Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Multi-Medical Services,

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-561

Decision No. CR3042

Date: December 20, 2013

DECISION

I sustain the revocation of the Medicare enrollment and billing privileges of Multi-Medical Services (Petitioner) based on its noncompliance with 42 C.F.R. § 424.57(c)(2), (c)(10) and (c)(26) (Supplier Standards 2, 10, and 26).

I. Background

Petitioner, a supplier of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), enrolled in Medicare in 1996. By letter dated August 20, 2012, Palmetto GBA National Supplier Clearinghouse (NSC), a Medicare contractor responsible for enrolling and issuing billing numbers to Medicare suppliers, revoked Petitioner's Medicare number and billing privileges effective September 19, 2012 and imposed the minimum one-year re-enrollment bar after determining that Petitioner was not in compliance with supplier standards. Centers for Medicare & Medicaid Services Exhibit (CMS Ex.) 3.

Petitioner submitted a corrective action plan (CAP) and a request to reconsider the revocation to NSC. CMS Ex. 4. By letter dated December 11, 2012, NSC determined that Petitioner's CAP did not demonstrate its compliance with supplier standards and forwarded Petitioner's request to reconsider the revocation decision to its "Medicare Fair

Hearing Officer." CMS Ex. 5. NSC issued its reconsideration decision on January 22, 2013, determining that Petitioner was noncompliant with Supplier Standards 2, 10, and 26 and informing Petitioner that it could not "be granted access to the Medicare Trust Fund by way of a Medicare supplier number." CMS Ex. 6.

Petitioner timely filed a request for hearing on March 19, 2013. Petitioner's hearing request does not assert that it was in compliance with supplier standards as of April 30, 2012, the date NSC conducted an inspection of Petitioner. Instead, as discussed below, Petitioner asserts that it came into compliance with supplier standards at a later date. Petitioner filed copies of four documents with its hearing request: a document entitled "Surety Bond, Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies, Medicare Program" that the American Safety Casualty Insurance Co. issued on December 13, 2012 in the amount of $50,000; a Certificate of Liability Insurance issued June 1, 2012; the "Sender's Copy" of a FedEx transmittal showing that Petitioner sent a package to NSC on February 11, 2012; and the NSC Medicare Hearing Officer's January 22, 2013 reconsideration decision.[1]

The case was assigned to me for hearing and decision on March 28, 2013, and I issued an Acknowledgment and Pre-hearing Order (Order) on that date. In the Order, I set dates for the parties to exchange arguments and evidence. I informed the parties that I would only schedule a hearing if a party filed admissible, written direct testimony, and the opposing party then requested cross-examination. Order ¶10.

On May 2, 2013, CMS filed a motion for summary judgment (CMS Br.), accompanied by eight exhibits (CMS Exs. 1-8), which I admit without objection. CMS did not list any witnesses or file written direct testimony.

On June 7, 2013, Petitioner filed a one-page response titled "Petitioner Motion to Dismiss" (P. MTD) asking me to dismiss the determination revoking Petitioner's Medicare enrollment and billing privileges and assuring me that it would henceforth remain in compliance with supplier standards. Petitioner did not list any witnesses or file any written direct testimony. Petitioner asserts under its "Exhibit List" that it is offering

[1] Under the notation "Enclosed" on the bottom left-hand corner of page two of its hearing request, Petitioner states it is enclosing a "Western Company Surety Bond," a "VGM Insurance Certificate," "an 855s Application – Proof of Mailing," and a "Request of change Medicare Letter (confirmed letter has been mailed out to our company address and has not been received)." While the first three documents Petitioner filed appear to be the first three documents that Petitioner indicates are enclosed, Petitioner did not file a "Request of change Medicare Letter" with its March 19, 2013 filing. However, as explained below, whether or not Petitioner filed this letter does not impact my decision in the case.

documents "previously provided." Petitioner indicates that, as "P. Ex. 1," it is offering "General Liability Coverage," as "P. Ex. 2," it is offering "Surety Bond," and as "P. Ex. 3," it is offering "Medicare Change of Ownership Application." However, Petitioner did not previously file a document titled "Medicare Change of Ownership Application." See supra, p. 2, n.1. I accept the Certificate of Liability Insurance issued June 1, 2012 as P. Ex. 1, and I accept the Surety Bond issued by American Safety Casualty Insurance Co. on December 13, 2012 as P. Ex. 2.[2]

I do not find it necessary to convene an in-person hearing because neither party filed admissible written direct testimony. Accordingly, the record is closed. Having considered all of the documentary evidence, I issue this decision based on the complete written record. *See* Order ¶ 10.

II. Discussion

A. Applicable Authority

The Social Security Act (Act) requires that the Secretary of the U.S. Department of Health and Human Services issue regulations establishing a process for the Medicare enrollment of providers and suppliers. Act, section 1866(j) (42 U.S.C. § 1395u(a). A provider or supplier must be enrolled in the Medicare program and be issued a billing number to have billing privileges and thus be eligible to receive payment for services rendered to eligible Medicare beneficiaries. 42 C.F.R. § 424.505. DMEPOS suppliers are subject to on-site surveys, both announced and unannounced, for accreditation purposes. 42 C.F.R. § 424.58(a).

DMEPOS suppliers must meet the supplier standards found at 42 C.F.R. § 424.57(c) in order to enroll in Medicare and maintain Medicare billing privileges. As relevant here, section 424.57(c) provides:

> (c) *Application certification standards.* The supplier must meet and must certify in its application for billing privileges that it meets and will continue to meet the following standards: . . . .

[2] CMS objects to admission of the documents attached to Petitioner's hearing request as exhibits, asserting that they constitute new documentary evidence not previously produced to the contractor hearing officer. CMS Br. at 6 n.3, citing 42 C.F.R. § 498.56(e); *Homemakers A+ Servs.*, DAB CR2322, at 3 (2011). I admit these documents into evidence because they do not prejudice CMS and actually corroborate Petitioner's past noncompliance with supplier standards.

> (2) Has not made, or caused to be made, any false statement or misrepresentation of a material fact on its application for billing privileges. (The supplier must provide complete and accurate information in response to questions on its application for billing privileges. The supplier must report to CMS any changes in information supplied on the application within 30 days of the change.); . . .
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> (10) Has a comprehensive liability insurance policy in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier . . . Failure to maintain required insurance at all times will result in revocation of the supplier's billing privileges retroactive to the date the insurance lapsed; . . .
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> (26) Must meet the surety bond requirements specified in paragraph (d) of this section.

The regulations provide generally that CMS will revoke a supplier's billing privileges if the supplier is found not to meet the supplier standards or other requirements in section 424.57(c). 42 C.F.R. § 424.57(e).[3] CMS may also revoke a currently enrolled supplier's Medicare billing privileges and any corresponding supplier agreement for noncompliance when the supplier is determined not to be in compliance with enrollment requirements. 42 C.F.R. § 424.535(a)(1). A supplier may be granted an opportunity to correct the deficient compliance before a final determination to revoke billing privileges.[4] 42 C.F.R. § 424.535(a)(1) Failure to comply with even one supplier standard is a sufficient basis to revoke a supplier's billing privileges. *1866ICPayday.com, LLC*, DAB No. 2289, at 13 (2009).

B. Issue

The issue in this case is whether CMS was legally authorized to revoke Petitioner's Medicare billing privileges based upon its noncompliance with supplier standards.

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[3] Paragraph (e) of section 424.57 was previously designated paragraph (d) and was re-designated by the rulemaking that imposed the surety bond requirements at paragraph (d); however, the re-designations have not yet been incorporated in the Code of Federal Regulations. 42 C.F.R. § 424.57, Editorial Note (2012).

[4] Petitioner was given the opportunity to file a CAP, but the contractor did not accept it. In a letter dated December 11, 2012, the contractor stated that Petitioner's "CAP does not demonstrate [Petitioner's] compliance with supplier standards." CMS Ex. 5, at 1. I do not have the authority to review the rejection of a CAP. *See, e.g., Conchita Jackson, M.D.*, DAB No. 2495, at 6-7 (2013); *DMS Imaging, Inc.*, DAB No. 2313, at 5-8 (2010).

C. Findings of Fact and Conclusions of Law

On September 26, 2005, Petitioner's "President/Owner," Samuel De Avila, signed a CMS Form 855S certification statement agreeing to adhere to, and continue to meet, all Medicare enrollment requirements. CMS Ex. 7, at 13. It is a Medicare supplier's duty to familiarize itself with program requirements. *Waterfront Terrace, Inc.*, DAB No. 2320, at 7 (2010), *citing Heckler v. Cmty. Health Servs. of Crawford County,* 467 U.S. 51, 63-64 (1984). Petitioner also admits that "Multi Medical Services did not meet compliance with these standards upon inspection." P. MTD.

1. Petitioner failed to comply with Medicare requirements by not timely notifying CMS of a change in ownership, violating 42 C.F.R. § 424.57(c)(2) (Supplier Standard 2).

A supplier is required to notify CMS of any changes in the information it previously provided on its enrollment application. This update must be completed within 30 days of the change. 42 C.F.R. § 424.57(c)(2). Here, however, Petitioner failed to notify CMS of a change in its ownership within 30 days of the change occurring. NSC's Supplier Audit and Compliance Unit (SACU) uncovered Petitioner's failure to report the change in ownership during the April 30, 2012 inspection.

The SACU site investigation report indicates that "Sam De Avila" is the "sole owner" of Petitioner. CMS Ex. 1, at 1. However, documentation on file with the NSC shows another individual, "Arturo De Avila," is also an owner. CMS Ex. 7, at 6.

Petitioner asserts that it:

> took action on February 11, 2013 by means of resending the 855s application to Medicare indicating the changes of ownership and/or managing control information within the organization. It was stated to the Medicare Hearing Officer that this change took effect in 1999. Alternatively, it was understood by Sam De Avila that the announcement of this change had been reported years ago. The official application was sent and confirmed received on February 14, 2013 but was not able to be processed on March 12, 2013 due to the revocation of the Medicare number.

P. MTD. Nowhere in this communication, however, does Petitioner offer evidence to show that the purported 1999 change of ownership was reported to Medicare within 30 days of the change.[5] In contrast, CMS offers a form 855S enrollment application that

[5] On October 15, 2012, Petitioner submitted one page of a CMS 855S enrollment application purporting to show that Arturo De Avila was no longer an owner as of

Petitioner filed with NSC in 2005, which lists Arturo De Avila as one of Petitioner's owners in 2005. CMS Ex. 7, at 6, 13. Petitioner has thus not proven that it submitted notification deleting Arturo De Avila as an owner within 30 days of the purported 1999 change of ownership date. Absent such a showing, Petitioner was not in compliance with 42 C.F.R. § 424.57(c)(2).

2. Petitioner failed to comply with Medicare requirements by failing to maintain liability insurance at all times, violating 42 C.F.R. § 424.57(c)(10) (Suppler Standard 10).

CMS found Petitioner out of compliance with 42 C.F.R. § 424.57(c)(10) because Petitioner failed to submit information supporting the existence of a valid, active insurance policy for its business, where the information provided could be verified with the underwriter as the company covering Petitioner's business. CMS Ex. 5, at 1.

Petitioner does not assert that it was in compliance with Supplier Standard 10 at all times. Instead, it asserts that it "took action on June 1, 2012 by means of contacting VGM Insurance Services and requested to revise the certificate to identify The National Supplier Clearinghouse-AG-495 as the insurance certificate holder. The requested revision was processed and a new certificate of liability insurance was provided with coverage of three million dollars for coverage from 05/24/12 – 05/24/13 with certificate holder National Supplier Clearinghouse AG-495." P. MTD. Petitioner has not shown, however, that it maintained a comprehensive liability insurance policy at all times, including at the time of the inspection.

3. Petitioner failed to comply with Medicare requirements by failing to comply with supplier surety bond requirements, violating 42 C.F.R. § 424.57(c)(26) (Supplier Standard 26).

The Secretary may not issue or renew a Medicare provider number to a DMEPOS supplier unless the supplier "provides the Secretary on a continuing basis . . . with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000." Act, section 1834(a)(16)(B) (42 U.S.C. § 1395m(a)(16)(B)). A DMEPOS supplier must submit a surety bond from an authorized surety of $50,000 which is continuous, names CMS as obligee, and provides that the surety is liable for unpaid

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September 9, 1999. CMS Ex. 4, at 4. The January 22, 2013 reconsideration decision notes that until October 15, 2012, CMS had not been apprised of this change in ownership. CMS Ex. 6, at 2.

claims, civil money penalties, or assessments that occur during the term of the bond. 42 C.F.R. § 424.57(c)(26), (d)(1)(ii), (2), (4), (5), (10).[6] The supplier must meet the specific surety bond requirements at section 424.57(d), and CMS will revoke a DMEPOS supplier's billing privileges if the supplier fails to obtain, file timely, or continuously maintain the surety bond. 42 C.F.R. §§ 424.57(c)(26), 424.57(d)(4).

On June 27, 2012, Petitioner's surety company canceled Petitioner's surety bond as of September 30, 2012. CMS Ex. 8, at 1. Petitioner admits that it let its surety bond lapse and did not obtain a new bond until December 2012. CMS Ex. 8, at 1; CMS Ex. 4, at 8, 10; Petitioner Hearing Request. Petitioner asserts specifically that it "took action on December 4, 2012 by means of contacting American Safety Insurance Company requesting confirmation of Surety Bond Coverage in the amount of fifty thousand dollars for Medicare DMEPOS. The requested documentation was furnished and consists of a two year coverage term from 12/14/2013-12/14/2015." P. MTD. The undisputed fact that Petitioner obtained a surety bond over two months after its prior surety bond lapsed does not satisfy the statutory and regulatory objective of providing continuous protection to the Medicare program, which requires revocation of billing privileges where the supplier doesn't provide a new surety bond before the effective date of the cancellation. During the time the surety bond was lapsed, CMS was unprotected from potential fraud or billing errors. *Pepper Hill Nursing & Rehab. Ctr., LLC,* DAB CR2293, at 6-7 (2010), *aff'd,* DAB No. 2395, at 5-7 (2011); *A Brighter Future Healthcare Servs., Inc.,* DAB CR2267, at 6 (2010). Accordingly, Petitioner is not in compliance with Supplier Standard 26.

Petitioner argues that it will henceforth remain in compliance with supplier standards. Asserting that it will prospectively comply with supplier standards, however, is not a valid defense to the revocation of Petitioner's Medicare enrollment and billing privileges. Even if I assume Petitioner's statements to be true, the 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.

4. CMS was authorized to revoke Petitioner's Medicare enrollment and billing privileges due to its failure to comply with Supplier Standards effective September 19, 2012 .

I must sustain CMS's determination to revoke if a legitimate basis exists and where the facts establish noncompliance with one or more of the regulatory standards.

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[6] As noted at footnote 3, paragraph (d) of 42 C.F.R. § 424.57 was amended to add surety bond requirements. However, the re-designation has not yet been incorporated into the Code of Federal Regulations. 42 C.F.R. § 424.57, Editorial Note (2012).

1866ICPayday.com, LLC, DAB No. 2289, at 13. Petitioner failed to comply with three supplier standards, any one of which authorizes CMS to revoke its enrollment and billing privileges.

Revocation generally becomes effective 30 days after CMS or the CMS contractor mails notice of its determination to the supplier. 42 C.F.R. § 424.535(g). Here, I find NSC mailed notice of Petitioner's revocation and one-year re-enrollment bar on August 20, 2012 giving 30-day notice before the September 19, 2012 revocation date.

A supplier whose billing privileges are revoked is "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). The length of the re-enrollment bar CMS imposes is not a determination subject to review by an administrative law judge. *See Ravindra Patel, M.D.*, DAB CR2171, at 7 n.5 (2010); *Emmanuel Brown M.D. and Simeon K. Obeng, M.D.*, DAB CR2145, at 10 (2010); *see also* 42 C.F.R. § 498.3(b)(17) (establishing as an initial decision subject to review "[w]hether to deny or revoke a . . . supplier's Medicare enrollment . . . ," but not the length of re-enrollment bar).

III. Conclusion

CMS, through its contractor NCS, had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges based on any of the three supplier standards with which it was noncompliant. Accordingly, I sustain the September 19, 2012 revocation of Petitioner's Medicare enrollment and billing privileges and its one year re-enrollment bar.

/s/
Joseph Grow
Administrative Law Judge