of suppliers, any changes, other than in ownership or control, must be reported within 90 days of the reportable event, which is consistent with 42 C.F.R. § 424.516(e). Furthermore, as referenced in both declarations, the

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[6] It is also possible that Petitioner may have evidence showing that it notified CMS of its relocation within 90 days. The initial determination put Petitioner on notice that it had violated two supplier standards as a result of its failure to notify the CMS contractor of its relocation at the time of the March 9 and 19, 2015 site visits. Thus, Petitioner was not put on notice that, in response to the initial determination, it could show that it had provided appropriate notice before or *after* the March 2015 site visits, so long as the notice was given within 90 days of its relocation. I observe that the current record does not yield any evidence that Petitioner provided notice of its relocation within 90 days, but nonetheless, in the event that CMS issues another unfavorable initial determination upon remand, Petitioner will now have notice of and the opportunity to present any evidence that it gave timely notice within 90 days of its relocation. Furthermore, while CMS or its contractors unquestionably had no obligation to give the supplier the opportunity to correct a deficiency in advance of the violation, I observe that the first unsuccessful site inspection occurred more than five weeks prior to the conclusion of the reporting period. Although the inspector telephonically contacted the business occupying Petitioner's former address, neither the inspector nor the CMS contractor contacted Petitioner with respect to its relocation until *after* the 90-day reporting period concluded.

Medicare Program Integrity Manual (MPIM) indicates that "[p]hysicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives; clinical social workers; clinical psychologists; registered dietitians or nutrition professionals; and organizations (e.g., group practices) consisting of any of the [previously listed] categories of individuals" must report a change in practice location within 30 days, but all other providers and suppliers, other than DMEPOS and independent diagnostic testing facilities, must report a change of address within 90 days. MPIM, Pub. 100-08, Chapter 15, Section 15.10.1. Finally, Novitas, the Medicare contractor who issued the initial determination in this case, clearly distinguishes portable X-ray suppliers from both physicians and nonphysician practitioners in its Enrollment Guide. Novitas Solutions Enrollment Guide, Chapter 3, Section 3.2 (listing three categories of suppliers, physicians, and nonphysician practitioners). *See http://www.novitas-solutions.com/webcenter/spaces/MedicareJH/page/pagebyid?contentId=00004825* (last visited January 7, 2016).

Based on the discussion above, I conclude that CMS mistakenly applied the reporting requirements at 42 C.F.R. § 424.516(d) and, consequently, erred in relying on section 424.535(a)(9) as a basis for revocation in this case.

Although CMS has also argued that Petitioner violated 42 C.F.R. § 424.535(a)(5) because it was non-operational at the time of the attempted site inspections, I find in this instance that this issue is inextricably intertwined with the issue of whether Petitioner timely reported its relocation. As this matter is being remanded, it is thus premature for me to determine whether Petitioner was operational and in compliance with 42 C.F.R. § 424.535(a)(5). As previously discussed, Petitioner was not required to have informed CMS of its relocation *at the time* of the March 2015 site visits.

The Departmental Appeals Board has held that in cases involving a provider or supplier's Medicare enrollment, 42 C.F.R. § 498.5(l) "limits ALJs to considering the basis or bases for denial or revocation of enrollment and billing privileges set forth in the CMS contractor's reconsidered determination." *Precision Prosthetics, Inc.*, DAB No. 2597, at 11 (2014)(citations omitted). *See also Ortho Rehab Designs Prosthetics and Orthotics, Inc.*, DAB No. 2591, at 8 (2014); *Keller Orthotics, Inc*., DAB No. 2588, at 7 (2014); *Neb Group of Arizona LLC*, DAB No. 2573, at 7 (2014); *see also Cornerstone Medical Inc*., DAB No. 2585 (2014); *Norpro Orthotics & Prosthetics, Inc*., DAB No. 2577 (2014); *Benson Ejindu, d/b/a Joy Medical Supply*, DAB No. 2572, at 8-9 (2014). CMS has submitted evidence that raises a new basis for revocation, and this evidence, in the form of a declaration by a CMS employee, expressly contradicts the previous reasons given in the reconsidered determination that was authored by the same CMS employee. As explained above, Petitioner had no duty to have reported its relocation *at the time* of the site inspections in March 2015. Here, because the reconsidered determination did not address the question whether section 424.516(e) (as opposed to section 424.516(d)) controlled Petitioner's

obligation to report its change of location and if so, whether Petitioner complied with that requirement, I may not now address this issue. Rather, the regulations provide that I may remand the case for CMS to consider the issue in the first instance. *See* 42 C.F.R. § 498.56(d). Therefore, because CMS, through its submissions, has raised a possible new basis for revocation, I remand this case to CMS.

As Petitioner's Medicare billing privileges and enrollment were previously revoked, time is of the essence. Therefore, within **30 days from the date of this order,** CMS or its contractor must issue an initial determination *revoking **or** declining to revoke* Petitioner's Medicare enrollment and billing privileges. If Petitioner receives an unfavorable initial determination and wishes to request reconsideration, Petitioner must request reconsideration.[7] If Petitioner is dissatisfied with the outcome of any reconsideration request, it may file a request for a hearing before me under this same docket number which I will leave open. 42 C.F.R. § 498.56(d). Petitioner also has the right to decline further review. If this case is returned to me for a new hearing, I will issue a scheduling order with new and *expedited* deadlines for pre-hearing briefs.

It is so ordered.

/s/
Leslie C. Rogall
Administrative Law Judge

[7] If Petitioner requests reconsideration, CMS or its contractor must issue a reconsidered determination. Consistent with this order, I fully expect that CMS and/or its contractor will act expeditiously.