Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

DeVille Pharmacies, Inc., d/b/a DeVille Medical Equipment and Oxygen,

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-12-47

Decision No. CR2527

Date: April 16, 2012

DECISION

I grant the Centers for Medicare and Medicaid Services' (CMS's) motion for summary judgment and sustain the revocation of the Medicare billing privileges of DeVille Pharmacies, Inc., d/b/a DeVille Medical Equipment and Oxygen (Petitioner), based on Petitioner's failure to comply with the supplier standard set out at 42 C.F.R. § 424.57(c)(22) relating to active accreditation.

I. Background and Procedural History

Petitioner previously maintained a Medicare supplier number and billing privileges as a supplier of durable medical equipment. The CMS contractor, Palmetto GBA National Supplier Clearinghouse (Palmetto, NSC), revoked Petitioner's Medicare supplier number by notice letter dated June 2, 2011. The letter provided the following "Reasons for Revocation of your Supplier Number:"

> *A review of your Medicare file reveals that your accreditation expired on August 24, 2010 and has not been renewed. Suppliers choosing to obtain and/or maintain Medicare billing privileges must be accredited by a recognized independent accreditation organization approved by CMS and must submit proof of accreditation documentation to the National Supplier Clearinghouse.*

CMS Ex. 1, at 1 (emphasis in original). The letter stated that the revocation was effective 30 days from the date of postmark and that Petitioner was barred from re-enrolling in the Medicare program for one year from the effective date of the revocation. CMS Ex. 1, at 1. The letter also informed Petitioner that it could appeal the decision by requesting reconsideration within 60 days or submitting a corrective action plan (CAP) within 30 days. CMS Ex. 1, at 1.

Petitioner submitted a CAP to Palmetto, NSC dated June 30, 2011. CMS Ex. 2. Petitioner's CAP stated that Petitioner "has properly submitted all required documentation to Healthcare Quality Association on Accreditation (HQAA) (a recognized independent accreditation organization approved by CMS) and is awaiting a site visit to perform a review." CMS Ex. 2. Palmetto, NSC replied on July 8, 2011 and stated that it was returning the CAP because it had not been signed by an authorized official. CMS Ex. 3. Petitioner then submitted a letter dated July 14, 2011 identified as a "Corrective Action Plan (CAP) and Reconsideration Request." CMS Ex. 4. In this letter, Petitioner again stated that it was awaiting a site visit by the HQAA.

A Medicare hearing officer denied Petitioner's reconsideration appeal in a decision dated August 22, 2011, on the basis that Petitioner "has not shown compliance [with] supplier standard #22." CMS Ex. 5, at 2. The decision relied on the following language from CMS's Medicare Program Integrity Manual (MPIM):

> In reviewing an initial enrollment decision or a revocation, a Medicare contractor, including the NSC, should limit the scope of its review to the contractor's reason for imposing a denial or revocation at the time it issued the action and whether the Medicare contractor made the correct decision (i.e., denial/revocation). If a provider or supplier provides evidence that demonstrates or proves that they met or maintained compliance **after** the date of denial or revocation, the contractor shall exclude this information from the scope of the review.

CMS Ex. 5, at 2 (emphasis added).

Petitioner then filed a hearing request (HR) with the Civil Remedies Division of the Departmental Appeals Board, and the case was assigned to me for a hearing and a decision. In accordance with my Acknowledgment and Pre-hearing Order issued on October 24, 2011, CMS submitted a brief and a motion for summary judgment (CMS Br.) and its exhibits 1 – 5 (CMS Exs. 1-5). In the absence of any objection, I admit CMS Exs. 1-5 to the record. Petitioner subsequently submitted a letter in response to the motion for summary judgment. P. Response.

II. Applicable Law and Regulations

Section 1834(a)(20)(F)(i) of the Social Security Act states that the Secretary "shall require suppliers . . . on or after October 1, 2009 . . . to have submitted to the Secretary evidence of accreditation by an accreditation organization designated . . . as meeting applicable quality standards . . . ."

CMS's regulations implement this requirement among the "supplier standards," at 42 C.F.R. § 424.57(c), that suppliers of "durable medical equipment, prosthetics, orthotics and supplies" (DMEPOS) must meet to maintain Medicare billing privileges. As relevant here, section 424.57(c) provides:

> (c) *Application certification standards*. The supplier must meet and must certify in its application for billing privileges that it meets and will continue to meet the following standards. The supplier:
>
> * * * *
>
> (22) All suppliers of DMEPOS and other items and services must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment for those specific products and services.

The regulations also provide generally that CMS will revoke a supplier's billing privileges if it is found not to meet the supplier standards or other requirements in section 424.57(c). 42 C.F.R. § 424.57(e) (formerly § 424.57(d)).[1] A supplier that has had its billing privileges revoked is "barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar. The re-enrollment bar is a minimum of one year, but not greater than three years depending on the severity of the basis for revocation." 42 C.F.R. § 424.535(c).

[1] Paragraph (e) of section 424.57 was previously designated paragraph (d) and was redesignated by the rulemaking that imposed the surety bond requirements at paragraph (d); however, the redesignations have not yet been incorporated in the Code of Federal Regulations. *See* 42 C.F.R. Ch. IV (Oct. 1, 2010) § 424.57, Editorial Note.

III. Issue, Findings of Fact, Conclusions of Law

A. Issue

The issue in this case is whether CMS is entitled to summary judgment on the basis that undisputed facts demonstrate that the revocation of Petitioner's Medicare billing privileges was legally authorized.

B. Applicable standard

The Board stated the standard for summary judgment:

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

Senior Rehab. & Skilled Nursing Ctr., DAB No. 2300, at 3 (2010) (citations omitted). The role of an Administrative Law Judge (ALJ) in deciding a summary judgment motion differs from the ALJ's role in resolving a case after a hearing. The ALJ should not assess credibility or evaluate the weight of conflicting evidence. *Holy Cross Vill. at Notre Dame, Inc.*, DAB No. 2291, at 5 (2009).

C. Findings of Fact and Conclusions of Law

1. CMS was authorized to revoke Petitioner's billing privileges based on undisputed evidence that Petitioner was not accredited as required by 42 C.F.R. § 424.57(c)(22) .

The basis relied on in the revocation notice and in the reconsideration decision was that Petitioner failed to continue to meet the accreditation requirement. Petitioner agrees that, at the time of the revocation of its billing privileges, it was not in compliance with supplier standard 22. P. Response.

Petitioner concedes that it was accredited *after* its revocation. It is also undisputed that Petitioner's accreditation expired on August 24, 2010, and Petitioner remained

unaccredited for almost one year. HR; CMS Ex. 1. In its hearing request and response, Petitioner asserted that it became accredited effective July 19, 2011, and it is currently in complete compliance. HR; P. Response.

For summary judgment purposes, I will infer that Petitioner did become fully accredited after its revocation. A showing of compliance subsequent to the revocation however, is not a legitimate basis to reverse a revocation. The regulations require that a supplier "must meet and must certify in its application for billing privileges that it meets ***and will continue to meet***" the supplier standards. 42 C.F.R. § 424.57(c) (emphasis added). The preamble to the regulations implementing the appeals process for suppliers whose billing privileges are revoked explained:

> When a Medicare contractor makes an adverse enrollment determination (for example, enrollment denial or revocation of billing privileges) . . . appeal rights are limited to provider or supplier eligibility at the time the Medicare contractor made the adverse determination. . . . Accordingly, a provider or supplier is required to furnish the evidence that demonstrates that the Medicare contractor made an error at the time an adverse determination was made, not that the provider or supplier is now in compliance.

73 Fed. Reg. 36,448, 36,452 (June 27, 2008).

Given Petitioner's concession that it was not accredited at the time of revocation, and given that Petitioner alleges no error by Palmetto, NSC, CMS is entitled to summary judgment sustaining the revocation on the basis of failure to comply with 42 C.F.R. § 424.57(c)(22).

2. I have no authority to provide Petitioner with the equitable relief it requests

To support continued Medicare billing privileges in spite of its gap in accreditation, Petitioner argues that its Medicare Compliance Specialist and Office Manager had fallen ill "resulting in errors of judgment in the past 12 months," that Petitioner has served the community for many years prior to the revocation, and that Petitioner is located in a rural community and the loss of Medicare coverage would cause a hardship for local residents. HR. Petitioner further contends that the violation of 42 C.F.R. § 424.57(c)(22) was not intentional and Petitioner has been in the community for over 30 years and has "maintained a business that is fair, reputable and necessary . . . ". Petitioner argues that "a short lag in paperwork" should not necessitate the revocation of its Medicare billing privileges.

Petitioner's arguments are equitable in nature and do not show that Petitioner was in fact accredited at the time of the revocation or that the contractor or CMS incorrectly applied

the regulatory criteria. Even if true, Petitioner's equitable claims provide no basis for me to reverse its revocation. Petitioner points to no source of authority for me to grant it an exemption from regulatory compliance. Moreover, I have no authority to declare statutes or regulations invalid or ultra vires. *1866ICPayday.com, L.L.C.*, DAB No. 2289, at 14 (2009) ("An ALJ is bound by applicable laws and regulations and may not invalidate either a law or regulation on any ground."). I must sustain CMS's determination to revoke if a legitimate basis exists and where the facts establish noncompliance with one or more of the relevant regulations. *Id.* at 13; *See 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.").

IV. Conclusion

After reviewing the evidence in the light most favorable to Petitioner, I conclude there is no genuine issue of material fact at issue and the undisputed facts entitle CMS to summary judgment as a matter of law. Petitioner was not in compliance with Medicare supplier standards because Petitioner was not properly accredited at the time of its revocation. Further, I am unauthorized to provide Petitioner with the equitable relief it requests. I therefore grant summary judgment to CMS because CMS acted within its regulatory authority to revoke Petitioner's Medicare billing privileges and implement a one year re-enrollment bar.

/s/
Joseph Grow
Administrative Law Judge