Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Eastern Plumas District Hospital d/b/a Eastern Plumas Health Care
(PTAN: 036649002),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-10-345

Decision No. CR2168

Date: June 28, 2010

DECISION

I grant the motion of the Centers for Medicare and Medicaid Services (CMS) for summary disposition and sustain the revocation of the Medicare billing privileges of Eastern Plumas District Hospital d/b/a Eastern Plumas Health Care, based on its failure to comply with two specific standards applicable to suppliers of durable medical equipment.

I. Applicable Law and Regulations

CMS revoked Petitioner's billing privileges for failure to have complied with requirements that a CMS-approved accrediting organization accredit a supplier and provide a surety bond. Those requirements are as follows.

Section 1834(a)(16)(B) of the Social Security Act (Act), 42 U.S.C. § 1395m(a)(16)(B), states that the Secretary of Health and Human Services "shall not provide for the issuance (or renewal) of a provider number for a supplier of durable medical equipment for purposes of payment . . . for durable medical equipment furnished by the supplier unless the supplier provides the Secretary on a continuing basis . . . with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000." Section 1834(a)(20)(F)(i) of the Act states that the Secretary "shall require suppliers . . . on or after October 1, 2009 . . . to have submitted to the Secretary evidence of accreditation by an accreditation organization designated . . . as meeting applicable quality standards . . .."

CMS's regulations implement these requirements among the "supplier standards" at 42 C.F.R. § 424.57(c) that suppliers of "durable medical equipment, prosthetics, orthotics and supplies" (DMEPOS) (42 C.F.R. § 424.57(a)) must meet to maintain Medicare billing privileges. As relevant here, section 424.57(c) provides:

> (c) *Application certification standards.* The supplier must meet and must certify in its application for billing privileges that it meets and will continue to meet the following standards. The supplier:
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> * * * *
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> (22) All suppliers of DMEPOS and other items and services must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment for those specific products and services. [supplier standard 22]
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> * * * *
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> (26) Must meet the surety bond requirements specified in paragraph (d) of this section. [supplier standard 26]

The surety bond requirements at 42 C.F.R. § 424.57(d) referenced in supplier standard 26 state, as relevant here, that "beginning October 2, 2009, each Medicare-enrolled DMEPOS supplier . . . must submit a bond that is continuous," which "must meet the minimum requirements of liability coverage ($50,000)" and which provides that "[t]he surety is liable for unpaid claims, CMPs [civil money penalties], or assessments that occur during the term of the bond." 42 C.F.R. § 424.57(d)(1)(ii), (4), (5). "The term of the initial surety bond must be effective on the date that the application is submitted to the NSC." 42 C.F.R. § 424.57(d)(2). The regulations provide that failure to submit a surety bond as required is grounds for revocation of a supplier's billing privileges:

> CMS requires a supplier to submit a bond that on its face reflects the requirements of this section. CMS revokes or denies a DMEPOS supplier's billing privileges based upon the submission of a bond that does not reflect the requirements of paragraph (d) of this section [42 C.F.R. § 424.57].

See 42 C.F.R. § 424.57(d)(4)(ii)(B); *see also* 42 C.F.R. § 424.57(d)(11) ("CMS revokes the DMEPOS supplier's billing privileges if an enrolled supplier fails to obtain, file timely, or maintain a surety bond as specified in this subpart and CMS instructions.").

The regulations also provide more generally that CMS "will revoke a supplier's billing privileges if it is found not to meet" the supplier standards or other requirements in section 424.57(c). 42 C.F.R. § 424.57(e) (formerly § 424.57(d)).[1]

A supplier that has had its billing privileges revoked is "barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar. The re-enrollment bar is a minimum of 1 year, but not greater than 3 years depending on the severity of the basis for revocation." 42 C.F.R. § 424.535(d).

II. Background - Undisputed Facts and Procedural History

The CMS contractor, Palmetto GBA National Supplier Clearinghouse (Palmetto, NSC), revoked Petitioner's Medicare supplier number by notice dated October 9, 2009. The letter provided the following "Reasons for Revocation of Your Supplier Number:"

> *In accordance with 42 C.F.R. §§ 424.57(c)(22) and 424.57(d), the NSC has not received proof of accreditation as required by October 1, 2009. In addition, in accordance with 42 C.F.R. § 424.57(c)(26) and 424.57(d), "All existing DMEPOS suppliers subject to the bonding requirement shall submit a copy of the required surety bond to the NSC no later than October 2, 2009." You failed to submit the surety bond to the NSC as required.*

CMS Ex. 1, at 1 (emphasis in original).[2] The letter stated that the revocation was effective 30 days from the date of postmark and that Petitioner was barred from re-enrolling in the Medicare program for one year from the effective date of the revocation. CMS Ex. 1, at 1; *see* 42 C.F.R. § 405.874(b)(2) (revocation effective 30 days after CMS or the CMS contractor mails the notice of its determination). The letter informed Petitioner that he could appeal the decision by requesting reconsideration within 60 days of the date of postmark, and/or submit a corrective action plan within 30 days. CMS Ex. 1, at 2.

Petitioner submitted to Palmetto both a corrective action plan and a request for reconsideration and enclosed what it identified as its surety bond.[3] CMS Ex. 2.

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[1] Paragraph (e) of section 424.57 was previously designated paragraph (d) and was redesignated by the rulemaking that imposed the surety bond requirements at paragraph (d); however, the redesignations have not yet been incorporated in the Code of Federal Regulations. *See* 42 C.F.R. Ch. IV (Oct. 1, 2009) § 424.57, Editorial Note.

[2] The language in quotations is from CMS's Medicare Program Integrity Manual (MPIM), chapter 10, § 21.7.

[3] The disposition of the corrective action plan is not before me. The Departmental Appeals Board has held that a contractor has discretion as to whether to accept such later

(continued…)

Petitioner subsequently submitted to Palmetto a letter from the "Board of Certification/ Accreditation, International," dated November 19, 2009, stating that "[y]ou have completed part one of your two-part accreditation process." CMS Ex. 3, at 1. The letter further explained that the second part would involve an on-site survey to validate the attestations in Petitioner's application for accreditation. *Id*.

A Medicare hearing officer denied the request for reconsideration in a decision dated December 30, 2009, on the ground that Petitioner "has not shown compliance [with] supplier standards #22 and 26." CMS Ex. 4, at 3. The hearing officer found that the surety bond Petitioner submitted "was not signed by the authorized official on file with the NSC as it did not contain a signature for the principal (supplier)" and that the bond "was also submitted after the October 2, 2009 deadline for submission." *Id*. Thus, the hearing officer concluded that, "[a]s of the date of the revocation, the surety bond information was not properly submitted." *Id*. The hearing officer also found that Petitioner "failed to obtain their accreditation in the time frame allotted," because Petitioner's letter from the accrediting organization, dated November 19, 2009, "was sent after the October 1, 2009 deadline." *Id*. The decision relied on the following language from CMS's MPIM:

> In reviewing an initial enrollment decision or a revocation, the HO [hearing officer] should limit the scope of its review to the Medicare contractor's reason for imposing a denial or revocation at the time it issued the action and whether the Medicare contractor made the correct decision (i.e., denial/revocation). . . . If a provider or supplier provides evidence that demonstrates or proves that they met or maintained compliance **after** the date of denial or revocation, the HO shall exclude this information from the scope of its review.

Id.; MPIM, ch. 10, § 19.A (emphasis added).

Petitioner timely requested a hearing before an Administrative Law Judge (ALJ). The case was originally assigned to ALJ Alfonso J. Montaño and was reassigned to me for hearing and decision pursuant to 42 C.F.R. § 498.44, which permits designation of a Member of the Departmental Appeals Board (Board) to hear appeals taken under Part 498.

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[3](…continued)

correction and reverse a revocation. *DMS Imaging, Inc.*, DAB No. 2313 (2010). During the reconsideration and appeal process, the issue is whether a basis for revocation legally sufficient to support CMS's action existed at the time of the revocation notice, not whether that basis was later eliminated pursuant to a corrective action plan.

ALJ Montaño convened a prehearing conference by telephone on February 19, 2010, which he summarized in a Pre-Hearing Conference Summary and Order (Pre-Hearing Order) issued that day. The parties agreed during the conference that the matter could be decided on their written submissions, and CMS indicated that it intended to file a motion for summary judgment. Pre-Hearing Order at 2 (Feb. 19, 2010). The ALJ set a schedule for submission of CMS's motion and supporting documentation, for Petitioner's response and supporting documentation, and for reply briefs. *Id*.

Pursuant to the briefing schedule, CMS submitted a brief and a motion for summary disposition (CMS Br.) and its exhibits 1 - 4. Petitioner subsequently informed the staff attorney that it would not file a response to CMS's motion for summary disposition unless the ALJ requested additional information. On May 24, 2010, I issued an order closing the record.

With its hearing request (HR), Petitioner submitted the reconsideration decision, a copy of a certificate of accreditation for 2010 from the Board of Certification/Accreditation, and a copy of the surety bond that Petitioner's Chief Financial Officer (CFO) had signed as "Principal." I designate these documents as Petitioner's exhibits 1, 2, and 3 respectively. In the absence of any objection, I admit them to the record for purposes of resolving the summary disposition motion.[4]

III. Issues, Findings of Fact, Conclusions of Law

A. Issues

The issue in this case is whether CMS is entitled to summary disposition on the ground that the undisputed facts demonstrate that the revocation of Petitioner's Medicare billing privileges was legally authorized.

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[4] The regulations governing provider and supplier enrollment appeals require "good cause" for a petitioner to submit "new documentary evidence . . . for the first time at the ALJ level." 42 C.F.R. § 498.56(e). CMS did not challenge Petitioner's documentary evidence, and Petitioner did not explain whether the new documents had been submitted at the reconsideration level or whether good cause justified their late submission. The reconsideration decision does not mention either document and instead cites a surety bond that had not been signed by a principal for Petitioner (CMS Ex. 2, at 2-3), and a November 19, 2009 letter from the accrediting organization (CMS Ex. 3). The certificate of accreditation is for 2010 and contains no date of issuance, so it may not have been available at the time of the reconsideration. I do not further explore whether the documentary evidence is new or its submission justified, however, since CMS did not object and since the documents do not demonstrate any dispute over facts material to the outcome of this appeal.

B. Applicable Standard

CMS's motion made clear that the disposition, which it sought, was in the nature of summary judgment. CMS Br. at 5-6. The Board stated the standard for summary judgment as follows.

> Summary judgment is appropriate when the record shows that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. . . . The party moving for summary judgment bears the initial burden of showing that there are no genuine issues of material fact for trial and that it is entitled to judgment as a matter of law. . . . To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact – a fact that, if proven, would affect the outcome of the case under governing law. . . . In determining whether there are genuine issues of material fact for trial, the reviewer must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor.

Senior Rehab. & Skilled Nursing Ctr., DAB No. 2300, at 3 (2010) (citations omitted). The role of an ALJ in deciding a summary judgment motion differs from the ALJ's role in resolving a case after a hearing. The ALJ should not assess credibility or evaluate the weight of conflicting evidence. *Holy Cross Vill. at Notre Dame, Inc*, DAB No. 2291, at 5 (2009).

C. Analysis

My findings and conclusions are in the italicized headings supported by the subsequent discussions below.

1. CMS was authorized to revoke Petitioner's billing privileges based on undisputed evidence that Petitioner was not accredited as required by 42 C.F.R. § 424.57(c)(22).

As noted, one of the bases relied on in the revocation notice and on reconsideration was that Petitioner failed to meet the accreditation requirement on time. Petitioner agreed during the pre-hearing conference that, at the time of the revocation of its billing privileges, it was not in compliance with supplier standard 22, the accreditation requirement. Pre-Hearing Order at 2 (Feb. 19, 2010). Petitioner's concession, like Palmetto's findings upon revocation and reconsideration, is consistent with the November 19, 2009 letter from the accrediting organization that Petitioner submitted to Palmetto, which indicated that, as of the date of the letter, Petitioner had only completed "one part of your two-part accreditation process." CMS Ex. 3, at 1. The letter goes on to state that the accrediting organization still needed to conduct an unannounced inspection of Petitioner's facility, interview personnel, and perform a home visit with a patient. *Id*.

Thus, no dispute exists that Petitioner was not accredited when Palmetto revoked its billing privileges.

Petitioner alleges that it was accredited **after** the revocation. In the hearing request and during the pre-hearing conference, Petitioner asserted only that "we ***are*** accredited by a CMS-approved accrediting organization" (HR, emphasis added) and that it was ***currently*** in compliance with the required supplier standards (Pre-Hearing Order at 2, emphasis added). The use of the present tense in these statements is consistent with the fact that the certificate of accreditation submitted with the hearing request is for the year 2010, and nowhere states that it was effective as of the date of revocation.

A showing of compliance subsequent to the revocation is not a ground to reverse the revocation. The regulations require that a supplier "must meet and must certify in its application for billing privileges that it meets ***and will continue to meet***" the supplier standards. 42 C.F.R. § 424.57(c) (emphasis added). The preamble to the regulations implementing the reconsideration and appeals process for suppliers whose billing privileges are revoked explained:

> 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. . . . 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). This rulemaking also amended the enrollment regulations to provide that "suppliers have the opportunity to submit evidence related to the enrollment action" and "must, at the time of their request [for reconsideration], submit all evidence that they want to be considered." 42 C.F.R. § 405.874(c)(3); *1866ICPayday.com, L.L.C.*, DAB No. 2289, at 8-9 (2009). The MPIM language that the hearing officer cited, stating that "evidence that demonstrates or proves that [the supplier or provider] met or maintained compliance after the date of denial or revocation" must be excluded from the hearing officer's review, is consistent with the preamble language. CMS Ex. 4, at 3 (HO decision); MPIM, ch. 10, § 19.A.

Thus, Petitioner's allegation in its January 13, 2010 hearing request that it was accredited shows no error in the revocation on October 9, 2009, or in the reconsideration decision on December 30, 2009. The certificate of accreditation that Petitioner submitted on appeal, which does not show accreditation at the time of revocation, is not material. Given Petitioner's concession that it was not accredited at the time of revocation and the absence of any contrary evidence, CMS is entitled to summary disposition sustaining the revocation on the basis of failure to comply with supplier standard 22.

2. CMS was authorized to revoke Petitioner's billing privileges based on undisputed evidence that Petitioner had not submitted a surety bond as required by 42 C.F.R. §§ 424.57(c)(26) and 424.57(d).

As far as its compliance with supplier standard 26, the surety bond requirement, Petitioner similarly takes the position that it is presently in compliance. HR. In support of that assertion, Petitioner submitted a copy of a surety bond. P. Ex. 3.

The hearing officer noted that the contractor case file included a surety bond that Petitioner submitted. However, the hearing officer found that the bond did not contain any signature by a principal of Petitioner, where required on the bond form, and that the bond was submitted after the October 2, 2009 deadline. CMS Ex. 4, at 3. The hearing officer concluded that no surety bond was submitted as of the date of revocation. *Id*.

The surety bond submitted with the HR differs from the one submitted to Palmetto on reconsideration in that it bears the signature of Petitioner's CFO. P. Ex. 3, at 2. CMS did not rely separately on the absence of the principal's signature as a basis for revocation and did not discuss in its motion for summary judgment what significance, if any, should be attributed to the addition of that signature in the copy submitted as Petitioner's Exhibit 3. Petitioner did not deny that the surety bond it submitted at the reconsideration level was not signed by the CFO and proffered no explanation of when the CFO's signature was added.

I need not decide whether a surety bond must always be signed by a supplier's authorized representative to constitute a bond "that on its face reflects the requirements" of the supplier standard. 42 C.F.R. § 424.57(d)(4)(ii)(B). Even the version of the surety bond submitted to me on appeal fails to demonstrate compliance. As with the unsigned version submitted on reconsideration, this version states on its face that it is effective October 27, 2009. *Compare* CMS Ex. 2, at 3 *with* P. Ex. 3, at 2. That date is beyond the October 2, 2009 date upon which each Medicare-enrolled DMEPOS supplier was required to submit a compliant bond, and is also after the date Palmetto revoked Petitioner's Medicare enrollment. 42 C.F.R. § 424.57(d)(1)(ii); *see* 73 Fed. Reg. 36,448, 36,452; MPIM, ch. 10, § 19.A. The undisputed facts thus demonstrate that Petitioner was not in compliance with supplier standard 26 at the time of the revocation.

IV. Conclusion

The undisputed facts entitle CMS to summary disposition as a matter of law. I therefore grant summary judgment in favor of CMS and sustain the revocation of Petitioner's enrollment.

/s/
Leslie A. Sussan
Board Member