Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Rosaleen Runnalls, LCSW
(NPI: 1861738908 / PTAN: Z171686),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-16-800

Decision No. CR4790

Date: February 9, 2017

DECISION

The Medicare enrollment and billing privileges of Petitioner, Rosaleen Runnalls, LCSW, are revoked pursuant to 42 C.F.R. §§ 424.535(a)(5)(ii) and 424.535(a)(9)[1] based on a violation of 42 C.F.R. § 424.516(d)(1)(iii). The effective date of revocation is December 28, 2015, the date it was determined that Petitioner was not operating a practice location at the address listed in her Medicare enrollment application. 42 C.F.R. § 424.535(g).

I. Procedural History and Jurisdiction

On April 22, 2016, Noridian Healthcare Solutions (Noridian), a Medicare administrative contractor (MAC), notified Petitioner of its initial determination to revoke Petitioner's Medicare enrollment and billing privileges effective December 28, 2015, and to impose a two-year re-enrollment bar. Noridian cited 42 C.F.R. §§ 424.535(a)(5) and 424.535(a)(9) as authority for the revocation and alleged it was determined, based on an on-site review,

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

that Petitioner was not operational and that Petitioner failed to notify the Centers for Medicare & Medicaid Services (CMS) of a change of practice location as required by 42 C.F.R. § 424.516. CMS Exhibit (Ex.) 4.

Petitioner requested reconsideration by letter dated May 24, 2016. CMS Ex. 1 at 5, 19. Petitioner submitted with her request for reconsideration a CMS-855I application that she signed and dated May 23, 2016, reporting a change in her practice location to 119 East Goodwin Street, Prescott, Arizona (Goodwin Street location), effective May 23, 2016, with a statement that she first saw patients at the location on March 1, 2015. Petitioner does not state in that CMS-855I what practice location she was deleting or moving from. CMS Ex. 1 at 6, 10-11, 13. Petitioner argued in her request for reconsideration that she submitted a change of address several times by facsimile and by mail. Petitioner did not state that she submitted a CMS-855I by mail or attempted to enter the change of address through the Provider Enrollment, Chain, and Ownership System (PECOS) system prior to the submission of the CMS-855I with her reconsideration request.

A Noridian hearing officer issued a reconsidered determination on July 15, 2016. The hearing officer upheld the revocation of Petitioner's Medicare enrollment and billing privileges. The hearing officer found that Noridian received a CMS-855I application on September 15, 2014, to enroll Rosaleen Runnalls, LCSW, into the Medicare program as a sole proprietor. The practice address on the application was 223 E. Union Street, Suite 3, Prescott, Arizona (Union Street location). A site visit on December 28, 2015 at the Union Street location confirmed that the provider was not operational at that location. The hearing officer found that there was no record Noridian received a CMS-855I from Petitioner reporting a change in practice location prior to the site visit and Petitioner did not submit evidence showing that a CMS-855I was submitted and received by Noridian. CMS Exs. 1, 3.

Petitioner requested a hearing before an administrative law judge (ALJ) by letter dated August 4, 2016 (RFH), postmarked August 5, 2016. The case was assigned to me and an Acknowledgement and Prehearing Order (Prehearing Order) was issued on August 11, 2016. Petitioner's request for hearing was timely and I have jurisdiction.

CMS filed a motion for summary judgment and prehearing brief on September 9, 2016 (CMS Br.) with CMS exhibits 1 through 4. On October 7, 2016, Petitioner filed a prehearing brief and response in opposition to the CMS motion (P. Br.), together with Petitioner's exhibits (P. Exs.) 1 through 5. CMS filed a reply brief on October 24, 2016 (CMS Reply) and Petitioner filed a sur-reply (P. Reply) on November 1, 2016. Neither party objected to my consideration of the other party's exhibits and CMS Exs. 1 through 4 and P. Exs. 1 through 5 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 Noridian. 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. § 1395u(h)(1)). Petitioner, a licensed clinical social worker, is a supplier. Act § 1842(b)(18).

The Act requires the Secretary of Health and Human Services (Secretary) to issue regulations that establish a process for enrolling providers and suppliers in Medicare, including the requirement to provide 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. § 424.505, suppliers such as Petitioner 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.

The Secretary has delegated the authority to revoke enrollment and billing privileges to CMS. 42 C.F.R. § 424.535. CMS or its Medicare contractor may revoke an enrolled supplier's Medicare enrollment and billing privileges and supplier agreement for any of the reasons listed in 42 C.F.R. § 424.535.

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

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[2] A "supplier" furnishes services under Medicare and includes 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) (42 U.S.C. § 1395f(g)) and 1835(e) (42 U.S.C. § 1395n(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.

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) - (ii). Pursuant to 42 C.F.R. § 424.535(a)(9), CMS may revoke a supplier's enrollment and billing privileges if the supplier did not comply with the reporting requirements specified in § 424.516(d)(1)(iii), which requires a nonphysician practitioner such as Petitioner to report to their Medicare contractor within 30 days any change in practice location.

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). However, 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. Issue

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 followed by the pertinent findings of fact and analysis.

1. Summary judgment is appropriate.

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 at 42 C.F.R. pt. 498 that establish the procedure to be followed in adjudicating Petitioner's case 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 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, para. II.D and G. The parties were given notice by my 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 material fact for adjudication and/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 and/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 differ from that used in 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 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 & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd*, *Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 Fed. App'x 181 (6th Cir. 2005).

There is no genuine dispute as to any material fact in this case related to whether Petitioner notified CMS or Noridian using a CMS-855I within 30 days of her change in practice location as required by 42 C.F.R. § 424.516(d)(1)(iii). Summary judgment is appropriate as to revocation pursuant to 42 C.F.R. § 424.525(a)(5)(ii) and (9), for failure to comply with 42 C.F.R. § 424.516(d)(1)(iii), and the effective date of revocation. The issues in this case that require resolution related to revocation on these bases, are issues of law related to the interpretation and application of the regulations that govern enrollment and billing privileges in the Medicare program and application of the law to the undisputed facts of this case.

There are genuine disputes of material fact related to whether or not Petitioner was operational at another location at the time of the on-site review based on Petitioner's affidavit (P. Ex. 1). On summary judgment all inferences must be drawn in favor of the non-movant, in this case, Petitioner. CMS is not entitled to judgment as a matter for law for revocation pursuant to 42 C.F.R. § 424.535(a)(5)(i). Therefore, summary judgment is not appropriate for revocation pursuant to 42 C.F.R. § 424.535(a)(5)(i). If CMS wishes to attempt to prove Petitioner was not operational, as that term is defined in 42 C.F.R. § 424.502, as of the date of the on-site review, CMS may file a motion to reopen.

2. It is a requirement to maintain enrollment in Medicare that a nonphysician practitioner report a change in practice location to their Medicare contractor within 30 days of a change in practice location. 42 C.F.R. § 424.516(d)(1)(iii).

3. CMS or its contractor is authorized to revoke the Medicare enrollment and billing privileges of a provider or supplier that is found upon on-site review to fail to satisfy any Medicare enrollment requirement. 42 C.F.R. § 424.535(a)(5)(ii).

4. There is a basis to revoke Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(5)(ii) because Petitioner failed to report to its Medicare contractor using a CMS-855I its change of practice location as required by 42 C.F.R. § 424.516(d)(1)(iii).

5. There is also a basis to revoke Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(9) because Petitioner failed to report her change of practice location to the Medicare contractor using a CMS-855I within 30 days as required by 42 C.F.R. § 424.516(d)(1)(iii).

6. Revocation of Petitioner's Medicare enrollment and billing privileges is effective December 28, 2015, the date it was determined by CMS that Petitioner was not operational at the practice location listed in Petitioner's Medicare enrollment application (CMS-855I). 42 C.F.R. § 424.535(g).

a. Facts

The material facts are not disputed.

Noridian approved Petitioner's application to enroll in Medicare on November 26, 2014, with an effective date of August 16, 2014. CMS Ex. 2 at 1, 3. On March 1, 2015, Petitioner moved her practice location from the Union Street location to the Goodwin Street location. P. Ex. 1, ¶ 3. I accept as true for purposes of summary judgment that on or about March 1, 2015, Petitioner faxed and mailed a form to EDI (Electronic Data

Interchange)[3] Support Services. I further accept as true that after receiving a mailing from either CMS or Noridian addressed to Petitioner's old address, Petitioner faxed the change of address information to EDI again on about April 16, 2015. Attachment to RFH; P. Ex. 3. I accept as true for summary judgment that in October 2015, Petitioner contacted Noridian because she had not received payment on claims. Petitioner subsequently spoke to Todd Peterson, of either Noridian or CMS. I accept Petitioner's assertion that Todd Peterson did not tell her to file a CMS-855I. On October 20, 2015 and again on February 22, 2016, Petitioner or her staff faxed a note to Todd Peterson with information that Petitioner's practice location was changed to the Goodwin Street location. P Exs. 4, 5.

Petitioner does not allege and has not submitted any evidence that she reported her change of practice location within 30 days of the move on March 1, 2015, by sending a CMS-855I to either Noridian or CMS or by reporting the change using PECOS.

On December 28, 2015, a CMS inspector conducted an on-site inspection at the Union Street location. The Union Street location was the location Petitioner listed in the CMS-855I when she enrolled and the location on file as Petitioner's practice location when the on-site inspection occurred. CMS Ex. 2. The inspector determined that Petitioner did not operate a practice at the Union Street location at the time of the inspection, a fact not disputed by Petitioner. CMS Exs. 2, 3.

b. Analysis

There is no dispute that Petitioner was enrolled as a supplier in Medicare from November 26, 2014 until her enrollment was revoked by Noridian. In order to maintain an active enrollment status in Medicare, Petitioner had to comply with 42 C.F.R. § 424.516. Pursuant to 42 C.F.R. § 424.516(d)(1)(iii), Petitioner was required to report a change of practice location to her Medicare contractor within 30 days. A report of a change in

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[3] EDI is related to the submission of claims transactions electronically. EDI is unrelated to a provider and supplier enrolling and maintaining enrollment in Medicare. A provider or supplier must be enrolled in Medicare before it may use EDI transactions. Further information on EDI is available at the following sites:

www.cms.gov/Medicare/Billing/ElectronicBillns/indingEDITraex.html;
www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/EDISupport.html.

practice location must be accomplished by filing with the Medicare contractor the applicable enrollment application, in Petitioner's case a CMS-855I. 42 C.F.R. § 424.515. CMS has the right to perform on-site inspections to verify information and confirm that a provider or supplier continues to meet enrollment requirements. 42 C.F.R. §§ 424.510(d)(8), 424.517. Petitioner bears the burden to demonstrate that she meets enrollment requirements and to produce documents demonstrating compliance. 42 C.F.R. § 424.545(c).

Petitioner concedes that she did not report her change of practice location using the correct form. RFH at 2. Petitioner admits that she did not file a CMS-855I to report the change of practice location until May 23, 2016, more than a year after she moved her practice location on March 1, 2015. P. Br. at 4. Contrary to Petitioner's argument (P. Br. at 4), the regulations do require the use of the appropriate enrollment application (CMS-855) or PECOS to report changes in enrollment information such as a change of practice location. 42 C.F.R. §§ 424.502, 424.515.

There is no dispute that Petitioner failed to notify Noridian by filing within 30 days of March 1, 2015, a CMS-855I reporting that Petitioner changed her practice location from the Union Street location to the Goodwin Street location. Accordingly, there is a basis for revocation of Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. §§ 424.535(a)(5)(ii) and (9) for violation of 42 C.F.R. § 424.516(d)(1)(iii).

Having found that there is a basis for revocation, I have no authority to review the exercise of discretion by CMS to revoke Petitioners' Medicare enrollment and billing privileges. *Dinesh Patel, M.D.*, DAB No. 2551 at 10 (2013); *Fady Fayad, M.D.*, DAB No. 2266, at 16 (2009), *aff'd*, 803 F. Supp. 2d 699 (E.D. Mich. 2011); *Abdul Razzaque Ahmed, M.D.*, DAB No. 2261 at 16-17, 19 (2009), *aff'd*, 710 F. Supp. 2d 167 (D. Mass. 2010).

Summary judgment is also appropriate as to the effective date of 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). Petitioner does not dispute that at the time of the site visit there was no practice location at the Union Street location. Pursuant to 42 C.F.R. § 424.535(g), CMS is authorized to establish an effective date of revocation based on the date CMS determined that Petitioner's practice location was no longer operational. The Noridian investigator found that Petitioner did not have an operational practice at the Union Street location on December 28, 2015. Therefore, December 28, 2015 is the correct effective date of revocation.

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 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 such relief. *US Ultrasound*, DAB No. 2302 at 8 (2010). 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 (2009).

III. Conclusion

For the foregoing reasons, Petitioner's Medicare enrollment and billing privileges are revoked pursuant to 42 C.F.R. § 424.535(a)(5)(ii) and 424.535(a)(9). The effective date of revocation is December 28, 2015.

/s/
Keith W. Sickendick
Administrative Law Judge