Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Lake Shore Healthcare & Rehabilitation Center,
(CCN: 14-5244),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-1144

Decision No. CR4510

Date: January 21, 2016

DECISION

Lake Shore Healthcare & Rehabilitation Center (Petitioner or the facility) challenges the determination of the Centers for Medicare & Medicaid Services (CMS) that it was not in substantial compliance with Medicare program participation requirements. CMS imposed against Petitioner a total civil money penalty (CMP) of $17,150.

For the reasons discussed below, I grant summary judgment to CMS. I find the undisputed evidence shows that Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(m)(2) (Tag F333, Medication Errors). I also find the undisputed evidence shows that CMS's determination of immediate jeopardy was not clearly erroneous, and the CMP that CMS imposed is reasonable in amount and duration.

I. Background

The Social Security Act (Act) sets forth requirements for skilled nursing facility participation in the Medicare program. The Act authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations implementing those statutory provisions. Act § 1819 (42 U.S.C. § 1395i-3). The Secretary's regulations are found at

42 C.F.R. Part 483. To participate in the program, a facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. Act § 1864(a) (42 U.S.C. § 1395aa(a)); 42 C.F.R. §§ 488.10, 488.20. The Act and regulations require that facilities be surveyed on average every 12 months, and more often if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A) (42 U.S.C. § 1395i3(g)(2)(A)); 42 C.F.R. §§ 488.20(a), 488.308.

Here, surveyors from the Illinois Department of Public Health (state agency) completed a survey of Petitioner, a skilled nursing facility in Chicago, Illinois, on January 10, 2014. Based on the findings of that survey, the state agency found that Petitioner was not in substantial compliance with twenty-eight participation requirements and that Petitioner returned to compliance by February 3, 2014. CMS informed Petitioner, by letters dated March 7 and April 10, 2014, that it had imposed a CMP of $5,400 for immediate jeopardy on December 17, 2013, and a $250 per day CMP, from December 18, 2013 through February 2, 2014, for a total penalty of $17,150.

Petitioner requested an Administrative Law Judge (ALJ) hearing to dispute the determination that it was not in substantial compliance with program requirements, CMS's determination of immediate jeopardy, and the associated proposed remedies. Petitioner's request was received at the Civil Remedies Division, assigned to me for hearing and decision, and on May 22, 2014, I issued an Acknowledgment and Initial Pre-Hearing Order (Pre-Hearing Order), which consolidated previous hearing requests from Petitioner relating to the same survey cycle.[1]

I instructed the parties that their pre-hearing briefs must contain any argument that a party intended to make and that I may exclude an argument and evidence that relates to such argument if a party fails to address it in its pre-hearing brief without good cause. *Acknowledgement and Initial Pre-Hearing Order*, March 12, 2014, ¶¶ 3, 7. In accordance with my Pre-Hearing Order, on August 11, 2014, CMS filed its pre-hearing brief (CMS Br.) along with 95 proposed exhibits (CMS Exs. 1-95). On September 15, 2014, Petitioner filed its pre-hearing brief (P. Br.) along with three proposed exhibits (P. Exs. 1-3). I admit all proposed exhibits into the record absent any objection from the parties. After reviewing Petitioner's pre-hearing exchange, CMS chose to file a motion

[1] The parties did not object to the consolidation of this case with C-14-772 and C-14-811.

for summary judgment (CMS Motion) on October 23, 2014. Petitioner filed a brief responding to the CMS Motion (P. Resp.) on November 11, 2014.

II. Issues

Whether the undisputed evidence establishes:

1. Petitioner was in substantial compliance with 42 C.F.R. § 483.25(m) (Tag F333, Medication Errors);

2. CMS's determination of immediate jeopardy level noncompliance was clearly erroneous; and

3. The CMPs that CMS imposed are reasonable in amount and duration.

III. Summary Judgment Standard

Summary judgment is appropriate when a case presents no issue of material fact, and its resolution turns on questions of law. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-48 (1986); *Livingston Care Ctr. v. United States Dep't of Health & Human Servs.*, 388 F.3d 168, 173 (6th Cir. 2004). *See also Illinois Knights Templar Home*, DAB No. 2274, at 3-4 (2009) (citing *Kingsville Nursing Ctr.*, DAB No. 2234, at 3-4 (2009)). The moving party may show the absence of a genuine factual dispute by presenting evidence so one-sided that it must prevail as a matter of law, or by showing that the non-moving party has presented no evidence "sufficient to establish the existence of an element essential to [that party's] case, and on which [that party] will bear the burden of proof at trial." *Livingston Care Ctr.*, 388 F.3d 168, 173 (quoting *Celotex Corp. v. Catrett*, 477 U.S. 317, 323-24 (1986)).

To avoid summary judgment, the non-moving party must then act affirmatively by tendering evidence of specific facts showing that a dispute exists. *See Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 n.11 (1986); *see also Vandalia Park*, DAB No. 1939 (2004); *Lebanon Nursing & Rehab. Ctr.*, DAB No. 1918 (2004). To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but it must furnish evidence of a dispute concerning a material fact. *Illinois Knights Templar Home*, DAB No. 2274, at 4; *Livingston Care Ctr.*, DAB No. 1871, at 5 (2003).

In examining the evidence for purposes of determining the appropriateness of summary judgment, I must draw all reasonable inferences in the light most favorable to the non-moving party. *Brightview Care Ctr.*, DAB No. 2132, at 2, 9 (2007); *Livingston Care Ctr.*, 388 F.3d at 168, 172; *Guardian Health Care Ctr.*, DAB No. 1943, at 8 (2004); *but see Cedar Lake*, DAB No. 2344, at 7; *Brightview Care Ctr.*, DAB No. 2132, at 10

(upholding summary judgment where inferences and views of non-moving party are not reasonable). However, drawing factual inferences in the light most favorable to the non-moving party does not require that I accept the non-moving party's legal conclusions. *Cedar Lake*, DAB No. 2344, at 7; *Guardian Health Care Ctr.*, DAB No. 1943, at 11 ("A dispute over the conclusion to be drawn from applying relevant legal criteria to undisputed facts does not preclude summary judgment if the record is sufficiently developed and there is only one reasonable conclusion that can be drawn from those facts.").

IV. Findings of Fact and Conclusions of Law

A. The undisputed evidence establishes that Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(m)(2) because Petitioner erred significantly when administering medications to Residents 7 and 31.

A skilled nursing facility must ensure that it is free of any significant medication errors. *See* 42 C.F.R. § 483(m)(2). A medication error may be considered significant if it "jeopardizes" - that is, has the potential to harm - the resident's health. *Life Care Ctr. of Tullahoma*, DAB No. 2304, at 44 (2010). No showing of actual harm to a resident is necessary to conclude that an error is significant. *Northern Montana Care Ctr.*, DAB No. 1930 (2004); *Rosewood Care Ctr. of Peoria*, DAB No. 1912 (2004).

In the preamble to the rule-making provision that adopted subsection 483.25(m), the Secretary explained:

> A significant medication error is judged by a surveyor, using factors which have been described in interpretive guidelines since May 1984. The three factors are: (1) Drug category. Did the error involve a drug that could result in serious consequences for the resident[?;] (2) Resident condition. Was the resident compromised in such a way that he or she could not easily recover from the error[?;] (3) Frequency of error. Is there any evidence that the error occurred more than once[?] Using these criteria, an example of a significant medication error might be as follows: A resident received twice the correct dose of digoxin, a potentially toxic drug. The resident already had a slow pulse rate, which the drug would further lower. The error occurred three times last week.

56 Fed. Reg. 48,826, at 48,853 (Sept. 26, 1991). These criteria are also reiterated in CMS's interpretive guidelines for section 483.25(m)(2) in the State Operations Manual (SOM):

> **"Resident Condition" -** The resident's condition is an important factor to take into consideration. For example, a fluid pill erroneously administered

> to a dehydrated patient may have serious consequences, but if administered to a resident with a normal fluid balance may not. If the resident's condition requires rigid control, a single missed or wrong dose can be highly significant.
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> **"Drug Category" -** If the drug is from a category that usually requires the patient to be titrated to a specific blood level, a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. This is especially important with a drug that has a Narrow Therapeutic Index (NTI) (i.e., a drug in which the therapeutic dose is very close to the toxic dose). Examples of drugs with NTI are as follows: . . . Anticoagulants . . . .
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> **"Frequency of Error"** - If an error is occurring with any frequency, there is more reason to classify the error as significant. For example, if a resident's drug was omitted several times . . . , classifying that error as significant would be in order. This conclusion should be considered in concert with the resident's condition and the drug category.

SOM, App. PP (tag 333) (bold in original).

1. The undisputed evidence establishes that Petitioner significantly erred because Petitioner did not provide Resident 7 with an anticoagulant pursuant to doctor's orders.

CMS has moved for summary judgment based on circumstances involving Resident 7, an 82-year-old man with undisputed diagnoses including diabetes, cardiomyopathy, chronic subdural hematoma, and chronic venous stasis, whose physician ordered him to receive the anticoagulant Heparin through subcutaneous injections. CMS Motion at 4-6; CMS Ex. 31 at 5, 7; CMS Ex. 6 at 80-81. Resident 7's physician initially ordered that he receive 1 milliliter of Heparin every 12 hours, but as of December 11, 2013, the physician halved that order to 0.5 milliliter every 12 hours. CMS Ex. 31 at 5, 7; CMS Ex. 6 at 80-81.

A nurse surveyor, however, observed a facility nurse preparing to administer 1 milliliter of Heparin to Resident 7 on December 17, 2013. CMS Ex. 92. A photograph of the medication label that the facility nurse was relying upon provided for 1 milliliter of Heparin every 12 hours, instead of the updated 0.5 milliliter amount the resident's physician ordered. CMS Ex. 31 at 14. CMS asserts that the nurse admitted during the survey that the facility never revised the dosage and had been administering 1 milliliter of Heparin instead of the prescribed 0.5 milliliter dosage for several days since December 11, 2013. CMS Motion at 5 (citing the survey's Statement of Deficiencies (SOD), CMS Ex. 6 at 81).

CMS argued that the frequency of Petitioner's error, compounded with the drug type, made the medication error significant. Specifically, the error occurred twice daily for nearly a week, and Heparin is an anticoagulant, a type of medication for which the prescribed amount is particularly important because the drug must be titrated to a specific blood level. CMS Motion at 5; CMS Ex. 95 at 2. In response to the CMS Motion, Petitioner comes forward with no specific evidence to contest CMS's allegations in order to identify a genuine issue of material fact I must decide. As a result, I do not find a factual dispute with regard to Petitioner's noncompliance with Medicare requirements involving this significant medication error in administering Heparin to Resident 7.

2. The undisputed evidence establishes Petitioner erred significantly when it did not comply with its policy and professional standards of care when administering the anticoagulant to Resident 7.

CMS also argued that Petitioner did not comply with its own policy when administering Resident 7's medication. CMS Motion at 5. A facility's failure to follow or implement its own resident care policy may constitute a deficiency under 42 C.F.R. § 483.25. *The Laurels at Forest Glenn*, DAB No. 2182, at 18 (2008). According to the facility's policy, *Subcutaneous Injections*, Petitioner instructed its employees to verify a physician's medication order for an injection and to verify the dose of the medication. CMS Ex. 78 at 87. Petitioner presents no specific evidence to suggest its nurse did this for Resident 7's administration of Heparin.

A resident care policy "is also evidence of the standard of care the facility expect[s] its staff to provide" and of professional standards of care. *The Laurels at Forest Glenn*, DAB No. 2182, at 18. It is undisputed that Petitioner did not comply with its *Subcutaneous Injections* policy. It follows that it therefore did not meet the standard of care for its facility, which further supports the medication error deficiency.

3. The undisputed evidence establishes that Petitioner erred significantly when it improperly administered a diuretic to Resident 31 without accurately taking the resident's blood pressure and not following manufacturer instructions.

Resident 31 was a 64-year-old man with undisputed diagnoses including anemia, hypertension, gastroesophageal reflux disease, diabetes mellitus, and a hip fracture. CMS Ex. 46 at 18-19. On December 4, 2013, Resident 31's physician prescribed the diuretic Furosemide, 40 mg (4 ml) intravenously every 12 hours. *Id.* at 48, 58. On December 17, 2013, at 10:00 a.m., a nurse surveyor observed a facility LPN administer Furosemide intravenously to Resident 31. CMS Ex. 6 at 75-79; CMS Ex. 18 at 2; CMS Ex. 90. The nurse surveyor specifically observed the LPN test Resident 31's blood pressure, flush the intravenous line with saline, administer the total dosage of 4 ml of Furosemide within 30 seconds, and then again flush the intravenous line with saline. CMS Ex. 6 at 75-76.

CMS asserts that the LPN erred in administering the Furosemide because she did not take an accurate blood pressure reading. Specifically, she did not properly calibrate the blood pressure machine before taking the resident's blood pressure prior to administering the drug. CMS Motion at 6; CMS Ex. 6 at 75. CMS contends that the pointer of the dial was set at 300 instead of being reset to 0 before the measurement. *Id*. Further, CMS asserts that administering Furosemide without a proper blood pressure reading put the resident at risk for hypotension. CMS Motion at 7; CMS Ex. 90 at 2-3.

In addition, CMS asserts that the LPN did not administer the diuretic in compliance with the manufacturer's instructions. CMS Motion at 7. Specifically, the nurse surveyor observed the LPN administer the medication over a 30-second period, but the manufacturer's instruction for Furosemide directs that an intravenous dose of 40 mg should be given slowly over 1-2 minutes. CMS Ex. 46 at 84. CMS also relied on the manufacturer's instruction to assert that rapid injections have been associated with cases of tinnitus and reversible or irreversible hearing impairment, and this put Resident 31 at significant risk of serious medical problems. CMS Motion at 7; CMS Ex. 46 at 84; CMS Ex. 90 at 2. CMS also argued that the error may have been repeated because the same LPN had administered Resident 31's Furosemide eleven times from December 4, 2013 through the date of the observation at issue, December 17, 2013. CMS Motion at 7; P. Ex. 1 (Declaration of LPN); CMS Ex. 46 at 58; CMS Ex. 95 at 2.

Petitioner does not come forward now with specific evidence to show there are any material facts I need to resolve with regard to these particular issues. Therefore, I find as a matter of law that Petitioner did not comply with Medicare requirements when it

improperly administered Resident 31's diuretic and caused an additional significant medication error. [2]

B. The undisputed evidence establishes that CMS's determination of immediate jeopardy was not clearly erroneous.

"Immediate jeopardy" exists if a facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. 42 C.F.R. § 488.301. The regulation does not require that a resident actually be harmed. *See Lakeport Skilled Nursing Ctr.*, DAB No. 2435, at 8 (2012). An immediate jeopardy determination must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). "Under the clearly erroneous standard, CMS's immediate jeopardy finding is presumed to be correct, and the [facility] has a heavy burden to overturn it." *Stone Cty. Nursing & Rehab. Ctr.*, DAB No. 2276, at 16 (2009).

The facility's burden of demonstrating clear error in CMS's immediate jeopardy determination "extends to overcoming CMS's determination as to how long the noncompliance remained at the immediate jeopardy level." *Azalea Court*, DAB No. 2352, at 17 (2010), citing *Brian Ctr. Health & Rehab. Goldsboro*, DAB No. 2336, at 7 (2010). As the Board concluded in *Brian Center*, "[a] determination by CMS that a [facility's] ongoing [noncompliance] remains at the level of immediate jeopardy during a given period constitutes a determination about the 'level of noncompliance' and, therefore, is subject to the clearly erroneous standard of review under section 498.60(c)(2)." *Brian Ctr.* at 7-8.

Here, CMS contends that Petitioner's significant medication errors were likely to cause serious injury and harm to Residents 7 and 31. Specifically, CMS contended Resident 7 was at serious risk for one of the many possible side effects of Heparin, the improperly administered anticoagulant, which the SOM categorizes as a dangerous drug category that requires titration to a specific blood level. CMS Motion at 8; CMS Ex. 95 at 2; *see also* CMS Br. at 5-6, 23; CMS Ex. 6 at 80-81. Further CMS contended Resident 31 was at serious risk for hypotension as well as tinnitus and hearing loss due to the facility's improper administration of Furosemide. CMS Motion at 6-9; CMS Ex. 46 at 84; CMS Ex. 90; CMS Ex. 6 at 73-82; *see also* CMS Br. at 23.

Rather than coming forward with specific evidence to challenge the specific allegations of CMS's motion, Petitioner contends that I must deny summary judgment because, at

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[2] CMS did not move for summary judgment on the specific grounds from its pre-hearing brief that Petitioner was noncompliant with 42 C.F.R. § 483.25(m) due to the administration of intravenous push medications by an unsupervised LPN, and I do not consider the merits of that allegation in my ruling here.

the time of the survey, the state agency found that conditions posed immediate jeopardy for one day based on different grounds. Specifically Petitioner contends the state agency found immediate jeopardy for *only* one day related to its medication error involving RN nursing supervision of LPNs when administering intravenous push medications, and CMS has not moved for summary judgment based on those specific grounds. P. Resp at 2 (citing CMS Ex. 6 at 129). However, the SOD cited immediate jeopardy based on significant medication errors including all aspects of the medication error noncompliance with respect to Resident 7 and Resident 31. *See* CMS Ex. 6 at 73. Moreover, even if CMS were to have asserted immediate jeopardy under different grounds than the surveyors, my review of CMS's determination of immediate jeopardy and its duration is *de novo*. *See Sunbridge Care & Rehab. for Penbroke*, DAB No. 2170, at 37 (2008).

Petitioner also alleges the information on a website CMS cites does not suggest a likelihood of serious harm, rather simply a potential for serious harm. P. Resp.at 6. However, CMS's determination of immediate jeopardy is presumed to be correct, and Petitioner has the burden to rebut the presumption with evidence and argument showing that the harm or threatened harm did not meet any reasonable definition of seriousness. *See Daughters of Miriam Ctr.*, DAB No. 2067 at 9-11 (2007)(determining that it was not CMS's burden to make a prima facie showing of immediate jeopardy in a case involving medication errors).

As I previously discussed, Petitioner has not demonstrated the existence of a genuine issue of material fact because it has not come forward with any *specific* evidence to dispute CMS's contentions about CMS's allegations including Resident 7's diagnoses, that Resident 7 received twice as much of the anticoagulant Heparin than the amount Resident 7's physician ordered him to receive, the recurring frequency of the error, the drug category of the anticoagulant Heparin that requires the titration to a specific blood level, or Petitioner's noncompliance with its *Subcutaneous Injections* policy. Similarly, Petitioner has not come forward with any *specific* evidence to dispute CMS's contentions about Resident 31's diagnoses, the manner in which the surveyor observed Petitioner's staff's administration of a diuretic to Resident 31, the severity of the alleged harm, or the recurring frequency of the error. *Compare, e.g., Innsbruck HealthCare Center*, DAB No. 1948 at 6 (2004) (concluding there were genuine issues of material fact precluding summary judgment when a petitioner presented evidence of expert testimony over the assessment of the degree of risk to residents).

I am also not required to make unreasonable inferences in favor of Petitioner. *See Brightview Care Ctr.*, DAB No. 2132, at 10 (upholding summary judgment where inferences and views of non-moving party are not reasonable). Based on the undisputed evidence of the improper administration of medication to Residents 7 and 31, and the evidence supporting the seriousness of them, and the lack of specific evidence that Petitioner has proffered, it would be unreasonable to infer that Petitioner's errors were not likely to result in serious harm, injury, impairment, or death.

C. The undisputed evidence establishes the CMP that CMS imposed is reasonable in amount and duration.

CMS imposed a $5,400 CMP for one day of immediate jeopardy on December 17, 2013, and a $250 per day CMP for 15 days of noncompliance which is not immediate jeopardy from December 18, 2013 through February 2, 2014. CMS must consider several factors when determining the amount of a CMP, which an ALJ considers *de novo* when evaluating the reasonableness of the CMP that CMS imposed: (1) the facility's history of noncompliance; (2) the facility's financial condition, i.e., its ability to pay the CMP; (3) the severity and scope of the noncompliance, the "relationship of the one deficiency to other deficiencies resulting in noncompliance," and the facility's prior history of noncompliance; and (4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. 42 C.F.R. §§ 488.438(f), 488.404(b), (c).

The regulations leave the decision regarding the choice of remedy to CMS and the amount of the remedy to CMS and the ALJ, requiring only that the regulatory factors at 42 C.F.R. §§ 488.438(f) and 488.404 be considered when determining the amount of a CMP within a particular range. 42 C.F.R. §§ 488.408,(g)(2), 498.3(d)(11); *see also* 42 C.F.R. § 488.438(e)(2); *Alexandria Place*, DAB No. 2245, at 27 (2009); *Kenton Healthcare, LLC*, DAB No. 2186, at 28-29.

Petitioner has the burden to introduce evidence or argument challenging the application of the regulatory factors for determining the reasonableness of the CMP amount. *Ridgecrest Healthcare Ctr.*, DAB No. 2493, at 12 (2013), quoting *The Windsor House*, DAB No. 1942, at 62 (2004). Moreover, there is "a presumption that CMS has considered the regulatory factors" in setting the amount of the CMP "and that those factors support" the CMP amount CMS imposed. *Id.* at 13, quoting *Coquina Ctr.*, DAB No. 1860, at 32 (2002). The Board has concluded that "[t]he burden is on the facility to show that it timely completed the implementation of [its] plan [of correction] and in fact abated the jeopardy (to reduce the applicable CMP range) or achieved substantial compliance (to end the application of remedies)." *Lake Mary Healthcare*, DAB No. 2081, at 29 (2007), *citing*, *e.g.*, *Spring Meadows Health Care Ctr.*, DAB No. 1966 (2005); *see also Brian Ctr.* at 9; *Azalea Court* at 21 (both citing *Lake Mary*).

I instructed the parties that their pre-hearing briefs must contain any argument that a party intended to make and that I may exclude an argument and evidence that relates to such argument if a party fails to address it in its pre-hearing brief without good cause. *Acknowledgement and Initial Pre-Hearing Order*, March 12, 2014, ¶¶ 3, 7. CMS contends Petitioner, in its pre-hearing brief, did not challenge the application of any regulatory factor in disputing the reasonableness of the CMP amount and therefore has

waived its right to contest the reasonableness of the CMP. I agree. Petitioner only generally argued that:

> A CMP of the amount imposed in this case would not have been assessed but for the clearly erroneous "immediate jeopardy" determination under tag F333. Furthermore, there is no basis for any CMP of any amount. Lake Shore was in substantial compliance with all of the requirements cited on the January 10 survey, which began before December 20, 2013 – the date by with Lake Shore was promised that no remedies would be imposed if it was substantial compliance. Therefore, the CMP in this case is unreasonable and cannot be upheld.

P. Br. at 17. Petitioner also now argues that when it argued against CMS's determination of immediate jeopardy, it was also arguing, in effect, the factor of culpability. P. Resp. at 8-9 (citing P. Br. at 3-5, 17). Even if I were to equate the two arguments, as I discussed previously I do not find that Petitioner has come forward with specific evidence to demonstrate a genuine issue of material fact that I am obligated to resolve with regard to CMS's determination of immediate jeopardy. Therefore, Petitioner has similarly not come forward with any specific argument and evidence to dispute the reasonableness of the amount of the CMP imposed and its duration.

V. Conclusion

I grant CMS's motion for summary judgment finding the undisputed evidence established that Petitioner was not in compliance with Medicare requirements, CMS's determination of immediate jeopardy to residents' health and safety was not clearly erroneous, and the $17,150 penalty that CMS imposed is reasonable in amount and duration. Petitioner has not come forward with any specific evidence to successfully demonstrate a genuine issue of material fact, so I must decide these issues as a matter of law in favor of CMS.

/s/
Joseph Grow
Administrative Law Judge