Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Shaun's Respiratory Solutions,

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-17-334

Decision No. CR4868

Date: June 15, 2017

DECISION

I affirm the determination of the Centers for Medicare & Medicaid Services (CMS) to revoke Shaun's Respiratory Solutions' (Petitioner) Medicare billing privileges.

I. Background

Petitioner was enrolled in the Medicare program as a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). On or about August 26, 2016, Petitioner sent a CMS-855S Medicare enrollment form to a CMS administrative contractor indicating that Petitioner was voluntarily terminating its Medicare enrollment as of August 31, 2016. CMS Exhibit (Ex.) 2.

On September 2, 2016, a CMS administrative contractor issued an initial determination to revoke Petitioner's Medicare billing privileges. CMS Ex. 3. The CMS administrative contractor identified four bases for the revocation:

1. 42 C.F.R. § 424.57(c)(1): Petitioner failed to maintain a state license as a wholesale distributor of compressed gas.

2. 42 C.F.R. § 424.57(c)(10): Petitioner failed to maintain a liability insurance policy.

3. 42 C.F.R. § 424.57(c)(22): Petitioner failed to maintain accreditation by a CMS-approved accrediting organization.

4. 42 C.F.R. § 424.57(c)(26): Petitioner failed to maintain a valid surety bond.

CMS Ex. 3 at 1-2. The CMS administrative contractor made the revocation retroactive to April 4, 2016, because Petitioner's surety bond expired on that date. CMS Ex. 3 at 2. The CMS administrative contractor also barred Petitioner from reenrolling in the Medicare program for two years. CMS Ex. 3 at 1.

Petitioner timely requested that the CMS administrative contractor reconsider the revocation. Petitioner stated in its request that its business operations ceased April 1, 2016. Petitioner indicated that it sold its contracts to another business and sold all its equipment at auction. Petitioner acknowledged that it failed to timely inform the CMS administrative contractor that it discontinued its business operations. In response to the specific bases for revocation, Petitioner confirmed that it: was no longer a distributor of compressed gas as of April 1, 2016; maintained general liability insurance until April 8, 2016; was accredited until July 14, 2016; and cancelled all vendor contracts when Petitioner "turned over operations" to the business that bought its contracts. Petitioner requested that the CMS administrative contractor permit Petitioner to voluntarily forfeit its supplier number rather than have its Medicare billing privileges revoked. CMS Ex. 4.

On November 28, 2016, a hearing officer with the CMS administrative contractor issued a reconsidered determination upholding the revocation. The hearing officer stated that on September 2, 2016, the CMS administrative contractor received Petitioner's CMS-855S enrollment application indicating that Petitioner wanted to voluntarily terminate its enrollment; however, also on that date, the CMS administrative contractor revoked Petitioner. Based on this, the hearing officer stated that the revocation took effect before the CMS administrative contractor was able to process the voluntary termination of enrollment. Further, the hearing officer upheld all four bases for revocation. CMS Ex. 6.

Petitioner timely requested a hearing before an administrative law judge. After this case was assigned to me, I issued an Acknowledgment and Pre-hearing Order (Order) that established a prehearing exchange schedule for the parties. In response to my Order, CMS filed a motion for summary judgment and brief as well as 9 exhibits (CMS Exs. 1-9). Petitioner filed a brief (P. Br.) and three exhibits (P. Exs. 1-3).

II. Decision on the Record

I admit all of the parties' proposed exhibits into the record because neither party objected to them. Order ¶ 7; Civil Remedies Division Procedures (CRDP) § 14(e).

I directed the parties to submit written direct testimony for each proposed witness. Order ¶ 8. CMS did not submit any written direct testimony. Petitioner submitted written direct testimony for two witnesses (P. Exs. 2, 3). I advised the parties in my Order that an in-person hearing would only be necessary if the opposing party requested an opportunity to cross-examine a witness. Order ¶ 9; CRDP §§ 16(b), 19(b). I required CMS to file such a request within 15 days of receipt of Petitioner's exchange. Order ¶ 9. Although Petitioner uploaded the written direct testimony for its witnesses to the Departmental Appeals Board's e-filing system on March 30, 2017, CMS did not upload its request to cross-examine Petitioner's witnesses until May 9, 2017. CMS did not provide a reason for missing the deadline to request to cross-examine Petitioner's witnesses; therefore, I do not find good cause to accept CMS's late request and issue this decision based on the written record. Order ¶¶ 10-12; CRDP §§ 19(d), 23.

III. Issue

Whether CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges.

IV. Jurisdiction

I have jurisdiction to decide the issue in this case. 42 C.F.R. §§ 405.803(a), 424.545(a), 498.3(b)(17), 498.5(l)(2); *see also* 42 U.S.C. § 1395cc(j)(8).

V. Findings of Fact, Conclusions of Law, and Analysis[1]

Under his authority to promulgate regulations concerning enrollment standards for providers and suppliers (42 U.S.C. § 1395cc(j)), and requirements for DMEPOS suppliers (42 U.S.C. § 1395m(j)(1)(B)(ii)), the Secretary of Health and Human Services (Secretary) established supplier standards that DMEPOS suppliers must meet and maintain, and rules related to the revocation of Medicare billing privileges. 42 C.F.R. § 424.57(c). A DMEPOS supplier is subject to revocation of its Medicare billing privileges if it violates the DMEPOS supplier standards or any of the regulatory requirements applicable to all suppliers. 42 C.F.R. §§ 424.57(e)(1), 424.535(a).

[1] My numbered findings of fact and conclusions of law are set forth below in italics and bold.

1. Petitioner's surety bond expired on April 4, 2016.

Petitioner contracted with Merchants Bonding Company for a surety bond in the amount of $50,000. The bond type was "Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies, Medicare Program." On March 4, 2016, Merchants Bonding Company issued a Notice of Cancellation, which indicated that the cancellation of Petitioner's bond was going to be effective on April 4, 2016. CMS Ex. 1.

Petitioner concedes that its surety bond expired on April 4, 2016. P. Br. at 6. Therefore, I find that Petitioner no longer had a surety bond on April 4, 2016.

2. CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges because Petitioner failed to maintain a surety bond in violation of 42 C.F.R. § 424.57(c)(26).

DMEPOS suppliers must maintain a surety bond of at least $50,000. 42 C.F.R. § 424.57(d). A failure to meet this requirement is a basis for revocation of Medicare billing privileges. 42 C.F.R. § 424.57(c)(26), (e)(1).

In the present case, Petitioner asserts that when Petitioner ceased its business operations on April 1, 2016, it was automatically terminated under 42 C.F.R. § 489.52(b)(3). Petitioner's surety bond was in effect until April 4, 2016. Therefore, Petitioner argues, it was compliant with the surety bond requirement through to the time that it ceased its business operations and voluntarily terminated itself from the Medicare program on April 1, 2016. P. Br. at 5-6.

Petitioner's argument is flawed because it relies on 42 C.F.R. § 489.52, which relates to the termination of a *provider* agreement and not to supplier enrollment in the Medicare program. Providers include entities such as hospitals, skilled nursing facilities, and home health agencies. 42 U.S.C. § 1395x(u); 42 C.F.R. § 400.202 (definition of *Provider*). In order for a provider to be eligible to receive payments from the Medicare program, it must file an agreement with the Secretary. 42 U.S.C. § 1395cc(a). The types of entities subject to this requirement are: hospitals; skilled nursing facilities; home health agencies; clinics, rehabilitation agencies, and public health agencies; comprehensive outpatient rehabilitation facilities; hospices; critical access hospitals; community mental health centers; and religious nonmedical health care institutions. 42 C.F.R. § 489.2(b). Once CMS accepts a provider agreement, the provider can voluntarily terminate the provider agreement. 42 U.S.C. § 1395cc(b)(1). As indicated by Petitioner, one way that a provider can voluntarily terminate its provider agreement is through the cessation of business. 42 C.F.R. § 489.52(b)(3). However, Petitioner was not a provider, and this provision does not apply to it.

Rather, Petitioner is a supplier in the Medicare program because it is not an entity that is identified in the statute or regulations as a provider. 42 U.S.C. § 1395x(d) (defining "supplier" as physicians, other practitioners, and entities "other than a provider of services" that furnishes items or services in the Medicare program); 42 C.F.R. § 400.202 (definition of *Supplier*); *see also* 42 C.F.R. § 498.2 (definition of *Supplier* that specifically identifies DMEPOS suppliers as suppliers in the Medicare program). Because suppliers do not operate under provider agreements, the rules pertaining to the termination of provider agreements do not apply to them.

Suppliers must timely inform CMS of changes to the information that they provide on their enrollment applications. 42 C.F.R. § 424.516(b)-(e). DMEPOS suppliers have 30 days to inform CMS of such changes. 42 C.F.R. § 424.57(c)(2). Therefore, if Petitioner ceased to operate on April 1, 2016, Petitioner needed to submit a CMS-855S enrollment application (i.e., the enrollment application for DMEPOS suppliers) to CMS by May 1, 2016, indicating that Petitioner was voluntarily terminating its Medicare enrollment.[2] *See* CMS Ex. 2 at 5-6.

Petitioner asserts that even if Petitioner needed to file a request to terminate its enrollment, it did so in August 2016, prior to the CMS administrative contractor's revocation of Petitioner's billing privileges. Petitioner provides testimony that its August 2016 effort to voluntarily terminate enrollment was not motivated by any knowledge that the CMS administrative contractor was going to revoke its billing privileges. P. Exs. 2-3. Petitioner argues that the CMS administrative contractor had to process the voluntary termination of enrollment rather than revoke Petitioner's billing privileges. P. Br. at 8-9.

Petitioner cites no authority in support of its argument that the CMS administrative contractor had to accept Petitioner's voluntary termination of enrollment. Based on records reviewed by the hearing officer who issued the reconsidered determination, the CMS administrative contractor issued the revocation on the same day that it received Petitioner's CMS-855S. CMS Ex. 6 at 1, 2. However, the mere filing of a CMS-855S does not serve to preclude CMS's authority to revoke Medicare billing privileges. In the

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[2] Even if Petitioner was a provider and not a supplier, and 42 C.F.R. § 489.52(b)(3) applied to Petitioner, Petitioner still would have been required to timely request that CMS accept its voluntary termination of enrollment from the Medicare program. *See* 42 C.F.R. § 424.516(e); CMS-855A (Medicare Enrollment Application Institutional Provider) at 4, 6 (https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS019475.html, *last visited* June 8, 2017). The rules and requirements related to accepting and terminating provider agreements are distinct from the rules and requirements related to provider and supplier enrollment, and the revocation of billing privileges. *Compare* 42 U.S.C. § 1395cc(a)-(h) and 42 C.F.R. pt. 489, subpts. A, B, E *with* 42 U.S.C. § 1395cc(j) and 42 C.F.R. pt. 424, subpt. P.

present case, Petitioner filed untimely notice that it was voluntarily terminating its enrollment and misleadingly indicated that it was seeking voluntary termination as of August 31, 2016, rather than as of the date it ceased operations, on April 1, 2016. CMS Ex. 2 at 6. The CMS administrative contractor acted within its authority to revoke Petitioner's billing privileges and then to treat Petitioner's untimely and inaccurate CMS-855S as moot.

Therefore, I conclude that Petitioner failed to maintain a surety bond from April 4, 2016, through the date on which the CMS administrative contractor revoked Petitioner's billing privileges, September 2, 2016, and that this serves as a legitimate basis for the revocation of billing privileges. 42 C.F.R. § 424.57(c)(26), (d).

3. CMS properly set April 4, 2016, as the effective date for Petitioner's revocation of Medicare billing privileges.

In its initial determination, the CMS administrative contractor stated that: "The effective date of this revocation has been made retroactive to April 4, 2016, which is the date your surety bond on file with the [the CMS administrative contractor] cancelled." CMS Ex. 3 at 1. On reconsideration, the hearing officer acknowledged this and did not disturb the effective date. CMS Ex. 6 at 4. Petitioner asserts that the CMS administrative contractor acted arbitrarily to set the effective date of revocation as April 4, 2016. Petitioner points out that the CMS administrative contractor revoked Petitioner based on multiple violations of the DMEPOS supplier standards, two of which require a prospective effective date of revocation. P. Br. at 6-8.

Petitioner is correct that the regulations support a prospective revocation effective date that is 30 days following the notice of revocation for violations of 42 C.F.R. § 424.57(c)(1) and (c)(22). 42 C.F.R. §§ 405.800(b)(2), 424.57(e)(1), 424.535(g). However, violations of 42 C.F.R. § 424.57(c)(10) and (c)(26) both have provisions requiring retroactive effective dates for revocation. 42 C.F.R. § 424.57(c)(10), (d)(11).

As found above, Petitioner's surety bond was cancelled as of April 4, 2016. CMS Ex. 1 at 1. As concluded above, following cancellation of the surety bond, Petitioner violated 42 C.F.R. § 424.57(c)(26) because Petitioner no longer complied with the surety bond requirements in 42 C.F.R. § 424.57(d). When Petitioner violated 42 C.F.R. § 424.57(c)(26), Petitioner was subject to revocation under 42 C.F.R. § 424.57(e)(1). Although section 424.57(e)(1) generally requires a prospective date of revocation, specific to Petitioner's situation, the regulations require that: "CMS revokes the DMEPOS supplier's billing privileges if an enrolled supplier fails to . . . maintain a surety bond as specified in this subpart . . . . Notwithstanding paragraph (e) of [section 424.57],

the revocation is effective the date the bond lapsed . . . ." 42 C.F.R. § 424.57(d)(11)(i).[3] Therefore, the CMS administrative contractor correctly followed the regulations to set Petitioner's effective date of revocation as the date its surety bond was cancelled.[4]

VI. Conclusion

I affirm CMS's determination to revoke Petitioner's Medicare billing privileges effective April 4, 2016.

/s/
Scott Anderson
Administrative Law Judge

[3] Due to a number of errors by both CMS and the Office of the Federal Register, the current provisions in 42 C.F.R. § 424.57(d) remained uncodified for years and those in 42 C.F.R. § 424.57(e)(1) had been accidentally deleted for years (*see Better Living/Better Health, LLC*, ALJ Ruling No. 2014-36 at 14-17 (HHS CRD July 11, 2014). However, these issues were corrected before any of the events in this case. 79 Fed. Reg. 69,772 (Nov. 24, 2014).

[4] Because Petitioner's failure to maintain a surety bond required CMS to revoke Petitioner's billing privileges and to make the revocation retroactive to April 4, 2016 (42 C.F.R. § 424.57(d)(11)(i)), it is unnecessary for me to determine whether Petitioner violated 42 C.F.R. § 424.57(c)(1), (10), and (22).