Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Jersey City Medical Supplies, Inc.
Docket No. A-16-123
Decision No. 2766
January 25, 2017

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Jersey City Medical Supplies, Inc. (Petitioner) appeals the Administrative Law Judge's decision sustaining the revocation of Petitioner's Medicare enrollment and billing privileges for not being accredited as a Medicare supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) as required by Medicare law and regulations. *Jersey City Med. Supplies, Inc.*, DAB CR4651 (2016) (ALJ Decision). The ALJ sustained the revocation based on his findings that Petitioner's accreditation lapsed for nearly seven months and that Petitioner was not accredited at the time of the revocation. The ALJ also changed the effective date for the revocation from October 2, 2015 to February 6, 2016, based on his having reversed another basis for the revocation that is not at issue in the appeal. Petitioner's hearing request does not challenge the ALJ's effective date determination, and that determination, in any event, is legally correct under the applicable regulations.

For the reasons discussed below, we affirm the ALJ decision.

Legal background

DMEPOS suppliers that enroll in Medicare and receive associated billing privileges from the Centers for Medicare & Medicaid Services (CMS) must comply with the conditions for Medicare payment in Part 424 of 42 C.F.R., and with the "[s]pecial payment rules for items furnished by DMEPOS suppliers and issuance of DMEPOS supplier billing privileges" in section 424.57, including the "supplier standards" in 42 C.F.R. § 424.57(c). Standard 22, at section 424.57(c)(22), states that a DMEPOs supplier "must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number." 42 C.F.R. § 424.57(c)(22) (2007). Standard 22 implements section 1834(a)(20)(A) of the Social Security Act (42 U.S.C. § 1395m(a)(20)(A)) requiring the Secretary of Health and Human Services to "establish and implement quality standards . . . to be applied by recognized independent accreditation organizations . . . with which [DMEPOS] suppliers shall be required to comply in order to— . . . receive or retain a provider or supplier number used to submit claims for reimbursement" under Medicare.

The Centers for Medicare & Medicaid Services (CMS) "revokes a supplier's billing privileges if it is found not to meet the standards in paragraphs (b) and (c)" of section 424.57. 42 C.F.R. § 424.57(e)(1) (2015); *see also 1866ICPayday.com, L.L.C.*, DAB No. 2289, at 13 (2009) ("failure to comply with even one supplier standard is a sufficient basis for revoking a supplier's billing privileges"). A revocation is effective 30 days after the supplier is sent notice of the revocation, except where section 424.57 provides otherwise. 42 C.F.R. § 424.57(e)(1) (2015). Revocation also results in termination of the supplier's Medicare agreement, and the supplier is barred from re-enrolling in Medicare from one to three years, depending on "the severity of the basis for revocation." 42 C.F.R. § 424.535(c)(1).

A supplier may request reconsideration of the revocation by CMS, may request a hearing before an ALJ to challenge CMS's reconsidered determination, and may then seek Board review of an unfavorable ALJ decision. 42 C.F.R. §§ 424.545, 498.5(1), 498.22, 498.40, 498.80. In enrollment appeals by Medicare suppliers and providers, the Board may not admit evidence into the record in addition to the evidence introduced before the ALJ. *Id*. § 498.86(a).

Case background and ALJ Decision

By notice of January 7, 2016, the Medicare contractor, Palmetto GBA National Supplier Clearinghouse (NSC), revoked Petitioner's Medicare enrollment and billing privileges for noncompliance with four DMEPOS supplier standards: the requirement to be accredited by a CMS-approved accreditation organization noted above, and also requirements that a DMEPOs supplier have a comprehensive liability insurance policy (§ 424.57(c)(10)), maintain an acceptable surety bond (§ 424.57(c)(26)), and respond to CMS's requests for information (§ 424.57(c)(21)). CMS Ex. 3. NSC imposed a two-year bar on re-enrolling in Medicare. *Id*. at 1. NSC upheld the revocation on reconsideration on March 25, 2016 (CMS Ex. 11), and Petitioner appealed the reconsidered determination by requesting an ALJ hearing. Before the ALJ, CMS moved for summary judgment and filed proposed exhibits including the declarations of two NSC managers (CMS Exs. 1-18), and Petitioner moved for summary judgment and filed two proposed exhibits (P. Exs. 1-2).[1] ALJ Decision at 1. Petitioner did not ask to examine either of CMS's declarants. The ALJ accepted the parties' exhibits into evidence, declined to rule on the motions for summary judgment and decided the case based on the parties' written evidence. *Id*. at 2.

The ALJ sustained the revocation on the ground "that Petitioner failed to comply with the accreditation requirements of 42 C.F.R. § 424.57(c)(22)." *Id*. The ALJ also held that Petitioner had complied with the requirements to maintain comprehensive liability

[1] The ALJ identified documents Petitioner filed with its Pre-Hearing Brief and Motion for Summary Judgment as P. Ex. 1, and documents attached to Petitioner's hearing request as P. Ex. 2. ALJ Decision at 1.

insurance and possess an acceptable surety bond, and found it "unnecessary that I decide whether Petitioner failed to comply with the information requirements of 42 C.F.R. § 424.57(c)(21) inasmuch as its failure to comply with the accreditation requirement is ample basis for revoking its billing privileges." *Id*. at 2-3; *see also id*. at 3 ("Petitioner failed to comply with the accreditation requirement and revocation is justified on that basis alone."). CMS did not appeal those determinations and they are not before us.

As to Petitioner's noncompliance with the accreditation requirement, the ALJ found that on August 13, 2009 the Healthcare Quality Association on Accreditation (HQAA) issued Petitioner a certificate of accreditation that was effective for three years, that the HQAA accreditation expired on July 10, 2015, and that Petitioner was subsequently accredited by a different organization, the Accreditation Commission for Health Care (ACHC), beginning February 3, 2016. ALJ Decision at 3, citing CMS Ex. 2, at 42 (HQAA certificate of accreditation); CMS Ex. 10, at 7 (ACHC certificate of accreditation); CMS Ex. 15, at 1-2 (spreadsheet); and CMS Ex. 18, at 5 (decl. of NSC hearings and appeals manager). The ALJ rejected Petitioner's assertions that the ACHC accreditation began effective July 14, 2015 and that it was "completely covered" by the two accreditation organizations, finding that Petitioner "proved only that it was accredited by ACHC beginning February 3, 2016."[2] *Id*. The ALJ found that the evidence Petitioner cited, a "screenshot" from the ACHC website, appeared to show only that Petitioner submitted an application to ACHC on July 14, 2015, "and that its application status was 'In Progress.'" *Id*. citing P. Ex. 2, at unnumbered 7; and CMS Ex. 8, at 5-6. The ALJ found this evidence "roughly consistent" with CMS exhibits showing that Petitioner "submitted its completed application for accreditation with ACHC on July 23, 2015, and ACHC surveyed Petitioner for accreditation on October 1, 2015[,]" and that Petitioner's accreditation "was not actually *effective* until February 3, 2016." *Id*. (ALJ italics), citing CMS Ex. 16, at 2; and CMS Ex. 10, at 7.

The ALJ accordingly found "that there was a period during which Petitioner was not accredited by any organization, and it was not accredited as of January 7, 2016, the date on which the contractor sent Petitioner notice of its revocation determination" and concluded that revocation "is justified in this case by Petitioner's failure to be accredited as of the date that the contractor sent notice to it." ALJ Decision at 3.

[2] Even if the ALJ had accepted Petitioner's assertion as to when the ACHC accreditation began, there would have been a lapse in Petitioner's accreditation from July 10 through July 13, 2015.

Standard of review

We review a disputed finding of fact to determine whether the finding is supported by substantial evidence in the record as a whole, and a disputed conclusion of law to determine whether it is erroneous. *Guidelines -- Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program* (*Guidelines*);[3] *Golden Living Ctr. – Frankfort v. Sec'y of Health & Human Servs.***,** 656 F.3d 421, 426-27 (6th Cir. 2011) (stating that this is "the correct standard of review").

Analysis

I. The ALJ's determination that revocation was justified because Petitioner did not comply with the requirement to be accredited was supported by substantial evidence and free of legal error.

A. The evidence supports the ALJ's finding that Petitioner was not accredited as required by the regulations and does not support Petitioner's claim that its accreditation did not lapse.

As an initial matter, we note that Petitioner's request for review does not specify any ALJ findings or legal conclusions with which it disagrees or its reasons for disagreeing. *See* 42 C.F.R. § 498.82(b) (stating that a request for review "***must specify*** the ***issues***, the ***findings of fact*** or ***conclusions of law*** with which the party disagrees, and the basis for contending that ***the findings and conclusions*** are incorrect") (emphasis added); *Guidelines* (Board "will not consider issues not raised in the request for review"). More specifically, Petitioner does not dispute that the HQAA accreditation expired on July 10, 2015, that the ACHC accreditation was not effective until February 3, 2016, and that Petitioner thus "failed to comply with the accreditation requirement" of section 424.57(c)(22), justifying the revocation (ALJ Decision at 3). Petitioner's request for review argues only that Petitioner is currently in compliance with the Medicare requirements and seeks relief from the revocation on equitable grounds.

Petitioner's reply to CMS's response to the request for review, however, argues essentially that Petitioner's accreditation did not lapse because the new accreditation organization, ACHC, had effectively approved Petitioner's accreditation prior to issuing its certificate of accreditation that was effective February 3, 2016. Petitioner argues that "[t]here was no lapse in accreditation of seven months [from July 10, 2015 when the HQAA accreditation expired to February 3, 2016 when the ACHC accreditation began]

[3] The *Guidelines* are available at http://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/enrollment/index.html.

because during that time we were being scheduled and reviewed and instructed by ACHC, as the invoice and the web screenshot that is included in this case shows." P. Reply at 2. Petitioner explains that "our new accreditation was started for review and visit on 07/14/2015" and "we were under supervision and review by ACHC awaiting their appointment to come to our facility while converting from HQAA to ACHC . . . ." *Id*. at 2, 3.

Petitioner should have made these arguments in its request for review, not in its reply. In any event, these arguments fail because the evidence Petitioner cites does not support its claim to have been continuously accredited. The "web screenshot" Petitioner cites does not state or indicate that Petitioner's accreditation was effective as of July 10, 2015, when the prior HQAA accreditation expired, or at any time prior to the commencement of the ACHC accreditation on February 3, 2016. This document, which is undated, states that Petitioner's application with the ACHC was "In Progress," that it was both "SUBMITTED" and "LAST UPDATED" on July 14, 2015 at 11:39 a.m., and that its "STATUS" was "Advisor Approved." P. Ex. 2, at 7 (unnumbered); CMS Ex. 8, at 5-6.[4] That fact that the application was represented as being only "in progress" and had been approved only by an advisor but not by ACHC on the unknown date it was printed evidences that it had not yet been approved.

Thus, the evidence Petitioner cites is consistent with the other evidence of record showing that the ACHC accreditation began on February 3, 2016, most notably a "CERTIFICATE *of* ACCREDITATION" from the ACHC stating that Petitioner was accredited "FROM *February 3, 2016* THROUGH *February 2, 2019*." P. Ex 2, at 1 (italics and small caps in original); CMS Ex. 10, at 7 (same document). The screenshot is also, as the ALJ found, "roughly consistent" with what one of the NSC manager witnesses identified as one of "the weekly spreadsheets sent by accreditation companies to Palmetto GBA[,]" showing that Petitioner "submitted its completed application for accreditation with ACHC on July 23, 2015, and ACHC surveyed Petitioner for accreditation on October 1, 2015" and that Petitioner's ACHC accreditation "was not actually *effective* until February 3, 2016." CMS Ex. 16; CMS Ex. 18, at 5; ALJ Decision at 3 (ALJ italics). (Petitioner does not dispute the ALJ's finding that the prior accreditation by HQAA expired on July 10, 2015.)

Accordingly, substantial evidence supports the ALJ's findings that "Petitioner's accreditation was not actually *effective* until February 3, 2016" and that "there was a period during which Petitioner was not accredited by any organization . . . ." ALJ Decision at 3 (ALJ italics). This substantial evidence also supports the ALJ's further conclusion that Petitioner "was not accredited as of January 7, 2016, the date on which the contractor sent Petitioner notice of its revocation determination." *Id.*

[4] This document appears in Petitioner's exhibits as a partial screenshot on one page and in CMS's exhibits as the complete screenshot over two pages.

B. Petitioner's current accreditation does not permit reversal of the revocation.

Petitioner argues that the revocation should be reversed because it is currently "in total compliance" and "in full compliance with Accreditation." P. Reply at 1, 3. That Petitioner became accredited again on February 3, 2016, after CMS's January 7, 2016 revocation decision, did not permit the ALJ (and does not permit the Board) to reverse the revocation. "[A]ppeal rights are limited to provider or supplier eligibility at the time the Medicare contractor made the adverse determination[,]" including the "revocation of billing privileges[.]" 73 Fed. Reg. 36,448, 36,452 (June 27, 2008); *Pepper Hill Nursing & Rehab. Ctr., LLC*, DAB No. 2395, at 6 (2011) (holding that "[t]he ALJ's focus on compliance at the time of the revocation action . . . is consistent with [that] preamble [language]").

Moreover, the fact that Petitioner is currently accredited does not change the fact that its accreditation lapsed before the revocation. The DMEPOS supplier regulations require a supplier to "be accredited by a CMS-approved accreditation organization in order to receive and **retain** a supplier billing number" and that the supplier "must meet and must certify in its application for billing privileges that it meets and **will continue to meet**" the supplier standards in section 424.57(c). 42 C.F.R. § 424.57(c), (c)(22) (emphasis added). *See also A TO Z DME, LLC*, DAB No. 2303, at 6-7 (2010) (stating that similar language in the preamble to the supplier (and provider) appeal regulations "demonstrates the intent of the regulations . . . that a supplier must **maintain**, and be able to demonstrate, **continued compliance** with the requirements for receiving Medicare billing privileges." (emphasis added)). Thus, a DMEPOS supplier whose accreditation lapses is not in compliance with the supplier standards. It is the lapse of Petitioner's accreditation prior to the revocation that provided the basis for the revocation; accordingly, that fact, not Petitioner's current status, is the fact material to our determination.

II. Petitioner's other arguments do not show any error in the ALJ Decision.

A. Petitioner's argument that it should be considered to have been accredited under 42 C.F.R. § 424.57(c)(23) is untimely and has no merit.

Petitioner alternatively argues that even if its accreditation lapsed, it was nonetheless "assumed as accredited" and was "considered in full compliance" by the ACHC, which thus "had no rush to place a site visit and they decided to give us a longer time of accreditation to my understanding." P. Reply at 3. Petitioner cites section 424.57(c)(23), which requires DMEPOS suppliers to notify their accreditation organization when they open a new DMEPOS location and provides that "[t]he accreditation organization may

accredit the new supplier location for three months after it is operational without requiring a new site visit." (Neither party has challenged the ALJ's finding that there was "no dispute that, as of January 2016, Petitioner was doing business at an address other than the address it had filed as its official place of business." ALJ Decision at 3).[5]

Petitioner did not make this argument before the ALJ or cite 424.57(c)(23). The Board *Guidelines* state that the Board "will not consider . . . issues which could have been presented to the ALJ but were not." Nevertheless, we find it appropriate to note that section 424.57(c)(23) on its face does not apply because there is no evidence that ACHC did accredit Petitioner without a site visit for three months under this provision. Indeed, the evidence in the record, as we discussed above, supports the ALJ's finding that the ACHC did not accredit Petitioner prior to February 3, 2016. Even if ACHC had accredited Petitioner for three months under this regulation, that would not have covered the nearly seven-month lapse in accreditation.

B. The Board cannot grant Petitioner equitable relief from the revocation, or reduce the duration of the re-enrollment bar, or review denied claims for Medicare payment.

Petitioner argues for reversal on equitable grounds, alleging that the revocation would effect hardship on its customers. Petitioner asserts its community will lose "one of the few small providers left in the area that cater[s] face to face to meet the patient's needs and provide personal, store to person delivery which most providers don't do anymore" and that if patients "can't get to a provider they will have to be interned" at a hospital "costing the Medicare program far more in inpatient and outpatient costs [than] having supplies delivered to their home." P. Request for Review at 1; P. Reply at 4. Petitioner asserts "we are currently in compliance" and questions "why they [CMS] are so adamant about keeping a small provider like us revoked from the Medicare program . . . ." P. Reply at 1, 3. Petitioner asks the Board to "be more lenient so as to not cause us to be revoked from the Medicare program, the patients in our area depend on us" and requests, if not reversal, then "shortening the term of the revocation because two years is extensive." P. Request for Review at 1; P. Reply at 4.

[5] Petitioner below and on appeal has not stated when it opened its new location. In its request for reconsideration Petitioner claimed to have updated its address "a while ago," and an insurance document Petitioner submitted to CMS, which shows the new address, was issued May 23, 2015 and effective May 3, 2015. CMS Ex. 8, at 1, 2. An enrollment application Petitioner filed to change its business address location states the change to the new location was effective September 1, 2015. CMS Ex. 14, at 7; P. Ex. 2, at 14.

Even assuming Petitioner's claims about the adverse effects of revocation are true (Petitioner filed no evidence supporting them), they do not permit us to reverse the revocation. The Board "has consistently held that neither it nor the ALJs have the authority to provide equitable relief." *Sunview Care & Rehab Ctr. LLC*, DAB No. 2713, at 12 (2016). The Board there cited *US Ultrasound*, DAB No. 2302, at 8 (2010), where the Board held that "[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." The Board "is bound by the regulations, and may not choose to overturn the agency's lawful use of its regulatory authority based on principles of equity." *Cent. Kan. Cancer Inst.*, DAB No. 2749, at 10 (2016), citing *Pepper Hill Nursing & Rehab. Ctr*. at 10. Here, the applicable regulation states that "CMS revokes" a supplier's billing privileges if it does not meet the supplier standards in section 424.57(c). 42 C.F.R. § 424.57(e)(1) (2015). In light of that directive and authority, neither the ALJ nor the Board may reverse a revocation that CMS was legally authorized to impose.

The Board also does not have authority to reduce the two-year bar on Petitioner re-enrolling in the Medicare program following the revocation of its enrollment and billing privileges. As the Board has held, "CMS's determination of the length of the reenrollment bar under section 424.535(c) is not subject to review." *Mohammad Nawaz, M.D., & Mohammad Zaim, M.D., PA*, DAB No. 2687, at 15 (2016), citing *Vijendra Dave, M.D.*, DAB No. 2672, at 10-11 (2016). This is because the duration of a revocation is not among the "initial determinations" identified in 42 C.F.R. Part 498 that are subject to ALJ and Board review. *Patrick Brueggeman, D.P.M.*, DAB No. 2725, at 15 (2016). The Board "'has emphasized that with respect to appeals under Part 498, ALJs and the Board may only review issues specifically identified as appealable administrative actions (i.e., 'initial determinations') in section 498.3' which '[o]n its face . . . does not describe any matter related to a post-revocation re-enrollment bar.'" *Id.*, quoting *Mohammad Nawaz, M.D., & Mohammad Zaim, M.D., PA* at 15-16, quoting *Vijendra Dave, M.D.* at 10.

For the same reasons, the Board may not review Medicare payment claims that Petitioner, in an unaddressed memorandum filed with the Board on August 22, 2016, says were denied "after we were reactivated until" February 6, 2016. Petitioner with that memorandum filed 73 computer printout pages of claims and asked that they be reviewed and "reprocessed and paid or denied . . . ."[6] However, "[d]enials of individual Medicare

[6] Petitioner asked the Board to review the claims listed in the printout but did not specifically request that the printout be admitted into the record. The regulation at 42 C.F.R. § 498.86(a) forbids the Board, in provider or supplier enrollment appeals, from admitting into the record evidence not introduced before the ALJ. We also note that the computer printout pages contain personally identifiable information which should be redacted in the event the pages are released.

payment claims are not among the initial determinations in Part 498 that the Board or its administrative law judges are authorized to review." *BioniCare Med. Technologies, Inc.*, DAB No. 2338, at 3 (2010); *see also Vijendra Dave, M.D.* at 12 ("appealable initial determinations do not include an adverse Medicare coverage or payment determination").

Conclusion

For the reasons discussed above, the Board affirms the ALJ Decision upholding the revocation of Petitioner's Medicare enrollment and billing privileges.

/s/
Constance B. Tobias

/s/
Susan S. Yim

/s/
Sheila Ann Hegy
Presiding Board Member