Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Dallas County Hospital District
d/b/a East Dallas Health Center
d/b/a Hatcher Station Health Center Pharmacy
(NPI: 1346234093 \ PTAN: 4633300007),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-16-663

Decision No. CR4754

Date: December 8, 2016

DECISION

The Medicare enrollment and billing privileges of Petitioner, Dallas County Hospital District d/b/a East Dallas Health Center d/b/a Hatcher Station Health Center Pharmacy, are revoked pursuant to 42 C.F.R. §§ 424.57(e)(1) [1] and 424.535(a)(5)(ii) based on a violation of 42 C.F.R. § 424.57(c)(2) (Supplier Standard 2). Revocation is effective February 16, 2016. 42 C.F.R. §§ 424.57(e)(1); 424.535(g).

I. Background

Petitioner was enrolled in the Medicare program as a pharmacy and supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). CMS Exhibit (CMS Ex.) 1 at 32-38. The National Supplier Clearinghouse (NSC) operated by Palmetto GBA,

---

[1] Citations are to the 2015 revision of the Code of Federal Regulations (C.F.R.), unless otherwise indicated.

notified Petitioner by letter dated February 24, 2016, that Petitioner's Medicare billing number and billing privileges were revoked effective February 16, 2016. NSC cited 42 C.F.R. §§ 405.800, 424.57(e), 424.535(a)(1), 424.535(a)(5), and 424.535(g) as the legal authority for the revocation. NSC alleged noncompliance with 42 C.F.R. §§ 424.57(c)(1) (Supplier Standard 1); 424.57(c)(2) (Supplier Standard 2); and 424.57(c)(7) (Supplier Standard 7). NSC advised 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 18-25.

Petitioner requested reconsideration and submitted a corrective action plan (CAP) by letter dated March 8, 2016. CMS Ex. 1 at 26-38; P. Ex. 2. NSC rejected the CAP on April 18, 2016. CMS Ex. 1 at 39-42. On April 25, 2016, a contractor hearing officer (hearing officer) issued a reconsidered determination in which she upheld the revocation effective February 16, 2016, citing 42 C.F.R. § 424.57, and concluding that Petitioner was "in violation" of 42 C.F.R. §§ 424.57(c)(7) and 424.535(a)(5)(ii) "and was out of compliance with" 42 C.F.R. § 424.57(c)(2) (Supplier Standard 2) and (7) (Supplier Standard 7). CMS Ex. 1 at 5. On June 23, 2016, Petitioner requested a hearing (RFH) before an administrative law judge (ALJ). On June 30, 2016, the case was assigned to me for hearing and decision, and an Acknowledgement and Prehearing Order (Prehearing Order) was issued at my direction.

On August 1, 2016, CMS filed a motion for summary judgment and supporting brief (CMS Br.), with CMS Ex. 1. On August 29, 2016, Petitioner filed an opposition to CMS's motion (P. Br.) with two exhibits, Petitioner's exhibits (P. Exs.) 1 and 2. On September 13, 2016, CMS filed its reply brief (CMS Reply). The parties have not objected to my consideration of the offered exhibits and CMS Ex. 1 and P. Exs. 1 and 2 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 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.[2] Act §§ 1834(j)(1) (42 U.S.C. § 1395m(j)(1));

---

[2] 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
(Continued next page.)

1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395u(h)(1)). Petitioner is a supplier.

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. §§ 424.57 and 424.505, a DMEPOS supplier such as Petitioner must be enrolled in the Medicare program to be reimbursed for durable medical equipment, prosthetics, orthotics, or supplies sold or rented to Medicare beneficiaries. The regulations establish detailed requirements that suppliers must meet and maintain to enroll in Medicare and to receive and maintain Medicare billing privileges. 42 C.F.R. pt. 424, subpt. P. DMEPOS suppliers have additional requirements imposed by 42 C.F.R. § 424.57(b) and (c). 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 be 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 operate and furnish Medicare-covered items in compliance with all applicable federal and state licensure and regulatory requirements. 42 C.F.R. § 424.57(c)(1). A DMEPOS supplier is required to submit completed application and enrollment forms for each separate physical location it uses to furnish DMEPOS, with the exception of warehouses or repair facilities. 42 C.F.R. § 424.57(b)(1). 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 changes in information supplied on the application within 30 days of the change. 42 C.F.R. §§ 424.57(c)(2); 424.516(c). Additionally, 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

---

(Continued from preceding page.)

"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.

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 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. Noncompliance with enrollment requirements established by 42 C.F.R. § 424.57(b) and (c) for DMEPOS suppliers is also a basis for revocation of billing privileges and enrollment in Medicare pursuant to 42 C.F.R. § 424.57(e)(1). 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, or has otherwise failed to satisfy any of the Medicare enrollment requirements. 42 C.F.R. § 424.535(a)(5)(i) and (ii).

Generally, when CMS revokes a supplier's Medicare billing privileges for not complying with enrollment requirements, the revocation is effective 30 days after CMS or its contractor mails notice of its determination to the supplier. 42 C.F.R. §§ 424.57(e)(1); 424.535(g). When CMS revokes a supplier's billing privileges because the supplier's "practice location" is not operational, the revocation is effective as of the date CMS determined the supplier's practice location was no longer operational. 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 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(*l*)(2). CMS is also granted the right to request ALJ review of a reconsidered determination with which it is dissatisfied. 42 C.F.R. § 498.5(*l*)(2). 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. Summary judgment is appropriate.

CMS filed a motion for summary judgment which Petitioner opposes.

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 on the merits after a hearing or when hearing is waived. 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 I conclude that there is no genuine dispute as to any material fact pertinent to revocation pursuant to 42 C.F.R. §§ 424.57(e)(1) and 424.535(a)(5)(ii) that requires a trial. Petitioner concedes its noncompliance with 42 C.F.R. §§ 424.57(c)(2) by admitting it moved to another location and failed to notify CMS of its new address by filing the

required form. Petitioner admits that it did not file the required CMS-855S to report its change in enrollment information, i.e., its change of address, within 30 days of the change of address. CMS Ex. 1 at 26. Accordingly, summary judgment is appropriate.

Summary judgment is not appropriate for revocation based on the alleged violation of 42 C.F.R. § 424.57(c)(7) (Supplier Standard 7), which requires that a DMEPOS supplier maintain a physical facility on an appropriate site that meets specified criteria. Summary judgment is also not appropriate for revocation pursuant to 42 C.F.R. § 424.535(a)(5)(i) on the theory that Petitioner was not operational at the times of the site visits. In fact, CMS does not dispute that Petitioner was operational at another location. If all favorable inferences are drawn in favor of Petitioner, as required in ruling on summary judgment, I conclude that there are genuine disputes of material fact related to revocation for noncompliance on these additional grounds that would require a trial. Drawing all favorable inferences for Petitioner, I conclude that there is a genuine dispute as to whether Petitioner was operational and satisfied the requirements of 42 C.F.R. §§ 424.57(c)(7) and 424.535(a)(5)(i) on July 14, 2015 and February 16, 2016, when the site visits occurred, albeit at a location other than that on file with CMS. CMS Ex. 1 at 26-38.

Summary judgment is appropriate as to the effective date of revocation. Petitioner does not dispute that at the time of the second site visit its practice location at 3320 Live Oak Street, Dallas, Texas was not operational. Pursuant to 42 C.F.R. § 424.535(g), CMS is authorized by regulation to establish an effective date of revocation based on the date CMS determined that Petitioner's practice location was no longer operational.

2. **Petitioner violated 42 C.F.R. §§ 424.57(c)(2) (Supplier Standard 2) because Petitioner failed to notify CMS within 30 days of its change of location.**

3. **There is a basis for revocation of Petitioner's enrollment and billing privileges pursuant to 42 C.F.R. § 424.57(e)(1) for failure to comply with the Medicare enrollment requirement established by 42 C.F.R. § 424.57(c)(2).**

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 noncompliance with 42 C.F.R. § 424.57(c)(2).**

5. **The effective date of revocation of Petitioner's Medicare enrollment and billing privileges is February 16, 2016. 42 C.F.R. § 424.535(g).**

The February 24, 2016 notice of the initial determination by NSC advised Petitioner that revocation was pursuant to 42 C.F.R. §§ 405.800, 424.57(e), 424.535(a)(1),

424.535(a)(5), and 424.535(g). NSC advised Petitioner that Petitioner was found not in compliance with 42 C.F.R. §§ 424.57(c)(1) (Supplier Standard 1), 424.57(c)(2) (Supplier Standard 2); and 424.57(c)(7) (Supplier Standard 7). CMS Ex. 1 at 18-19, 22-23. The reconsidered determination dated April 25, 2016, refers in the "Rationale" section to the initial determination and various regulations, including 42 C.F.R. §§ 405.800; 424.57(c)(2), and (7), 424.535(a)(5) and (a)(5)(ii); 424.57(e), 424.535(a)(1), and 424.535(g). CMS Ex. 1 at 4-5. However, in the "Decision" section, the hearing officer concluded that Petitioner was "in violation of 42 C.F.R. § 424.57(c)(7) and 424.535(a)(5)(ii)" and Petitioner was "out of compliance with applicable Medicare requirements, as stated in Supplier Standards 2, and 7." The hearing officer applied 42 C.F.R. § 424.535(g) to determine a retroactive effective date of revocation. CMS did not request review of the reconsidered determination pursuant to 42 C.F.R. § 498.5(*l*)(2). It is the basis for revocation determined on reconsideration that is subject to review in this proceeding because that is the determination that triggers the right to an ALJ hearing.[3] 42 C.F.R. § 498.5(*l*)(2); *Neb Group of Arizona, LLC*, DAB No. 2573, at 7 (2014). Petitioner is not entitled to ALJ review of the bases for revocation cited in the initial determination. Although the reconsidered determination is not a model of clarity,[4] I conclude that the

---

[3] The undisputed facts also support conclusions that Petitioner violated 42 C.F.R. §§ 424.57(b)(1) and (c)(8). A DMEPOS supplier is required to submit completed application and enrollment forms for each separate physical location it uses to furnish DMEPOS, with the exception of warehouses or repair facilities. 42 C.F.R. § 424.57(b)(1). Petitioner violated this requirement as it admittedly failed to file a CMS-855S adding the new practice location at 4600 Scyene Road. Additionally, 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). Petitioner violated this requirement because relocating without notifying CMS frustrated the CMS effort to complete an on-site inspection to ascertain compliance. However, because neither violation is reflected in the reconsidered determination, they are not considered further as a basis for revocation.

[4] The hearing officer did not clearly state that there was authority for revocation under both 42 C.F.R. §§ 424.57(g) and 424.535(a)(5)(ii). She cited generally to 42 C.F.R. § 424.57 and specifically to 42 C.F.R. § 424.535(a)(5)(ii) in her decision. She specifically cited 42 C.F.R. § 424.57(c)(7) but not 42 C.F.R. § 424.57(c)(2), but she specifically refers to both Supplier Standards 2 and 7. She also specifically cited 42 C.F.R. § 424.535(g) when determining that a retroactive date for revocation was authorized. CMS Ex. 1 at 5. I conclude Petitioner suffered no prejudice because the notice met the requirements of 42 C.F.R. § 498.25 as it adequately informed Petitioner of the reasons for the reconsidered determination, including the conditions or requirements of the regulations that Petitioner failed to meet, and of the right to request ALJ review.

hearing officer revoked Petitioner's Medicare enrollment and billing privileges based on noncompliance with 42 C.F.R. § 424.57(c)(2) (Supplier Standard 2) and (c)(7) (Supplier Standard 7) and 42 C.F.R. § 424.535(a)(5)(ii). As already discussed, summary judgment is not appropriate on the issue of whether or not Petitioner violated 42 C.F.R. § 424.57(c)(7) (Supplier Standard 7) and that allegation is not examined further. Therefore the issue before me for resolution on summary judgment is whether noncompliance with 42 C.F.R. § 424.57(c)(2) (Supplier Standard 2) is a basis for revocation of Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. §§ 424.57(e)(1) and 424.535(e)(ii). If there is a basis for revocation, there is also an issue of the correct effective date for revocation.

a. Facts

The material facts are not in dispute. Prior to May 19, 2015, Petitioner was enrolled in Medicare as a pharmacy and supplier of DMEPOS operating at 3320 Live Oak Street, Dallas, Texas. CMS Ex. 1 at 26, 44; RFH at 6. Petitioner admits that on May 19, 2015, Petitioner's name was changed from East Dallas Pharmacy to Hatcher Station Pharmacy and Petitioner moved to 4200 Scyene Road, Dallas, Texas. Petitioner also concedes that no CMS-855S was submitted to NSC reporting the changes. CMS Ex. 1 at 26; RFH at 3, 6; P. Br. at 2-3.

On July 14, 2015, a NSC investigator visited 3320 Live Oak Street, Dallas, Texas and found Petitioner was no longer located at that address. The investigator found a sign on the door that stated that Petitioner moved to 4600 Scyene Road, Dallas, Texas on May 19, 2015. CMS Ex. 1 at 8-14. The investigator made a second visit to 3320 Live Oak Street on February 16, 2016, and Petitioner was still not at that location. The investigator found the same sign that he noted on July 14, 2015. CMS Ex. 1 at 14-17.

b. Analysis

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. *1866ICPayday.com*, DAB No. 2289. at 13 (2009). Supplier Standard 2 (42 C.F.R. § 424.57(c)(2)) requires that Petitioner, as a DMEPOS supplier, provide complete and accurate information on its application and report any changes in information on the application within 30 days of the change. 42 C.F.R. § 424.57(c)(2). A supplier is required to provide CMS notice of any change in its enrollment information, including a change of address of a practice location, using the appropriate CMS-855 enrollment application. 42 C.F.R. §§ 424.510-.515. A provider or supplier is required to be able to demonstrate that it meets enrollment requirements and to produce the documents necessary to show it is in compliance with enrollment requirements. 42 C.F.R. § 424.545(c).

Prior to May 19, 2015, Petitioner was enrolled in Medicare as a pharmacy and supplier of DMEPOS operating at 3320 Live Oak Street, Dallas, Texas. CMS Ex. 1 at 26, 44; RFH at 3, 6. Petitioner admits that on May 19, 2015, Petitioner's name was changed from East Dallas Pharmacy to Hatcher Station Pharmacy and Petitioner moved to 4200 Scyene Road, Dallas, Texas. On July 14, 2015 and February 16, 2016, an investigator visited 3320 Live Oak Street, Dallas, Texas and found Petitioner was no longer operational at that practice location. The investigator found a sign on the door that stated that Petitioner moved to 4600 Scyene Road, Dallas, Texas on May 19, 2015. CMS Ex. 1 at 8-17. Petitioner concedes that no CMS-855S was submitted to NSC reporting the changes. CMS Ex. 1 at 26; RFH at 3, 6; P. Br. at 2-3.

The undisputed facts establish that Petitioner violated 42 C.F.R. § 424.57(c)(2) (Supplier Standard 2) because Petitioner failed to report its change of practice location using a CMS-855S within 30 days of May 19, 2015, the date Petitioner changed its practice location from 3320 Live Oak Street, Dallas, Texas to 4200 Scyene Road, Dallas, Texas. Accordingly, revocation for violation of 42 C.F.R. § 424.57(c)(2) is required by 42 C.F.R. § 424.57(e)(1), which provides that "CMS revokes a supplier's billing privileges if it is found not to meet the standards in paragraphs (b) and (c) of this section." The violation of Supplier Standard 2 was discovered as a result of an on-site inspection. Therefore, revocation is also authorized by 42 C.F.R. § 424.535(a)(5)(ii). The regulation grants CMS discretion to revoke enrollment and billing privileges if, upon on-site review or other reliable evidence, CMS determines that a provider or supplier fails to satisfy any Medicare enrollment requirement. In this case, Petitioner concedes it failed to satisfy the Medicare enrollment requirement applicable especially to DMEPOS suppliers under 42 C.F.R. § 424.57(c)(2) to report any change in enrollment information within 30 days using the applicable CMS-855S.

Pursuant to 42 C.F.R. § 424.57(e)(1), revocation for noncompliance with the requirements of 42 C.F.R. § 424.57(b) or (c) is effective 30 days after the provider or supplier is sent notice of the revocation. Pursuant to 42 C.F.R. § 424.535(g):

> (g) *Effective date of revocation.* Revocation becomes effective 30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier, except if the revocation is based on Federal exclusion or debarment, felony conviction, license suspension or revocation, **or the practice location is determined by CMS or its contractor not to be operational**. When a revocation is based on a Federal exclusion or debarment, felony conviction, license suspension or revocation, **or the practice location is determined by CMS or its contractor not to be operational**, **the revocation is effective** with the date of exclusion or debarment, felony conviction, license suspension

> or revocation or **the date that CMS or its contractor determined that the provider or supplier was no longer operational.**

(Emphasis added.) Both 42 C.F.R. § 424.57(e)(1) and 42 C.F.R. § 424.535(g) are applicable in this case because revocation is required by 42 C.F.R. § 424.57(e)(1) and also authorized by 42 C.F.R. § 424.535(a)(5)(ii). No provision of the Act or the regulations limits CMS or its contractor to applying one regulatory provision or the other. I find no abuse of discretion in the agency's choice to apply 42 C.F.R. § 424.535(g) to fix a retroactive date of revocation of Petitioner's Medicare enrollment and billing privileges that coincides with the date of the second site inspection based on which CMS determined that Petitioner was no longer operational at the practice location visited.

Petitioner's arguments to excuse its violation of Supplier Standard 2 and avoid revocation are without merit.

Petitioner argues that revocation pursuant to 42 C.F.R. § 424.535(a)(ii) for violation of 42 C.F.R. § 424.57(c)(7) is improper because Petitioner had an operational facility. RFH at 3. I have concluded that summary judgment is not appropriate as to the alleged violation of 42 C.F.R. § 424.57(c)(7). However, violation of only one supplier standard is a sufficient basis for revocation of Medicare enrollment and billing privileges. *1866ICPayday.com*, DAB No. 2289, at 13. In this case, I conclude that Petitioner violated 42 C.F.R. § 424.57(c)(2) (Supplier Standard 2), and that violation is a basis for revocation under 42 C.F.R. § 424.57(e)(1) and § 424.535(a)(5)(ii). Accordingly, there is no need to set this case for a trial to determine whether or not Petitioner violated 42 C.F.R. § 424.57(c)(7) and I give no further consideration to Petitioner's argument.

Petitioner argues that the only regulatory basis for revocation in this case is 42 C.F.R. § 424.535(a)(1), which was not cited as the basis for revocation. Petitioner argues that it corrected the alleged violation of 42 C.F.R. § 424.57(c)(2) by its CAP. Petitioner further argues that because it submitted a CAP, revocation is barred under 42 C.F.R. § 424.535(a)(1). RFH at 3-4, 7-11; P. Br. at 5-10. Petitioner's argument that CMS is only authorized to revoke its Medicare billing privileges pursuant to 42 C.F.R. § 424.535(a)(1) is in error. The regulation provides that CMS may revoke enrollment and billing privileges if "[t]he provider or supplier is determined to not be in compliance with the enrollment requirements described in subpart P or the enrollment application. . . ." 42 C.F.R. § 424.535(a)(1). Subpart P of 42 C.F.R. includes 42 C.F.R. §§ 424.500-.570. The hearing officer on reconsideration determined, and I agree, that Petitioner violated 42 C.F.R. § 424.57(c)(2) by failing to report the change of address by filing a CMS-855S. Section 424.57(c)(2) of 42 C.F.R. is in subpart D of 42 C.F.R., not subpart P. CMS also does not allege in this case a failure to comply with a requirement found in the enrollment application. In this case, the authority for revocation is found at 42 C.F.R. § 424.57(e)(1) and 42 C.F.R. § 424.535(a)(5)(ii). Accordingly, 42 C.F.R.

§ 424.535(a)(1) and its requirement to permit submission of a CAP simply have no application in this case. Because 42 C.F.R. § 424.535(a)(1) is not applicable, Petitioner had no right to submit a CAP, and any review or action related to the CAP has no impact upon this case.

Even if one concluded that Petitioner was entitled to submit a CAP, CMS and NSC action related to the CAP have no effect in this case. Petitioner argues that the revocation should be overturned because NSC failed to properly review and consider Petitioner's CAP. Petitioner argues it can show compliance with 42 C.F.R. § 405.809(b). RFH at 4, 11-12; P. Br. at 11. CMS and contractor review of a CAP are governed by 42 C.F.R. § 405.809(b). The regulation grants CMS or its contractor authority to reinstate a supplier if the CAP is accepted or deny reinstatement if the CAP is found inadequate. However, 42 C.F.R. § 405.809(b)(2) provides that the refusal of CMS or its contractor to accept a CAP and reinstate a provider or supplier is not an initial determination subject to my review under 42 C.F.R. pt. 498. *Marcia M. Snodgrass, APRN*, DAB No. 2646, at 18 (2015); *Pepper Hill Nursing & Rehab. Ctr. LLC*, DAB No. 2395, at 9-10 (2011); *DMS Imaging, Inc.*, DAB No. 2313, at 5, 7-10 (2010).

Petitioner claims that its failure to notify CMS was a "minor administrative oversight;" the sign on the door of its old location gave constructive notice to CMS and NSC that it had changed its location; certainly by his second visit the inspector was aware Petitioner had moved and the inspector elected not to call and visit Petitioner at its new location. P. Brief at 2, 3, 6-7. Petitioner also asserts CMS was on notice the other clinics with which Petitioner was affiliated provided CMS with timely notifications of their move and any on-site inspections of those other entities would show that Petitioner had an operational facility at the new location. P. Brief at 2, 8. I accept for purposes of summary judgment that there was a sign on the door clearly showing that Petitioner had moved, that the inspector was well aware of the move, at least by his second visit, and that other clinics had given CMS notice that they had moved. The problem for Petitioner is not that CMS and NSC could have determined that Petitioner had moved. Rather, Petitioner's problem is the violation of its legal obligation under 42 C.F.R. § 424.57(c)(2) to give CMS and its contractor timely notice of its change of address by filing a properly executed CMS-855S. The violation of that legal obligation is a basis for revocation under both 42 C.F.R. § 424.57(e)(1) and 42 C.F.R. § 424.535(a)(5)(ii).

Petitioner argues that the revocation of its Medicare billing privileges and the two-year re-enrollment bar are "unduly harsh" in light of the "extent and depth of services" it provides as part of a larger community health clinic. P. Brief at 12-13. Petitioner states that it has been a community clinic for 13 years with an emphasis on providing services to the indigent, who will be adversely affected by the revocation of its Medicare billing privileges. RFH at 4-5. Petitioner notes that it did not commit any serious crime, such as patient harm or fraud, but merely made a "minor, ministerial mistake." P. Brief at 12. Petitioner also points out that the other component entities of the clinic did timely notify

CMS of their address changes, and that once CMS and its contractors became aware that Petitioner had moved, they should have inspected Petitioner at its new location. P. Brief at 13. Even if I accept Petitioner's assertions as true for purposes of summary judgment, these facts have no impact on the outcome of this case as those facts are not material to the determination of whether or not Petitioner failed to fulfill its legal obligation under 42 C.F.R. § 424.57(c)(2) (Supplier Standard 2) to give timely notice of its change of address by filing a properly executed CMS-855S. Furthermore, when 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). There is no statutory or regulatory language establishing a right to review of the duration of the re-enrollment bar CMS imposes. Act § 1866(j)(8) (42 U.S.C. § 1395cc(j)(8)); 42 C.F.R. §§ 424.535(c), 424.545; 498.3(b), 498.5. The Board has held that the duration of a revoked supplier's re-enrollment bar is not an appealable initial determination listed in 42 C.F.R. § 498.3(b) and not subject to ALJ review. *Vijendra Dave*, DAB No. 2672, at 10-11 (2016).

To the extent that Petitioner's arguments may be construed as a request for equitable relief, I have no authority to grant equitable relief. *US Ultrasound*, DAB No. 2302, at 8 (2010) ("Neither 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."). I am also required to follow the Act and regulations and have no authority to declare statutes or regulations invalid. *1866ICPayday.com, L.L.C.*, DAB No. 2289, at 14 ("An ALJ is bound by applicable laws and regulations and may not invalidate either a law or regulation on any ground.")

III. Conclusion

For the foregoing reasons, I conclude that there is a basis to revoke Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. §§ 424.57(e)(1) and 424.535(a)(5)(ii) for violation of 42 C.F.R. § 424.57(c)(2) (Supplier Standard 2).

/s/
Keith W. Sickendick
Administrative Law Judge