Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Gibraltar Healthcare Supplies, LLC,
(PTAN: 4595770001),

Petitioner,

v.

Centers for Medicare & Medicaid Services

Docket No. C-14-1079

Decision No. CR3422

Date: October 17, 2014

DECISION

Petitioner, Gibraltar Healthcare Supplies, LLC, is a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), currently located in Calabasas, California that, until recently, participated in the Medicare program. The Centers for Medicare & Medicaid Services (CMS) found that Petitioner is no longer operational and revoked its Medicare supplier number. Petitioner challenged the revocation, and, in a reconsidered determination, dated March 25, 2014, a hearing officer for the Medicare contractor upheld the revocation. Petitioner appeals, and CMS has moved for summary judgment.

I deny CMS's motion for summary judgment.

Because CMS has not proposed any witnesses and has not asked to cross-examine Petitioner's sole witness, an in-person hearing would serve no purpose. I therefore close the record and decide the case. *See* Acknowledgment and Pre-hearing Order at 6 (¶¶ 10, 11).

For the reasons set forth below, I reverse the reconsidered determination. I find that Petitioner is operational and that CMS improperly revoked its supplier number.

Background

Until December 19, 2013, Petitioner participated in the Medicare program as a supplier of DMEPOS. *See* 42 C.F.R. § 424.57. In a letter dated January 22, 2014, the Medicare contractor, National Supplier Clearinghouse (a division of Palmetto GBA), notified Petitioner that, based on an inspector's report, it determined that the facility was "not operational to furnish Medicare covered items and services." The supplier therefore violated 42 C.F.R. § 424.535(a)(5)(ii) and all supplier standards, 42 C.F.R. § 424.57(c). Petitioner's Medicare supplier number was revoked retroactively, pursuant to 42 C.F.R. §§ 405.800; 424.57(e); 424.535(a)(1); 424.535(a)(5)(ii); and 424.535(g). CMS Ex. 2.

Petitioner sought reconsideration. In a reconsidered determination dated March 25, 2014, a Medicare hearing officer affirmed the revocation, finding that the supplier had not shown compliance with two supplier standards, 42 C.F.R. § 424.57(c)(1) (requiring state licensure) and 42 C.F.R. § 424.57(c)(7) (requiring a physical facility on an appropriate site). CMS Ex. 4 at 5. Petitioner now appeals that determination pursuant to 42 C.F.R. § 424.545.

CMS moved for summary judgment and filed a prehearing brief (CMS Br.), along with five exhibits (CMS Exs. 1-5). In the absence of any objections, I admit into evidence CMS Exs. 1-5.

Petitioner's Exhibits. Petitioner filed a response to CMS's motion and brief, along with nine exhibits (P. Exs. 1-9). CMS objects to my admitting P. Ex. 2, which is a copy of CMS Form 855S, dated October 9, 2013, because it was not submitted to the hearing officer at the reconsideration stage. I may consider new documentary evidence only if I find good cause for Petitioner's having submitted it for the first time at this level. 42 C.F.R. § 498.56(e). Petitioner concedes that it did not submit the document at reconsideration but argues that good cause justifies my admitting it here. Petitioner points out that it was not represented by counsel at the reconsideration stage and criticizes the language of the notice letter as ambiguous.

I have previously expressed my concern that CMS's notice letter may not adequately advise a supplier that it *must* submit its documents at the reconsideration level or lose the right to do so. *Cornerstone Medical, Inc.*, DAB CR3022 (2013), *remanded on other grounds*, DAB No. 2585 (2014). While the notice letter explicitly warns the supplier to request reconsideration or waive all rights to further review, it simply "invites" the supplier to submit additional information – "[y]ou may submit additional information with the reconsideration that you believe may have a bearing on the decision." CMS Ex. 2 at 3. The letter does not suggest that this will be the supplier's only opportunity to

submit such evidence. CMS Ex. 2 at 3. Other judges have found good cause, based solely on the quality of this notice. *See, e.g.*, *Optimart, Inc.*, DAB No. CR3238 at 2 (2014).

Without commenting on the quality of its notice, CMS claims that, when Petitioner requested reconsideration, "it was aware that the decision was based on CMS's failure to receive notice of Gibraltar's change of practice location." CMS's Objection at 5. According to CMS, Petitioner "has always been aware that the central issue in this case was its failure to give CMS notice of its change in practice location." *Id* at 6. But the contractor's January 22, 2014 notice letter does not support this assertion.[1] That notice says that Petitioner's supplier number is revoked because: 1) Petitioner's state-issued home medical device retail license is no longer valid; and 2) an inspector was unable to inspect the facility because the site location was vacant. The notice does not provide an address nor mention the site location on file. CMS Ex. 2 at 2. One *might* be able to deduce from this that the inspector went to the wrong address because the Medicare contractor did not have the correct address on file, and that the contractor did not have the correct address on file because it did not receive notice of the change in practice location. But that is only one of many possible explanations. According to Petitioner's president, Eric Ezeuka, he considered the visit "simply a bureaucratic mixup" (not unlike the licensing problem), which would resolve when the contractor realized that, in fact, it had the facility's new address on file. He did not submit the 855S at the reconsideration stage because he thought that the contractor already had it; after all, he had mailed it to them. P. Ex. 1 at 2-3 (Ezeuka Decl. ¶¶ 6, 10). This was not an unreasonable assumption on his part.

I therefore find good cause for admitting P. Ex. 2.[2]

CMS also objects to my admitting P. Exs. 3 through 8 as not material to any issue in this case. P. Exs. 4 through 8 include proof that Petitioner paid its business insurance, copies of telephone bills, and a bond rider for the business (which, incidentally, reflect the address change). These are all indicia of the supplier's ongoing operation, and, as such, they are directly relevant and material to the issue addressed in the reconsideration determination: whether the supplier is operational.

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[1] In fact, as I discuss below, if I follow recent Departmental Appeals Board decisions, I may not have the authority to review the question of whether Petitioner timely submitted the 855S.

[2] In any event, I need not rely on the 855S to resolve this case. If unrebutted, President Ezeuka's testimony alone is sufficient to establish that he mailed in the appropriate form.

P. Ex. 3 is a copy of an earlier Form 855S, dated July 28, 2008. Petitioner submits this document to buttress his claim that he properly submitted the Form 855S in October 2013. He testified that he followed the same procedures when he previously moved, without any problem. He knew what was required and would not have deviated from his prior actions. P. Br. at 6. Based on this, I find the document relevant and material.

I therefore admit P. Exs. 1- 9.

Scope of Review. CMS maintains that the "sole factual dispute in this case is the question of whether Gibraltar complied with 42 C.F.R. § 424.57(c)(2), which requires DMEPOS suppliers to notify CMS within 30 days of a change in practice location." CMS Br. at 3. Petitioner points out, repeatedly, that, until it submitted its brief in these proceedings, CMS "never mentioned" that it was missing the Form 855S, which advised the contractor of the change. P. Br. at 3.

Unquestionably, there exists a disconnect between the bases for revocation cited in the reconsidered determination and the arguments CMS presents here. The reconsidered determination does not mention section 424.57(c)(2), much less base its decision on that provision. *See* CMS Ex. 5 at 5. Until May of this year, this would not have presented a significant problem. Notwithstanding the quality or content of the reconsidered determination, administrative law judges (ALJs) could consider bases other than those relied on by the hearing officer, so long as the parties were given adequate notice.[3] The Departmental Appeals Board summarized the scope of the ALJ's review authority in *Fady Fayad, M.D.*, DAB No. 2266 (2009), *aff'd*, 803 F. Supp. 699 (E.D. Mich. 2011). There, a physician (supplier), whose Medicare billing privileges had been revoked, argued that, during the administrative review process, CMS changed the bases for its actions. He claimed that the revocation notice did not cite the applicable statutes and regulations and contained no "detailed factual rationale" for the determination, deficiencies that, he maintained, were not corrected by the hearing officer at reconsideration. The Board rejected this position:

> To the extent that Petitioner is claiming that the revocation should be overturned because he lacked sufficient notice of the basis of CMS's revocation determination *at the reconsideration stage* . . . we stress that Petitioner subsequently received a de novo hearing before the ALJ concerning the validity of the revocation determination. In general, *the ALJ proceeding is not an appellate or quasi-appellate review of the adequacy of the federal agency's decision-making or review process. Rather, the ALJ hearing*

[3] I recognize that ALJs may be limited with respect to admitting new evidence. *See* 42 C.F.R. § 498.56(e) and discussion above.

> *under 42 C.F.R. Part 498 is a de novo proceeding*, in which the ALJ determines the legality of the challenged determination based on the evidence presented in that proceeding.

DAB No. 2266 at 11-12 (first emphasis in the original; second emphasis added). The *Fayad* decision reflected the Board's long-standing position on the scope of the ALJ's review under Part 498. It was consistent with general principals of administrative law, allowing the ALJ to correct administratively any errors made below. It achieved the laudable goals of administrative efficiency and ensuring that cases are decided on their merits, without being side-tracked because the contractor hearing officer omitted a reference or committed some procedural error. Indeed, hearings held pursuant to section 205(b) of the Social Security Act (Act), as provider and supplier enrollment cases are (Act § 1866(j)(8)), have long been considered de novo. *Heckler v. Campbell*, 461 U.S. 458, 463 n.6 (1983); *see also Matthews v. Eldridge*, 424 U.S. 319, 339 n.21 (1976).

The regulations have not changed since the Board issued *Fayad*. However, without mentioning that decision or any of the myriad of decisions that consistently describe Part 498 hearings as de novo, the Board recently issued three decisions that dramatically change the scope of ALJ review to something even more limited than standard appellate review. The Board now says that 42 C.F.R. § 498.5(l) "limits ALJs to considering the basis or bases for denial or revocation of enrollment and billing privileges set forth in the CMS contractor's reconsidered determination." *Precision Prosthetic, Inc.*, DAB No. 2597 at 11 (2014).[4]

[4] Most recently the Board said that it has "repeatedly" articulated this view and chided an ALJ for his apparent disregard of its position. *Precision Prosthetic, Inc.*, DAB No. 2597 at 11 (2014). The Board cites *Ortho Rehab Designs Prosthetics and Orthotics, Inc.*, DAB No. 2591 (2014), and *Better Health Ambulance*, DAB No. 2475 (2012) as the "repeated" instances in which it held that section 498.5(l) restricts an ALJ's previously de novo review authority. But *Better Health Ambulance* did not say that. It said that ALJ jurisdiction is triggered by the reconsidered determination; it said nothing about the scope of the ALJ's review. *See Better Health Ambulance*, DAB No. 2475 at 4. Moreover, *Ortho Rehab* and the decisions it cites all were issued after May 2014. *See Ortho Rehab*, DAB No. 2591 at 9. The harshness of the Board's admonishment in *Precision Prosthetic* is puzzling since the ALJ decision in that case predated *Joy Medical* and its progeny, having been issued on April 2, 2014, more than a month before the first of those Board decisions, when the prevailing – indeed, the *only* – view was that ALJs provided *de novo* review.

In *Benson Ejindu d/b/a Joy Medical Supply*, the Board mentioned, for the first time, that ALJs are limited to the four corners of the reconsideration determination. The Board there cited with approval the ALJ's limiting the scope of his review:

> The ALJ properly refrained from going beyond that issue to address other possible grounds for revocation because the reconsidered determination which Petitioner appealed (*in contrast to the initial determination*) did not rely on any additional legal ground for revocation . . . . 42 C.F.R. § 498.5(l)(2) (with respect to denial or revocation of billing privileges, the provider or supplier's appeal rights lie from the reconsidered or revised reconsidered determination, not the initial determinations.).

DAB No. 2572 at 5 (emphasis added).

The impact of the *Joy Medical Supply* decision might not have been great, since the Board was not resolving an issue raised in the case before it. The language quoted is dicta. However, immediately thereafter the Board issued *Neb Group of Arizona*. Citing *Joy Medical Supply*, the Board faulted the ALJ for considering whether the facility was operational and therefore subject to revocation under 42 C.F.R .§ 424.535(a)(5)(ii). The Board acknowledged that CMS's initial determination made that finding, but ruled that, because the contractor's reconsideration determination did not, the ALJ improperly considered the issue. In the Board's view, the "only issue properly before the ALJ" was that addressed in the reconsidered determination. DAB No. 2573 at 7 (2014). Several months later, in *Ortho Rehab*, the Board relied on *Joy Medical Supply* and *Neb Group* to reach the same conclusion, faulting the ALJ for considering an issue raised in CMS's initial determination but not mentioned in the reconsideration.

The Board's newfound position creates some serious problems.

I am not aware of any reviewing authority that is so limited – and with good reason. Issues raised in the initial determination, as well as issues raised by the parties during the reconsideration process, are necessarily before the hearing officer. But the issues raised do not always find their way into the final reconsidered determination. Indeed, a hearing officer could preclude further review of a thorny issue by simply omitting it from his/her written determination. Under the *Neb Group* reasoning, the issue is lost forever. A petitioner would have no definitive way of preserving an issue for appeal, which seems a fairly obvious denial of due process.

Moreover, like everyone else, hearing officers make mistakes. They cite the wrong regulation, they leave things out. Sometimes they cite regulations unrelated to the case before them. Pre-*Neb Group*, ALJs were empowered to correct such errors. Post-*Neb*

Group, they are hamstrung by them. In *Rey R. Palop, M.D.*, DAB CR3273, for example, the proper outcome was certain: the supplier's Medicare number had to be revoked retroactively because, in his application for it, he misled the Medicare contractor about an earlier felony conviction. The parties to the ALJ proceedings were fully apprised of the issues. Basing my decision there on the weaknesses of the reconsidered determination, at best, would have caused the parties needless expenses of time and money, and, at worst, would have perverted the administrative review process:

> I recognize that the quality of the reconsidered determination here leaves something to be desired. Nevertheless, the purpose of administrative review is to correct agency errors and reach the correct decision, based on the evidence presented. Here, Petitioner has been fully apprised of the bases for CMS's actions and has not complained about the adequacy of the notice provided. The matter has been fully briefed, and the law and undisputed facts lead to one conclusion. Petitioner is absolutely not entitled to prevail, no matter what the shortcomings of the reconsidered determination. My remanding the case – to allow CMS to present a more thorough determination – would unnecessarily prolong these proceedings, requiring all parties to expend additional time and resources to achieve the same result.

DAB CR3273 at 5 n.4 (2014).

In *Precision Prosthetic*, the Board cast doubt on the ALJ's authority to remand these cases. There, because the reconsidered determination discussed revocation under 42 C.F.R. § 424.535(a)(3) only, the Board held that the ALJ could not properly remand the matter to CMS to consider denial under 42 C.F.R. § 424.530(a)(3) (a provision that, substantively, is nearly identical to section 424.535(a)(3)).[5] If ALJs can neither correct reconsideration errors nor remand cases so that CMS can correct them, they could be left with no recourse but to rule against CMS in those cases where CMS plainly should prevail on the merits, but the hearing officer fails to articulate a proper basis for his/her

[5] The Board was particularly harsh in this regard, suggesting that the ALJ effectively coerced CMS. *Precision Prosthetic*, DAB No. 2597, at 13 (stating, without any citation to the record, that the ALJ's remand order "clearly influenced CMS" to make a different determination). I find baffling the suggestion that either CMS or a petitioner would act improperly rather than appeal a purportedly objectionable ruling. In any event, remanding the case to CMS for more careful analysis seems preferable to issuing a plainly incorrect decision – *e.g.*, on the one hand, allowing an obvious bad actor to remain in the program, or, on the other hand, wrongfully barring a perfectly blameless supplier from program participation for up to three years.

determination. Such results defeat the purpose of the statute and regulations, which is to protect the integrity of the Medicare program and the welfare of its beneficiaries.

Except for referring to its own decisions, the Board's sole basis for limiting the scope of the ALJ's review is its new interpretation of 42 C.F.R. § 498.5(l)(2). That regulation provides that any supplier "dissatisfied with a reconsidered determination . . . or a revised reconsidered determination is entitled to a hearing before an ALJ." I see nothing in this regulation that precludes de novo review of the reconsidered determination. Moreover, the language of section 498(l)(2) is *identical* in all key respects to the language of 42 C.F.R. § 498(l)(3): any supplier "dissatisfied with a hearing decision may request Board review." To my knowledge, the Board has *never* interpreted this language to limit its own review of ALJ decisions. *See, e.g., Complete Home Care, Inc*., DAB No. 2525 (2013) ("We conclude that CMS had authority to revoke Complete Home Care's enrollment based on the same facts . . . but on a different legal basis."); *Main Street Pharmacy*, DAB No. 2349 (2010) ("[W]e uphold the revocation of MSP's billing privileges but modify the rationale."); *Robert F. Tzeng, M.D.*, DAB No. 2169 (2008) ("Although our analysis . . . differs . . . we . . . affirm [the ALJ's] ultimate conclusion.").

Finally, ALJ reliance on prior Board decisions makes obvious practical sense, given the Board's review authority. Of course, this is much more difficult when, as here, the Board decisions are in conflict. *Compare Fayad*, DAB No. 2266 (reaffirming the ALJ's review of a revocation determination as de novo) *with Neb Group*, DAB No. 2573 (limiting the ALJ's review of a revocation determination to the four corners of the reconsidered determination). In any event, with only one exception, I am aware of no authority, inherent or express, establishing that a Board decision binds the ALJs beyond the immediate case in which it is rendered. The Secretary has been explicit in defining what she considers binding authorities. She has expressly provided that Board decisions in cases reviewing local coverage determinations have a degree of precedential effect. 42 C.F.R. § 426.431(a)(4) ("Treat as precedent any previous Board decision under § 426.482 that involves the same LCD provision(s), same specific issue and facts in question, and the same clinical conditions."). Outside this narrow standard, the ALJ is directed to follow "all applicable laws, regulations, rulings, and [national coverage determinations]." 42 C.F.R. § 426.431(c).

Likewise, the Secretary made CMS rulings, which are published under the authority of the CMS Administrator, binding "on all HHS components that adjudicate matters under the jurisdiction of CMS . . . ." 42 C.F.R. § 401.108(c); *see also* 42 C.F.R. § 405.1063(b); 70 Fed. Reg. 11,420, 11457 (Mar. 8, 2005) (expanding the scope of CMS rulings to all matters in CMS jurisdiction was done to "help ensure consistency among appeals decisions"); 42 C.F.R. § 401.108(a) (providing that "a precedent final opinion or order or

a statement of policy or interpretation . . . may be published in the Federal Register as a CMS Ruling and will be made available in the publication entitled *CMS Rulings*").[6]

I note also that, if the Board decisions were binding precedent, such departure from its prior norms without any explanation would be contrary to generally accepted administrative procedures. As the Supreme Court has noted, we presume that an agency will follow its existing policies, procedures, and decisions in order to uphold Congressional mandates. From this presumption "flows the agency's duty to explain its departure from prior norms." *Atchison, Topeka & Santa Fe Ry. Co. v. Wichita Board of Trade*, 412 U.S. 800, 808 (1973). The Board made no attempt to do so in *Joy Medical*, *Neb Group*, or *Ortho Rehab*. Moreover, the United States Circuit Court of Appeals for the District of Columbia Circuit has determined that "agencies act arbitrarily and capriciously when they 'ignore [their] own relevant precedent,'" and that "agencies may depart from precedent, but 'an agency changing its course must supply a reasoned analysis indicating that prior policies and standards are being deliberately changed, not casually ignored.'" *Nat'l Fed'n of Fed. Emps. v. FLRA*, 412 F.3d 119, at 121 (2005) (quoting *B B & L, Inc. v. NLRB*, 52 F.3d 366, 369 (D.C.Cir.1995) and *Greater Boston Television Corp. v. FCC*, 444 F.2d 841, 852 (D.C.Cir.1970)).

For all of these reasons, I follow the Board's well-reasoned decision in *Fayad*, and its predecessors and consider whether Petitioner properly advised the Medicare contractor of its new location.

Discussion

CMS improperly revoked Petitioner's Medicare supplier number, because the evidence establishes that the supplier was operational at a new location and that it timely and properly advised the Medicare contractor that it had relocated.[7]

To receive Medicare payments for items furnished to a Medicare-eligible beneficiary, a supplier of medical equipment and supplies must have a supplier number issued by the Secretary of Health and Human Services. Act § 1834(j)(1)(A). To obtain and retain its supplier number, a Medicare supplier must be operational and must meet the standards set forth in 42 C.F.R. § 424.57(c). CMS may revoke the supplier's billing privileges if it fails to do so. 42 C.F.R. § 424.57(c)(1) and (d); 42 C.F.R. § 424.535(a)(1). Among other requirements, the supplier must permit CMS or its agents to conduct on-site inspections

[6] In contrast, Board and ALJ decisions are merely posted on the DAB website in order to comply with the requirements of the Freedom of Information Act, 5 U.S.C. § 552(a)(2)(A).

[7] I make this one finding of fact/conclusion of law.

to ascertain its compliance with governing regulations. 42 C.F.R. §§ 424.57(c)(7) and (8).

Within 30 days, the supplier must report to CMS any changes in information it has previously supplied, including changes in location. 42 C.F.R. § 424.57(c)(2).

Here, the parties agree that, on December 19, 2013, an inspector for the Medicare contractor went to 1791 Erringer Road, Suite 102, Simi Valley, California, to inspect the facility. The location was vacant, with a "For Lease" sign posted. The building's owner advised the inspector that Petitioner had moved out. CMS Ex. 1; CMS Br. at 3; P. Br. at 3.

The evidence is virtually undisputed that Petitioner was, in fact, operational, but not at the Simi Valley address. P. Exs. 4, 5, 6, 7, 8. The inspector went to the supplier's old location. Two months earlier, the business moved to 27001 Agoura Road, Suite 170, Calabasas, California. P. Ex. 1 at 2 (Ezeuka Decl. ¶ 5). Petitioner maintains that, on the day of the move, October 9, 2013, Company President Ezeuka mailed, by United States mail, with proper postage prepaid, the appropriate form, CMS Form 855S, to the Medicare contractor. *Id* (Ezeuka Decl. ¶ 6). At the same time, he notified other interested parties – the California Department of Public Health and the Joint Commission – of the move. Those entities received the notice; in fact, the Department of Public Health inspected the new location on November 26, 2013, and issued a new license reflecting the new address. P. Ex. 1 at 2 (Ezeuka Decl. ¶ 9); P. Ex. 8.

Petitioner has thus presented evidence that, if unrebutted, establishes that it is operational at a new practice location, and the Medicare contractor knew or should have known of the new location. In error, the contractor visited the wrong site.

CMS argues that the inspector went to the "location listed on CMS records as the practice location for Gibraltar." CMS Br. at 2. The problem with CMS's argument is that – aside from the fact that the inspector went there – it offers virtually no actual evidence to establish that 27001 Agoura Road was, in fact, the practice location listed in its records. In the absence of countervailing evidence, the investigator's appearance at an old practice location may be sufficient to justify the inference that he visited the location on file, and, from that, that the supplier did not properly notify the contractor of its relocation. *El Jardin Pharmacy, Inc.*, DAB No. 2438 at 6 (2012). But here, Petitioner presented credible evidence that he properly and timely notified the Medicare contractor of the location change. CMS did not respond to Petitioner's evidence. It did not submit evidence or testimony from the Medicare contractor denying timely receipt of Petitioner's Form 855S or explaining what efforts it made to determine whether it received the document. *See Arkady B. Stern, M.D.*, DAB No. 2329 (2010).

I therefore conclude that Petitioner has the appropriate state license,[8] is operational, and properly advised the Medicare contractor of its change in location. CMS has not established a basis to revoke Petitioner's enrollment pursuant to 42 C.F.R. §§ 424.57 or 424.535.

Conclusion

Petitioner has established that it was operational and furnishing Medicare covered items and services, and CMS improperly revoked its supplier number.

/s/
Carolyn Cozad Hughes
Administrative Law Judge

[8] The hearing officer found that Petitioner did not meet Supplier Standard 1, which requires the appropriate state licenses. CMS has not argued that Petitioner lacked a license, and Petitioner has unquestionably established that it had one. P. Ex. 8.