C. Advanced Provider Enrollment—Forewarned is Forearmed

Julie Burns
Office of the General Counsel
US Department of Health and Human Services,
CMS Division
Windsor Mill, MD

Louise M. Joy
Joy & Young LLP
Austin, TX

Seth A. Killingbeck
HCA
Nashville, TN
Medicare Provider Enrollment: 
Forewarned is Forearmed—Preventing 
Your Cattle from Drowning in the Ford 
(Denials, Deactivations, Revocations and Appeals)

Medicare Medicaid Law Institute 
March 24, 2015

Louise M. Joy, Esq. 
Joy & Young, LLP 
Austin, TX 
(512)-330-0228 
ljoy@joyyounglaw.com

Seth A. Killingbeck 
HCA 
Nashville, TN 
(615) 344-1551 
seth.killingbeck@hcahealthcare.com

Overview

• It’s Not Always Easy Getting In or Staying In
• Keeping things straight: Returns, Rejections, 
Denials, Deactivations, Revocations
• How Can You Right the Wrongs?
• Recent Case review— it’s pretty bleak.
Getting the Terms Straight

Lots of the terms seem synonymous, but they aren’t.

Returned, Rejected and Denied

Not to be confused with the lyrics of your favorite country western tune.
Returned Applications

• Considered a “non-application” – no appeal rights
• Reasons include:
  – Sent to wrong contractor
  – Supplier application received more than 60 days prior to effective date
  – Provider, ASC and PXRS application received more than 180 days prior to effective date
  – CHOW application submitted more than 90 days prior to anticipated date of sale
  – Submitted prior to expiration of appeal or re-enrollment bar
  – Application not needed

Rejected Applications:
Same Song—Different Verse

• Prior to 05/14/2012, issues were handled as returns
• Rejection now means application was not processed due to incomplete information or not received in timely manner
  – 30 days to respond to requests for additional information (CMS/MAC has discretion to extend)
• No appeal rights
• Rejections give rise to deactivations
• Must start over with 855/application process
Rejected Applications

• Reasons include:
  – Form unsigned, undated, contains copied/stamped signature or signed by wrong person
  – Outdated form used
  – All forms for reassignment not filed within 15 calendar days of receipt
  – Form completed in pencil
  – Wrong application submitted
  – Form does not appear to be downloaded from CMS website
  – Application sent via fax or email
  – Application fee (or hardship waiver) not submitted

Denied Applications

• Enrolling provider ineligible to receive billing privileges
• Appeal rights attach
• No longer applies to situations where providers fail to submit documentation in a timely manner (now grounds for rejection)
Reasons for Denial

- Provider not eligible for billing privileges (e.g. marriage counselor, hearing aid clinic)
- Trying to reapply while enrollment bar in place
- Felony conviction within past 10 years (provider, owner, or managing employee)
- Provider not licensed
- Noncompliance with enrollment requirements (including false/misleading 855 info or bad on-site review)
- Provider (or owner) has existing Medicare debt (or had unpaid debt that existed at time of termination)

Denial Cases

- Fellow avoided denial because fellowship program was not approved GME program.
- Retroactive denial for failure to report felony conviction in previous application
  - Worse than revocation because revocation power dates back to 1/1/2009
- Retroactive denials also applied when ineligible provider was given billing privileges by mistake
Moratorium Denial

- 12/08/11 HHA submitted 855A
- 08/09/12 MAC approved 855A
- 10/01/13 TJC accreditation effective
- 01/08/14 CMS authorized PGBA to conduct pre-tie-in review
- 01/30/14 CMS imposed HHA moratorium
- 02/03/14 Enrollment denied

*UpturnCare Co. v. CMS C-14-839 (9/24/14)*

---

Denial Overturned

- PA who owned an RHC tried to revalidate as PA, but app was denied because she applied as a sole practitioner
- Although PAs cannot enroll for their own practice, they can if they operate an RHC
- PA filed pro se appeal; ALJ gave big assist and identified that the PA could revalidate because her RHC “employed” her.
- *Pugh v. CMS CR3420 (10/17/14)*
Deactivation of Part A or Part B Numbers

Putting Providers in Time Out

Reasons for Deactivation

• Claims not submitted for 12 consecutive full calendar months
• Failure to report change in 30 or 90 days
• Failure to report CHOW in 30 days
• Failure to respond to MAC request for supplemental information within 30 days of request
• Failure to respond to revalidation request within 90 days of request
Impact of Deactivation

- Does not affect Participation Agreement
- No appeal rights
- May be “cured”

CMS deactivated
20,000 PTANs per month

2007 2008 2009 2010

Reactivation

<table>
<thead>
<tr>
<th>Part A</th>
<th>Part B (except DMEPOS, ASC, PXRS)</th>
<th>DMEPOS</th>
</tr>
</thead>
</table>
| - File 855A  
- Existing provider number reactived  
- Billing privileges restored without affecting “effective billing date” | - File Revalidation Certification Statement or 855B, 855J, or 855R  
- Reactivation Effective date is set to date of deactivation per PIM change October 2013. (Prior - later of first day services provided or 30 days before date new 855 received) | - File 855S  
- Show proof of accreditation  
- New site visit  
- Effective billing date established after all steps completed |
Example:
Deactivation & Reactivation

• Michael MacCormac, M.D. (DAB 2014-31, 5/22/14)
  – 9/30/11: Palmetto requested revalidation
  – 2/10/12: Dr. M submitted reval on old 855I
  – 2/28/12: Palmetto accepted but requested current form
  – 4/16/12: Palmetto deactivated PTAN
  – 10/19/12: Dr. M submitted reval on current form (Palmetto treated like new enrollment—approved effective 10/19/12, with retro billing date 9/19/12)
  – ALJ remanded for Palmetto to consider whether reactivation date should be deactivation date based on 10/8/13 PIM revisions
  – Compare *East Cooper Surgical Associates* (DAB CR3235, 4/1/14) & contrast *Reppuhn* (DAB CR3186, 5/20/14)

Revocations

Not your everyday jilting.
Causes of Revocations

• Failure to respond to revalidation request*
  – Not for now Effective 07/16/2012
• Site visit identified closed/nonoperational practice location
• Failure to report license suspension or revocation
• DMEPOS supplier’s noncompliance with DME standards
• Failure to report adverse legal actions/convictions within 30 days
• ZPIC or CMS RO finds claims submitted for services that could not have been provided.
• Felony conviction within past 10 years (provider, owner, or managing employee)
• Abuse of billing privileges, *including “pattern or practice” of submitting noncompliant claims*

Re-enrollment Bar
*(mandatory)*

<table>
<thead>
<tr>
<th>1 Year</th>
<th>2 Years</th>
<th>3 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>- License revocation/suspension of deactivated provider that was enrolled but not actively billing</td>
<td>- Provider is no longer operational</td>
<td>- Medical license revocation/suspension and provider continued to bill</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Felony conviction and provider continued to bill</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Falsification of information</td>
</tr>
</tbody>
</table>

*Re-enrollment bar is effective 30 days after CMS/MAC mails notice of revocation to provider.*
Submission of Claims

• Claims for services provided prior to revocation must be submitted within 60 days of revocation being imposed.
  – IDTFs, group practices, individual providers
    • For HHAs: later of (i) effective date of revocation or (ii) end date of last payable episode
  – But the notice is not always given within 60 days of revocation being imposed.

Dealing with the Contractor

“Pretty Please”
Dealing with the Contractor

• Receive returned application, rejected application, deactivation, denial, revocation
  — Contact Contractor
• Remain aware of deadlines to file Corrective Action Plan and Request for Reconsideration
• Beware – you may be speaking to someone who really does not understand the process but acts as if s/he does.

Medicare / Medicaid Enrollment

Overlapping Fees

• Preamble to 2/2/11 Application Fee Final Rule:
  o “We agree that providers enrolled in more than one program, be it Medicare, Medicaid, and CHIP, including Medicaid and CHIP in multiple States must only be required to pay the application fee once” (76 Fed. Reg. 5916).
  o Providers enrolled in both Medicare and Medicaid “will only be subject to the application fee at the time of Medicare enrollment or revalidation” (76 Fed. Reg. 5914).
  o 42 CFR 424.514 (Medicare fee) vs 42 CFR 455.460 (Medicaid fee)
    o Despite preamble, leads to disparity based on which is paid first.
    o CMS does not allow Medicaid fee in lieu of Medicare fee.
Medicare / Medicaid Enrollment

Overlapping Fees

- **Preamble to 2/2/11 Application Fee Final Rule:**
  - *Comment:* A commenter suggested that a provider or supplier enrolled in more than one program (that is, Medicare, Medicaid or CHIP) be subject to only one application fee. *Response:* We agree. Dually-participating providers and suppliers will only be subject to the application fee at the time of Medicare enrollment or revalidation. (76 Fed. Reg. 5862 at 5914, emphasis added)

- **12/31/11 CMS Bulletin**
  - “This requirement [that states collect application fee] does not apply to individual physicians or non-physician practitioners, or providers that are enrolled in Medicare or another State’s Medicaid program or CHIP or to those that have already paid the fee to Medicare or another State Medicaid program or CHIP.” (emphasis added)
  - This language is reiterated in 11/18/14 Provider Enrollment Q&A sheet published by CMS Center for Medicaid, CHIP and Survey & Certification.

- **However, some states are imposing 12-month limitation**
  - States are not required to rescreen the providers if the providers have been screened by Medicare or another state’s Medicaid (or CHIP) program within the previous 12 months.
  - Will this be challenged?

Corrective Action Plans

Know when to hold ‘em;
Know when to fold ‘em.
Corrective Action Plans

• Purpose
  – To correct an identified error in the process that was committed by the applicant
    • Failure to report closure of practice location
    • Failure to revalidate timely
    • Failure to report change in controlling persons
    • Failure to respond to request for supplemental information
  – Effective 2/3/15 applies only to revocations based on noncompliance with enrollment requirements

CAP Elements

• Provide evidence of compliance with Medicare requirements
  – Letter explaining background of denial or revocation
  – Steps taken to file 855 application to address alleged error
  – Arguments as to why alleged error was not an error
  – Signed by provider, authorized/delegated official or legal representative
• MACs may create standard CAP form
• Acceptance of CAP could lead to rescission of revocation and reinstatement of former billing privileges
Contractor Actions on CAP

- **Approval** - If Application is approved, limited retroactivity is allowed
  - Physicians and practitioners -- claims for services performed from date of correction forward. No retroactive approval because provider was not in compliance with Medicare requirements until corrective actions were taken.
  - DMEPOS suppliers may bill only for those items that were furnished on or after the date that they are issued a billing number.
  - The effective date for billing privileges for a newly-enrolled independent diagnostic testing facility (IDTF) is the later of (1) the filing date of a signed provider enrollment application that the Medicare contractor is able to process to approval, or (2) the date the IDTF first started furnishing services at its new practice location.
  - With respect to providers of services and for those suppliers required to be surveyed prior to enrollment, the provider or a supplier can bill Medicare for services furnished on or after the effective date of the provider agreement or the effective date of the approval of the supplier.

More CAP Issues

- **CAP shall be processed in 60 days**
  - MACs’ deadlines don’t mean much; timeframes can be much longer depending on the MAC
- **Appeal deadlines are not tolled during CAP processing**
- **If CAP and Request for Reconsideration filed simultaneously, CAP must be processed first**
  - Request for Reconsideration processed after by Hearing Officer unrelated to initial determination or CAP determination
- **No appeals from the rejection of a CAP, even if CAP rejected in error**
Request for Reconsideration

“Sheriff, you got it all wrong.”

Filing Deadlines

• 60 days from date of notice of denial or revocation
• If submitted after deadline, Hearing Officer required to make a finding of good cause before taking any other action
  – Time limits may be extended if good cause is shown
    • Ex: unusual or unavoidable circumstances; destruction by fire or damage to records
RfR Elements

- Provider identification (NPI/PTAN)
- Restate alleged basis for denial/revocation
- Background and area of concern
- Arguments to show application incorrectly denied or billing privileges revoked erroneously
- Scope of review limited to MACs stated reasons for denial/revocation – was this correct?
- Cannot introduce new denial/revocation reasons
- Proof of later compliance
- Identify action requested and effective billing date
- Signed by provider, authorized/delegated official, legal representative

More RfR Issues

- Communicate with Hearing Officer
  - Additional information may be needed
- Hearing Officer must be knowledgeable about provider enrollment and not involved in original decision
- Decision deadline
  - 90 days from date of appeal request
    - May be shorter/longer depending on MAC
Departmental Appeals Board Appeal Process

DAB is to CMS PECOS as Judge Roy Bean was to Pecos, Texas

ALJ Hearing

• Filing deadline
  – 60 days from receipt of written notice of adverse decision
  – Even if provider never receives written notice may still file
• “Request for Hearing” filed with Civil Remedies Division
Request for Hearing Elements

• Letter to DAB Civil Remedies Division
  – Identification of provider (name, PTAN, NPI)
  – Basis for dispute
  – Procedural background
  – Standard of review
  – Issues for appeal/argument
  – Explanation of timely filing of appeal or good cause for extended time to file appeal, if applicable
  – Relieve requested
  – Copy of Written Notice

Request for Hearing Process

• Acknowledgement and Pre-hearing Order
  – List of exhibits with copies
  – List of witnesses, if any
  – Copy of prior written statement by witnesses
  – Brief summarizing all issues of law and fact, including Motion to Dismiss or Motion for Summary Judgment

• CMS attorney must provide within 30 days
Request for Hearing Process

• Provider has 30 days from receipt of CMS information to provide the same items to CMS
• CMS’s respond to any Motion for Summary Judgment by provider is due within 15 days
• Provider has right to cross-examine witnesses; must include with brief
• Case is considered closed after exchange unless in person hearing is needed

DAB Hearing

• Filing deadline
  – 60 days after receipt of ALJ decision
  – CMS, MAC or provider may request
• Failure to request DAB deemed waiver of all rights to further administrative review
• DAB may admit additional evidence if relevant and material
Judicial Review

Tell it to the Judge.
The buck stops here.

Judicial Review

- Appeal from DAB decision
  - File civil action in a US District Court
- Filing deadline
  - 60 days from receipt of notice of DAB’s decision
DAB/ALJ Cases

It’s usually a lost cause.

Recent Cases aren’t pretty

2014-15 ALJ and DAB decisions:
Denials of Billing Privileges
Effective date of billing privileges following an approval of the 855
Revocations of billing privileges
Procedural/Legal issues contained in decisions
Note: All decisions cited are ALJ decisions unless noted as DAB decisions
All cited decisions are available at http://www.hhs.gov/dab/decisions/dabdecisions/
Denial of Billing Privileges

1. Pradeep Srivastava (CR3297)
   - Dr. was convicted of federal tax evasion and filing false return (felony charges) on 10/8/09
   - CMS revoked his Medicare enrollment as of 10/8/09 + 3 yr re-enrollment bar
   - Dr. attempted to re-enroll in March 2013 (ie, > 3 yrs later), but Novitas denied
   - Dr. argued that the re-enrollment bar cannot be longer than 3 years
   - ALJ found no conflict in the regulations—3 yr re-enrollment bar does not replace 10-yr past felony review

Retroactive Denials:  
*As bad as it gets*

Appeals of Denial of Billing Privileges

2. Precision Prosthetic – Part 1 (CR3187, 4/2/14)
   - ALJ upheld denial of revalidation application and retroactive denial (~6 yrs) of billing privileges due to supplier listing as an owner an individual who was convicted of mail fraud
   - ALJ found that mail fraud was a felony and was a “financial crime” permitting denial of enrollment under 424.530(a)(3)(i)(B)
   - “Petitioner remarkably went through two revalidation cycles since being ‘approved’ in 2006. It remains unclear what methods, if any at all, NSC had in place to ensure that providers or suppliers or their owners did not have prohibited felony convictions”
**Retroactive Denials:**
*As bad as it gets – but wait...*

**Appeals of Denial of Billing Privileges**

2. *Precision Prosthetic – Part 2 (A1480, 9/29/14)*
   - DAB found error with ALJ’s remand to CMS with instructions “to consider whether NSC had intended [instead] to deny Petitioner’s enrollment retroactively.”
   - “The question of whether CMS should have made a determination denying enrollment retroactively rather than revoking enrollment retroactively does not involve a new issue...but, rather, a wholly different administrative action.”
   - Appeals regulations limit “ALJs to considering the basis or bases for denial or revocation of enrollment and billing privileges set forth in the CMS contactor’s reconsidered determination.”

**Dodged the Denial bullet**

3. *Eli Gordin, M.D. CR 3205*
   - Billing privileges were denied on the basis that physician was in a GME fellowship program and was not able to bill Medicare and therefore could not be enrolled.
   - ALJ reversed. ALJ noted that physicians could perform services outside of the fellowship program and bill Medicare. Gave example of a physician who primarily performs cosmetic surgery, which is not covered by Medicare, but who may perform covered services as well.
   - ALJ also found that the fellowship was not in an “approved” GME program
Effective date of billing privileges:  
*Timing is everything on appeal*

Appeals of Effective Date of Billing Privileges

1. *Carrie Cera-Hill (CR3274):* Physician alleged “late” filing of her 855 was due to clerical error of her staff, but ALJ said he had no authority to waive regulatory provision

2. *Christina Dziedzic Asig (CR3188):* Because she did not submit additional documentation w/in 30 days, application was rejected and effective date was based on subsequent application. Petitioner was in contact with NGS, but decision to allow extra time is purely discretionary; no appeal rights.

More Effective Date Issues  
*Having Withdrawals*

Appeals of Effective Date of Billing Privileges

3. *Mostafa Elyaman (CR3245)*
   - Physician mistakenly filed 855B and withdraw application and correctly filed an 855I
   - CMS argued that simply by virtue of filing the wrong form the petitioner could not receive an effective date based on the date of the 855B
   - ALJ disagreed with CMS, and pointed out that MPIM provides that a contractor may reject an application on the wrong form, but only if the applicant does not submit a new or corrected application within 30 days of contractor’s request.
   - *MPIM provisions did not apply because petitioner withdrew the original wrong application.*
More Effective Date Issues

Can you relate (back)?

Appeals of Effective Date of Billing Privileges

   • Petitioner filed outdated 855I. MAC requested current form w/in 30 days. Petitioner timely submitted current 855I. CMS set effective date based on the second 855I, but ALJ reversed.
     ▪ MPIM requires contractors to treat outdated application under the rejection provisions, which require contractors to give applicant 30 days to correct (here, file correct application) – if new application is timely filed and can be processed to completion, enrollment date relates back.
   • Compare Bird’s Song of North Carolina (CR3243) (MAC should develop the application, rather than return it) and Neurology Care Consultants, LLC (C14241) (“[W]here an applicant initially files its application on the wrong form, but timely corrects the error by furnishing the correct one, the contractor should consider these submissions all part of the same application, with the earlier filing date preserved.”)

More Effective Date Issues

Appeals of Effective Date of Billing Privileges

5. Abundant Health Family Medicine, LLC (CR3209)
   • Abundant (via SRG) attempted to enroll via PECOS on 8/20/12
     o Noted “numerous page errors, and computer glitches from screen to screen”
   • Abundant (via SRG) resubmitted enrollment (via PECOS?) on 4/16/13 (WPS rec’d signed certification stmts from Abundant on 4/17/13)
   • WPS enrolled Abundant effective 4/17/13 (billing retro to 3/18/13)
   • ALJ affirmed effective/billing dates assigned by WPS
     o WPS couldn’t locate control number from Aug 2012 submission
     o Abundant had no PECOS confirmation receipt or tracking number from Aug 2012
     o No signed certification statement submitted to WPS in Aug 2012
Effective date of billing privileges

Appeals of Effective Date of Billing Privileges

   - Issue was whether physicians and NP were able to reassign benefits to Supplier before Supplier was enrolled
   - Contractor established effective date of reassignment based on application of Supplier
   - Did physicians bill in their own name and if not was it too late to do so after appealing the effective date?

---

Revocations: *The Big Guns*

A. Abuse of Billing Privileges

1. *Ronald J. Grason* (CR3215)

Contractor revoked on basis that physician submitted multiple claims for services that he could not have furnished as billed.

ALJ upheld revocation. CMS made out a prima facie case and petitioner failed to prove by a preponderance of evidence that he furnished the services. Petitioner failed to rebut visitor logs that indicated he was on site at facility for only a few minutes. CMS was not required to establish a pattern of false billings.
Revocation – Home visits

Abuse of Billing Privileges

2. Jaimy H. Bensimon (CR3236)

Contractor revoked on basis that physician submitted multiple claims for services that he could not have furnished as billed

ALJ reversed revocation. Petitioner rebutted CMS's prima facie case that he could not possibly have performed the E&M services claimed, if he adhered to the typical time durations that were based on average times for various E&M services. Petitioner had expert witness evidence showing that he worked very long days and that he saw patients in groups, spending 15 minutes for new patients and 5 minutes for established patients and that the times reported were reasonable and accurate.

DME Revocations: Non-Operational

B. Revocations of DMEPOS Billing Numbers for “non-operational”

1. Optimum Sleep Associates (CR3059) – Supplier left behind note indicating it had relocated – new address not on file

2. Onic Med Supply LLC (CR3068) – Supplier claimed assistant was in office at the time and had no explanation as to why nobody was on site; argued site investigator could have telephoned him, but ALJ said no duty to telephone
DME – Non-Operational  
No Mailbox Rule

B. Revocations of DMEPOS Billing Numbers for “non-operational”

3. Omni Medical Supplies, LLC (CR3440)
   - NSC revoked effective 9/16/13 based on 9/10 & 9/16 site visits
     - 2 year re-enrollment bar
   - Omni provided evidence/proof that is had filed 855 on 8/15/13 to terminate enrollment effective 8/31/13
   - NSC gave testimony that it never received 855 termination
   - CMS makes prima facie case; preponderance burden shifts to Omni (compare Criskel Home Health, Inc. (CR3417))
     - No mailbox rule in enrollment cases—Omni must prove receipt
     - Implicit tracking requirement?

DME – Non-Operational  
No time for closing

B. Revocations of DMEPOS Billing Numbers for “non-operational”

4. Genuine Care Rehabilitation Services Inc. (CR3077)
   - Supplier argued that staff was temporarily unavailable during posted hours of operation because it did not schedule appointments on the date of the site visits and said it would have responded promptly had the inspector called the number posted at the entrance
     - ALJ said “incumbent on Petitioner to make whatever reasonable arrangements are necessary to keep its business open while allowing for patient consultations and visits”
DME Revocations: 
**Standard 7 – not accessible**

B. Revocations of DMEPOS Billing Numbers for “non-operational”

5. *Norpro Orthotics & Prosthetics Inc.* (DAB2577)
   
   • Supplier not open during 3 site visits, but reconsideration determination stated that billing number was revoked only due to violation of supplier standards; therefore date of revocation was modified (30 days from notice).
   
   • *See also Southeastern Orthotics and Prosthetics* (CR3208) (office’s posted hours did not indicate that office would be closed for lunch break, but date of revocation modified because reconsideration cited only supplier standard 7); *Superior Medical Products* (CR3224) (“CMS conflates revocation based on violation of supplier standard 7... which requires... facility be accessible and staffed during posted hours of operation; and violation of... 424.535(a)(5), which authorizes CMS to revoke because it has determined that a supplier is no longer operational”) -- date of revocation modified; *Orthopaedic Surgery Associates* (A1490); *Ortho Rehab Designs Prosthetics and Orthotics, Inc.* (A1482).

DME Revocation: 
**Standard 7- Not Accessible**

B. Revocations of DMEPOS Billing Numbers for “non-operational”

6. *Joy Medical Supply* (DAB2572)
   
   • After two site visits to closed facility, contractor advised that supplier’s billing privileges were revoked effective on the date of the 2nd site visit
   
   • Reconsideration determination upheld the initial revocation finding that the supplier was inaccessible and unstaffed during posted hours of operation on two occasions, in violation of [supplier standards]”
   
   • ALJ upheld revocation, despite taking as true supplier’s claim that he was inside the office with the door locked
     
     -- Office was not “accessible” because of locked door, and DAB agreed
**DME Revocation: Change of Address**

**B. Revocations of DMEPOS Billing Numbers for Non-operational**

7. *Potomac Medical Equipment* (CR3268)
   - Supplier was not operational at the location of the site-visit, but claimed it reported the change of address within 30 days as required
   - ALJ was not convinced that the supplier mailed the updated 855S. Although petitioner provided significant evidence that its owner mailed the 855S, it failed to produce any “objective evidence” to corroborate the testimony, such as a sales receipt.
   - Even if petitioner provided sufficient evidence to prove that the 855S was mailed, it was required to prove that the contractor received it timely.
     - Compare *Omni Medical Supplies, LLC* (CR3440) (no mailbox rule)

---

**DME Revocations: No time for holidays**

**B. Revocations of DMEPOS Billing Numbers for “non-operational”**

8. *Ortho Rehab Designs Prosthetetics and Orthotics, Inc.* (CR3193)
   - “[T]he presence of a sign would not have been a basis for overturning the revocation….Even if Ortho’s sign about its week-long closure had ‘stayed adhered to its front door…that fact would not have made it compliant’...because ‘[c]losure during posted business hours, even if only temporary, violates the regulations.”* (ultimately decided based on supplier standards, not non-operational)
Revocations of Physicians with DME

C. Revocations of Other Suppliers’ Billing Numbers for being non-operational

1. Advanced Medical Services (CR3284)
   - ALJ reversed revocation
   - Operational requirements for physician practice are different from those for DMEPOS suppliers
   - The fact that Petitioner had no sign posted or posted hours of operation is evidence but not determinative of whether petitioner was open to the public. Analysis also requires consideration of whether petitioner was prepared to submit Medicare claims, and whether his facility was properly staffed, equipped and stocked

Physician Revocations:  
*Is it a Medicare-related felony?*

   - ALJ reversed revocation
   - Petitioner physician was convicted in NJ of a “fourth degree crime” of possessing dum dum bullets (hollow points). He claimed he inherited the ammunition and guns from his father, a police officer, and that possession of the ammunition was legal in PA and that he did not know it was illegal in NJ.
   - ALJ found that a “fourth degree” crime in NJ is a felony. However, ALJ disagreed with CMS that its review was limited simply to whether CMS determined that a conviction was detrimental to the best interests of the Medicare program. ALJ remanded for the contractor to consider the seriousness of the crime.
Physician retroactive revocation: 
*Crimes must be revealed*

2. *Rey. R. Palop (CR3273)*
   - ALJ upheld revocation for failing to report felony conviction
   - Petitioner physician was convicted of felony drug fraud in 2008 but did not report it until 2013; his 2009 855R (which did not report felony) was approved
   - In 2013, WPS retroactively denied Petitioner’s 2009 enrollment application. ALJ said this was a problem of the petitioner’s own making.
   - Petitioner argued that 2009 version of 855 did not require him to list adverse action, but ALJ found that he had promised to abide by the Medicare rules and regulations and that he knew or should have known that he was required to report the conviction.

Physician Revocation: 
*License suspension must be reported*

3. *William Montiel (CR3258)*
   - ALJ upheld revocation because CMS established that petitioner’s license to practice medicine was suspended.
   - The fact that reconsideration determination referred to documents, issues and to an individual having nothing to do with petitioner’s case did not matter, as petitioner was put on adequate notice of the reason for the revocation.
Physician Revocation:  
*Can’t produce medical records*

3. *Carlos E. Fossi* (CR3294)
   - Regulation 424.516(f) requires supplier or provider of DMEPOS, clinical laboratory, imaging services, or HH services to maintain documentation and provide access to CMS
   - Regulation 524.535(a)(10) allows CMS to revoke for failure to meet requirements in 424.516(f)
   - ALJ upheld revocation of physician’s billing privileges because he could not produce 7 of 15 records requested pertaining to beneficiaries he certified for home health care
   - ALJ said he believed physician that physician could not produce records because he did not own them and the clinic was withholding the records because of an investigation

DPM DME Revocation  
*No holidays with DME*

4. *Marcus Singel* (CR3302)
   - ALJ upheld revocation because DMEPOS supplier failed to comply with requirement that it be accessible to the public and staffed during posted hours of operation and the requirement that it maintain a permanent and visible sign in plain view
   - Supplier alleged that it was closed for holidays (Jan 3 – Jan 7)
   - ALJ found that it was required to be open those days *and* (inconsistently?) that supplier did not have sign posting hours of operation
   - See also *Jeffrey D. Lubell* (CR3192) (“Supplier Standard 7 makes no exception for religious holidays and Petitioner presented no evidence that whatever signage he did have posted stated his facility was closed for religious holidays”).
DME Revocation:  
*Ok if it’s a disaster*

   - ALJ reversed revocation because DMEPOS supplier in Florida presented sufficient evidence that it was closed during site visits because of storm damage
   - ALJ found that whereas text of regulations do not list an emergency as an exception to rule that supplier must be open during posted hours, the preamble to the 2010 final rule indicates that a supplier does not need to be staffed during disasters, emergencies and State and Federal legal holidays.

HHA Revocation:  
*Home(less) on the Range*

1. Improving Life Home Care LLC (CR3076)
   - CMS revoked on the basis that physicians improperly certified beneficiaries for HH services because physicians did not have face-to-face encounter with beneficiaries.
   - ALJ upheld revocation. Although CMS was required to present a prima facie case, HHA did not come forward with evidence to show physicians actually saw the 21 beneficiaries in question.
   - ALJ found that (1) regulation 424.535(a) allows CMS to revoke a provider’s billing privileges if it is determined not to be in compliance with the enrollment requirements in the regulations or on the 855; (2) the 855 requires the provider to certify that it is in compliance with the Medicare laws, regulations, and program instructions; therefore, because the provider’s certification on the 855 was false, its billing number was properly revoked.
HHA Revocation:  
*Home(less) on the Range*

2. Proteam Healthcare, Inc. (CR3246)
   • Similar to Improving Life Home Care LLC and same ALJ
   • Provider argued that to allow CMS to consider non-compliance with any Medicare law, rule, or program instruction as a basis for revocation renders pointless the enumerated grounds for revocation in 42 C.F.R. 535(a) because all of those grounds would be subsumed under the enrollment requirements.
   • ALJ disagreed. He said 42 C.F.R. 535(a) provides that CMS may revoke billing privileges if the provider or supplier is not in compliance “with the enrollment requirements . . . in the enrollment application.”

*See also City Crown Home Health Agency* (CR3130). *But see Enery Home Health Care* (CR3125) (HHA rebutted “inference” that physician did not see the beneficiaries he certified for home care because he did not bill for them).

---

HHA Revocation:  
*Home(less) on the Range*

3. St. Catherine’s Health Services (CR 3130)
   • Similar to Improving Life Home Care LLC and Proteam
   • HHA argued that it was not responsible for what physician may have falsely certified
   • ALJ disagreed. “By necessity the ongoing relationship between a beneficiary and his or her physician contemplated by the regulations must involve communication between the home health agency and the beneficiary’s physician once the beneficiary is admitted to home health care.”
   • “The requirement that a home health agency remain in communication with a beneficiary’s physician impliedly imposes on a home health agency the duty to verify that the physician is actually ordering the services that he or she purports to order.”
Hardship Exemption and Revocation

*Pyrrhic Victory?*

6. *S.A. Brooks* (CR3216)
   - Enrollment revoked upon revalidation because of failure to pay application fee
   - ALJ reversed revocation, finding that he had authority to review whether waiver of the fee for hardship and that Petitioner’s assertion of the need for the hardship exception were unrebutted
   - Given what this person went through to get a hardship exemption, is it really worth the trouble to save less than $600???

---

**Procedure:** Count the days!!!

60 days ≠ 2 months!

5 extra days may not be added!

Procedural issues

1. *Lower Oconee Community Hospital* (C-14-1311)
   - Presumption that termination notice was received 5 days after mailing was overcome by showing it was received earlier
   - Attorney also made mistake in thinking 60 days was 2 months and filed on day 66.