Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Amann's Orthopedics and Prosthetics, Inc.,
(Supplier Number: 0229870001),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-10-1001

Decision No. CR2337

Date: March 15, 2011

DECISION

Petitioner, Amann's Orthopedics and Prosthetics, Inc., appeals a reconsideration decision by a Medicare hearing officer with National Supplier Clearinghouse (NSC), Palmetto GBA (Palmetto), a CMS contractor. The undisputed evidence establishes that Petitioner, a medical equipment supplier, was not in compliance with Medicare program requirements. As a consequence, I grant the motion of the Centers for Medicare and Medicaid Services (CMS) for summary judgment and uphold the determination to revoke Petitioner's enrollment in the Medicare program.

I. Applicable Law and Regulations

Section 1834(j)(1) of the Social Security Act, 42 U.S.C. § 1395m(j)(1), states the requirements for the issuance and renewal of a supplier number for suppliers of medical equipment and supplies. This section provides that "no payment may be made . . . for items furnished by a supplier of medical equipment and supplies unless such supplier obtains (and renews at such intervals as the Secretary may require) a supplier number."

To participate in Medicare as a medical equipment supplier and to maintain a supplier number and billing privileges, an entity must also meet the specific requirements, referred

to as "supplier standards," set forth at 42 C.F.R. § 424.57(c) for suppliers of "durable medical equipment, prosthetics, orthotics, and supplies" (DMEPOS). 42 C.F.R. § 424.57(a). As relevant here, supplier standard eight requires a supplier to allow CMS or CMS contractors to conduct on-site inspections to ascertain supplier compliance with Medicare requirements. 42 C.F.R. § 424.57(c)(8). Also, a supplier's location must be accessible to beneficiaries and to CMS during reasonable business hours, and the supplier must maintain a visible sign and post its hours of operation. 42 C.F.R. § 424.57(c)(7).

Regulations provide that CMS will revoke a supplier's billing number if it is found not to meet the supplier standards or other requirements in section 424.57(c). 42 C.F.R. § 424.57(d), (e). Furthermore, CMS may revoke a currently enrolled supplier's Medicare billing privileges if it determines, based on an on-site review, that the supplier: (1) is no longer operational to furnish Medicare covered items or services; or (2) otherwise fails to meet Medicare enrollment requirements. 42 C.F.R. § 424.535(a)(5).

II. Background and Procedural History

Petitioner is a DMEPOS supplier. NSC conducts site inspections on behalf of CMS to determine if a supplier is in compliance with applicable Medicare DMEPOS supplier standards. On March 31, 2010 at 2:00 p.m. and on April 8, 2010 at 2:30 p.m., NSC attempted to inspect Petitioner's facility during Petitioner's posted hours of operation.[1] CMS Ex. 8, at 2-3. At both times, the facility was locked, and the inspector observed no one at Petitioner's facility. *Id*. at 7. Photographs included in the site inspection reports show no note on the facility door to indicate why the facility was not open. *Id*. at 9-10.

On April 22, 2010, Palmetto issued a notice informing Petitioner that it was revoking its supplier number because NSC was twice unable to conduct an on-site inspection during Petitioner's posted hours of operation. CMS Ex. 6, at 1. On April 27, 2010, Petitioner submitted a reconsideration request and a corrective action plan (CAP), explaining that Petitioner often worked by appointment in hospitals, nursing homes, and patient homes during business hours. CMS Ex. 5. Petitioner proposed shortening his office hours to 9:00 a.m. to 3:00 p.m. and stated that, when leaving the office, he would post the time he would return along with his telephone number. *Id*.

NSC processed Petitioner's CAP and attempted to conduct a site inspection on June 4, 2010 at 10:10 a.m. On this date, the facility was locked, and a notice was posted on the door indicating that Petitioner would return at 1:00 p.m. CMS Ex. 9, at 7, 9. NSC made another attempt to conduct a site inspection on June 8, 2010 at 1:05 p.m. Again, the facility was locked, and a posted notice stated that Petitioner would return at 3:00 p.m. *Id*. at 7, 10. Date-stamped photographs indicate Petitioner's posted hours of operation as 9:30 a.m. to 2:30 p.m., Monday through Friday. *Id*. at 10.

[1] During this time period, Petitioner's posted hours of operation were Monday through Friday from 8:30 a.m. to 3:30 p.m.

On June 17, 2010, Palmetto sent a letter to Petitioner acknowledging receipt of Petitioner's request for reconsideration and CAP. However, Palmetto refused to reinstate Petitioner's Medicare billing privileges because compliance with Medicare supplier standards could not be verified. CMS Ex. 3. Palmetto advised Petitioner that it forwarded Petitioner's request for reconsideration and CAP to a Medicare Hearing Officer for review. *Id*. On September 3, 2010, a Medicare Hearing Officer issued a decision denying Petitioner's request for reconsideration. CMS Ex. 1. The decision states that Petitioner failed to comply with 42 C.F.R. § 424.535(a)(5)(ii), specifically with regard to site inspection compliance. *Id.* at 3.

On September 20, 2010, Petitioner filed a hearing request (HR) with the Civil Remedies Division of the Departmental Appeals Board (Board) to appeal the reconsideration decision. This case was initially assigned to Board Member Leslie A. Sussan, pursuant to 42 C.F.R. § 498.44, which permits a Board Member to hear appeals under 42 C.F.R. Part 498. An Acknowledgment and Pre-hearing Order was sent to the parties on October 4, 2010. On October 8, 2010 Petitioner submitted a letter in response to the Pre-hearing Order.

On October 25, 2010, this case was reassigned to me for hearing and decision. On November 15, 2010, CMS filed a motion for summary judgment. With its brief (CMS Br.), CMS submitted nine exhibits (CMS Exs. 1-9). On December 31, 2010, Petitioner submitted a letter in response to CMS's motion for summary judgment (P. Letter). Petitioner also submitted two exhibits, marked as Exhibit A and B (P. Exs. A and B), and requested a brief extension to gather evidence. On January 12, 2011, Petitioner submitted a brief in support of its motion for summary judgment (P. Br.). With its brief, Petitioner filed seven exhibits (P. Exs. 1-7). In the absence of objection, I admit CMS Exs. 1-9 and P. Exs. 1-7 and P. Exs. A and B to the record.

III. Issue, Findings of Fact, Conclusions of Law

A. Issue

The sole issue in this case is whether CMS was legally authorized to revoke Petitioner's enrollment as a supplier in the Medicare program

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). The Board has further stated, "[i]n addition, it is appropriate for the tribunal to consider whether a rational trier of fact could regard the parties' presentation as sufficient to meet their evidentiary burden under the relevant substantive law." *Dumas Nursing and Rehab., L.P.*, DAB No. 2347, at 5 (2010).

C. Findings of Fact and Conclusions of Law

My findings and conclusions are in the italicized heading supported by the subsequent discussion below.

CMS had a legitimate basis to revoke Petitioner's billing privileges because Petitioner was not operational pursuant to applicable regulations.

CMS moves for summary judgment asserting that no material facts are in dispute. CMS contends that it was unable to conduct an on-site inspection of Petitioner's business on four separate occasions. CMS Br. at 6. Petitioner does not dispute, in its letter dated October 8, 2010, that on March 31, 2010 and April 8, 2010 and again on June 4, 2010 and June 8, 2010 that an NSC inspector found Petitioner's facility closed and locked during its posted hours of operation. Because neither party asserts that a genuine dispute as to a material fact exists, and because the evidence does not reflect such a dispute, summary judgment is appropriate.

The issues in this case turn on the legal interpretation of the regulations, 42 C.F.R. §§ 424.57 and 424.535, and other regulatory provisions that govern the revocation of Medicare billing privileges. It is undisputed that on four occasions CMS attempted and was unable to conduct an on-site inspection of Petitioner's facility during its posted hours of operation because the facility was closed. CMS Ex. 5, 8-9. Petitioner admits that he often works by himself and leaves the facility at unexpected times during the day, and he had inadequate staffing in the past. CMS Ex. 5; P. Letter of October 8, 2010; P. Br. at 2. CMS will revoke a Medicare supplier's billing privileges if CMS determines that the supplier is not in compliance with any of the supplier enrollment standards. 42 C.F.R. §

424.57(d); *A to Z DME, LLC*, DAB No. 2303, at 3 (2010). A Medicare supplier must be "*open to the public* for the purpose of providing health care related services . . .and [be] *properly staffed*. . . to furnish these services." 42 C.F.R. § 424.502 (emphasis added). A DMEPOS supplier must permit CMS or its agent to conduct on-site inspections to ascertain supplier compliance with each of the enrollment standards and must be accessible and staffed during the posted hours of operation. 42 C.F.R. § 424.57(c)(7), (8). A supplier is neither "staffed" nor "accessible," if the supplier's location is closed and locked. It is incumbent on Petitioner to hire adequate staff and make whatever reasonable arrangements are necessary to keep its business open while still allowing for patient visits at nursing homes and hospitals. "A Medicare supplier differs from a strictly private business in that it is an integral part of a publicly run program. The requirement that a supplier be open at all times during normal business hours reflects CMS's determination that a supplier be available to beneficiaries to meet their needs and to alleviate their medical conditions." *A to Z DME, LLC*, DAB CR1995, at 6 (2009).

Petitioner essentially argues that evidence suggesting that a business is customarily operational can overcome evidence of a brief absence, especially if Petitioner mainly works by appointment outside of the facility. *See* P. Letter of October 8, 2010; P. Br. The Board has held, however, that the supplier standard "would have no meaning if suppliers could deviate from their posted hours of operation on a regular basis." *Ita Udeobong, d/b/a/ Midland Care Med. Supply and Equip't,* DAB No. 2324, at 7 (2010). In *Udeobong*, the petitioner admitted that it was closed from noon until 1:00 p.m. every day for lunch, which was outside of its regularly posted hours of 10 am to 5 pm, Monday through Friday. The Board further held that "[t]his problem would not be cured even if . . . its employees posted temporary signs when they left, stating when they would return." *Id.* CMS and its contractors have limited resources and cannot be compelled to attempt multiple on-site inspections during a supplier's posted business hours to determine if a supplier is complying with all Medicare requirements.

Petitioner states he was confused regarding which regulations applied to his business. However, Petitioner noted that he plans to correct his past noncompliance by implementing Medicare requirements in his office policies in the future. P. Br. at 2. Even if I assume all Petitioner's statements are true and Petitioner's noncompliance was due to a staffing shortage during an isolated period of time and that Petitioner will make necessary corrections in the future, applicable regulations still bind me. I lack authority to invalidate or change an existing regulation or grant Petitioner an exemption from compliance with regulatory requirements. *1866ICPayday.com*, DAB No. 2289, at 14. I must sustain CMS's determination if a legitimate basis exists and where the facts established noncompliance with one or more of the regulatory standards. *Id.* at 13. For the reasons explained above, I conclude that CMS appropriately revoked Petitioner's supplier number for failure to comply with Medicare DMEPOS supplier requirements. Accordingly, I grant summary judgment in favor of CMS.

IV. Conclusion

After reviewing the evidence in the light most favorable to Petitioner, I conclude that the regulatory language is plain, and there is no genuine issue of material fact. I therefore grant summary judgment to CMS because CMS acted within its regulatory authority to revoke Petitioner's billing privileges.

/s/
Joseph Grow
Administrative Law Judge