Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Proteam Healthcare, Inc.
Docket No. A-14-97
Decision No. 2658
September 28, 2015

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Proteam Healthcare, Inc. (Proteam) appeals an Administrative Law Judge (ALJ) decision affirming the determination by the Centers for Medicare & Medicaid Services (CMS) to revoke Proteam's enrollment in Medicare as a home health agency. *Proteam Healthcare, Inc.*, DAB CR3246 (2014) (ALJ Decision).

CMS ultimately contended here that Proteam's inclusion of the identification number of the wrong physician on certain claims in itself constituted noncompliance with Medicare enrollment requirements and formed a sufficient legal basis to revoke Proteam's Medicare billing privileges. We conclude that CMS's position is inconsistent with the plain language of the regulations and with multiple published statements by CMS about the scope of its revocation authority. CMS adopted specific regulations governing when false information submitted in claims would trigger revocation, and stated in a preamble that such revocation authority would not extend to accidental billing errors. Furthermore, in recently adding regulatory authority to revoke in certain situations involving a pattern or practice of submitting non-compliant claims, CMS expressly stated that the preexisting provisions governing revocation (which includes the one on which it relied here) did not authorize it to revoke for noncompliant billing alone. Moreover, the regulatory language does not establish that error in billing in itself constitutes a violation of an "enrollment requirement."

For these and other reasons explained below, we conclude that the general regulatory provision addressing noncompliance with enrollment requirements does not extend to revoking based on errors in claims, where CMS has not shown abusive billing or patterns of noncompliant claims, in the absence of other evidence of noncompliance with enrollment requirements.

We therefore reverse the ALJ Decision.

Factual and Procedural Background[1]

Proteam enrolled in Medicare as a home health agency (HHA) in November 2005. CMS Ex. 20, at 1-2. By letter dated June 24, 2013, CMS, through a contractor, notified Proteam that Proteam's Medicare billing privileges and corresponding provider agreement were being revoked pursuant to 42 C.F.R. § 424.535(a)(1). CMS Ex. 1. The revocation arose from a review of claims relating to 12 patients. The revocation letter stated:

> Proteam Healthcare Inc. failed to abide by the Medicare laws, regulations and program instructions when it failed to obtain a valid order from a physician when it submitted claims using Dr. [I]'s NPI [National Provider Identifier] for Medicare patients from November 1, 2009 through October 21, 2012. Dr. [I] signed an attestation indicating that she has neither provided any Part B services to or referred these beneficiaries for home health services provided by Proteam Healthcare Inc. . . .

Id. at 1.[2] The letter also referenced a certification statement signed by Proteam's authorized official as part of its 2004 enrollment application, agreeing to abide "by the Medicare laws, regulations, and program instructions that apply to this provider." *Id.*; *see also* CMS Ex. 20, at 3-4. The letter further advised that Proteam could challenge the revocation by requesting reconsideration or could submit a corrective action plan (CAP) to show that Proteam had corrected the deficiency and was now in compliance with the Medicare enrollment requirements. CMS Ex. 1, at 2.

In response, Proteam submitted a CAP in which it admitted failing to "have a system in place to monitor and routinely review all physician orders and verify the accuracy of the Physician NPI prior to submission of billing." CMS Ex. 2, at 2. The CAP then outlined steps Proteam had taken to address this failure, including repaying the disputed claims. *Id.* at 3. According to Proteam, for the claims at issue, Dr. I initially saw the patient, but a different physician later assumed responsibility for the patient's care, and Proteam's staff "did not address the change in physician and correct the NPI number prior to billing." *Id.* at 2.

After CMS denied the CAP, Proteam requested reconsideration of the revocation. In its request, Proteam alleged that it did have valid physician orders, albeit from physicians other than Dr. I, for each of the claims at issue. CMS Ex. 3, at 6. Proteam contended that it "simply made a scrivener's error when failing to insert the NPI of the correct ordering

[1] The summary in this section is drawn from the ALJ Decision and undisputed facts in the record and is not intended to replace, modify, or supplement any findings of fact made by the ALJ.

[2] We replace individuals' names with initials for privacy purposes.

physician when it submitted information to its billing agency." *Id.* Proteam also argued that submitting claims "with the NPI of a physician other than the physician who signed the valid order" amounted to only a "failure to satisfy a condition for payment," rather than a violation of the enrollment requirements, and hence did not justify CMS's revocation determination. *Id.*

CMS issued an unfavorable reconsideration decision revoking Proteam's billing privileges and terminating its provider agreement under section 424.535(a)(1). CMS Ex. 3, at 9-11. The reconsideration stated that Proteam "did not abide by Medicare law, regulations, and program instructions when it submitted claims for Medicare patients for home health services without a valid physician certification/plan of care." *Id*. at 10. The decision reiterated that Dr. I had initialed the names of 12 beneficiaries that she denied having treated or referred. *Id.* The reconsideration concluded that "Proteam has argued against these allegations but with no proof that combats such allegations." *Id.*

Proteam timely requested a hearing before an ALJ to challenge CMS's determination. ALJ Decision at 3. Neither party sought to present any witness testimony, and the ALJ therefore proceeded to decision on the written record. *Id*. at 4.

Applicable authorities and standard of review

The Medicare program provides health insurance benefits to persons who qualify based on age or disability. Social Security Act (Act) § 1811. CMS, a component of the Department of Health and Human Services (HHS), administers Medicare and issues regulations governing participation. In order to receive Medicare payment for services furnished to program beneficiaries, a medical provider, including a home health agency like Proteam, must be "enrolled" in Medicare. 42 C.F.R. § 424.505. Contractors process claims for Medicare coverage, handle the enrollment system, and perform other program functions. *See* Act § 1842.

A provider or supplier seeking billing privileges must submit enrollment information to the appropriate contractor on the applicable enrollment application for review. When that process is successfully completed, CMS enrolls the provider or supplier into the Medicare program. 42 C.F.R. § 424.510(a). CMS may revoke a provider or supplier's Medicare billing privileges for a variety of reasons including if it 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 . . . ." 42 C.F.R. § 424.535(a)(1).[3]

[3] The regulation read as quoted when the revocation issued. As of February 3, 2015, the regulation refers instead to "enrollment requirements described in this subpart P." 79 Fed. Reg. 72,500, 72,532 (Dec. 5, 2014).

"Home health services" are defined as specified "items and services furnished to an individual, who is under the care of a physician . . . under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician . . ." and generally provided "on a visiting basis in a place of residence . . . ." Act § 1861(m). Such services may include skilled nursing care, skilled therapies, and medical supplies. *Id.*

A "home health agency" must be "primarily engaged" in providing skilled nursing and therapy, must meet the "conditions of participation in section 1891(a)" of the Act as well as other conditions of participation specified in regulations, and must meet other requirements such as applicable licensure and bonding provisions. Act § 1861(o).

Home health services are paid under a prospective payment system in amounts determined by CMS. Act § 1895. The Act prohibits any payment for such services unless a physician (or listed practitioner) not affiliated with the HHA certifies that home health services "are or were required because the individual is or was confined to his home . . . and needs or needed skilled nursing care" or other home health services. Act § 1814(a)(2)(C)(requirement for certifications). The physician certification must show that the needed services are provided under a plan of care established and reviewed by the physician under whose care the individual remains and with whom the individual has had a face-to-face encounter. *Id.; see also* Act § 1835(a)(2)(A)(parallel procedure for payment of HHA claims).

Regulations at 42 C.F.R. § 424.22 and 484.18 contain implementing provisions requiring that an individual receiving home health services be under the care of a physician who establishes and reviews their plan of care and with whom the HHA is to consult about any changes. *See also* Medicare Benefit Policy Manual, CMS Pub. 100-102, Ch. 7 (Home Health Services), § 30.5.1.1. Section 424.507(b)(1) in subpart P specifically requires HHAs to identify the ordering or certifying physician by name and NPI.

ALJ Decision

The ALJ found that Proteam initially admitted filing claims for services to 12 beneficiaries with an NPI for a physician (Dr. I) who denied providing orders for these beneficiaries. ALJ Decision at 6. The ALJ further found that Proteam later submitted documentation showing that physicians other than Dr. I had ordered the home health services. *Id.,* citing CMS Exs. 3, 7-19.

The ALJ nevertheless upheld CMS's revocation determination on the ground that Proteam's continued enrollment "was subject to its full compliance with all Medicare laws, regulations, and program instructions." *Id*. at 7. In so deciding, the ALJ relied on

the language of the regulation authorizing revocation for noncompliance with "the enrollment requirements described in this section, or in the enrollment application applicable for its provider or supplier type." *Id*. at 6, quoting 42 C.F.R. § 424.535(a) (emphasis omitted).

Proteam's enrollment application included a certification statement which required an authorized signature and which was to be "used to officially notify the provider of additional requirements that must be met and maintained in order for the provider to be enrolled in the Medicare program." CMS Ex. 20, at 3. Among the items then listed in the certification statement are the following:

> 3.) I agree to abide by the Medicare laws, regulations, and program instructions that apply to this provider. The Medicare laws, regulations, and program instructions are available through the Medicare contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including. but not limited to, the Federal anti-kickback statute and the Stark law), and on the provider's compliance with all applicable conditions of participation in Medicare.
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> 6.) I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

Id. The ALJ read this certification as sufficient to inform Proteam that any deviation from a Medicare law, regulation or program instruction would necessarily constitute noncompliance with an applicable enrollment requirement, and hence authorize revocation. ALJ Decision at 7. The ALJ rejected Proteam's contention that a clear dividing line existed between enrollment requirements and conditions for payment, concluding that the certification "at the center of this case expressly binds the participation and payment requirements together." *Id*.

The ALJ recognized that Proteam asserted that providing an incorrect NPI on claims "was merely a mistake." *Id*. at 8. Nevertheless, the ALJ concluded that, "even an unintentional error with regard to claims may serve as a basis for revocation if the relevant regulation does not require fraudulent or dishonest intent." *Id*., citing *Louis J. Gaefke, D.P.M.*, DAB No. 2554, at 7 (2013). While quoting the Board's comment in another case that "[r]epeatedly making" the same errors "reduces their credibility as 'accidental' and establishes a pattern of improper billing that suggests a lack of attention to detail," the ALJ concluded that CMS was not required to "assert or prove" here that Proteam's actions "involve fraud." ALJ Decision at 9, quoting *Howard B. Reife, D.P.M.*, DAB No. 2527, at 6 (2013).

Issues on appeal and arguments of the parties

Section 424.507(b)(1)(ii) requires that, to be paid, a HHA's claim must identify the "ordering/certifying physician" by "his or her NPI." Proteam concedes that it entered the wrong physician NPI on 12 claims for payment, but contends that the entries were clerical errors and that had valid certifications from other physicians. Request for Review (RR) at 2. CMS originally made allegations suggesting possible wrongdoing beyond mere error. *See, e.g.,* CMS Pre-Hearing Br. at 2 (alleging use of the NPI of the physician who denied seeing the patients involved 28 beneficiaries over multiple certification periods); CMS Ex. 3, at 10 (asserting that revocation resulted from analytical review of billing practices to identify "questionable or suspicious patterns that could indicate fraudulent activity" and that Dr. I initialed "attestation forms identifying fraudulent activity"). The ALJ concluded, however, that "CMS slightly adjusted its factual basis for the revocation" to base it solely on Proteam providing the NPI of a physician who did not order the home health services in question. ALJ Decision at 8, citing CMS Ex. 3, at 9. CMS has not appealed this conclusion, and we therefore limit our discussion to that alleged circumstance, i.e., entry of erroneous NPI information on HHA claims in the absence of any determination of fraud, intentional error or negligence, or evidence of noncompliance with specific enrollment requirements.

In that context, Proteam contends that mistakenly entering the wrong NPI is not a sufficient ground for revocation. RR at 6. Proteam argues that *Gaefke* does not support a revocation for accidental error in claiming under section 424.535(a)(1) but rather interprets the specific language of section 424.535(a)(8), authorizing revocation for abuse of billing privileges by submitting "a claim or claims for services that could not have been furnished to a specific individual on the date of service." RR at 6-7.

Proteam further contends that CMS's position that the certification statement contained in all Medicare enrollment applications renders "every deviation by a provider or supplier from any Medicare law, regulation, or program instruction . . . grounds for revocation of billing privileges pursuant to 42 C.F.R. § 424.535(a)(1) is untenable." RR at 8. Accepting that view, according to Proteam, would make the listing of all the other grounds for revocation in section 424.535(a) "meaningless" since they all involve some deviation from a law, regulation or instruction that could be viewed as already covered by the noncompliance language if so broadly interpreted. *Id*. Finally, Proteam reiterates its argument to the ALJ that the inclusion of a correct NPI on each home health services claim is merely a condition of payment of the claim rather than an enrollment or participation requirement for the HHA. RR at 9.

CMS responds that Proteam "concedes that its 'scrivener's error was a violation of a condition for payment – not a violation of an enrollment requirement." CMS Br. at 6, quoting RR at 9. CMS contends, however, that Proteam's signature on its enrollment application amounted to a promise to "'abide by the Medicare laws, regulations and

program instructions that apply to' all home health agencies, under penalty of revocation of enrollment." CMS Br. at 7. CMS concludes that, therefore, violation of such laws, regulations or instructions also breaches this enrollment certification.

Moreover, CMS asserts that the NPI requirement of section 424.507 is an enrollment requirement by virtue of its inclusion in subpart P of Part 424. *Id*. at 6. CMS points to section 424.500 as defining the scope of subpart P, as follows:

> The provisions of this subpart contain the requirements for enrollment, periodic resubmission and certification of enrollment information for revalidation, and timely reporting of updates and changes to enrollment information. These requirements apply to all providers and suppliers. . . . Providers and suppliers must meet and maintain these enrollment requirements to bill either the Medicare program or its beneficiaries for Medicare covered services or supplies.

Id. at 3, quoting section 424.500 (emphasis omitted). CMS states that, while it agrees with the ALJ's "reasoning" in relying on the certification statement in Proteam's enrollment application, it still contends on appeal that section 424.500 "expressly designated" section 424.507, along with every provision of subpart P, as an enrollment requirement. CMS Br. at 3-4. Thus, CMS argues that we should find that Proteam was not in compliance with an enrollment requirement and was subject to revocation on this basis as well as based on the certification statement.

Analysis

We note first the narrowness of the basis on which this revocation action now stands before us on appeal. The specific issue before us is whether section 424.535(a)(1) established that submitting claims with inaccurate NPI information was in itself a basis for revocation. We therefore need not address what other conduct related to billing or claiming might be sufficient to authorize revocation under section 424.535(a)(1) or any other regulation. We are not required to decide more generally which deviations from a Medicare rule or instruction may constitute noncompliance under that regulation. We also need not resolve CMS's general claim that the fact that subpart P contains enrollment requirements implies that every provision in subpart P constitutes such an enrollment requirement.

We find, as detailed in the following section, that CMS has consistently treated section 424.535(a)(1) as inapplicable to mere errors in claiming and has stated that its authority to revoke for inaccurate billing is set out in other provisions. We further conclude in the following section that erroneous billing does not constitute noncompliance with enrollment requirements.

1. *CMS's regulatory language and history show that section 424.535(a)(1) does not authorize revocation based solely on submission of erroneous claims.*

CMS relied solely on the authority of section 424.535(a)(1) for its action in this case. That provision, as noted above, authorizes revocation of providers "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[.]" The language does not specifically refer to claims submission. Other subsections of the same regulation do specifically discuss situations in which improper claims activity may lead to revocation. We therefore look at the structure and history of the regulation to determine whether section 424.535(a)(1) should be interpreted as extending to submission of erroneous claims, based on nothing more than error in entering required information on a claim.

The revocation regulations specify certain "reasons for revocation" in section 424.535(a). CMS stated, in the preamble to the proposed rule adopting the revocation provisions, that it intended to consider various factors in applying the reasons, including balancing program and beneficiary risk and beneficiary access to care. 71 Fed. Reg. 20,754, 20,761 (Apr. 21, 2006). CMS explained that the revocation reasons were generally similar to reasons that initial enrollment could be denied. *Id*. Under section 424.535(a)(1), CMS contemplated that a provider might face revocation if it is determined "to be out of compliance with the Medicare enrollment requirements outlined in subpart P including the failure to report changes to enrollment information timely or failure to adhere to corrective action plans[.]" *Id*. The Medicare Program Integrity Manual (MPIM) instructs contractors about when to use section 424.535(a)(1) as the reason for revocation, such as when a provider no longer has a business location or has not paid assessed user fees. MPIM, Ch. 15, § 15.27.2.A (eff. Jan. 28, 2014). Other appropriate situations for use of this provision include, among others, lack of appropriate license, failure to meet the regulatory requirement for the relevant specialty, lack of valid social security numbers, failing to submit all required documentation within 60 days of being notified to submit an enrollment application, and otherwise not meeting "general enrollment requirements." *Id*. Although the circumstances listed in the MPIM are not necessarily exclusive, it is noteworthy that the MPIM provides no guidance about any situation in which submission of a claim containing incorrect information would be a reason for a contractor to revoke under section 424.535(a)(1).

Section 424.535(a)(8) authorizes revocation when a provider submits a claim for services that could not have been furnished as described (such as situations where the beneficiary was deceased or away at the claimed time of services). CMS proposed adding this reason in 2007 to "expand" revocations with a "new revocation authority" in line with other existing authorities. 72 Fed. Reg. 9479, 9485 (Mar. 2, 2007). CMS explained that Medicare "ought not to be forced to rely solely on its authority to deny claims on a piecemeal basis" and ought to be able to protect public funds from "providers whose

motives and billing practices are questionable, at best," and criminal at worst. *Id*. The implication of this explanation is that the preexisting authority under section 424.535(a)(1) did not empower CMS to take revocations based on claims for services that could not possibly have provided as claimed.

Commenters on the proposal to add submitting such claims as a basis for revocation expressed concern that contractors would implement the new policy "too widely." 73 Fed. Reg. 36,448, 36,455 (June 27, 2008). CMS responded as follows:

> CMS, not a Medicare contractor, will make the determination for revocation under the authority at § 424.535(a)(8). We will direct contractors to use this basis of revocation after identifying providers or suppliers that have these billing issues. 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 service to a beneficiary who could not have received the service which was billed. **This revocation authority is not intended to be used for isolated occurrences or accidental billing errors**. **Rather, this basis for revocation is directed at providers and suppliers who are engaging in a pattern of improper billing.**
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> . . . We believe that it is both appropriate and necessary that we have the ability to revoke billing privileges when services could not have been furnished by a provider or supplier. **We recognize the impact that this revocation has, and a revocation will not be issued unless sufficient evidence demonstrates abusive billing patterns. Accordingly, we will not revoke billing privileges under § 424.535(a)(8) unless there are multiple instances, at least three, where abusive billing practices have taken place**. . . .

Id. (emphasis added). This explanation would make little sense if CMS were reading the general provision on revocation for noncompliance with enrollment requirements (section 424.535(a)(1)) as already authorizing revocation for simply submitting one or more erroneous claims.

Neither the plain language of section 424.535 (read as a whole) nor the regulatory history described above communicates that simple error on one or more claims would potentially trigger revocation under section 424.535(a)(1) for noncompliance with requirements for

the content of claims. Thus, we find no basis for concluding that section 424.535(a)(1) was intended to encompass the filing of erroneous claims, without more, as a ground for revocation.

Our conclusion as to the scope of section 424.535(a)(1) is further reinforced by the quoted discussion in the preamble to the final rule adopting section 424.535(a)(8). In addressing concerns that its new authority to revoke for abusive claims might be applied overbroadly, CMS stressed that even that authority would not be used for "isolated occurrences or accidental billing errors" but rather to remove providers where evidence shows abusive billing patterns. 73 Fed. Reg. at 36,455. This reassurance was further bolstered by the assertion that revocations under section 424.535(a)(8), unlike those under section 424.535(a)(1), would be made by CMS itself rather than by its contractors in the first instance. *Id*. It is not possible to reconcile these assertions by CMS with the view that contractors themselves already had authority to revoke a provider under section 424.535(a)(1) simply for submitting one or more erroneous claims without more..

Our interpretation is confirmed by more recent statements by CMS about the scope of its revocation authority. CMS added an additional revocation basis relating to abusive billing effective February 2015 as section 424.535(a)(8)(ii) (the prior language becoming 424.535(a)(8)(i)). Under the added provision, CMS may revoke where it finds a "pattern or practice" of improper claims with a list of considerations including the percentage of and reasons for claims denials. In finalizing this new authority, CMS expressly stated (in response to a comment that CMS already had adequate tools to revoke the billing privileges of those that defraud the program) that CMS did not currently "have the ability to revoke a provider or supplier's billing privileges based on a pattern or practice of submitting non-compliant claims, hence the need for § 424.535(a)(8)(ii)." 79 Fed. Reg. 72,500, 72,515 (Dec. 5, 2014). The explicit statement by CMS that, prior to 2015, it lacked authority to revoke providers' participation in Medicare based on having submitted multiple non-compliant claims directly supports our reading of section 424.535(a)(1) as not providing such authority.

Our reading is also consistent with usual canons of regulatory interpretation. Where a rule provides specific details in one provision, those specifics would normally control over more general language elsewhere in the rule. *See, e.g., Morales v. TVA*, 504 U.S. 374, 384 (1992) ("[I]t is a commonplace ... that the specific governs the general[.]"). Even if "noncompliance" might be read to encompass filing of any erroneous claim, therefore, it would not be reasonable to read it so where, as here, the scope of revocation authority for erroneous claims has been specifically articulated.

2. *We do not limit CMS's authority to revoke under other subsections or to apply section 424.535(a)(1) to noncompliance with enrollment requirements (including those involving claiming practices), but only conclude that error in claims submission without more does not constitute noncompliance with enrollment requirements under this regulatory provision.*

Our decision does not suggest that CMS has limited its revocation authority to claims submitted with fraudulent intent. The Board has rejected such a limitation in prior cases, holding that CMS's authority extends to the bases set out in section 424.535(a)(8), which has no such restriction. *Gaefke* at 7. We do not alter that holding. We simply hold here that revocation for claims submission must be based on noncompliance with specific enrollment requirements.

In reaching our conclusion, moreover, we need not and do not accept Proteam's view that, to support revocation, CMS must show noncompliance with provisions expressly denominated as addressing enrollment, nor that all provisions setting out payment conditions are necessarily excluded from consideration as enrollment requirements. The cases on which Proteam relies for this proposition discuss distinctions between "conditions of participation" and "conditions of payment" in the context of the False Claims Act (FCA), 31 U.S.C. § 3729 et seq. RR at 9, n.1, citing *U.S. ex rel. Conner v. Salina Regional Health Ctr., Inc.*, 543 F.3d 1211 (10th Cr. 2008) and *U.S. ex rel. Landers v. Baptist Memorial Health Care Corp.*, 525 F.Supp.2d 972, 978-80 (W.D. Tenn. 2007). In *Conner*, the Tenth Circuit rejected an effort to treat an alleged false statement in a hospital cost report as a basis for a qui tam suit absent a showing that the government was induced to make a payment, because to do otherwise would allow private parties to preempt the regulatory process for sanctioning failure to comply with conditions of participation. The court in *Landers* declined to consider a corporation's alleged failure to meet a condition of participation as necessarily establishing that the corporation would have been ineligible to receive any payment for otherwise proper claims under a "worthless services" theory. In other words, the courts found that violating a condition of participation did not establish that a false claim was filed in violation of conditions of payment. In neither case was the court called upon to answer the question of whether a revocation may be based on violating a condition of payment.

On the other hand, while we do not decide here the precise scope of section 424.535(a)(1), we have concerns about CMS's assertions that (1) every provision contained anywhere in subpart P constitutes a revocable enrollment requirement or (2) that the certification statement in enrollment applications converts every Medicare regulation and instruction into a revocable enrollment requirement. CMS relied on these assertions to argue that failing to include the correct NPI in Proteam's claims in violation of section 424.507(b)(1) (in subpart P) necessarily proved that Proteam was noncompliant with an enrollment requirement. We do not find support for the position taken by CMS.

First, CMS has not explained how the language of section 424.535(a)(1) can bear such expansive weight without rendering much of the regulatory scheme for enrollment and revocation virtually meaningless. As Proteam points out, there would be little sense to the listing of most of the specific grounds for revocation other than 424.535(a)(1), if that were the intent. We generally do not read one provision of a regulation in a manner that makes others superfluous where that reading can be avoided. *See, e.g., Ridgeview Hosp.*, DAB No. 2593, at 7 (2014), and authorities cited therein.

Moreover, section 424.535(a)(1) does not state that it applies to noncompliance with any provision contained in subpart P. CMS points to proposed revisions to the regulations which (it now says) would have served "to clarify" section 424.535(a)(1) "to recognize that all the provisions" in subpart P "were enrollment requirements." CMS Br. at 4, citing 78 Fed. Reg. 25,013, 25,025-26 (Apr. 29, 2013) (Proposed Rule). Those revisions were not adopted, however. A final rule, effective February 2015 as mentioned earlier, does make a "technical change" by replacing "enrollment requirements described in this section" with "enrollment requirements described in this subpart P." 79 Fed. Reg. at 72,524. CMS explained the purpose of the change as clarifying that providers must comply "with all of the provider enrollment provisions in 42 CFR subpart P, not merely those in § 424.530." *Id*. The new language, however, even had it been in effect at the relevant period, does not say that all provisions in subpart P are enrollment requirements but rather indicates that violations of any provisions in subpart P which <u>are</u> enrollment requirements may subject a provider to revocation under section 424.535(a)(1). The regulation (and the regulatory history) do not tell us precisely which provisions those are, and we need not attempt in the present case to delineate them.

We are also not persuaded that the duty undertaken by a provider in certifying that it will comply with Medicare requirements amounts to acknowledging that <u>any</u> noncompliance with <u>any</u> requirement in the submission of a claim may result in revocation as CMS contends here. The certification does clearly require the applicant to agree to abide by "the Medicare laws, regulations, and program instructions" applicable to its provider type. CMS Ex. 20, at 3. The certification also calls for an acknowledgment that "payment of a claim by Medicare is conditioned" on compliance. *Id*. The certification statement does not, however, inform the applicant that submission of a claim inconsistent with any law, regulation or instruction, without more, may result in revocation of billing privileges as opposed to nonpayment of the claim.

Here again, while concluding that the certification statement does not on its face convert every failure to comply with a Medicare requirement in submitting a claim into noncompliance with an enrollment requirement, we do not attempt to resolve to what extent provisions in enrollment applications for particular provider types such as HHAs <u>do</u> indeed contain enrollment requirements in addition to those in subpart P. As with our discussion of subpart P above, it suffices here to determine that the certification statement

standing alone does not make submitting a claim noncompliant with section 424.507 (without more) into a violation of an enrollment requirement triggering revocation authority.

Our decision thus does not address other forms of conduct or dereliction in compliance with Medicare laws, regulations and instructions by providers or restrict what actions CMS may otherwise undertake to protect the integrity of the program. Where a provider fails to comply with an enrollment requirement set out in subpart P or specified in the appropriate enrollment application, CMS is authorized to revoke billing privileges. We hold only that CMS may not revoke under the general provisions of section 424.535(a)(1) for errors in billing claims (without more) where it has already specified in other regulations the conditions under which it will revoke for incorrect claiming.

Moreover, we do not reach any conclusion about whether CMS could have relied on other revocation authority apart from section 424.535(a)(1) under the circumstances of the present case. As we have repeatedly explained, the regulations provide for an appeal from the reconsideration decision imposing a revocation. *Neb Group of Arizona LLC*, DAB No. 2573, at 7 (2014) and *Benson Ejindu, d/b/a Joy Medical Supply*, DAB No. 2572, at 8-9 (2014). They do not empower the ALJ or the Board to decide on a revocation basis that was either not asserted or abandoned by CMS or its contractor.

Conclusion

For the reasons explained above, we reverse the ALJ Decision and overturn the revocation of Proteam's enrollment.

/s/
Stephen M. Godek

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member