Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

TEHC, LLC
(NPI: 1487651915),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-1469

Decision No. CR4371

Date: October 29, 2015

DECISION

The Centers for Medicare & Medicaid Services (CMS) revoked the Medicare billing privileges of TEHC, LLC (Petitioner) because Petitioner failed to comply with Medicare enrollment requirements when it sought reimbursement for providing home health care services allegedly without a physician's order for such services. Petitioner requested a hearing to dispute the revocation. Because Petitioner reasonably relied on orders that it received from a physician's office to provide home health services, and filed claims with Medicare for reimbursement for such services based on those orders, Petitioner did not violate any enrollment requirements subjecting Petitioner to revocation. Therefore, I reverse CMS's determination to revoke Petitioner's billing privileges.

I. Background

In 2003, Petitioner filed an application (Form CMS-855A) for enrollment in the Medicare program as a home health agency (HHA). *See* CMS Exhibit (Ex.) 3. As part of that application, Petitioner's president, Mark Nord, signed a Certification Statement agreeing to the following "Additional Requirements for Medicare Enrollment":

> I agree to abide by the Medicare laws, regulations and program instructions that apply to [HHAs]. 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 (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the supplier's compliance with all applicable conditions of participation in Medicare.

CMS Ex. 3 at 7. CMS enrolled Petitioner as a Medicare provider.

In a December 10, 2014 initial determination, a CMS administrative contractor revoked Petitioner's Medicare billing privileges based on the following:

> **42 CFR 424.535(a)(1) Non-Compliance**
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> With its authorized official's signature on the Medicare enrollment 855A application, TEHC, LLC agreed to abide by Medicare laws, rules, and program instructions. TEHC failed to abide by these Medicare laws, rules, and program instruction when it submitted home health care services without a valid order from a physician.
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> TEHC, LLC provided CMS with medical records of five beneficiaries who received HHA services that were ordered using Dr. Alfred Salas' [National Provider Identification] NPI. Dr. Salas reviewed the medical records of all five beneficiaries and attested that the signatures on the referrals and plans of care were not his. Additionally, Dr. Salas was not a treating physician for any of the five beneficiaries whose medical records he reviewed.

Petitioner (P.) Ex. 1 at 1. The initial determination notified Petitioner that it could submit a corrective action plan and/or a request for reconsideration. P. Ex. 1 at 1-2.

Petitioner filed a corrective action plan on January 5, 2015, which CMS rejected on January 28, 2015. P. Exs. 2, 3.

On February 1, 2015, Petitioner asked CMS to reconsider its determination to revoke Petitioner's Medicare billing privileges. Specifically, Petitioner asserted that it "has been in compliance with the requirements for obtaining written and signed physician orders

and plans of care." P. Ex. 4 at 4. Petitioner further stated that in 2014 Petitioner received nine patient referrals from Dr. Salas, eight of whom Petitioner accepted for care. P. Ex. 4 at 5. At the time Petitioner received those referrals, Petitioner had previously received referrals from other physicians at a practice called Mobile Doctors, the same practice with which Dr. Salas was affiliated. P. Ex. 4 at 5. Petitioner followed its internal procedures to screen Dr. Salas before accepting him patients. As stated in the reconsideration request:

> Therefore, [Petitioner] has policies and procedures requiring: (1) verification of a physician's current licensure status, (2) verification of a current enrollment with Medicare, and (3) absence of an [Office of the Inspector General] OIG exclusion. Enclosed are copies of [Petitioner's] physician license and Medicare enrollment verification policies and evidence that Dr. Salas (1) held and continues to hold a current, unrestricted license to practice medicine in Florida, (2) had and continues to have a current enrollment with Medicare, and (3) has not been subject to an OIG exclusion.

P. Ex. 4 at 5; *see also* P. Ex. 4 at 17-24; P. Ex. 8. Petitioner also argued that it believed Dr. Salas' orders for HHA services were authentic because they were written on a prescription pad that included his Drug Enforcement Administration (DEA) prescription number. P. Ex. 4 at 5.

Petitioner asserted that it was in compliance with 42 C.F.R. § 424.22 (requirements for home health services) because:

> For each of the eight patients that were referred via signed orders written on Dr. Salas' prescription pads and accepted for care, [Petitioner] obtained initial certifications, along with the required face-to-face [physician] encounter documents, <u>all evidencing they were signed by Dr. Salas who was certifying</u> not only the need for HHA services but that <u>the patients were under his care</u>. [Petitioner], therefore, complied with the Medicare regulations for obtaining signed certifications and face-to-face encounter forms. There simply is no basis for [the CMS contractor] to assert that [Petitioner] could not rely on the certifications provided by Dr. Salas.
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> . . . .
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> The regulations related to the detailed referral merely require a signature by a physician. For each of the eight patients that

> were referred by Dr. Salas and accepted for care, [Petitioner]: (1) received orders on a Mobile Doctors anti-forgery prescription pad used for ordering [controlled drugs], by fax from Mobile Doctors' fax machine, which included Dr. Salas' written name and NPI number, and which were signed and dated; and, (2) obtained plans of care which included Dr. Salas' written name and were signed.
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> We have enclosed redacted copies of the physician orders, face-to-face encounter forms, initial certifications and plans of care that clearly reflect the fax transmission of these signed documents came from Mobile Physicians. We are providing these documents to additionally demonstrate there is no factual basis to allege [Petitioner] could have or should have known that Dr. Salas was providing a false certification that the patients were under his care.

P. Ex. 4 at 5-6 (emphasis in original) (internal citation omitted); *see also* P. Ex. 4 at 26-47; P. Ex. 7.

In a February 18, 2015 reconsidered determination, CMS's Center for Program Integrity upheld the initial determination. CMS Ex. 1 at 2. The determination stated that CMS reviewed the documents Petitioner submitted, but CMS did not think they were sufficient to reverse the revocation:

> Specifically, the submitted copies of the prescriptions and plans of care for patients is not verifiable and do not correct the cited grounds for this revocation. Also, there are no Part B claims for the five beneficiaries in the case. The lack of claims further supports the attestation that the signatures on the referrals and plans of care were not the physician['s]. Therefore, the proposed reconsideration is denied.

CMS Ex. 1 at 2.

Petitioner requested a hearing to dispute the revocation. In response to my Acknowledgment and Pre-hearing Order (Order), CMS filed a brief (CMS Br.) and 12 exhibits as its pre-hearing exchange. Petitioner filed a brief (P. Br.) and 15 exhibits as its pre-hearing exchange. Petitioner also filed a document entitled a motion to dismiss. CMS filed a reply brief (CMS Reply Br.).

II. Decision on the Record

My Order advised the parties that they must submit written direct testimony for each proposed witness and that an in-person hearing would only be necessary if the opposing party requested an opportunity to cross-examine a witness. Order ¶¶ 8-10; Civil Remedies Division Procedures §§ 16(b), 19(b). CMS submitted written direct testimony for one witness. CMS Ex. 6. Petitioner submitted written direct testimony for two witnesses. P. Exs. 6, 11. Further, Petitioner requested a subpoena to compel the testimony of Dr. Salas, an individual who authored a "Physician Attestation" and a "Physician Statement" that CMS submitted as exhibits. P. Br. at 21; CMS Exs. 7, 9.

Petitioner also moved for dismissal of this case. Petitioner asserted that CMS failed to meets its burden of showing a prima facie case to revoke Petitioner's Medicare billing privileges. Specifically, Petitioner argued that CMS did not identify any specific Medicare enrollment statute, regulation, or enrollment application requirement that Petitioner failed to follow. As stated by Petitioner:

> In order for CMS to have met its initial burden, it would have needed to produce evidence that Petitioner was not in compliance with the requirements in 42 C.F.R., Part 424, Subpart P or that Petitioner did not comply with the application requirements contained in Chapter 15 of the [Medicare Program Integrity Manual] MPIM or in the CMS 855 application instructions. CMS has produced no such evidence.
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> Given that this case involves orders Petitioner received from Dr. Salas and claims that Petitioner submitted for HHA services based on Dr. Salas' orders, the only pertinent Medicare enrollment regulations within 42 C.F.R., Part 424, Subpart P are: (i) 42 C.F.R. § 424.506(c), which requires the reporting of NPI numbers on claims; (ii) 42 C.F.R. § 424.507, which requires that orders for imaging tests, clinical laboratory services, durable medical equipment, prosthetics, orthotics, medical supplies, and home health services be from a physician who has a current Medicare enrollment or who has validly opted out of Medicare and include the ordering physician's legal name and NPI number on the claim form; and (iii) 42 C.F.R. § 424.516(f), requiring the providers and suppliers noted in (ii) to maintain documentation of orders on file for seven years. There are simply no allegations that Petitioner failed to have the ordering physician's name or NPI number on the claims that Petitioner failed to ensure that Dr.

> Salas has a current Medicare enrollment when the services were ordered, or that Petitioner failed to maintain the required documentation related to orders.
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> . . . .
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> Rather, CMS argues that Petitioner is required to have known independently that Dr. Salas had an ongoing clinical relationship with the patients he referred for HHA services. Unfortunately, for CMS's position, there is no legal support for such an assertion. The Medicare enrollment statutes, regulations, and other legal requirements do not require providers or suppliers to assess and determine that the physician who referred the patient actually has a clinical relationship with the patient. On the contrary, the rules allow for providers and suppliers to rely on a signed order, without having to question the legitimacy of the signature or clinical relationship between the referring physician and the patient, so long as the order is received from a Medicare-enrolled physician.

P. Br. at 16-17.

Although Petitioner called this document a motion to dismiss, I interpret it as a motion for a favorable decision on the record. This is because Petitioner initiated the present case when it requested a hearing, and dismissal of that hearing request would result in CMS's reconsidered determination becoming binding on the parties. *See* 42 C.F.R. §§ 498.25(b)(2), 498.40(a), 498.68. Petitioner obviously does not intend this result, but rather seeks a favorable resolution without an in-person hearing and, if this cannot be obtained, to have an in-person hearing to cross-examine witnesses. *See* P. Br. at 15-18, 21. Because, as explained below, I agree with Petitioner that the law and facts in this case dictate reversal of the revocation, I issue this decision based on the written record.

CMS did not object to any of Petitioner's exhibits. *See* Order ¶ 7. Therefore, I admit Petitioner's Exhibits 1-15 into the record.

Petitioner objects to CMS Exhibits 6 through 9. Petitioner objected to admission of CMS's written direct testimony for a CMS employee (CMS Ex. 6) as well as the statements Dr. Salas signed unless these individuals were subject to cross-examination. P. Br. at 20-21. I overrule this objection since, as explained below, I am granting Petitioner's request for a favorable decision on the record. Therefore, cross-examination is unnecessary.

Petitioner also objects to CMS Exhibit 8, which is comprised of documents related to a site visit for Mobile Doctors that showed Mobile Doctors was no longer operating from the address CMS had in its files, because the inspection occurred after the dates Petitioner dealt with Mobile Doctors. P. Br. at 21. I overrule the objection because Mobile Doctors plays a significant role in this case and CMS's efforts to locate it during its inquiry into Petitioner is relevant and accounts for the reason that no one from Mobile Doctors was called as a witness for either party. Therefore, I admit CMS Exhibits 1-12 into the record.

III. Issue

Whether CMS had a legitimate basis to revoke Petitioner's Medicare billing privileges based on Petitioner's failure to comply with Medicare enrollment requirements under 42 C.F.R. § 424.535(a)(1).

IV. Jurisdiction

I have jurisdiction to decide the issue in this case. 42 C.F.R. §§ 498.3(b)(17), 498.5(l)(2); *see also* 42 U.S.C. § 1395cc(j)(8).

V. Findings of Fact, Conclusions of Law, and Analysis[1]

The Social Security Act (Act) authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations governing the enrollment process for providers and suppliers. 42 U.S.C. §§ 1302, 1395cc(j). Under the Secretary's regulations, a provider or supplier that seeks billing privileges under the Medicare program must "submit enrollment information on the applicable enrollment application. Once the provider or supplier successfully completes the enrollment process . . . CMS enrolls the provider or supplier into the Medicare program." 42 C.F.R. § 424.510(a). CMS may revoke a provider or supplier's Medicare billing privileges for a variety of reasons including if it is "determined not to be in compliance with the enrollment requirements described in [section 424.535], or in the enrollment application applicable for its provider or supplier type . . . ." *Id.* § 424.535(a)(1) (2014).[2]

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[1] My numbered findings of fact and conclusions of law are set forth in italics and bold font.

[2] CMS amended 42 C.F.R. § 424.535(a)(1) effective February 3, 2015. 79 Fed. Reg. 72,500 (Dec. 5, 2014). Because the alleged conduct that serves as a basis for revocation in this matter occurred before the effective date, I apply the 2014 version of 42 C.F.R. § 424.535(a)(1) here.

HHAs are providers for Medicare purposes. 42 U.S.C. § 1395x(u). The term "home health services" is defined 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 . . ." *Id*. § 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 . . . ." *Id*. § 1395f(a)(2)(C); *see also* 42 U.S.C. § 1395n(a)(2)(A). 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).

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. *Id*. § 424.22(a)(iii), (iv). A physician and HHA must review a Medicare beneficiary's plan of care at regular intervals. *Id*. § 484.18(b). Also, HHAs are required to "promptly alert the physician" to significant changes that suggest a need to alter the plan of care. *Id*. HHAs consult with the individual's physician to obtain approval of any "additions or modifications to the original plan" of care. *Id.* § 484.18(a).

1. ***Petitioner received nine referrals faxed from Mobile Doctors purporting to be orders from Dr. Salas for home health services to be rendered to nine patients, Petitioner confirmed that Dr. Salas was a licensed physician who was enrolled in Medicare, and Petitioner sought reimbursement from Medicare for the home health services it provided to eight of these patients based on the signed orders, face-to-face encounter forms, and care plans bearing Dr. Salas' signature received from Mobile Doctors.***

Petitioner receives an average of 80 patient referrals a month. P. Ex. 6 ¶ 4. Starting in March 2013, physicians from a practice called Mobile Doctors commenced referring patients to Petitioner. P. Ex. 6 ¶ 5. Between April 2, 2014, and July 3, 2014, Mobile Doctors faxed Petitioner orders from Dr. Salas to provide home health services to nine patients. P. Ex. 6 ¶ 6; P. Ex. 11 ¶ 6; *see also* P. Ex. 7 at 2, 4-7 (copies of signed orders related to five patients identified by CMS as the basis for revocation).

When Petitioner received the orders from Mobile Doctors, Petitioner followed its office policy and confirmed that Dr. Salas was enrolled in Medicare, was not excluded by the Office of the Inspector General, and was licensed to practice medicine in the state of Florida. P. Ex. 11 ¶¶ 3-5; *see also* P. Ex. 6 ¶¶ 7, 8. Petitioner accepted eight of the nine patients for which Mobile Doctors provided orders and, for those eight patients, Petitioner provided Mobile Doctors with a face-to-face encounter form. P. Ex. 11 ¶ 7.

Petitioner received signed face-to-face encounter forms faxed back from Mobile Doctors with Dr. Salas' signature on them. P. Ex. 11 ¶ 7; *see also* P. Ex. 7 at 10, 12-15 (copies of signed face-to-face encounter forms related to five patients identified by CMS as the basis for revocation).

Petitioner also sent plans of care for the eight accepted patients to Mobile Doctors and Mobile Doctors faxed back the plans of care with Dr. Salas' signature on them. P. Ex. 11 ¶ 8; *see also* P. Ex. 7 at 18, 21-25 (copies of signed plans of care related to five patients identified by CMS as the basis for revocation).

Petitioner's practitioners and administrative staff generally have contact with referring physicians, which is sometimes oral or in writing, and Petitioner provided documentation of communication with Dr. Salas concerning three of the five patients at issue in this case. P. Ex. 11 ¶ 9; P. Ex. 14.

During a CMS investigation into the number of HHA referrals Dr. Salas made in 2014, Dr. Salas provided a written statement that he never treated five of the patients that Mobile Doctors referred to Petitioner. CMS Ex. 6 ¶¶ 7-8, 14-16; CMS Ex. 9 at 1. Petitioner also reviewed the copies of orders, face-to-face encounter forms, and plans of care for those patients provided by Petitioner and asserted that the physician signatures purporting to be his were in fact not his. CMS Ex. 9 at 2-34. Dr. Salas stated that he never authorized anyone to create a stamp with his name and NPI on it. CMS Exs. 7, 9. CMS's inquiry showed that according to Medicare records, Dr. Salas never billed Medicare for seeing two of the five patients upon which the revocation in this case is based. CMS Exs. 10, 11.

2. CMS did not have a legitimate basis to revoke Petitioner's Medicare billing privileges because Petitioner did not fail to comply with any specific enrollment requirement when it erroneously submitted Medicare claims for home health services that it reasonably believed were ordered by Dr. Salas.

CMS may revoke a supplier who has failed to comply with enrollment requirements in section 424.535 of the regulations or in the supplier's enrollment application. 42 C.F.R. § 424.535(a)(1). On the Medicare enrollment application that HHAs must sign, Petitioner had to certify that it:

> [A]gree[s] to abide by the Medicare laws, regulations and program instructions that apply to [home health agencies]. The Medicare laws, regulations, and program instructions are available through the fee-for-service 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 (including, but

> not limited to, the Federal anti-kickback statute and the Stark law), and on the supplier's compliance with all applicable conditions of participation in Medicare.

CMS Ex. 2 at 49.

CMS argues that, based on the certification statement signed by providers, providers must adhere to all Medicare laws, regulations, and program manual provisions, and CMS may revoke providers for violating any of those rules. In the present case, CMS argues that Petitioner did not obtain a proper physician certification related to five patients. CMS Br. at 2, 13; CMS Reply at 2-3. However, CMS's position is contrary to a recent decision. Relevant excerpts from that decision are as follows:

> We find, as detailed in the following section, that CMS has consistently treated section 424.535(a)(1) as inapplicable to mere errors in claiming and has stated that its authority to revoke for inaccurate billing is set out in other provisions. We further conclude in the following section that erroneous billing does not constitute noncompliance with enrollment requirements.
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> . . . .
>
> The revocation regulations specify certain "reasons for revocation" in section 424.535(a). CMS stated, in the preamble to the proposed rule adopting the revocation provisions, that it intended to consider various factors in applying the reasons, including balancing program and beneficiary risk and beneficiary access to care. 71 Fed. Reg. 20,754, 20,761 (Apr. 21, 2006). CMS explained that the revocation reasons were generally similar to reasons that initial enrollment could be denied. *Id*. Under section 424.535(a)(1), CMS contemplated that a provider might face revocation if it is determined "to be out of compliance with the Medicare enrollment requirements outlined in subpart P including the failure to report changes to enrollment information timely or failure to adhere to corrective action plans[.]" *Id*. The Medicare Program Integrity Manual (MPIM) instructs contractors about when to use section 424.535(a)(1) as the reason for revocation, such as when a provider no longer has a business location or has not paid assessed user fees. MPIM, Ch. 15, § 15.27.2.A (eff. Jan. 28, 2014). Other appropriate situations for use of this provision include, among

others, lack of appropriate license, failure to meet the regulatory requirement for the relevant specialty, lack of valid social security numbers, failing to submit all required documentation within 60 days of being notified to submit an enrollment application, and otherwise not meeting "general enrollment requirements." *Id*. Although the circumstances listed in the MPIM are not necessarily exclusive, it is noteworthy that the MPIM provides no guidance about any situation in which submission of a claim containing incorrect information would be a reason for a contractor to revoke under section 424.535(a)(1).

. . . .

Neither the plain language of section 424.535 (read as a whole) nor the regulatory history described above communicates that simple error on one or more claims would potentially trigger revocation under section 424.535(a)(1) for noncompliance with requirements for the content of claims. Thus, we find no basis for concluding that section 424.535(a)(1) was intended to encompass the filing of erroneous claims, without more, as a ground for revocation.

. . . .

On the other hand, while we do not decide here the precise scope of section 424.535(a)(1), we have concerns about CMS's assertions that (1) every provision contained anywhere in subpart P constitutes a revocable enrollment requirement or (2) that the certification statement in enrollment applications converts every Medicare regulation and instruction into a revocable enrollment requirement. CMS relied on these assertions to argue that failing to include the correct NPI in Proteam's claims in violation of section 424.507(b)(1) (in subpart P) necessarily proved that Proteam was noncompliant with an enrollment requirement. We do not find support for the position taken by CMS.

First, CMS has not explained how the language of section 424.535(a)(1) can bear such expansive weight without rendering much of the regulatory scheme for enrollment and revocation virtually meaningless. As Proteam points out, there would be little sense to the listing of most of the specific

> grounds for revocation other than 424.535(a)(1), if that were the intent. We generally do not read one provision of a regulation in a manner that makes others superfluous where that reading can be avoided.
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> Moreover, section 424.535(a)(1) does not state that it applies to noncompliance with any provision contained in subpart P.
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> . . . .
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> We are also not persuaded that the duty undertaken by a provider in certifying that it will comply with Medicare requirements amounts to acknowledging that any noncompliance with any requirement in the submission of a claim may result in revocation as CMS contends here. The certification does clearly require the applicant to agree to abide by "the Medicare laws, regulations, and program instructions" applicable to its provider type. CMS Ex. 20, at 3. The certification also calls for an acknowledgment that "payment of a claim by Medicare is conditioned" on compliance. *Id*. The certification statement does not, however, inform the applicant that submission of a claim inconsistent with any law, regulation or instruction, without more, may result in revocation of billing privileges as opposed to nonpayment of the claim.

Proteam Healthcare Inc., DAB No. 2658, at 7, 8, 9-10, 11, 12 (2015).

Based on a review of the record in this case, I conclude that it is sufficiently similar to *Proteam* to compel reversal of the revocation. The basis for revocation in the reconsidered determination was that Petitioner billed Medicare for home health services without a valid physician order in five claims. CMS Ex. 1 at 1-2. The requirement that an HHA have a physician's order comes from 42 C.F.R. § 424.507, which was the same section of the regulations that was at issue in *Proteam*. Further, in both cases, CMS made arguments that the additional enrollment requirement provision in the certification statement of the enrollment application authorized revocation. Finally, it is significant that CMS did not allege fraud on the part of the provider in either *Proteam* or this case. CMS Br. at 2 n.1; CMS Reply Br. at 3.

Because there is no allegation of fraud, I do not need to resolve whether Dr. Salas did or did not sign the physician orders that Mobile Doctors sent to Petitioner concerning the five patients in question in this case. I conclude that even if Dr. Salas did not sign the orders for home health services in question in this case, Mobile Doctors provided those

orders to Petitioner by fax. Petitioner reasonably concluded, after checking that Dr. Salas was enrolled in Medicare and a licensed physician, that he ordered the home health services on an anti-forgery prescription that displayed Dr. Salas' DEA number. Petitioner also followed-up by faxing Mobile Doctors forms confirming face-to-face examinations between Dr. Salas and the five patients as well and plans of care for the patients, which Mobile Doctors returned with Dr. Salas' signature. To the extent that Petitioner billed Medicare for home health services that Dr. Salas did not order, I conclude that this was done in error based on documents received from Mobile Doctors. As made clear in *Proteam*, a billing error, without more, is insufficient to support revocation based on 42 C.F.R. § 424.535(a)(1). DAB No. 2658, at 10.

VI. Conclusion

For the reasons stated above, I reverse CMS's determination to revoke Petitioner's Medicare billing privileges.

/s/
Scott Anderson
Administrative Law Judge