Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
DMS Imaging, Inc.	)	Date: December 01, 2009
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-09-683
	)	Decision No. CR2040
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION GRANTING SUMMARY DISPOSITION TO CENTERS FOR MEDICARE & MEDICAID SERVICES AND DENYING PETITIONER'S MOTION FOR SUMMARY DISPOSITON

I grant the motion for summary disposition of the Centers for Medicare & Medicaid Services (CMS) and deny the cross motion for summary disposition of Petitioner, DMS Imaging, Inc.

I. Background

Petitioner is a large, multi-state corporation that has an extensive fleet of mobile diagnostic imaging units. CMS revoked the provider enrollment of four of these units because it determined that Petitioner had improperly combined their enrollment under a single Medicare enrollment number. Petitioner requested reconsideration of CMS's determination. Reconsideration was denied and Petitioner requested a hearing. The case was assigned to me for a hearing and a decision. CMS then moved for summary disposition. Petitioner opposed the motion and cross moved for summary disposition. CMS replied to the cross motion.

II. Issue, findings of fact and conclusions of law

A. Issue

The issue in this case is whether CMS properly determined to revoke the provider enrollment of four of Petitioner's mobile diagnostic imaging units.

B. Findings of fact and conclusions of law

I make findings of fact and conclusions of law (Findings) to support my decision in this case. I set forth each Finding below as a separate heading.

1. CMS properly determined to revoke the provider enrollment of four of Petitioner's mobile diagnostic imaging units.

It is undisputed that Petitioner combined four of its mobile diagnostic imaging units under a single provider enrollment, Medicare Provider Transaction Number 47000010. That was an obvious violation of Medicare enrollment requirements governing independent diagnostic testing facilities (IDTFs) including the four mobile units whose enrollment revocations are at issue here.

Medicare enrollment requirements governing IDTFs allow such entities to be a fixed location, a mobile entity, or an individual non-physician practitioner. 42 C.F.R. § 410.33(a)(1). The regulation governing IDTFs establishes numerous standards that an IDTF must comply with in order to qualify for enrollment and Medicare reimbursement. 42 C.F.R. § 410.33(b) – (g)(1)-(15). It is evident from the face of the regulation that close oversight of an IDTF may be necessary to assure regulatory compliance with the many participation requirements. CMS attempts to assure that oversight may be obtained by requiring that an IDTF with multiple practice locations separately enroll each practice location into the Medicare program. Medicare Program Integrity Manual, Chapter 10, § 4.19.1.C. Thus:

> The IDTFs must separately enroll each of their practice locations (with the exception of locations that are used solely as warehouses or repair facilities). This means that each enrolling IDTF can only have one practice location on its CMS-855B enrollment application: thus, if an IDTF is adding a practice location to its existing enrollment, it must submit a new, complete CMS-855B application for that location and have that location undergo a separate site visit. *Also, each of the IDTF's mobile units must enroll separately*.

> Consequently, if a fixed IDTF site also contains a mobile unit, the mobile unit must enroll separately from the fixed location.

Id. (emphasis added).

CMS is authorized to revoke a provider or supplier's Medicare enrollment whenever it determines the provider or supplier not to be complying with Medicare enrollment requirements. 42 C.F.R. § 424.535(a)(1). CMS's determination to revoke the enrollment of the four mobile units in question was authorized by this regulation because Petitioner plainly was not complying with Medicare enrollment requirements with respect to these four units.

2. Whether Petitioner corrected its deficiencies is not an issue that I am authorized to hear and decide.

Petitioner asserts that the issue in this case is whether it "corrected the deficiencies in the enrollment of its . . . [IDTFs] . . . and properly enrolled each of its mobile imaging units as separate IDTFs prior to CMS's final determination regarding . . . [Petitioner's] billing privileges." Petitioner's brief at 1. Petitioner acknowledges that the four mobile units in question were improperly enrolled under a single Medicare enrollment. But, according to Petitioner, CMS was obligated to continue the enrollment of these units or to at least re-enroll them because Petitioner corrected its deficiency by applying to enroll the four units separately prior to the date when CMS effectuated its dis-enrollment of these units.

However, Petitioner's assertion is irrelevant even if its fact contentions concerning correction are true.[1] As a matter of law, CMS is not required to accept corrections offered by a deficient provider prior to terminating that provider's enrollment in Medicare. And, also as a matter of law, CMS's determination not to accept proffered corrections is not an initial determination giving rise to a right to a hearing. Consequently, I have no authority to address Petitioner's contention.

Regulations governing enrollment of providers permit a deficient provider to submit a corrective action plan in order to correct its deficiencies prior to the date when CMS has determined to terminate enrollment. 42 C.F.R.

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[1] CMS asserts that the plan of correction was inadequate. I do not address the merits of this assertion because the adequacy of the plan of correction is beyond my authority to hear and decide and is, therefore, irrelevant.

§ 424.535(a)(1). However, although a deficient provider has a right to *submit* a corrective action plan, there is no requirement in the regulations that CMS must *accept* that plan prior to terminating that provider's enrollment. Moreover, the regulations state explicitly that a determination not to accept a corrective action plan is not an initial determination giving rise to a right to a hearing. 42 C.F.R. § 405.874(e).

Thus, the fact that Petitioner submitted a plan of correction in this case neither prohibits CMS from terminating its enrollment nor does it create an issue that I may hear and decide. My *sole* authority in a case such as this one is to hear and decide the issue of whether a basis existed to terminate a provider's enrollment as of the point in time when CMS (or a contractor) determined it to be deficient. What transpired subsequently between the provider and CMS is simply beyond the ambit of what I may hear and decide.

The merits of Petitioner's plan of correction are irrelevant. Because I have no authority to direct CMS to accept that plan or to revoke the termination of enrollment based on submission of the plan, I also have no authority to consider the merits of whatever it is that Petitioner proposed to do to rectify its deficiency. CMS or its contractor, and only those entities, have the authority to consider the merits of a plan of correction and to determine whether to accept a plan.

Petitioner asserts that CMS is obligated to consider new evidence that is brought to its attention after it made its initial determination and that failure to do so is at least a basis for vacating the determination to dis-enroll Petitioner and remanding the case back to CMS for additional review. As support for this argument it relies on a decision that I issued in the case of *Center for Organ Recovery and Education*, DAB CR313 (1994) (*CORE).* Petitioner's reliance on *CORE* is misplaced. *CORE* involved a totally different legal process and fact situation from this case and is not analogous in any sense. *CORE* involved a challenge to CMS's (at the time known as the Health Care Financing Administration or HCFA) determination to allocate territories for organ harvesting among competing organ procurement organizations (OPOs). I remanded the case back to HCFA because I found that HCFA had failed to follow its procedures governing competitive bids. Specifically, I found that the procedures required review of new information relevant to bids that might be received during a reconsideration process.

CORE involved a regulatory competitive bidding process and not a compliance enforcement process as is the case here. The OPOs involved in *CORE* were in competition for exclusive rights to serve a specific territory. Under the regulatory process governing competitive bids, HCFA was required to consider and to make a determination based on *all* of the facts presented to it both initially and on reconsideration. Such is not the case here. Here, in the context of compliance enforcement, CMS is not required to base its determination on any facts presented to it which address a provider's compliance at a point in time after CMS determines that provider to be deficient. Thus, and unlike in *CORE*, CMS is not required to accept facts presented to it by Petitioner after the point in time when it made its initial determination.

/s/
Steven T. Kessel
Administrative Law Judge