Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

ASAP Home Oxygen, Inc.
(Supplier Number: 4051890001),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-11-75

Decision No. CR2364

Date: May 2, 2011

DECISION

I grant the motion of the Centers for Medicare and Medicaid Services (CMS) for summary judgment and sustain the revocation of Medicare enrollment and billing privileges of Petitioner, ASAP Home Oxygen, Inc. in accordance with 42 C.F.R. § 424.535(a)(8) for submitting claims for deceased beneficiaries.

I. Background and Procedural History

Petitioner is a supplier of home oxygen services for Medicare beneficiaries. On May 27, 2010, the National Supplier Clearinghouse (NSC), a CMS contractor, notified Petitioner by letter that it would revoke its Medicare billing privileges effective 30 days from the postmark of the letter. CMS Ex. 1. The notice letter stated that NSC determined Petitioner was in violation of 42 C.F.R. § 424.535(a)(8) for the abuse of Medicare billing privileges. *Id*. at 1. According to the notice letter, "[d]uring the period of January 1, 2006 through February 28, 2010 [Petitioner's] facility submitted claims for deceased Medicare beneficiaries." *Id.*

On June 9, 2010, Petitioner submitted both a corrective action plan (CAP) and a request for reconsideration. CMS Ex. 2. In its CAP, Petitioner admitted that it submitted claims for Medicare beneficiaries who were deceased on the alleged date of service, but it argued that such errors represented a very small percentage of Petitioner's total claims,[1] and the errors were primarily the result of the fact that it is difficult to immediately know when a patient dies because of the large number of patients Petitioner services. *Id*. On June 23, 2010, NSC rejected Petitioner's CAP and stated that "the information submitted does not support proof of compliance with all failed standards." CMS Ex. 3. NSC forwarded the matter to a Medicare Hearing Officer for reconsideration. *Id*.

Before the contractor issued its reconsideration decision, Petitioner submitted a second request for reconsideration on August 24, 2010. P. Ex. 2, at 9-11. With this request, Petitioner submitted what it refers to as "Remit Data" consisting of voluminous spreadsheets. Although Petitioner has not submitted a copy of this "Remit Data" for ALJ review, CMS has submitted what it denotes as excerpts of this data as CMS Ex. 9. Petitioner argued at the reconsideration level that the "Remit Data" revealed that the majority of its claims were valid and that only a very small percentage of its total claims submitted were erroneously billed.

On September 14, 2010, NSC issued an unfavorable reconsideration decision. CMS Ex. 4. The decision states:

> According to the information in the case file which includes a detailed Claim History Summary for [Petitioner], it is noted that during the period of January 1, 2006 through February 28, 2010 [Petitioner] has billed durable medical equipment and supplies to Medicare for beneficiaries that are deceased. The claim history summaries indicate that Service Dates occurred well after the date of beneficiary death and the frequency of billing is more than that indicated by [Petitioner]. Sent to this hearing officer by [Petitioner] is a detailed spreadsheet of Remit Data information by quarter starting in October of 2006 through February 2010 . . . . In review of this information and the Claim History Summary from Medicare it is noted that [Petitioner] had billed for deceased Medicare beneficiaries well after the beneficiary date of death, in greater frequency than indicated by [Petitioner]. This is in direct violation of 42 CFR 424.535(a)(8).

Id. at 2.

[1] Petitioner claims that for the fourth quarter of 2009, nine out of 3,472 claims for oxygen concentrators were denied for inadvertent billing to deceased patients. CMS Ex. 2.

Petitioner filed a hearing request (HR) with the Civil Remedies Division of the Departmental Appeals Board to appeal the reconsideration decision. I issued an Acknowledgment and Pre-hearing Order (Pre-Hearing Order) on November 10, 2010, and in accordance with that order CMS filed a Motion for Summary Disposition and Brief in Support Thereof (CMS Br.), accompanied by 11 exhibits (CMS Ex. 1-11). Petitioner filed its Motion in Opposition of Summary Disposition and Pre-Hearing Brief (P. Br.), accompanied by 6 exhibits (P. Exs. 1-6). CMS then filed a Reply Brief (CMS Reply) and objected to Petitioner's proposed exhibits. CMS argues that these exhibits constitute new evidence which must be excluded at the Administrative Law Judge (ALJ) level, and the new evidence is not relevant. In accordance with the terms of my Pre-Hearing Order, witness affidavits shall not be considered new evidence. Furthermore, as I discuss below, none of Petitioner's new exhibits are material to the outcome of this case. I therefore overrule the CMS objection. I admit CMS Exs. 1-11 and P. Exs. 1-6 to the record.

II. Applicable Law

Section 424.535(a) of 42 C.F.R. authorizes CMS to "revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement or supplier agreement" for reasons including, as relevant here:

> (8) *Abuse of billing privileges*. 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 situations where the beneficiary is deceased. . . .

III. Issue, Findings of Fact, Conclusions of Law

A. Issue

The issue in this case is whether CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing in violation of 42 C.F.R. § 424.535(a)(8).

B. Applicable Standard

The Departmental Appeals Board (Board) stated 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). The ALJ's role in deciding a summary judgment motion differs from the ALJ's 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).

C. Analysis

My findings and conclusions are in the italicized headings and subsequent discussions below.

1. CMS was authorized to revoke Petitioner's Medicare enrollment and billing privileges under 42 C.F.R. § 424.535(a)(8).

Pursuant to 42 C.F.R. § 424.535(a)(8), CMS is authorized to revoke the billing privileges of a supplier who abuses its billing privileges by submitting claims for services that could not have been furnished to the specific beneficiary on the date of service. Regulatory intent contemplated revocations being "initiated when evidence demonstrates multiple instances, **at least three**, where abusive billing practices have taken place." 73 *Fed. Reg.* 36,448, 36,455 (June 27, 2008) (emphasis added).

CMS argues that Petitioner abused its billing privileges and improperly submitted claims for services provided to deceased beneficiaries on at least 50 occasions. In its hearing request, Petitioner concedes that it billed Medicare for services to beneficiaries who were deceased on multiple instances. Specifically, it is undisputed that Petitioner submitted claims to Medicare for services for 49 beneficiaries who were deceased on the date of service reported by Petitioner. P. Br. at 11-13. Of these claims, 39 of the 49 improperly submitted claims are attributed to Petitioner's past practice of submitting claims for maintenance and servicing fees to Medicare on an automated and systemic basis without any checks or monitoring of billing to ensure individual eligibility. P. Br. at 12. It is also undisputed that Petitioner billed Medicare for services for deceased individuals on ten other occasions. Petitioner states that these improper claims were simply "data entry keying errors" and "accidental billing errors." P. Br. at 13.
Petitioner presents a material issue of fact with regard to the deceased status of one beneficiary who CMS claimed Petitioner improperly billed Medicare for services. P. Ex.

3, at 46. I accept Petitioner's assertions with regard to this particular Medicare beneficiary as true. However, this one claim alone does not create a genuine material issue of fact with regard to Petitioner's other separate abusive billing practices which would defeat the CMS motion for summary judgment.

Petitioner claims it is currently able to prevent the errors which led to the 39 improperly submitted Medicare claims and has instituted a new billing procedure to ensure eligibility of its patients. P. Br. at 12; P. Ex. 6. However, as previously discussed, a revocation under 42 C.F.R. § 424.535(a)(8) "may be initiated when evidence demonstrates multiple instances, **at least three**, where abusive billing practices have taken place." 73 *Fed. Reg. at* 36,455 (emphasis added). It is undisputed that Petitioner billed Medicare at least 39 times for maintenance and servicing fees for beneficiaries who were actually deceased on the reported date of service. *See* CMS Ex. 5. All of these claims sought payment for services allegedly rendered several months after the beneficiary had died. *Id*. Petitioner admits that it has submitted claims for services for deceased individuals on numerous instances over several years. HR; P. Br. at 11-13. The facts clearly establish a pattern of improper billing which, as Petitioner concedes, resulted in well over three wrongly submitted Medicare claims.

Petitioner also claims that it did not have adequate information regarding the claims CMS questioned during the reconsideration process and was therefore deprived of its due process rights. P. Br. at 6-7. However, a Petitioner is not deprived of due process when CMS provides Petitioner sufficient notice of the legal basis for the revocation and a reasonable opportunity to respond at the ALJ hearing level. *See Green Hills Enters.*, LLC, DAB No. 2199, at 8 (2008); *see also Abercrombie v. Clarke*, 920 F.2d 1351, 1360 (7th Cir. 1990), *cert. denied*, 520 U.S. 809 (1991) (holding that defects in formal notice may be cured during the course of an administrative proceeding, and due process is satisfied as long as the party is reasonably apprised of, and given opportunity to address, the issues in controversy). Here I find that CMS, through its brief, provided Petitioner sufficient notice, and I provided a reasonable opportunity to respond to CMS's basis for revocation involving the submission of 49 Medicare claims for deceased individuals.

Finally, Petitioner argues that its billing errors were accidental and that it is committed to complying with the regulatory requirements. Petitioner claims it instituted a new billing procedure and believes it should be allowed the opportunity to rectify any deficiencies in its billing. P. Br. at 12-14. Even if I assume all Petitioner's statements are true and that Petitioner will make necessary corrections in the future, applicable regulations still bind me. I lack authority to invalidate or change an existing regulation or grant Petitioner an exemption from compliance with regulatory requirements. *1866ICPayday.com*, DAB

No. 2289, at 14 (2009). I must sustain CMS's determination and may not second guess CMS's judgment if a legitimate basis for the revocation exists and where the facts

established noncompliance with one or more of the regulatory standards at the time of the revocation.

Because Petitioner repeatedly submitted claims for deceased beneficiaries, CMS was authorized to revoke Petitioner's billing privileges. Petitioner argues that a CMS policy allowed Petitioner to charge service and maintenance fees to deceased beneficiaries retrospectively. Pr. Br. at 11-12. I find this defense unavailing, however, considering the policy states in part, "… the equipment must be medically necessary as of the date such payment is claimed." *Id.* Thirty-nine individuals were deceased at the time Petitioner made its claims, so clearly these individuals did not then have a medical necessity for oxygen equipment.

2. The issues involving Petitioner's corrective action plan are not reviewable in this forum.

Petitioner also argues that it should have been afforded the opportunity to submit a comprehensive corrective action plan. However, I cannot address this issue, as CMS's decision whether or not to accept a CAP is not an initial determination and not reviewable by an ALJ. 42 C.F.R. § 405.874(e).

The Board recently addressed the issue of an opportunity to correct through a CAP and explained how it is distinct from the contractor reconsideration process:

> After the initial notice of revocation, the supplier has two tracks to seek to avoid revocation and may elect to pursue either or both concurrently. [Medicare Program Integrity Manual (MPIM)], Ch. 10, § 19.A. The supplier, within 60 days, may request "reconsideration" of whether the basis for revocation is erroneous or, within 30 days, it may submit a CAP to demonstrate that it has corrected that basis. If the contractor accepts the CAP, it notifies the supplier, and any reconsideration request is withdrawn. If the contractor denies the CAP, the reconsideration process may proceed to a hearing before a hearing officer, who reviews "the Medicare contractor's reason for imposing a . . . revocation at the time it issued the action . . . ." *Id.* An unfavorable hearing officer decision is appealable to an ALJ, who reviews the basis for the revocation. *Id.* No provision is made for an appeal of the contractor's decision not to reinstate based on the CAP. *Id.* The hearing officer conducting the reconsideration (and the ALJ on appeal of the hearing officer decision) are limited to reviewing the basis for revocation set out in the initial notice, not the merits of any contractor decision that corrective action under a CAP was unacceptable.

DMS Imaging, Inc., DAB No. 2313, at 7-8 (2010) (footnote omitted).

Thus, the contractor's evaluation of whether to accept a CAP is not an initial determination and not appealable. However, CMS's reconsideration decision arises from the contractor's initial determination to revoke Petitioner's Medicare billing privileges and is appealable through the administrative process, including the present review. *Emmanuel Brown M.D. and Simeon Obeng M.D.*, DAB CR2145, at 6-8 (2010).

IV. Conclusion

The undisputed facts establish that CMS is entitled to summary judgment as a matter of law. I therefore grant summary judgment in favor of CMS and sustain the revocation of Petitioner's Medicare enrollment and billing privileges.

/s/
Joseph Grow
Administrative Law Judge

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