DEPARTMENTAL APPEALS BOARD
Appellate Division

Better Living/Better Health LLC
Docket No. A-15-19
Decision No. 2634
May 1, 2015

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Better Living/Better Health, LLC (BL/BH) appeals the September 26, 2014 Administrative Law Judge (ALJ) decision (as revised October 8, 2014) that upheld the revocation of BL/BH's Medicare enrollment by the Centers for Medicare & Medicaid Services (CMS) and modified the effective date of that revocation to May 25, 2013. *Better Living/Better Health, LLC*, DAB CR3388 (2014) (ALJ Decision).

BL/BH participated in Medicare as a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). The ALJ found that BL/BH violated applicable DMEPOS supplier standards because its location was not accessible during two unannounced site visits and that CMS therefore was authorized to revoke BL/BH's enrollment. The ALJ reached his decision after first remanding the matter to CMS to consider the corrective action plan (CAP) submitted by BL/BH. CMS rejected the CAP and the matter returned to the ALJ, who issued a final decision. BL/BH contends that CMS did not properly review the CAP during the remand and that the ALJ erred by not holding CMS in contempt. BL/BH asks us to reverse the ALJ Decision and remand for CMS to review the CAP in the manner BL/BH argues is proper. Request for Review (RR) at 2-5. As explained below, we uphold the ALJ Decision.

Case background and applicable authority

The procedural history of this matter is fairly complicated but understanding its course is essential to a clear view of BL/BH's argument on appeal. We set out here the applicable regulations and the relevant events in this case as reflected in the record before the ALJ.

In order to maintain Medicare enrollment and associated "billing privileges," a DMEPOS supplier must be in compliance with the 30 "supplier standards" set forth in 42 C.F.R. § 424.57(c). Under section 42.57(c)(7) (supplier standard 7), a DMEPOS supplier is required to maintain "a physical facility on an appropriate site." An "appropriate site" must, among other things, be "accessible and staffed during posted hours of operation." 42 C.F.R. § 424.57(c)(7)(i)(C). CMS (through its contractors) performs on-site inspections to verify compliance with the supplier standards and other Medicare

requirements. *See id*. §§ 424.57(c)(8), 424.517. Supplier standard 10 requires a DMEPOS supplier to carry certain liability insurance and supplier standard 22 requires maintenance of a certificate of accreditation. *Id*. § 424.57(c)(10), (22). CMS is authorized to revoke a DMEPOS supplier's billing privileges for noncompliance with any of the supplier standards. *Id*. § 424.57(c) and (e).[1] The Board has repeatedly held that section 424.57(e) provides the effective date of revocation for noncompliance with any of the supplier standards under section 424.57(c) which is 30 days after the supplier is sent notice of the revocation. *See, e.g., Orthopaedic Surgery Assoc.*, DAB No. 2594 (2014); 75 Fed. Reg. 52,629, 52,648-49 (Aug. 27, 2010).

CMS is also authorized to revoke a supplier's billing privileges for any of the "reasons" listed in section 424.535(a), which applies to all types of Medicare providers and suppliers. Revocation under section 424.535(a)(1), with exceptions not applicable here, requires the supplier to be granted "an opportunity to correct the deficient compliance requirement before a final determination to revoke billing privileges." Under section 424.535(a)(5)(ii), CMS may revoke a supplier's billing privileges if an on-site review reveals that the supplier is "no longer operational." A supplier is operational if, among other things, 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 [the] items or services [being rendered]." 42 C.F.R. § 424.502. The effective date of revocation on this basis is the date CMS determines the supplier was "no longer operational" as a result of an on-site review. *Id*. § 424.535(g).

In April 2013, an inspector for Palmetto GBA National Supplier Clearinghouse (NSC), a Medicare contractor for DMEPOS suppliers, attempted to perform unannounced site visits on two consecutive days to BL/BH's business location. CMS Ex. 3, at 20-31. The inspector reported that he rang the bell and waited but could not obtain entry during the posted hours of operation.

On April 25, 2013, NSC issued an initial determination to revoke BL/BH's supplier number on multiple bases. *Id*. at 17-19. The revocation letter stated --

> Recently, a representative of the NSC attempted to conduct a visit of your facility on April 9, 2013 and April 10, 2013; however, the visit was unsuccessful because your facility was closed during posted business hours. Because we could not complete an inspection of your facility, we could not

[1] An editorial note following section 424.57 in the Code of Federal Regulations noted that a January 2, 2009 final rule (74 Fed. Reg. 198) re-designated paragraph (d) of section 424.57 as paragraph (e), but that this and other changes to section 424.57 were not incorporated into the codified text of the regulations because of an "inaccurate amendatory instruction." As explained in multiple Board decisions, we apply the re-designated section 424.57(e) without regard to the codification error to determine the effective date of revocation in supplier standard revocations. *See, e.g., Sonoma Prosthetic Eyes*, DAB No. 2622, at 9 (2015) and cases cited therein.

> verify your compliance with the supplier standards. Based upon a review of the facts, we have determined that your facility is not operational to furnish Medicare covered items and services. Thus, you are considered to be in violation of 42 CFR § 424.535(a)(5)(ii) and all supplier standards as defined in 42 CFR § 424.57(c).

Id. at 18. The letter went on to specifically cite violations of supplier standards 7, 10, and 22, as well as the finding that the facility was not operational in violation of section 424.535(a)(5)(ii). *Id*. at 17-19. The revocation was made effective retroactive to April 10, 2013, the date of the second site visit as of which CMS determined that BL/BH was not operational. *Id*. at 17.

BL/BH timely sought reconsideration and an NSC hearing officer issued a reconsidered decision on June 24, 2013. *Id*. at 11-16, 33-47; CMS Ex. 2. The reconsidered decision based revocation only on BL/BH's failure to show compliance with supplier standards 7 (accessible and staffed) and 22 (accreditation). CMS Ex. 2, at 5, citing 42 C.F.R. § 424.57. The hearing officer expressly found that BL/BH was in compliance with supplier standard 10 (liability insurance) and not in compliance with standards 7 and 22. The reconsideration decision made no explicit findings, however, about whether BL/BH was operational even though the decision contained a definition of the term "operational." CMS Ex. 2, at 3.

BL/BH requested an ALJ hearing which was held on January 28, 2014. After post-hearing briefing, the ALJ issued a ruling in which he held that, although the hearing had addressed whether BL/BH was operational, he had determined that he lacked authority to adjudicate that issue. ALJ Ruling 2014-36, at 3-4 (July 11, 2014), *citing Neb Group of Arizona LLC*, DAB No. 2573, at 7 (2014) and *Benson Ejindu, d/b/a Joy Medical Supply*, DAB No. 2572, at 8-9 (2014).

Having concluded that his decision must be limited to the bases set out in the reconsideration, the ALJ made a number of factual findings about the events surrounding the attempted site visits, including evaluating the inspector's testimony as credible and that of BL/BH's owner and a neighboring businessperson as not credible. ALJ Ruling at 5-13. In particular, the ALJ noted that the owner stated in the reconsideration request that she was out of the office at the time of the site visits but testified at the hearing that she was present at both times but did not hear the doorbell. *Id*. at 7. The ALJ found the owner's claim that she realized belatedly that she was there because she only did her "due diligence" to check on this after having filed her ALJ hearing request to be implausible. He further found her response to his questions at the hearing intended to clarify if she was away at any time on the two days in question to be "less than candid and not believable." *Id*. at 8. He quoted that testimony as follows:

> To the extent that I was out of the office at any time on those dates between the posted hours of 9:00 and 5:00, no, I was not. I did on April the 10th I had a patient that I did service. And I had submitted that documentation but it was after close of business hours on April the 10th. But for April 9th and 10th the reason why I said I was servicing deliveries is I could have ran to the store. Tr. 136-37.

Id. However, because he concluded that he could only uphold the revocation based on the violation of supplier standards, not on the basis that the supplier was not operational, the ALJ ruled that the regulations relating to the supplier standards alone must be applied which precluded a retroactive effective date and required an opportunity to correct. *Id.* at 13-14. The ALJ therefore concluded that he had to remand for CMS to provide the required opportunity to correct, finding that, although BL/BH submitted a CAP, the contractor had not actually considered it. *Id*. at 18. The ALJ's instructions to CMS on remand were as follows:

> Because I have not issued a decision in this case yet, I hereby remand this matter to CMS under 42 C.F.R. § 498.78(b). On remand CMS shall:
>
> 1. Consider the CAP Petitioner submitted to NSC (P. Ex. 10);
> 2. Consider any supplemental information that Petitioner may submit to CMS **within 14 days** of the date on this Order of Remand;
> 3. Conduct a full review of the CAP under 42 C.F.R. § 405.809;
> 4. Issue a decision reinstating Petitioner's Medicare billing privileges or refusing to reinstate[] those privileges **within 45 days** of the date on this Order of Remand;
> 5. File a copy of the CAP decision with the DAB's Civil Remedies Division along with a request that I dismiss the RFH (if CMS has reinstated billing privileges) or a request that I issue a decision consistent with the findings and conclusions in this Order of Remand (if CMS has not reinstated billing privilege); and
> 6. Submit, with a request that I issue a decision, any argument it may want to make concerning CMS's authority to revoke Petitioner and the effective date of the revocation.

Id. at 18-19 (bold in original).

CMS asked the ALJ to reconsider his remand ruling arguing that the ALJ should not follow the Board decisions that he cited in his ruling because their late application in the present case prejudiced CMS. The ALJ rejected this argument because CMS was in no worse position than if it had known from the outset of the appeal that only those bases included in the reconsideration were within the scope of review. ALJ Order at 1-2 (July 24, 2014), citing (in n.1) two additional Board decisions – *Cornerstone Medical Inc.*,

DAB No. 2585 (2014) and *Norpro Orthotics & Prosthetics, Inc.*, DAB No. 2577 (2014). The ALJ further rejected CMS's claim that the CAP had already been considered as part of the reconsideration determination and concluded that a remand was the best way to ensure the opportunity for a CAP had been provided. *Id*. at 3, citing CMS Ex. 2, at 4.

On remand, CMS reviewed the CAP and supplemental information provided by BL/BH and determined that BL/BH "has failed to provide sufficient evidence that it has complied fully with the Medicare requirements." CMS letter dated Aug. 21, 2014, at 1. Because the explanation for this determination is directly at issue in this appeal, we quote the rationale fully:

> Petitioner's CAP asserts that Petitioner has implemented new policies and procedures to address Petitioner's noncompliance with the Supplier Standard at 42 C.F.R. § 424.57(c)(7). Petitioner represents that it will implement a change in the hours of operation, it will post its new hours of operation, and it will leave a sign/note on the door to inform the public of when someone will return if the office is left unattended. P. Ex. 10 at 2. Petitioner further represents that it has secured the services of an independent contractor who is available to work at Petitioner's physical office location to ensure that the office is staffed at all times during its pos[t]ed business hours in the event such services are needed. Letter from Petitioner's Counsel dated July 23, 2014.
>
> Petitioner provided a picture verifying that, in fact, it has already changed its sign to notify the public of its new hours of operation. However, the other elements of Petitioner's CAP are based on Petitioner's representation and promise that, moving forward it will fully comply with the requirements of the Supplier Standard at 42 C.F.R. § 424.57(c)(7). CMS does not accept Petitioner's CAP. CMS is unable to find that this Petitioner has complied fully with the Medicare requirements at 42 C.F.R. § 424.57(c)(7) based on this Petitioner's representations and promises that the provider has fully come into compliance with the Medicare requirements.
>
> At this point, Petitioner has made numerous representations under oath during the administrative appeal process which have not been truthful. Specifically, Petitioner declared under penalty of perjury in an affidavit dated October 16, 2013 that she was present in her office at the times of the two site inspections. Similarly, Petitioner testified under oath at the hearing that she was present in her office at the times of the two site inspections. The ALJ found, and CMS agrees, that Ms. Thomas' testimony at the hearing and in her affidavit were not credible. ALJ opinion at pages 8-10. The ALJ stated at page 8 that "I do not find credible Ms. Thomas'

> testimony that she was present in her office at the times of the two inspections because her statements directly contradict her prior assertions contained in her request for reconsideration and her request for hearing." He explained at page 10 "Ms. Thomas' testimony and affidavit clearly contradict her earlier admissions that she was away from the office and appear to constitute an after the fact attempt to rebut CMS's case and avoid revocation of Petitioner's Medicare billing privileges." Accordingly, CMS does not accept Petitioner's CAP because CMS cannot find Petitioner in compliance with the requirement at 42 C.F.R. § 424.57(c)(7) based on Petitioner's representations and promises that the provider is now fully compliant where Petitioner has a history of having made false representations under oath and under penalty of perjury.
>
> Based on the above, CMS has determined that it will not reinstate Petitioner's Medicare billing privileges in response to Petitioner's CAP or the additional information submitted in the July 23, 2014 correspondence.

Id. at 1-2 (emphasis in original). The matter returned to the ALJ, who issued a decision on September 26, 2014 upholding the revocation of BL/BH's Medicare enrollment and setting an effective date of May 25, 2013 relying on 42 C.F.R. § 424.535(g). The ALJ rejected BL/BH's contentions that CMS had not proceeded properly on remand and therefore no final decision should be issued. ALJ Decision of September 26, 2014, at 4.

On October 8, 2014, the ALJ revised his decision to change the basis for setting the effective date (without changing the date) to 42 C.F.R. § 424.57(e). ALJ Decision at 5, 18, citing *Orthopaedic Surgery Assoc*., DAB No. 2594, at 8 (2014).

Parties' arguments

BL/BH appealed on narrow grounds, arguing that CMS failed to comply with the ALJ's order in its consideration of the CAP on remand and that the matter should be remanded to enforce the ALJ's order. RR at 1-2. BL/BH argued that CMS merely "went through the motions to purportedly comply" with the remand order but, in fact, "improperly considered information outside of the CAP and supplemental information in violation of" the remand order, with the effect that "CMS **penalized** BL/BH for availing itself of its appeal rights by denying the CAP based solely on its own assessment of the evidence offered at the hearing before the ALJ." RR at 3 (bold in original). In so doing, according to BL/BH, CMS usurped the ALJ's role of holding the hearing and weighing the evidence and should be held in contempt. RR at 4. BL/BH explains the narrow scope of its appeal as follows:

> Significantly, BL/BH is *not* requesting that the DAB review CMS's *decision* to refuse to reinstate its billing privileges. BL/BH is merely requesting that the DAB enforce the ALJ's Order of Remand, namely, that CMS review BL/BH's CAP and supplemental information in accordance with 42 C.F.R. § 405.809, and not the evidence offered at the ALJ hearing, which is within the exclusive domain of the ALJ to assess.

RR at 5.[2]

CMS noted that the ALJ had already held a hearing and opined on the credibility of BL/BH's owner's accounts of the site visits when he remanded for CMS to review the CAP. CMS Resp. Br. at 7. CMS quoted the instructions in the remand order (set out above) and the ALJ's further statement that BL/BH should "understand that I do not have jurisdiction to review CMS's decision to refuse to reinstate billing privileges based on a CAP." *Id.* at 7-8, quoting ALJ Ruling 2014-36 (citations omitted from quotation). CMS argued that BL/BH's appeal amounted to a backdoor attempt to challenge the rejection of the CAP when the regulations clearly do not permit that. *Id*. at 11-12, citing 42 C.F.R. §§ 405.809 (refusal to reinstate billing privileges based on a CAP not an initial determination), 498.3(b) (list of appealable initial determinations); *DMS Imaging, Inc*., DAB No. 2313, at 7-8 (2010); *Pepper Hill Nursing & Rehab. Ctr., LLC*, DAB No. 2395 (2011). Finally, CMS contended that it fully complied with the ALJ's remand order and that it could properly consider any information bearing on the issue of whether a supplier fully complied including the inconsistent statements made by BL/BH's owner. *Id*. at 12-13. Doing so, according to CMS, does not preempt the appeal process, usurp the role of the ALJ, or penalize BL/BH for exercising its appeal rights. *Id*. at 13-17.[3]

Standard of review

The standard of review on a disputed factual issue is whether the ALJ decision is supported by substantial evidence in the record as a whole. The standard of review on a disputed issue of law is whether the ALJ decision is erroneous. *See* Guidelines — Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program, at http://www.hhs.gov/dab/divisions/appellate/guidelines/prosupenrolmen.html.

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[2] BL/BH also requested that the case be referred for alternative dispute resolution. RR at 6. Such a referral requires consent from both parties. On November 25, 2014, CMS filed a notice that it did not agree to mediation.

[3] CMS also reiterated its position before the ALJ that the remand was uncalled for because the ALJ should not have determined that a legal basis for revocation was abandoned merely because that basis was not repeated in the reconsideration decision. CMS Resp. Br. at 8-9. CMS did not appeal the ALJ Decision and hence has no standing to raise arguments against it at this level. We therefore do not discuss this contention here.

Analysis

We find no support for BL/BH's contention that CMS's process on remand was somehow in contempt of the ALJ's remand order. The ALJ declined to find contempt and, for the reasons explained below, we see no error in that evaluation.[4]

CMS in no way usurped the ALJ's role in conducting the hearing and evaluating the testimonial and other evidence, since the ALJ had already performed those tasks prior to the remand. Furthermore, CMS's evaluation of the owner's credibility mirrored the ALJ's, but was expressly independent of it. We therefore do not perceive a threat to the "integrity" of the ALJ process itself, contrary to BL/BH's suggestion. RR at 1.

We turn therefore to the question of whether CMS violated the instructions on remand or otherwise acted improperly in issuing its decision rejecting BL/BH's CAP. The instructions in the ALJ remand order are explicit about what CMS **must** consider on remand – the CAP, BL/BH's supplemental submissions, and that CMS must conduct a full review under section 405.809. The instructions, however, do not expressly restrict CMS to considering **only** the CAP and the supplier's submissions. It would make little sense to do so since the revocation was obviously based on other sources of information about the deficiencies needing correction, such as the site visit reports.

On remand, the ALJ instructed CMS to consider any supplemental information provided by BL/BH within 14 days of the remand. The instructions are silent about whether or how CMS may take into account other events that occurred after the reconsideration determination issued or other evidence that accumulated during the ALJ proceeding. We do not construe the ALJ remand order, however, as somehow implicitly limiting CMS from considering information gained in the ALJ proceedings, especially given that the ALJ permitted BL/BH to add new material to the record before the CMS decision-maker rather than requiring it to rely on what it submitted with its original CAP request. The order is more reasonably read as anticipating a full review based on all the evidence as of the date of the CAP review.

[4] BL/BH points to a comment in the ALJ's original decision as showing that the ALJ was "obviously troubled" by the CAP review but thought that he did not have the authority to find contempt. RR at 5, citing ALJ Decision of September 26, 2014, at 22. The ALJ chose to omit the comment from his final, revised decision, and in any case, we do not read it as supporting BL/BH's claims that the CAP review was conducted improperly. The ALJ had commented that, although he had "concerns about CMS's review of the CAP, based both on the content of the CAP decision, and the tone and content of CMS counsel's opposition to the DAB's recent decisions that restrict my review of this case, CMS has rendered a decision on the CAP that basically complied with the Order of Remand." ALJ Decision of September 26, 2014, at 22. The ALJ nowhere suggested he lacked authority to respond if he believed his order had been violated but only that he did not have authority to review the content of CMS's rejection of the CAP. Neither do we.

BL/BH has not identified any authority that would bar CMS from considering all information in its possession in evaluating whether to accept a CAP, and we have not found any. Certainly, BL/BH was privy to all the information on which CMS relied, since the material to which BL/BH objects was derived from the proceedings before the ALJ in which BL/BH was an active participant. The CAP rejection letter implies that CMS understood itself to be making an independent assessment of all the evidence relating to BL/BH in deciding whether to accept BL/BH's representations about future compliance, rather than simply deferring to the ALJ's findings. For example, CMS reports the ALJ's findings about the owner's credibility and then states "CMS agrees." CMS letter dated Aug. 21, 2014, at 2. While it may well be true that the official reviewing the CAP was not present at the ALJ hearing, we do not see that he was therefore required to ignore what occurred on the record and under oath at that hearing in determining whether to credit the statements in the CAP. In particular, we note that the supplemental material submitted to that officer made no attempt to revise or explain the statements in the original CAP to the effect that BL/BH was changing its policies and procedures to address the fact that at the time of the site visits its sole owner/operator was "servicing clients with set ups and/or deliveries" off site and to "avoid this absence in the future and to adhere to supplier standards." P. Ex. 10, at 2.

It is not surprising that no authority directly contemplates how a CAP review process would interact with an ALJ proceeding because the regulations anticipate that CAP review would normally occur before the contractor went on to issue a reconsideration determination. *See DMS Imaging, Inc*., DAB No. 2313, at 6-7, citing Medicare Program Integrity Manual, Ch. 10, § 19.A. The circumstances here were highly unusual in that CMS was required to review a CAP after the reconsideration determination had not only been issued but appealed and a complete hearing conducted on appeal. CMS may bear some responsibility for that necessity by not foreseeing that a CAP review would have to occur if its reconsideration were not upheld on the "non-operational" basis and not conducting a CAP review prior to going forward with the reconsideration on multiple bases. Nevertheless, we do not see any ground for requiring CMS to wear blinders while reviewing the CAP on remand or to ignore conflicting representations made by the owner at different levels of review. We are not persuaded that CMS's considering representations made during the appeals process in deciding whether to accept claims of correction amounts to penalizing the supplier for having elected to exercise its appeal rights.

As BL/BH itself recognizes, we have no authority to review the merits of CMS's decision to reject the CAP. That means we do not evaluate whether CMS had a good basis for deciding that it did not trust BL/BH's assurances of future compliance. BL/BH asked us only to consider whether CMS violated the remand order. We conclude that it did not.

Conclusion

We uphold the ALJ Decision and sustain the revocation of BL/BH's Medicare enrollment effective May 25, 2013.

/s/
Constance B. Tobias

/s/
Susan S. Yim

/s/
Leslie A. Sussan
Presiding Board Member