Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Velocity Healthcare Services, LLC,

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-213

Decision No. CR3849

Date: May 8, 2015

DECISION

The Centers for Medicare & Medicaid Services (CMS), through its administrative contractor, Novitas Solutions (Novitas), revoked Petitioner Velocity Healthcare Services, LLC's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(8). Novitas took this action after it determined that Petitioner submitted numerous claims for services that Medicare does not cover. Novitas imposed a three-year re-enrollment bar effective from the date of Petitioner's revocation, March 16, 2014. I find Novitas did not have a legal basis to revoke Petitioner's Medicare enrollment and billing privileges at the time of the action, and I must reverse CMS's determination.

I. Procedural Background

Health Integrity LLC (HI), a Medicare Zone Program Integrity Contractor, recommended that Novitas revoke Petitioner's Medicare enrollment and billing privileges, pursuant to 42 C.F.R. § 424.535(a)(1), due to Petitioner's "noncompliance with requirements of Medicare enrollment." CMS Ex. 9 at 4. Novitas thereafter revoked Petitioner's Medicare enrollment and billing privileges on February 14, 2014, effective March 16, 2014. Novitas identified 42 C.F.R. § 424.535(a)(8), rather than 42 C.F.R. § 424.535(a)(1), as the legal basis for revocation. Novitas justified the revocation explaining that Petitioner failed to abide by Medicare laws, rules, and program

instructions when it submitted a number of claims for services that Medicare does not cover. Novitas imposed a three-year re-enrollment bar. CMS Ex. 7 at 1-2.

On February 26, 2014, Petitioner submitted a Corrective Action Plan (CAP). In it, Petitioner offered to repay the amounts that it erroneously billed and promised that it was engaging in additional training for management and staff. CMS Ex. 6. Novitas rejected Petitioner's CAP in a May 1, 2014 letter. CMS Ex. 5.

Petitioner requested reconsideration on May 20, 2014. CMS Ex. 4. A hearing officer upheld Petitioner's revocation in an August 19, 2014 reconsidered determination and continued to cite 42 C.F.R. § 424.535(a)(8) as the revocation basis. CMS Ex. 1. The hearing officer explained that:

> Specifically on February 14, 2014, Novitas Solutions revoked [Velocity Healthcare Services, LLC's] billing privileges effective March 16, 2014. With its authorized official's signature on Medicare enrollment form 855B, Velocity Healthcare Services LLC agreed to abide by Medicare laws, rules, and program instructions. Velocity Healthcare Services LLC failed to abide by these laws, rules, and program instructions when it submitted claims indicating that it had transported beneficiaries either to or from a residence to hospital, but data analysis indicates that the beneficiaries had no inpatient or non-CMHC outpatient claim for the same date of service as that of the ambulance transport. There is however, a CMHC claim for the same date of service as that of the ambulance transport. Medicare does not cover ambulance transport to or from a CMHC.

CMS Ex. 1 at 1. The hearing officer determined that Novitas could not remove Petitioner's revocation because Petitioner "knowingly submitted claims for services that do not meet Medicare regulations," and it had "not provided evidence to show full compliance with the standards for which" it was revoked." CMS Ex. 1 at 2.

Petitioner filed a timely request for hearing on October 14, 2014. The case was assigned to me for hearing and decision on November 6, 2014, and I issued an Acknowledgment and Pre-hearing Order (Order) on that date. In the Order, I set dates for the parties to exchange evidence and arguments. I informed the parties that I would only schedule a hearing if a party filed written direct testimony for a witness, and the opposing party requested to cross-examine the witness. Order ¶ 10.

On December 11, 2014, CMS filed a motion for summary judgment and pre-hearing brief (CMS Br.), along with 14 exhibits (CMS Exs. 1-14). CMS listed two witnesses but only provided written direct testimony for one witness. *See* CMS Ex. 2. Petitioner neither requested to cross-examine the witness for whom CMS provided written direct testimony nor objected to CMS's exhibits. I admit CMS Exs. 1-14.

On January 14, 2015, Petitioner filed a cross-motion for summary judgment and pre-hearing brief (P. Br.), along with 18 exhibits (P. Exs. 1-18). Petitioner listed two witnesses and provided sworn statements for both. *See* P. Exs. 2, 10, 11. CMS neither requested to cross-examine the witnesses nor objected to Petitioner's exhibits. I admit P. Exs. 1-18.

I informed the parties that I would only conduct a hearing if either party submitted affidavits of direct testimony from a witness and the opposing party wished to cross-examine that witness. Pre-hearing Order ¶ 10. I also informed the parties that they must submit, as part of their pre-hearing exchange and in addition to any motion for summary judgment, "a brief addressing all issues of law and fact," as well as "all proposed exhibits" and "each proposed witness," including written direct testimony for their witnesses. Pre-hearing Order ¶¶ 4, 8. I do not find it necessary to convene an in-person hearing here because neither Petitioner nor CMS sought to cross-examine any witnesses. Prehearing Order ¶ 11; *Marcus Singel, D.P.M.*, DAB No. 2609, at 5-6 (2014). Accordingly, the record is closed. Having considered all the documentary evidence, I issue this decision based on the full merits of the written record and find it unnecessary to rule on summary judgment. Order ¶¶ 10, 11.

II. Analysis

A. Issues

1. Whether CMS had a legal basis to revoke Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(8); and

2. Whether my review is limited to the sole revocation basis that CMS identified in its reconsidered determination.

B. Applicable Law

A provider or supplier must be enrolled in the Medicare program and have a billing number in order to be eligible to receive payment for services rendered to a Medicare-eligible beneficiary. 42 C.F.R. § 424.505. "Suppliers" include physicians, other practitioners, and "entities (other than providers of services) that furnish[] items or services . . . ."[1] 42 U.S.C. § 1395x(d).

CMS may revoke a supplier's Medicare enrollment and billing privileges if, among other things, the supplier "submits a claim or claims for services that could not have been furnished to a specific individual on the date of service." 42 C.F.R. § 424.535(a)(8) (2014).[2] The regulation also includes a non-exhaustive list of the kinds of services to which it applies, i.e., of services that could not have been provided to a specific individual on a specific date: "situations where the beneficiary is deceased, the directing physician is not in the State or country when services were furnished, or when the equipment necessary for testing is not present where the testing is said to have occurred." *Id.*; *see also* 73 Fed. Reg. 36,448, 36,455 (June 27, 2008).

The Secretary of the Department of Health and Human Services (the Secretary) explained in the preamble to subsection 424.535(a)(8):

> We have found numerous examples of situations where a physician claims to have furnished a service to a beneficiary more than a month after their recorded death, or when the provider or supplier was out of state when the supposed services had been furnished. In these instances, the provider has billed the Medicare program for services *which were not provided* and has submitted Medicare claims for services to a beneficiary who could not have received the service which was billed.

73 Fed. Reg. at 36,455 (emphasis added).

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[1] "Providers" include hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, and hospice programs. 42 U.S.C. § 1395x(u); 42 C.F.R. § 400.202.

[2] I have quoted the text of the applicable regulation in effect at the time CMS revoked Petitioner's enrollment and billing privileges. As I discuss *infra*, CMS has subsequently broadened the bases for revoking a supplier's enrollment and billing privileges under this subsection.

C. Findings of Fact and Conclusions of Law

Petitioner provides ambulance services and is a "supplier" under the Social Security Act and implementing regulations. *See* 42 U.S.C. § 1395x(d); 42 C.F.R. § 400.202. Petitioner "transport[s] mentally challenged beneficiaries from point A to point B according to the order of reasonable medical necessity written by their physicians." P. Br. at 5. On November 26, 2013, CMS notified Petitioner that Petitioner received a payment in error due to four claims that were "not considered medically necessary . . . based on either the documentation that was submitted or the failure by the physician/supplier to furnish information that was requested to support the claim." CMS Ex. 12. On November 29, 2013, CMS again notified Petitioner that Petitioner received an overpayment, identified 16 more claims, and cited the same basis for each claim that it identified for the four previous claims. CMS Ex. 11. Petitioner requested a redetermination of several of the overpayments and identified an alleged medical necessity for the transports. CMS Ex. 10. Thereafter, CMS revoked Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(8). CMS Ex. 7.

1. *CMS lacked the legal basis to revoke Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(8).*

CMS is authorized to revoke a supplier's billing privileges pursuant to subsection 424.535(a)(8) where the supplier has billed for services that "could not have been furnished to a specific individual on the date of service." The Departmental Appeals Board (Board) examined the meaning of subsection 424.535(a)(8) in *Louis J. Gaefke, D.P.M.*, DAB No. 2554 (2013), and *Howard B. Reife, D.P.M.*, DAB No. 2527 (2013), both of which CMS relies on here. In *Reife*, the Board upheld the revocation of a supplier who submitted claims for "services that were claimed as either having been rendered to beneficiaries who had died before the dates of service or performed on both feet of beneficiaries who each had one leg amputated." DAB No. 2527, at 3. In *Gaefke*, the Board sustained the revocation where the supplier billed for services to "eight beneficiaries who had died before the dates of service, and eight additional claims for debriding six or more toenails on eight beneficiaries who had had one foot amputated prior to the dates of service." DAB No. 2554, at 3. Neither party argued that they had actually furnished the services in question, nor could they, a supplier can neither perform services for a deceased individual nor on an amputated leg.

Unlike the Board decisions in *Gaefke* and *Reife*, here there is no dispute that Petitioner furnished the services in question. P. Br. at 3; CMS Br. at 2. Petitioner undoubtedly provided transportation services for the 20 individuals identified in CMS Exs. 11 and 12. CMS cannot argue that Petitioner billed for services that "could not have been provided," because CMS's own contractor acknowledges that Petitioner did provide the ambulance transportation services. CMS Ex. 9 at 3 ("The supplier transported beneficiaries from

residential locations to Partial Hospitalization Programs (PHP) and/or Community Mental Health Centers."). Nowhere did CMS or its contractors allege that Petitioner did not provide the services in question; rather, both the initial and reconsidered determinations claimed that Petitioner "knowingly submitted claims for services that do not meet Medicare regulations." *See, e.g.*, CMS Ex. 1 at 2. HI concluded that the services Petitioner provided are not *reimbursable* under 42 C.F.R. § 410.40, yet there is no question Petitioner provided ambulance services to the beneficiaries in question. *See* CMS Exs. 9, 11, 12. The issue of whether Medicare could legally *reimburse* Petitioner for providing ambulance services is materially different from the issue of whether Petitioner could possibly *furnish* those services. Here, CMS identified subsection 424.535(a)(8) as the basis for revocation, which only permitted it to revoke Petitioner's enrollment and billing privileges for billing for services Petitioner could not have furnished, rather than services for which Medicare could not reimburse Petitioner under Medicare coverage requirements.[3]

Recent amendments to the regulation support my finding of an improper revocation of Petitioner's enrollment and billing privileges under subsection 424.535(a)(8). In a Final Rule that the Department of Health and Human Services published on December 5, 2014 (on behalf of CMS), the Secretary significantly modified the text of subsection 424.535(a)(8) to include, for the first time, the conduct of which CMS accuses Petitioner in this case. *See* 79 Fed. Reg. 72,500 (December 5, 2014) (effective February 3, 2015). CMS announced a new paragraph, subsection 424.535(a)(8)(ii), in addition to the existing language (now found at (a)(8)(i)), which permits CMS to revoke a supplier's enrollment and billing privileges where "CMS determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements." *Id.* at 72,532. In the preamble to the revised subsection (a)(8)(ii), CMS concedes that it "currently ***does not have the ability to revoke*** a provider or supplier's billing privileges based on ***a pattern or practice of submitting noncompliant claims, hence the need for § 424.535(a)(8)(ii)***." *Id.* at 72,515 (emphasis added). Yet, a pattern of submitting noncompliant claims is precisely the factual basis upon which CMS revoked Petitioner's billing privileges. CMS Br. at 7 ("Novitas determined that Petitioner submitted 20 claims for ambulatory services, which did not conform to the Medicare laws, regulations, and program instructions for ambulance services . . . ."). Because the Secretary's explanatory comments clarify that subsection 424.535(a)(8) did not encompass Petitioner's conduct at the time of Novitas's action, I do not sustain CMS's revocation of Petitioner's enrollment and billing privileges on that basis.

[3] A separate appeals process is available to Medicare suppliers to challenge reimbursement determinations regarding their claims. *See* 42 C.F.R. pt. 405.

2. *I am bound by the sole basis for revocation that Novitas, on behalf of CMS, cited in the reconsidered determination and cannot consider additional bases.*

CMS argues that "the issue on appeal is whether CMS[] has a legitimate basis to revoke Petitioner's Medicare billing privileges and enrollment in Medicare." CMS Br. at 6. CMS is partially correct – the issue on appeal is whether CMS has a legitimate basis *pursuant to 42 C.F.R. § 424.535(a)(8)* to revoke Petitioner's billing privileges because that is the only basis CMS offered in the reconsidered determination. *See* 42 C.F.R. § 498.5(*l*)(2) (granting appeal rights from a reconsidered determination).

Though CMS revoked Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(8) (CMS Ex. 1), its argument that Petitioner "was not in compliance with Medicare program requirements" invokes a different subsection of the regulations. *See* CMS Br. at 1. Subsection 424.535(a)(1) does give CMS the authority to revoke a supplier's billing privileges where it fails to comply with the enrollment requirements for Medicare. However, that is not the basis on which CMS revoked Petitioner's enrollment and billing privileges in this case. HI did *recommend* that Novitas revoke Petitioner's enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(1). CMS Ex. 9 at 2. But Novitas chose a different, singular basis to revoke Petitioner's billing privileges, which was 42 C.F.R. § 424.535(a)(8), and cited only that basis in both the initial and reconsidered determinations. *See* CMS Exs. 1, 7. CMS does argue in its brief before me that 42 C.F.R. § 424.535(a)(1) justifies Petitioner's revocation. CMS Br. at 3. It is now well-established that I am limited to the revocation basis cited in Petitioner's reconsidered determination; therefore, I cannot consider CMS's argument that revocation is justified under subsection 424.535(a)(1). *See Orthopedic Surgery Assoc.*, DAB No. 2594, at 7 (2014); *Keller Orthotics, Inc.*, DAB No. 2588, at 7 (2014); *Neb Group of Arizona LLC*, DAB No. 2573, at 7 (2014).

III. Conclusion

I find CMS and its contractor did not have a legal basis, on March 16, 2014, for revoking Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(8), because Petitioner actually furnished the ambulance services in question. I therefore reverse Petitioner's revocation and the three-year re-enrollment bar that CMS imposed on it.

/s/
Joseph Grow
Administrative Law Judge