Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Wellness Corner Corp.,
(NPI: 1689974941),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-716

Decision No. CR2963

Date: October 23, 2013

DECISION

In this matter now before me, both parties have filed motions for summary judgment. For the reasons set out below, I DENY Petitioner's Motion for Summary Judgment, GRANT the CMS Motion, and AFFIRM the denial of Petitioner Wellness Corner Corp.'s enrollment as a supplier in the Medicare program.

I. Procedural History

Petitioner, a medical group practice located in Florida, filed an application to enroll as a supplier in the Medicare program in February 2012 with First Coast Service Options (First Coast), a Medicare contractor. As part of the application process, First Coast conducted unannounced on-site visits on July 5, 2012 to two practice locations identified in Petitioner's enrollment application — a practice location in Hialeah, Florida and a practice location in Hollywood, Florida. Having found both practice locations not operational, by letter dated September 25, 2012, First Coast informed Petitioner that its enrollment application had been denied. CMS Ex. 1; Request for Hearing (RFH) at 3; *see also* P. Answer Br. at 2. Petitioner sought reconsideration of this determination on November 15, 2012. RFH at 2; CMS Ex. 2. Upon receipt of Petitioner's reconsideration

request, First Coast sought additional information from Petitioner and included a notation directing that Petitioner delete the practice location in Hialeah since Petitioner had indicated in its reconsideration request that it had moved from that location to a new practice location. CMS Exs. 2, 3. In its response to First Coast, Petitioner stated that it began providing healthcare services at the Hollywood location effective May 1, 2012 and that the first Medicare beneficiary was seen at the Hollywood location on May 10, 2012. P. Ex. 1, at 5 (CMS-855B section 4: "Practice Location Information," adding the Hollywood practice location as of May 1, 2012.)

Upon receipt of the additional information, First Coast conducted another on-site visit on February 4, 2013, at Petitioner's practice location in Hollywood, Florida. During the site visit the investigator determined that Petitioner had not yet seen a Medicare patient at the Hollywood location.

Based on the findings of the on-site visits conducted on July 5, 2012 and February 4, 2013, the hearing officer issued a reconsideration decision on February 26, 2013, upholding the denial of Petitioner's enrollment application on two bases: (1) for not being operational, in reliance on 42 C.F.R. § 424.530(a)(5); and (2) that Petitioner had provided false and misleading information in stating that it had begun seeing Medicare patients as of May 10, 2012, in reliance on 42 C.F.R. § 424.530(a)(4). CMS Ex. 7.

Petitioner timely perfected this appeal by filing a request for a hearing with the Departmental Appeals Board, Civil Remedies Division on April 24, 2013.[1] My May 2, 2013 Acknowledgment and Initial Docketing Order allowed for motion practice. After the parties filed their readiness reports,[2] CMS filed a Motion for Summary Judgment and a brief in support of its motion (CMS Br.), and proffered seven exhibits identified as CMS Exs. 1-7.[3] In response to an Order to Show Cause issued on July 25, 2013,

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[1] I note that with its RFH Petitioner filed several documents that Petitioner marked as Attachments A–F. Although the documents are not marked in compliance with the terms of Civil Remedies Division Procedures § 9, I will admit them into the record.

[2] Petitioner filed its Report of Readiness (ROR) after the filing date outlined in my Initial Docketing Order. Petitioner's ROR was accompanied by a Motion to File Out of Time. I find good cause to grant Petitioner's motion. Additionally, on May 22, 2013, Petitioner emailed a document titled "Motion [sic] for Summary Disposition," noting that it was in response to being informed earlier by CMS that CMS intended to file a motion for summary judgment. In the email, Petitioner states that the document summarizes the principle issues of in its appeal. The May 22, 2013 email and attached pleading were accepted into the record.

[3] CMS filed its Motion of Summary Judgment on June 24, 2013, accompanied by a Request to File Out of Time. The terms of my Initial Docketing Order permitted the

Petitioner filed a response to the CMS Motion (P. Answer Br.) accompanied by a motion to file out of time, a Motion for Summary Judgment, and proffered eleven exhibits identified as P. Exs. 1-11.[4] In the absence of objection, I admit CMS Exs. 1-7 and P. Exs. 1-11 into the record. The cycle of motion practice and briefing closed on August 8, 2013.

II. Issue

The issue before me is whether CMS, acting through First Coast, properly denied Petitioner's enrollment in the Medicare program.

III. Controlling Statutes and Regulations

The Social Security Act (Act) authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations governing the enrollment process for providers and suppliers. Act §§ 1102, 1866(j), 42 U.S.C. §§ 1302, 1395cc(j). Under the Secretary's regulations, a provider or supplier that seeks billing privileges under Medicare "must submit a complete enrollment application and supporting documentation to the designated Medicare fee-for-service contractor," and the application must include "complete . . . responses to all information requested within each section as applicable to the provider or supplier type." 42 C.F.R. § 424.510(d)(1)-(2). Once the provider or supplier successfully completes the enrollment process . . . CMS enrolls the provider or supplier into the Medicare program." 42 C.F.R. § 424.510(a).

The Secretary also has discretion to refuse to enter into an agreement or to terminate or refuse to renew an agreement with a provider or supplier. Act § 1842(h)(8), 42 U.S.C. § 1395u(h)(8). The Secretary has delegated the authority to accept or deny enrollment applications to CMS, and CMS may deny a supplier's enrollment application if the supplier is not in compliance with Medicare enrollment requirements. 42 C.F.R. § 424.530(a)(1).

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parties to file dispositive motions by May 22, 2013. However, I find good cause for CMS's late filing and grant its request.

[4] As noted, Petitioner's response to CMS's Motion for Summary Judgment was filed in response to an Order to Show Cause. My Order required that Petitioner file its responsive pleading with its showing of good cause. I acknowledge Petitioner's explanation of good cause and the responsive pleading filed by Petitioner is received into the record. I take note however, that P. Exs. 1-11, are not marked in accordance with the plain terms of Civil Remedy Division Procedures § 9. As Petitioner appears here *pro se*, I afford Petitioner an extra measure of consideration — and hope to avoid any additional delays in the progress of this case — and so receive the evidence into the record.

A supplier "must be operational to furnish Medicare covered items or services before being granted Medicare billing privileges." 42 C.F.R. § 424.510(d)(6). A supplier is "operational" when it 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 . . . to furnish these items and services." 42 C.F.R. § 424.502. CMS has a right to perform on-site visits to verify the accuracy of a supplier's enrollment information and to determine the provider's compliance with Medicare enrollment requirements. 42 C.F.R. § 424.510(d)(8); *see also* 42 C.F.R. § 424.517(a)(1). The on-site visit permits the Secretary "to verify . . . that [she] is paying an entity that actually exists or that is providing a service that it represented it would provide in its enrollment application." 71 Fed. Reg. 20,754, 20,755 (Apr. 21, 2006).

IV. Analysis

My findings of fact and conclusions of law are set forth in italics and bold in the discussion captions of this decision.

A. This case is appropriate for summary judgment.

Both parties argue that they are entitled to summary judgment. The Departmental Appeals Board (Board) stated the standard for summary judgment:

> Summary judgment is appropriate when the record shows that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. . . . The party moving for summary judgment bears the initial burden of showing that there are no genuine issues of material fact for trial and that it is entitled to judgment as a matter of law. . . . To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact – a fact that, if proven, would affect the outcome of the case under governing 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.

Senior Rehabilitation and Skilled Nursing Center, DAB No. 2300, at 3 (2010) (citations omitted).

The Board has further explained that the role of an Administrative Law Judge (ALJ) in deciding a summary judgment motion differs from its role in resolving a case after a hearing. The ALJ should not assess credibility or evaluate the weight of conflicting evidence. *Holy Cross Village at Notre Dame, Inc.*, DAB No. 2291, at 5 (2009).

Petitioner provides some history leading up to this case in its pleadings and supporting documents and exhibits. RFH at 1-5 and Attachments A-F; P. ROR at 1; P. Answer Br. I accept Petitioner's rendition as true for purposes of summary judgment. Although Petitioner argues that there are material facts in dispute (P. Answer Br. at 3), I find that Petitioner has not disputed any fact material to my resolution of the case. Accordingly, I conclude that summary judgment in favor of CMS is appropriate in this case even after drawing all reasonable inferences in favor of Petitioner.

B. Petitioner was not "operational" on July 5, 2012 as required under 42 C.F.R. § 424.530(a)(5).

Petitioner filed its application for Medicare enrollment in February 2012, listing a practice location in Hollywood, Florida. On July 5, 2012, First Coast conducted an on-site visit at 2303 Hollywood Blvd, Suite 10, Hollywood, Florida 33020. The inspector found the location was not operational. An on-site visit was also conducted at the Hialeah location, 900 West 49 Street, Suite 322, a second location listed on Petitioner's enrollment application. The inspector found the Hialeah location vacant; moreover, the building manager at the Hialeah location advised the inspector that Petitioner had moved out of the location approximately three months earlier.[5] CMS Ex. 1; CMS Br. at 2.

Petitioner disagrees that on July 5, 2012, its Hollywood location was "vacant." Petitioner claims that the location was occupied, but under repair. P. Answer Br. at 2. Petitioner further claims that on July 5, 2012, the Hollywood location was furnished and equipment was in place, although covered with protective material, but because of "a force majeure situation" it was not operating that day. P. ROR at 1; P. Exs. 3-11. Petitioner explains that its Hollywood location sustained serious physical damage caused by rain from the building's roof that caused flooding in its office. Petitioner states that repairs were needed that required that it close its office for several days, from June 29 through July 9, 2012, which, says Petitioner, explains why its office was closed during the on-site visit on July 5, 2013. RFH at 3-4; P. Answer Br. at 2; *see also* CMS Ex. 5.

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[5] Petitioner claims that on May 25, 2012, it did submit updated information on a CMS-855B form noting its new address of 2300 Hollywood Blvd, Suite 10 in Hollywood, Florida. Petitioner acknowledges, however, that at that time it did not delete the Hialeah, Florida address of 990 W. 49 St. Petitioner states it was "an oversight." RFH at 3; *see also* P. Answer Br. at 2. However, for purposes of this decision I do not need to address whether Petitioner was operational at the Hialeah location at the time of the July 5, 2012 on-site survey. Rather, because the July 5, 2012 on-site visit to Petitioner's Hollywood practice location found as an undisputed and material fact that the practice was not operational, this provides a sufficient basis for CMS to deny Petitioner's enrollment.

A supplier disputing a CMS denial under section 424.530(a)(5)(ii) must show that it in was in fact operational during the time period relevant to the on-site visit and review. Under the regulations, it is insufficient for a supplier to demonstrate that it became operational at a later point in time. *A To Z DME, LLC*, DAB No. 2303, at 6-8 (2010); *see* 73 Fed. Reg. 36,448, 36,542 (June 27, 2008).

An noted above, the term "operational" means that a supplier is open to the public for the purpose of providing health care related services. 42 C.F.R. § 424.502. Moreover, to be "operational" requires not simply having a qualified physical practice location, but further requires that the supplier is actually furnishing the types of Medicare-covered services that it claims to be furnishing. *CompRehab*, DAB No. 2406, at 7 (2011), *citing* 42 C.F.R. § 424.502; *see also A To Z DME, LLC*, DAB No. 2303, at 9-10.

The record before me shows that Petitioner has not disputed the material facts relevant in determining if Petitioner's practice was "operational" as defined in the regulation at 42 C.F.R. § 424.502, and as required by 42 C.F.R. § 424.530(a)(5) for enrollment in the Medicare program. Here, Petitioner acknowledges that its office was indeed not open on July 5, 2012, and admits that its office was not open to the public for a time period prior to and subsequent to the on-site visit.

C. Petitioner had not seen Medicare patients at its Hollywood practice location by May 10, 2012, as Petitioner had certified in its enrollment application.

Petitioner admits that at the time of the February 4, 2013 on-site visit it had not seen any Medicare beneficiaries at its Hollywood location. Petitioner explains that it was scheduled to have a visit from the State of Florida's Agency for Health Care Administration (AHCA) to obtain a new license as its license had expired on September 6, 2012. Petitioner relates that Florida state law precluded it from treating patients without a current state license. RFH at 1, 4. Petitioner asserts that its state license was granted on February 6, 2013, two days following the February 4, 2012 Medicare on-site visit. RFH at 5 *citing* Attachment G (copy of the AHCA certificate showing an effective date of February 13, 2013).

Here, Petitioner admits that at the time of the February 4, 2013 on-site visit its state license had expired and concedes that the Hollywood practice location was not seeing Medicare patients at that time. RFH at 4. Petitioner noted on its enrollment application that it saw its first Medicare patient at the Hollywood location on May 10, 2012 —this information was obvioulsy false and misleading and provided an additional basis for First Coast to deny Petitioner's application pursuant to 42 C.F. R. § 424.530(a)(4).

Even though Petitioner encountered some unfortunate events that coincided with its Medicare on-site visits, I must sustain a denial where the facts establish that the supplier was not operational. There is nothing in the regulations that authorize me to make an

exception based on a Petitioner's showing of good cause for noncompliance, nor do I have the authority to waive the regulations' strict requirements on a showing of extenuating circumstances or as a matter of equity.

As noted above, CMS may deny a supplier's enrollment if, upon on-site review, CMS determines that a "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. § 424.530(a)(5)(ii).

Accordingly, the undisputed facts show that CMS properly denied Petitioner's enrollment in the Medicare program pursuant to the regulations at 42 C.F.R. §§ 424.530(a)(5) and 424.530(a)(4).

V. Conclusion

The undisputed evidence establishes that CMS was authorized to deny Petitioner's enrollment in the Medicare program because Petitioner was not operational on July 5, 2012, during an on-site visit as outlined at 42 C.F.R. § 424.530(a)(5) and it provided false and misleading information as outlined at 42 C.F.R. § 424.530(a)(4). Accordingly, I DENY Petitioner's Motion for Summary Judgment and GRANT summary judgment in favor of CMS. The denial of Petitioner's enrollment in the Medicare program must be, and it is, AFFIRMED.

/s/
Richard J. Smith
Administrative Law Judge