**Department of Health and Human Services**

**DEPARTMENTAL APPEALS BOARD**

**Civil Remedies Division**

V Care Medical Equipment, Inc.,
(NPI: 1093864126; Supplier No. 4547500001)

Petitioner

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-997

Decision No. CR3426

Date: October 20, 2014

# DECISION

The Medicare enrollment and billing privileges of Petitioner, V Care Medical Equipment, Inc. are revoked pursuant to 42 C.F.R. § 424.57(e) and 424.535(a)(1),[1] effective December 22, 2013, based on noncompliance with 42 C.F.R. § 424.57(c)(7) (supplier standard 7).

## I. Procedural History and Jurisdiction

Palmetto GBA, National Supplier Clearinghouse (Palmetto), a Medicare administrative contractor for the Centers for Medicare & Medicaid Services (CMS), notified Petitioner by letter dated November 22, 2013, that Petitioner's Medicare enrollment was revoked effective October 17, 2013. CMS Exhibit (CMS Ex.) 2 at 1, 4. Palmetto cited 42 C.F.R.

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

§§ 405.800, 424.57(e), 424.535(a)(1), 424.535(a)(5)(ii), and 424.535(g) [2] as the legal authority for the revocation based on noncompliance with 42 C.F.R. §§ 424.57(c)(7) (supplier standard 7), and 424.57(c)(10) (supplier standard 10). Palmetto 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. 2 at 1, 4.

On January 6, 2014, Petitioner requested reconsideration of the initial determination. CMS Ex. 3. On February 25, 2014, Palmetto issued a reconsidered determination upholding the revocation of Petitioner's Medicare enrollment and billing number based on a violation of supplier standard 7 (42 C.F.R. § 424.57(c)(7)) and supplier standard 10 (42 C.F.R. § 424.57(c)(10)). CMS Ex. 4.

Petitioner requested a hearing before an administrative law judge (ALJ) by letter dated April 15, 2014 (RFH) that was filed on April 21, 2014. The case was assigned to me for hearing and decision on April 25, 2014, and an Acknowledgment and Prehearing Order (Prehearing Order) was issued at my direction. No issue has been raised as to the timeliness of Petitioner's request for hearing, the parties do not challenge my authority to decide this case, and I conclude that I have jurisdiction.

On May 23, 2013, CMS filed a motion for summary judgment (CMS Br.) with CMS Exs. 1 through 6. On June 23, 2014, Petitioner filed a response to CMS's motion for summary judgment (P. Br.) with attachments 1A through 1C, 2A and 2B, 3A through 3H, 4A through 4F, and 5A and 5B.[3] CMS filed a reply (CMS Reply) on July 7, 2014. The parties have not objected to my consideration of any of the offered exhibits and all are admitted.

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[2] Sections 405.800 and 424.57(g) of Title 42 establish notice requirements and effective date determinations for revocations.

[3] The attachments offered by Petitioner were clearly offered as substantive evidence. However, Petitioner violated Civil Remedies Division Procedures § 9 when marking the attachments. There is also little likelihood of confusion based on the current marking of the exhibits. Therefore the attachments are treated as Petitioner's exhibits (P. Exs.) 1A, 1B, 1C, 2A, 2B, 3A, 3B, 3C, 3D, 3E, 3F, 3G, 3H, 4A, 4B, 4C, 4D, 4E, 4F, 5A, and 5B.

## 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 Palmetto. 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.[4] 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 is a durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) supplier.

The Act requires the Secretary to issue regulations that establish a process for the enrollment of providers and suppliers, including the right to a hearing and judicial review in the event of denial or non-renewal. Act § 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to 42 C.F.R. § 424.505, a supplier 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. To receive direct-billing privileges, a DMEPOS supplier must meet and maintain the Medicare application certification standards set forth in 42 C.F.R. § 424.57(c). Among other requirements, a DMEPOS supplier must maintain a physical facility on an appropriate site. 42 C.F.R. § 424.57(c)(7). An appropriate site for the physical facility must meet certain criteria, including that the practice location is in a location accessible to the public, Medicare beneficiaries, and CMS and its agents, and that the practice location must be accessible and staffed during posted hours of operation. 42 C.F.R. § 424.57(c)(7)(i)(B), (C). A DMEPOS supplier must provide complete and accurate information in response to questions on its application for Medicare billing privileges and must report to CMS any

[4] A "supplier" furnishes services and supplies under Medicare. The term supplier applies to 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) and 1835(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.

changes in information supplied on the application within 30 days of the change. 42 C.F.R. § 424.57(c)(2). A DMEPOS supplier must permit CMS or its agent to conduct on-site inspections to ascertain supplier compliance with the Medicare enrollment standards. 42 C.F.R. § 424.57(c)(8). Finally, a DMEPOS supplier must at all times be "operational," which means 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 or services." 42 C.F.R. § 424.502.

The Secretary has delegated the authority to revoke enrollment and billing privileges to CMS. 42 C.F.R. § 424.535. CMS or its Medicare contractor may revoke an enrolled supplier's Medicare enrollment and billing privileges and supplier agreement for any of the reasons listed in 42 C.F.R. § 424.535. Specifically, CMS may revoke a supplier's enrollment and billing privileges if the supplier is determined not to be in compliance with the enrollment requirements. 42 C.F.R. § 424.535(a)(1). CMS may also revoke a currently enrolled supplier's Medicare 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, or the supplier fails 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). 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, 748-751 (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. Issue**

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. Summary judgment is appropriate.

CMS has requested summary judgment. 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 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.

Summary judgment is appropriate when there is no genuine dispute as to any issue of 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, there is no genuine dispute as to any material fact pertinent to revocation under 42 C.F.R. §§ 424.57(e) and 424.535(a)(1) based on noncompliance with 42 C.F.R. § 424.57(c)(7) (supplier standard 7) that requires a trial. The issues Petitioner raises related to revocation under 42 C.F.R. §§ 424.57(e) and 424.535(a)(1) are issues of law. The issues in this case must be resolved against Petitioner as a matter of law. The undisputed evidence shows that there is a basis for revocation of Petitioner's Medicare enrollment and billing privileges. Accordingly, summary judgment based on the violation of 42 C.F.R. § 424.57(c)(7) is appropriate.

Summary judgment is not appropriate for revocation pursuant to 42 C.F.R. §§ 424.535(a)(5)(ii) on a theory that Petitioner was no longer operational when a site visit occurred. Summary judgment is also not appropriate for revocation based on an alleged violation of 42 C.F.R. § 424.57(c)(10) (supplier standard 10) on the theory that Petitioner did not have the required liability insurance. Both of the alternative grounds for revocation involve genuine disputes as to material fact that would require a trial. CMS argues in its motion for summary judgment that Petitioner also violated 42 C.F.R. § 424.57(c)(8) (supplier standard 8). CMS acknowledges that this additional basis was

not cited in the initial determination. Though not specifically acknowledged by CMS, 42 C.F.R. § 424.57(c)(8) was also not mentioned in and apparently not considered on reconsideration. The Secretary has accorded Petitioner a right to reconsideration and specific notice of what requirements of law or regulations that Petitioner failed to meet prior to an ALJ hearing. 42 C.F.R. §§ 498.22(a), 498.25(a)(2)-(3). Accordingly, before passing upon the alleged violation of 42 C.F.R. § 424.57(c)(8), remand to CMS to ensure Petitioner received a reconsidered determination on the new basis for revocation may be appropriate. Even if I concluded that remand was not necessary, whether or not Petitioner failed to permit CMS or its agents an opportunity to conduct an on-site inspection in violation of 42 C.F.R. § 424.57(c)(8), involves disputed issues of material fact that would require a trial.

**2. There was a basis to revoke Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. §§ 424.57(e) and 424.535(a)(1) for violation of 42 C.F.R. § 424.57(c)(7) (supplier standard 7).**

**3. The effective date of revocation of Petitioner's Medicare enrollment and billing privileges based on a violation of 42 C.F.R. § 424.57(c)(7) (supplier standard 7) is December 22, 2013, 30 days after the date on which notice of revocation was mailed to Petitioner.**

**a. Facts**

The facts are not disputed and any inferences are drawn in favor of Petitioner.

On October 17, 2013, Inspector Doug Warner went to 2096 S. Wayne Road, Suite A, Westland, Michigan 48166, to conduct a site inspection of Petitioner. Petitioner does not dispute that the 2096 S. Wayne Road, Suite A address was the address for Petitioner on-file with Palmetto and CMS on October 17, 2013. Inspector Warner found that there were no signs showing the Petitioner was located at the address and no posted hours of operation. Inspector Warner looked through the door of the office and determined that the suite was empty. Petitioner does not deny that it was no longer operating at 2096 S. Wayne Road, Suite A on October 17, 2013. Inspector Warner called Petitioner's owner, Vidhya Jain on October 17, 2013, and left a message. Ms. Jain returned Inspector Warner's call and advised him that Petitioner had moved and that she would be contacting Medicare soon but she did not give Inspector Warner the new address for Petitioner. Inspector Warner included in his report that he advised Ms. Jain to notify CMS of Petitioner's new address. CMS Ex. 1. Photographs submitted by CMS are not clear enough to determine the condition of the interior of 2096 S. Wayne Road, Suite A. CMS Ex. 1 at 10-11; CMS Ex. 6 at 2-3.

In its request for reconsideration dated January 6, 2014, Petitioner admitted that on October 17, 2013 Petitioner was moving its inventory to a new location. Petitioner stated

that the move was not completed until November 15, 2013. Petitioner asserted that it was still operational at its practice location on October 17, 2013. Petitioner does not assert and has not presented any evidence that it was open and accessible to the public at 2096 S. Wayne Road, Suite A at any time on October 17, 2013, or at any time thereafter. Petitioner also asserted in its request for reconsideration that it has submitted all required paperwork for a change of address and proof of liability insurance coverage but the dates of submission are not alleged. CMS Ex. 3 at 1-2. Petitioner filed with its request for reconsideration a lease agreement dated August 1, 2012, that Ms. Jain signed as President of Petitioner for 33116 Palmer Road, Suite C, Westland, Michigan 48186. CMS Ex. 3 at 6; P. Ex. 1B. Petitioner filed with its request for reconsideration a letter to Palmetto dated December 2, 2013, advising that Petitioner relocated effective November 15, 2013 from 2096 S. Wayne Road, Suite A, Westland, Michigan, the address Investigator Warner visited, to 8010 Greenfield Road, Detroit, Michigan. CMS Ex. 3 at 7. Petitioner also filed a copy of a Medicare enrollment application dated December 2, 2013, reporting a change in enrollment information, specifically its current business location. The form indicates Petitioner changed its business location to 8010 Greenfield Road, Detroit, Michigan, effective November 15, 2013. CMS Ex. 3 at 8-20.

In its April 15, 2014 request for hearing, Petitioner admits that its President, Ms. Jain, did tell the site inspector that Petitioner was moving its inventory to a new location in Detroit and the inspector informed her to report the change to Medicare within 30 days. Petitioner does not assert that it was open and accessible to the public at 2096 S. Wayne Road at any time on October 17, 2013, or at any time thereafter.

Petitioner asserts in its response to the CMS motion for summary judgment that Petitioner evacuated its 2096 S. Wayne Road location due to a fire on July 16, 2012, and relocated to 33116 Palmer Road, Westland, Michigan. This is inconsistent with the December 2, 2013 letter to Palmetto. CMS Ex. 3 at 7. Petitioner asserts that a "change of location due to fire" was mailed to Palmetto on August 3, 2012. P. Br. at 1-2. Petitioner filed no affidavit or declaration in support of these assertions and they are entitled to no weight as I may only consider testimony that is under oath or affirmation. 42 C.F.R. § 498.62. Petitioner submitted as evidence a Westland Fire Department report showing that a fire occurred on July 16, 2012, between 4:00 and 7:00 a.m. at 2118 S. Wayne Road in Westland, Michigan. P. Ex. 1A. Petitioner submitted the August 1, 2012 lease agreement for 33116 Palmer Road, Suite D. CMS Ex. 3 at 6; P. Ex. 1B. Petitioner submitted insurance and bond documents reflecting the Palmer Road address but those documents are dated August 13, 2013 and November 27, 2013, more than a year after the alleged fire (P. Ex. 2A and 2B). Petitioner also submitted a letter dated August 28, 2012, from Palmetto to Petitioner at yet another address at 6658 Whispering Woods Drive, West Bloomfield, Michigan, advising Petitioner that there was an update to Petitioner's file related to liability insurance. P. Ex. 1C. The August 28, 2012, Palmetto letter makes no reference to the 33116 Palmer Road address, and I can draw no inference from the Palmetto letter or the other documents that Petitioner notified Palmetto that it was

operating at an address other than 2096 S. Wayne Road. Petitioner admits that it was not open and accessible to the public at 2096 S. Wayne Road on October 17, 2013; that Inspector Warner did call Ms. Jain on October 17, 2013, and Ms. Jain explained Petitioner was moving to a new address, and Inspector Warner told her to notify CMS within 30 days. Petitioner asserts, pointing to the evidence it submitted, that had Inspector Warner gone to the 33116 Palmer Road address, he would have found Petitioner open and accessible to the public with signage and posted hours of operation. P. Br. at 2-3.

**b. Analysis**

CMS argues that Petitioner's billing privileges and participation in Medicare may be revoked: (1) for violation of 42 C.F.R. § 424.57(c)(7) (supplier standard 7) because Petitioner's facility at the address on file with CMS was not operational in that it was not accessible to the public, Medicare beneficiaries, CMS, or its agents; (2) for violation of 42 C.F.R. § 424.57(c)(10) because Petitioner did not have a current liability insurance policy; (3) for violation of 42 C.F.R. § 424.57(c)(8) (supplier standard 8) because CMS agents could not conduct a site investigation of the vacant facility; and (4) pursuant to 42 C.F.R. § 424.535(a)(5), because it was determined that Petitioner was not operational when an on-site review was attempted. CMS Br. at 1-2, 5-11; CMS Reply. Petitioner has submitted evidence, which if viewed in a light most favorable to Petitioner and with all inferences drawn in Petitioners favor, shows the existence of genuine disputes of material facts related to whether or not Petitioner had the required liability insurance and was operational and could have been inspected on October 17, 2013, albeit at a different address than the address on file with CMS. Therefore, summary judgment will not lie for revocations based on 42 C.F.R. §§ 424.57(c)(8) and (10) and 424.535(a)(5). There are no genuine disputes as to the facts that establish a violation of 42 C.F.R. § 424.57(c)(7) and, as matter of law, revocation pursuant to 42 C.F.R. §§ 424.57(e) and 424.535(a)(1) is appropriate.

I also note that revocation was upheld on reconsideration based on noncompliance with 42 C.F.R. §§ 424.57(c)(7) and (10) (supplier standards 7 and 10) not 42 C.F.R. § 424.535(a)(5). CMS Ex. 4. Therefore, whether or not there was a basis for revocation pursuant to 42 C.F.R. § 424.535(a)(5) because Petitioner was not operational, is not at issue before me because it was not a basis for revocation upheld on reconsideration. However, it is well established that even a single violation of a single supplier standard is an adequate basis for revocation of billing privileges and enrollment. *Complete Home Care*, DAB No. 2525, at 6 (2013) (not necessary to decide whether or not operational where supplier found to be in violation of supplier standard 7*); 1866ICPayday.com*, DAB No. 2289, at 13 (2009).

Supplier standard 7 (42 C.F.R. § 424.57(c)(7)) requires that Petitioner maintain an appropriate site that meets specified criteria, including that it be accessible and staffed

during posted hours of operation. CMS or its agents must also be able to inspect the site during normal hours of operation to ensure compliance with participation requirements. Petitioner does not deny it was not accessible and staffed during normal hours of operation at the address on file with CMS when Investigator Warner attempted to conduct an inspection on October 17, 2013. Accordingly, Petitioner violated supplier standard 7 (42 C.F.R. § 424.57(c)(7)(i)(C)) and there is a basis for the revocation of Petitioner's enrollment and billing privileges pursuant to 42 C.F.R. §§ 424.57(e) and 424.535(a)(1).

I conclude that the effective date for revocation of Petitioner's Medicare enrollment and billing privileges based on a violation of 42 C.F.R. § 424.57(c)(7) (supplier standard 7) is 30 days after the date on which notice of revocation was mailed. My conclusion is based on the analysis of the Board in *Neb Group of Arizona LLC*, DAB No. 2573, at 7-8 (2014) in which the Board gave effect to regulatory changes to 42 C.F.R. § 424.57 that were published in the Federal Register but not the C.F.R. Accordingly, I conclude that the effective date of the revocation of Petitioner's Medicare enrollment and billing privileges is December 22, 2013.[5]

## III. Conclusion

For the foregoing reasons, I conclude that Petitioner's Medicare enrollment and billing privileges are properly revoked effective December 22, 2013.

/s/
Keith W. Sickendick
Administrative Law Judge

[5] CMS argues that the effective date should be October 17, 2013, the date the failed inspection attempt found Petitioner's location empty and closed. The retroactive effective date of October 17, 2013, would only be authorized in this case if revocation was based on a determination that Petitioner was no longer operational. 42 C.F.R. § 424.535(g). If CMS wishes to attempt to prove that Petitioner was not operational in order to establish the earlier effective date, CMS may file a motion to reopen in accordance with 42 C.F.R. § 498.100(a) within 60 days of the date of notice of this decision.