Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Colorado Medical Pain Management Center,
(PTAN: 5543530001)

Petitioner,

v.

Centers for Medicare & Medicaid Services

Docket No. C-16-914

Decision No. CR4822

Date: March 30, 2017

DECISION

The Centers for Medicare & Medicaid Services (CMS), through its Medicare administrative contractor, Palmetto GBA (Palmetto), revoked the Medicare enrollment and billing privileges of Colorado Medical Pain Management Center (Petitioner) pursuant to 42 C.F.R. § 424.535(a)(1). Palmetto found that Petitioner did not comply with the supplier standards at 42 C.F.R. § 424.57(c)(2), (c)(21), and (c)(25) because it billed for custom orthotics when it was not accredited to bill for such items and because it did not respond to Palmetto's requests for medical records related to the claims at issue. CMS moved for summary judgment only on the grounds that Petitioner failed to comply with the supplier standards at 42 C.F.R. § 424.57(c)(2) and (c)(25) (supplier standards 2 and 25). CMS did not offer argument or evidence regarding Petitioner's alleged noncompliance with the supplier standard at 42 C.F.R. § 424.57(c)(21). CMS has not established that there is a basis for revocation of Petitioner's Medicare enrollment and billing privileges based on Petitioner's alleged noncompliance with supplier standards 2 and 25. Accordingly, I reverse CMS's determination to revoke Petitioner's Medicare enrollment and billing privileges.

I. Background and Procedural History

Petitioner is a supplier of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) located in Colorado Springs, Colorado. By letter dated May 9, 2016, Palmetto, in its capacity as the National Supplier Clearinghouse Supplier Audit and Compliance Unit, notified Petitioner that Petitioner's billing privileges were being revoked because of Petitioner's failure to comply with the requirements of DMEPOS supplier standards 2, 21, and 25. CMS Exhibit (Ex.) 7 at 1. Palmetto also informed Petitioner that it was barred from re-enrolling in Medicare for one year. *Id.* Petitioner requested reconsideration of that determination (CMS Ex. 8), and the hearing officer issued an unfavorable reconsidered determination dated July 25, 2016 (CMS Ex. 9). Petitioner timely requested a hearing before an administrative law judge and the case was assigned to me for hearing and decision. I issued an Acknowledgment and Pre-Hearing Order dated October 3, 2016 (Pre-Hearing Order).

In accordance with my Pre-Hearing Order, CMS filed a motion for summary judgment (CMS Br.) and eleven exhibits (CMS Exs. 1-11). In its motion, CMS asserted that it is entitled to summary judgment because the undisputed facts support Palmetto's determination to revoke Petitioner's Medicare enrollment and billing privileges for failing to comply with supplier standards 2 and 25. CMS's motion does not address Palmetto's conclusion that Petitioner also failed to comply with supplier standard 21. Petitioner, which is not represented by counsel, did not respond timely to CMS's brief. I therefore issued an Order to Show Cause. In response to the Order to Show Cause, Petitioner submitted a letter dated January 10, 2017, signed by its chief executive officer (P. Br.). Petitioner's letter disputes that Petitioner failed to comply with supplier standards 2 and 25. With its letter, Petitioner submitted exhibits (P. Exs.) that it labeled "A" through "J". CMS filed a reply brief (CMS Reply) and exhibits it labeled "1R" and "2R". Petitioner filed a response to CMS's Reply (P. Sur-Reply), as well as its exhibit "K". Neither party offered the written direct testimony of a witness, nor did either party object to any of the exhibits offered by the opposing party. Therefore, in the absence of objection I admit into the record CMS Exs. 1-11, 1R, and 2R; I also admit P. Exs. A-K.[1]

II. Issue

The issue in this case is whether CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges under 42 C.F.R. § 424.535(a)(1).

[1] Neither party fully complied with the provisions of my Pre-Hearing Order, which directed that exhibits were to be marked using whole numbers. Pre-Hearing Order ¶ 5. Nor did my Pre-Hearing Order authorize a sur-reply by Petitioner. Nevertheless, in the absence of objections by either party I am admitting all exhibits as marked by the offering party and I have considered all the parties' submissions in reaching this decision.

III. Jurisdiction

I have jurisdiction to hear and decide this case. 42 C.F.R. §§ 498.3(b)(17), 498.5(l)(2); *see also* 42 U.S.C. § 1395cc(j)(8).

IV. Discussion

A. Statutory and Regulatory Background

The Social Security Act (Act) requires that a DMEPOS supplier obtain a supplier number from the Secretary of Health and Human Services (Secretary) to enroll and establish billing privileges as a Medicare supplier. Act § 1834(j)(1)(A). The Act also requires, in relevant part, that DMEPOS suppliers comply with the applicable state and federal licensure and regulatory requirements and any other requirements the Secretary may specify. Act § 1834(j)(1)(B)(ii)(I) and (IV).

The Secretary has established 30 standards that a DMEPOS supplier must certify it meets and will continue to meet in its application for a supplier number and billing privileges. 42 C.F.R. § 424.57(c)(1)-(30); *Main Street Pharmacy, Inc*., DAB No. 2349 at 2 (2010).[2] If a DMEPOS supplier already enrolled in the Medicare program fails to comply with any of the requirements set forth in section 424.57(c), CMS will revoke that supplier's billing privileges. 42 C.F.R. § 424.57(e); *see also 1866ICPayday.com, L.L.C.*, DAB No. 2289 at 13 (2009) ("[F]ailure to comply with even one supplier standard is a sufficient basis for revoking a supplier's billing privileges.").

DMEPOS suppliers bill Medicare using the Healthcare Common Procedure Coding System (HCPCS). CMS developed HCPCS codes to provide uniform national definitions of health care services, codes for those services, and payment modifiers in order to process, screen, identify, and pay Medicare claims. *See* 42 C.F.R. §§ 414.2 and 414.40. HCPCS codes fall into two categories: Level I codes are defined in Current Procedural Terminology-4 (CPT-4), a numeric coding system maintained by the American Medical Association (AMA); Level II codes primarily describe products, supplies, and services not included in CPT-4, such as ambulance services and items of DMEPOS used outside a physician's office. *See* *https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/HCPCS_Coding_Questions.html* (last visited March 27, 2017). CMS has delegated to the Medicare Pricing, Data Analysis and Coding Contractor (PDAC) responsibility to determine appropriate HCPCS codes to use when submitting claims to Medicare. *See* CMS Reply at 2; *see also* CMS Ex. 2R.

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[2] Administrative decisions cited in this decision are accessible via the HHS website at: https://www.hhs.gov/about/agencies/dab/decisions/index.html.

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

1. I decide this case based on the written record.

My Pre-Hearing Order advised the parties that they must submit written direct testimony for each proposed witness and that an in-person hearing would only be necessary if the opposing party requested an opportunity to cross-examine a witness. Pre-Hearing Order ¶¶ 8-11; *see Vandalia Park*, DAB No. 1940 (2004); *Pacific Regency Arvin*, DAB No. 1823 at 7-8 (2002) (holding that the use of written direct testimony for witnesses is permissible so long as the opposing party has the opportunity to cross-examine those witnesses). Neither party proposed to call witnesses or submitted written direct testimony. Therefore, there is no need for an in-person hearing, and I issue this decision based on the written record. Pre-Hearing Order ¶¶ 8-11.

2. CMS failed to establish a basis to revoke Petitioner's Medicare enrollment and billing privileges under 42 C.F.R. §§ 424.535(a)(1), 424.57(c)(2), and 424.57(c)(25).

Supplier standard 25 requires DMEPOS suppliers to disclose (and be accredited for) the products they supply to Medicare beneficiaries:

> All DMEPOS suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation. If a new product line is added after enrollment, the DMEPOS supplier will be responsible for notifying the accrediting body of the new product so that the DMEPOS supplier can be re-surveyed and accredited for these new products.

42 C.F.R. § 424.57(c)(25). Supplier standard 2 requires, among other things, that a supplier "report to CMS any changes in information supplied on the [enrollment] application within 30 days of the change." 42 C.F.R. § 424.57(c)(2).

The following facts are undisputed. Petitioner applied and was approved for Medicare enrollment as a supplier of, among other things, off-the-shelf (OTS) orthoses. CMS Ex. 1 at 10; CMS Br. at 1. Petitioner at no time requested to be enrolled (or accredited) to supply custom-fitted orthoses. CMS Br. at 1-2; CMS Ex. 8 at 1. Petitioner billed Medicare for orthoses using HCPCS codes L0456, L0631, and L0637. CMS Br. at 2; P. Sur-Reply at 1. Prior to January 1, 2014, these codes described OTS orthoses and were within the scope of Petitioner's Medicare enrollment and accreditation. CMS Br. at 7. Effective January 1, 2014, the definitions of these codes were changed to refer to custom-fitted orthoses. CMS Br. at 7-9; P. Sur-Reply at 1. For example, the definition for HCPCS code L0456 was modified by adding the following language: "prefabricated

item that has been trimmed, bent, molded, assembled, or otherwise *customized to fit a specific patient by an individual with expertise*." CMS Ex. 4 at 1 (emphasis added).[3] Nevertheless, Petitioner continued to bill Medicare using HCPCS codes L0456, L0631, and L0637 after January 1, 2014. CMS Br. at 9-10; CMS Ex. 6; P. Br. at 3.

Petitioner represents, and CMS does not dispute, that before and after January 1, 2014, Petitioner continued to supply the same OTS orthoses using the same HCPCS codes. *See, e.g.*, CMS Ex. 8 at 1; CMS Br. at 10. That is, Petitioner did not begin offering a new product line of custom orthoses.[4] However, because Petitioner continued to use HCPCS codes L0456, L0631, and L0637 on and after January 1, 2014, Petitioner billed Medicare for custom orthoses, when it had actually supplied OTS orthoses. P. Br. at 3.

According to CMS, these undisputed facts support a conclusion that Petitioner violated supplier standards 2 and 25. *See, e.g.*, CMS Br. at 11. I disagree. A DMEPOS supplier violates standards 2 and 25 when it adds a new product line after initial enrollment without notifying the enrollment contractor and the accrediting body of the change. In this case, Petitioner did not offer a new product line. Because Petitioner did not offer a new product line, Petitioner was under no obligation to inform the contractor or the accrediting body of a change.

In ruling that Petitioner did not violate supplier standards 2 and 25, I do not endorse Petitioner's actions in billing for custom orthoses when it supplied OTS orthoses. Petitioner concedes that it billed incorrectly for its existing product line, at least on some occasions in 2014. P. Br. at 3. It is arguable that, in doing so, Petitioner violated 42 C.F.R. § 424.535(a)(8)(ii), by engaging in a pattern or practice of "submitting claims that fail to meet Medicare requirements." However, Palmetto and CMS did not revoke Petitioner's Medicare enrollment and billing privileges for failing to comply with

[3] The definitions for HCPCS codes L0631 and L0637 were changed to add similar language. *See* CMS Ex. 4 at 2-3.

[4] In response to Petitioner's assertion that it did not supply or bill for custom-fitted orthoses, CMS responds that the evidence shows that Petitioner *billed for* custom orthoses. CMS Br. at 10. CMS points to no evidence that Petitioner *supplied* custom orthoses.

42 C.F.R. § 424.535(a)(8)(ii).[5] CMS Exs. 7, 9. An appellate panel of the Departmental Appeals Board has held that administrative law judge review is limited to the grounds for revocation cited in the reconsidered determination. *Neb Group of Arizona LLC*, DAB No. 2573 at 7 (2014). Thus, I may not uphold the revocation of Petitioner's Medicare enrollment and billing privileges based on possible noncompliance with 42 C.F.R. § 424.535(a)(8)(ii).

3. CMS did not assert or prove that there was a basis to revoke Petitioner's Medicare enrollment and billing privileges under 42 C.F.R. § 424.57(c)(21).

Palmetto's reconsidered determination cited Petitioner's noncompliance with supplier standard 21 as an additional basis for revoking Petitioner's Medicare enrollment and billing privileges. CMS Ex. 9 at 2-3. Supplier standard 21 requires a supplier to comply with CMS's (or its contractor's) requests for documentation. 42 C.F.R. § 424.57(c)(21). However, CMS has not argued before me that Petitioner failed to comply with supplier standard 21.[6] Nor did CMS offer any evidence of Petitioner's noncompliance with this standard. Accordingly, CMS has not proved that there is a basis to revoke Petitioner's Medicare enrollment and billing privileges based on noncompliance with supplier standard 21.

My Pre-Hearing Order informed both parties that they must submit, as part of their prehearing exchanges, a brief addressing "all issues of law and fact, including any Motion to Dismiss or Motion for Summary Judgment." Pre-Hearing Order ¶ 4.c.i. My Pre-Hearing Order further informed the parties that I would "consider the record of this case closed and the case ready for decision immediately after Petitioner's exchange or after the CMS response, if applicable." Pre-Hearing Order ¶ 11. Thus, CMS was on notice that it must include all legal arguments and factual contentions in its exchange and that I would issue my decision based on the parties' submissions. In summary, CMS could not reasonably expect that it would have the opportunity to assert additional grounds for revocation if I were to deny its motion for summary judgment.

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[5] Both parties devote their submissions to arguing when (or if) Petitioner should be held to have notice of the changes to the definitions of HCPCS codes L0456, L0631, and L0637. However, these arguments are irrelevant to the question of whether or not Petitioner began offering a new product line for which it was required to seek accreditation. Because CMS did not cite improper billing as a basis to revoke Petitioner's Medicare enrollment and billing privileges, I need not decide at what point Petitioner should have changed the codes it was using to bill Medicare.

[6] Indeed, CMS's motion for summary judgment explicitly states that two supplier standards are at issue and identifies standards 2 and 25. CMS Br. at 1.

V. Conclusion

For the foregoing reasons, I conclude CMS has not shown a legal basis for revoking Petitioner's Medicare enrollment and billing privileges. The reconsidered determination is reversed.

/s/
Leslie A. Weyn
Administrative Law Judge