Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: April 8, 2010
DMS Imaging, Inc.	Civil Remedies CR2040
	App. Div. Docket No. A-10-39
Petitioner,	
	Decision No. 2313
- v. -	
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

DMS Imaging, Inc. (DMS), an independent diagnostic testing facility (IDTF), requests review of a decision by Administrative Law Judge (ALJ) Steven T. Kessel, dated December 1, 2009. DMS Imaging, Inc., DAB CR2040 (2009) (ALJ Decision). The ALJ Decision granted summary judgment sustaining the determination of the Centers for Medicare & Medicaid Services (CMS) revoking DMS's Medicare billing privileges for four mobile diagnostic imaging units. CMS, through its contractor, Wisconsin Physician Services (WPS), based the revocation on its finding that Medicare requires IDTFs to "enroll each of their mobile units separately" and that these four units "were combined into one Medicare enrollment" under one Provider Transaction Access Number (47000010). CMS Exhibit (Ex.) 1, at 1.

DMS does not dispute the ALJ's conclusion that CMS "properly determined to revoke the [supplier] enrollment of four of Petitioner's mobile diagnostic imaging units" because the units were not enrolled separately. ALJ Decision at 2. Rather, DMS argues that it corrected the noncompliance as shown in its corrective action plan (CAP) and that the ALJ erred by

concluding that DMS was not entitled to a hearing on WPS's rejection of the CAP and consequent refusal to reinstate. DMS further contends that, had the ALJ reviewed the CAP, he would have found that DMS had corrected the noncompliance and that WPS should have reinstated its billing privileges for these units.

For the reasons discussed below, we uphold the ALJ Decision.

Standard of review

Whether summary judgment is appropriate is a legal issue that we address de novo. 1866ICPayday.com, DAB No. 2289, at 2 (2009), citing Lebanon Nursing and Rehabilitation Center, DAB No. 1918 (2004). Summary judgment is appropriate when the record shows that there is no genuine dispute of fact material to the result. See 1866ICPayday.com at 2, citing Celotex Corp. v. Catrett, 477 U.S. 317, 322-25 (1986). Our standard of review on a disputed issue of law is whether the ALJ decision is erroneous. Guidelines -- Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program, www.hhs.gov/dab/divisions/appellate/guidelines/prov.html.

Background

The following facts from the ALJ Decision and the record are undisputed.

DMS is a multi-state corporation that operates multiple mobile diagnostic imaging testing units. ALJ Decision at 1. By a notice dated February 6, 2009, WPS advised that DMS's billing privileges for four of these units would be revoked, effective March 8, 2009, because DMS had combined "all information [for the units] into one Medicare enrollment." CMS Ex. 1, at 1. The notice informed DMS that, if DMS believed the determination was not correct, it could "request a reconsideration" within 60 days. Id. at 2. The notice also provided DMS with an opportunity to correct the noncompliance if it believed that it would be "able to correct the deficiencies and establish [its] eligibility to participate in the Medicare program." Id. In order to avail itself of this opportunity, DMS was required to submit a CAP within 30 days. Id. The notice explained that the CAP "should provide evidence that you are in compliance with Medicare requirements." Id. (emphasis added).

On March 6, 2009, DMS submitted a CAP, which it represented "establish[ed] separate enrollment applications for each mobile unit performing scans and for which DMS Imaging is billing for

that service." CMS Ex. 2. On March 16, 2009, WPS rejected the CAP, stating that, among other things, the new applications were incomplete because they failed to show that "all of the units have supervising physicians" as required by 42 C.F.R. §§ 410.32(b) and 410.33(a)(1). CMS Ex. 3.

DMS also filed a request for a reconsideration of the revocation on April 6, 2009, by a contractor hearing officer. CMS Ex. 4. However, although DMS did assert in a footnote that the requirement for separate enrollment of mobile units was "not consistent with the regulations", the rest of DMS's reconsideration request focused instead on adequacy of the corrections proffered in its CAP. Id. at 1 n.1.

On July 2, 2009, the contractor hearing officer issued a decision upholding WPS's revocation of DMS's billing privileges for noncompliance. CMS Ex. 6.

DMS then requested an ALJ hearing. CMS moved for summary judgment, arguing that the only issue before the ALJ was whether WPS's February 6 action revoking DMS's billing privileges was proper. DMS responded that the ALJ should also review whether DMS had corrected the deficiencies and come into compliance with Medicare requirements by its CAP submission.

The ALJ granted summary judgment and made the following two numbered findings of fact and conclusions of law (FFCLs):

> 1. CMS properly determined to revoke the [supplier] enrollment of four of [DMS's] mobile diagnostic imaging units.
>
> 2. Whether [DMS] corrected its deficiencies is not an issue that I am authorized to hear and decide.

ALJ Decision at 2, 3. DMS appealed the ALJ Decision.

Analysis

Section 424.535 of 42 C.F.R. sets forth bases for revocation of a supplier's Medicare billing privileges. DMS's billing privileges were revoked pursuant to section 424.535(a)(1), which provides for revocation on the basis of noncompliance. It states, in relevant part:

> *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 . . . . All providers and suppliers are granted an opportunity to correct the deficient compliance requirement before a final determination to revoke billing privileges.

The notice of revocation (CMS Ex. 1, at 2) and the Medicare Program Integrity Manual (MPIM), Chapter 10, § 19.A (http://www.cms.hhs.gov/manuals/downloads/pim83c10.pdf) inform a supplier that it may seek to demonstrate that it has corrected deficient compliance by submitting a CAP with evidence that the supplier has come into compliance.[1]

DMS does not deny that it received an opportunity to correct through submission of a CAP. Therefore, we need not reach the question of whether the scope of review by an ALJ of a revocation under section 424.535(a)(1) includes determining whether CMS granted a supplier an opportunity to correct.[2]

DMS instead argues that it timely corrected the noncompliance and therefore WPS should have reinstated it. On that basis, it challenges the second FFCL holding that whether DMS in fact corrected its deficiencies was an issue that the ALJ was not authorized to hear and decide. Request for Review (RR) at 6-10. DMS argues that the contractor hearing officer and the ALJ should have reviewed its CAP and asks the Board to remand the case to the ALJ "to decide whether DMS corrected its deficiencies and was in compliance with the IDTF enrollment requirements" under its CAP. RR at 10.

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[1] The MPIM and the notice of revocation to DMS make clear that a CAP, in this context, is not merely a plan to make corrections at some future time but rather must explain and provide evidence that corrections have been made that have reestablished compliance. CMS Ex. 1, at 2 (stating “The CAP should provide evidence that you are in compliance with Medicare requirements.”)

[2] The CMS manual instructs contractors to make a “final determination” after receiving the CAP with any additional information. MPIM, Ch. 10, §19.A. Thus, “final determination” in the context of this regulation appears to refer not to the initial notice of revocation but to the contractor’s action on CMS’s behalf after review of a CAP. As we explain further below, CMS uses the term “final determination” here in a manner that distinguishes it from the initial determination to revoke, which is subject to further reconsideration by CMS and review in the administrative appeals process under Part 498.

For the following reasons, we conclude that the ALJ correctly held that, under the authorities cited by the parties, he was not authorized to review WPS's refusal to reinstate its billing privileges for these units on the basis of the corrective action asserted by DMS in its CAP.

A. Neither the Social Security Act nor the implementing regulations provide for administrative review of a contractor's refusal to reinstate a supplier's billing privileges on the basis of a CAP.

Section 1866(j)(2) of the Social Security Act (Act)(42 U.S.C. § 1395cc(j)(2)) provides administrative and judicial hearing rights to suppliers whose Medicare billing privileges are revoked.[3] CMS implemented section 1866(j) by providing for administrative hearing rights for revoked suppliers in 42 C.F.R. §§ 424.545 and 405.874 and Part 498. The parties cited no additional source of legal authority for administrative review of supplier revocation or refusals to reinstate revoked billing privileges.[4]

Section 424.545(a) of 42 C.F.R. provides that a "supplier whose Medicare enrollment has been revoked may appeal CMS's decision in accordance with part 498, subpart A of this chapter." Part 498 of 42 C.F.R. sets forth "Appeal Procedures for Determinations that Affect Participation in the Medicare

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[3] Section 1866(j)(2) provides:

> (2) Hearing rights in cases of denial or non-renewal.—A provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) under this title is denied may have a hearing and judicial review of such denial under the procedures that apply under subsection (h)(1)(A) to a provider of services that is dissatisfied with a determination by the Secretary.

While the plain language of this section does not specifically refer to hearing rights for enrolled providers and suppliers whose billing privileges are revoked, CMS has interpreted it as authority for providing hearing rights in such situations. See, e.g., 42 C.F.R. § 498.1(g); 72 Fed. Reg. 9479 (March 2, 2007).

[4] DMS did cite 42 C.F.R. § 498.24(b), but that section applies to the appeal rights of prospective suppliers and providers and is not applicable here. RR at 9.

Program." Section 498.3(b) provides that a supplier may appeal CMS's "initial determinations" and then lists actions that constitute initial determinations. For example, section 498.3(b)(17), applicable here, states that "[w]hether to . . . revoke a . . . supplier's Medicare enrollment in accordance with . . . § 424.535 of this chapter" is an initial determination. While the regulations require a contractor to provide an opportunity to correct, they do not indicate that a supplier may challenge a contractor's rejection of a CAP proffered after notice of revocation. The refusal of a contractor to reinstate the supplier after a correction attempt is not listed as an action that constitutes an initial determination under section 498.3(b).[5]

Additionally, section 405.874, "Appeals of CMS or CMS contractor," applies where a CMS contractor determines that a supplier "fails to meet the requirements for Medicare billing privileges." Section 405.874(c)(1) provides that a supplier may appeal an "initial determination . . . to revoke current billing privileges by following the procedures specified in part 498 of this chapter." As the ALJ pointed out, section 405.874(e) provides that a contractor may reinstate revoked billing privileges pursuant to a CAP submitted after notice of revocation but that a contractor's refusal to reinstate is not an initial determination. ALJ Decision at 4. Section 405.874(e) states:

> (e) *Reinstatement of provider or supplier billing privileges following corrective action.* If a provider or supplier completes a [CAP] and provides sufficient evidence to the CMS contractor that it has complied fully with the Medicare requirements, the CMS contractor may reinstate the provider's or supplier's billing privileges. . . . A CMS contractor's refusal to reinstate a supplier's billing privileges based on a [CAP] is not an initial determination under part 498 of this chapter.

(Emphasis added.)

[5] Section 498.3(d) sets forth examples of actions that are not initial determinations and "therefore not subject to appeal under this part." Section 498.3(d) does not list a contractor's rejection of a CAP. It states, however, that actions that do not constitute initial determinations "include but are not limited" to those listed therein.

CMS treats the opportunity to submit a CAP with evidence of compliance prior to the final determination as the opportunity to correct that is established by section 424.535(a)(1). Thus, its manual explains that a "CAP is the process that gives the provider or supplier an opportunity to correct the deficiencies (if possible) that resulted in the denial or revocation of billing privileges." MPIM Ch. 10, § 19.A. Further, CMS requires that, in order to demonstrate correction, "[t]he CAP should provide evidence that the provider or supplier is in compliance with Medicare requirements." Id. (emphasis added).

CMS interprets "reinstatement" following acceptable corrective action made within 30 days of the initial revocation notice to be distinct from "re-enrollment," which is the only option for a supplier who has exhausted any challenge to a final CMS revocation determination. Compare 42 C.F.R. §§ 405.874(e) and 424.535(d). Once a revocation has become final (either because the contractor declined to reinstate the supplier after submission of a CAP or because the supplier did not prevail in challenging the basis for the revocation), the regulations do not permit simple reinstatement based on acceptable corrections. Instead, the supplier may only seek to reenroll by submitting a new application and new documentation which must be validated as if the entity applying were a new supplier. 42 C.F.R. § 424.535(d). Additionally, revoked suppliers are subject to a reenrollment bar of a minimum of one year. 42 C.F.R. § 424.535(c).

After the initial notice of revocation, the supplier has two tracks to seek to avoid revocation and may elect to pursue either or both concurrently. MPIM, Ch. 10, § 19.A. The supplier, within 60 days, may request "reconsideration" of whether the basis for revocation is erroneous or, within 30 days, it may submit a CAP to demonstrate that it has corrected that basis.[6] If the contractor accepts the CAP, it notifies the supplier, and any reconsideration request is withdrawn. If the contractor denies the CAP, the reconsideration process may proceed to a hearing before a hearing officer, who reviews "the Medicare contractor's reason for imposing a . . . revocation at the time it issued the action . . . ." Id. An unfavorable hearing officer decision is appealable to an ALJ, who reviews

[6] "[R]evocation . . . of billing privileges is effective 30 days after . . . the CMS contractor mails the notice . . . ." 42 C.F.R. § 405.874(b); CMS Ex. 1. Thus, the CAP should generally be submitted after notice but before the effective date of the revocation.

the basis for the revocation. Id. No provision is made for an appeal of the contractor's decision not to reinstate based on the CAP. Id. The hearing officer conducting the reconsideration (and the ALJ on appeal of the hearing officer decision) are limited to reviewing the basis for revocation set out in the initial notice, not the merits of any contractor decision that corrective action under a CAP was unacceptable.

Thus, the ALJ correctly found that, under section 405.874(e), a contractor's refusal to reinstate a supplier's billing privileges on the basis of its CAP is not an initial determination, as that term is used in Part 498, and, therefore, the sole issue before him was "whether a basis existed to terminate [DMS's] enrollment as of the point in time when [WPS] determined it to be deficient." ALJ Decision at 4.

B. DMS's arguments in support of a different construction of 42 C.F.R. § 405.874(e) are without merit.

In response to the ALJ's construction of section 405.874(e), DMS makes a number of arguments, none of which provide a basis for concluding the ALJ erred.

First, DMS argues that the language in section 405.874(e) does not preclude ALJ review of WPS's rejection of its CAP. DMS asserts:

> The regulation simply means that the denial of a corrective action plan does not create a new, additional appeal right. In other words, the regulations are merely specifying the point at which the supplier must appeal a revocation of billing privileges is at the time of the initial revocation, not at the time the CAP is rejected. A supplier who failed to file an appeal of initial revocation is not permitted to appeal a denial of a CAP because the decision on the CAP is not an initial determination. The regulation neither states nor implies that a decision to reject a CAP is unreviewable, or that the information submitted as part of the CAP is not reviewable by the Hearing Officer or the ALJ.

RR at 7.

We reject this argument. The term "initial determination" is used in Part 498 to mean a determination that may be reviewed by an ALJ under that part. It is clear from the preambles proposing and adopting section 405.874(e) (decades after section 498.3 was adopted) that the term "initial determination" in

section 405.874(e) was intended to mean that a contractor's refusal to reinstate billing privileges based on a CAP is not subject to ALJ review. In the preamble to the proposed rule revising section 405.874(e), CMS wrote:

> We propose revising § 405.874(e), Reinstatement of provider's or supplier's billing privileges following corrective action, to state that if a provider or supplier completes a corrective action plan and provides sufficient evidence to the carrier that it has complied fully with the Medicare requirements, the carrier may reinstate the supplier's billing privileges. The carrier may pay for services furnished on or after the effective date of the reinstatement. The effective date of the reinstatement will be based on the date the provider or supplier is in full compliance with all Medicare requirements. However, a carrier's refusal to reinstate billing privileges based on the submission of a corrective action plan is not an initial determination and may not be appealed.

72 Fed.Reg. 9479, at 9483 (March 2, 2007)(emphasis added).

When publishing section 405.874(e) as a final rule, CMS wrote:

> When a Medicare contractor makes an adverse enrollment determination (for example, enrollment denial or revocation of billing privileges) . . . appeal rights are limited to provider or supplier eligibility at the time the Medicare contractor made the adverse determination. If a Medicare contractor determines that a provider or supplier does not meet State licensure requirements on June 1, 2007, it is the provider's responsibility to demonstrate during the appeals process that State licensure requirements were met on June 1, 2007. Conversely, if a provider only can demonstrate that State licensure requirements were met on a later date, such as, August 16, 2007, we believe that the contractor made the correct determination, and that the provider or supplier may reapply for Medicare billing privileges. Accordingly, a provider or supplier is required to furnish the evidence that demonstrates that the Medicare contractor made an error at the time an adverse determination was made, not that the provider or supplier is now in compliance.

73 Fed. Reg. 36,448, 36,452 (June 27, 2008) (emphasis added).

Therefore, the language of the regulations and the related preambles support the ALJ's conclusion that WPS's refusal to reinstate DMS's billing privileges based on its CAP was not an action subject to administrative appeal under Part 498.

Second, DMS argues that section 424.535(a)(1) gives a supplier "an absolute right to correct deficiencies . . . prior to a final determination by CMS" to revoke its billing privileges. Reply at 2. It asserts that the ALJ's determination that he could not review WPS's refusal to reinstate its billing privileges based on its CAP amounts to a denial of this "regulatory right." RR at 2-3.

DMS's description of the opportunity given to an allegedly noncompliant supplier mischaracterizes the nature of this opportunity for the following reasons.

- Section 424.535(a)(1) indicates only that CMS will, when revoking billing privileges on the grounds stated in that regulation, offer a supplier an opportunity to take corrective action in an effort to avoid a final CMS determination of revocation, which WPS (CMS's contractor) did here by notifying DMS that it could submit a CAP to show its corrective action.

- Section 405.874(e) is permissive. It provides that if the "supplier completes the [CAP] and provides sufficient evidence to the CMS contractor that it has complied fully with Medicare requirements, the contractor may reinstate the billing privileges." (Emphasis added.) Thus, while section 424.535(a)(1) provides that "[a]ll providers and suppliers are granted an opportunity to correct," section 405.874(e) does not give a supplier an appealable "right" to reinstatement pursuant to this opportunity even if the supplier could show that, under its CAP, it corrected the initial deficiency.

- It is fundamental that Medicare suppliers "must meet and maintain all Federal and State requirements for their . . . supplier type to . . . maintain their enrollment." 73 Fed. Reg. at 36,452. Consistent with section 1866(j)(2) of the Act, the regulations provide that, where a supplier fails to maintain compliance, CMS may revoke the supplier's billing privileges and the supplier may seek ALJ and Board review of this action. 42 C.F.R. §§ 424.535; 498.3(b)(17). However, nothing in the Act requires CMS to give the

> supplier an opportunity to correct a failure to meet applicable requirements. Here, CMS has elected to provide suppliers an opportunity to correct, with a CAP, deficiencies that they were obligated to prevent in the first place. CMS has not elected to provide an administrative hearing on the contractors' rejection of a CAP. DMS has cited no authority for the proposition that an agency is required to provide administrative review for any action that may have adverse consequences. Thus, we see no basis for concluding that CMS's election to give suppliers an opportunity to correct deficiencies means that CMS must also provide for a hearing on rejection of a CAP, where a supplier has availed itself of that opportunity.[7]

Third, DMS argues that construing these regulations as not providing ALJ review of the contractor's rejection of a supplier's CAP results in impermissible delegation of CMS's authority to a contractor and is contrary to 5 U.S.C. § 760(2)(A) (the Administrative Procedure Act), judicial precedent, and due process. RR at 6-10.

These arguments are not properly raised before the Board because DMS did not make them before the ALJ. In any event, the arguments do not provide a basis to conclude the ALJ erred because the ALJ and the Board are bound by the cited regulations. See 1866ICPayday, DAB No. 2289, at 14 (stating "an ALJ is bound by applicable laws and regulations and may not invalidate either a law or regulation on any ground"); Sentinel Medical Laboratories, Inc., DAB No. 1762, at 9 (2001), aff'd, Teitelbaum v. Health Care Financing Admin., No. 01-70236 (9th Cir. Mar. 15, 2002), reh'g denied, No. 01-70236 (9th Cir. May 22, 2002). As discussed above, the regulations preclude ALJ review of a contractor's rejection of a supplier's CAP. Moreover, the section of the Administrative Procedure Act and the case law relied on by DMS (RR at 7-9) are inapposite because they concern standards for judicial review of agency action, while this case involves administrative review of agency action.

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[7] This is a different question from whether an ALJ's scope of review in a timely filed appeal of an initial determination to revoke reaches the issue of whether CMS, in fact, offered a procedural opportunity to correct. As indicated earlier in our decision, we need not address that issue since DMS does not deny that it received the opportunity and, in fact, submitted a CAP.

Conclusion

For the reasons stated above, we conclude that the ALJ did not err in granting summary judgment in favor of CMS, sustaining the revocation of DMS's billing privileges for these mobile units.

_____/s/_____
Judith A. Ballard

_____/s/_____
Sheila Ann Hegy

_____/s/_____
Leslie A. Sussan
Presiding Board Member