Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

CJN Enterprises, Inc.,
(NPI: 1598933681; PTAN: 67-3126),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-409

Decision No. CR3659

Date: February 20, 2015

DECISION

Petitioner, CJN Enterprises, Inc.,[1] a home health agency, appeals a reconsideration decision, dated October 17, 2013, upholding the revocation of Petitioner's Medicare enrollment and billing privileges. The undisputed evidence establishes that Petitioner was not in compliance with Medicare program requirements for home health care certification. Consequently, I find the Centers for Medicare & Medicaid Services (CMS) had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges and impose a three-year re-enrollment bar.

Background

Petitioner is a home health agency located in Houston, Texas. CMS Exhibit (Ex.) 1. By letter dated June 24, 2013, Palmetto GBA (Palmetto) notified Petitioner that it was revoking Petitioner's provider transaction access number (PTAN) and terminating Petitioner's provider agreement. CMS Ex. 3. Palmetto stated it was taking this action under 42 C.F.R. § 424.535(a)(1), which provides CMS with the authority to revoke billing privileges and any corresponding provider or supplier agreement for noncompliance with enrollment requirements. Palmetto noted that the form CMS 855A

[1] Petitioner conducted its business as "CJ Home Health Services." CMS Ex. 2, at 1.

enrollment application (CMS 855A) for home health agencies contains a certification statement requiring the appropriate agency official to certify:

> I agree to abide by the Medicare laws, regulations and program . . . instructions that apply to this provider. The Medicare laws, regulations, and program instructions are available through the Medicare contractor. I understand that payment of a claim . . . by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions . . . and on the provider's compliance with all applicable conditions of participation in Medicare.

CMS Ex. 3, at 1. Palmetto determined that Petitioner failed to abide by Medicare laws, regulations, and program instructions when it:

> . . . failed to obtain a valid order from a physician when it submitted claims using [Dr. B.I.'s[2]] NPI [national provider identifier] for Medicare patients from November 1, 2009 through October 21, 2012. [Dr. B.I.] signed an attestation indicating that she has neither provided any Part B services to or referred these beneficiaries for home health services provided by CJN Enterprises Inc. In addition, a review of the eight sets of records delivered by CJN showed some of the records just listed [Dr. B.I.] as the patient's physician and included what was purported to be her signature. Some of the records included [Dr. B.I.] with [Dr. P.O.], while another set included her with [Dr. T.S.]. However one set of the records showed [Dr. B.I.] along with [Dr. J.P.], [Dr. J.G.], [Dr. S.Z.], and [Dr. T.L.]. While another set of records only showed [Dr. T.L.], with no mention at all of [Dr. B.I.].

CMS Ex. 3, at 1. Palmetto gave Petitioner the opportunity both to file a corrective action plan (CAP) and to request reconsideration. CMS Ex. 3, at 1-2. Petitioner requested reconsideration on August 20, 2013.[3] CMS Ex. 2. In its reconsideration request, Petitioner asserted that Palmetto's Notice was vague and did not reference the beneficiaries by name. However, Petitioner "assume[d]" they were the beneficiary claims Petitioner had previously provided to HI, the CMS entity which apparently requested the information. Petitioner noted that it had not been provided a copy of Dr. B.I.'s statement. Petitioner stated that Dr. B.I. did refer and provide services to three of the beneficiaries in question. Petitioner also noted that according to Petitioner's

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[2] I refer to some individuals by their initials.

[3] The reconsideration decision in this case explains that Petitioner submitted a CAP to Palmetto on July 18, 2013 and provides reasons for rejecting it. I do not have authority to review those reasons.

owner, Obinna Ujari (whose affidavit Petitioner attached), Dr. B.I. provided services to over 80 patients she had referred to Petitioner since 2008. CMS Ex. 2, at 1-3.

On October 17, 2013, CMS's Center for Program Integrity (CPI) issued a decision in response to Petitioner's reconsideration request. CPI stated that it had reviewed the evidence and determined that Petitioner did not abide by Medicare law, regulations, and program instructions in submitting claims for Medicare beneficiaries without a valid certification or plan of care. Specifically, Petitioner failed to obtain a valid order from a physician when submitting claims using Dr. B.I.'s NPI for Medicare beneficiaries. CMS Ex. 1, at 2-3.

Petitioner filed a timely request for an administrative law judge hearing. The case was assigned to me for hearing and decision. I ordered the parties to file pre-hearing exchanges including all of their arguments and evidence. CMS filed a motion for summary judgment (CMS Br.), accompanied by 19 exhibits.[4] Petitioner did not file a responsive brief or any exhibits by the deadline I ordered. I ordered Petitioner to show good cause for its omission, and then I granted its request for an extension. Petitioner eventually filed 11 exhibits, P. Exs. 1-11, including the affidavit of Petitioner's owner, Obinna Ujari (P. Ex. 1), and the affidavit of Helen Ujari, R.N., a quality assurance nurse for Petitioner responsible for auditing Petitioner's clinical records. (P. Ex. 11).

My pre-hearing order advised the parties that they must submit written direct testimony for each proposed witness and that an in-person hearing is only necessary when the opposing party affirmatively requests an opportunity to cross-examine a witness. Pre-Hearing and Acknowledgment Order (Order) ¶¶ 8, 9; *see Vandalia Park,* DAB No. 1940 (2004); *Pacific Regency Arvin,* DAB No. 1823, at 8 (2002) (holding that the use of written direct testimony for witnesses is permissible so long as the opposing party has the opportunity to cross-examine those witnesses). Considering neither party requested the opportunity to cross-examine any witnesses, I find that an in-person hearing in this case is unnecessary and issue this decision on the full merits of the written record. Order ¶¶ 10, 11.

Issue

Whether CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges.

[4] CMS Ex. 9 consists of CMS Ex. 9 and 9.1; CMS Ex. 13 consists of CMS Ex. 13 and 13.1; and CMS Ex. 16 consists of CMS Ex. 16, 16.1, and 16-2.

Findings of Fact and Conclusions of Law

1. CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges because Petitioner filed Medicare reimbursement claims containing improper physician certifications for at least four beneficiaries.

CMS's authority to revoke a provider or supplier's enrollment and billing privileges is codified at 42 C.F.R. § 424.535. The pertinent subsection of the regulation states:

> (a) *Reasons for revocation.* CMS may revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement or supplier agreement for the following reasons:
>
> > (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 . . . .

The Medicare statute defines "home health services" as "items and services furnished to an individual, who is under the care of a physician . . . under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician . . ." 42 U.S.C. § 1395x(m). Home health services are covered by Medicare only if "a physician . . . certifies . . . that . . . home health services . . . are or were required because the individual is or was confined to his home . . . and needs or needed skilled nursing care . . . ." 42 U.S.C. § 1395f(a)(2)(C); 42 U.S.C. § 1395n(a)(2)(A). Thus, a home health agency may receive Medicare payment for home health services for individuals only after the home health agency has obtained a valid certification from a physician that the individual is homebound and requires home health services. Home health services must be furnished while the individual is under the care of a physician, and a physician must establish and periodically review a plan of care for furnishing the services. 42 C.F.R. § 424.22(a)(1)(iii), (iv). Also, the certifying physician is required to know the Medicare beneficiary's medical status, and therefore there must be a face-to-face encounter with the individual. 42 C.F.R. § 424.22(a); Medicare Benefit Policy Manual; CMS Pub. 100-102, Ch. 7 (Home Health Services), § 30.5.1.1. The face-to face encounter must be "related to the primary reason the patient requires home health services . . . ." 42 C.F.R. § 424.22(a)(1)(v).

To enroll in Medicare, a home health agency must complete an enrollment application, the CMS 855A. The CMS 855A requires a home health agency to have its authorized official sign a statement acknowledging that its signature binds the provider to the laws, regulations and program instructions of the Medicare program and to acknowledge that

the petitioner will not knowingly submit false claims or submit claims with deliberate ignorance or reckless disregard for their truth or falsity. *See* CMS Ex. 16, at 32-35 (CMS 855A signed by Petitioner's authorized official in 2005).

CMS argues that Petitioner submitted Medicare claims lacking the requisite valid physician certification from a physician involved in the care, treatment, or monitoring of the beneficiaries, and doing so constituted noncompliance. CMS Br. at 1-2. CMS submitted evidence to that effect (CMS Exs. 4-16, 18, 19; *see* CMS Br. at 7-11).

Petitioner's owner, Obinna Ujari, testified that of the eight beneficiaries CMS cited, and for whom Petitioner claimed payment, Dr. B.I. actually treated only four of them. P. Ex. 1. Petitioner's nurse auditor, Helen Ujari, testified that four of the beneficiaries "were seen by a different doctor." P. Ex. 11. Combined, I find their testimony establishes that, for at least four Medicare beneficiaries for whom Petitioner claimed payment, Dr. B.I. was not the treating physician or involved in their care or monitoring and thus Dr. B.I. could not be the certifying physician. It is unnecessary for me to find that Petitioner improperly claimed payment for other beneficiaries to uphold the revocation.

2. Petitioner may not avoid revocation by assigning blame to a third party biller for its improper certifications to CMS's contractor.

Obinna Ujari and Helen Ujari both testified that Dr. B.I. was not the treating physician for at least four beneficiaries (Obinna Ujari testifying that Dr. B.I. only treated four of the beneficiaries and Helen Ujari testifying that four beneficiaries for whom Petitioner claimed payment were actually seen by a physician other than Dr. B.I., identifying those beneficiaries as B.W., C.H., H.N. and J.L.). P. Exs. 1, 11; CMS Ex. 6 (Home Health Certification and Treatment Plan for C.H.); CMS Ex. 7 (Home Health Certification and Treatment Plan for H.N.); CMS Ex. 8 (Home Health Certification and Treatment Plan for B.W.); CMS Ex. 15 (Home Health Certification and Treatment Plan for J.L.). The only evidence Petitioner presents suggesting why it claimed that Dr. B.I. was the certifying physician for beneficiaries she did not treat is that:

> The independent biller hired by [Petitioner] billed under the wrong [NPI] . . . The independent biller made errors in the billing by confusing some of the other doctor's patients with [Dr. B.I.].

P. Ex. 11, at 1 (Helen Ujari's affidavit). However, it is home health agencies' responsibility to "take the necessary steps to ensure that they are billing appropriately for

services furnished to Medicare beneficiaries." *See* 73 Fed. Reg. 36,448, 36,455 (June 27, 2008).[5] The Departmental Appeals Board concluded:

> Medicare suppliers and providers certify that they are responsible for the accuracy of their claims for reimbursement, and the regulation contains no exception for improper claims prepared and submitted by billing agents, which is consistent with the preamble stating that providers and suppliers are responsible for claims submitted on their behalf . . . . Petitioner's position, if adopted, would effectively shield a supplier from any consequences for the submission of an unlimited number of improper claims on his behalf, so long as he could point to an agreement with a billing agent, who is not a party to the supplier's Medicare agreement, to submit the claims. Petitioner's efforts to assign blame for the improper billing to his billing agent . . . do not relieve him of his responsibility for the improper claims or bar CMS from revoking his billing privileges.

Louis J. Gaefke, D.P.M., DAB No. 2554, at 6 (2013).

The CMS 855A enrollment application signed on behalf of Petitioner placed Petitioner on notice that submitting claims with reckless disregard for their truth or falsity could lead to revocation of its enrollment and billing privileges. Simply relying on a billing agent without checking that the claims filed are correct could clearly lead to the submission of incorrect and invalid claims. Petitioner's failure to assure that the claims it submitted were correct persuades me that Petitioner submitted claims with reckless disregard for the truth or falsity of the physician certification in at least four cases.[6]

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[5] At least three instances of filing a claim for services that could not have been furnished to a specific individual on the date of service may constitute a "pattern of improper billing," which could have constituted a separate basis for revocation. 42 C.F.R. § 424.535(a)(8); 73 Fed. Reg. 36,448, 36,455 (June 27, 2008).

[6] In a separate and independent decision issued on the same date as this decision, I upheld CMS's revocation of another home health agency also finding its owner, Obinna Ujari, filed improper claims based on Dr. B.I.'s physician certifications which undisputedly never occurred. *See Oakwest Healthcare Services, Inc.*, DAB CR3658 (2015).

Accordingly, I find that Petitioner's evidence showing that it submitted invalid claims due to invalid physician certifications for four Medicare beneficiaries, whether or not due to its billing agent's error, supports CMS's revocation of its enrollment and billing privileges.

/s/
Joseph Grow
Administrative Law Judge