Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

LF Medical Services of NY, P.C.,
(NPI: 1699916957; PTAN: A100001711),

Petitioner,

v.

Centers for Medicare & Medicaid Services

Docket No. C-15-2177

Decision No. CR4350

Date: October 21, 2015

DECISION

The Medicare enrollment and billing privileges of Petitioner, LF Medical Services of NY, P.C., are revoked pursuant to 42 C.F.R. § 424.535(a)(9), effective January 7, 2015.

I. Background

National Government Services (NGS), the Medicare contractor, notified Petitioner by letter dated December 8, 2014, that its Medicare billing privileges were being revoked effective January 9, 2015. NGS cited 42 C.F.R. § 424.535(a)(9) as the basis for the revocation and notified Petitioner that it was subject to a two-year reenrollment bar pursuant to 42 C.F.R. § 424.535(c). Centers for Medicare & Medicaid Services (CMS) Exhibit (Ex.) 1 at 8-9.

Petitioner requested reconsideration of the revocation. CMS Ex. 1 at 4-6. In a reconsideration decision dated February 23, 2015, CMS upheld the revocation, again citing 42 C.F.R. § 424.535(a)(9) as the basis for revoking Petitioner's billing privileges. CMS Ex. 1 at 1-2.

On April 22, 2015, Petitioner timely filed a request for hearing before an administrative law judge (ALJ). On May 15, 2015, the case was assigned to me for hearing and decision and an Acknowledgement and Prehearing Order (Prehearing Order) was issued at my direction.

On June 15, 2015, CMS filed a combined prehearing brief and motion for summary judgment (CMS Br.) with CMS Exs. 1 through 13. On July 14, 2015, Petitioner filed a combined prehearing brief and opposition to CMS's motion for summary judgment (P. Br.) with Petitioner's Exhibits (P. Exs.) 1 and 2. On July 29, 2015, CMS filed a reply brief (CMS Reply). No objections have been made to my consideration of CMS Exs. 1 through 13 and P. Exs. 1 and 2, and they are admitted as evidence.

II. Discussion

A. Applicable Law

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. Administration of the Part B program is through contractors, such as NGS. Act § 1842(a) (42 U.S.C. § 1395u(a)). Payment under the program for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of services and suppliers.[*] Act §§ 1835(a) (42 U.S.C. § 1395n(a)), 1842(h)(1) (42 U.S.C. § 1395u(h)(1)). Petitioner is a supplier.

The Act requires the Secretary of Health and Human Services (Secretary) to issue regulations that establish a process for the enrollment in Medicare of providers and suppliers, including the right to a hearing and judicial review of certain enrollment

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[*] A "supplier" furnishes services under Medicare and includes physicians or other practitioners and facilities that are not included within the definition of the phrase "provider of services." Act § 1861(d) (42 U.S.C. § 1395x(d)). A "provider of services," commonly shortened to "provider," includes hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, hospice programs, and a fund as described in sections 1814(g) (42 U.S.C. § 1395f(g)) and 1835(e) (42 U.S.C. § 1395n(e)) of the Act. Act § 1861(u) (42 U.S.C. § 1395x(u)). The distinction between providers and suppliers is important because they are treated differently under the Act for some purposes.

determinations, such as revocation of enrollment and billing privileges. Act § 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to 42 C.F.R. § 424.505, a supplier such as Petitioner must be enrolled in the Medicare program and be issued a billing number to have billing privileges and to be eligible to receive payment for services rendered to a Medicare eligible beneficiary.

Suppliers must submit complete, accurate, and truthful responses to all information requested in the enrollment application. 42 C.F.R. § 424.510(d)(2). Pursuant to 42 C.F.R. §§ 424.502 and 424.510(d)(3), a supplier's application to enroll in Medicare must be signed by an authorized official, i.e., one with authority to bind the provider or supplier both legally and financially. The regulation provides that the signature attests to the accuracy of information provided in the application. The signature also attests to the fact that the provider or supplier is aware of and agrees to abide by all applicable statutes, regulations, and program instructions. 42 C.F.R. § 424.510(d)(3). Suppliers must meet basic requirements depending on their type of service. 42 C.F.R. §§ 424.505, 424.516, 424.517. Suppliers are also subject to additional screening requirements depending upon the type of service they provide. 42 C.F.R. § 424.518.

The Secretary has delegated the authority to revoke enrollment and billing privileges to CMS. 42 C.F.R. § 424.535. CMS or its Medicare contractor may revoke an enrolled supplier's Medicare enrollment and billing privileges and supplier agreement for any of the reasons listed in 42 C.F.R. § 424.535. Pursuant to 42 C.F.R. § 424.535(a)(1), CMS may revoke a supplier's enrollment and billing privileges if the supplier is determined not to be in compliance with enrollment requirements. Relevant here, revocation is also authorized under 42 C.F.R. § 424.535(a)(9) when a provider or supplier fails to comply with the reporting requirements in 42 C.F.R. § 424.516(d)(1)(ii) and (iii). Those reporting requirements provide that physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations must report any adverse legal action or change in practice location to their Medicare contractor within 30 days. 42 C.F.R. § 424.516(d)(1)(ii), (iii).

If CMS revokes a supplier's Medicare billing privileges, the revocation becomes effective 30 days after CMS or one of its contractors mails the revocation notice to the supplier, subject to some exceptions not applicable in this case. 42 C.F.R. § 424.535(g). After a supplier's Medicare enrollment and billing privileges are revoked, the supplier is barred from reenrolling in the Medicare program for one to three years. 42 C.F.R. § 424.535(c).

A supplier whose enrollment and billing privileges have been revoked may request reconsideration and review as provided by 42 C.F.R. pt. 498. 42 C.F.R. § 424.545(a). A supplier submits a written request for reconsideration to CMS or its contractor. 42 C.F.R. § 498.22(a). CMS or its contractor must give notice of its reconsidered determination to the supplier, giving the reasons for its determination and specifying the conditions or

requirements the supplier failed to meet, and the right to an ALJ hearing. 42 C.F.R. § 498.25. If the decision on reconsideration is unfavorable to the supplier, the supplier has the right to request a hearing by an ALJ and further review by the Departmental Appeals Board (the Board). Act § 1866(j)(8) (42 U.S.C. § 1395cc(j)(8)); 42 C.F.R. §§ 424.545, 498.3(b)(17), 498.5. A hearing on the record, also known as an oral hearing, is required under the Act. *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743, 748-51 (6th Cir. 2004). The supplier bears the burden to demonstrate that it meets enrollment requirements with documents and records. 42 C.F.R. § 424.545(c).

B. Issues

Whether summary judgment is appropriate; and

Whether there was a basis for revocation of Petitioner's billing privileges and enrollment in Medicare.

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

My conclusions of law are set forth in bold text followed by my findings of fact and analysis.

1. Summary judgment is appropriate.

CMS has requested summary judgment. As noted above, a supplier whose enrollment has been revoked has a right to a hearing and judicial review, and a hearing on the record is required under the Act. Act §§ 205(b), 1866 (h)(1), (j); 42 C.F.R. §§ 498.3(b)(1), (5), (6), (8), (15), (17), 498.5; *Crestview*, 373 F.3d at 748-51. A party may waive appearance at an oral hearing but must do so affirmatively in writing. 42 C.F.R. § 498.66. In this case, Petitioner has not waived the right to oral hearing or otherwise consented to a decision based only upon the documentary evidence or pleadings. Accordingly, disposition on the written record alone is not permissible, unless CMS's motion for summary judgment has merit.

Summary judgment is not automatic upon request but is limited to certain specific conditions. The Secretary's regulations at 42 C.F.R. pt. 498 that establish the procedure to be followed in adjudicating Petitioner's case do not establish a summary judgment procedure or recognize such a procedure. However, the Board has long accepted that summary judgment is an acceptable procedural device in cases adjudicated pursuant to 42 C.F.R. pt. 498. *See, e.g.*, *Ill. Knights Templar Home*, DAB No. 2274 at 3-4 (2009); *Garden City Med. Clinic*, DAB No. 1763 (2001); *Everett Rehab. & Med. Ctr.*, DAB No. 1628 at 3 (1997). The Board also has recognized that the Federal Rules of Civil Procedure do not apply in administrative adjudications such as this, but the Board has accepted that Fed. R. Civ. Pro. 56 and related cases provide useful guidance for

determining whether summary judgment is appropriate. Furthermore, a summary judgment procedure was adopted as a matter of judicial economy within my authority to regulate the course of proceedings and made available to the parties in the litigation of this case by my Prehearing Order. The parties were given notice by the Prehearing Order that summary judgment is an available procedural device and that the law as it has developed related to Fed. R. Civ. Pro. 56 will be applied.

Summary judgment is appropriate when there is no genuine dispute as to any issue of material fact for adjudication and/or the moving party is entitled to judgment as a matter of 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. The party requesting summary judgment bears the burden of showing that there are no genuine issues of material fact for trial and/or that it is entitled to judgment as a matter of law. Generally, the non-movant may not defeat an adequately supported summary judgment motion by relying upon the denials in its pleadings or briefs but must furnish evidence of a dispute concerning a material fact, i.e., a fact that would affect the outcome of the case if proven. *Mission Hosp. Reg'l Med. Ctr.*, DAB No. 2459, at 4 (2012) (and cases cited therein); *Experts Are Us, Inc.*, DAB No. 2452, at 4 (2012) (and cases cited therein); *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 3 (2010) (and cases cited therein); *see also Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986).

The standard for deciding a case on summary judgment and an ALJ's decision-making in deciding a summary judgment motion differ from that used in resolving a case after a hearing. On summary judgment, the ALJ does not make credibility determinations, weigh the evidence, or decide which inferences to draw from the evidence, as would be done when finding facts after a hearing on the record. Rather, on summary judgment, the ALJ construes the evidence in a light most favorable to the non-movant and avoids deciding which version of the facts is more likely true. *Holy Cross Vill. at Notre Dame, Inc.*, DAB No. 2291, at 5 (2009). The Board also has recognized that on summary judgment it is appropriate for the ALJ to consider whether a rational trier of fact could find that the party's evidence would be sufficient to meet that party's evidentiary burden. *Dumas Nursing & Rehab., L.P.*, DAB No. 2347, at 5 (2010). The Secretary has not provided in 42 C.F.R. pt. 498 for the allocation of the burden of persuasion or the quantum of evidence required to satisfy the burden. However, the Board has provided some persuasive analysis regarding the allocation of the burden of persuasion in cases subject to 42 C.F.R. pt. 498. *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 Fed. App'x 181 (6th Cir. 2005).

There is no genuine dispute as to any material fact pertinent to revocation under 42 C.F.R. § 424.535(a)(9) or the effective date of the revocation that requires a hearing. The issues in this case raised by Petitioner related to revocation under 42 C.F.R.

§ 424.535(a)(9) are issues of law that must be resolved against Petitioner as a matter of law. The undisputed evidence shows that there is a basis for revocation of Petitioner's Medicare enrollment and billing privileges. Accordingly, summary judgment is appropriate.

2. There is a basis for revocation of Petitioner's billing privileges pursuant to 42 C.F.R. § 424.535(a)(9).

3. The effective date of revocation of Petitioner's Medicare enrollment and billing privileges is January 7, 2015.

a. Facts

The facts are not disputed and any inferences are drawn in favor of Petitioner.

In June 2009, Petitioner first applied to enroll as a Medicare supplier by completing and submitting a CMS-855I form. Its practice location at the time of enrollment was 3057 Coney Island Avenue, Brooklyn, New York 11235. CMS Ex. 2 at 17.

On September 23, 2009, Petitioner submitted a CMS-855I to "add" a new practice location at 52 Lorraine Street, Brooklyn, New York 11231. CMS Ex. 3 at 2, 8, 19. The CMS-855I has three check-boxes in section 4 – "change," "add," or "delete" – and it is not disputed that Petitioner checked only the "add" box. CMS Ex. 3 at 19. NGS approved the added practice location effective September 1, 2009. CMS Ex. 1 at 12.

On January 14, 2013, Petitioner submitted a CMS-855I form marked to "add" a new practice location at 2174 Flatbush Avenue, Brooklyn, New York 11234. CMS Ex. 4 at 1-2, 4-6, 18. Again, it is not disputed that Petitioner checked only the "add" box on the CMS-855I, not the "change" or "delete" boxes. CMS Ex. 4 at 18. CMS ultimately rejected the application after Petitioner failed to provide requested information. CMS Ex. 4 at 33-34. On August 6, 2013, Petitioner applied to "change" its practice location to the 2147 Flatbush Avenue address. On this CMS855-I, Petitioner checked only the "change" box. CMS Ex. 5 at 1-2, 4-6, 18. NGS subsequently informed Petitioner that it had approved the "new practice location" effective July 1, 2013. CMS Ex. 1 at 15.

On June 26, 2014, Petitioner applied to "add" a new practice location at 424 Lafayette Avenue, Brooklyn, New York 11238. On this CMS-855I, it is undisputed that Petitioner checked the "add" box and not the "change" or "delete" boxes. Following the address for the practice location, Petitioner noted "Secondary Location." CMS Ex. 6 at 1-3, 7-8, 20. NGS approved the "new practice location . . . added" effective July 1, 2014. CMS Ex. 1 at 19.

On September 27, 2014, a CMS contractor attempted to conduct a site verification survey at Petitioner's Lorraine Street practice location, but found that the building was occupied by a candy store. CMS Exs. 7-8. On October 1, 2014, a CMS contractor attempted to conduct a site verification survey at Petitioner's Flatbush Avenue practice location, but found that the building was vacant. CMS Exs. 9-10. On October 7, 2014, a CMS contractor attempted to conduct a site verification survey at Petitioner's Coney Island Avenue practice location, but found that the building was vacant. CMS Exs. 9, 11. Petitioner does not deny that it was not operating at the three locations when the site visits were made. P. Br. at 3, P. Ex. 1-2.

By letter dated December 8, 2014, NGS notified Petitioner that its Medicare billing privileges would be revoked effective January 9, 2015, pursuant to 42 C.F.R. § 424.535(a)(9) because Petitioner had failed to notify CMS within 30 days that it had ceased operating at the Lorraine Street, Flatbush Avenue, and Coney Island Avenue practice locations as required by 42 C.F.R. § 424.516(d)(1)(iii). CMS Ex. 1 at 8-9, 22-23.

Petitioner admits that it only operated the Coney Island Avenue location until October 2009, the Lorraine Street location until 2013, and the Flatbush Avenue location until July 2014. P. Br. at 3; P. Ex. 1 at 2.

b. Analysis

Petitioner agreed as a condition for enrolling in Medicare to notify NGS of any "change in practice location" within 30 days. 42 C.F.R. §§ 424.500, 424.505, 424.510, 424.516(d)(1)(iii). Section 4 of the CMS-855I enrollment application provides boxes for providers and suppliers to check to report a change, addition, or deletion of a practice location. CMS Ex. 3 at 19; CMS Ex. 5 at 18; CMS Ex. 6 at 20. There is no dispute that Petitioner notified NGS each time it started practicing at a new practice location by submitting a CMS-855I to "add" or "change" a practice location. But there is also no dispute that Petitioner never notified NGS that it was ceasing operations at its practice locations on Coney Island Avenue, Lorraine Street, and Flatbush Avenue by completing a CMS-855I to alert NGS and CMS that those practice locations were no longer operating and should be deleted. Because Petitioner failed to comply with the reporting requirements of 42 C.F.R. § 424.516(d)(1)(iii), there is a basis for revocation of Petitioner's Medicare enrollment and billing privileges under 42 C.F.R. § 424.535(a)(9).

Petitioner argues that it timely notified CMS of its new practice locations, and did not understand that it needed to "affirmatively remove practice locations" in order to comply with the reporting requirements. P. Br. at 2; P. Ex. 1 at 3; P. Ex. 2 at 2. Petitioner argues that 42 C.F.R. § 424.535(a)(9) is unconstitutionally vague and that the CMS-855I provides inadequate instructions about how to report a change in practice location. P. Br. at 5-10. My authority is limited to determining whether there is a basis for revocation of

Petitioner's Medicare enrollment and billing privileges. *Abdul Razzaque Ahmed, M.D.*, DAB No. 2261 at 19 (2009). I am required to follow the Act and regulations, and I have no authority to declare statutes or regulations invalid. *1866ICPayday.com, L.L.C.*, DAB No. 2289 at 14 (2009) (noting that "[a]n ALJ is bound by applicable laws and regulations and may not invalidate either a law or regulation on any ground"). Thus, even though I accept for purposes of summary judgment that Petitioner's owner and employee (P. Exs. 1, 2) did not understand either the regulations or the CMS-855I, that fact is not a basis on which I may conclude that the regulations are invalid and that Petitioner's failure to comply with the regulations is not a basis for revocation.

Petitioner further argues that CMS's decision to revoke its billing privileges was unreasonable, unjust, and an abuse of discretion, and that a two-year reenrollment bar is excessive. P. Br. at 11-12. CMS is authorized to impose a bar to reenrollment of one to three years. 42 C.F.R. § 424.535(c). The regulations grant Petitioner no right to review of the CMS decision as to the appropriate period of the bar, and I have no authority to conduct review of that issue. 42 C.F.R. § 424.545. I also have no authority to review the exercise of discretion by CMS to revoke where there is a basis for revocation. *Ahmed*, DAB No. 2261 at 19. To the extent Petitioner's arguments are construed as a request for equitable relief, I have no authority to grant equitable relief. *US Ultrasound*, DAB No. 2302 at 8 (2010) ("Neither 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.").

NGS notified Petitioner on December 8, 2015, that the effective date of the revocation of Petitioner's enrollment and billing privileges was January 9, 2015. CMS Ex. 1 at 8-9, 22-23. The regulation is clear that when CMS revokes a supplier's Medicare billing privileges, the revocation becomes effective 30 days after CMS or one of its contractors mails the revocation notice to the supplier, subject to some exceptions not applicable in this case. 42 C.F.R. § 424.535(g). The thirtieth day after December 8, 2015 (the date the letter was mailed has not been disputed) was January 7, 2015, not January 9, 2015. Accordingly, by operation of 42 C.F.R. § 424.535(g), the effective date of revocation was January 7, 2015, and not January 9, 2015.

III. Conclusion

For the foregoing reasons, Petitioner's Medicare enrollment and billing privileges were properly revoked due to noncompliance with 42 C.F.R. § 424.535(a)(9), effective January 7, 2015.

/s/
Keith W. Sickendick
Administrative Law Judge