Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Keyz EMS, Inc.
(NPI: 1295007904 / PTAN: AMB1296),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-1070

Decision No. CR4090

Date: July 31, 2015

DECISION
GRANTING PARTIAL SUMMARY JUDGMENT

The Medicare enrollment and billing privileges of Petitioner, Keyz EMS, Inc., are revoked pursuant to 42 C.F.R. § 424.535(a)(5)(ii)[1] because an on-site visit found that Petitioner had not satisfied all of the applicable Medicare enrollment requirements. The effective date of the revocation is November 16, 2014, 30 days after Novitas Solutions (Novitas), a Medicare administrative contractor for the Centers for Medicare & Medicaid Services (CMS), notified Petitioner of the factual and legal basis for the revocation. 42 C.F.R. § 424.535(g). CMS has imposed a two-year bar on Petitioner's re-enrollment in the Medicare program, which is permissible under the applicable regulations. 42 C.F.R. § 424.545(c).

Summary judgment is not granted upholding revocation with an earlier effective date on the basis that Petitioner was not operational during various attempted on-site inspections. Not more than ten days from the date of this decision, CMS may request a hearing on the

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[1] Citations are to the 2013 revision of the Code of Federal Regulations (C.F.R.), unless otherwise indicated.

merits to attempt to establish Petitioner was not operational and that an earlier effective date of revocation is justified. Either party may request review of this decision by the Departmental Appeals Board (Board) within 60 days of receipt. 42 C.F.R. §§ 498.80 - .82. However, if CMS requests a hearing on the merits regarding whether or not Petitioner was operational and whether or not an earlier effective date of revocation is justified, the period for requesting Board review will run from receipt of the decision following the hearing on the merits.

I. Background

Petitioner was enrolled in the Medicare program as a supplier[2] of ambulance services in Texas. CMS Exhibit (CMS Ex.) 4 at 1-2; Petitioner Exhibit (P. Ex.) C. Novitas notified Petitioner by letter dated July 10, 2014, that Petitioner's Medicare billing number and billing privileges were revoked effective June 27, 2014, pursuant to 42 C.F.R. § 424.535(a)(5). CMS Ex. 1 at 7-8. Novitas cited two attempted on-site inspections of Petitioner's location in Fresno, Texas, on June 26, 2014, at 1:00 p.m., and June 27, 2014, at 10:25 a.m., during which the contractor's inspector found Petitioner's office closed to the public with no sign of employees or customer activity. CMS Ex. 1 at 7. Novitas also notified Petitioner that it was subject to a two-year bar to re-enrollment pursuant to 42 C.F.R. § 424.535(c). CMS Ex. 1 at 8.

On July 15, 2014, Petitioner submitted a request for reconsideration to Novitas. CMS Ex. 1 at 5-6. Petitioner's owner stated in the reconsideration request that, on or around June 20, 2014, he decided to move Petitioner's office from his residence in Fresno, Texas, to an office building in Houston, Texas. CMS Ex. 1 at 5. Petitioner's owner submitted with the reconsideration a copy of a lease dated June 20, 2014, for the new office space in Houston. CMS Ex. 1 at 9-22. The contractor subsequently attempted to conduct two on-site inspections of the Houston office, first on September 17, 2014, at 11:25 a.m., and again on September 25, 2014, at 12:35 p.m. CMS Ex. 2 at 3-5. During both on-site inspections, the contractor's inspector found Petitioner's office closed and no one answered when the inspector knocked on the door. CMS Ex. 2 at 3. The inspector

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[2] 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.

photographed a sign on the office door with Petitioner's name and office hours. CMS Ex. 2 at 5. On October 17, 2014, a contractor hearing officer issued a reconsidered determination in which she upheld the revocation pursuant to 42 C.F.R. § 424.535(a)(5). CMS Ex. 1 at 1-4.

On November 14, 2014, Petitioner requested a hearing (RFH) before an administrative law judge (ALJ). On January 30, 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 March 2, 2015, CMS filed a motion for summary judgment and supporting brief (CMS Br.), with CMS Exs. 1 through 4. On April 27, 2015, Petitioner filed an opposition to CMS's motion (P. Br.), with three exhibits marked P. Exs. A, B, and C,[3] and another document not labeled as an exhibit, but labeled as an "Additional Supporting Document." On May 13, 2015, CMS filed its reply brief (CMS Reply) with four additional exhibits, labeled CMS Exs. 5 through 8. Petitioner has not objected to CMS Exs. 1 through 8 and they are admitted as evidence. CMS has not objected to P. Exs. A through C, or the "Additional Supporting Document" that Petitioner filed on April 27, 2015, 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 Novitas. 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 §§ 1834(j)(1) (42 U.S.C. § 1395m(j)(1)); 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395u(h)(1)). Petitioner is a supplier of ambulance services. 42 C.F.R. § 410.41.

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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[3] Petitioner filed three documents on February 20, 2015, but these documents were unlabeled. I stated in my April 13, 2015 Order to Show Cause that I did not accept these documents as proposed exhibits or as Petitioner's prehearing exchange. Petitioner resubmitted the three documents labeled P. Exs. A through C.

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. Subsection 424.510(d)(3) 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 abides 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 authority to CMS or its Medicare contractor to revoke an enrolled supplier's Medicare enrollment and billing privileges and any supplier agreement for any of the reasons listed in 42 C.F.R. § 424.535. Pursuant to 42 C.F.R. § 424.535(a)(5), CMS may revoke a supplier's enrollment and billing privileges if CMS determines, upon on-site review, that the supplier is no longer operational to furnish Medicare covered items or services, has failed to satisfy any or all of the Medicare enrollment requirements, or has failed to furnish Medicare covered items or services as required by the statute or regulations. 42 C.F.R. § 424.535(a)(5)(ii).

If CMS revokes a supplier's Medicare billing privileges for not complying with enrollment requirements, then the revocation is effective 30 days after CMS or its contractor mails notice of its determination to the supplier. 42 C.F.R. § 424.535(g). When CMS revokes a supplier's billing privileges because the supplier is not operational, the revocation is effective as of the date CMS determined the supplier to be not operational. 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. 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 advising the supplier of its 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 the revocation of Petitioner's billing privileges and Medicare enrollment.

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. **Partial Summary judgment is appropriate.**

2. **Petitioner did not file a CMS-855B with the CMS contractor to provide notice of a change in Petitioner's practice location within 90 days of the change as required by 42 C.F.R. § 424.516(e)(2).**

3. **Petitioner was not in compliance with 42 C.F.R. § 424.516(e)(2) because an on-site review determined Petitioner changed its practice location but did not properly notify the CMS contractor of that change within 90 days as required.**

4. **There is a basis for revocation of Petitioner's enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(5)(ii) for failure to comply with the Medicare enrollment requirement established by 42 C.F.R. § 424.516(e)(2).**

a. Facts

The material facts that establish a basis to revoke Petitioner's Medicare billing privileges pursuant to 42 C.F.R. § 424.535(a)(5)(ii) are not disputed. Petitioner enrolled in the Medicare program as a supplier of ambulance services effective December 6, 2011. RFH, P. Ex. C. On April 24, 2014, Petitioner's owner signed a CMS-855B application that changed Petitioner's correspondence address and practice location to 1734 Teal Bend Court in Fresno, Texas. CMS Ex. 3 at 4, 6-9; P. Ex. A. Petitioner argues that the

CMS-855B signed April 24, 2014, provided CMS and its contractor with notice that Petitioner moved to 9898 Bissonnet Street, Suite 375-H. Petitioner's argument is not credible. The CMS-855B signed on April 24, 2014, does not list the 9898 Bissonnet Street address. P. Br. at 4; P. Ex. A. The CMS-855B that Petitioner submitted to Novitas only lists the 1734 Teal Bend Court address as Petitioner's practice location effective April 1, 2014. Two months later, on June 20, 2014, Petitioner's owner signed a lease for 9898 Bissonnet Street, Suite 375-H in Houston, Texas. CMS Ex. 1 at 9, 17; P. Ex. B. The lease provided Petitioner with the right of occupancy in Suite 375-H as of June 18, 2014. CMS Ex. 1 at 17; P. Ex. B.

On June 23, 2014, two months after Petitioner notified Novitas of its move to 1734 Teal Bend Court and three days after Petitioner signed the lease for 9898 Bissonnet, Inspector Ronald McSwain made an unsuccessful attempt to conduct an on-site visit of Petitioner at 17512 Highway 6, Suite 3 in Manvel, Texas. CMS Ex. 2 at 1-2. That address appears to have been Petitioner's location prior to Petitioner's move to 1734 Teal Bend Court. CMS Ex. 4. On June 26, 2014, at 1:00 p.m., and again on June 27, 2014, at 10:25 a.m., Inspector Paul Farmer made unsuccessful attempts to conduct on-site visits of Petitioner at 1734 Teal Bend Court. CMS Ex. 2 at 6-7. By the time of the June 26, 2014 attempted on-site inspection, however, it is undisputed that Petitioner's owner had already signed the lease for the 9898 Bissonnet Street, Suite 375-H and Petitioner had moved or was in the process of moving to that new location. CMS Ex. 1 at 9-22; P. Br. at 6. At the time of the June 26 and 27, 2014 failed attempts to conduct an on-site inspection at 1734 Teal Bend Court, Petitioner had not filed a CMS-855B with Novitas advising the contractor of the change in practice location from 1734 Teal Bend Court in Fresno to 9898 Bissonnet Street, Suite 375-H, in Houston. But, pursuant to 42 C.F.R. § 424.516(e)(2), Petitioner had 90 days, or until about September 18, 2014, to file a CMS-855B notifying Novitas and CMS of the move. Based on the failed attempts to complete on-site inspections at 1734 Teal Bend Court, Inspector Farmer determined that he was "unable to ascertain if [Petitioner] is operational since no one was at the location on both visits." CMS Ex. 2 at 6. Despite stating that he could not conclude the actual operational status of Petitioner, Inspector Farmer nevertheless checked a box on his report that indicated Petitioner was not operational. CMS Ex. 2 at 6. On July 10, 2014, Novitas issued an initial determination revoking Petitioner's Medicare billing privileges because it had determined Petitioner was "no longer operational at 1734 Teal Bend Court, Fresno, Texas 77545 to furnish Medicare covered items or services." CMS Ex. 1 at 7.

In its reconsideration request dated July 15, 2014, Petitioner's owner explained that he submitted to Novitas a CMS-855B application and EFT-588 form in April 2014 "to update the bank account information on file and the correspondence, practice location, and special payments address." CMS Ex. 1 at 5. Petitioner's owner acknowledged that the address on the CMS-855B he sent in April 2014 was for his residence, 1734 Teal Bend Court, and further stated that he "decided to move the business from my residence to an actual office, with the company's best interests in mind." CMS Ex. 1 at 5.

The owner said that the April 2014 application was still being processed at the time he moved Petitioner's offices from his residence, and that "he was told that [he] would be able to make changes to the existing application in the case that another development letter was issued." CMS Ex. 1 at 5. He then explained that Petitioner "had already begun relocating the company to the new address" at the time of the June 26, 2014 and June 27, 2014 on-site inspection attempts. CMS Ex. 1, at 5.

Petitioner does not allege and has presented no evidence that he ever filed a CMS-855B reporting a change of practice location from 1734 Teal Bend Court to 9898 Bissonnet Street. There is no record of "another development letter" having been issued from Novitas, and no evidence in the record to support an inference that Petitioner attempted to correct its April 2014 CMS-855B to notify Novitas of its change in location from 1734 Teal Bend Court to 9898 Bissonnet Street. Prior to the reconsidered determination and apparently based on the allegation in Petitioner's request for reconsideration, Novitas directed on-site visits for Petitioner's 9898 Bissonnet Street location. CMS Ex. 1 at 1. On September 17, 2014, at 11:25 a.m., Inspector Farmer found the door to Suite 375-H at 9898 Bissonnet closed and no one answered when he knocked. CMS Ex. 2 at 3. He took photographs of the sign outside of Suite 375-H, which listed Petitioner's name, "Keyz EMS, Inc.," and listed its hours as "Monday – Friday" from "9:00 a.m. – 5:00 p.m." CMS Ex. 2 at 4. Petitioner was also listed on the building directory, which listed Petitioner's location in the building as Suite 375-H. CMS Ex. 2 at 5. On September 25, 2014, at 12:35 p.m., Inspector Farmer attempted another on-site inspection and again found Petitioner's door closed and no answered when he knocked. CMS Ex. 2 at 3. He completed a report that indicated Petitioner did not "appear to be operational," but that there was a sign that listed Petitioner's name. CMS Ex. 2 at 3. Petitioner's owner does not dispute that the 9898 Bissonnet Street, Suite 375-H office was closed at the times of both attempted on-site inspections. RFH; P. Br. at 2.

On October 17, 2014, the contractor hearing officer issued a reconsidered determination that notified Petitioner it "did not pass" the attempted on-site inspections. The hearing officer cited 42 C.F.R. § 424.535(a)(5) as the basis for revocation and stated next to that regulatory citation that it related to "On-Site Review – Requirements Not Met." CMS Ex. 1 at 1. The hearing officer accepted the fact that Petitioner had begun to move from the 1734 Teal Bend Court address to 9898 Bissonnet Street, Suite 375-H, which was "the reason why the site visit failed at the Teal Bend Court address on June 26, 2014 and June 27, 2014." CMS Ex. 1 at 2. Petitioner did not submit, and the contractor did not consider, a CMS-855B application listing the 9898 Bissonnet Street, Suite 375-H location as Petitioner's practice location. The hearing officer found that the only CMS-855B that Petitioner submitted was dated April 24, 2014, which listed the Teal Bend Court address. CMS Ex. 1 at 2.

b. Analysis

CMS requested summary judgment in this case. A provider or supplier denied enrollment in Medicare or whose enrollment has been revoked has a right to a hearing and judicial review pursuant to section 1866(h)(1) and (j) of the Act and 42 C.F.R. §§ 498.3(b)(1), (5), (6), (8), (15), (17); 498.5. A hearing on the record, also known as an oral hearing, is required under the Act. Act §§ 205(b), 1866 (h)(1) and (j)(8); *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 the CMS motion for summary judgment has merit.

Summary judgment is not automatic upon request but is limited to certain specific conditions. The Secretary's regulations that establish the procedures to be followed in adjudicating Petitioner's case are at 42 C.F.R. pt. 498. 42 C.F.R. §§ 405.800, 405.803(a); 424.545(a), 498.3(b)(5), (6), (15), (17). The regulations 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 (Fed. R. Civ. P.) do not apply in administrative adjudications such as this, but the Board has accepted that Fed. R. Civ. P. 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. P. 56 will be applied.

Summary judgment is appropriate when there is no genuine dispute as to any material fact for adjudication and/or the moving party is entitled to judgment as a matter of law. 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. 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. 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 differs 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 & Conv. Ctr.*, DAB No. 1904 (2004), *aff'd*, *Batavia Nursing & Conv. Ctr. v. Thompson*, 129 Fed. App'x 181 (6th Cir. 2005).

In this case, the reconsidered determination cited 42 C.F.R. § 424.535(a)(5) as the basis for revocation of Petitioner's Medicare billing privileges. CMS requests summary judgment in its favor arguing that there is a basis for revocation of Petitioner's billing privileges pursuant to 42 C.F.R. § 424.535(a)(5)(ii) on grounds that Petitioner was not operational at the time of the multiple site visits. CMS Br. at 1, 6-7. However, the contract hearing officer did not conclude in the reconsidered determination that Petitioner was not operational. Rather, the hearing officer stated "Revocation Reason: 42 C.F.R. § 424.535(a)(5) – On-Site Review – Requirements Not Met." CMS Ex. 1 at 1.

The hearing officer cited to 42 C.F.R. § 424.535(a)(5), and did not limit her determination to one of the three bases for revocation established by that section. CMS Ex. 1 at 1. The hearing officer's citation to 42 C.F.R. § 424.535(a)(5) is sufficient notice to Petitioner of the law that the contractor hearing officer relied upon to revoke Petitioner's Medicare billing privileges. But it is necessary to consider whether Petitioner violated any of the three stated bases for revocation in 42 C.F.R. § 424.535(a)(5), not simply whether Petitioner was operational. As the Board has noted in *Neb Group of Arizona, LLC*, DAB No. 2573, at 7 (2014), in provider and supplier enrollment cases, an ALJ reviews the basis for revocation cited in the reconsidered determination. Thus, my review in this case is not limited to whether or not Petitioner was "operational" simply because that is the focus of the parties' arguments. The reconsidered determination cited 42 C.F.R. § 424.535(a)(5) generally as the basis for revocation, and my de novo review must consider all the bases for revocation established by that regulation.

Subsection 424.535(a)(5)(i) of Title 42 applies only to providers and there can be little doubt Petitioner understands it is not a provider. 42 C.F.R. § 424.502. Subsection 42 C.F.R. § 424.535(a)(5)(ii) applies to Petitioner as a supplier of ambulance services. The regulation authorizes CMS to revoke a supplier's Medicare billing privileges under the following circumstances, among others:

> (5) *On-site review.* CMS determines, upon on-site review, that the provider or supplier is no longer operational to furnish Medicare covered items or services, or is not meeting Medicare enrollment requirements under statute or regulation to supervise treatment of, or to provide Medicare covered items or services for, Medicare patients. Upon on-site review, CMS determines that —
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> (ii) A Medicare Part B supplier is no longer operational to furnish Medicare covered items or services, or the supplier has failed to satisfy any or all of the Medicare enrollment requirements, or has failed to furnish Medicare covered items or services as required by the statute or regulations.

42 C.F.R. § 424.535(a)(5)(ii) (italics in original). The plain language of the regulation makes clear that there are three separate bases for revocation following an on-site review: (1) the supplier is no longer operational to furnish Medicare covered items or services; (2) the supplier has failed to satisfy any or all of the Medicare enrollment requirements; or (3) the supplier has failed to furnish Medicare covered items or services as required by the Act or the Secretary's implementing regulations. CMS has not alleged or presented any evidence that Petitioner failed to furnish Medicare covered items or services as required, so that basis for revocation is not at issue. As discussed hereafter, there remains a genuine dispute about whether Petitioner was operational to provide Medicare covered items or services at the times of the on-site inspections, so summary judgment is not appropriate on that basis for revocation. Therefore, the only remaining basis for revoking Petitioner's billing privileges pursuant to 42 C.F.R. § 424.535(a)(5)(ii) for which summary judgment may be appropriate is whether Petitioner failed to satisfy any or all of the Medicare enrollment requirements.

The reconsidered determination gave the parties adequate notice that Petitioner's failure to meet Medicare enrollment requirements was a basis for the revocation in this case. The hearing officer described in the reconsidered determination that in April 2014, Petitioner submitted a Form CMS-855B, updating Petitioner's bank account information, Petitioner's correspondence and special payment address, and Petitioner's practice

location. The updated practice address listed in the CMS-855B was a residence on Teal Bend Court. The hearing officer found that Petitioner was relocating to another address, 9898 Bissonnet Street, Suite 375-H, Houston, when site visits were attempted at the Teal Bend Court address on June 26 and 27, 2014. After Petitioner's July 15, 2014 reconsideration request was received by Novitas, site visits were requested for the 9898 Bissonnet Street address. When site visits at 9898 Bissonnet Street were attempted on September 17 and 25, 2014, signage with Petitioner's name and hours of operation were observed, confirming that Petitioner had moved to that address, but the office appeared to be closed. CMS Ex. 1 at 2. The hearing officer did not specifically conclude on these facts that Respondent was not operational, but she concluded that Petitioner did not meet Medicare requirements. CMS Ex. 1 at 1-2.

CMS focused in its motion for summary judgment on whether Petitioner was operational. But Petitioner has repeatedly focused on the issue of whether it provided CMS with proper notification of the location change to 9898 Bissonnet Street, Suite 375-H. CMS has pointed out in its pleadings that the only CMS-855B enrollment application in the record notified CMS of Petitioner's change of practice location from 1734 Teal Bend Court, and there is no CMS-855B changing Petitioner's address to 9898 Bissonnet Street, Suite 375-H. CMS Br. at 1, 4 n.1, 7 n.2. I conclude that both parties are fully aware of the issue of whether Petitioner gave Novitas and CMS the required notice of Petitioner's change of practice location and have had an adequate opportunity to present argument on the issue.

The undisputed facts support partial summary judgment for CMS on the issue of whether or not Petitioner met the Medicare requirement established by 42 C.F.R. § 424.516(e)(2) to give CMS and its contractor notice of a change in practice location within 90 days of the change. It is undisputed that on about April 24, 2014, Petitioner's owner signed a CMS-855B, notifying CMS and Novitas of Petitioner's new practice location at 1734 Teal Bend Court, Fresno, Texas. CMS Ex. 3, P. Ex. A. The hearing officer that issued the reconsidered determination acknowledged that the CMS-855B submitted by Petitioner in April 2014, was received by Novitas. CMS Ex. 1 at 2. It is undisputed that on about June 20, 2014, Petitioner signed a lease for a new practice location at 9898 Bissonnet, Suite 375-H, Houston, Texas. CMS Ex. 1 at 5, 9-22. It is undisputed that when the site inspector visited 1734 Teal Bend Court on June 26 and 27, 2014, Petitioner was no longer at that address. CMS Ex. 1 at 6-7. There is no dispute that when the site inspector visited 9898 Bissonnet in Houston on September 17 and 25, 2014, he observed and photographed signage showing that Petitioner had relocated to that address, even though the site inspector was unable to gain access to Petitioner's office on those dates. CMS Ex. 2 at 3-4. Petitioner asserts that it notified CMS and Novitas of its change of practice location from 1734 Teal Bend Court to 9898 Bissonnet by the CMS-855B signed April 24, 2014 (P. Ex. A). P. Br. at 2-3, 5. However, there no genuine dispute that the CMS-855B signed April 24, 2014, notified CMS and Novitas of Petitioner's change of practice location to 1734 Teal Bend Court not to 9898 Bissonnet, the latter a location for

which Petitioner did not enter a lease until June 20, 2014. In fact, Petitioner has presented no evidence that it notified CMS or Novitas at any time of its change of practice location from 1734 Teal Bend Court to 9898 Bissonnet by filing a CMS-855B. Therefore, there is no genuine dispute that Petitioner failed to submit a CMS-855B notifying CMS and Novitas of its June 2014 change of practice location from 1734 Teal Bend Court, Fresno to 9898 Bissonnet, Houston within 90 days of the change.

Petitioner was required by 42 C.F.R. § 424.516(e)(2) to notify CMS or its contractor within 90 days of a change of practice location by filing a CMS-855B. There is no evidence that Petitioner filed the required CMS-855B. Therefore, there is no genuine dispute that Petitioner failed to file the required CMS-855B notifying Novitas of the change of address from 1734 Teal Bend Court in Fresno to 9898 Bissonnet in Houston. Accordingly, there is a basis for revocation of Petitioner's billing privileges and Medicare enrollment pursuant to 42 C.F.R. § 424.535(a)(5)(ii) because Petitioner failed to satisfy the Medicare enrollment requirement under 42 C.F.R. § 424.516(e)(2) to timely notify CMS of the change in its practice location. Summary judgment in favor of CMS is appropriate on the issue of whether there is a basis for revocation of Petitioner's enrollment and billing privilege.

However, only partial summary judgment may be granted as I also conclude that there is a genuine dispute about whether Petitioner was "operational" at the time of the attempted on-site inspections. Whether Petitioner's enrollment is revoked because Petitioner was not operational results in a different effective date of revocation than a revocation based on failure to timely file a CMS-855B notifying CMS and Novitas of a change of practice location.

It is undisputed that site inspectors never found Petitioner's office open at the sites they inspected. CMS Ex. 2; RFH; P. Br. at 1. However, suppliers of ambulance services such as Petitioner are not required by regulation to have an office open to the public during posted or at any other specific times and, therefore, a closed office alone is insufficient to prove that Petitioner was non-operational.[4] 42 C.F.R. §§ 410.40-.41. The definition of "operational" requires that a supplier be "open to the public for the purpose of providing health care related services," and a supplier of ambulance services is arguably open to the public if it can be contacted to dispatch an ambulance even when the business office may

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[4] "Operational" is defined as "the provider or supplier has a qualified physical practice location, is open to the public for the purpose of providing health care related services, is prepared to submit valid Medicare claims, and is properly staffed, equipped, and stocked (as applicable, based on the type of facility or organization, provider or supplier specialty, or the services or items being rendered), to furnish these items or services." 42 C.F.R. § 424.502.

be closed and inaccessible to the public. Petitioner argues that, while its office was not open to the public it was "operational" at the time of the inspections because it was able to provide ambulance services to Medicare beneficiaries even though its administrative offices may not have been open to the general public. P. Br. at 5-6. Drawing all favorable inferences for Petitioner, as I must on summary judgment and without making any credibility determinations, I conclude that a reasonable fact finder could find that Petitioner was operational at the time of the site visits. I conclude that there is a genuine dispute of material fact as to whether Petitioner was "open to the public for the purpose of providing health care related services" at the time of the various site inspections. Accordingly, summary judgment on the issue of whether there is a basis for revocation on grounds that Petitioner was not "operational" is not appropriate in this case.

5. The effective date of revocation of Petitioner's enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(5)(ii), is determined pursuant to 42 C.F.R. § 424.535(g), and is November 16, 2014, which is 30 days after the reconsidered determination notice was mailed to Petitioner.

a. Facts

Novitas notified Petitioner that, pursuant to 42 C.F.R. § 424.535(g), its Medicare billing privileges were revoked effective June 26, 2014, the date Novitas determined Petitioner was not operational based on the second attempted on-site visit at the 1734 Teal Bend Court location. CMS Ex. 1 at 7. On reconsideration, the contractor attempted to conduct two additional on-site reviews of the 9898 Bissonnet Street, Suite 375-H location. In the reconsidered determination dated October 17, 2014, the hearing officer concluded that, as a result of the attempted on-site visits, including the two at the 9898 Bissonnet Street location, Petitioner had not shown compliance with 42 C.F.R. § 424.535(a)(5). CMS Ex. 1 at 2. The hearing officer did not conclude that Petitioner was not operational, nor did she address the effective date of Petitioner's revocation. CMS Ex. 1 at 1-2. The October 17, 2014 reconsidered determination from the hearing officer was the first notice to Petitioner that the on-site visits to 9898 Bissonnet Street demonstrated that Petitioner did not comply with 42 C.F.R. § 424.535(a)(5).

b. Analysis

By regulation, the effective date of revocation is 30 days after CMS or its contractor mails notice of its determination to the supplier with the exception of four circumstances. 42 C.F.R. § 424.535(g). In its initial determination, Novitas relied on one of the four listed exceptions to establish June 26, 2014, as the effective date of Petitioner's revocation. CMS Ex. 1 at 7. If a supplier is found to be non-operational, then "the revocation is effective with the date . . . that CMS or its contractor determined that the provider or supplier was no longer operational." 42 C.F.R. § 424.535(g).

Partial summary judgment is granted in favor of CMS in this case not because Petitioner was non-operational. Rather, partial summary judgment is appropriate because an on-site visit revealed that Petitioner had not satisfied all of the Medicare enrollment requirements. 42 C.F.R. § 424.535(a)(5)(ii). Failure to comply with enrollment requirements is not an authorized basis for backdating the effective date of revocation. 42 C.F.R. § 424.535(g). Therefore, as a matter of law, the effective date of a revocation based on a supplier's failure to comply with enrollment requirements must be 30 days after CMS or its contractor provided notice of the basis for revocation.

In this case, the contractor's first notice to Petitioner that revocation was based on failure to meet all Medicare enrollment requirements was the October 17, 2014 reconsidered determination. CMS Ex. 1 at 1. Presuming the reconsidered determination was mailed on October 17, 2014, a permissible presumption, the 30th day was November 16, 2014. Accordingly, pursuant to 42 C.F.R. § 424.535(g), the effective date of Petitioner's revocation must be November 16, 2014, based on my conclusion that partial summary judgment for CMS is appropriate.

III. Conclusion

For the foregoing reasons, I conclude that Petitioner's Medicare enrollment and billing privileges are properly revoked effective November 16, 2014, pursuant to 42 C.F.R. § 424.535(a)(5)(ii) because a September 25, 2014 on-site visit found that Petitioner had moved its practice location and had not notified CMS or its contractor of the move with 90 days as required by 42 C.F.R. § 424.526(e)(2).

Right to Request an Evidentiary Hearing: CMS may request a hearing for the presentation of evidence to show that Petitioner was not operational within the meaning of 42 C.F.R. § 424.502, and that an earlier effective date of revocation is appropriate. CMS must affirmatively request in writing, an evidentiary hearing within 10 days of the date of this decision.

Notice of Appeal Rights: Either party may request that the Board review this decision. A request for review must be filed within 60 days of the date of this decision. 42 C.F.R. § 498.82. The parties are presumed to receive a copy of this decision through the Department Appeals Board's electronic filing system the same day it is issued. A request for Board review must be filed electronically at: https://dab.efile.hhs.gov and following the link for "Appeals of CRD/ALJ Decisions." Pursuant to regulation, a request for review must specify the issues, the findings of fact or conclusions of law with which a party disagrees, and the basis for contending that the findings and conclusions are incorrect. 42 C.F.R. § 498.82(b).

However, in the event that CMS requests an evidentiary hearing within 10 days of the date of this decision, the 60-day period for requesting Board review will run from the date of the decision following the hearing on the merits.

/s/
Keith W. Sickendick
Administrative Law Judge