Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Ultrasound & Radiology Specialist, Inc.,
(NPI: 1518007798),

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-12-522

Decision No. CR2558

Date: June 25, 2012

DECISION

The Medicare billing privileges of Petitioner, Ultrasound & Radiology Specialist, Inc., are revoked, effective June 25, 2011, for noncompliance with enrollment requirements.

I. Background

Petitioner is an independent diagnostic testing facility (IDTF) located in Coral Springs, Florida. On September 10, 2010, First Coast Service Options, Inc. (First Coast), a contractor for the Centers for Medicare and Medicaid Services (CMS), sent Petitioner a request to complete and submit an enrollment application and supporting documentation within 60 days in order for First Coast to revalidate and update Petitioner's Medicare enrollment information, pursuant to 42 C.F.R. § 424.515(d)(1). CMS Exhibit (Ex.) 1, at 10-11.

On May 26, 2011, First Coast notified Petitioner that its Medicare billing number and billing privileges were being revoked effective June 25, 2011, based on Petitioner's failure to timely furnish complete and accurate information and all supporting

documentation. CMS Ex. 1, at 82-83.[1] Petitioner requested reconsideration. First Coast denied Petitioner's reconsideration request in a decision dated January 25, 2012, upholding the revocation of Petitioner's "Provider Transaction Access Number (PTAN) for participation and enrollment in the Medicare program." CMS Ex. 1, at 1-9. Evan Sade filed a hearing request on Petitioner's behalf on March 23, 2012.[2]

The case was assigned to me for hearing and decision on April 3, 2012, and I issued an Acknowledgment and Prehearing Order (Prehearing Order) on that date. On May 3, 2012, CMS filed a motion for summary judgment and brief (CMS Br.), accompanied by three exhibits, CMS Exs. 1 through 3. Petitioner responded by letter dated May 6, 2012 (P. Br.), but Petitioner filed no exhibits. CMS declined to file a reply on May 16, 2012. CMS Exs. 1 through 3 are admitted as evidence.

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[1] The May 26, 2011 notice letter issued by First Coast advised Petitioner that CMS was revoking Petitioner's Medicare billing number and billing privileges pursuant to 42 C.F.R. § 424.535(a)(6). First Coast cited as grounds for the revocation that Petitioner failed to furnish complete and accurate information within 60 calendar days of the request for information from CMS. The citation to 42 C.F.R. § 424.535(a)(6) was in error because the regulation was amended effective March 25, 2011, and 42 C.F.R. § 424.535(a)(6) was changed. 76 Fed. Reg. 5862, 5891 (Feb. 2, 2011). When the revocation notice was issued on May 26, 42 C.F.R. § 424.535(a)(6) provided for revocation based on failure to meet screening requirements. The correct regulatory citation to the basis for revocation should have been 42 C.F.R. § 424.535(a)(1), which authorized revocation of billing privileges if a supplier was not in compliance with Medicare enrollment requirements or the enrollment application applicable for its supplier type, including failure to submit requested documents within 60 days. The reconsideration decision also incorrectly refers to 42 C.F.R. § 424.535(a)(6). CMS Ex. 1, at 2. I conclude Petitioner suffered no prejudice due to these clerical errors as the grounds for revocation were adequately described and Petitioner has demonstrated throughout this proceeding awareness of the actual grounds for revocation.

[2] Mr. Sade attached documents to the hearing request that he asserted were documents requested by First Coast. I have not marked these documents and admitted them as evidence as their content is not relevant to any issue before me. However, based upon the language of the request for hearing, Mr. Sade apparently concedes that not all documents requested by First Coast were actually submitted to First Coast within 60 days, or prior to the reconsideration determination.

II. Discussion

A. Applicable Law

Section 1831 of the Social Security Act (the Act) (42 U.S.C. § 1395j) establishes the supplementary medical insurance benefits program for the aged and disabled known as Medicare Part B. Payment under the program for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of services and suppliers. Act §§ 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395u(h)(1)). Petitioner is a supplier under the applicable definitions, and below I discuss the law only as it applies to suppliers.[3] Administration of the Part B program is through contractors such as First Coast. Act § 1842(a) (42 U.S.C. § 1395u(a)).

The Act requires the Secretary of Health and Human Services (the Secretary) to issue regulations that establish a process for the enrollment of suppliers, including the right to a hearing and judicial review of certain enrollment determinations. Act § 1866(j) (42 U.S.C. § 1395cc(j)); 42 C.F.R. § 424.545(a).

Pursuant to 42 C.F.R. § 424.505, a provider or supplier must be enrolled in the Medicare program and be issued a billing number to have billing privileges and to be eligible to receive payment for services rendered to a Medicare eligible beneficiary. If enrollment is approved, a supplier is issued a National Provider Identifier (NPI) to use for billing Medicare and a PTAN, an identifier for the supplier for inquiries. Medicare Program Integrity Manual (MPIM), Chapter 10, Healthcare Provider/Supplier Enrollment, § 6.1.1. Providers and suppliers must submit complete, accurate and truthful responses to all information requested in the enrollment application. 42 C.F.R. § 424.510(d)(2). Suppliers must meet basic requirements depending on their type of service. 42 C.F.R. §§ 424.505, 424.516, 424.517. Suppliers are also subject to additional screening requirements depending upon their type of service. 42 C.F.R. § 424.518.

If a provider or supplier is accepted for enrollment and granted billing privileges, the enrollee is subject to revalidation every five years. Every five years, the enrollee is

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[3] A "supplier" furnishes services under Medicare and the term applies to physicians or other practitioners that are not included within the definition of the phrase "provider of services." Act § 1861(d) (42 U.S.C. § 1395x(d)). A "provider of services," commonly shortened to "provider," includes hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, hospice programs, and a fund as described in sections 1814(g) and 1835(e) of the Act. Act § 1861(u) (42 U.S.C. § 1395x(u)). The distinction between providers and suppliers is important because they are treated differently under the Act for some purposes.

required to resubmit and recertify the accuracy of its enrollment information and the information is verified by the CMS contractor. CMS is also permitted to conduct "off-cycle" revalidation that may be conducted at any time and which may be triggered by random checks, adverse information, national initiatives, complaints, or other reasons that cause CMS to question whether the provider or supplier continues to meet enrollment requirements. A provider or supplier must submit the applicable enrollment information, complete and accurate, and supporting documentation within 60 calendar days of CMS's notification. 42 C.F.R. § 424.515.

CMS may revoke a supplier's billing privileges, and any corresponding "supplier agreement," if a supplier is determined to not be in compliance with Medicare enrollment requirements or the enrollment application applicable for the supplier type and has not submitted a corrective action plan (CAP). Suppliers are given the opportunity to correct the deficient compliance requirements before final determination to revoke billing privileges, with certain exceptions not applicable here. 42 C.F.R. § 424.535(a)(1). CMS's contractor notifies a supplier in writing when it revokes enrollment and explains the reasons for the determination and information regarding the supplier's right to appeal. 42 C.F.R. § 498.20(a); MPIM Ch. 10, §§ 6.2, 13.2. The supplier may submit a written request for reconsideration to CMS. 42 C.F.R. § 498.22(a). CMS must give notice of its reconsidered determination to the supplier, giving the reasons for its determination and specifying the conditions or requirements the supplier failed to meet. 42 C.F.R. § 498.25. If the CMS decision on reconsideration is unfavorable to the supplier, the Act provides for a hearing by an ALJ and judicial review. Act § 1866(j)(2).

B. Issues

Whether CMS is authorized to revoke Petitioner's Medicare billing privileges and enrollment.

C. Findings of Fact, Conclusions of Law, and Analysis

My conclusions of law are set forth in bold text followed by my findings of fact and analysis.

1. Summary judgment is appropriate.

CMS filed a motion for summary judgment. Summary judgment is not automatic upon request but is limited to certain specific conditions. The Secretary's regulations that establish the procedures to be followed in adjudicating Petitioner's case are at 42 C.F.R. Part 498. The regulations do not establish a summary judgment procedure or recognize such a procedure. However, the Departmental Appeals Board (the Board) has long accepted that summary judgment is an acceptable procedural device in cases adjudicated

pursuant to 42 C.F.R. Part 498. *See, e.g., Ill. Knights Templar Home,* DAB No. 2274, at 3-4 (2009); *Garden City Med. Clinic,* DAB No. 1763 (2001); *Everett Rehab. & Med. Ctr.*, DAB No. 1628 (1997). The Board also has recognized that the Federal Rules of Civil Procedure do not apply in administrative adjudications such as this, but the Board has accepted that Federal Rule of Civil Procedure 56 and related cases provide useful guidance for determining whether summary judgment is appropriate. Furthermore, a summary judgment procedure was adopted as a matter of judicial economy within my authority to regulate the course of proceedings and made available to the parties in the litigation of this case by my Prehearing Order dated April 3, 2012. The parties were given notice by the Prehearing Order that summary judgment is an available procedural device and that the law as it has developed related to Fed. R. Civ. Pro. 56 will be applied.

Summary judgment is appropriate when there is no genuine dispute as to any issue of material fact for adjudication and/or the moving party is entitled to judgment as a matter of 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. The party requesting summary judgment bears the burden of showing that there are no genuine issues of material fact for trial and/or that it is entitled to judgment as a matter of law. Generally, the non-movant may not defeat an adequately supported summary judgment motion by relying upon the denials in its pleadings or briefs but must furnish evidence of the case if proven. *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 3 (2010) (and cases cited therein). *See also Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). The standard for deciding a case on summary judgment and an ALJ's decision-making in deciding a summary judgment motion differs from resolving a case after a hearing. On summary judgment, the ALJ does not make credibility determinations, weigh the evidence, or decide which inferences to draw from the evidence, as would be done when finding facts after a hearing on the record. Rather, on summary judgment the ALJ construes the evidence in a light most favorable to the non-movant and avoids deciding which version of the facts is more likely true. *Holy Cross Vill. at Notre Dame, Inc.*, DAB No. 2291, at 5 (2009). The Board has also recognized that on summary judgment it is appropriate for the ALJ to consider whether a rational trier of fact could find that the parties' evidence would be sufficient to meet that party's evidentiary burden, in this proceeding a preponderance of the evidence. *Dumas Nursing and Rehab., L.P.*, DAB No. 2347, at 5 (2010). The Secretary has not specified the allocation of the burden of persuasion or the quantum of evidence in 42 C.F.R. Part 498. However, the Board has provided some persuasive analysis regarding the allocation of the burden of persuasion in cases subject to 42 C.F.R. Part 498. *Batavia Nursing and Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson,* 129 Fed. App'x 181 (6th Cir. 2005).

Petitioner concedes that there are no material facts in dispute. P. Br. I concur that there is no genuine dispute as to any material fact that requires a trial. The issues in this case that require resolution are issues of law related to the interpretation of the regulations that govern enrollment and billing privileges in the Medicare program and the application of the regulations to the undisputed facts of the case. Accordingly, summary judgment is appropriate and the CMS motion is granted.

2. Petitioner failed to timely submit revalidation information and documentation pursuant to 42 C.F.R. § 424.515.

3. There is a basis for revocation of Petitioner's Medicare billing privileges pursuant to 42 C.F.R. § 424.535(a)(1).

A supplier, such as Petitioner, must resubmit and recertify the accuracy of its enrollment information every five years or as requested by CMS, to maintain billing privileges and enrollment. 42 C.F.R. § 424.515(a) and (d). The supplier must submit the appropriate enrollment application to CMS with complete and accurate information and supporting documentation, within 60 calendar days of CMS's notification to resubmit and certify the accuracy of the supplier's enrollment application. 42 C.F.R. § 424.515(a)(2). CMS may revoke a supplier's billing privileges and enrollment in Medicare if the supplier fails to comply with enrollment requirements, including the requirement to submit requested documentation in 60 calendar days. 42 C.F.R. § 424.535(a)(1).

a. Facts

The undisputed facts show that on September 10, 2010, First Coast sent Petitioner a letter requesting that Petitioner complete and submit an enrollment application and supporting documentation in order for First Coast to revalidate and update Petitioner's Medicare enrollment information, as required by 42 C.F.R. § 424.515(d)(1). The letter instructed Petitioner that the information had to be submitted within 60 days and advised Petitioner that failure to submit the required information within the time permitted would result in revocation of Petitioner's billing privileges. CMS Ex. 1, at 10-11.

On October 8, 2010, Petitioner's President, Wendy Browne-Foye submitted a CMS-855B Medicare supplier enrollment application and additional documentation to First Coast. CMS Ex. 1, at 12-34. First Coast acknowledged receipt by letter dated October 20, 2010. CMS Ex. 1, at 35-36.

On November 11, 2010, First Coast informed Petitioner by letter that additional information was required to complete the application. The letter listed what the information and documents required. The letter also advised Petitioner that it needed to

submit the required information and documents within 30 days or the application could be closed and billing privileges revoked. CMS Ex. 1, at 37-40.

On December 15, 2010, First Coast notified Petitioner by letter that it was closing Petitioner's application because Petitioner had not submitted the requested information within 30 days. CMS Ex. 1, at 42-45, 89-90.

Petitioner sent additional information to First Coast on December 21, 2010. CMS Ex. 1, at 46-69. First Coast acknowledged receipt of Petitioner's revised application by letter dated January 4, 2010. CMS Ex. 1, at 70-71. On January 14, 2011, Petitioner submitted more information to First Coast. CMS Ex. 1, at 72-81.

On May 26, 2011, First Coast notified Petitioner by letter that Petitioner's Medicare "billing number and billing privileges" were being revoked effective June 25, 2011. First Coast stated that the revocation was based on Petitioner's failure to furnish complete and accurate information and all supporting documentation within 60 days of the notification to submit an enrollment application and supporting documentation. First Coast informed Petitioner that it was ineligible to apply for enrollment in Medicare for a one-year period, but noted that to correct the deficiencies and reapply to establish its eligibility Petitioner had 30 days to submit a CAP. First Coast also informed Petitioner that if it disagreed with First Coast's determination it could request reconsideration of First Coast's decision within 60 days. CMS Ex. 1, at 82-83.

On October 12, 2011, First Coast denied Petitioner's CAP because Petitioner did not identify an adverse action on its application. CMS Ex. 1, at 142-43. Petitioner submitted a letter to First Coast on October 21, 2011, which First Coast treated as a request for reconsideration of the revocation decision. On December 27, 2011, Quanita Jones, an Enrollment Appeals Analyst for First Coast, informed Ms. Browne-Foye that First Coast had received Petitioner's reconsideration request on October 25, 2011. Ms. Jones also sent a facsimile coversheet to Petitioner listing the sections of the enrollment application not yet completed and referencing additional documents that Petitioner needed to provide to First Coast by December 31, 2011, in order for First Coast to process Petitioner's enrollment application. CMS Ex. 1, at 2, 147-51.

Petitioner sent additional information by facsimile to Ms. Jones at First Coast on December 29, 2011. Petitioner also requested an extension to the first week of January 2012 to more fully respond. CMS Ex. 1, at 152-64. Ms. Jones also spoke to Ms. Browne-Foye on December 29, 2011, to review the missing information Petitioner still needed to provide. CMS Ex. 1, at 4. On January 3, 2012, after receiving information from Petitioner by facsimile, Ms. Jones again advised Petitioner of missing and incomplete information needed to complete the file. CMS Ex. 1, at 5, 165-67. Ms. Jones spoke with Ms. Browne-Foye again on January 5, 2012, to review the missing

information and to go over specific items that needed correction. Ms. Browne-Foye informed Ms. Jones that Petitioner had moved. The uncontested evidence shows that Ms. Browne-Foye sent additional documents to First Coast by facsimile on January 3, 6, 9, 10, 13, 18, and 19, 2012. CMS Ex. 1, at 168-201; CMS Ex. 2, at 1-3.

On January 25, 2012, Ms. Jones signed First Coast's reconsideration decision denying Petitioner's request to reconsider the revocation of Petitioner's billing privileges and enrollment, on grounds that Petitioner failed to timely submit required information and documentation. CMS Ex. 1, at 1-9. The reconsideration decision notified Petitioner that it had 60 days to request an Administrative Law Judge (ALJ) hearing. Even after the January 25, 2012 denial of the reconsideration request, however, Ms. Browne-Foye continued to send documents to First Coast. CMS Ex. 2.

b. Analysis

CMS asserts that Petitioner's Medicare billing privileges were properly revoked pursuant to 42 C.F.R. § 424.535(a)(1) based on Petitioner's failure to furnish CMS with a complete revalidation enrollment application and supporting documentation within 60 days of First Coast's notification that revalidation was necessary. Petitioner does not dispute that First Coast requested this information September 10, 2010. Petitioner also does not dispute that it failed to fully comply with First Coast's request within 60 days, or at any time prior to January 25, 2012, the date First Coast denied its reconsideration request, more than a year after the notice to submit enrollment application and supporting documents.

Pursuant to the regulations that control participation in Medicare, Petitioner was obliged to provide complete information to First Coast concerning its enrollment status. 42 C.F.R. § 424.515(a)(2). Petitioner does not dispute that it was still submitting requested information and documentation at the time First Coast issued its reconsideration decision. Accordingly, CMS had a basis for revocation of Petitioner's billing privileges and enrollment.

Petitioner argues that "fairness" should compel First Coast to continue to process its application. The argument is without merit. There is no requirement that CMS, or its contractor First Coast, keep an enrollment application open indefinitely. First Coast requested in September of 2010 that Petitioner submit an enrollment application and supporting documentation in order for First Coast to revalidate and update Petitioner's Medicare enrollment information. Petitioner had 60 days to do so. Petitioner not only failed to successfully complete its application in 60 days, it failed to do so for more than a year. To the extent that Petitioner's argument is for equitable relief, I am not authorized to provide equitable relief. *US Ultrasound,* DAB No. 2302, at 8 (2010). However, even if I had authority to grant equitable relief, the equities are not in Petitioner's favor. The

evidence shows that CMS and First Coast were very fair and reasonable in granting Petitioner multiple attempts to correct its application, well beyond the 60 days. Petitioner's inability to comply with the very specific requests of First Coast reflects a clear lack of diligence on Petitioner's part, or worse a clear lack of competence for an entity seeking to participate in Medicare.

Petitioner also argues that First Coast should continue to process its application because: First Coast has implemented an "unpublished, internal moratorium" on completing IDTF applications in South Florida; First Coast is not complying with Medicare enrollment timeframes in its review of CMS 855B applications; and on-site inspections are not being performed. Petitioner argues that First Coast should not be allowed to disregard Medicare enrollment timeframes to complete IDTF enrollments, yet on the other hand hold IDTF applicants firmly to other Medicare deadlines. Petitioner asserts that in four cases involving IDTF applications in South Florida, First Coast has not held itself to any timeframes whatsoever with regard to on-site inspections. Petitioner's arguments have no relevance or bearing upon the issues before me.

III. Conclusion

For the foregoing reasons, Petitioner's Medicare billing privileges and enrollment are revoked effective June 25, 2011, for noncompliance with enrollment requirements.

/s/
Keith W. Sickendick
Administrative Law Judge