Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Sonoma Prosthetic Eyes,
(PTAN: 6811110001),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-1660

Decision No. CR3455

Date: November 12, 2014

DECISION

I. Introduction

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to revoke the Medicare enrollment of Petitioner, Sonoma Prosthetic Eyes, as a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). I find that Petitioner failed to comply with the requirements of 42 C.F.R. § 424.57(c)(7). However, I do not find that Petitioner failed to comply with the requirements of 42 C.F.R. § 424.535(a)(5)(ii). Therefore, the effective date of Petitioner's loss of billing privileges is November 12, 2013.

CMS filed a brief and six proposed exhibits that it identified as CMS Ex. 1 – CMS Ex. 6. Petitioner filed a brief and six proposed exhibits that it identified as P. Ex. 1 – P. Ex. 6. Neither party objected to my receiving any of the proposed exhibits. I receive the parties' exhibits into the record.[1]

[1] Petitioner must show good cause for me to receive any documentary evidence that it did not offer at reconsideration. 42 C.F.R. § 498.56(e). The reconsideration determination in this case is silent as to what exhibits may have been offered by

CMS styled its brief as a motion for summary judgment. It is unnecessary for me to decide whether the criteria for summary judgment are met here, because neither CMS nor Petitioner offered written direct testimony. Consequently, there is no need for me to convene an in-person hearing in order to permit cross-examination of witnesses. I decide the case based on the parties' written submissions.

II. Issues, Findings of Fact and Conclusions of Law

A. Issues

The issues are: whether CMS is authorized to revoke Petitioner's enrollment as a DMEPOS supplier; and the effective date of Petitioner's loss of billing privileges.

B. Findings of Fact and Conclusions of Law

CMS asserts two grounds for revoking Petitioner's enrollment. First, it contends that Petitioner failed to comply with the requirements of 42 C.F.R. § 424.57(c)(7). In relevant subparts, this regulation requires that a DMEPOS supplier must be accessible and staffed during posted hours of operation and that it maintain a permanent visible sign in plain view that posts its hours of operation. 42 C.F.R. § 424.57(c)(7)(i)(C), (D). Second, CMS argues that Petitioner was not "operational" within the meaning of 42 C.F.R. § 424.535(a)(5)(ii). The grounds for revocation have meaning here, because as I shall discuss further, revocation for noncompliance with 42 C.F.R. § 424.57 is prospective whereas revocation for failure to comply with 42 C.F.R. § 424.535 may be retroactive.

CMS asserts that, on October 1 and 4, 2013, an inspector working for a Medicare contractor attempted to visit Petitioner's site in order to verify that it was complying with applicable participation requirements. On both occasions, according to CMS, the site was dark and no one answered the door. Petitioner did not have a visible sign posting its hours of operation. CMS Ex. 4.

These facts plainly establish grounds for revoking Petitioner's enrollment for noncompliance with the requirements of 42 C.F.R. § 424.57(c)(7). Petitioner was obligated to post its hours of operation and, moreover, it was obligated to be accessible during whatever hours it posted. It failed in both respects based on the facts offered by CMS.

Petitioner, so I have no way of knowing from the face of the determination what was or what was not offered by Petitioner there. CMS Ex. 1. I infer that the exhibits were offered at reconsideration from the absence of objection by CMS counsel to my receiving Petitioner's exhibits.

Petitioner asserts that it was open "by appointment only" and that CMS's contractor was aware of that. Petitioner's brief at 2. It contends that it was available immediately by telephone and that it "scheduled . . . appointments at the earliest convenient time for the inspector and in both instances gave prompt and unlimited access to the office." *Id.* I infer from this assertion that Petitioner is asserting that it had made appointments with the inspector to be open for inspection and that the Medicare contractor knew that Petitioner's office was open only by appointment. But, Petitioner has not explained why – if appointments were made – the inspector arrived to find a dark and un-staffed facility. I note that Petitioner does not contend that it had staff ready and waiting at the appointed times but that no one showed up to inspect its facility at those times. Nor does Petitioner deny that there was no sign at the entrance of the facility that stated its operating hours (even if they were limited to pre-arranged appointments). Thus, Petitioner's assertions, assuming them to be true, do not squarely meet CMS's contentions, nor do they rebut the evidence offered by CMS showing that Petitioner failed to post its hours of operation.

Petitioner argues additionally that "the site inspector officer was unable to complete the site inspection because they did not follow protocol for suppliers with By Appointment Only Status." Petitioner's brief at 6. Petitioner does not explain what it means by this assertion. However, Petitioner does not contend that it had specific appointment times for inspections and that the inspector did not show up at these times. Petitioner never contends that it was open and available for inspections at pre-arranged times.

Petitioner also alleges that it was not provided an opportunity to file a corrective action plan. That may be so. However, the regulations governing participation by DMEPOS suppliers do not contain language mandating CMS to afford a non-compliant supplier the opportunity to submit a corrective action plan before revoking that supplier's billing privileges for noncompliance with regulatory requirements. Indeed, the regulation makes revocation for noncompliance mandatory:

> CMS *will* revoke a supplier's billing privileges if it is found not to meet the standards in paragraphs (b) and (c) of this section.

42 C.F.R. § 424.57(d) (emphasis added). CMS had no discretion in this instance. It was required to revoke Petitioner's billing privileges based on its noncompliance. A corrective action plan, had Petitioner submitted one, would have been irrelevant.

Petitioner makes additional arguments that add up to a complaint that it was denied due process by CMS. I find these arguments to be without merit. It contends, for example, that it did not receive an acknowledgement that its reconsideration request had been received. But, Petitioner hasn't demonstrated any harm from this oversight. In particular, it hasn't shown that it was denied the opportunity to present evidence and/or argument at reconsideration. It asserts also that the information and arguments that it

presented at reconsideration were reviewed "carelessly." Petitioner's brief at 6. However, Petitioner hasn't explained what that alleged carelessness consisted of, nor has it shown that the alleged carelessness has prejudiced it.

My authority to hear these cases is de novo, of course, and that includes addressing or correcting errors that were made either during the initial determination or reconsideration of this case. Whatever "carelessness" may have occurred during prior reviews is, therefore, no longer relevant in the de novo hearing before me.

CMS has provided no detailed explanation of why there is a basis to revoke Petitioner's Medicare enrollment under 42 C.F.R. § 424.535(a)(5)(ii). However, the language of the section is self-explanatory, allowing for revocation where a supplier has "failed to satisfy any or all of the Medicare enrollment requirements . . . ." Here, Petitioner plainly failed to comply with the DMEPOS Medicare enrollment requirement at 42 C.F.R. § 424.57(c)(7) and that certainly satisfies the quoted language of 42 C.F.R. § 424.535(a)(5)(ii).

However, I decline to find that a basis exists to revoke Petitioner's enrollment pursuant to 42 C.F.R. § 424.535(a)(5)(ii). Although CMS's initial determination in this case cited to both 42 C.F.R. §§ 424.57(c)(7) and 424.535(a)(5) as grounds for its action, the reconsideration determination cited only to 42 C.F.R. § 424.57(c)(7) as a basis for affirming the determination. CMS Ex. 1; CMS Ex. 3. I am sure that the omission in the reconsideration determination was one of oversight because that determination was based on the identical documents and evidence as was the initial determination and, also because there is not an iota of explanation in the reconsideration determination for the failure to discuss 42 C.F.R. § 424.535(a)(5). In other words, the reconsideration officer almost certainly erred in limiting the scope of his analysis.

I would not normally consider that to be a problem because, as I have stated, my authority to hear and decide issues is de novo and there is absolutely nothing in the regulations governing hearings that even hints that the administrative law judge's authority is so limited as to preclude him or her from correcting oversights or failures to address issues at reconsideration.

However, in a series of recent decisions, appellate panels of the Departmental Appeals Board have held that administrative law judges are limited to addressing only the issues that were resolved at reconsideration in cases involving CMS. The Board has effectively taken the position that the scope of an administrative law judge's review in these cases is narrower than the Board's scope of review on appeal, inasmuch as the Board regularly

takes up issues that were never raised by the parties below. I believe that the Board is wrong in this analysis.[2]

That said, I see no benefit in issuing a decision that would be overturned on appeal given the Board's current mindset. I therefore decide that the issue of whether CMS may revoke Petitioner's billing privileges is not before me by virtue of the fact that this issue was not addressed at reconsideration and also by virtue of the Board's evident determination to limit the administrative hearing only to what was decided at reconsideration.[3]

My decision has substantive effect in this case. In its initial determination CMS determined that the effective date of Petitioner's loss of billing privileges was October 4, 2013. That date is based on 42 C.F.R. § 424.535(g), which states that the effective date of revocation is the date when CMS or its contractor determines that a supplier such as Petitioner is "no longer operational." October 4, 2013 would be that date because that is the date of the last inspection of Petitioner's facility at which it was determined that Petitioner was not operational.

However, this regulation is no longer a basis for deciding this case because it was not cited in the reconsideration determination. Therefore, the effective date of Petitioner's

[2] Administrative Law Judge Hughes discusses these decisions in depth in two recent decisions, *Kimberly Bergeron, NP*, DAB CR3438 (2014), and *Gibraltar Healthcare Supplies*,LLC, DAB CR3422 (2014). Her decisions do not bind me, but I cannot improve on her history and analysis, so I adopt them as my own.

[3] As Judge Hughes observed in *Bergeron*, sometimes reconsideration determinations are so poorly written as to be gibberish. In that situation the Board would leave the administrative law judge with no choice but to throw out the reconsideration determination entirely, whatever the merits of the case.

loss of billing privileges is that stated at 42 C.F.R. § 424.57(d), 15 days after Petitioner was sent notice of revocation. The notice was sent on October 28, 2013 and, therefore, the effective date of revocation is November 12, 2013.[4]

/s/
Steven T. Kessel
Administrative Law Judge

[4] I have been advised that, in some of their decisions, Board panels have held that the effective date of loss of billing privileges should be 30 days rather than 15 days after the date of notice of revocation. Apparently, the authority that these panels rely on for their actions is 42 C.F.R. § 424.57(e). However, the current version of that section says nothing whatsoever about the effective date of loss of billing privileges. It is a section that sets criteria for revalidation of billing privileges. The current language governing effective date of revocation is, as I have stated, at 42 C.F.R. § 424.57(d), and that subsection unequivocally sets the effective date at 15 days from the notice.