Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

YCM Home Health Care, Inc.,
(PTAN: 10-9474; NPI: 1548434897),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-750

Decision No. CR3406

Date: October 7, 2014

DECISION

The Medicare enrollment and billing privileges of Petitioner, YCM Home Health Care, Inc., are revoked pursuant to 42 C.F.R. § 424.535(a)(1),[1] effective November 6, 2013 for three years.

I. Procedural Background and Jurisdiction

Palmetto GBA (Palmetto), a Medicare administrative contractor (MAC), notified Petitioner by letter dated October 7, 2013, that its Medicare enrollment and billing privileges were revoked effective November 3, 2013. Palmetto cited 42 C.F.R. § 424.535(a)(1) as the basis for the revocation. Palmetto also barred Petitioner from re-enrolling in the Medicare program for three years, pursuant to 42 C.F.R. § 424.535(c). Petitioner was offered the opportunity to submit a corrective action plan and notified that

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[1] References are to the 2013 revision of the Code of Federal Regulations (C.F.R.), unless otherwise stated.

it could request reconsideration of the revocation. Centers for Medicare & Medicaid Services (CMS) Exhibit (Ex.) 1 at 136-37.

Petitioner requested reconsideration by letter dated December 5, 2013. CMS Ex. 1 at 120-86. Petitioner was notified by letter dated December 31, 2013, that the reconsideration hearing officer declined to overturn the revocation.[2] CMS Ex. 1 at 1-3.

Petitioner requested a hearing before an administrative law judge (ALJ) on February 28, 2014. On March 12, 2014, the case was assigned to me for hearing and decision and an Acknowledgement and Prehearing Order (Prehearing Order) was issued. CMS filed a motion for summary judgment (CMS Br.) and CMS Exs. 1 through 14 on April 11, 2014. Petitioner filed a cross-motion for summary judgment (P. Br.) and a letter from Petitioner's "President/Administrator" Crislayne Abraham on June 18, 2014. The letter from Ms. Abraham was not properly marked as an exhibit, but I treat the letter as Petitioner's exhibit (P. Ex.) 1. CMS filed a reply brief on July 2, 2014 (CMS Reply) with a motion for leave to file out-of-time, which is granted. The parties have not objected to my consideration of P. Ex. 1 and CMS Exs. 1 through 14, and the offered exhibits are admitted and considered as evidence.

II. Discussion

A. Applicable Law

A home health agency is a public agency or private organization that is primarily engaged in providing skilled nursing and other therapeutic services to patients in their homes. Social Security Act (Act) § 1861(o) (42 U.S.C. § 1395x(o)). The Act sets forth requirements for home health agencies participating in the Medicare and Medicaid programs, and authorizes the Secretary of Health and Human Services (the Secretary) to

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[2] Petitioner submitted a corrective action plan (CAP) on November 6, 2013. CMS Ex. 1 at 187-213. The reconsidered determination acknowledged that Petitioner submitted a CAP and states that Petitioner failed to "establish prospective compliance" and "[w]e are not satisfied that any of the submitted information has corrected the deficient compliance outlined in our letter of October 7, 2013." CMS Ex. 1 at 2. The refusal of CMS or its contractor to accept Petitioner's CAP is not an initial determination subject to my review. 42 C.F.R. §§ 405.809, 424.545(a), 498.3(b); *Conchita Jackson, M.D.*, DAB No. 2495 at 5-7 (2013); *Pepper Hill Nursing & Rehab. Ctr., LLC*, DAB No. 2395 at 9 (2011); *DMS Imaging, Inc.*, DAB No. 2313 at 5-8 (2010).

promulgate regulations implementing the statutory provisions. Act §§ 1861(m) and (o), and 1891 (42 U.S.C. §§ 1395x(m) and (o), and 1395bbb).

The Act defines "home health services" as:

> [I]tems and services [listed in the statute] furnished to an individual, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan . . . established and periodically reviewed by a physician, which items and services are, . . . provided on a visiting basis in a place of residence used as such individual's home . . . .

Act § 1861(m). Home health services are reimbursable by Medicare only if a physician certifies that home health services are required for that beneficiary for the reasons specified in the Act. Act §§ 1814(a)(2)(C), 1835(a)(2)(A) (42 U.S.C. §§ 1395f(a)(2)(C);1395n(a)(2)(A)). Section 1861(m) and (o) require that home health services be delivered according to a plan of care established and reviewed by a physician. Pursuant to section 1891(a)(4) (42 U.S.C. § 1395bbb(a)(4)) of the Act, a home health agency must include the plan of care required by section 1861(m) of the Act as part of its clinical records for a Medicare beneficiary receiving home health services. Section 1861(o)(3) of the Act requires that a home health agency maintain clinical records on all patients.

The regulations generally applicable to ordering medical services for Medicare beneficiaries recognize that a physician has a major role in deciding about patient admissions, testing, drugs, and treatments. Therefore the regulations establish as a condition for Medicare payment that a physician certify, and in some cases recertify, the necessity of medical services. 42 C.F.R. § 424.10. The regulations state that there are no specific procedures or forms required for physician certification and recertification, rather the provider may adopt any procedure or form that permits verification. 42 C.F.R. § 424.11(b). The regulations specify that it is the responsibility of the provider,[3] the

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[3] A "supplier" furnishes items or services under Medicare and the term supplier applies to physicians or other practitioners and facilities that are not included within the definition of the phrase "provider of services." Act § 1861(d) (42 U.S.C. § 1395x(d)). A "provider of services," commonly shortened to "provider," includes hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, hospice programs, and a fund as described in sections 1814(g) and 1835(e) of the Act. Act § 1861(u) (42 U.S.C. § 1395x(u)). The distinction *(Footnote continued next page.)*

home health agency in the case of home health services, to obtain required certifications and recertifications and keep them on file for verification by CMS or its contractor, if necessary. 42 C.F.R. § 424.11(a).

The regulations specifically applicable to home health services provide that Medicare Part A and Part B will pay for home health services only when a physician signs a certification that the individual needs the home health services specified in the regulations. 42 C.F.R. §§ 409.40-.50, 424.22. The contents of the certification are specified by 42 C.F.R. § 424.22(a). The certification must include a statement that a plan of care for furnishing the services has been established and periodically reviewed by a physician who is a doctor of medicine, osteopathy, or podiatric medicine. 42 C.F.R. § 424.22(a)(iii). A physician responsible for performing the initial certification must document that a face-to-face patient encounter, which is related to the primary reason the patient requires home health services, has occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care. The documentation must include an explanation of why the clinical findings of the encounter support that the patient is homebound and in need of services. The face-to-face encounter can be, but need not be, performed by the certifying physician or by a nurse practitioner, clinical nurse specialist, certified nurse midwife, or physician assistant under the supervision of the physician (or for patients admitted to home health direct from an acute or post-acute stay by the physician who cared for the patient during that stay). The documentation of the face-to-face encounter must be in a separate and distinct section of, or an addendum to, the certification, and must be titled, dated and signed by the certifying physician. If the certifying physician does not perform the face-to-face encounter himself, the nonphysician practitioner or other physician who cared for the patient in an acute or post-acute facility performing the face-to-face encounter must communicate the clinical findings of that face-to-face encounter to the certifying physician. 42 C.F.R. § 424.22(a)(1)(v). Recertification is required every 60 days; must be signed and dated by the physician who reviewed the plan of care; and contain the information specified in the regulation. 42 C.F.R. § 424.22(b). Similar requirements for plan of care contents, certification, and recertification for home health services subject to payment by Medicare Part A are found at 42 C.F.R. § 409.43(b), (c), and (e). The regulations do not specify a form for the certification and plan of care. However, for home health services the Form CMS-485, "Home Health Certification and Plan of Care" appears to satisfy regulatory certification and recertification requirements, if properly completed.

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(Footnote continued.)

between providers and suppliers is important because they are treated differently under the Act for some purposes. Petitioner, as a home health agency, is a provider of services.

Pursuant to 42 C.F.R. § 424.505, a provider such as Petitioner must be enrolled in the Medicare program and be issued a billing number to have billing privileges and to be eligible to receive payment for services rendered to a Medicare eligible beneficiary.

When a home health agency seeks to enroll in the Medicare program as a provider it must complete an enrollment application, the CMS-855A, an example of which was admitted as CMS Ex. 2. Completion of the CMS-855A requires that an authorized official of the provider sign a certification statement, found at section 15 of the application. The authorized official's signature binds the provider "to the laws, regulations, and program instructions of the Medicare program." CMS Ex. 2 at 39. Instructions contained in the CMS-855A regarding certification statements advise the applicant that by signing the application the authorized official "binds the provider to all of the requirements listed in the Certification Statement," and subject the applicant to revocation for noncompliance. CMS Ex. 2 at 37. The home health agency, "agree[s] to abide by the Medicare laws, regulations and program instructions that apply." CMS Ex. 2 at 38.

A home health agency that submits a claim for payment must identify the certifying physician on the claim. 42 C.F.R. § 424.507(b). It is the provider filing the claim that is accountable for the validity and integrity of the information represented. 42 C.F.R. §§ 424.5(a)(4), 424.11. Home health agencies submit a claim for payment electronically using the Form 837I or by completing the CMS-1450 (also known as the UB-04). 42 C.F.R. § 424.32(b); CMS Pub. 100-04, Medicare Claims Processing Manual, chap.10 § 10.A. The CMS-1450 states that the act of submitting the claim "constitutes certification" that the information recited on the claim is "true, accurate, and complete." CMS Ex. 4 at 2.

Pursuant to 42 C.F.R. § 424.535(a)(1), a provider's enrollment and billing privileges may be revoked for:

> (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. . . .

42 C.F.R. § 424.535(a)(1).

A provider whose enrollment and billing privileges have been revoked may request reconsideration and review as provided by 42 C.F.R. pt. 498. A provider submits a written request for reconsideration to CMS or its contractor. 42 C.F.R. § 498.22(a).

CMS or its contractor must give notice of its reconsidered determination to the provider, giving the reasons for its determination and specifying the conditions or requirements the provider failed to meet, and informing the provider about the provider's right to an ALJ hearing. 42 C.F.R. § 498.25. If the reconsidered determination is unfavorable to the provider, the provider has a right to request a hearing by an ALJ and further review by the Departmental Appeals Board (Board). Act § 1866(j)(8) (42 U.S.C. § 1395cc(j)(8)); 42 C.F.R. §§ 424.545, 498.3(b)(17), 498.5. A hearing on the record, also known as an oral hearing, is required under the Act. *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743, 748-50 (6th Cir. 2004).

The standard of proof and quantum of evidence required to prove a fact in this proceeding is a preponderance of the evidence. CMS has the burden of going forward with the evidence and making a prima facie showing of a basis for denial of an application for participation, revocation of Petitioner's billing privileges, or termination of Petitioner's agreement with the Secretary. Petitioner bears the burden of persuasion to show by a preponderance of the evidence that it met participation requirements or was not in violation of program participation requirements when the reconsidered determination was made. 42 C.F.R. § 424.545(c); *see Hillman Rehab. Ctr.*, DAB No. 1611 (1997), *aff'd, Hillman Rehab. Ctr. v. United States Dep't of Health and Human Servs., Health Care Fin. Admin.*, No. 98-3789 (GEB), slip op. at 25 (D.N.J. May 13, 1999); *Cross Creek Health Care Ctr.*, DAB No. 1665 (1998); *Emerald Oaks*, DAB No. 1800 (2001); *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 Fed. App'x. 181 (6th Cir. 2005); *Batavia Nursing & Convalescent Inn*, DAB No. 1911 (2004).

B. Issue

Whether summary judgment is appropriate; and

Whether there is a basis for the revocation of Petitioner's Medicare enrollment and billing privileges effective November 3, 2013.

C. Findings of Fact, Conclusions of Law, and Analysis

My conclusions of law are set forth in bold text followed by my findings of fact and analysis.

1. The parties' motions for summary judgment are denied and I decide the case based on the written record.

Both parties requested that I decide this case on summary judgment. However, Petitioner also waived its right to oral hearing (P. Br. at 1), stating that "[d]ue to economic constraints imposed . . . [Petitioner] requests that a decision be rendered based on the

record, together with relevant case law on point . . . ." P. Br. at 1. Because Petitioner has waived its right to oral hearing, I decide the case based on the written record, not under the summary judgment procedure described in paragraph II.G of the Prehearing Order. In deciding this case on the merits on the documentary record after a waiver of an oral hearing, I make credibility determinations, weigh the evidence, and decide which inferences to draw from the evidence.[4]

2. There is a basis to revoke Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(1).

3. The effective date of the revocation of Petitioner's Medicare enrollment and billing privileges is November 6, 2013.

a. Facts

Petitioner is enrolled in Medicare as a home health agency located at 15291 NW 60th Avenue, Miami Lakes, Florida with National Provider Identifier (NPI) 1548434897. CMS Ex. 3 at 3, 7. Petitioner's enrollment application dated March 20, 2009, was signed by Crislayne Abraham, who listed her title as "President." CMS Ex. 3 at 5. The application included the standard certification that Petitioner agreed to comply with the Medicare laws, regulations, and program instructions that applied to Petitioner's provider type. The certification also states that Petitioner understood that payment of claims is conditioned upon the claim and underlying transaction complying with the law, regulations, and program instructions. The certification statement also states that Petitioner acknowledged that its enrollment could be revoked for failure to meet any requirements of the certification statement. Petitioner agreed, by signing the application, not to knowingly present or cause to be presented a false or fraudulent claim for payment

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[4] If I were to decide this case on summary judgment the result would be no different. The undisputed facts are that Petitioner submitted the claims related to the 11 beneficiaries in issue; Dr. Lazo denied to federal agents that he signed the supporting documents or ordered the home health services for the 11 beneficiaries; and Petitioner has presented no evidence to rebut the testimony of the agents and the evidence they collected. The CMS evidence constitutes a prima facie showing and Petitioner has failed to present affidavits or other evidence to show a genuine dispute as to any of the material facts. The issue that remains to be resolved is whether the undisputed evidence constitutes a basis for revocation under 42 C.F.R. § 424.535(a)(1), an issue of law which is resolved against Petitioner.

and not to submit claims with deliberate ignorance or reckless disregard for whether the claims were true or false. CMS Ex. 3 at 8-9.

CMS offered as evidence the declaration[5] of Cecilia Franco, the Director of the CMS Miami Field Office. Her testimony is that her staff became aware of a large number of orders and certifications for home health services by Dr. Angel Lazo related to claims for such services by a number of home health agencies including Petitioner. CMS records showed only 4 certifications of home health services by Dr. Lazo in calendar-year 2011, but the number jumped to 168 in calendar-year 2012, and 137 as of September 2013. CMS examined claims of Petitioner and found claims by Petitioner for home health services to 11[6] Medicare beneficiaries allegedly ordered and certified by Dr. Lazo in 2012 and 2013. However, upon examining the records of the 11 beneficiaries, CMS found no other records that showed that Dr. Lazo treated those beneficiaries. Dr. Lazo was interviewed by CMS agents on August 27 and September 16, 2013, and showed the home health certification paperwork provided by Petitioner for each of the 11 beneficiaries. Dr. Lazo denied ordering home health services for any patients for several years; he stated that the sheet from the prescription pad filed with the claims bore an incorrect address; he denied that he ever worked at the address listed on the prescription pad; he denied that he authorized the printing of a prescription pad with his name and the address listed on the sheet filed with the claims; he denied that the signatures on the pad and other records were his; and he denied he ordered home health services for any of the 11 Medicare beneficiaries involved. CMS Ex. 7. The testimony of Director Franco is undisputed and unrebutted, credible, and entitled to weight.

CMS also presented the declaration[7] of Carmen Oquendo, Health Insurance Specialist with the CMS Miami Field Office. Ms. Oquendo states that she investigated the

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[5] The declaration is substantially in the form required by 28 U.S.C. §1746, and is therefore admissible as if it were sworn testimony. 42 C.F.R. § 498.62 (witness testimony must be under oath or affirmation).

[6] The initial and reconsidered determinations incorrectly refer to 12 Medicare beneficiaries. CMS Ex. 1 at 2, 136. There is no dispute that the evidence shows that there were only 11 Medicare beneficiaries, but home health service claims were made for one beneficiary on two separate occasions. CMS Ex. 1 at 12, 15, 17-119.

[7] The declaration is substantially in the form required by 28 U.S.C. § 1746, and is therefore admissible as if it were sworn testimony. 42 C.F.R. § 498.62 (witness testimony must be under oath or affirmation).

information found on the prescription pad sheet provided with Petitioner's claims for home health services ordered and certified by Dr. Lazo. She found no evidence that Dr. Lazo had ever used office space at the address listed on the prescription pad sheet or that he had ever been assigned the telephone number listed. CMS Ex. 11. The testimony of Ms. Oquendo is undisputed and unrebutted, credible, and entitled to weight.

A Report of Investigation (ROI) by the Miami Field Office reports an interview of Dr. Lazo on September 16, 2013, regarding the 11 beneficiaries for which Petitioner filed claims for home health services. The ROI is consistent with the declaration of Director Franco. CMS Ex. 1 at 11-13. There is no dispute that the ROI shows that CMS obtained the records for the 11 beneficiaries by requesting them from Petitioner. CMS Ex. 1 at 14-16. The records obtained from Petitioner were admitted as evidence without objection marked as CMS Ex. 1 at 17-119. Each document bears a signature that is purportedly the signature of Dr. Lazo. Each document also bears a stamp that attests that the signature is not that of Dr. Lazo with a signature, which is undisputed to be the signature of Dr. Lazo. Although a lay-witness is generally thought to be competent to compare signatures, in this case it is not possible for me to compare the alleged signatures with the actual signatures and find that the two are not made by the same person.

Petitioner submitted with its request for reconsideration[8] and CAP the affidavit of Crislayne Abraham, Petitioner's owner and manager. Ms. Abraham testifies that she reviewed the documents submitted to CMS related to the claims for services for the 11 Medicare beneficiaries. She states that she found nothing that raised a question regarding the validity of Dr. Lazo's signatures. She asserts that Dr. Lazo lied when he denied signing the documents. She described how Petitioner verified Dr. Lazo's identity, license, and enrollment in Medicare, including contacting the physician's office to confirm the referral for home health services and the home-bound status of the patients involved. She testified that Petitioner's staff also assessed the individual patients to ensure they qualify for home health services; they develop and write the plan of care; and the written plan of care is then taken by courier to the ordering physician who is required to sign the plan of care. She testified that all of Petitioners processing steps were followed without incident in the cases of the 11 Medicare beneficiaries at issue. CMS Ex. 1 at 142-47, 200-05.

I may not consider as substantive evidence the letter of Ms. Abraham dated June 18, 2014, which I have marked as P. Ex. 1, because it is not sworn or affirmed or executed as a declaration. 42 C.F.R. § 498.62 (witness testimony must be under oath or affirmation);

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[8] The request for reconsideration also incorrectly refers to 12 Medicare patients. CMS Ex. 1 at 120-21.

28 U.S.C. § 1746 (declaration may be accepted as sworn testimony if executed in substantially the form prescribed). However, P. Ex. 1 does not add to the information already contained in Ms. Abraham's affidavits which are considered as evidence.

I do not discount Ms. Abraham's testimony regarding the procedures Petitioner followed related to the 11 Medicare beneficiaries involved in this case. I do not find credible or weighty Ms. Abraham's conclusion that Dr. Lazo lied to federal agents when responding to questions during his interview on September 16, 2013 as reflected in the ROI and the declaration of Director Franco. Petitioner has not offered evidence to support Ms. Abraham's conclusion. Petitioner has not asserted that it wished to elicit testimony from Dr. Lazo in an oral hearing or requested a subpoena for that purpose. Petitioner has not offered the affidavit or declaration of any employee who actually visited Dr. Lazo's office for the purpose of obtaining his signatures or for any other purpose. Petitioner has not requested to present testimony of its staff or requested subpoenas for that purpose. Ms. Abraham does not state in her affidavits that she ever met Dr. Lazo or visited his office. Petitioner also failed to offer the testimony, an affidavit, or declaration of any of the 11 Medicare beneficiaries to establish that they were treated or evaluated by Dr. Lazo. Therefore, the evidence is insufficient to support a finding that Dr. Lazo lied. I also have no bases on which to discount the testimony of Director Franco or Ms. Oquendo as set forth in their declarations.

Petitioner also offered with its request for reconsideration some copies of signatures that purport to be those of Dr. Lazo on documents in Miami-Dade County, Florida, publically accessible land records. CMS Ex. 1 at 156. Those signatures are significantly different from the signatures that appear on the claim related records at CMS Ex. 17-119, including both the false signatures and the known signatures of Dr. Lazo. The signatures found in CMS Ex. 1 at 156 are also different from those that appear on pages of Dr. Lazo's Medicare enrollment application, which were admitted without objection as CMS Ex. 9 at 4, 7. Due to the nature of Dr. Lazo's signature very little may be found based on comparison of the signatures.

b. Analysis

Palmetto revoked Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(1) for noncompliance with the requirements for Medicare enrollment. CMS argues that Petitioner billed Medicare for home health services for 11 Medicare beneficiaries without valid physician certifications. CMS alleges specifically that the physician Petitioner identified as treating the 11 beneficiaries, Dr. Lazo, was not involved in their treatment, care or monitoring. CMS argues that by filing claims for home health services for the 11 beneficiaries without proper supporting documentation with valid signatures, Petitioner failed to comply with Medicare law, regulations, program instructions and the terms of its enrollment application. CMS Br. at 3, 14-15. CMS presented sufficient evidence to make a prima facie showing that Petitioner billed

Medicare for home health services without valid supporting documentation signed by a physician. Therefore, the burden is upon Petitioner to rebut the prima facie case, a burden Petitioner has failed to meet. The preponderance of the evidence shows that Petitioner filed claims for home health services for 11 Medicare beneficiaries. The preponderance of the evidence shows that when CMS requested that Petitioner produce the physician certifications, orders, plans of care, and other documents supporting the claims, Petitioner produced the requested documents. The documents produced by Petitioner purported to bear the signature of Dr. Lazo. According to Director Franco, when Dr. Lazo reviewed the documents submitted by Petitioner, he denied that the 11 beneficiaries were his patients and he denied that he signed the documents required to support Petitioner's claims for home services for the 11 beneficiaries. Petitioner was committed when enrolling in Medicare to comply with the law, regulations, program instructions, and the terms of its enrollment agreement. Because Petitioner submitted claims for home health services for the 11 Medicare beneficiaries that were not properly certified by a physician, Petitioner violated the requirements of 42 C.F.R. §§ 409.40-.50; 424.10; and 424.22, all of which require physician certification of the necessity of the medical services for which Medicare claims are submitted. Petitioner also violated the terms of its enrollment application because Petitioner failed to ensure that the transactions underlying its claims complied with the Medicare law, regulations, and program instructions. CMS Ex. 3 at 8-9.

The gist of Petitioner's defense is that Dr. Lazo lied and that Petitioner did all it could be expected to do to ensure that it had proper certifications by Dr. Lazo. CMS Ex. 1 at 121-24, 142-47, 200-05. I have no evidence other than the assertion of Ms. Abraham that Dr. Lazo lied and her assertion is unsupported by any credible evidence. Petitioner also argues that it had no reason to know that Dr. Lazo's signatures were not legitimate. CMS Ex. 1 at 129. Petitioner's arguments that it did all it could to verify that the certifications were proper and that it had no reason to know Dr. Lazo's signatures were not legitimate are not persuasive. There is no evidence that Petitioner verified Dr. Lazo's address through the publically accessible NPI registry or that Petitioner's staff questioned why that address differed from the address provided with the certification documents. Although Ms. Abraham testified that a courier would have taken the plan of care and certification to Dr. Lazo's office for signature, there is no evidence that a courier actually found Dr. Lazo and obtained his signature at the address listed in the certification documents. Petitioner also fails to point to any other evidence that would support its belief that Dr. Lazo was a physician for any of the 11 beneficiaries who could certify a need for home health services. Considering the simple approaches Petitioner failed to take that could have been used to verify that Dr. Lazo's certifications were legitimate, I cannot conclude that Petitioner did all it could or all that it could be expected to do. Petitioner argues that the evidence I should rely upon is in the medical records. P. Br. Petitioner filed with its request for reconsideration many pages from the clinical records for the 11 beneficiaries. CMS Ex. 1 at 214-1395. However, Petitioner does not explain how the medical records submitted rebut the evidence that Dr. Lazo did not sign the

certifications and other documents (CMS Ex. 1 at 17-119) that support Petitioner's claims for home health service for the 11 beneficiaries. Petitioner also does not explain how the medical evidence submitted shows that Dr. Lazo lied about not signing the documents. Petitioner objected in its request for reconsideration that it had no opportunity to test the veracity of Dr. Lazo. CMS Ex. 1 at 121-22. In its brief, Petitioner argues that I should not give Dr. Lazo's statements any weight because they were not executed as declarations under 28 U.S.C. § 1746. P. Br. I agree with Petitioner that the CMS case could have been stronger had Dr. Lazo been required to swear to an affidavit or execute a declaration under 28 U.S.C. § 1746. However, I do not rely upon Dr. Lazo's statement to investigators as testimony. Rather, my decision turns on the testimony of the two investigators offered as declarations that do substantially comply with 28 U.S.C. § 1746. I further note that Petitioner's opportunity to test the veracity of Dr. Lazo was waived when Petitioner failed to request that Dr. Lazo be subpoenaed to testify and then waived the opportunity for an oral hearing to receive his testimony.

Petitioner was not in compliance with the laws, regulations, and program instructions of the Medicare program to which it agreed to be bound when it filed claims for Medicare payment for 11 beneficiaries without valid physician certifications. Thus, Petitioner was not in compliance with the requirements for enrolling and maintaining enrollment in Medicare and the terms of the enrollment application it signed. Accordingly, there was a basis to revoke Petitioner's enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(1).

The Palmetto notice of the initial determination to revoke Petitioner's enrollment and billing privileges effective November 3, 2013, was dated October 7, 2013. Absent evidence to the contrary, I find that the letter was mailed to Petitioner on October 7, 2013. The effective date of a revocation pursuant 42 C.F.R. § 424.535(a)(1) is 30 days after CMS or the MAC mails notice of the revocation. 42 C.F.R. § 424.535(g). Accordingly, the effective date of revocation of Petitioner's enrollment and billing privileges is November 6, 2013, not November 3, 2013.

III. Conclusion

For the foregoing reasons, Petitioner's Medicare enrollment and billing privileges are revoked for three years beginning on November 6, 2013.

/s/
Keith W. Sickendick
Administrative Law Judge