Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Acute Care Homenursing Services, Inc.
Docket No. A-17-88
Decision No. 2837
December 19, 2017

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Acute Care Homenursing Services, Inc. (Petitioner), a home health agency (HHA), appeals an administrative law judge's decision granting summary judgment and sustaining the revocation of Petitioner's Medicare enrollment by the Centers for Medicare & Medicaid Services (CMS). *Acute Care Homenursing Servs., Inc.*, DAB CR4835 (2017) (ALJ Decision). The ALJ determined that Petitioner violated Medicare enrollment requirements and provided false information on its Medicare revalidation enrollment application because the State of Ohio had revoked its corporate status, and because it used, on the application, the legal business name of another HHA, not enrolled in Medicare, with which it shares common ownership.

Petitioner argues that the revocation should be reversed because its corporate status was later restored retroactively, and because it had no deceptive intent in using the business name of the non-Medicare HHA, which the ALJ accepted in granting summary judgment for CMS. For the reasons explained below, we affirm the ALJ Decision.

Legal Background

To receive payment for services furnished to Medicare beneficiaries, a Medicare "provider" must be enrolled in Medicare and maintain active enrollment status.[1] 42 C.F.R. § 424.505. "Enrollment" is the process that CMS, which acts through Medicare contractors, uses to (1) identify the prospective provider; (2) validate the provider's eligibility to provide items or services to Medicare beneficiaries; (3) identify and confirm a provider's owners and "practice location(s)"; and (4) grant the provider "Medicare billing privileges." *Id.* § 424.502.

[1] HHAs are Medicare "providers"; other providers include hospitals and skilled nursing facilities. 42 C.F.R. § 400.202.

To enroll, a provider or supplier must meet the requirements in the regulations in 42 C.F.R. Part 424, subpart P (§§ 424.500-570). Those requirements include submitting an appropriate enrollment application and documentation establishing the applicant's "eligibility to furnish Medicare covered items or services to beneficiaries in the Medicare program." *Id.* § 424.510(d)(1), (d)(2)(iii). The application must include "[c]omplete, accurate, and truthful responses to all information requested within each section as applicable to the provider or supplier type" and "documentation required by CMS . . . to uniquely identify the provider or supplier" and include a "certification statement . . . signed by an individual who has the authority to bind the provider or supplier both legally and financially" and who has "an ownership or control interest in the provider or supplier[.]" *Id.* § 424.510(d)(2)(i), (ii), (d)(3). Each provider or supplier "must resubmit and recertify the accuracy of its enrollment information every 5 years" and "must submit to CMS the applicable enrollment application with complete and accurate information and applicable supporting documentation within 60 calendar days" after being notified to resubmit and certify to the accuracy of its enrollment information. *Id.* § 424.515(a), 424.515(a)(2).

CMS "may revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement or supplier agreement" for various specified "reasons" including noncompliance with the Medicare enrollment requirements and providing false or misleading information on the enrollment application. 42 C.F.R. § 424.535(a)(1), (a)(4). The regulations bar a revoked provider from re-enrolling in Medicare for one to three years. *Id.* § 424.535(c).

A revoked provider or supplier may request that CMS (via the contractor) reconsider the revocation, may request a hearing before an ALJ to challenge an unfavorable reconsidered determination, and may seek Board review of an unfavorable ALJ decision, as may CMS. 42 C.F.R. §§ 424.545, 498.5(1), 498.22, 498.40, 498.80.

Background

The parties do not dispute the following background information gleaned from the ALJ Decision and the record.

Petitioner was incorporated as AC Homenursing Services, Inc. and used the legal business name Acute Care Homenursing Services, Inc., as registered in records of the Ohio Secretary of State. Petitioner's president and principal owner, Bruce C. Peters, also owned another HHA, AC Heath Care Services, that used the legal business name Primary Nursing Care, shared practice location addresses with Petitioner, and was not enrolled in Medicare. ALJ Decision at 3-4; CMS Exs. 6-8, 15-16; 30; Peters Decl. (CMS Ex. 2, at 3) ¶¶ 2, 7, 8.

In February 1999, the Ohio Secretary of State cancelled Petitioner's articles of incorporation and its authority to do business as a corporation for failing to pay corporate franchise taxes, and did not reinstate Petitioner until October 14, 2014. ALJ Decision at 4, 7; CMS Exs. 9-11. During this interval, in January 2012, Petitioner filed a Medicare application (CMS form 855A) to revalidate its enrollment (and filed amendments to the application in March and April 2012), as required of providers every five years. Petitioner on the application used its correct identifying numbers but, at seven places on the application, Petitioner's owner entered "Primary Nursing Care," the legal business name of his non-Medicare HHA, as Petitioner's own "Doing Business As Name" (or "dba") – twice as "identifying information," and at five places reporting Petitioner's practice locations.[2] ALJ Decision at 5; CMS Ex. 30, at 13, 22-26, 32. On March 13, 2012, an investigator working for the CMS contractor visited Petitioner's address of record and found signs identifying "Primary Nursing Care" and "Apex Medical Supply" but no sign identifying Petitioner as Acute Care Homenursing Services, Inc., its Medicare enrollment name and business name. ALJ Decision at 5.

Petitioner's owner stated in a sworn declaration that when he completed the revalidation application, he "had no knowledge that the corporation's articles of incorporation had been canceled" and that his "purpose and intention in listing Primary Nursing Care on the form 855A was to disclose that Primary Nursing Care is a dba, legally registered to an entity under the ownership and control of the undersigned, i.e. the owner listed in Section 6 on the 855A," i.e., himself. Peters Decl. (CMS Ex. 2, at 3) ¶¶ 6, 8. He further stated that "[t]here was no hidden agenda," that "my purpose was to make full disclosure of the ownership of the entities (Medicare certified and non-certified) doing business at the subject office locations," and that "[t]he dba Primary Nursing Care was legally registered to the undersigned's company AC Health Care Services, Inc. on January 22, 2003, and renewed on October 15, 2007, as shown in the online records of the Ohio Secretary of State[.]" *Id.* ¶ 8.

On April 25, 2012, the Medicare contractor, Palmetto GBA, revalidated Petitioner's enrollment with the "doing business as" name of Primary Nursing Care. CMS Ex. 34. Palmetto asked Petitioner's owner to "verify the accuracy of [his] enrollment information" and also reminded him of the requirement to report "updates and changes" to its enrollment information, including changes to its legal business name and ownership. *Id*. The ALJ found, and Petitioner does not dispute, that Petitioner "did not correct or clarify the enrollment information it had provided." ALJ Decision at 5.

[2] The identifying numbers comprise Petitioner's national provider identifier or NPI; its Medicare provider transaction number, or PTAN; and its tax identification number. ALJ Decision at 5.

On October 21, 2014, Palmetto notified Petitioner that its "Medicare privileges" were being revoked effective November 21, 2014, for a period of two years, based on the cancellation of Petitioner's corporate status and from Petitioner having used, on its revalidation application, the business name of the other, non-Medicare HHA, Primary Nursing Care. CMS Ex. 1. As authority for the revocation, Palmetto cited the following provisions in 42 C.F.R. § 424.535(a) ("Revocation of enrollment in the Medicare program. . . . (a) *Reasons for revocation*"), which, as of the date of the revocation letter, stated:

> (1) *Noncompliance*. The provider or supplier is determined not to be in compliance with the enrollment requirements described in this section, or in the enrollment application applicable for its provider or supplier type, and has not submitted a plan of corrective action as outlined in part 488 of this chapter. . . .
> (4) *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. (Offenders may be subject to either fines or imprisonment, or both, in accordance with current law and regulations.) . . .
> (7) *Misuse of billing number.* The provider or supplier knowingly sells to or allows another individual or entity to use its billing number. This does not include those providers or suppliers who enter into a valid reassignment of benefits as specified in § 424.80 or a change of ownership as outlined in § 489.18 of this chapter.

Palmetto stated that Petitioner "failed to abide" by "Medicare laws, rules, and program instructions" when "its authorized official claimed to bind the home health agency to Medicare laws, rules, and program instructions, when he and the corporation lacked authority to conduct new business"; that Petitioner "falsely identified itself as ACHS, doing business as Primary Nursing Care . . . a separate corporation"; and that Petitioner "allowed AC Health Care Services [i.e, Primary Nursing Care] to use its billing number and Medicare provider agreement to participate in Medicare and Medicaid." CMS Ex. 1, at 1-2. The contractor noted that Petitioner had applied (in 2012; *see i.e.*, CMS Ex. 30) for revalidation beyond the five-year period that Ohio law grants a revoked corporation for "winding down" its business affairs. *Id.* at 1, citing Ohio Revised Code § 1701.88(A).

Petitioner requested reconsideration, which CMS denied, and Petitioner requested an ALJ hearing. CMS Ex. 5. Before the ALJ, CMS filed a motion for summary judgment and supporting brief as well as 45 exhibits, and Petitioner filed its response brief and motion for summary judgment (P. Br.) and five exhibits. ALJ Decision at 2. Petitioner proposed to call one witness, Mr. Peters, whom CMS asked to cross-examine.

The ALJ Decision

The ALJ made "one finding of fact/conclusion of law," that "CMS is entitled to summary judgment because the undisputed evidence establishes that Petitioner did not comply with Medicare enrollment requirements" and "provided false information on its revalidation application. CMS therefore properly revoked its Medicare enrollment pursuant to 42 C.F.R. §§ 424.535(a)(l) and (4)." ALJ Decision at 2; *see id*. at 1 ("[T]he uncontroverted facts establish that Petitioner was not authorized to do business in the State of Ohio, and it provided false information on its 2012 [revalidation] enrollment application.").

As to false information, the ALJ found that "as Petitioner concedes, it reported another corporation's name instead of its own" on the 2012 revalidation application, and that, "[t]hroughout the 855A [enrollment application], Owner Peters mis-identified Petitioner" as "Primary Nursing Care" and "did not correct or clarify the enrollment information it had provided" in response to Palmetto's letter asking Petitioner to verify the accuracy of the information it provided. *Id*. at 5, 6. Petitioner's owner also made the "false" claim that he was authorized to conduct business on behalf of Petitioner and "signed the application [when] neither he nor anyone else had the authority to bind Petitioner to anything because Petitioner could not legally transact business at that time," due to Ohio's cancellation of Petitioner's corporate status and its trade name. *Id*. at 7.

The ALJ concluded that "because Petitioner submitted false information, it did not comply with multiple enrollment requirements" and "CMS could therefore revoke Petitioner's billing privileges and provider agreement under section 424.535(a)(1)." *Id*. at 6. The ALJ cited regulations requiring that the application include "complete, accurate, and truthful responses to all information requested" (§ 424.510(d)(2)), that the information submitted must be such that CMS can validate it for accuracy "at the time of submission" (§ 424.510(d)(4)), that the provider must be operational to furnish Medicare-covered items or services (§ 424.510(d)(6)), that the provider must certify its compliance with federal and state licensure, certification, and regulatory requirements (§ 424.516(a)(2)), and that the application "be signed by an individual who has the authority to bind the provider . . . both legally and financially" to the Medicare requirements (§ 424.510(d)(3)). *Id*. at 6, 7.

The ALJ found "not material" the owner's declaration that his intent in completing the application was "to disclose that he owned Primary Nursing Care" and, for summary judgment purposes, the ALJ did not question the owner's claim "that, for more than a decade, [he] did not know that his corporation no longer existed as a legal entity." *Id*. The ALJ held that section 424.535(a)(4) "does not require proof that the provider intended to convey false information, only that he 'in fact provided misleading or false information that he certified as true.'" *Id*. at 6, citing *Sandra E. Johnson, CRNA*, DAB No. 2708, at 15 (2016), quoting *Mark Koch, D.O.*, DAB No. 2610, at 4 (2014). The ALJ

also rejected Petitioner's argument that under Ohio law, the retroactive restoration of Petitioner's corporate status in 2014 rendered valid its filing of the 2012 application, because the "Medicare regulations are explicit: the information submitted by the provider '*must* be such that CMS can validate it for accuracy *at the time of submission*.'" *Id*. at 7, citing 42 C.F.R. § 424.510(d)(4) (ALJ's emphasis).

The ALJ thus sustained the revocation under 42 C.F.R. § 424.535(a)(1) and (4).[3]

<u>Standard of Review</u>

Whether summary judgment is appropriate is a legal issue that we address de novo. *1866ICPayday.com*, DAB No. 2289, at 2 (2009), citing *Lebanon Nursing & Rehab. Ctr.*, DAB No. 1918 (2004). Summary judgment is appropriate when the record shows that there is no genuine dispute of fact material to the result. *See 1866ICPayday.com* at 2, citing *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986). The Board's standard of review on a disputed conclusion of law is whether the ALJ Decision is erroneous. *See Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program*, available at http://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/enrollment/index.html.

<u>Analysis</u>

Petitioner concedes its 2012 revalidation application certified inaccurate information including representing the business name of a different, non-Medicare HHA as its own dba, and does not dispute that it submitted the application while its corporate status had been cancelled or revoked. These undisputed facts authorized CMS to revoke Petitioner's Medicare enrollment under 42 C.F.R. § 424.535(a)(4) and (a)(1) for providing false information and for noncompliance with enrollment requirements, for reasons that the ALJ discussed, and supported the ALJ's determination to grant CMS's motion for summary judgment.

[3] The ALJ did "not reach the question of whether [Petitioner] allowed another entity to use its billing number" in violation of 42 C.F.R. § 424.535(a)(7) "[b]ecause Petitioner's violations under subsections 424.535(a)(l) and (a)(4) amply justify revocation." ALJ Decision at 7 n.5. CMS argues that Petitioner "failed to introduce any specific financial or other documentation or testimony to rebut the evidence that its sister corporation was using ACHS's billing number and provider agreement to serve 'Primary Nursing Care (PNC) clients'" and "asks this Tribunal to affirm its revocation pursuant to 42 C.F.R. § 424.535(a)(7)." CMS Resp. at 29, 30. We do not address CMS's argument because, since we uphold the ALJ Decision sustaining the revocation based on the grounds stated therein, we need not address whether section 424.535(a)(7) also supports the revocation.

Petitioner does not identify any disputed material facts or claim the ALJ erred in finding that "the dispositive facts are not in dispute" and has thus not shown that summary judgment was not appropriate. ALJ Decision at 3. As we discuss below, Petitioner's arguments that its provision of false information was innocent and harmless error, and that the reinstatement of its corporate status was effective retroactively, show no error in the ALJ Decision.

I. Petitioner has shown no error in the ALJ Decision upholding the revocation under 42 C.F.R. § 424.535(a)(4).

Petitioner concedes that it identified itself as Primary Nursing Care, the legal business name of its owner's other, non-Medicare HHA, at seven places on the revalidation application even though in reality "Petitioner did not use the name 'Primary Nursing Care' as a dba." P. Request for Review (RR) at 2. Petitioner contends, however, that this "was intentional and does not constitute any wrongdoing, other than an honest misunderstanding of the instructions for completing the Form 855A." *Id.* Petitioner asserts, essentially, that it represented itself as "Primary Nursing Care" merely to notify CMS of the existence of the owner's other HHA with which it shared locations. Petitioner explains that its owner, who acted without counsel, misunderstood the application question asking for business names and "was simply disclosing the fact that a company of his operated under the dba Primary Nursing Care" and also did so to "identify[] the name of Petitioner's principal's company's buildings in which Petitioner's offices were located." *Id.* Petitioner also argues that the ALJ Decision imposes a strict liability standard permitting revocation where it is not warranted for minor errors made without any wrongdoing or bad intent.

As discussed above, the ALJ accepted, for summary judgment purposes, Petitioner's owner's declaration that he entered the inaccurate information about Petitioner's business name on the revalidation application in order to disclose his ownership of Primary Nursing Care, which shared business locations with Petitioner. ALJ Decision at 5, 6. The ALJ found, however, that the owner's intent was "not material" to the issue of whether CMS could revoke Petitioner's Medicare enrollment for providing false information because section 424.535(a)(4) "does not require proof that the provider intended to convey false information." *Id.* at 6.

The ALJ's conclusion was correct. The ALJ accurately cited the Board's decision in *Johnson* which, quoting *Koch,* stated that "[s]ection 424.535(a)(4) does not require proof that the [provider or supplier] intended to provide false information, only proof that he *in fact provided* misleading or false information that he certified as true." *Johnson* at 15,

quoting *Koch*, cited in ALJ Decision at 6 (emphasis in *Koch*).[4] The dispositive fact in *Johnson* was that the petitioner "in fact provided misleading or false information that she certified as true," and "once CMS determined that Petitioner submitted Medicare enrollment applications that contained false or misleading statements that Petitioner certified as 'true,' CMS had a legal basis for revocation." *Id.*

Petitioner argues that *Johnson* and *Koch* are inapplicable because they "are both cases in which medical practitioners failed to disclose medical license suspensions and revocations" whose "fact scenarios go to the essence of Medicare reimbursements and patient care." RR at 4. Petitioner sees that aspect as dispositive here because "[m]edical licenses and corporation dba's are not analogous" and "[q]ualification and competency in providing patient care must not be equated with accuracy in reciting corporate dba's." *Id.* We see nothing in *Johnson* or *Koch*, however, that conditioned the decisions to sustain the revocations for providing false information on the type of information that was false, or which raised or contemplated any potential impact on patient care, or any other detrimental effect on the Medicare program that could ensue from the provision of the false information. Instead, the Board relied solely on the fact of that the suppliers had certified as true the false information contained in their applications in sustaining the revocations under section 424.535(a)(4). Petitioner also does not cite any authority (nor are we aware of any) for the notion that that revocation authority for providing false or misleading information is limited to preventing unqualified practitioners from participating in Medicare.

Petitioner also argues that the ALJ Decision creates "a strict liability standard of review" under which "the slightest error on a reporting form, regardless of the importance of the information or the context, could be determined to be 'false' or 'misleading'" and "[m]isspellings, typographical errors, word processing errors, punctuation errors, etc. can all be deemed to be 'false' information, because the information is literally incorrect." RR at 4. In making this argument, Petitioner notes, "[f]or example, the False Claims Act only applie[s] in circumstances where a claimant acted 'knowingly.'" RR at 3, citing 31 U.S.C. § 3729. Petitioner also argues that "[g]ranting a Summary Judgment against a Petitioner, who is clearly asserting that the harmless error in completing a form was the result of a Provider inadvertently misconstruing a question, is inappropriate." RR at 3.

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[4] A provider or supplier applying for revalidation (or initial enrollment) must "certify to the accuracy of its enrollment information" on its application and is therefore by law responsible for the accuracy of all information on the application. 42 C.F.R. § 424.515(a)(2); *see also* CMS Ex. 30, at 52 (2012 revalidation application stating that "[b]y my signature, I certify that the information contained herein is true, correct, and complete").

What Petitioner describes is not this appeal. Petitioner does not dispute that on its revalidation application it provided false information about its corporate identity at a time when its corporate existence had been revoked, and does not allege that this false information constituted such slight error as Petitioner raises in its examples. Certainly, the identity of the applicant is material, if not central, to any enrollment application. We make no pronouncement on whether hypothetical errors like the typos or "punctuation errors" Petitioner describes could support revocation for providing false information on an enrollment application, as that issue is not before us. Petitioner, again, cites no authority requiring CMS to consider the nature, importance or potential for program detriment of providing undisputedly false information on an enrollment or revalidation application in determining whether to exercise its authority to revoke a provider or supplier's Medicare enrollment. At a minimum, Petitioner has not shown why the consequences of providing false information sufficient to support revocation could not include confusion and disruption to the billing and claims process that could ensue upon a provider being enrolled under the name of a provider with its same address but which is not enrolled in Medicare.

The use of "knowingly" in the False Claims Act does not benefit Petitioner. To begin with, the False Claims Act contains express knowledge requirements whereas the revocation provision applied here contains none, which suggests that the omission of a scienter requirement may imply that no such showing is required to revoke for false or misleading statements in enrollment applications. Furthermore, as CMS points out, the definitions of "knowing" and "knowingly" even in the False Claims Act context "'require *no proof of specific intent to defraud*,' and encompass situations in which the person 'has actual knowledge of the information,' 'acts in deliberate ignorance of the [] falsity of the information,' *or* 'acts in reckless disregard of the truth or falsity of the information.'" CMS Resp. at 18-19 n.8, citing 31 U.S.C. § 3729(b) (CMS's italics).

Section 424.535(a) provides CMS with some discretion in whether to take action in relation to a false or misleading statement, providing that "CMS ***may*** revoke a currently enrolled provider or supplier's Medicare billing privileges . . . ." The role of the ALJ, and the Board, however, is limited to determining whether CMS's action is legally authorized and does not extend to second-guessing whether CMS properly exercised its discretion in deciding to revoke a particular provider.

In *Johnson*, where the petitioner "suggested below that CMS could have or should have exercised its discretion to decide not to revoke," the Board pointed out that "CMS *did* decide to revoke Petitioner's enrollment and billing privileges based on section 424.535(a)(4)" and that "[o]ur (and the ALJ's) task is to decide whether that determination is grounded in law and fact." *Johnson* at 16 (italics in original). The

Board thus "has held that it does not review CMS's exercise of discretion to take other actions the regulations authorize relating to the enrollment of suppliers and providers." *Decatur Health Imaging, LLC*, DAB No. 2805, at 8 (2017), *citing, generally*, *Brian K. Ellefsen, DO*, DAB No. 2626, at 7 (2015) ("where CMS is legally authorized to deny an enrollment application, an ALJ cannot substitute his or her discretion for that of CMS (or CMS's contractor) in determining whether, under the circumstances, denial is appropriate. Nor can the Board."), *and Douglas Bradley, M.D.*, DAB No. 2663, at 13 n.13 (2015) (citations omitted) ("the reasonableness of CMS's exercise of discretion is not a reviewable issue under any standard of review"); *see also Decatur Health Imaging* at 8 (regulation authorizing CMS "at its discretion" to extend 30-day period for prospective provider or supplier to respond to CMS request for information needed to process application "vests discretion to seek information in CMS, not in the reviewing authority such as an ALJ or the Board").

Petitioner argues that the ALJ's determination "that mental state is irrelevant . . . would be a harsh standard" with "devastating effects on employees, their families and patients caused by the closings of rural home health care facilities" and that Petitioner's "[m]isconstrual of the intent of the drafter of a voluminous agency reporting form is not valid cause for rescinding the license of a Medical Provider." RR at 3. This argument, like Petitioner's argument that its provision of false information was not as potentially detrimental as in other cases, in effect seeks equitable relief that the Board is not authorized to grant. "The applicable regulations . . . do not provide for consideration of such equitable arguments in ALJ or Board appeals of CMS enrollment determinations." *Amber Mullins, N.P.*, DAB No. 2729, at 5 (2016) (sustaining CMS's determination of supplier's effective date of enrollment based on date the contractor received the enrollment application that it approved). The Board thus "has consistently held that neither it nor an ALJ may provide equitable relief[.]" *Id.* at 6, citing *US Ultrasound*, DAB No. 2302, at 8 (2010) ("Neither the ALJ nor the Board is authorized to provide equitable relief by reimbursing or enrolling a supplier who does not meet statutory or regulatory requirements."); *Pepper Hill Nursing & Rehab. Ctr., LLC,* DAB No. 2395, at 11 (2011) (holding that the ALJ and Board were not authorized to provide equitable relief by reimbursing or enrolling a supplier who does not meet statutory or regulatory requirements); *UpturnCare Co., d/b/a Accessible Home Health Care*, DAB No. 2632, at 19 (2015) (Board may not overturn denial of provider enrollment in Medicare on equitable grounds).

II. Petitioner has shown no error in the ALJ Decision upholding the revocation under 42 C.F.R. § 424.535(a)(1).

Petitioner does not dispute the ALJ's determination that a corporate provider that applies for revalidation while its legal corporate status has been revoked by state authorities has failed to comply with enrollment requirements, authorizing CMS to revoke its enrollment under section 424.535(a)(1). ALJ Decision at 7. Instead, Petitioner repeats a single

argument (which the ALJ rejected): that under state law, the later reinstatement of Petitioner's corporate status had retroactive effect and validated or legitimized Petitioner's earlier filing of the application as a corporation. *Compare* RR at 4-6 *and* P. Br. at 3-5.

Petitioner quotes Ohio law as providing that, "[u]pon reinstatement of a corporation's or association's articles" of incorporation, "[t]he exercise of . . . any rights, privileges, or franchises on behalf of the corporation . . . has the same force and effect that the exercise . . . would have had if the corporation's or association's articles had not been canceled, if," two conditions apply, including that the corporate "officer, agent, or employee" who acted on behalf of the corporation "had no knowledge that the corporation's or association's articles of incorporation had been canceled." RR at 5, citing Ohio Rev. Code § 1701.922(B)(1).[5] As noted, Petitioner's owner testified that when he completed the revalidation application, he "had no knowledge that the corporation's articles of incorporation had been canceled[.] Peters Decl. (CMS Ex. 2, at 3) ¶ 6. Petitioner asserts that "[i]n accordance with Ohio law (ORC 1701.922), Appellant's corporate existence and trade name registrations were restored retroactively, as though there had been no gap in corporate or trade name registration." RR at 4.

The ALJ noted CMS's skepticism "that, for more than a decade, Owner Peters did not know that his corporation no longer existed as a legal entity" but she did "not . . . question the owner's veracity or look behind the underlying legitimacy of the state's actions, certainly not for summary judgment purposes." ALJ Decision at 7. Instead, the ALJ found Petitioner's reliance on the Ohio law unavailing because the "Medicare regulations are explicit: the information submitted by the provider '*must* be such that CMS can validate it for accuracy *at the time of submission*.'" *Id.*, quoting 42 C.F.R. § 424.510(d)(4) (ALJ's emphasis). The plain language of the enrollment regulation at section 424.510(d)(4) effectively requires that the information on a Medicare enrollment application be accurate at the time the provider (or prospective provider) files the application.

Here, there is no dispute that when Petitioner filed its application representing itself as a valid corporation authorized to do business as a corporation, its corporate status had been revoked by the state and would not be restored for several years. The retroactivity provision in the Ohio law provides no basis to overlook the requirement in the Medicare enrollment regulations that a provider's representations on its enrollment application (here, that Petitioner was a valid corporation authorized to do business) be accurate at the

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[5] The other condition for giving reinstatement retroactive effect is that the "exercise of . . . the right, privilege, or franchise was within the scope of the corporation's or association's articles of incorporation that existed prior to cancellation[.]" Ohio Rev. Code § 1701.922(B)(1)(2).

time the application is filed because, as the Board has held in various contexts, "*federal law*, not state law, governs Medicare enrollment and reimbursement." *Green Hills Enters., LLC*, DAB No. 2199, at 12 (2008) (italics in original) (federal law requiring that community mental health centers meet state certification requirements controlled over state law that Petitioner read as imposing no certification requirement to receive Medicare reimbursement). The Board has thus held that "[f]ederal law, not State law, governs what constitutes substantial compliance (or noncompliance) with the requirements for long-term care facilities participating in the Medicare program" (*Cedar Lake Nursing Home*, DAB No. 2344, at 10 (2010)), and that "federal law — not state law — governs whether a supplier has been 'convicted' of an offense, as that term is used in section 424.535(a)(3)" authorizing revocation for felony convictions (*John Hartman, D.O.*, DAB No. 2564, at 3 (2014)). Ohio's law does not alter CMS's obligation to assess the accuracy of the information on Petitioner's revalidation application, including whether Petitioner had the legal authority as a corporation to apply for revalidation, as of the time when Petitioner filed its application.

Moreover, the ALJ's conclusion that Petitioner was not in compliance with Medicare enrollment requirements, authorizing revocation under section 425.535(a)(1), does not rest solely on Petitioner's factually false representations that it was a valid corporation authorized to do business in Ohio at the time it filed the application. The ALJ also found that the false information Petitioner provided on the application about its legal identity caused it to "not comply with multiple enrollment requirements," including the requirements to provide "complete, accurate, and truthful responses to all information requested" and "be operational to furnish Medicare-covered items or services." ALJ Decision at 6-7, citing, e.g., 42 C.F.R. § 424.510(d)(2), (d)(6).

As it did before the ALJ, Petitioner also argues that Ohio's retroactivity provision should control and legitimize the revalidation application because "Federal courts recognize consistently that the capacity to sue, and standing to bring suit in federal court, are questions to be determined by the laws of the state in which the corporate entity is chartered." RR at 6, citing Federal Rule of Civil Procedure 17(b) (citations to federal court decisions omitted); *see* P. Br. at 4. The ALJ did not address this argument, and instead relied on the requirement in section 424.510(d)(4) that the information on a Medicare enrollment application be accurate at the time the provider (or prospective provider) files the application. We agree with CMS that Petitioner's reliance on this rule of civil procedure is misplaced. CMS Resp. at 24. Petitioner has not shown why this rule, or the court cases Petitioner cites, have any bearing on the Medicare enrollment process or would override the clear requirement of section 424.510(d)(4).

In sum, there is no dispute that, when it filed the revalidation application, Petitioner was not legally authorized to do business as a corporation in Ohio, rendering its filing of the application noncompliance with enrollment requirements, authorizing CMS to revoke its Medicare enrollment.

Conclusion

For the reasons stated above, we affirm the ALJ Decision upholding the revocation of Petitioner's Medicare enrollment and billing privileges.

/s/

Leslie A. Sussan

/s/

Constance B. Tobias

/s/

Christopher S. Randolph
Presiding Board Member