Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Optimum Sleep Associates, Inc.,

Petitioner

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-982

Decision No. CR3059

Date: January 3, 2014

DECISION

The Medicare enrollment and billing privileges of Petitioner, Optimum Sleep Associates, Inc., are revoked pursuant to 42 C.F.R. §§ 424.57(d) and 424.535(a)(1) and (5)(ii),[1] effective February 18, 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), the Medicare administrative contractor for the Centers for Medicare & Medicaid Services (CMS), notified Petitioner by letter dated March 28, 2013, that Petitioner's Medicare enrollment was revoked effective February 18, 2013. CMS Exhibit (CMS Ex.) 1, at 8-10.

On April 2, 2013, Petitioner requested reconsideration of the initial decision arguing that Petitioner had relocated to a new address and the new location had approximately 2,400

[1] Citations are to the annual revision of the Code of Federal Regulations (C.F.R.) in effect at the time of the pertinent agency action, unless otherwise indicated.

square feet with store front accessibility. CMS Ex. 1, at 11. On May 23, 2013, Palmetto issued a reconsideration decision denying Petitioner's request for reconsideration and finding that Petitioner's Medicare enrollment was properly revoked because Petitioner did not comply with durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) supplier standard 7, at 42 C.F.R. § 424.57(c)(7). CMS Ex. 1, at 1-4.

Petitioner requested a hearing before an administrative law judge (ALJ) by letter dated June 11, 2013 (RFH), seeking review of the revocation of its Medicare enrollment and billing privileges. The case was assigned to me for hearing and decision on July 8, 2013, 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 and neither party alleges that I lack jurisdiction to decide this matter.

On August 7, 2013, CMS filed a prehearing brief and motion for summary judgment (CMS Br.) with CMS Exs. 1 and 2. Petitioner has not objected to my consideration of CMS Exs. 1 and 2 and they are admitted as evidence. On September 6, 2013, Petitioner filed a letter in response to CMS's motion for summary judgment (P. Br.) with no exhibits. On September 16, 2013, CMS notified my office that CMS would not file a reply brief.

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

[2] A "supplier" furnishes services 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
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The Act requires the Secretary of Health and Human Services (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 of certain enrollment determinations. Act § 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to 42 C.F.R. § 424.505, a provider or 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). The appropriate site for the physical facility must meet certain criteria including that the practice location is at least 200 square feet,[3] is in a location accessible to the public, Medicare beneficiaries, CMS and its agents, and the practice location must be accessible and staffed during posted hours of operation. 42 C.F.R. § 424.57(c)(7)(i)(A),(B),(C). Additionally, 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). Finally, 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). 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 may revoke a currently enrolled supplier's Medicare

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providers and suppliers is important because they are treated differently under the Act for some purposes.

[3] The requirement that the practice location be at least 200 square feet began September 27, 2010 for prospective DMEPOS suppliers, the first day after termination of an expiring lease for an existing DMEPOS supplier with a lease that expired on or after September 27, 2010 and before September 27, 2013, and September 27, 2013 for an existing DMEPOS supplier with a lease that expires on or after September 27, 2013. 42 C.F.R. § 424.57(c)(7)(i)(A)(1)-(3).

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 the right to an ALJ hearing. 42 C.F.R. § 498.25. If the decision on reconsideration is unfavorable to the supplier, the supplier has a right to request a hearing by an ALJ and further review by the Departmental Appeals Board (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 provider or 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.

A provider or supplier denied enrollment in Medicare or whose enrollment had 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. §§ 424.454(a), 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); *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743, 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 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 procedures established by 42 C.F.R. pt. 498 do not include a summary judgment procedure. However, appellate panels of the Board have long recognized the availability of summary judgment in cases subject to 42 C.F.R. pt. 498, and the Board's interpretative rule has been recognized by the federal courts. *See, e.g., Crestview,* 373 F.3d at 749-50. 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.

Summary judgment is appropriate when there is no genuine dispute as to any issue of material fact for adjudication or the moving party 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. The party requesting summary judgment bears the burden of showing that there are no genuine issues of material fact for trial or that it is entitled to judgment as a matter of law. 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 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 parties' 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 for the allocation of the burden of persuasion or the quantum of evidence in 42 C.F.R. pt. 498. 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 & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 Fed. App'x 181 (6th Cir. 2005).

Petitioner asserts that at the time of the attempted inspection by Palmetto on February 18, 2013, it had relocated. But, Petitioner presented no affidavit, declaration, or other evidence that creates a genuine dispute that it was in fact operational at another location at the time of the inspection. Viewing the evidence actually before me in a light most favorable to Petitioner and drawing all inferences in Petitioner's favor, I conclude that there are no genuine disputes as to any material facts in this case. As discussed in more detail hereafter, the undisputed evidence shows that there is a basis for the revocation of Petitioner's Medicare billing privileges effective February 18, 2013. Accordingly, I conclude that summary judgment is appropriate.

2. There was a basis to revoke Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. §§ 424.57(d) and 424.535(a)(1) and (5)(ii) for violation of 42 C.F.R. § 424.57(c)(7).

3. No equitable relief is available in this forum.

a. Background

The facts are not disputed and any inferences are drawn in favor of Petitioner. On February 18, 2013, a Palmetto representative attempted to inspect Petitioner's facility at Petitioner's address on file with CMS, 4460 Red Bank Road, Suite 220, Cincinnati, Ohio 45227. CMS Ex. 1, at 5-7. Upon arrival, the Palmetto inspector found the building to be vacant and found a note taped to the door, stating that Petitioner had relocated to 7714 Montgomery Road, Suite L, Kenwood, Ohio 45236 on February 1, 2013. CMS Ex. 1, at 6-7. Although the note states that Petitioner had relocated, it does not support an inference that Petitioner was actually operational at that new location at the time.

On March 28, 2013, Palmetto revoked Petitioner's Medicare enrollment and billing privileges effective February 18, 2013, the date of the attempted site inspection. In the notice letter, Palmetto stated that the revocation was pursuant to 42 C.F.R. § 405.800, 424.57(e), 424.535(a)(1), 424.535(a)(5)(ii), and 424.535(g), based on Petitioner's failure to comply with DMEPOS supplier standard 42 C.F.R. § 424.57(c)(7). CMS Ex. 1, at 8-10. Petitioner subsequently requested reconsideration and stated that Petitioner had relocated to a new address at 7714 Montgomery Road, Suite L, Cincinnati, Ohio 45236[4]

[4] The note found posted on the door at Petitioner's old location stated that Petitioner had relocated to Kenwood, Ohio. CMS Ex. 1, at 7. Petitioner stated in its request for reconsideration dated April 2, 2013, that its new location is in Cincinnati, Ohio. CMS Ex. 1, at 11. I note that Kenwood, Ohio is a suburb of Cincinnati.

and kept the same telephone and fax numbers, and the new location was approximately 2,400 square feet, with store front accessibility. CMS Ex. 1, at 11. Although Petitioner asserted in its reconsideration request that Petitioner relocated, there is no allegation by Petitioner that it was actually operational at the new location and no inference that it was operational is supported.

On May 23, 2013, a hearing officer issued a reconsideration decision, upholding the revocation of Petitioner's Medicare enrollment and billing privileges. CMS Ex. 1, at 1-4. The hearing officer determined that Petitioner failed to comply with supplier standard 7, at 42 C.F.R. § 424.57(c)(7).

b. Analysis

CMS argues that there are four bases for revoking Petitioner's billing privileges and participation in Medicare: (1) 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) 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; (3) violation of 42 C.F.R. § 424.57(c)(2) (supplier standard 2) because Petitioner failed to properly notify CMS within 30 days of the change of location of its facility; and (4) pursuant to 42 C.F.R. § 424.535(a)(5), CMS is authorized to revoke the enrollment of a supplier who is determined not to be operational upon on-site review. CMS Br. at 5-7.

Section 424.57(c)(7) of 42 C.F.R. requires that Petitioner maintain an appropriate site that meets specified criteria, including that it be accessible and staffed during posted hours of operation and which CMS or its agents can inspect to ensure compliance with participation requirements. Section 424.535(a)(5) authorizes CMS to revoke if a supplier is determined not to be operational when CMS or its agents attempt to conduct an inspection. In this case, the alleged violation of 42 C.F.R. § 424.57(c)(7) and CMS's authority to revoke at 42 C.F.R. § 424.535(a)(5), have the same factual basis and are not separate grounds for revocation. Furthermore, Palmetto and CMS did not notify Petitioner of revocation based on violation of either 42 C.F.R. § 424.57(c)(2) (supplier standard 2) or § 424.57(c)(8) (supplier standard 8) (CMS Ex. 1, at 8-10) and the reconsideration decision is not based on violation of those standards (CMS Ex. 1, at 1-4). Therefore, the alleged violations of 42 C.F.R. §§ 424.57(c)(2) and (8) are not properly before me due to lack of proper notice. The only basis for revocation properly before me is the alleged violation of 42 C.F.R. § 424.57(c)(7). 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).

Petitioner does not dispute that it was not operational at the address on file with CMS on February 18, 2013. Petitioner does not deny that its facility at 4460 Red Bank Road,

Suite 220, Cincinnati, Ohio 45227 was not staffed and the public, Medicare beneficiaries, and CMS and its agents had no ability to access the facility on February 18, 2013. P. Br. There is some evidence that Petitioner relocated its operation to another address effective February 1, 2013. CMS Ex. 1, at 7 and 11. However, Petitioner has presented no evidence from which I may infer that Petitioner was operational at another location at the time of the February 18, 2013 inspection attempt, or that Petitioner met the requirement of 42 C.F.R. § 424.57(c)(7) at that time.

Petitioner urges me to consider extenuating circumstances and lessen the penalty imposed in this case. However, my authority is limited to determining whether there is a basis for revocation. I have no authority to review the exercise of discretion by CMS to revoke where there is a basis for revocation. I also have no authority to review the reasonableness of the duration of the period of the re-enrollment bar imposed by CMS. Finally, I have no authority to create or grant equitable relief. *US Ultrasound*, DAB No. 2302, at 8 (2010), ("[n]either the ALJ nor the Board is authorized to provide equitable relief by reimbursing or enrolling a supplier who does not meet statutory or regulatory requirements.")

III. Conclusion

For the foregoing reasons, I conclude that Petitioner's Medicare enrollment and billing privileges are properly revoked effective February 18, 2013.

/s/
Keith W. Sickendick
Administrative Law Judge