Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Kelli Prather, OT,
(NPI: 1609981984),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-355

Decision Number: CR3252

Date: June 2, 2014

DECISION

National Government Services (NGS), an administrative contractor for the Centers for Medicare & Medicaid Services (CMS), revoked the Medicare enrollment and billing privileges of Petitioner, Kelli Prather, OT, a Medicare supplier.[1] I sustain NGS's reconsideration determination upholding the revocation because Petitioner submitted false or misleading information to CMS, failed to notify CMS of changes to her practice locations within the required timeframe, and was not operational at six practice locations on file with NGS and CMS during on-site inspections and site verifications.

I. Background

Petitioner submitted numerous Medicare enrollment applications (CMS 855I forms) to NGS between March 2012 and February 2013.

[1] A "supplier" is a physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare." 42 C.F.R. § 400.202.

NGS received the first Medicare enrollment application in question from Petitioner on March 9, 2012. CMS Exhibit (Ex.) 2. In that application, Petitioner provided information to reactivate her Medicare enrollment and added three practice locations: 1835 Richmond Road, Ground Floor, Staten Island, New York 10306; 8815 168th Street, Suite 1P, Jamaica, New York 11432; and, 3044 Coney Island Avenue, 2nd Floor, Brooklyn, New York 11235. CMS Ex. 2, at 4, 17-19. Petitioner certified that all information contained in the application was true as of March 7, 2012. CMS Ex. 2, at 28-29.

NGS received a second Medicare enrollment application from Petitioner on May 4, 2012. CMS Ex. 5. In that application, Petitioner added two additional practice locations: 14843 Hillside Avenue, Jamaica, New York 11435, and 7819 18th Avenue, Brooklyn, New York 11214. CMS Ex. 5, at 18-19. Petitioner certified that the information contained in the application was true as of April 25, 2012. CMS Ex. 5, at 28-29.

NGS received a third Medicare enrollment application from Petitioner on July 13, 2012. CMS Ex. 6. Petitioner added an additional practice location in this application, located at 174 Bay 29th Street, Brooklyn, New York 11214. CMS Ex. 6, at 17. Petitioner certified the accuracy of the information contained in this application on July 12, 2012. CMS Ex. 6, at 26-27.

NGS received a fourth Medicare enrollment application from Petitioner on January 11, 2013. CMS Ex. 7. Petitioner added another practice location in this application, 2761 Bath Avenue, Lower Level, Brooklyn, New York 11214. CMS Ex. 7, at 17. She certified the truth of the information in the application on December 11, 2012. CMS Ex. 7, at 26-27.

NGS received a fifth Medicare enrollment application from Petitioner on January 17, 2013. CMS Ex. 8. Petitioner added a new practice location, 2327 83rd Street, Suite A, Brooklyn, New York 11214. CMS Ex. 8, at 15. Petitioner asserted that she saw her first patient at this practice location on January 7, 2013. CMS Ex. 8, at 15. Petitioner certified the accuracy of the information contained in the application on "12/12/12." CMS Ex. 8, at 24-25.

NGS received a sixth Medicare enrollment application from Petitioner on February 12, 2013. CMS Ex. 9. Petitioner added another practice location in this application, located at 145 Highlawn Avenue, Brooklyn, New York 11223. CMS Ex. 9, at 17. Petitioner certified the truth of the information contained in the application on February 1, 2013. CMS Ex. 9, at 26-27.

NGS received a seventh Medicare enrollment application from Petitioner on February 26, 2013. CMS Ex. 10. Petitioner sought to reactivate her Medicare enrollment under a corporation, Life Skills Enhancement Occupational Therapy Services PC and added her

three most recent practice locations: 2761 Bath Avenue, Basement Level, Brooklyn, New York 11214; 2327 83rd Street, Suite A, Brooklyn, New York 11214; and, 145 Highlawn Avenue, Brooklyn, New York 11223. CMS Ex. 10, at 2, 14, 17-19. Petitioner deleted a practice location as well, 5110 12th Avenue, Brooklyn, New York 11219. CMS Ex. 10, at 20.

In late March 2013, Safeguard Services LLC (SGS), a Medicare contractor, sought to verify certain aspects of the information that Petitioner had provided to Medicare. *See* CMS Ex. 11. On March 19, 2013, SGS conducted a site visit to Petitioner's practice location at 14843 Hillside Avenue, Jamaica, New York. CMS Ex. 11, at 2. On March 20, 2013, SGS conducted a site visit at 1835 Richmond Road, Staten Island, New York. CMS Ex. 11, at 2. SGS performed site verifications of: 7819 18th Avenue, Brooklyn, New York; 174 Bay 29th Street, Brooklyn, New York; 3044 Coney Island Avenue, 2nd Floor, Brooklyn, New York; and, 8815 168th Street, Suite 1P, Jamaica, New York. CMS Ex. 11, at 2. SGS determined Petitioner was no longer actively practicing at any of the six locations the investigator visited or verified. CMS Ex. 11, at 2; Petitioner's (P.) Ex. 2, at 3-4.

NGS received an eighth Medicare enrollment application from Petitioner on May 16, 2013. CMS Ex. 12. In this application, and subsequent supplemental information supplied at NGS's request, Petitioner revalidated her Medicare enrollment and terminated her enrollment with respect to several of her practice locations. CMS Ex. 12, at 5, 7-9, 45-47.

CMS informed Petitioner that it was revoking her Medicare billing privileges in a revised letter dated August 13, 2013. CMS Ex. 13. The letter informed Petitioner that CMS was revoking her enrollment and billing privileges due to Petitioner's violations of 42 C.F.R. § 424.535(a)(4) (certifying as "true" false or misleading information in an enrollment application), (a)(5) (failing to be operational to furnish Medicare covered items or services), and (a)(9) (failing to comply with reporting requirements), effective May 20, 2013. CMS Ex. 13, at 1-2. Petitioner timely sought reconsideration of the decision in a letter dated September 12, 2013. P. Ex. 2; CMS Ex. 14. NGS issued an unfavorable decision in response to Petitioner's request for reconsideration on October 15, 2013. CMS Ex. 15. Petitioner sought review in a timely filed request for hearing on December 4, 2013. Request for Hearing (RFH).

The case was assigned to me for hearing and decision. I issued an Acknowledgment and Pre-Hearing Order on December 11, 2013. Pursuant to my Acknowledgment and Pre-Hearing Order, which established deadlines for a complete prehearing briefing including any motions for summary judgment, CMS filed a brief and a motion for summary judgment (CMS Br.), as well as fifteen exhibits (CMS Exs. 1 – 15). Petitioner filed an opposition and brief (P. Br.) and eight exhibits (P. Exs. 1 – 8). I admit all of CMS's exhibits and Petitioner's exhibits into the record without objection.

My Acknowledgment and Pre-Hearing 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 affirmatively requested an opportunity to cross-examine a witness. Acknowledgment and Pre-Hearing Order ¶¶ 8-10; *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). Neither party offered the written direct testimony of any witnesses for a hearing. Therefore, I find that an in-person hearing in this case is unnecessary, and I issue this decision on the full merits of the written record. Acknowledgment and Pre-Hearing Order ¶¶ 10, 11.

The regulations at 42 C.F.R. Part 498 set forth the procedures for hearings and appeals here. In cases subject to Part 498, the Departmental Appeals Board (Board) has found that CMS must establish a prima facie showing of a regulatory violation, and the regulated entity then bears the burden of showing by a preponderance of the evidence that it was compliant with the Social Security Act (Act) or regulations, or that it had a defense. *Evergreene Nursing Care Ctr.,* DAB No. 2069, at 7-8 (2007); *Batavia Nursing and Convalescent Inn,* DAB No. 1911 (2004); *Batavia Nursing and Convalescent Ctr.,* DAB No. 1904 (2004); *Emerald Oaks,* DAB No. 1800 (2001); *Cross Creek Health Care Ctr.,* DAB No. 1665 (1998). The Board has found this allocation of the burden of going forward with the evidence and the burden of persuasion properly applied in supplier enrollment cases. *MediSource Corp.,* DAB No. 2011, at 2-3 (2006).

II. Applicable Law

Suppliers such as Petitioner must enroll in the Medicare program to "receive payment for covered Medicare items or services from either Medicare (in the case of an assigned claim) or a Medicare beneficiary (in the case of an unassigned claim). . . ." 42 C.F.R. § 424.505. The regulations at 42 C.F.R. Part 424, subpart P, establish requirements for a supplier to enroll in the Medicare program. S*ee also* Social Security Act (Act) § 1866(j)(1)(A) (authorizing the Secretary of the U.S. Department of Health and Human Services to establish by regulation the process for enrolling providers and suppliers in the Medicare program).

In order to be enrolled in the Medicare program, suppliers must meet a number of requirements. A supplier must submit an enrollment application that contains "complete, accurate, and truthful responses to all information requested . . . ." 42 C.F.R. § 424.510(d)(2). The enrollment application contains a certification statement that the supplier must sign "attest[ing] that the information submitted is accurate and that the . . . supplier is aware of, and abides by, all applicable statutes, regulations and program instructions." 42 C.F.R. § 424.510(d)(3). A supplier in the Medicare program "must be operational to furnish Medicare covered items or services before being granted Medicare

billing privileges." 42 C.F.R. § 424.510(d)(6). In order to be considered "operational" at a given practice location, a supplier must "[be] open to the public for the purpose of providing health care related services, [be] prepared to submit valid Medicare claims, and [be] properly staffed, equipped, and stocked . . . to furnish these items or services." 42 C.F.R. § 424.502. Nonphysician suppliers must report any change in practice locations to their Medicare contractor within 30 days. 42 C.F.R. § 424.516(d)(1)(iii). CMS may perform onsite review of a supplier to verify the information a supplier has submitted in an enrollment application. 42 C.F.R. § 424.510(d)(8); 42 C.F.R. § 424.517(a).

CMS may revoke a supplier's enrollment in the Medicare program if it finds a supplier not to be in compliance with enrollment requirements. 42 C.F.R. § 424.535(a)(1). Federal regulations permit CMS to revoke a supplier's Medicare enrollment and billing privileges for a variety of reasons including:

> *False or misleading information*. The provider or supplier certified as "true" misleading or false information on the enrollment application to be enrolled or maintain enrollment in the Medicare program. (Offenders may be subject to either fines or imprisonment, or both, in accordance with current law and regulations.);
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> *On-site review*. CMS determines, upon on-site review, that the provider or supplier is no longer operational to furnish Medicare covered items or services, or is not meeting Medicare enrollment requirements under statute or regulation to supervise treatment of, or to provide Medicare covered items or services for, Medicare patients; or
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> *Failure to report*. The provider or supplier did not comply with the reporting requirements specified in § 424.516(d)(1)(ii) [requirement to report adverse legal action within 30 days] and (iii) [requirement to report change in practice location within 30 days] of this subpart.

42 C.F.R. § 424.535(a)(4), (a)(5), and (a)(9).

When a supplier's billing privileges are revoked, the supplier is barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar, a minimum of 1 year but not greater than 3 years. 42 C.F.R. § 424.535(c).

III. Discussion

A. Issue Presented

Whether NGS, acting on behalf of CMS, had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges as an occupational therapist.

B. Findings of Fact and Conclusions of Law

1. CMS had a legitimate basis to revoke Petitioner's enrollment and billing privileges because Petitioner submitted false information in Medicare enrollment applications.

Medicare enrollment applicants must provide complete and accurate responses to all information requested within each section of their enrollment applications. 42 C.F.R. § 424.510(d)(2)(i). CMS has a legitimate basis to revoke a supplier's Medicare billing privileges where the supplier fails to provide complete and accurate information in his or her enrollment application. 42 C.F.R § 424.535(a)(1), (a)(4).

NGS received an enrollment application from Petitioner on January 17, 2013. CMS Ex. 8. In that application, Petitioner certified that she first started seeing Medicare patients at her practice location at 2327 83rd Street, Suite A, Brooklyn, New York, on January 7, 2013. CMS Ex. 8, at 15. Petitioner signed the certification statement in the enrollment application on "12/12/12." CMS Ex. 8, at 24-25. By signing the certification statement, Petitioner attested that the information contained in the application was "true, correct, and complete." CMS Ex. 8, at 24. Yet, Petitioner certified that she had *already* begun seeing patients nearly a month *before* she claims to have seen the first patient.

Petitioner provides no explanation for the inconsistency, which CMS pointed out in its brief. She asserts only that "the information contained in the application . . . is accurate." P. Br. at 5. While Petitioner's statement that she first started seeing patients at 2327 83rd Street, Suite A, Brooklyn, New York, on January 7, 2013, very well may be true, she cannot have certified its truth nearly a month before it happened.

Furthermore, NGS received a different enrollment application containing false or misleading information from Petitioner on March 9, 2012. CMS Ex. 2. In that application, Petitioner informed Medicare that she had begun seeing patients at a new practice location, 1835 Richmond Road, Ground Floor, Staten Island, New York ("1835 Richmond Rd. location"). CMS Ex. 2, at 17. Petitioner asserted that she first started seeing patients at the 1835 Richmond Road location on "1/16/2012." CMS Ex. 2, at 17. Petitioner signed the certification statement in the enrollment application, asserting she had "read the contents of [the] application, and the information contained [there]in is

true, correct, and complete." CMS Ex. 2, at 28-29. By her own admission, however, Petitioner never saw patients at the 1835 Richmond Road location. P. Br. at 7. Petitioner concedes that "although [she] did at one time fully intend to provide services at this location, ultimately she never did." P. Br. at 7. Therefore, the addition of the 1835 Richmond Road location and the assertion that Petitioner first began seeing patients at this location on "l/16/2012" constitute false information that Petitioner submitted on an enrollment application.

Petitioner defends her submission of false information by blaming her credentialing company, Rio Consulting Group (Rio). Petitioner claims that Rio submitted the information regarding the 1835 Richmond Road location "unbeknownst to her." P. Br. at 7. Petitioner's signature on the enrollment application suggests otherwise. CMS Ex. 2, at 29. Petitioner does not question the authenticity of her signature on the enrollment application, and her signature plainly certifies that she had "read the contents of [the] application." CMS Ex. 2, at 28. As a result, Petitioner cannot claim that she was unaware that Rio added the 1835 Richmond Road location. Moreover, the Board has made clear that suppliers are responsible for actions taken on their behalf by companies with whom they have contracted to supply such services. *See Louis J. Gaefke, DPM*, DAB No. 2554, at 5-6 (2013) (holding Medicare suppliers responsible for the accuracy of reimbursement claims when submitted by a billing company). Petitioner's culpability is even clearer in the instant case than in *Gaefke* because here there is no dispute that Petitioner actually signed the submissions. Petitioner's false statements provide a legitimate basis for CMS to revoke Petitioner's enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(4).

2. CMS had a legitimate basis to revoke Petitioner's enrollment and billing privileges because Petitioner was not operational at multiple practice locations on file with CMS when NGS attempted to verify those locations.

As part of the enrollment process, a prospective supplier must state its practice location on its enrollment application. *See* 42 C.F.R. § 424.510(a). CMS may perform periodic revalidations and on-site reviews to verify the enrollment information a supplier submits, determine the supplier's compliance with Medicare enrollment requirements, and determine whether the supplier is operational. 42 C.F.R. §§ 424.510(d)(8), 424.515(c), 424.517(a). The regulations define "operational" as:

> [having] a qualified physical practice location, [being] open to the public for the purpose of providing health care related services, [being] prepared to submit valid Medicare claims, and [being] properly staffed, equipped, and stocked (as applicable, based on the type of facility or organization,

> provider or supplier specialty, or the services or items being rendered), to furnish these items or services.

42 C.F.R. § 424.502.

On March 19, 2013, an inspector for SGS attempted to conduct a site inspection of Petitioner's practice location at 14843 Hillside Avenue, Jamaica, NY. CMS Ex. 11, at 2. The inspector learned that Petitioner "was no longer at the location and had departed the location back in July 2012," approximately eight months before the visit. CMS Ex. 11, at 2. On March 20, 2014, the inspector attempted to conduct a site inspection of another of Petitioner's practice locations, the 1835 Richmond Road location. CMS Ex. 11, at 2. The inspector learned "that [Petitioner] had applied for a job at the location, but had never worked a single day at the location." CMS Ex. 11, at 2. The inspector subsequently learned through site verifications that Petitioner "was not at any of the . . . locations" that CMS had on file for her. CMS Ex. 11, at 2. Those locations included: 7819 18th Avenue, Brooklyn, New York; 174 Bay 29th Street, Brooklyn, New York; 3044 Coney Island Avenue, 2nd Floor, Brooklyn, New York; and, 8815 168th Street, Suite 1P, Jamaica, New York. CMS Ex. 11, at 2. Petitioner contacted the inspector on March 21, 2013, and confirmed that the only location at which she was actively practicing was 2761 Bath Avenue, Brooklyn, New York. CMS Ex. 11, at 3.

Petitioner again now concedes the inspector's finding that she was not operational at one of the practice locations on file with Medicare in March 2013, the 1835 Richmond Road location. P. Br. at 7. Petitioner argues, however, that she notified Medicare that she was terminating five of the six locations in January 2013. P. Br. at 6-7. As evidence, Petitioner cites a grainy, undated, non-consecutive series of pages which appear to be selections from various Medicare enrollment applications. *See* P. Ex. 8. Without any supporting explanation as to how the pages demonstrate Petitioner's alleged compliance, or dates to verify when Petitioner allegedly submitted them to CMS, I am not persuaded by them.

Both SGS's investigation and Petitioner's admissions demonstrate that Petitioner was not operational at six practice locations on file with CMS. Petitioner again seeks to assign blame to Rio, her credentialing company, for her failure to notify NGS that she was no longer practicing (or had never practiced) at numerous practice locations on file with CMS. P. Br. at 6-7. As previously discussed, Petitioner is ultimately responsible for the information she submits, or fails to submit, to CMS. Therefore, CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(5) because Petitioner was not operational at six practice locations on file with CMS on the dates CMS' contractor sought to inspect or verify the practice locations.

3. CMS had a legitimate basis to revoke Petitioner's enrollment and billing privileges because Petitioner failed to timely notify CMS when she ceased to provide services at six separate practice locations on file with CMS.

Non-physician practitioners such as Petitioner must report changes to their practice locations within 30 days of the change in location. 42 C.F.R. § 424.516(d)(1)(iii). If a supplier fails to report such a change within 30 days, CMS may revoke the supplier's Medicare enrollment and billing privileges. 42 C.F.R. § 424.535(a)(9).

As previously discussed, Petitioner was not providing services at six practice locations on file with CMS on March 19 and 20, 2013, when SGS's investigator conducted site visits and attempted site verifications of the locations. The investigator reported that when Petitioner contacted her, Petitioner admitted that she had either ceased to practice at these locations a number of months before or had never practiced at the locations at all. CMS Ex. 11, at 2-3. For instance, the investigator reported that Petitioner informed her that "she left 174 Bay 29th. Street, Brooklyn, NY at some point in October 2012," that she left "14843 Hillside Avenue, Jamaica, NY in July 2013,"[2] and that she "left the location of 7819 18th. Avenue, Brooklyn, NY in January 2013." CMS Ex. 11, at 2-3. The investigator concluded that each of these locations was on file with Medicare as active locations when the investigator conducted site verifications on March 20, 2013. CMS Ex. 11, at 2-3. The approximate dates on which Petitioner ceased providing services at each of these locations were considerably more than 30 days before SGS's investigation in March 2013, which concluded that she had not notified CMS of any of these changes. CMS Ex. 11, at 3.

In at least two instances, Petitioner asserts that her failure to notify NGS was due to the fact that "she was unaware that she was required to remove" the practice locations from Medicare's files. P. Br. at 6-7. As previously discussed, Petitioner is ultimately responsible for the information she submits or fails to submit to CMS. Additionally, the certification statement that Petitioner signed on each of her enrollment applications stated that "if [Petitioner] become[s] aware that any information in this application is not true, correct, or complete, [Petitioner] agrees to notify the Medicare fee-for-service contractor . . . ." *See, e.g.*, CMS Ex. 2, at 28. Petitioner cannot credibly claim that she was unaware of the requirement to notify NGS of the changes to her practice locations because she signed no fewer than seven enrollment applications, each of which stated that she must inform NGS of any changes to her practice locations.

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[2] The investigator's report, dated May 23, 2013, listed Petitioner as having left this location in "July 2013." This was an obvious typographical error, as Petitioner's subsequent submissions confirm. *See, e.g.*, P. Br. at 6. Therefore, the investigator's report actually suggests that Petitioner left 7819 18th Avenue, Brooklyn, New York practice location in July 2012.

Petitioner also argues that she did notify CMS that she had ceased to practice at five of the six locations in January 2013. P. Br. at 6-7. As evidence, Petitioner cites the previously discussed grainy, undated, non-consecutive series of pages which appear to be selections from various Medicare enrollment applications. P. Br. at 6-7. Even if I were to accept Petitioner's argument and evidence that she notified CMS of the termination of five practice locations in January 2013, Petitioner still concedes that her notifications came many months after she ceased utilizing the practice locations. *See* P. Br. at 6-7. Therefore, CMS had a legitimate basis to revoke Petitioner's enrollment and billing privileges based on her failure to notify it of changes to her practice locations *within 30 days*. 42 C.F.R. § 424.535(a)(9); 42 C.F.R. § 424.516(d)(1)(iii).

4. I am not authorized to grant Petitioner's request for equitable relief.

Petitioner argues that her credentialing company, Rio, was responsible for many of the deficiencies in her enrollment applications and subsequent failures to update CMS with respect to her active practice locations. RFH at 1-2; P. Br. at 3-4. She argues that she "has gone to great lengths to satisfy applicable Medicare requirements," and that "she has now taken a much more active role in maintaining her privileges and now has direct oversight as to what information and documentation is prepared and submitted to Medicare . . . ." P. Br. at 8. Petitioner has not shown, however, any basis in fact or in law that would legally excuse her prior failure to comply with regulations requiring her to file truthful enrollment applications, to be operational at practice locations on file with Medicare, and to notify Medicare of changes to her practice locations within 30 days. I am bound by the applicable statutes and regulations and am not authorized to provide Petitioner with the equitable relief she seeks. *See US Ultrasound*, DAB No. 2302, at 8 (2010); *1866ICPayday.com, L.L.C.*, DAB No. 2289, at 14 (2009) ("[a]n ALJ is bound by applicable laws and regulations and may not invalidate either a law or regulation on any ground . . .").

IV. Conclusion

CMS was authorized to revoke Petitioner's enrollment and billing privileges because Petitioner submitted inaccurate or misleading enrollment forms to CMS, was not operational at practice locations on file with CMS, and failed to update NGS within 30 days of changing numerous practice locations. Petitioner is subject to the one-year enrollment bar that CMS imposed.

/s/
Joseph Grow
Administrative Law Judge