Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Arizona Medical Boutique, LLC,

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-12-939

Date: November 30, 2012

DECISION NO. CR2674

Arizona Medical Boutique, LLC (Petitioner), appeals an April 13, 2012 reconsideration decision. I sustain the Centers for Medicare and Medicaid Services (CMS) determination to deny Petitioner's enrollment as a supplier in the Medicare program. I find that there is a legal basis for CMS to deny enrollment effective July 1, 2007 because Petitioner was not in compliance with Medicare enrollment requirements. Specifically, Petitioner does not dispute that its Medicare enrollment application did not have the required authorizing signatures.

I. Background and Procedural History

Petitioner submitted a Medicare Enrollment Application for Clinics/Group Practices and Certain Other Suppliers (CMS-855B), for a single specialty clinic providing family practice services, on or about September 5, 2007. The application listed Shuree Oldehoeft, a physician's assistant, as Petitioner's owner and manager. CMS Exhibits (Exs.) 1, 4. The application also showed Petitioner employed Wanda Juarros, M.D., as a supervising physician.[1] Both Ms. Oldehoeft and Dr. Juarros apparently signed the CMS-855B as Petitioner's authorized officials.

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[1] For Medicare reimbursement purposes, a physician's assistant needs to have his or her work generally supervised by a physician. *See* 42 C.F.R. §§ 410.74; 410.150(b)(15).

Petitioner also employed Donna Tomich as a billing consultant, and Ms. Tomich appears on the enrollment application as Petitioner's point of contact person for CMS. CMS Ex. 4, at 6. CMS approved Petitioner's enrollment in Medicare effective September 1, 2007, with retrospective billing effective as of July 1, 2007. CMS Exs. 7, 8; CMS Br. at 4.

By letter dated August 22, 2011, CMS's contractor, Noridian Administrative Services LLC (Noridian), informed Petitioner that it was revoking Petitioner's Medicare enrollment because Petitioner had certified as "true" misleading information on its Medicare enrollment application. Noridian also informed Petitioner that it was barred from participating in the Medicare program for a three-year period, commencing on the effective date of the revocation, July 1, 2007. The letter noted that Petitioner could both submit a corrective action plan and appeal Noridian's decision. CMS Ex. 7. On September 8, 2011, Petitioner timely requested a reconsideration decision and also submitted a corrective action plan. P. Ex. 4. On October 24, 2011, Noridian issued a decision unfavorable to Petitioner. CMS Ex. 8; Petitioner Supplemental Exhibit (P. Supp. Ex.) 1. Petitioner timely requested a hearing, and the case was assigned to an Administrative Law Judge (ALJ). On February 6, 2012, CMS filed a motion to remand or stay the proceedings to assess the impact of new evidence and to issue a revised reconsideration decision. The ALJ granted CMS's motion on March 1, 2012 and dismissed the case. CMS Ex. 8.

On April 13, 2012, CMS notified Petitioner of its reconsidered determination to uphold the revocation of Petitioner's enrollment and billing privileges. CMS noted that the revocation was effective July 1, 2007 and that Petitioner was barred for three years from enrolling in Medicare. CMS also noted that pursuant to 42 C.F.R. § 424.535(c), Petitioner was eligible to reapply to Medicare on or after July 1, 2010. CMS specifically determined that Petitioner's CMS-855B application, submitted on or near September 5, 2007, contained the forged signature of Dr. Juarros, whose identification was, unbeknownst to her, used during the application process. Dr. Juarros also denied the application's representation that she had an ownership interest in Petitioner. CMS also determined that Petitioner submitted a Medicare Enrollment Application for Reassignment of Medical Benefits (CMS-855R) containing the forged signature of Dr. Juarros. CMS Ex. 8.

In addition, CMS determined that an Electronic Funds Transfer Authorization Agreement (CMS 588) that Petitioner submitted during the enrollment application process contained false and misleading bank account information by listing Dr. Juarros as the provider. Specifically, CMS found that Dr. Juarros was neither a signatory on, nor had access to, nor control over, the account and that only Ms. Oldehoeft had such access. CMS explained that during an investigative interview, Ms. Tomich admitted forging Dr. Juarros's signature. Finally, CMS determined that after receiving approval to become a

Medicare provider, Petitioner submitted claims between July 2007 and May 2010 under Dr. Juarros's National Provider Identifier (NPI) and was paid approximately $473,000. CMS Ex. 8.

On June 3, 2012, Petitioner filed a new hearing request with the Civil Remedies Division of the Departmental Appeals Board, and the case was assigned to me for hearing and decision. In accordance with my July 2, 2012 Acknowledgment and Pre-hearing Order, CMS filed a prehearing brief/motion for summary judgment and supporting memorandum (CMS Br.), accompanied by 14 exhibits (CMS Exs. 1-14). Petitioner filed its response in opposition (P. Br.), accompanied by eight exhibits (P. Exs. 1-8). In response to my Order of October 17, 2012, requesting that the parties address how CMS's revocation effective date reconciles with the effective date authority set out at 42 C.F.R. § 424.535(g), both parties filed supplemental briefs (CMS Supp. Br. and P. Supp. Br.), and each party filed one supplemental exhibit (CMS Supp. Ex. 1 and P. Supp. Ex. 1). I admit CMS Exs. 1-14 and CMS Supp. Ex. 1 and P. Exs. 1-8 and P. Supp. Ex. 1 into the record.

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 beneficiaries may only be made to eligible providers of services and suppliers.[2] Act §§ 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395u(h)(1)). The Act requires the Secretary of Health and Human Services to issue regulations that establish a process for the enrollment of providers and suppliers, including the right to a hearing and judicial review of certain enrollment determinations. Act § 1866(j) (42 U.S.C. § 1395cc(j)).

II. Issue

The issue in this case is whether CMS had a legitimate basis to deny Petitioner's enrollment in the Medicare program as of July 1, 2007.

III. Discussion

A. Summary judgment is appropriate.

CMS argues that it is entitled to summary judgment. Members of the Departmental Appeals Board (Board) explained the standard for summary judgment:

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[2] Petitioner is a "supplier" for purposes of the Act. A "supplier" can furnish services under Medicare and refers to facilities that are not included within the definition of the phrase "provider of services." Act § 1861(d) (42 U.S.C. § 1395x(d)).

> 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). An ALJ's role in deciding a summary judgment motion differs from his or her 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). The Board has further stated, "[i]n addition, it is appropriate for the tribunal to consider whether a rational trier of fact could regard the parties' presentation as sufficient to meet the evidentiary burden under the relevant substantive law." *Dumas Nursing and Rehab., L.P.,* DAB No. 2347, at 5 (2010).

Petitioner objects to CMS's motion for summary judgment, asserting there are material facts in dispute. Below, I accept all the contested material facts Petitioner asserts to be true. P. Br. at 2, 8-9. In addition, I draw all reasonable inferences in Petitioner's favor. However, no dispute exists that Dr. Juarros's signature was forged on the documents in question, and Petitioner, the non-moving party, asserts that Ms. Oldehoeft's signature was also forged, and it did not ratify any forged signatures. Accepting these facts as true, the forged signatures alone, as discussed below, support denial of Petitioner's enrollment application.

B. Petitioner's enrollment application and supporting documents were not legitimately signed.

Section 424.510(d) of 42 C.F.R. sets forth application requirements for supplier enrollment in the Medicare program including:

> (3) Signature(s) required on the enrollment application. The certification statement found on the enrollment application must be signed by an individual who has the authority to bind the provider or supplier, both legally and financially, to the requirements set forth in this chapter. This person must also have an ownership or control interest in the provider or supplier, as that term is defined in section 1124(a)(3) of the Act, such as, the general partner, chairman of the board, chief financial officer, chief executive officer, president, or hold a position of

> similar status and authority within the provider or supplier organization. The signature attests that the information submitted is accurate and that the provider or supplier is aware of, and abides by, all applicable statutes, regulations, and program instructions.

The specific enrollment application language on the CMS-855B required the signatures of authorized officials to certify:

> I have read the contents of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete and I authorize the Medicare fee-for-service contractor to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare fee-for-service contractor of this fact immediately.

CMS Ex. 4, at 7; CMS Ex. 9.

Petitioner's enrollment application only lists the names of Shuree K. Oldehoeft and Wanda D. Juarros as Petitioner's authorized officials. *Id.* Both individuals appeared to have signed the application on September 5, 2007. *Id.* However, both parties agree that Ms. Tomich, Petitioner's third party billing consultant, forged Dr. Juarros's signature on the enrollment application (CMS 855B), the EFT authorization agreement (CMS 588), and the reassignment of Medicare benefits form (CMS 855R) without Dr. Juarros's knowledge.

CMS alleges, however, that Ms. Oldehoeft signed the enrollment application and other documents as an authorized official certifying that the documents were true, correct and complete. Petitioner asserts that Ms. Oldehoeft did not sign these documents and that Ms. Tomich also forged Ms. Oldehoeft's signature. Petitioner asserts that Ms. Oldehoeft relied on Ms. Tomich's expertise and believed that because Ms. Tomich was presenting documents for her signature, Ms. Oldhoeft had no reason to believe Ms. Tomich was forging hers or anyone else's signatures.

CMS argues that because Petitioner has not disavowed the enrollment application it submitted on September 5, 2007, it is responsible for the truth and accuracy of the information in it. CMS Br. at 7-9. CMS notes Petitioner's argument that it bears no responsibility for Ms. Tomich's forgeries. However, CMS asserts that because Ms. Tomich was Petitioner's agent, and listed as such on Petitioner's enrollment application, Petitioner is responsible for Ms. Tomich's actions, as a principle is responsible for the acts of its agent in the course of employment. However, even if Ms. Tomich had not been Petitioner's agent, CMS asserts that Ms. Oldehoeft certified the application was true and correct, thereby ratifying the forgery. CMS Br. at 9.

In response to my October 17 Order, CMS notified Petitioner that, in the alternative, considering Petitioner claims forged signatures on its enrollment application, Petitioner's Medicare enrollment must be denied *ab initio* pursuant to 42 C.F.R. § 424.530(a)(1). CMS Supp. Br. at 4-8.

For purposes of summary judgment, I will accept as true Petitioner's assertions that Ms. Oldehoeft's signature was forged, without her knowledge, and that she did not ratify the forged application. Therefore, the effect of this forged application is that no authorized official agreed to be bound by Medicare's laws, regulations, and program instructions. Further no authorized official certified to the accuracy of the information in Petitioner's application, and no authorized official agreed to be bound to notify the Medicare contractor of inaccurate information.

C. CMS had a legitimate basis to deny Petitioner's enrollment application.

Although CMS initially stated in this proceeding that it was revoking Petitioner's enrollment application, CMS is not precluded from later establishing that it is denying Petitioner's enrollment application. The Board has consistently held that a federal agency may assert or rely on new or alternative grounds for a challenged action after an administrative appeal has commenced, so long as the non-federal party has notice of, and a reasonable opportunity to respond to, the asserted new grounds during the administrative proceeding. *See Green Hills Enterprises, LLC,* DAB No. 2199, at 8 (2008); *see also Abercrombie v. Clarke,* 920 F.2d 1351, 1360 (7th Cir. 1990), *cert. denied,* 502 U.S. 809 (1991). I find that Petitioner received proper notice of the facts CMS was alleging, and, during the supplemental briefing period, Petitioner had an opportunity to respond to CMS's basis for the denial of Petitioner's enrollment application.

"Denial" of a Medicare enrollment application means an enrolling provider or supplier has been determined to be ineligible to receive Medicare billing privileges for Medicare covered items or services provided to Medicare beneficiaries. 42 C.F.R. § 424.502. CMS may deny a provider's or supplier's enrollment in the Medicare program for the following reasons, among others:

> (1) *Compliance.* The provider or supplier at any time is found not to be in compliance with the Medicare enrollment requirements described in this section or on the applicable enrollment application to the type of provider or supplier enrolling, and has not submitted a plan of corrective action . . . .

> (4) *False or misleading information.* The provider or supplier has submitted false or misleading information on the enrollment application to gain enrollment in the Medicare program.

42 C.F.R. § 424.530(a)(1), (4).

Petitioner acknowledges in its supplemental brief that it tried to rectify the problem by submitting a corrective action plan with a properly executed enrollment application. P. Ex. 4, at 44-150. CMS did not approve Petitioner's plan, and I do not have the authority to review a corrective action plan. *See DMS Imaging, Inc.,* DAB No. 2313, at 5-8 (2010).

D. CMS may deny Petitioner's enrollment and billing privileges retrospectively to July 1, 2007.

CMS may deny a supplier's enrollment in the Medicare program *at any time* if it is found not to be in compliance with the Medicare enrollment requirements or on the applicable enrollment application. 42 C.F.R. § 424.530(a)(1); *see US Ultrasound,* DAB No. 2302, at 6-7 (2010) (sustaining a denial of an application previously approved in error where CMS discovered the supplier did not meet enrollment requirements for its type at the time of enrollment).

Noridian, through no fault of its own, approved Medicare enrollment for Petitioner based on the application without the required authorized signatures. Without a legitimately signed application, Petitioner clearly was not eligible for enrollment.

Petitioner argues it believed for four years that it was properly enrolled in the Medicare program, and it provided services in reliance on that belief. Petitioner argues that it should not be penalized for Ms. Tomich's illegal actions with the loss of all its Medicare reimbursement for services rendered to Medicare beneficiaries beginning July 1, 2007. Instead, Petitioner argues that it should be permitted to amend its Medicare enrollment application and retain its Medicare certification. P. Br. at 1-4, 7-8; P. Supp. Br. at 4-6.

Even assuming everything that Petitioner asserts is true, Petitioner's equitable arguments give me no grounds to reinstate Petitioner's Medicare enrollment. *See US Ultrasound,* DAB No. 2302, at 8 ("[n]either the ALJ nor the board is authorized to provide equitable relief by reimbursing or enrolling a supplier who does not meet statutory or regulatory requirements."). Moreover, I have no authority to declare statutes or regulations invalid or ultra vires. *1866IPayday.com, L.L.C.,* DAB No. 2289, at 14 (2009) ("[a]n ALJ is bound by applicable laws and regulations and may not invalidate either a law or regulation on any ground.").

Although any suspected fraudulent billing scheme involving Petitioner may continue to be investigated (P. Br. at n. 1; CMS Ex. 14), it is clear without full resolution of that

matter that CMS had a legal basis to deny Petitioner's enrollment application based on a lack of required signatures of authorized officials. Therefore, I grant CMS summary judgment and sustain a denial of Petitioner's Medicare billing privileges effective July 1, 2007.

/s/
Joseph Grow
Administrative Law Judge