Department of Health and Human Services

DEPARTMENTAL APPEALS DAB

Civil Remedies Division

Madison County Ambulance,
NPI No. 1740369784,

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-11-382

Decision No. CR2442

Date: October 4, 2011

DECISION

Petitioner filed a September 27, 2010 Medicare enrollment application for revalidation, which the Centers for Medicare and Medicaid Services (CMS) denied. Petitioner now appeals, and CMS moves for summary judgment. Petitioner has shown good cause for filing an untimely hearing request; however, the undisputed facts compel the denial of Petitioner's enrollment application because Petitioner filed the application during a one year reenrollment bar. Therefore, I grant CMS's Motion for Summary Judgment.

I. Background

Cigna Government Services (Cigna), a Medicare contractor, sent a request to Petitioner on October 14, 2009, directing Petitioner to submit a revalidation application within 60 days. CMS Ex. 1, at 23. Petitioner did not submit the revalidation application, which resulted in the revocation of Petitioner's billing privileges, effective April 4, 2010. CMS Ex. 1, at 34. CMS imposed a one-year reenrollment bar so that Petitioner could not reenroll in Medicare until April 4, 2011. *Id.* at 34. Petitioner eventually filed an interlocutory enrollment application for revalidation on September 27, 2010. CMS Ex. 2, at 5, 51. On October 14, 2010, Cigna denied Petitioner's request to be enrolled in the Medicare program because of the reenrollment bar. CMS Ex. 1, at 27-28. Petitioner

requested reconsideration, and Cigna issued an unfavorable reconsideration determination to Petitioner on January 7, 2011 and informed Petitioner of its appeal rights. *Id.* at 3.

Petitioner's hearing request to the Departmental Appeals Board (DAB) is dated February 9, 2011, but the DAB received it on April 8, 2011 by facsimile. The facsimile cover sheet had a handwritten note on it from Petitioner's billing agent stating "[w]e had originally sent this appeal on 2-8-11 but your office doesn't have any record of receiving it."

In response to Petitioner's hearing request, this case was assigned to me for hearing and decision. An Acknowledgment and Pre-hearing Order was sent to the parties on April 8, 2011. CMS filed a Motion for Summary Judgment accompanied by four exhibits, CMS Exs. 1-4. Petitioner filed a response to CMS's Motion for Summary Judgment accompanied an affidavit from Mikel Walker, which I have labeled as Petitioner's exhibit 1 (P. Ex. 1).

On August 1, 2011, I issued an Order to Show Cause because of my question about the timeliness of Petitioner's request for hearing. On August 11, 2011, Petitioner submitted its response to the Order to Show Cause accompanied by an affidavit from its billing agent and four exhibits, labeled A-D (P. Exs. A-D). On August 19, 2011, CMS submitted its reply to Petitioner's Response. I receive and admit all the exhibits into the record of this case.

II. Issues

The issues in this case are whether:

> Petitioner's hearing request must be dismissed as untimely under 42 C.F.R. § 498.70(c); and
>
> CMS had a legitimate basis to deny Petitioner's September 27, 2010 Medicare enrollment application.

III. Findings of Fact, Conclusions of Law, and Supporting Discussion

My findings of fact and conclusions of law are set out as separate headings followed by supporting discussion.

A. Good cause exists to extend the time for filing of Petitioner's hearing request.

I initially questioned the timeliness of Petitioner's hearing request. Clear authority requires that Petitioner must file its request for hearing in writing within 60 days from receipt of the notice of the reconsidered determination. 42 C.F.R. § 498.40(a)(2). The "date of receipt will be presumed to be 5 days after the date on the notice unless there is a showing that it was, in fact, received earlier or later." 42 C.F.R. § 498.22(b)(3). If the request for hearing was not filed within 60 days, the affected party must show good cause as to why I should extend the time for filing a request for hearing. 42 C.F.R. § 498.40(c). The number of days between the presumed date of the reconsideration decision, January 12, 2011, and the date of receipt of the request for hearing, April 8, 2011, is clearly more than 60 days.

Petitioner contends that it prepared an appeal letter on February 9, 2011 to the DAB and sent it by regular mail to the DAB's address. As support, Petitioner provides an affidavit from Petitioner's billing agent, who avers that she personally prepared and mailed the hearing request to the correct address. Further, Petitioner points to a stamp showing the date March 4, 2011 on the bottom right corner of the copy of the hearing request, which CMS provided in its exchange, and states that "[i]t appears to me that would be the date the Department of Health and Human Services received the letter." Affidavit of Brandy Young; P. Ex. C; CMS Ex. 1, at 2. Petitioner contends that, when it had not heard from the DAB about its hearing request, Petitioner contacted the DAB and was informed that the February 9, 2011 hearing request had never been received. Petitioner reportedly faxed the hearing request to the DAB immediately thereafter.

The date stamp Petitioner described was in fact on a proposed CMS exhibit provided with CMS's prehearing exchange. CMS did not deny stamping the document, and I have no other reasonable explanation as to what other organization may have stamped it. I will therefore infer that March 4, 2011 is the date that CMS received Petitioner's hearing request at CMS's address. The hearing request, therefore, would have been timely filed had Petitioner sent the hearing request to the correct DAB address or if CMS had properly forwarded the hearing request to the DAB. I find it likely that CMS did not forward the request to the DAB because it simply believed it was a courtesy copy, even though it was not notated as such. Because Petitioner apparently did send a timely written request for hearing to CMS, I will find good cause to allow an untimely hearing request pursuant to 42 C.F.R. § 489.40(c)(2).

B. This case is appropriate for summary judgment.

CMS argues that it is entitled to summary judgment. The Appellate Board of the DAB (the Board) explained the standard for summary judgment:

> Summary judgment is appropriate when the record shows that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. . . . The party moving for summary judgment bears the initial burden of showing that there are no genuine issues of material fact for trial and that it is entitled to judgment as a matter of law. . . . To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact – a fact that, if proven, would affect the outcome of the case under governing law. . . . In determining whether there are genuine issues of material fact for trial, the reviewer 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). An Administrative Law Judge's (ALJ's) role in deciding a summary judgment motion differs from its role in resolving a case after a hearing. The ALJ should not assess credibility or evaluate the weight of conflicting evidence. *Holy Cross Vill. at Notre Dame, Inc*, DAB No. 2291 at 5 (2009). The Board has further stated, "[i]n addition, it is appropriate for the tribunal to consider whether a rational trier of fact could regard the parties' presentation as sufficient to meet their evidentiary burden under the relevant substantive law." *Dumas Nursing and Rehab., L.P.*, DAB No. 2347, at 5 (2010).

CMS argues that it is entitled to summary judgment because there "are no material facts in dispute." CMS Br. at 13. Petitioner has not disputed the material facts in this case, specifically, that Petitioner never requested a reconsideration decision from its revocation and reenrollment bar effective April 4, 2010 – April 4, 2011. Therefore, the revocation and reenrollment bar became the final Agency decision after the time period to request a reconsideration decision expired. Further, Petitioner does not dispute that it filed its September 27, 2010 enrollment application during this reenrollment bar. Therefore, summary judgment in favor of CMS is appropriate.

C. CMS's prior determination, to revoke Petitioner' s Medicare billing privileges and to impose a one-year bar on reenrollment, became final and is not the subject of this appeal.

To maintain Medicare billing privileges, a supplier must resubmit and recertify the accuracy of its enrollment information every five years. 42 C.F.R. § 424.515. CMS also reserves the right to perform off-cycle revalidations or to adjust the five-year revalidation schedule. 42 C.F.R. § 424.515(d)(1)-(2). A carrier, such as Cigna, may request that an ambulance supplier complete and return the CMS designated ambulance supplier form and provide the carrier with documentation of compliance with emergency vehicle and

staff licensure and certification requirements in accordance with State and local laws. 42 C.F.R. § 410.41(c)(2).

A supplier must furnish complete and accurate information, and all supporting documentation, within 60 calendar days of receiving notice from CMS to submit an enrollment application. 42 C.F.R. § 424.535(a)(6). CMS can revoke a currently enrolled supplier's Medicare billing privileges and supplier agreement if the supplier fails to provide complete and accurate information and all supporting documentation within 60 calendar days of receiving CMS's notification to submit or resubmit and certify the accuracy of its enrollment certification. *Id.* Revocation becomes effective 30 days after CMS or its contractor mails the notice of its determination to the supplier. 42 C.F.R. § 424.535(g). Depending of the severity of the revocation, a supplier is subject to a reenrollment bar that is a minimum of one year, but not greater than three years. 42 C.F.R. § 424.535(c).

Petitioner had previously been enrolled in the Medicare program since 1993. CMS sent Petitioner an enrollment revalidation request on October 14, 2009. CMS Ex. 1, at 23. Petitioner was required to submit a Medicare enrollment application and all supporting documentation within 60 calendar days of the October 14, 2009 letter. The October 14, 2009 letter informed Petitioner that "[f]ailure to submit a complete application and all supporting documentation within 60 days of the date of this letter may result in your Medicare billing privileges being revoked." *Id.*

On December 14, 2009, Cigna sent Petitioner notice that it was revoking Petitioner's billing privileges, effective January 13, 2010, pursuant to 42 C.F.R. § 424.535(a)(6), for failure to furnish complete and accurate information and all supporting documents within 60 days of CMS's notification. *Id.* at 21. With this notice, Cigna gave Petitioner an opportunity to submit a corrective action plan (CAP) and provided notice on how Petitioner could request reconsideration within sixty days. *Id.* Petitioner never submitted a CAP or requested reconsideration.

Cigna apparently did not follow through on its timeline because, on March 5, 2010, Cigna sent Petitioner another notice, notifying it this time that Cigna was revoking Petitioner's billing privileges effective as of April 4, 2010, pursuant to 42 C.F.R. § 424.535(a)(6), for failure to furnish complete and accurate information and all supporting documents within 60 days of CMS's notification. CMS Ex. 1, at 34. Cigna also cited 42 C.F.R. § 424.515, which requires a supplier to resubmit and recertify the accuracy of its enrollment information every five years to maintain Medicare billing privileges. *Id.* The March 5, 2010 letter stated that Cigna had previously requested that Petitioner submit a revalidation application, and, as of March 5, 2010, Cigna had not received an application from Petitioner. Cigna also informed Petitioner that "[p]ursuant to 42 C.F.R. § 424.535(c), Cigna Government Services is establishing a re-enrollment bar for a period of one year." CMS Ex. 1, at 35. Cigna gave Petitioner an opportunity to submit a CAP

within 30 days of the postmark date of the March 5, 2010 letter. Petitioner never submitted a CAP to Cigna. Cigna also informed Petitioner that Petitioner could request reconsideration of this determination within 60 days of the postmarked date. *Id.* Petitioner never requested reconsideration of the revocation, and the revocation and one-year reenrollment bar became final with no further right to a hearing request. *See* 42 C.F.R. §§ 498.22, 498.40(a)(2), 498.5(d). Petitioner admits receiving the notice letters dated October 14, 2009, December 14, 2009, and March 5, 2010. CMS Ex. 1, at 17. However, despite CMS's multiple warnings of the revocation of its Medicare billing privileges, Petitioner never contacted CMS to report that it was actively trying to obtain information to complete its application.

D. CMS properly denied Petitioner's September 27, 2010 Medicare enrollment application because Petitioner filed it during Petitioner's April 4, 2010 – April 4, 2011 bar on reenrollment.

Petitioner submitted its enrollment application on September 27, 2010, almost one year after the October 14, 2009 request for revalidation. CMS Ex. 2, at 5, 51. On October 14, 2010, Cigna denied Petitioner's enrollment in the Medicare program based on its September 27, 2010 application because Petitioner had not timely revalidated its enrollment, resulting in a revocation of its billing privileges and a reenrollment bar of one year that was still in effect until April 4, 2011. CMS Ex. 1, at 27. Petitioner wrote to Cigna on November 18, 2010 requesting reconsideration, stating that its September 27, 2010 application was late due to "difficulty obtaining the correct documentation from the [Internal Revenue Service (IRS)]." *Id.* at 17.

Petitioner does not dispute that it failed to timely submit an application and supporting documents that CMS had requested several times. Thus, even if inferring for summary judgment purposes that Petitioner's September 27, 2010 application was fully complete and accurate, this fact may not now change the legitimate revocation and reenrollment bar. *See* 73 *Fed. Reg.* 36,448, 36,452 (June 27, 2008)("[A] provider or supplier is required to furnish the evidence that demonstrates that the Medicare contractor made an error at the time an adverse determination was made, not that the provider or supplier is now in compliance."). *See also Eastern Plumas Dist. Hosp. d.b.a. Eastern Plumas Health Care*, DAB CR2168, at 7 (2010) ("A showing of compliance subsequent to a revocation is not grounds to reverse the revocation.").

CMS has authority to further determine the duration of a provider's billing privileges revocation in any case where it has the authority to impose revocation. The regulations provide:

> After a provider, supplier . . . has had their billing privileges revoked, they are barred from participating in the Medicare program

> from the effective date of the revocation until the end of the re-enrollment bar. The re-enrollment bar is a minimum of 1 year but not greater than 3 years depending on the severity of the basis for revocation.

42 C.F.R. § 424.535(c). CMS determined to bar Petitioner from reenrolling for a period of one year, until April 4, 2011. However, Petitioner submitted its enrollment application on September 27, 2010, prior to the expiration of the reenrollment bar on April 4, 2011. CMS Ex. 2, at 5, 51. On October 14, 2010, in response to Petitioner's September 27, 2010 application, CMS denied Petitioner enrollment in the Medicare program because Petitioner had not timely revalidated its enrollment resulting in a revocation of its billing privileges and a reenrollment bar of one year that was still in effect until April 4, 2011. Cigna issued an unfavorable reconsideration decision on January 7, 2011. The reconsideration decision found that, because the one-year reenrollment bar was still in effect, Petitioner could not reenroll in the Medicare program until April 4, 2011.

Petitioner argues that it "abhors equity" for CMS to revoke its billing privileges when Petitioner's failure to submit a complete and accurate timely application is "based solely on the failure of the federal government." P. Br. at 6-7.[1] Petitioner also acknowledges that at the time of its revocation, although amended later, 42 C.F.R. § 424.535(a)(6) had no specific hardship exception for certain circumstances. Petitioner argues though, that, while the "regulation at issue does not explicitly contain a good cause exception, a good cause exception must be contained implicitly in the regulation." P. Br. at 6.

I may not, however, find good cause to make an exception to the regulations in this case. I am unable to exercise my discretion to find good cause, if CMS relies on a legitimate basis to revoke. *See 1866ICPayday.com, L.L.C.*, DAB No. 2289, at 14 (2009) ("An ALJ is bound by applicable laws and regulations and may not invalidate either a law or regulation on any ground."). Here, Petitioner did not appeal CMS's determination to revoke for one year on account of Petitioner not providing the required information updates. If Petitioner wanted to argue good cause for extending the time for filing a request for reconsideration, it needed to make that argument to CMS at the time of the original revocation process, an explicit regulatory requirement. 42 C.F.R. § 498.22(d)(2) ("CMS will extend the time for filing a request for reconsideration if the affected party shows good cause for missing the deadline.").

[1] In support of its argument, Petitioner attached an affidavit from Mikel Walker. P. Ex. 1. Mr. Walker's affidavit characterizing the interactions between Petitioner and the IRS is vague and not corroborated by any documentary evidence. Mr. Walker does not state the dates of his telephone conversations or the name of any IRS agents involved in any reported conversations.

To ensure accountability to the public, CMS must be able to verify the information of its enrollees in a timely manner. CMS was not able to do this prior to the Petitioner's April 4, 2010 revocation.

IV. Conclusion

Petitioner has shown good cause for me to consider its hearing request, despite a late filing. The undisputed facts, however, compel me to sustain CMS's Motion for Summary Judgment. CMS had a legitimate basis to deny Petitioner's September 27, 2010 Medicare enrollment application because Petitioner filed it during Petitioner's reenrollment bar. I may not disturb CMS's prior determination of Petitioner's revocation and reenrollment bar because Petitioner never appealed that decision pursuant to 42 C.F.R. § 498.22.

/s/
Joseph Grow
Administrative Law Judge