Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Med-Care Diabetic and Medical Supplies, Inc.,
(PTAN: 1289360001; NPI: 1619978434),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-16-311

Decision No. CR4615

Date: May 20, 2016

DECISION

I sustain the determination of a Medicare contractor, as affirmed on reconsideration and adopted by the Centers for Medicare & Medicaid Services (CMS), to revoke the Medicare enrollment and billing privileges of Petitioner, Med-Care Diabetic and Medical Supplies, Inc.

I. Background

Petitioner is a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). On November 12, 2015, a Medicare contractor revoked Petitioner's Medicare enrollment and billing privileges. That determination was affirmed on reconsideration and Petitioner requested a hearing.

CMS moved for summary judgment. It filed a brief and 20 proposed exhibits that are identified as CMS Ex. 1-CMS Ex. 20. Petitioner opposed the motion. It filed a brief (Petitioner's brief) and seven proposed exhibits that are identified as P. Ex. 1-P. Ex. 7. I am receiving all of the parties' exhibits into the record for purposes of deciding CMS's motion. I make no ruling as to whether "good cause" exists to receive some of

Petitioner's exhibits into evidence that were not provided at reconsideration. It is unnecessary that I make such a finding at this time. As I discuss below, this case rests on undisputed material facts. The parties disagree sharply as to the implications of those facts, but there is no dispute about the nature of Petitioner's conduct, even if the parties dispute the precise extent of it. There is nothing that could be established at a hearing that would possibly alter these facts. Consequently, summary judgment is appropriate.

II. Issue, Findings of Fact and Conclusions of Law

A. Issue

The issue is whether CMS is authorized to revoke Petitioner's Medicare participation and billing privileges.

B. Findings of Fact and Conclusions of Law

The following facts are material: During a period of about three years, beginning in 2012 and continuing into 2015, Petitioner filed numerous Medicare reimbursement claims for durable medical equipment, prosthetics, orthotics, and supplies allegedly sold to Medicare beneficiaries who were, in fact, deceased on the dates of sale. CMS Ex. 1; CMS Ex. 3; CMS Ex. 4 ¶ 6.

CMS revoked Petitioner's Medicare participation and billing privileges based on these undisputed facts and on the authority conferred by 42 C.F.R. § 424.535(a)(8). This section authorizes revocation under the following circumstances:

> 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 . . . .*

(emphasis added).

Revocation in this case plainly is authorized by the regulation. It is undisputed that Petitioner claimed reimbursement for services allegedly provided to individuals who were deceased on the alleged dates of service. The regulation unequivocally authorizes revocation of a supplier's Medicare participation and billing privileges in that circumstance.

Petitioner makes many arguments in opposition to CMS's motion. I find these arguments to be without merit. However, before discussing Petitioner's arguments, it is noteworthy to point out that Petitioner never denies that it filed reimbursement claims for products that it shipped to deceased Medicare beneficiaries. And, although Petitioner quibbles with CMS about the exact number of deceased beneficiaries for whom it filed claims, it never denies – or even addresses – the core of CMS's case.[1] *See* Petitioner's brief at 14-18. CMS's central argument is, in fact, untouched. Petitioner submitted claims for services allegedly provided to deceased beneficiaries in direct violation of regulatory requirements.

It is unnecessary for me to decide precisely how many claims Petitioner filed for services rendered to beneficiaries who were deceased. CMS asserts that there were more than 300 claims. Petitioner has specifically challenged CMS's assertions concerning some of these claims but has not challenged the great bulk of them. However, whether the precise number is somewhat less than 300 or a few more is irrelevant. As is made evident by the regulation the submission by Petitioner of even one claim for reimbursement for services to beneficiaries who were deceased is a sufficient basis for CMS to revoke participation and billing status. Here, there were many such claims even if the precise number is in dispute. That is sufficient to justify CMS's action. Given that, adjudicating the precise number of prohibited claims becomes a dry and useless academic exercise.

Petitioner's principal argument is that the language of 42 C.F.R. § 424.535(a)(8) is inapplicable here. Petitioner contends that applying the regulation in this case would be "incomprehensible and unprecedented." Petitioner's brief at 10. It contends that this regulation only makes sense in the context of alleged face-to-face transactions, such as a physician alleging to have provided a medical treatment to a beneficiary on a date when the beneficiary is deceased. It asserts that the regulation does not – or should not – apply to a business such as Petitioner's business, which is a mail order supply company. It asserts that it sells a high volume of products by mail and cannot reasonably be expected to know which of its customers (beneficiaries) are alive or dead. Thus, according to Petitioner, it should not be penalized for erroneous claims for sales to deceased beneficiaries when it allegedly had safeguards in place to prevent this and was not in a position to know whether those beneficiaries were alive or dead on the dates of the claimed transactions. This argument fails, foremost, because the regulation does not distinguish between mail order and face-to-face transactions. There is no language in the regulation – and Petitioner has identified none – that carves out the exception that Petitioner demands. Indeed, Petitioner's argument that it should be given a free pass to

[1] For example, Petitioner argues that CMS cannot come up with an exact and accurate number of the claims that Petitioner submitted for services provided to beneficiaries who were deceased when Petitioner submitted the claim. Petitioner's brief at 2, 14-18. But, even if that is so, there is no argument that Petitioner filed a large number of claims for services allegedly provided to deceased beneficiaries.

claim reimbursement for services allegedly provided to dead people is brazenly contrary to the regulation's explicit language and plain meaning. Nor has Petitioner identified interpretive language that would grant it an exception from the regulation's reach.

Petitioner's assertion that it ought to be exempt not only contradicts the regulation's plain meaning but it contradicts the regulation's obvious purpose. Medicare is a huge program that provides benefits to tens of millions of people. It is impossible for those charged with administering a program so vast to police every transaction for honesty or accuracy. For that reason, the Secretary imposes on providers and suppliers, as a requirement of their participation, the obligation that they self-police their transactions. That duty is implicit in 42 C.F.R. § 424.535(a) and its various subsections. Failure by a provider or a supplier to do what is required of it by the regulation – in this case not claim reimbursement for sales of products to dead beneficiaries – authorizes CMS to cease to do business with that provider or supplier.

CMS identified interpretive language that supports the regulation's plain meaning and purpose:

> For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill. This shall be done to ensure that the refilled item is necessary and to confirm any changes/modifications to the order. Contact with the beneficiary or designee regarding refills shall take place no sooner than 14 calendar days prior to the delivery/shipping date.

Medicare Program Integrity, Chapter 4, Section 4.26.1. This language puts the supplier on notice that it cannot blindly refill products without ascertaining first whether the consumer (the beneficiary) still needs the product. A beneficiary's death – which clearly obviates the need for a refill – is something that a supplier should ascertain before refilling the product. In fact, a substantial percentage of the claims that are at issue here involve refills. CMS Ex. 4 ¶ 7.

Petitioner argues that this language does not impose any burden on it to speak directly with beneficiaries before refilling products. It contends that the phrase "or designee" contained in Section 4.26.1 of the Medicare Program Integrity Manual gives it the right to speak to a beneficiary's designee in advance of refilling the product. But, Petitioner offered no affirmative proof that it contacted the beneficiaries *or* their designees for the product refills that are at issue. Petitioner has not contended, for example, that any beneficiary's designee misled it into believing that a beneficiary who was deceased was still alive as of the date that it shipped a product refill.

Petitioner also seems to characterize the claims that are at issue here as accidental and/or isolated. Relying on language in the preamble to 42 C.F.R. § 424.535(a), Petitioner

contends that it should not be held liable for what it characterizes as innocent mistakes that constitute only a small percentage of the huge volume of business that Petitioner does. Petitioner's brief at 11; *see* 73 Fed. Reg. 36,448, 36,455 (June 27, 2008). Petitioner's argument notwithstanding, the preamble to the regulation does not provide Petitioner with a defense. It is true that the regulation's preamble draws a distinction between random erroneous claims and those that comprise a pattern. But, the distinction is exceedingly narrow. The preamble suggests that a "pattern" exists where there are three or more claims that violate the regulation's proscription. Here, there are many more than that.

Petitioner asserts also that: "[i]t defies reason that any supplier can operate without making any mistakes over many years in operation." Petitioner's brief at 11. It argues that it is being pilloried for making mistakes that are simply the natural consequence of its substantial business operation. However, CMS did not make its determination based on a few random errors. It identified many Petitioner-generated claims for services provided to deceased individuals over a finite (three-year) period. Furthermore, Petitioner has offered nothing but self-serving statements about its alleged safeguards and processes (RFH; Petitioner's brief at 3, 13, 18-19) to show how it attempted to avoid making these claims. As I discuss above, it had an affirmative duty to contact beneficiaries or their designees to assure that refills were not being sent to deceased individuals and it offered no proof showing that it did that. At bottom, Petitioner's argument seems to be "stuff happens," an assertion which, in Petitioner's eyes, enables it to shrug and walk away from many claims that were at the very least, erroneous.

Petitioner argues that this case is distinguishable from other situations in which CMS revoked a supplier's Medicare participation and billing privileges on the ground that, in this case, Petitioner actually shipped the supplies for which it billed Medicare. Petitioner's brief at 13. But, if that is so, that is a distinction without a difference. The supplies that Petitioner shipped were unnecessary. Dead beneficiaries have no use for durable medical equipment, prosthetics, or the other products that Petitioner shipped. And, Medicare should not be billed for useless services.

Petitioner argues that CMS is attempting to advance a "new theory" in this case, one that was not a basis for the contractor's initial determination or for the reconsideration determination. Petitioner's brief at 13-14. According to Petitioner, that "new theory" is that Petitioner failed to exercise an affirmative duty to assure that the beneficiaries to whom it shipped supplies were not deceased. Petitioner contends that not only was this theory not part of the initial determination or reconsideration determination, but it departs from what is required by the Medicare Program Integrity Manual. *See* Medicare Program Integrity Manual, Chapter 4, Section 4.26.1.

I disagree with Petitioner that CMS is advancing a "new" theory and I disagree also that CMS is arguing anything beyond what is demanded by the Medicare Program Integrity Manual and recited in the reconsideration determination. The reconsideration determination is explicit. It quotes the relevant language of the Medicare Program Integrity Manual verbatim and in that context it charges that Petitioner failed to contact beneficiaries or their designees 14 days prior to sending refills of products.

Petitioner argues also that the reconsideration determination "misstated material facts" in that it inaccurately described the number of claims for reimbursement that Petitioner submitted for services allegedly provided to deceased beneficiaries. Petitioner's brief at 14-15. As I have discussed, the precise number of claims is irrelevant in this case because it is undisputed that Petitioner submitted far more claims for services allegedly provided to deceased beneficiaries than would be necessary to justify CMS's action.

Petitioner asserts that CMS constantly shifted the basis for revocation, failed to give Petitioner adequate notice of the claims that are at issue, relied on erroneous data, and misrepresented regulatory requirements, thereby depriving Petitioner of due process. Petitioner's brief at 21-25. I disagree. The reconsideration determination in this case clearly recites CMS's basis for revocation of Petitioner's Medicare participation and billing privileges, and CMS has made no argument that goes beyond the four corners of that document. Petitioner has not satisfied me that CMS failed to provide it with notice of its action. Nor has CMS misstated the regulatory criteria under which it has authority to act.

/s/
Steven T. Kessel
Administrative Law Judge