Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Pueblo Family Physicians
(NPI: 1790798072; PTAN: ZWCHTQ),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-16-246

Decision No. CR4661

Date: July 20, 2016

DECISION

The Centers for Medicare & Medicaid Services (CMS), through its administrative contractor, Noridian Healthcare Solutions (Noridian), revoked the Medicare enrollment and billing privileges of Pueblo Family Physicians (Petitioner) because Petitioner submitted to Noridian completed forms with the forged signatures of a physician in order for that physician's reimbursement payments to be paid to Petitioner and for the physician's address and contact information to be changed in CMS's records to that of Petitioner. Noridian revoked based on alleged false or misleading statements Petitioner made on an enrollment application (42 C.F.R. § 424.535(a)(4)) and on Petitioner's alleged failure to comply with Medicare enrollment requirements (42 C.F.R. § 424.535(a)(1)). Petitioner requested a hearing to dispute the revocation arguing that it had relied on a third party, who had contracted with the physician to provide certain services to Petitioner, to obtain the physician's signature on the forms sent to Noridian, but that Petitioner did not know the third party had forged the physician's signature on those forms.

Both parties in this case moved for summary judgment. As explained in more detail below, I grant summary judgment for Petitioner and deny it for CMS because the undisputed facts in this case show that the application forms filed with the physician's

forged signatures did not relate to enrollment, but only to the reassignment of Medicare benefits between enrolled suppliers and to the change of an address for an enrolled supplier. Therefore, I reverse the revocation because, as a matter of law, Petitioner did not violate 42 C.F.R. §§ 424.535(a)(1) or 424.535(a)(4).

I. Background and Procedural History

Petitioner is a physician organization that was enrolled in the Medicare program. On January 11, 2008, Petitioner entered into an "Equipment and Technician Lease Agreement" with Phoenix Neurology, Inc. CMS Exhibit (Ex.) 1 at 10-14. The purpose of this agreement was for Petitioner to lease mobile medical testing equipment. CMS Ex. 1 at 10. The lease placed the duty on Petitioner for determining the medical necessity for tests, providing physician supervision for all tests, and "billing [Petitioner's] patients for the Procedures performed on [Petitioner's] patients, including deductibles and coinsurance if applicable." CMS Ex. 1 at 11. Phoenix Neurology had the obligation to "employ or contract with physicians to read and interpret the Procedures performed on [Petitioner's] patients . . . ." CMS Ex. 1 at 11. The lease further provided that "[t]he Personnel provided pursuant to this Agreement shall be deemed to be employees or contractors of [Phoenix Neurology.]" CMS Ex. 1 at 10. Michael R. Grow, Jr. signed the lease for Phoenix Neurology. CMS Ex. 1 at 12.

Louis C. Kirby, M.D., a physician enrolled in the Medicare program, contracted with Michael Grow and Phoenix Neurology to provide test interpretations. Mr. Grow paid Dr. Kirby $25 per completed test. Dr. Kirby interpreted tests for Mr. Grow that involved Petitioner's patients. Mr. Grow annually provided a 1099 tax reporting document to Dr. Kirby for the compensation Phoenix Neurology/Mr. Grow paid to Dr. Kirby. CMS Ex. 4 at 1; CMS Ex. 5 at 1.

In 2010, Noridian advised Petitioner that it could not bill Medicare for the test interpretations that Dr. Kirby rendered unless Dr. Kirby reassigned his Medicare billing privileges to Petitioner. CMS Ex. 1 at 2. Therefore, Petitioner prepared CMS-855I and CMS-855R forms for the purpose of Dr. Kirby reassigning his Medicare benefits to Petitioner. CMS Ex. 1 at 2. Petitioner indicated on the CMS-855I (Physician and Non-physician practitioner Medicare enrollment application) that Petitioner's offices were to be added as Dr. Kirby's practice locations and that Petitioner was to be Dr. Kirby's point of contact for Medicare matters. CMS Ex. 2 at 16-18, 20, 24. Petitioner indicated on the CMS-855R (Reassignment of Medicare benefits application) that Dr. Kirby's Medicare benefits were to be reassigned to Petitioner. CMS Ex. 3 at 5. Donald Cunningham, D.O., signed the CMS-855R on March 3, 2010, on Petitioner's behalf. CMS Ex. 3 at 6. Petitioner sent the CMS-855I and CMS 855R forms to Phoenix Neurology for Phoenix Neurology to obtain Dr. Kirby's signatures. CMS Ex. 1 at 2. A signature purporting to be Dr. Kirby's signature appears on the forms that Petitioner submitted to Noridian with March 3, 2010, shown as the date of signing. CMS Ex. 2 at 27; CMS Ex. 3 at 6.

In 2014, an analyst with a CMS contractor and a special agent with the Department of Health and Human Services, Office of the Inspector General, investigated the relationship between Dr. Kirby and Petitioner. On January 29, 2014, they interviewed Dr. Kirby, who stated that he did not recall signing the CMS-855I and CMS-855R that Petitioner submitted in 2010. Dr. Kirby stated that the signatures that appear on those forms are not his and that his work for Petitioner was coordinated through Michael Grow. CMS Exs. 4, 5. Dr. Kirby indicated that he had a contractual relationship with Mr. Grow, but that he did not have a relationship with Petitioner. Dr. Kirby said that Mr. Grow would send test results to Dr. Kirby, and Dr. Kirby would read and report the results to Mr. Grow. CMS Ex. 4 at 1; CMS Ex. 5 at 1.

On January 30, 2014, after Dr. Kirby learned that Petitioner was billing Medicare for his services, Dr. Kirby: informed Mr. Grow that he would not read test results for Petitioner any longer; took steps to terminate the reassignment of Medicare benefits from Dr. Kirby to Petitioner; and informed Dr. Cunningham by letter that he would no longer read any test results for Petitioner. CMS Ex. 4 at 2; CMS Ex. 6. On January 31, 2014, Mr. Grow informed Dr. Kirby that he had signed Dr. Kirby's name to the CMS-855I and CMS-855R forms, although Mr. Grow indicated that Dr. Kirby had known that he was "credentialed" with Petitioner for several years. CMS Ex. 1 at 16. Also on January 31, 2014, Mr. Grow informed Petitioner of Dr. Kirby's decision to no longer interpret test results for Petitioner and of Mr. Grow's admission that he had signed Dr. Kirby's name to the CMS-855I and CMS-855R forms. P. Ex. 6 at 1.

On January 31, 2014, Petitioner filed a CMS-855R terminating Dr. Kirby's reassignment of Medicare benefits. CMS Ex. 1 at 1, 2, 22, 24. Petitioner's position is that it did not know that Mr. Grow forged Dr. Kirby's signature to the CMS-855I and CMS-855R forms signed in 2010, and that Dr. Kirby was aware that he was "credentialed as a part of [Petitioner's] practice and that [Petitioner] billed for his test interpretation services." P. Ex. 6 at 2; *see also* CMS Ex. 1 at 1-2; P Ex. 3; P. Ex. 4; P. Ex. 5 at 8.

In a July 23, 2015 initial determination, Noridian informed Petitioner that it was revoking Petitioner's Medicare enrollment and billing privileges effective August 22, 2015. CMS Ex. 7. The initial determination stated the following reasons for revocation:

> **42 CFR §424.535(a)(1) – Not in Compliance with Medicare Requirements**
>
> Pueblo Family Physicians submitted an 855I application and an 855R application with Dr. Louis Kirby as the enrollee in the Medicare Program and his signature. However, Dr. Louis Kirby has attested that these enrollment applications were submitted to Medicare without his knowledge or consent and that his signature was forged on both documents. This is in

> violation of the enrollment requirements in 42 C.F.R. § 424.510(d)(2)(i) which requires that each submitted enrollment application must include "[c]omplete, accurate, and truthful responses to all information requested within each section as applicable to the provider or supplier type."
>
> **42 CFR §424.535(a)(4) – False or Misleading Information on Application**
>
> On Pueblo Family Physicians' enrollment application, Dr. Louis Kirby is the signing practitioner. However, Dr. Louis Kirby has attested that he did not sign this enrollment application and that it was submitted to Medicare without his knowledge or consent.

CMS Ex. 7 at 1. The initial determination also stated that Petitioner had the right to file a corrective action plan (CAP) within 30 days and a request for reconsideration within 60 days. CMS Ex. 7.

On August 20, 2015, Petitioner timely submitted a CAP and a request for reconsideration. CMS Ex. 1. In an October 19, 2015 letter, Noridian informed Petitioner that it denied Petitioner's CAP, but that it was still considering Petitioner's reconsideration request. CMS Ex. 8 at 1-2. On November 17, 2015, Noridian issued an unfavorable reconsidered determination. CMS Ex. 9.

On December 1, 2015, Petitioner requested a hearing before an Administrative Law Judge (ALJ) to contest Noridian's October 19, 2015 denial of Petitioner's CAP. The Civil Remedies Division (CRD) docketed this case under C-16-147 and assigned it to Judge Joseph Grow. On December 8, 2015, Judge Grow issued an Acknowledgement and Pre-Hearing Order (Pre-Hearing Order) in which he provided a pre-hearing submission schedule. On January 12, 2016, CMS moved for dismissal of Petitioner's hearing request arguing that Noridian's October 19, 2015 CAP decision is not subject to further review. On January 14, 2016, Petitioner timely filed a new hearing request seeking to contest Noridian's November 17, 2015 reconsidered determination. CRD docketed the new hearing request under C-16-246 and assigned it to Judge Grow. On February 5, 2016, Judge Grow consolidated both of Petitioner's hearing requests under docket number C-16-246 and administratively dismissed C-16-147. Judge Grow also modified the pre-hearing submission due dates. On March 31, 2016, CRD assigned this case to me because Judge Grow transferred to another component of the Department of Health and Human Services.

In response to the Pre-Hearing Order, CMS filed a brief and motion for summary judgment (CMS Br.), and nine proposed exhibits (CMS Exs. 1-9). Petitioner filed a brief

and cross-motion for summary judgment (P. Br.), six exhibits (P. Exs. 1-6), which included an affidavit from its witness, Rick Johns (P. Ex. 6). CMS filed a reply to Petitioner's motion for summary judgment (CMS Reply), objected to all of Petitioner's proposed exhibits, and requested to cross-examine Petitioner's witness if I declined to grant summary judgment. Petitioner filed a rebuttal to CMS's objections.

II. Issues

1. Whether either party is entitled to summary judgment; and

2. Whether CMS had a legitimate basis for revoking Petitioner's Medicare billing privileges under 42 C.F.R. §§ 424.535(a)(1) and/or (a)(4).

III. Jurisdiction

I have jurisdiction to hear and decide this case. 42 C.F.R. §§ 498.3(b)(17), 498.5(l)(2); *see also* 42 U.S.C. § 1395cc(j)(8).

IV. Findings of Fact, Conclusions of Law, and Analysis

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.[1] 42 U.S.C. §§ 1302, 1395cc(j). Under the Secretary's regulations, a provider or supplier seeking 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 then establishes an effective date for billing privileges under the requirements stated in 42 C.F.R. § 424.520(d) and may permit limited retrospective billing under 42 C.F.R. § 424.521. CMS may revoke the enrollment and billing privileges of a provider or supplier for any reason stated in 42 C.F.R. § 424.535(a).

For Medicare Part B claims, a beneficiary may assign his or her benefits to a physician or non-physician practitioner providing services to that beneficiary. 42 U.S.C. § 1395u(b)(3)(B)(ii). In certain circumstances, a supplier who has received an assignment of benefits may reassign those benefits to an employer, or to an individual or entity with which the supplier has a contractual arrangement. 42 U.S.C. § 1395u(b)(6); 42 C.F.R. § 424.80(b)(1)-(2). CMS instructs its employees that reassignments of benefits may only occur between enrolled providers and suppliers. Medicare Program Integrity Manual (MPIM) § 15.5.20(A).

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[1] Petitioner is considered a "supplier" for purposes of the Act and the regulations. *See* 42 U.S.C. § 1395x(d),(u); 42 C.F.R. § 498.2; *see also* 42 C.F.R. § 400.202.

1. Summary judgment is appropriate in this case.

When appropriate, an ALJ may decide a case arising under 42 C.F.R. part 498 by summary judgment. *Livingston Care Ctr. v. U.S. Dep't of Health & Human Servs.*, 388 F.3d 168, 172 (6th Cir. 2004) (citing *Crestview Parke Care Ctr. v. Thomson*, 373 F.3d 743 (6th Cir. 2004)). "Matters presented to the ALJ for summary judgment will follow Rule 56 of the Federal Rules of Civil Procedure and federal case law . . . ." Civil Remedies Division Procedures § 19(a). As stated by the United States Supreme Court:

> Rule 56(c) of the Federal Rules of Civil Procedure provides that summary judgment 'shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.' By its very terms, this standard provides that the mere existence of *some* alleged factual dispute between the parties will not defeat an otherwise properly supported motion for summary judgment; the requirement is that there be no *genuine* issue of *material* fact.

Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 247-48 (1986) (emphasis in original).

To determine whether there are genuine issues of material fact for an in-person hearing, the ALJ must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 3 (2010) (citations omitted).

There is no genuine dispute of material fact in this case. For purposes of summary judgment, I accept all of the facts that CMS asserts as undisputed in its brief. These undisputed facts are quoted below:

> 1. Dr. Louis Kirby was never employed by [Petitioner] and was never in a contractual relationship with [Petitioner]. CMS Exhibit 1, at 1-2.
>
> 2. [Petitioner] certified to CMS on a Form CMS-855R that it would abide by all laws and regulations pertaining to the reassignment of benefits. CMS Ex. 3 at 6.
>
> 3. [Petitioner] certified to CMS on a Form CMS-855R that it had examined the information on the Form CMS-855R and that it was true, accurate and complete. CMS Ex. 3 at 6.

4. Dr. Kirby's signatures on the Form CMS-855I and on the Form CMS-855R were forgeries. CMS Exhibit 1, at 1-2.

CMS Br. at 5-6.

For purposes of summary judgment, I draw all reasonable inferences in favor of CMS. As explained below, Petitioner is entitled to judgment as a matter of law.

2. CMS did not have a legal basis to revoke Petitioner's Medicare enrollment and billing privileges based on 42 C.F.R. § 424.535(a)(4) because that regulation prohibits the submission of false or misleading information on an enrollment application used to enroll or maintain enrollment in the Medicare program; in this case, however, CMS revoked Petitioner for false or misleading information provided on an application for the <u>reassignment</u> of Medicare benefits.

CMS revoked Petitioner based on a violation of 42 C.F.R. § 424.535(a)(4) for submitting false or misleading information on an enrollment application. CMS Ex. 7 at 1; CMS Ex. 9 at 1. In this litigation, CMS asserts the facts quoted below support its revocation determination under section 424.535(a)(4):

1. Petitioner submitted a Medicare enrollment application (CMS Form-855R) in March 2010 for the purpose of reassigning the Medicare billing privileges of Dr. Kirby to Petitioner. CMS Ex. 3;

2. The March 3, 2010 CMS Form-855R indicated that Dr. Kirby authorized the reassignment of his Medicare billing privileges to Petitioner. CMS Ex. 3 at 4, 5, 6;

3. Petitioner, operating through its authorized representative, Dr. Cunningham, signed the March 3, 2010 CMS Form-855R which had the effect of certifying on the application that he had read its contents and that the information he had provided was true, accurate, and complete. CMS Ex. 3 at 6; and

4. The March 3, 2010 CMS Form-855R application included false or misleading information as Dr. Kirby never authorized the reassignment of his Medicare billing privileges to Petitioner and his signature on the application was admittedly forged. CMS Ex. 1 at 1-2, 16; CMS Exs. 4-6

CMS Reply at 9-10. Accepting these facts as true, they are insufficient, as a matter of law, to prove a violation of section 424.535(a)(4).

Section 424.535(a)(4) states that CMS may revoke under the following circumstance:

> *False or misleading information.* The provider or supplier certified as "true" misleading or false information on the enrollment application **to be enrolled or maintain enrollment in the Medicare program**.

42 C.F.R. § 424.535(a)(4) (emphasis added). Although the preamble to the final rule establishing section 424.535(a)(4) did not discuss that section in detail, the preamble's summarized version of section 424.535(a)(4) amplifies the limitations on the scope of that section: "The provider or supplier certified as 'true' deliberately submitted false or misleading information on the CMS 855 **in order to enroll or maintain** enrollment in the Medicare program." 71 Fed. Reg. 20,754, 20,761 (Apr. 21, 2006) (emphasis added). Therefore, in order to revoke under section 424.535(a)(4), a provider or supplier's misleading or false information must be on an enrollment application used for the purpose of enrolling or maintaining enrollment in the Medicare program, such as those referred to in 42 C.F.R. §§ 424.510(a), 424.515(a).

The regulations provide the following definition of the words *Enroll/Enrollment*:

> the process that Medicare uses **to establish eligibility to submit claims for Medicare-covered items and services, and the process that Medicare uses to establish eligibility to order or certify Medicare-covered items and services**. The process includes—
>
> (1) Identification of a provider or supplier;
>
> (2) Validation of the provider's or supplier's eligibility to provide items or services to Medicare beneficiaries;
>
> (3) Identification and confirmation of the provider or supplier's practice location(s) and owner(s); and
>
> (4) **Granting the Medicare provider or supplier Medicare billing privileges.**

42 C.F.R. § 424.502 (2009) (emphasis added).[2]

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[2] Effective on February 3, 2015, the Secretary changed the definition of the words *Enroll/Enrollment* to accommodate a new type of enrollment using a CMS-855O form. 79 Fed. Reg. 72,500, 72,501-502, 72,531 (Dec. 5, 2014). Although the changes would not affect this case, I quote in this decision the regulatory definition as it appeared when Petitioner filed the CMS-855I and CMS-855R forms in 2010 to Noridian.

It is significant that the definition of the words *Enroll/Enrollment* do not include the reassignment of Medicare benefits. As indicated by CMS in this litigation, the "enrollment" application referred to in its revocation determination is a CMS-855R. CMS Exs. 3, 7. Although a CMS-855R is generally titled as a "Medicare Enrollment Application," it is subtitled as "Reassignment of Medicare Benefits." CMS Ex. 3 at 1. The form itself explains what it is used for:

> Complete this application if you are reassigning your right to bill the Medicare program and receive Medicare payments, or are terminating a reassignment of benefits. Reassigning your Medicare benefits allows an eligible supplier to submit claims and receive payment for Medicare Part B services that you have provided. Such an eligible supplier may be an individual, a group practice or other organization.
>
> **Both the individual practitioner and the eligible supplier must be currently enrolled (or concurrently enrolling via submission of the CMS-855B for the eligible supplier and the CMS-855I for the practitioner) in the Medicare program before the reassignment can take effect.** Generally, this application is completed by a supplier, signed by the individual practitioner, and submitted by the supplier.

CMS Ex. 3 at 2 (emphasis added).

Nowhere does it state that the CMS-855R is used for enrollment in the Medicare program. Indeed, as indicated in the quote above from the CMS-855R, the parties to the reassignment must already be enrolled or concurrently filing enrollment applications in order for a reassignment to take place. This is also CMS's published policy. MPIM § 15.5.20(A).

The quoted material on the CMS-855R is consistent with the Act and the regulations. A reassignment does not involve the granting of Medicare billing privileges, but rather is a method of redirecting payment for services from the supplier who is providing services to another provider or supplier (e.g., to an employer of a supplier if reassignment is a condition of employment or to another supplier if there is a contractual arrangement between the suppliers), the provider or supplier's agent, a government agency, or a court-ordered recipient. 42 C.F.R. §§ 424.70, 424.80. In regard to reassignments based on a contractual relationship, 42 C.F.R. § 424.80 limits reassignment to occur between enrolled providers and suppliers; however, this does not mean an entity contracted to receive a reassignment from a supplier is automatically entitled to enroll as a supplier. *Wolverine State Inpatient Svcs.*, DAB No. 2509, at 6-7 (2013). Therefore, reassignment has no effect on the enrollment of providers or suppliers, but enrollment as a provider or supplier is usually the condition precedent to participate in a reassignment. *See Mound City Inpatient Srvcs.*, DAB CR2569, at 5 (2012) ("Further, considering CMS denied

Petitioner's CMS Form 855B because Petitioner did not meet the Medicare definition of an operational supplier, there would be no basis to approve any Medicare enrollment reassignments to Petitioner."); *Alexander C. Gatzimos, MD, JD, LLC*, DAB CR4421, at 14 (2015) (" Regardless of the form, it is essential for reassignment that the entity to which Medicare claims are reassigned be enrolled in Medicare in order for the reassignment to be effective."). It is significant that the regulations governing the reassignment of Medicare benefits, which are located in 42 C.F.R. part 424, subpart F, are not even included in the same subpart as the one that provides rules for establishing and maintaining Medicare billing privileges. *Compare* 42 C.F.R. part 424, subpart F *with* 42 C.F.R. part 424, subpart P.

I have previously noted, in cases involving the effective dates for reassignments, CMS conflated the enrollment of providers and suppliers with the reassignment of benefits. *Thomas Boyd, D.O.*, DAB CR3971, at 5 (2015); *see also Lindsey Faucette, D.O.,* DAB CR3992, at 8-9 (2015). It has done so again in this case.

In regard to CMS's past history of revoking providers or suppliers under section 424.535(a)(4), it appears that CMS has revoked when there are false or misleading statements on enrollment applications filed in instances where a provider or supplier was either trying to enroll in the Medicare program or revalidate its enrollment in the Medicare program. *See Mark Koch, D.O.*, DAB No. 2610 at 4 (2014); *Conchita Jackson, M.D.*, DAB No. 2495, at 3 (2013); *Leigh Gilburn, D.O.*, DAB CR1890, at 3-4 (2009). The present case, however, involves an application for the reassignment of Medicare benefits from an enrolled supplier to another enrolled supplier, and not an application to establish or maintain enrollment. As a result, section 424.535(a)(4) does not reach Petitioner's conduct involving the submission of a CMS-855R in which one of the signatures on the form was forged.

3. CMS did not have a legal basis to revoke Petitioner's Medicare enrollment and billing privileges based on a failure to comply with enrollment requirements under 42 C.F.R. § 424.535(a)(1) because Petitioner's alleged improper reassignment of Medicare benefits from a physician to Petitioner does not violate an enrollment requirement.

The initial and reconsidered determinations asserted that Petitioner was not in compliance with Medicare enrollment requirements under 42 C.F.R. § 424.535(a)(1) because the reassignment application and a CMS-855I submitted in support of the reassignment application were not accurate or truthful, in violation of 42 C.F.R. § 424.510(d)(2)(i). CMS Exs. 7, 9. In this proceeding, CMS has provided a detailed argument to explain this basis for revocation. I summarize its argument below, using some of the facts it alleges related to the violation alleged with regard to 42 C.F.R. § 424.535(a)(4) to fully convey CMS's concerns over Petitioner's actions.

In its brief, CMS asserts that despite the fact that Petitioner admits that Dr. Kirby was never an employee or contractor of Petitioner, Petitioner still took steps to obtain reimbursement from Medicare for the services that Dr. Kirby performed. CMS Br. at 9. CMS further asserts that although Petitioner did not contact Dr. Kirby about the reassignment, Petitioner submitted a CMS-855I that changed the address and contact information for Dr. Kirby to that of Petitioner. CMS Br. at 9. While CMS does not dispute that Petitioner worked through Mr. Grow and Phoenix Neurology to obtain Dr. Kirby's signatures on the reassignment form and CMS-855I, and that Petitioner did not know Mr. Grow forged Dr. Kirby's signature to the forms, CMS argues that Petitioner was responsible for submitting the forms that led to Petitioner receiving improperly reassigned payments for years. CMS Br. at 10. CMS is clear that Petitioner's revocation is not based on Petitioner knowingly submitting forms with Dr. Kirby's forged signatures, but rather, is based on the fact that Petitioner submitted the reassignment form and the CMS-855I in order to obtain reassignment in a misleading way because Dr. Kirby never worked for or was a contractor with Petitioner (i.e., Dr. Kirby was not eligible under 42 C.F.R. § 424.80 to reassign his benefits to Petitioner). CMS Br. at 10.

The main thrust of CMS's argument regarding Petitioner's alleged failure to comply with enrollment requirements is that "violating 42 C.F.R. § 424.80 [is] a separate bas[i]s for revocation." CMS Br. at 13. As a result, CMS asserts that "[i]n order to be in compliance with Medicare enrollment requirements, a supplier must at all times act in accordance with applicable Medicare regulations. 42 C.F.R. § 424.516(a)(1)." CMS Br. at 14. CMS supports this argument by pointing out that Petitioner certified, on the CMS-855R reassignment form, that it would abide by all laws and regulations pertaining to the reassignment of benefits. CMS Br. at 14; *see also* CMS Br. at 11. CMS concluded its argument as follows:

> Because [Petitioner] was actively receiving Medicare payments under an illegal reassignment in violation of 42 C.F.R. [§] 424.80, [Petitioner] was clearly not in compliance with all Medicare regulations at the time of the revocation. Non-compliance is a reason for revocation listed in 42 C.F.R. § 424.535(a)(1), and it was one of the reasons cited in CMS's letter of revocation to [Petitioner.] CMS Exhibit 7 at 1.

CMS Br. at 14-15; *see also* CMS Reply at 7 n.2.

As already discussed above, submission of a reassignment application is not an act directly related to the enrollment of a provider or supplier in the Medicare program. Although it may be true that Petitioner was not entitled under the Act or regulations to receive the reassignment of benefits from Dr. Kirby, a reassignment that violates the regulations does not violate provider or supplier enrollment requirements, but rather the requirements concerning reassignments. As noted earlier, the reassignment regulations

are not even contained in the same subpart as those dealing with the enrollment of providers and suppliers in the Medicare program. Even if they were, it is not clear that all provisions located in the enrollment subpart, i.e., 42 C.F.R. part 424, subpart P, are enrollment requirements for purposes of revocation under 42 C.F.R. § 424.535(a)(1). As can be seen in the quoted text below, the scope of section 424.535(a)(1) is significantly narrower than CMS urges in the present case.

> The revocation regulations specify certain "reasons for revocation" in section 424.535(a). CMS stated, in the preamble to the proposed rule adopting the revocation provisions, that it intended to consider various factors in applying the reasons, including balancing program and beneficiary risk and beneficiary access to care. 71 Fed. Reg. 20,754, 20,761 (Apr. 21, 2006). CMS explained that the revocation reasons were generally similar to reasons that initial enrollment could be denied. *Id.* Under section 424.535(a)(1), CMS contemplated that a provider might face revocation if it is determined "to be out of compliance with the Medicare enrollment requirements outlined in subpart P including the failure to report changes to enrollment information timely or failure to adhere to corrective action plans[.]" *Id.* The Medicare Program Integrity Manual (MPIM) instructs contractors about when to use section 424.535(a)(1) as the reason for revocation, such as when a provider no longer has a business location or has not paid assessed user fees. MPIM, Ch. 15, § 15.27.2.A (eff. Jan. 28, 2014). Other appropriate situations for use of this provision include, among others, lack of appropriate license, failure to meet the regulatory requirement for the relevant specialty, lack of valid social security numbers, failing to submit all required documentation within 60 days of being notified to submit an enrollment application, and otherwise not meeting "general enrollment requirements." *Id.*
>
> . . . .
>
> On the other hand, while we do not decide here the precise scope of section 424.535(a)(1), we have concerns about CMS's assertions that (1) every provision contained anywhere in subpart P constitutes a revocable enrollment requirement or (2) that the certification statement in enrollment applications converts every Medicare regulation and instruction into a revocable enrollment requirement. CMS relied on these assertions to argue that failing to include

> the correct NPI in Proteam's claims in violation of section 424.507(b)(1) (in subpart P) necessarily proved that Proteam was noncompliant with an enrollment requirement. We do not find support for the position taken by CMS.

Proteam Healthcare Inc., DAB No. 2658, at 8, 11 (2015). If all of the provisions in subpart P are not necessarily requirements the contravention of which can warrant revocation under 42 C.F.R. § 424.535(a)(1), then the reassignment regulations located in subpart F certainly cannot be considered enrollment requirements for purposes of revocation under 42 C.F.R. § 424.535(a)(1).

In the present case, CMS also attempts to use the certification statement that Petitioner's representative signed when completing the CMS-855R reassignment form to transform reassignment requirements into enrollment requirements. CMS Br. at 14. As indicated in the quote from the decision above, a certification statement cannot broadly make Medicare requirements into enrollment requirements. In that case, the issue involved compliance with Medicare billing requirements, but it is sufficiently analogous to the present case. As stated in that decision:

> We are also not persuaded that the duty undertaken by a provider in certifying that it will comply with Medicare requirements amounts to acknowledging that any noncompliance with any requirement in the submission of a claim may result in revocation as CMS contends here. The certification does clearly require the applicant to agree to abide by "the Medicare laws, regulations, and program instructions" applicable to its provider type. CMS Ex. 20, at 3. The certification also calls for an acknowledgment that "payment of a claim by Medicare is conditioned" on compliance. *Id*. The certification statement does not, however, inform the applicant that submission of a claim inconsistent with any law, regulation or instruction, without more, may result in revocation of billing privileges as opposed to nonpayment of the claim.

Proteam, DAB No. 2658, at 12. Based on the analysis in the *Proteam* decision, I conclude that while the certification statement signed by Petitioner's representative placed Petitioner on notice of the reassignment regulations, it did not turn the reassignment regulations into enrollment requirements for purposes of section 424.535(a)(1).

Although not raised by either party, it is significant that the reassignment regulations provide for the revocation of the right to receive assigned benefits if a provider or supplier "[e]xecutes or continues in effect a reassignment or power of attorney or any other arrangement that seeks to obtain payment contrary to the provisions of § 424.80."

42 C.F.R. § 424.82(c)(3). The Secretary has provided a right to a hearing to contest the revocation of the right to receive assigned benefits. 42 C.F.R. § 424.83-.84. Further, the reassignment regulations also provide for the termination of a provider agreement for violating the reassignment regulations. 42 C.F.R. § 424.74(a). Given the comprehensive nature of the reassignment regulations, I must conclude that had the Secretary meant for violations of the reassignment regulations to be considered violations of provider and supplier enrollment requirements, the reassignment regulations would have made some indication of it.

V. Conclusion

I grant Petitioner's motion for summary judgment, deny CMS's motion for summary judgment, and reverse CMS's determination to revoke Petitioner's Medicare enrollment and billing privileges.

/s/

Scott Anderson
Administrative Law Judge