Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

MedChoice Medical Center
(NPI: 1093716318; PTAN: 447370)

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-1358

Decision No. CR3506

Date: December 8, 2014

DECISION

The Medicare enrollment and billing privileges of Petitioner, MedChoice Medical Center, are revoked pursuant to 42 C.F.R. § 424.535(a)(1), [1] effective December 5, 2013. Pursuant to Centers for Medicare & Medicaid Services (CMS) policy and 42 C.F.R. § 424.535(c), Petitioner is subject to a two-year bar to re-enrolling in Medicare that expires December 4, 2015.

I. Background

On November 4, 2013, National Government Services, Inc., a Medicare administrative contractor (MAC), notified Petitioner that its billing privileges and Medicare enrollment were revoked effective December 5, 2013 pursuant to 42 C.F.R. § 424.545(a)(1). The MAC alleged in its notice that revocation was based on Petitioner's refusal to allow investigators of Cahaba Safeguard Administrators, LLC (Cahaba), the Zone Program Integrity Contractor (ZPIC), access to medical records during an attempted onsite audit of

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

Petitioner on September 4, 2013. The MAC alleged that access to medical records was authorized by sections 1833(e) and 1893(a) of the Social Security Act (the Act) (42 U.S.C. §§ 1395l(e), 1395ddd(a)). The notice advised Petitioner that it could submit a corrective action plan (CAP) within 30 days; and request reconsideration by a contractor hearing officer within 60 days. The MAC notice also advised Petitioner that it was subject to a three-year reenrollment bar pursuant to 42 C.F.R. § 424.535(c). CMS Exhibit (Ex.) 1 at 35-36.

Petitioner sent the MAC a CAP dated December 2, 2013. CMS Ex. 1 at 40-41. Petitioner requested reconsideration by letter dated January 2, 2014. CMS Ex. 1 at 4-12. Reconsidered determinations were issued by CMS on March 27, 2014 and April 24, 2014. The hearing officer upheld revocation of Petitioner's billing privileges and termination of Petitioner's provider agreement citing 42 C.F.R. § 424.535(a)(1). The hearing officer found that Petitioner admitted that it denied Cahaba investigators access to medical documents. The hearing officer commented that Petitioner's CAP was denied because there was "no evidence provided of future compliance." CMS Ex. 1 at 1-2.

On June 23, 2014, Petitioner filed a request for hearing (RFH) before an administrative law judge (ALJ). The case was assigned to me and an Acknowledgement and Prehearing Order (Prehearing Order) was issued on June 27, 2014.

On July 28, 2014, CMS filed its prehearing brief and alternative motion for summary judgment (CMS Br.) with CMS Exs. 1 through 5. Petitioner filed its prehearing brief and opposition to the CMS motion for summary judgment on August 27, 2014, with Petitioner's exhibits (P. Exs.) 1 and 2. CMS filed a reply brief on September 10, 2014 (CMS Reply). On September 22, 2014, Petitioner filed a motion for leave to file a sur-reply but Petitioner failed to attach a copy of its sur-reply as required by the Prehearing Order ¶ II.G. Petitioner's motion contains a detailed statement of points and authorities and I accept the motion as setting forth Petitioner's sur-reply, even though Petitioner failed to comply with the Prehearing Order.

Petitioner did not object to my consideration of CMS Exs. 1 through 5 and they are admitted as evidence. CMS objected to P. Exs. 1 and 2 on grounds they are not relevant. CMS Reply at 2. P. Ex. 1 is Petitioner's supplier agreement, which reflects Petitioner's name; Provider Transaction Access Number (PTAN); and Petitioner's effective date of Medicare participation of January 1, 1999. P. Ex. 1 also reflects that Petitioner agreed to accept the assignment of Medicare Part B payments from Medicare beneficiaries as full payment for covered Medicare Part B services plus the applicable deductible and coinsurance amounts. The agreement is clearly relevant to show that Petitioner was properly enrolled and entitled to receive assigned Medicare payments for covered services delivered to Medicare beneficiaries. P. Ex. 2 is a letter from CMS to Petitioner dated March 27, 2014, with the subject-line "MedChoice Medical Center Reconsideration Decision." Petitioner offers P. Ex. 2 because it shows that Petitioner's CAP was denied

March 27, 2014, and because it states the reconsidered determination in Petitioner's case. P. Br. at 8 n.8. CMS argues that P. Ex. 2 was superseded by the April 24, 2014 CMS letter announcing its reconsidered determination. CMS Reply at 2. The CMS letter dated April 24, 2014, also with the subject line "MedChoice Medical Center Reconsideration Decision," does not refer to the March 27, 2014 CMS notice and does not state whether it superseded the earlier notice or was a reopened and revised reconsideration determination. Given the lack of clarity in the CMS notices, Petitioner is entitled to ensure that I have the complete administrative record to consider. Although the Federal Rules of Evidence (Fed. R. Evid.) do not control in this case, CMS is referred to Fed. R. Evid. 106 as a current example of an expression of the rule of completeness. P. Exs. 1 and 2 are admitted and considered as evidence.

II. Discussion

A. Statutory and Regulatory Program Requirements

Section 1831 of the Act (42 U.S.C. § 1395j) establishes the supplementary medical insurance benefits program for the aged and disabled known as Medicare Part B. Administration of the Part B program is through contractors such as National Government Services, Inc. Act § 1842(a) (42 U.S.C. § 1395u(a)). Payment under the program for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of services and suppliers.[2] Act §§ 1835(a) (42 U.S.C. § 1395n(a)), 1842(h)(1) (42 U.S.C. § 1395(u)(h)(1)). Petitioner, a practice group, is a supplier.

The Act requires the Secretary of Health and Human Services (Secretary) to issue regulations that establish a process for the enrollment in Medicare of providers and suppliers, including the right to a hearing and judicial review of certain enrollment determinations, including revocation of enrollment and billing privileges. Act § 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to 42 C.F.R. § 424.505, a supplier such as Petitioner

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[2] A "supplier" furnishes items or services under Medicare and includes 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 between providers and suppliers is important because they are treated differently under the Act for some purposes.

must be enrolled in the Medicare program to accept an assignment of Medicare benefits and be reimbursed for services provided to Medicare beneficiaries.

Participation in Medicare imposes obligations upon a supplier. Suppliers must submit complete, accurate and truthful responses to all information requested in the enrollment application. 42 C.F.R. § 424.510(d)(2). Pursuant to 42 C.F.R. §§ 424.502 and 424.510(d)(3), a supplier's application to enroll in Medicare must be signed by an authorized official, i.e., one with authority to bind the provider or supplier both legally and financially. The regulation provides that the signature attests to the accuracy of information provided in the application. The signature also attests to the fact that the provider or supplier is aware of and agrees to abide by all applicable statutes, regulations, and program instructions. 42 C.F.R. § 424.510(d)(3). Suppliers must meet basic requirements depending on their type of service. 42 C.F.R. §§ 424.505, .516, .517. Suppliers may also be subject to additional screening requirements depending upon the type of service they provide. 42 C.F.R. § 424.518.

Once enrolled, the supplier receives billing privileges and is issued a billing number that is required to receive payment for services rendered to a Medicare beneficiary. 42 C.F.R. § 424.505. The supplier is subject to a five-year revalidation of enrollment cycle and CMS is authorized to perform off-cycle revalidations for a number of reasons. CMS has the right to perform on-site inspections to verify that the information CMS receives is correct. CMS contacts the supplier directly when it is time to revalidate enrollment information. A supplier must submit the applicable enrollment information, with complete and accurate information and supporting documentation, within 60 calendar days of CMS's notification. 42 C.F.R. § 424.515. There is no issue in this case that Petitioner was enrolled in Medicare as a supplier.

The Secretary has delegated authority to CMS to revoke an enrolled supplier's Medicare enrollment and billing privileges and any supplier agreement for any of the reasons listed in 42 C.F.R. § 424.535. Pursuant to 42 C.F.R. § 424.535(a)(1), CMS may revoke a supplier's enrollment and billing privileges if the supplier is determined not to be in compliance with enrollment requirements. If CMS revokes a supplier's Medicare billing privileges, the revocation becomes effective 30 days after CMS or one of its contractors mails the revocation notice to the supplier, subject to some exceptions not applicable in this case. After a supplier's Medicare enrollment and billing privileges are revoked, the supplier is barred from reenrolling in the Medicare program for one to three years. 42 C.F.R. § 424.535(c).

A supplier whose enrollment and billing privileges have been revoked may request reconsideration and review as provided by 42 C.F.R. pt. 498. 42 C.F.R. §§ 405.800-.803, 424.545(a). A supplier 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 supplier, giving the reasons for its determination and

specifying the conditions or requirements the supplier failed to meet, and the right to an ALJ hearing. 42 C.F.R. § 498.25. If the decision on reconsideration is unfavorable to the supplier, the supplier has the right to request a hearing by an ALJ and further review by the Departmental Appeals Board (the Board). Act § 1866(j)(8) (42 U.S.C. § 1395cc(j)(8)); 42 C.F.R. §§ 405.803, 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, 748-51 (6th Cir. 2004). The supplier bears the burden to demonstrate that it meets enrollment requirements with documents and records. 42 C.F.R. § 424.545(c).

B. Issues

Whether summary judgment is appropriate; and

Whether there was a basis for revocation of Petitioner's billing privileges and enrollment in Medicare.

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. Summary judgment is appropriate.

CMS has requested summary judgment. A provider or supplier denied enrollment in Medicare or whose enrollment has been revoked has a right to a hearing and judicial review pursuant to section 1866(h)(1) and (j) of the Act and 42 C.F.R. §§ 498.3(b)(1), (5), (6), (8), (15), (17), and 498.5. A hearing on the record, also known as an oral hearing, is required under the Act. Act §§ 205(b), 1866 (h)(1), (j)(8); *Crestview*, 373 F.3d at 748-51. A party may waive appearance at an oral hearing, but must do so affirmatively in writing. 42 C.F.R. § 498.66. In this case, Petitioner has not waived the right to oral hearing or otherwise consented to decision based only upon the documentary evidence or pleadings. P. Br. at 1. Accordingly, disposition on the written record alone is not permissible, unless the CMS motion for summary judgment has merit.

Summary judgment is not automatic upon request but is limited to certain specific conditions. The Secretary's regulations that establish the procedure to be followed in adjudicating Petitioner's case are at 42 C.F.R. pt. 498. 42 C.F.R. §§ 424.545(a), 498.3(b)(5), (6), (15), (17). The regulations do not establish a summary judgment procedure or recognize such a procedure. However, the Board has long accepted that summary judgment is an acceptable procedural device in cases adjudicated pursuant to 42 C.F.R. pt. 498. *See, e.g., Ill. Knights Templar Home*, DAB No. 2274, at 3-4 (2009); *Garden City Med. Clinic*, DAB No. 1763 (2001); *Everett Rehab. & Med. Ctr.*, DAB No. 1628, at 3 (1997). The Board also has recognized that the Federal Rules of Civil

Procedure (Fed. Civ. Pro.) do not apply in administrative adjudications such as this, but the Board has accepted that Fed. R. Civ. Pro. 56 and related cases provide useful guidance for determining whether summary judgment is appropriate. Furthermore, a summary judgment procedure was adopted as a matter of judicial economy within my authority to regulate the course of proceedings and made available to the parties in the litigation of this case by my Prehearing Order. The parties were given notice by the Prehearing Order that summary judgment is an available procedural device and that the law as it has developed related to Fed. R. Civ. Pro. 56 will be applied.

Summary judgment is appropriate when there is no genuine dispute as to any issue of material fact for adjudication and/or the moving party is entitled to judgment as a matter of law. In determining whether there are genuine issues of material fact for trial, the reviewer must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. The party requesting summary judgment bears the burden of showing that there are no genuine issues of material fact for trial and/or that it is entitled to judgment as a matter of law. Generally, the non-movant may not defeat an adequately supported summary judgment motion by relying upon the denials in its pleadings or briefs but must furnish evidence of a dispute concerning a material fact, i.e., a fact that would affect the outcome of the case if proven. *Mission Hosp. Reg'l Med. Ctr.*, DAB No. 2459, at 4 (2012) (and cases cited therein); *Experts Are Us, Inc.*, DAB No. 2452, at 4 (2012) (and cases cited therein); *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 3 (2010) (and cases cited therein); *see also Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986).

The standard for deciding a case on summary judgment and an ALJ's decision-making in deciding a summary judgment motion differs from that used in resolving a case after a hearing. On summary judgment, the ALJ does not make credibility determinations, weigh the evidence, or decide which inferences to draw from the evidence, as would be done when finding facts after a hearing on the record. Rather, on summary judgment, the ALJ construes the evidence in a light most favorable to the non-movant and avoids deciding which version of the facts is more likely true. *Holy Cross Vill. at Notre Dame, Inc.*, DAB No. 2291, at 5 (2009). The Board also has recognized that on summary judgment it is appropriate for the ALJ to consider whether a rational trier of fact could find that the party's evidence would be sufficient to meet that party's evidentiary burden. *Dumas Nursing & Rehab., L.P.*, DAB No. 2347, at 5 (2010). The Secretary has not provided in 42 C.F.R. pt. 498, for the allocation of the burden of persuasion or the quantum of evidence required to satisfy the burden. However, the Board has provided some persuasive analysis regarding the allocation of the burden of persuasion in cases subject to 42 C.F.R. pt. 498. *Batavia Nursing & Conv. Ctr.*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Conv. Ctr. v. Thompson*, 129 Fed. App'x 181 (6th Cir. 2005).

There is no genuine dispute as to any material fact pertinent to revocation under 42 C.F.R. § 424.535(a)(1) that requires a trial. The issues in this case raised by Petitioner

related to revocation under 42 C.F.R. § 424.535(a)(1), are issues of law. The issues in this case must be resolved against Petitioner as a matter of law. The undisputed evidence shows that there is a basis for revocation of Petitioner's Medicare enrollment and billing privileges. Accordingly, summary judgment is appropriate.

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

3. Petitioner's enrollment in Medicare and its billing privileges are revoked effective December 5, 2013.

a. Facts

The facts that are relevant to the revocation are not disputed. Any inferences are drawn in favor of Petitioner.

On September 2, 2013, which was the federal Labor Day holiday, Cahaba sent an email with an attached letter to Joseph Kimble, DC, Petitioner's President. The letter advised Dr. Kimble that Cahaba would conduct an on-site audit of two of Petitioner's practitioners on September 4, 2013, beginning at 8:30 a.m. A hard-copy of the letter was not received by Petitioner until September 6, 2013. The letter advised Petitioner that Cahaba wanted to review the records of 82 Medicare beneficiaries treated by a nurse practitioner and physician who were part of Petitioner's group. The letter did not list the 82 beneficiaries and suggested that other beneficiary records may also be reviewed. The letter stated that the auditors would tour the office; Petitioner was to provide a room for the auditors to work with access to a copy machine; and entrance and exit conferences would be conducted. The letter also specified that Petitioner would provide the auditors with staff schedules for 2012 and 2013; copies of employment contracts; daily patient appointment schedules; credentialing documents; training schedules and minutes for 2012 and 2013; and policy and procedure manuals. The September 2 letter stated that the purpose of the audit was post-payment review to determine if documentation in the beneficiaries' medical records supported the services claimed and substantiated the payment for the services. The letter stated that a medical record request would be provided during the entrance conference. The letter cited 42 C.F.R. § 424.5, which establishes the basic conditions for payment of Medicare claims. RFH at 1-2; CMS Ex. 1 at 4-12 (Petitioner's reconsideration request), 13-14 (Sep. 2, 2013 Announced On-site Letter), 18-19 (President Kimble's affidavit).

Petitioner's attorney sent Cahaba a letter dated September 3, 2013, advising Cahaba that a one-day notice was unrealistic and unfair and that Petitioner could not comply with the Cahaba requests by the deadline. RFH at 3; CMS Ex. 1 at 15.

Cahaba auditors arrived at Petitioner's office on September 4, 2013, at about 11:30 a.m. Patient care was on-going and Petitioner asked the Cahaba auditors not to disrupt patient care. Dr. Kimble advised the Cahaba auditors that they could not conduct the audit at that time. RFH at 3; P. Br. at 2.

President Kimble states in his affidavit dated January 2, 2014, that because Cahaba gave Petitioner such short notice of the audit: Petitioner did not have time to reschedule its patients for September 4, 2013; Petitioner's staff did not have time to meet Cahaba's requests and no space was available for the auditors due to scheduled patient visits; he could not attend either the entrance or exit conference due to scheduled patients; and it was not possible with only one-day notice to collect the requested documents and make necessary redactions. CMS Ex. 1 at 18-19.

Nadine Hukarevic, Medicare Investigator for Cahaba, states in her declaration that Cahaba operates under contract with CMS as a ZPIC. This fact is not disputed by Petitioner. Ms. Hukarevic states that she and two additional auditors, Jessica Drobick and Kathleen Heuertz, attempted to conduct an on-site audit of Petitioner on September 4, 2013. She states that when they arrived at Petitioner, Joseph Kimble, DC, the owner of Petitioner, refused to let them do the audit and he told the auditors to leave or he would call the police. She states that Dr. Kimble did not say the audit could not be done due to lack of space, he did not request time to assemble documents, and he did not ask to reschedule. CMS Ex. 4. Petitioner has not disputed the facts asserted by Ms. Hukarevic regarding the actions of Dr. Kimball.

Cahaba notified Petitioner on October 1, 2013, that Petitioner's Medicare payments were suspended citing reliable information of an overpayment and Petitioner's refusal to provide medical records. On November 4, 2013, the MAC notified Petitioner that its Medicare enrollment and billing privileges were revoked and that Petitioner was subject to a three-year re-enrollment ban. RFH at 3-4; P. Br. at 2.

Cahaba recommended to CMS on October 10, 2013, that CMS revoke Petitioner's enrollment in Medicare because Petitioner denied Cahaba auditors access to records and review the facility on September 4, 2013. According to the Cahaba recommendation, when auditors arrived at Petitioner's office on September 4, 2013, they properly identified themselves and their purpose, but Dr. Kimble informed the Cahaba auditors that they were not allowed on site; no information would be given to them; and if they stayed police would be summoned. CMS Ex. 1 at 37-39.

I advised the parties in the Prehearing Order that in considering a motion for summary judgment a fact alleged and not specifically denied may be accepted as true. Prehearing Order ¶ II.G. Dr. Kimble does not mention in his affidavit that he denied access to Petitioner's facility or that he threatened to call police. Petitioner does not deny in its RFH or pleadings that on September 4, 2013, Dr. Kimble told Cahaba auditors that they

had to leave Petitioner's facility and that he would call police if they did not leave. Therefore, I accept as true the alleged facts that on September 4, 2013, Dr. Kimble told Cahaba auditors that they had to leave Petitioner's facility and, if they did not, he would call the police.

In its enrollment application dated June 16, 2010, Petitioner identified itself as physical and/or occupational therapy group in private practice in Rockford, Illinois. Joseph L. Kimble is listed as an owner, managing employee, and an officer or director. The enrollment application included the standard certification statement, including the applicant's agreement to abide by the Medicare laws, regulations, and program instructions applicable and the statement that the applicant understood that payment of claims by Medicare is conditioned upon the claim being compliant with the law, regulations, and program instructions and the applicant's compliance with the applicable conditions for participation in Medicare. CMS Ex. 2.

CMS offered as CMS Ex. 3, Electronic Data Interchange (EDI) enrollment forms signed by Peter Park, MD and Antonio R. Baluga, MD, on September 25, 2003. The forms list MedChoice Medical Center, Ltd. as the physicians' practice group. The forms indicate that the listed "provider" agrees to listed conditions for submitting Medicare claims electronically to CMS or its contractor. Included as conditions are requirements to maintain source documents that can be readily associated with electronic claims that reflect the beneficiary name and insurance number, dates of service, diagnosis or nature of illness, and procedure or services performed; and to maintain original source documents and medical records pertaining to Medicare claims for no fewer than six years and three months after the claim is paid. Also included is the statement that the Secretary, his or her designee, or a contractor has the right to audit and confirm information submitted and has the right to access all original source documents and medical records related to Medicare claims. The EDI forms state that federal law governs their interpretation and for any appeal of a decision made by CMS under the document. The EDI forms do not cite the applicable provisions of the Act, regulations, or program instructions. CMS Ex. 3.

b. Analysis

Cahaba recommended to CMS that Petitioner's Medicare enrollment and billing privileges be revoked pursuant to 42 C.F.R. § 424.535(a)(1) because Petitioner denied access to its facility and medical records related to Medicare claims. CMS Ex. 1 at 37-39. The MAC notified Petitioner on November 4, 2013, that its Medicare billing privileges and enrollment were revoked effective December 5, 2013, pursuant to 42 C.F.R. § 424.545(a)(1) for noncompliance with enrollment requirements, specifically by denying Cahaba auditors access to medical records on September 4, 2013. CMS Ex. 1 at 35-36. On April 24, 2014, the reconsideration hearing officer upheld revocation of Petitioner's enrollment and billing privileges pursuant to 42 C.F.R. § 424.545(a)(1) on

grounds that Petitioner denied Cahaba auditors access to medical documentation when they attempted an on-site visit of Petitioner on September 4, 2014. CMS Ex. 1 at 1-3. Thus, CMS and its contractors have been consistent in their position that Petitioner's enrollment in Medicare and billing privileges should be revoked based on Petitioner's refusal to permit Cahaba auditors access to medical records on September 4, 2013.

CMS has clearly reserved the right for it or its contractors to conduct on-site inspections of any entity enrolled in Medicare as a provider of services or a supplier. The regulations provide that the purposes for such inspections are to verify enrollment information and to determine compliance with Medicare enrollment requirements. 42 C.F.R. §§ 424.510(d)(8), 424.515(c), 424.517. Petitioner erroneously attempts to distinguish between on-site inspections for prepayment or post-payment audits and on-site inspections to determine compliance with Medicare enrollment requirements. P. Br. at 9. Petitioner correctly notes that the Medicare Program Integrity Manual CMS Pub. 100-08 (MPIM) establishes policy related to prepayment and post-payment reviews and inspections in two different chapters, chapters 3 and 15. MPIM § 15.20 (eff. Jun. 9, 2012) and sets forth CMS policy regarding on-site inspections and site verifications. Section 15.20.1A2, specifies that a contractor will conduct a site verification in a manner which limits the disruption for the provider or supplier. Section 15.20.1B specifies that verifications are to be done Monday through Friday, except holidays, during posted business hours or between 9 a.m. and 5 p.m. if no hours are posted. My reading of MPIM chap. 15 convinces me that the CMS policies stated apply to all site visits by CMS or its contractors, whatever the specific reason for the visit. MPIM § 3.2 (eff. Jun. 28, 2011) establishes procedures for prepayment and post-payment reviews or audits. MPIM § 3.2.3 establishes the procedures for requesting additional documentation during prepayment review and post-payment review. The provisions of MPIM chap. 3 primarily involve the collection of records and auditing and do not appear to supersede the policy in MIPM chap. 15. Therefore, contrary to Petitioner's argument, I conclude that both MPIM §§ 3.2 and 15.20 apply in this case. There was a request for documents that was to be delivered during the entrance briefing. There was also a site visit which clearly had the purpose to collect and audit documents and determine whether or not Petitioner was compliant with Medicare enrollment requirements related to the claims that were the subject of the post-payment review.

Petitioner agreed to comply with the law, regulations, and policies related to Medicare when it enrolled in the Medicare program, including submitting to inspections and audits by CMS or its contractors. Petitioner has not disputed that its most recent enrollment or re-enrollment application was dated June 16, 2010 and signed by Joseph L. Kimble. Petitioner has not disputed that by filing the application dated June 16, 2010, it agreed to abide by the Medicare laws, regulations, and program instructions applicable to Petitioner. Petitioner has not disputed that by filing the application dated June 16, 2010, Petitioner acknowledged that it understood that payment of claims by Medicare is conditioned upon the claim being compliant with the law, regulations, and program

instructions and the Petitioner's compliance with the applicable conditions for participation in Medicare. CMS Ex. 2.

Petitioner has not disputed that Petitioner and its practitioners are obligated to maintain records, including medical records and other documentation, related to claims for payment submitted to Medicare. The obligation to maintain records is found in both the regulations and CMS policy.[3] The regulations specifically provide that failure to permit CMS access to documentation required to be maintained by 42 C.F.R. § 424.516(f) is a basis for revocation. 42 C.F.R. § 424.535(a)(10). Pursuant to 42 C.F.R. § 424.516(f)(1) providers or suppliers that furnish covered items of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), clinical laboratory services, imaging services, or home health services are required to maintain documents for seven years from the date of service and to give CMS or a Medicare contractor access to that documentation upon request. The evidence before me does not show that Petitioner furnished any items or services of the type specified by 42 C.F.R. § 424.516(f)(1). However, pursuant to 42 C.F.R. § 424.516(f)(2), a physician who orders and/or certifies home health services or a physician or other eligible provider who orders DMEPOS, clinical laboratory, or imaging services is required to maintain documentation for seven years from the date of service and, upon request, give CMS or a Medicare contractor access to that documentation. The documentation that must be maintained includes written and electronic documents relating to written orders, certifications, or requests for payments for items of DMEPOS, clinical laboratory services, imaging, and home health services. 42 C.F.R. § 424.516(f)(2)(ii). Petitioner does not deny that its physicians and other practitioners are subject to the requirement of 42 C.F.R. § 424.516(f)(2).

Petitioner does not deny that it uses the Medicare EDI system for submission of electronic claims or that its practitioners executed EDI enrollment forms that require that they agree to maintain records and to give CMS or its contractors access to those records on request. Medicare EDI policies are found in the Medicare Claims Processing Manual, CMS Pub. 100-04 (MCPM), chap. 24. MCPM chap. 24, § 30.2 (eff. Sep. 17, 2013) addresses new enrollments and maintenance of existing enrollments in EDI. MCPM chap. 24, § 30.2.A provides that when a provider or supplier submits Medicare claims electronically the provider or supplier agrees to 15 conditions. Included among the conditions that must be agreed to:

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[3] The obligation for physicians and other licensed practitioners to maintain medical records reflecting their care and treatment for their patients may be found in state law and other sources. The parties have not addressed state law or other sources and I consider only the Secretary's regulations and CMS policy statements.

- The Secretary, his or her designee, or a contractor designated by CMS has the right to audit and confirm information submitted by the provider or supplier and have access to all original source documents and medical records related to provider or supplier claims; and

- Retention of all original source documents and medical records pertaining to any Medicare claim for 6 years and three months after the claim is paid.

MCPM chap. 24, § 30.2A. Medicare Learning Network (MLN) Matters, No. SE1022 discusses medical record retention and media formats for medical records. Petitioner does not dispute that it was required to maintain original source documents and medical records related to Medicare claims. Petitioner does not deny that it had custody and/or control of such records, whether or not at the facility visited by the Cahaba auditors. Petitioner does not dispute that to have access to original source documents, Cahaba auditors had to have access to Petitioner's facility.

Petitioner does not deny before me that Cahaba is a Medicare contractor within the meaning of section 1893 of the Act and authorized to access records on behalf of CMS.

I find as undisputed fact and conclude as a matter of law, that Petitioner was obligated to maintain medical records and other documents related to claims for payment filed with Medicare by Petitioner and its practitioners. I further find and conclude that CMS or its contractors, the MAC and Cahaba, have the right to access original medical records and other original source documents related to claims for payment filed with Medicare by Petitioner and its practitioners. Petitioner was on notice based on 42 C.F.R. § 424.535, the CMS policies discussed above, its Medicare enrollment application, and the EDI enrollment forms of its obligations to maintain original source records and to give CMS or its contractors access to those records. Petitioner was also on notice that failure to give access is a basis for revocation of its Medicare enrollment and billing privileges under 42 C.F.R. § 424.535(a).

The undisputed facts are that on September 4, 2013, Dr. Kimble, an owner and officer of Petitioner, refused to permit Cahaba auditors access to medical and other records of two practitioners' related to Medicare claims they filed or that were filed on their behalf. Dr. Kimble threatened to call law enforcement to forcibly remove the Cahaba auditors, if necessary. I conclude that denying the Cahaba auditors access to original medical records on September 4, 2014, is a basis for revocation of Petitioner's enrollment in Medicare and its billing privileges.

CMS or its contractor is required to give notice of an initial determination to revoke enrollment and billing privileges. The pertinent regulation provides:

> (b) Revocation of Medicare billing privileges—(1) Notice of revocation. If CMS or a CMS contractor revokes a provider's or supplier's Medicare billing privileges, CMS or a CMS contractor notifies the supplier by certified mail. The notice must include the following:
>
> > (i) The reason for the revocation in sufficient detail for the provider or supplier to understand the nature of its deficiencies.
> > (ii) The right to appeal in accordance with part 498 of this chapter [42 C.F.R. pt. 498].
> > (iii) The address to which the written appeal must be mailed.

42 C.F.R. § 405.800(b). The notice of revocation was sufficient in this case. Pursuant to 42 C.F.R. § 424.535(g), the effective date of revocation is 30 days after the date CMS or its contractor mails the notice of revocation. 42 C.F.R. § 424.535(g). In this case, the MAC notice of the initial determination to revoke was dated November 4, 2013. December 4, 2013 is the thirtieth day after the date of the notice of initial determination. However, the notice of initial determination specified that the effective date of the revocation was December 5, 2013, not December 4, 2013. The MAC notice did not explain how the December 5, 2013 effective date was determined, but I do not disturb that determination.

Petitioner requested review of the reconsidered determination upholding the revocation. RFH at 4. Petitioner argues that it never refused to comply with the Cahaba request for records but merely informed Cahaba that it was unable to comply in the short-time permitted. RFH at 1, 4, 6-7; P. Br. at 1-2. Petitioner argued in its reconsideration request that it never refused requested material or denied Cahaba personnel access to Petitioner's premises. CMS Ex. 1 at 7-8. Petitioner's arguments are inconsistent with the undisputed facts. Petitioner has not specifically disputed the allegations of CMS that when Cahaba auditors arrived at Petitioner's facility on September 4, 2013, Dr. Kimble not only declined to provide access to any records at that time, he also forced the Cahaba auditors to leave Petitioner's facility, threatening to call law enforcement if necessary.

Petitioner cites MPIM § 8.4.6.1.1 as stating "where written notice is given of an impending audit, thirty (30) days' notice should be given to the provider to comply." RFH at 6 (footnote omitted); P. Br at 8-9. The section cited states:

> When advance notification is given, providers and suppliers have 30 calendar days to submit (for PSC or ZPIC BI unit or contractor MR unit site reviews) or make available (for provider/supplier site reviews) the requested documentation.

MPIM § 8.4.6.1.1. The section requires the Medicare contractor to advise the provider or supplier that claims for which documentation is not provided in 30 calendar days will be denied. The section also gives the contractor discretion to extend the time limit. The contractor is also given discretion to request documentation upon arrival at the provider's or supplier's site and to give no notification prior to arrival at the site. MPIM § 8.4.6.1. MPIM § 3.2.3.2(A) and (B), which are also cited by Petitioner (RFH at 6), also establish 30 to 45 day calendar periods for a provider or supplier to submit documents in response to prepayment and post-payment reviews. Petitioner's reliance upon the cited provisions of the MPIM as a defense to denying Cahaba auditors access is misplaced. The sections of the MPIM cited do not require that a contractor give Petitioner notice 30 days prior to a site visit, whether or not there is written notice. The MPIM sections simply provide that the contractor will give Petitioner 30 calendar days to produce records whether requested in advance of the site visit or during the site visit. In this case, Cahaba did not provide the list of records sought in advance and informed Petitioner that the list would be provided during the entrance conference (CMS Ex. 1 at 13, 27), which was within the discretion of Cahaba under the MPIM. However, Petitioner denied Cahaba access to its site so that the entrance conference was not conducted and the list of records sought was not delivered. Petitioner cannot excuse its denial of access to Cahaba based on the cited provisions of the MPIM.

Petitioner argues that CMS had no basis for the suspension of payments to Petitioner. RFH at 5-8. The suspension of Medicare payments is not an initial determination that is subject to appeal or my review. 42 C.F.R. § 405.375(c).

Petitioner argues in its request for hearing that it timely submitted a CAP and CMS erred by not giving time to respond or correct the alleged violation. Petitioner argues that "[t]he statutory scheme governing Medicare suspension and revocation – and basic principles of due process – entitles a provider to both notice of the specific findings made against it and an opportunity to respond to and correct those findings." Petitioner asserts that the cursory denial of its CAP failed to permit Petitioner a reasonable opportunity to comply with the Cahaba request for access to records. RFH at 8-9. Petitioner argues in its brief that CMS did not give Petitioner an opportunity to correct the alleged violation as required by 42 C.F.R. § 423.535(a)(1). P. Br. at 6-8. I note that Petitioner was notified of its right to submit a CAP (CMS Ex.1 at 35); Petitioner did submit a CAP (CMS Ex. 1 at 39-41); and the CAP was denied (CMS Ex. 1 at 2). Denial of a CAP and refusal to reinstate billing privileges is not an initial determination subject to review by an ALJ under 42 C.F.R. pt. 498.

Petitioner argues that summary judgment should not be granted in this case because its provider agreement (P. Ex. 1) entitles it to notice and opportunity for a hearing before termination. P. Br. at 2. Petitioner was given notice of both the initial determination and the reconsidered determination. Petitioner has not argued that the notices did not satisfy

the statutory or regulatory requirements applicable to those notices. There is no question that because the reconsidered determination was unfavorable to Petitioner, Petitioner has the right to request a hearing by an ALJ and further review by the Board. Act § 1866(j)(8) (42 U.S.C. § 1395cc(j)(8)); 42 C.F.R. §§ 405.803, 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,* 373 F.3d at 748-51. Summary judgment is a procedural process that deprives Petitioner of an oral hearing. Petitioner filed no objection to the Prehearing Order or its provisions making summary judgment available to the parties. Summary judgment is appropriate and no oral hearing is necessary when there is no genuine dispute as to the material facts and the case must be resolved by application of the law to the undisputed facts. The material facts are not disputed in this case and the only issues that require resolution are issues of law and the application of the law to the undisputed facts. Neither Petitioner's provider agreement nor the law prevents disposition of this case by summary judgment. I conclude that Petitioner received the notice and opportunity for a hearing required by its provider agreement (P. Ex. 1); the Act; and the regulations.

4. Petitioner is subject to a two-year bar to re-enrollment pursuant to CMS policy and CMS has articulated no reason to depart from its policy.

Petitioner argues that pursuant to 42 C.F.R. § 424.535(c), the re-enrollment bar does not apply to a revocation under 42 C.F.R. § 424.535(a)(1) when the revocation is based on a provider's or supplier's failure to timely respond to a revalidation request or other request for information. RFH at 9; P. Br. at 10. The regulation provides:

> (c) *Reapplying after revocation.* After a provider, supplier, delegated official, or authorizing official has had their billing privileges revoked, they are 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. **The re-enrollment bar does not apply in the event a revocation of Medicare billing privileges is imposed under paragraph (a)(1) of this section based upon a provider or supplier's failure to respond timely to a revalidation request or other request for information.**

42 C.F.R. § 424.535(c) (emphasis added). In this case, Petitioner enrollment and billing privileges are revoked pursuant to 42 C.F.R. § 424.535(a)(1), but not because Petitioner failed to respond timely to a revalidation request or request for information. In this case, the revocation is based upon Petitioner's denial of access to its records and facility on

September 4, 2013. Accordingly, Petitioner legal argument fails and Petitioner is subject to a one to three year bar to re-enrollment.

Section 1866 of the Act, and the Secretary's regulations at 42 C.F.R. §§ 405.803, 424.545, 498.3(b)(17), and 498.5, establish the right to appeal the denial of a Medicare enrollment application or the revocation of a current Medicare enrollment and billing privileges. The regulations do not mention a right to review of the reasonableness of the period of the bar to re-enrollment. The Board previously questioned the right to review as to the reasonableness of the duration of bar in *John Hartman, D.O.*, DAB No. 2564 at 5 (2014). The Board chose not to resolve the issue in *Hartman*, commenting that it would find the bar in that case reasonable if it did consider the issue reviewable.

I conclude that I have no authority to review the reasonableness of the period of the bar in the absence of an express delegation of authority in the regulations. Accordingly, I do not consider the reasonableness of imposing the maximum authorized bar of three years in this case.[4]

Nevertheless, CMS policy set forth in MPIM § 15.20.1E provides that for revocations based on regulatory noncompliance, the contractor will cite 42 C.F.R. § 424.535(a)(1) and establish a two-year enrollment bar. I am not bound to follow CMS policy as if it were the law, however I will give CMS policy effect to the extent consistent with the law. The MAC deviated from CMS policy by imposing a three-year ban in this case, which involves noncompliance with regulatory and policy provisions rather than noncompliance with the Act. CMS has offered no explanation for why it deviated from its policy in this case. Accordingly, I give the CMS policy effect and conclude that Petitioner is only subject to a two-year re-enrollment bar under that policy.[5]

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[4] If I concluded that I have authority to review the reasonableness of the duration of the bar, I would conclude that the maximum bar of three years is appropriate in this case. Petitioner's conduct in this case was egregious. The maximum bar of three years is reasonable to impress upon Petitioner the importance of its obligations under the Medicare program and the need for Petitioner to work cooperatively with CMS and its contractors to minimize program losses, whether through fraud, neglect, or innocent error.

[5] If CMS wishes to further litigate regarding its policy, it may do so by filing a proper motion reopening and revision. 42 C.F.R. §§ 498.100-.103.

III. Conclusion

For the foregoing reasons, Petitioner's Medicare enrollment and billing privileges are revoked pursuant to 42 C.F.R. § 424.535(a)(1), effective December 5, 2013. Pursuant to CMS policy and 42 C.F.R. § 424.535(c), Petitioner is subject to a two-year bar to re-enrolling in Medicare that expires December 4, 2015.

/s/
Keith W. Sickendick
Administrative Law Judge