Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Healthy Point Medical Care, PC
(NPI: 1881948313 / PTAN: A100079019),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-1614

Decision No. CR4258

Date: September 29, 2015

DECISION

The Medicare enrollment and billing privileges of Petitioner, Healthy Point Medical Care, PC, are revoked pursuant to 42 C.F.R. § 424.535(a)(9)[1] because Petitioner, a physician practitioner organization, failed to report a change in practice location within 30 days of the change as required by 42 C.F.R. § 424.516(d)(1)(iii). The effective date of the revocation is January 14, 2015, 30 days after National Government Services (NGS), 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).

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[1] Citations are to the 2014 revision of the Code of Federal Regulations (C.F.R.), unless otherwise indicated.

I. Background

Petitioner was enrolled in the Medicare program as a physician group practice in Brooklyn, New York. CMS Exhibit (CMS Ex.) 1 at 8; CMS Ex. 3; Petitioner Exhibits (P. Exs.) 1, 7. NGS notified Petitioner by letter dated December 15, 2014, that Petitioner's Medicare enrollment and billing privileges were revoked effective January 14, 2015, pursuant to 42 C.F.R. § 424.535(a)(9). CMS Ex. 1 at 10-11. NGS cited as grounds for revocation that an on-site inspection of Petitioner's location at 2769 Coney Island Avenue 2, Brooklyn, New York 11235, on September 23, 2014, revealed that Petitioner was no longer operating a practice at that location; an unrelated business was operating at that location; and Petitioner failed to notify CMS within 30 days of ending its practice at that location. CMS Ex. 1 at 10. NGS 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 11.

Petitioner requested reconsideration. On January 14, 2015, a contractor hearing officer issued a reconsidered determination in which she upheld the revocation pursuant to 42 C.F.R. § 424.535(a)(9). CMS Ex. 1 at 1-3. On February 24, 2015, Petitioner requested a hearing before an administrative law judge (ALJ). On March 23, 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 April 21, 2015, CMS filed a motion for summary judgment and supporting brief (CMS Br.), with CMS Exs. 1 through 4. On May 22, 2015, Petitioner filed an opposition to CMS's motion (P. Br.), with P. Exs. 1 through 7. On June 3, 2015, CMS filed a reply brief and on June 10, 2015, CMS filed an amended[2] reply (CMS Reply). The parties have not objected to my consideration of CMS Exs. 1 through 4 and P. Exs. 1 through 7, and they are admitted.

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 NGS. 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

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[2] The CMS motion for leave to file the amended reply is granted.

services and suppliers.[3] 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. § 1395(u)(h)(1)). Petitioner, a physician organization, is a supplier. 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 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. The regulation 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(a). Pursuant to 42 C.F.R. § 424.535(a)(9), CMS may revoke the enrollment and billing privileges of physician

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[3] 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.

practitioner organizations, such as Petitioner, if a change in practice location is not reported within 30 days as required by 42 C.F.R. § 424.516(d)(1)(iii).

If CMS revokes a supplier's Medicare billing privileges for not complying with enrollment requirements, such as those found at 42 C.F.R. § 424.516, 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). After a supplier's Medicare enrollment and billing privileges are revoked, the supplier is barred from re-enrolling 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, 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[4]; 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.

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[4] Petitioner purports to waive an oral hearing in its brief. P. Br. at 9. However, Petitioner states that it desires a decision based on the testimony, among other things. Realizing Petitioner's non-attorney representative may be unaware of the differing standards applied on summary judgment and a decision on the merits, I elect to resolve this case applying the more restrictive summary judgment procedures and standard.

1. **Summary judgment is appropriate.**

2. **Petitioner did not file a CMS-855 with the CMS contractor to provide notice of a change in Petitioner's practice location within 30 days of the change as required by 42 C.F.R. § 424.516(d)(1)(iii).**

3. **Petitioner was not in compliance with 42 C.F.R. § 424.516(d)(1)(iii) because an on-site review determined Petitioner stopped operating at a practice location on file with CMS, but Petitioner did not notify the CMS contractor of that change within 30 days as required by the regulation.**

4. **There is a basis for revocation of Petitioner's enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(9) for failure to comply with the Medicare enrollment requirement established by 42 C.F.R. § 424.516(d)(1)(iii).**

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)(9) are not disputed.

Petitioner was enrolled in the Medicare program as a physician's organization effective November 7, 2012. Petitioner had at various times as many as three practice locations on file with CMS: 1386 Flatbush Avenue, Brooklyn, New York 11210; 2769 Coney Island Avenue 2, Brooklyn, New York 11235; and 157 Greenpoint Avenue 1, Brooklyn, New York 11222. P. Ex. 7; CMS Ex. 3.

On September 23, 2014, a CMS inspector visited Petitioner's 2769 Coney Island Avenue 2, Brooklyn, New York address, which CMS records listed as one of Petitioner's practice locations. The inspector reported that Petitioner was no longer operating at that address. CMS Ex. 1 at 6-9.

NGS notified Petitioner by letter dated December 15, 2014, that Petitioner's Medicare enrollment and billing privileges were revoked effective January 14, 2015, pursuant to 42 C.F.R. § 424.535(a)(9), because Petitioner did not notify NGS within 30 days of closing its 2769 Coney Island Avenue 2 practice location. CMS Ex. 1 at 10-11; CMS Ex. 4 at 1; P. Ex. 7.

Petitioner submitted a Corrective Action Plan (CAP) received by NGS on January 5, 2015. CMS Ex. 4 at 1. Petitioner included as part of its CAP a CMS-855B dated December 30, 2014. CMS Ex. 4 at 6-12. The CMS-855B was completed to report the

deletion of Petitioner's practice location at 2769 Coney Island Avenue 2 effective July 1, 2014. CMS Ex. 4 at 7, 10. Petitioner states in the CAP that patients were no longer seen at that location beginning in July 2014 and that there were no Medicare claims from that location after that date. CMS Ex. 4 at 2.

On February 19, 2015, Petitioner submitted another CMS-855B to NGS for the purpose of reporting the closing of that practice location at 2769 Coney Island Avenue 2 effective July 1, 2014. P. Ex. 4 at 1-4, 8, 10.

Petitioner submitted an affidavit executed by Marina Morgulis, Petitioner's office manager, and non-attorney representative in this case. Ms. Morgulis states that it was her fault that a CMS-855B was not sent deleting "a non-operational facility." P. Ex. 2. She admits that she was told that the facility was no longer operational on about October 15, 2014, which was after the September 23, 2014 site visit had occurred. She states that the failure to submit the CMS-855B was simply a clerical error. P. Ex. 2.

Petitioner states in the request for hearing that the failure to report within 30 days that the 2769 Coney Island Avenue 2 practice location was no longer being used was a clerical error. P. Ex. 6.

b. Analysis

CMS requests 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. I have not accepted Petitioner's waiver and proceed to decide this case on summary judgment.

Summary judgment is not automatic upon request but is limited to certain specific conditions. The Secretary's regulations that establish the procedure 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. Pro.) do not apply in administrative adjudications such as this, but the Board has accepted that Fed. R. Civ. Pro. 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. Pro. 56 will be applied. Prehearing Order II.G.

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 differ from those 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)(9) as the basis for revocation of Petitioner's Medicare enrollment and billing privileges. CMS requests summary judgment in its favor, arguing that Petitioner failed to report within 30 days, as required by 42 C.F.R. § 424.516(d)(1)(iii), that it was no longer operating its practice

location at 2769 Coney Island Avenue 2, Brooklyn, New York. CMS Br. at 7-10; CMS Reply.

I conclude summary judgment is appropriate in this case as there is no genuine dispute as to a material fact necessary to resolve the issue before me, that is, whether or not there was a basis for revocation of Petitioner's enrollment and billing privileges. Petitioner does not deny that beginning about July 1, 2014, patients were no longer being seen at 2769 Coney Island Avenue 2, Brooklyn, New York. Petitioner admits that no Medicare claims were filed based on treatment at the 2769 Coney Island Avenue 2 address. Petitioner does not deny the findings of the CMS inspector based on the September 23, 2014 visit to 2769 Coney Island Avenue 2, which were that Petitioner no longer had a practice location at that address. Petitioner also does not deny that it did not notify CMS or NGS prior to December 30, 2014, of the fact that it was no longer using 2769 Coney Island Avenue 2 as a practice location in July 2014. Petitioner has identified no material fact that is in dispute that could affect the resolution of the issue. All that is required is to apply the law to the undisputed facts and summary judgment is appropriate.

"Practice location" is not specifically defined in 42 C.F.R. pt. 424. However the term "operational" is defined and that definition describes a "qualified physical practice location" as one that 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. Petitioner offers no evidence that after July 2014, it had a practice location at 2769 Coney Island Avenue 2 that fit the description of a practice location under 42 C.F.R. § 424.502.

Petitioner argues that there was no move or change to another location involved. Petitioner argues that about June 2014, a decision was made to move medical records from the 2769 Coney Island Avenue 2 location to another of Petitioner's practice locations for the convenience of CMS auditors. Petitioner states that it did not "make a decision at that time whether or not it [would] resume its practice at 2769 Coney Island Avenue floor #2 Brooklyn NY 11235, which **temporarily** stopped seeing patients as of July 1, 2014." P. Br. 2 (emphasis in original). Rather than identifying a genuine dispute of material fact, Petitioner concedes that patients were not being seen at 2769 Coney Island Avenue beginning about July 1, 2014. Petitioner, therefore, concedes that the 2769 Coney Island location was not open to the public for the delivery of health care services and that it was no longer a practice location. Petitioner argues that it made a

"definite decision" not to resume seeing patients at 2769 Coney Island Avenue 2 on about October 14 or 15, 2014. P. Br. at 3, 5. Even if I accept that fact as true, Petitioner still concedes it failed to file a notice of change in practice location within 30 days as required by 42 C.F.R. § 424.416(d)(1)(iii). Petitioner does not dispute that the first notice to NGS and CMS was when it filed a CMS-855R on December 30, 2014, more than 30 days after it made the decision to permanently cease operating the practice location in question. P. Br. at 4-6.

Petitioner argues that the two-year bar to re-enrollment is unfair. P. Br. at 4. CMS is authorized to impose a bar to re-enrollment of one to three years. 42 C.F.R. § 424.535(c). The regulations grant Petitioner no right to review of the CMS decision as to the appropriate period of the bar, and I have no authority to conduct review of that issue. 42 C.F.R. § 424.545.

Petitioner's arguments may be construed to be a plea for equitable relief. However, I have no authority to grant equitable relief. *US Ultrasound*, DAB No. 2302 at 8 (2010), ("[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."). Furthermore, I am bound to follow the Act and regulations, and I have no authority to declare statutes or regulations invalid or ultra vires. *1866ICPayday.com, L.L.C.*, DAB No. 2289 at 14 (2009) ("[a]n ALJ is bound by applicable laws and regulations and may not invalidate either a law or regulation on any ground.").

Petitioner is also not entitled to relief if I construe its arguments to be that the government should be estopped from revoking Petitioner's enrollment and billing privileges. It is well-established that: (1) estoppel cannot be the basis to require payment of funds from the federal fisc; (2) estoppel cannot lie against the government, if at all, absent a showing of affirmative misconduct, such as fraud; and (3) I am not authorized to order payment from the public fisc contrary to law based on equitable grounds. It is well-settled that those who deal with the government are expected to know the law and may not rely on the conduct of government agents contrary to law. *See, e.g., Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414 (1990); *Heckler v. Cmty. Health Servs. of Crawford Cnty., Inc.*, 467 U.S. 51 (1984); *Oklahoma Heart Hosp.*, DAB No. 2183 at 16 (2008); *Wade Pediatrics*, DAB No. 2153 at 22 n.9 (2008), *aff'd*, 567 F.3d 1202 (10th Cir. 2009); *US Ultrasound*, DAB No. 2302 at 8. Here, Petitioner has not alleged affirmative misconduct on behalf of the CMS contractor of the type that could be considered grounds for estoppel, and any argument that amounts to a claim of equitable estoppel must be rejected.

III. Conclusion

For the foregoing reasons, I conclude that Petitioner's Medicare enrollment and billing privileges are properly revoked effective January 14, 2015, pursuant to 42 C.F.R.

§ 424.535(a)(9) because Petitioner failed to report within 30 days as required by 42 C.F.R. § 424.516(d)(1)(iii), that it was no longer operating a practice location at 2769 Coney Island Avenue 2. A two-year bar to enrollment is within the authorized range and not subject to review.

/s/
Keith W. Sickendick
Administrative Law Judge