Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Washington County Life Savings Crew, Inc.,
(NPI: 1295723658),

Petitioner

v.

Centers for Medicare & Medicaid Services.

Docket No. C-10-838

Decision No. CR2285

Date: November 19, 2010

DECISION REMANDING CASE

I deny the motion for summary disposition of the Centers for Medicare & Medicaid Services (CMS), because I find that the record is not adequate to support a final resolution. I therefore dismiss without prejudice and remand the case so that either CMS or its contractor, TrailBlazer Health Enterprises, Inc. (TrailBlazer), may develop the record and issue a reconsideration decision based on the facts.

I. Background

By letter dated July 2, 2010, Washington County Life Savings Crew, Inc. (Petitioner) appealed the decision of CMS to revoke Petitioner's Medicare enrollment and Medicare billing privileges. Hearing Request (HR). With its hearing request, Petitioner attached various documents including a copy of a CMS-855B Medicare enrollment application and correspondence between Petitioner and TrailBlazer.

On August 19, 2010, CMS filed its Exchange of Evidence/Argument and Motion for Summary Disposition (CMS MSD) in this matter. CMS proffered five exhibits (CMS

Exs. 1-5), which I admit in the absence of objection. Petitioner responded to the CMS motion (P. Response) on October 7, 2010. Petitioner also enclosed other documents and a list of exhibits referencing these documents as its Exhibits 1-13. CMS did not object to any of the materials submitted by Petitioner. I therefore admit all documents submitted into evidence for this decision.

In this case, the following facts are undisputed. On September 28, 2009, TrailBlazer sent Petitioner a notice letter stating that 42 C.F.R. § 424.515 –

> requires Medicare providers to verify accuracy of their enrollment information every five years in order to maintain Medicare billing privileges. Please submit a completed CMS 855 application within **60** calendar days from the date of this letter to avoid revocation of your Medicare billing privileges. This is the **only** notice you will receive regarding this request.

CMS Ex. 1, at 1 (emphasis in original). This notice letter was sent to Petitioner at 65 Park St., Abingdon, VA 24210. *Id.*

Subsequently, on December 18, 2009, TrailBlazer mailed a document with the subject line of "Notice of Possible Revocation of Medicare Billing Privileges" to Petitioner at the same address in Abingdon, VA. CMS Ex. 2. The document stated that 42 C.F.R. § 424.535(a)(6) provides that if a –

> provider or supplier fails to furnish complete and accurate information and all supporting documentation within 60 [] calendar days of the provider or supplier's notification from CMS, the Medicare billing [] privileges may be revoked. TrailBlazer requested revalidation on 9/28/2009, but has not received a response to our original request.

CMS Ex. 2, at 1.

Then, on February 9, 2010, TrailBlazer wrote Petitioner that its Medicare billing privileges were revoked effective January 17, 2010. CMS Ex. 3. This letter advising Petitioner of its revocation due to noncompliance with the enrollment requirements of 42 C.F.R. § 424.515 was addressed to Petitioner at P.O. Box 290184, Wethersfield, CT 06129. *Id.* This different address for Petitioner was a "correspondence/pay-to" address that CMS acknowledges that it had in its files. CMS Ex. 5, at ¶ 8.

The February 9, 2010 letter advised that, if Petitioner believed it could correct the deficiencies, Petitioner could submit a corrective action plan (CAP) within 30 days. CMS Ex. 3. In addition, the letter stated that if Petitioner believed that the determination

was not correct, it could request reconsideration before a contractor hearing officer within 60 days. *Id.*

On April 9, 2010, Petitioner submitted a Part B CAP Request Form. HR; P. Response. Petitioner contends that it was advised –

> to submit the application along with a copy of the letter and postmarked envelop and request an appeal by completing the Part B CAP Request Form. Explaining that the request for revalidation was received after the 30 day return date.

P. Response.

On the Part B CAP Request Form Petitioner stated –

> IN S/W PE REP MIKE ON 2/17 @ 214 IN REGARDS TO REVOKE LTR RECEIVED. HE STATED TO SEND IN THIS APPEAL ALONG WITH WITH THE REQUEST FOR REVALIDATION THAT WAS RECEIVED ON 02/02. THE REQUEST DTD 12/18/09 WAS MAILED TO THE PHYSICAL LOCATION AND RETURNED B/C THAT IS NOT THEIR CORRESPONDENCE ADDRESS. THE ENVELOP WAS HAND WRITTEN WITH THE CORRECT ADDRESS, P.O. BOX 290184 (POST MARKED 01/26/2010) AND REC'D ON 02/02 . . . AFTER THE 30DAY/60DAY WARNING. NOTICES PRIOR TO THIS WERE NOT REC'D IE. LTR REF. DATE 09/14 AND 09/28 IN BOTH NOTICES. I'VE ATTACHED THE APPLICATION (855B) ALONG WITH EFT SET-UP, SUPPLIER AGREEMENT AND W9 AS REQUESTED BY MIKE. REVOKING THE PROVIDER NUMBER WILL CREATE A HARDSHIP ON THIS VOLUNTEER ORGANIZATION AND I HOPE DUE TO THE DISCREPENCIES IN THE ADDRESS THAT YOU WILL CONSIDER REACTIVATING THE PROVIDER NUMBER. . . .

CMS Ex. 4. Petitioner thus asserts in this statement, as it does before me, that it did not receive the September revalidation request or the December warning letter because these documents were not sent to the correspondence address of record.

CMS construed the form submitted by Petitioner on April 9, 2010 as a CAP request and returned it to Petitioner without action on May 6, 2010 because CMS determined it was received past the 30 calendar days allotted for such submission. CMS MSD at 2-3. CMS asserts that Petitioner never submitted a reconsideration request (but does not ask that the appeal be dismissed). *Id.* at 3. CMS argued that, in any case, Petitioner's revocation must stand because "the credible evidence, which includes the undisputed material facts,

supports that Petitioner was not in compliance with the applicable requirements," so that CMS is "entitled to summary judgment." *Id.* at 7.

II. Issue, Findings of Fact, Conclusions of Law

A. Issue

The sole issue presented by the parties in this case is whether the undisputed facts demonstrate that the revocation of Petitioner's Medicare billing privileges was legally authorized.

B. Applicable Standard

CMS seeks summary disposition in the nature of summary judgment. The Departmental Appeals Board (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 discussion below.

1. CMS did not document that Petitioner failed to respond to the September 28, 2009 revalidation notice within 60 days of receipt.

2. CMS is not entitled to summary disposition on the record before me.

CMS argues that "[t]his case requires an application of the law to undisputed facts, and the issues in this case turn on the legal interpretation of the regulations. . . These regulations govern revocation of Medicare enrollment and billing privileges, and interpretation of the regulations and application of those regulations to the undisputed material facts are required to resolve this case. Accordingly, summary judgment is appropriate in this matter." CMS MSD at 5-6. The undisputed facts upon which CMS relies are that TrailBlazer sent Petitioner notice by its September 28, 2009 letter that Petitioner had to provide a completed CMS 855 application within 60 calendar days from the date of that letter (CMS Ex. 1); Petitioner did not submit the required information in that time; TrailBlazer again notified Petitioner by its December 18, 2009 revocation warning (CMS Ex. 2) that Petitioner had to meet the revalidation requirements or face revocation; and Petitioner did not timely respond to that notice. Petitioner argues that both the September 28, 2009 revalidation letter and the December 18, 2009 revocation warning were sent to a street address that CMS knew was not Petitioner's mailing address. HR.

Petitioner asserts, and CMS does not dispute, that as with several other volunteer ambulance companies in the very rural area, they only have a street address "for 911 purposes" but cannot receive mail there because no mailbox exists at Petitioner's physical location. Letter from Petitioner to TrailBlazer, April 8, 2010. Petitioner claims that, as a result, it did not receive any correspondence related to this matter until February 2, 2010 when the revocation notice was resent to Petitioner's mailing address of P.O. Box 290184, Wethersfield, CT 06129. P. Response. Then, on February 17, 2010, Petitioner received a notice indicating that Petitioner's billing privileges had been revoked. *Id*.

As I have noted, CMS does not dispute that it had the information about the "correspondence/pay-to" address and does not explain why that address was not used for TrailBlazer's mailings. Neither party has submitted a copy of Petitioner's original enrollment material in TrailBlazer's files, but I note that a CMS-855 application provides different sections for listing Petitioner's practice location information, correspondence address, and other contact information. The revalidation CMS-855 attached to Petitioner's hearing request shows the post office address as the correspondence address. This application form states that this address "will be used by the fee-for-service contractor if it needs to contact you directly." The "65 Park Street" address is listed as Petitioner's practice location.

CMS argues that Petitioner was responsible for notifying TrailBlazer of any change in location, but CMS does not allege that either Petitioner's practice location address or correspondence address has changed since Petitioner enrolled in the Medicare program. *See* CMS Ex. 5, at ¶7. Moreover, CMS does not dispute that neither the September 28, 2009 notice letter nor the December 18, 2009 revocation notice were ever sent to

Petitioner at the post office address prior to late January of 2010. According to CMS, on January 20, 2010 TrailBlazer received the December 18, 2009 revocation warning letter back as undeliverable, which evidently triggered the decision to send the next notice to the correspondence address, in Connecticut, on February 9, 2010. *Id.* at ¶¶ 8-9.

CMS does not provide any argument or explanation in response to Petitioner's account of the events. This silence leaves me without the benefit of CMS's reasoning as to the legal significance of Petitioner's account. I cannot agree with CMS's claim that it is undisputed that Petitioner failed to respond to a revalidation request within 60 days of receipt. Because that claim is central to CMS's basis for summary judgment, I must deny CMS's motion

3. Dismissal without prejudice and remand is appropriate action based on the record before me.

I turn next to determining what further process is appropriate to resolve this dispute. As noted, TrailBlazer did not provide a reconsideration hearing to Petitioner because it construed Petitioner's request to be only to submit a CAP, which TrailBlazer rejected as untimely because it was received more than 30 days (though less than 60 days) after the revocation notice. I conclude for the reasons explained below that Petitioner's April 9, 2010 request to TrailBlazer is best construed as seeking reconsideration. A reconsideration process will allow CMS to develop the record concerning disputed facts related to the mailing and receipt of the revalidation notice.

After speaking with TrailBlazer representatives, Petitioner submitted to TrailBlazer a statement on a Part B CAP Request Form provided by TrailBlazer on April 9, 2010. CMS Ex. 4. TrailBlazer treated this document as only a request for a CAP and rejected it because the document was received past the 30 calendar days allotted to submit a request for a CAP. A review of the actual statement made by Petitioner (set out above) suggests that Petitioner was arguing that the revocation was in error, as well as seeking to show present compliance by submitting the revalidation information. Thus, Petitioner states that it is sending "this appeal" with a statement that the notices sent before February 2010 were not received because of TrailBlazer's use of an incorrect address. These statements are in the nature of assertions of past error by TrailBlazer rather of current compliance by Petitioner.

The Board has explained how a CAP is distinct from the contractor reconsideration process:

> 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. [Medicare Program Integrity Manual (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. 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 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.

DMS Imaging, Inc., DAB No. 2313, at 7-8 (2010) (footnote omitted).

In the event that a provider or supplier requests both a CAP and a reconsideration simultaneously, the Medicare contractor is directed to "first process and make a determination on the CAP." MPIM Ch. 15, § 15.25. If the contractor does not accept the CAP, a contractor Hearing Officer (HO) who was not involved in the initial determination and CAP review is then to process the reconsideration and determine whether the initial revocation was justified. *Id*. "In reviewing an initial enrollment decision or a revocation, the HO 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)." *Id*.

On summary judgment, I must view the factual evidence in the light most favorable to the non-movant, here Petitioner, and draw all reasonable inferences from the evidence in that light. I cannot therefore assume the fact that a document is entitled "Part B CAP Request Form" controls over the substance of the document itself. If the CMS contractor had treated the CAP Request Form as a request for reconsideration, it appears the request would have been timely received. In any event, CMS does not address whether, if considered a request for reconsideration, such request was received within the required 60-day timeframe. Viewing the facts in the light most favorable to Petitioner, I conclude that Petitioner intended to request reconsideration, which TrailBlazer, the CMS contractor, failed to provide. Because Petitioner did not receive reconsideration at the contractor level, this appeal is effectively premature.

Pursuant to 42 C.F.R. § 498.78(b), I may remand "at any time before notice of hearing decision is mailed." I therefore dismiss without prejudice and remand the matter to CMS so that CMS or its contractor may review all relevant files and materials and take appropriate action.

III. Conclusion

I therefore deny the CMS motion for summary disposition. I remand this case to CMS for actions consistent with this decision and dismiss the appeal without prejudice to Petitioner. 42 C.F.R. § 498.78(b). Thus, Petitioner may file a new request for hearing before me if the decision on remand is unfavorable.

/s/
Leslie A. Sussan
Board Member