Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
A TO Z DME, LLC,	)	Date: August 24, 2009
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-09-466
	)	Decision No. CR1995
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION GRANTING SUMMARY DISPOSITION TO CENTERS FOR MEDICARE & MEDICAID SERVICES

I grant summary disposition to the Centers for Medicare & Medicaid Services (CMS) sustaining its determination to revoke the Medicare supplier number of Petitioner, A TO Z DME, LLC.

I. Background

Petitioner, a business located in Grand Blanc, Michigan, was enrolled in the Medicare program as a supplier of durable medical equipment. On October 31, 2008, the National Supplier Clearinghouse (NSC), acting on behalf of CMS, notified Petitioner that its Medicare supplier number was being revoked. The basis for this determination was that Petitioner had failed to comply with standards governing its enrollment as a Medicare supplier. Petitioner requested reconsideration of this determination. Reconsideration was denied and Petitioner then requested an administrative hearing. I was assigned to hear and decide the case.

On May 28, 2009, I issued a pre-hearing order in which I directed the parties to file pre-hearing exchanges which included all of their proposed exhibits and the written direct testimony of each proposed witness. The pre-hearing order noted specifically that 42 C.F.R. § 498.56(e) barred Petitioner from offering evidence that it had not presented to CMS prior to requesting a hearing absent a showing of good cause and I told the parties that I would exclude any new evidence offered by Petitioner in the absence of a showing of good cause. Pre-hearing Order, May 28, 2009, at ¶¶ 3, 6.

Each party filed a pre-hearing exchange which included proposed exhibits. CMS filed a motion for summary disposition as part of its pre-hearing exchange and Petitioner subsequently opposed CMS's motion.

CMS's pre-hearing exchange included 11 proposed exhibits which it identified as CMS Ex. 1 – CMS Ex. 11. Petitioner's pre-hearing exchange included 16 proposed exhibits which it identified as P. Ex. 1 – P. Ex. 16. Many of these proposed exhibits contain evidence which Petitioner had not offered to CMS prior to requesting a hearing. Petitioner made no attempt to demonstrate good cause for its failure to present such evidence to CMS previously.

I am making CMS Ex. 1 – CMS Ex. 11 and P. Ex. 1 – P. Ex. 16 part of the record of this case. I make no ruling at this time as to whether any of Petitioner's exhibits should be excluded from evidence although it is probable that I would exclude many of them were I to hold a hearing. I do not need to address the issue of admissibility at this time because I issue summary disposition based on undisputed material facts. I make no evidentiary findings in this decision. I do not weigh the facts nor do I make credibility findings. I cite to some of the exhibits for purposes of reference, but only to illustrate facts that are not in dispute.

II. Issues, findings of fact and conclusions of law

A. Issue

The issue in this case is whether CMS is authorized to revoke Petitioner's enrollment in the Medicare program.

B. Findings of fact and conclusions of law

I make findings of fact and conclusions of law (Findings) to support my decision in this case. I set forth each Finding below as a separate heading.

1. CMS will revoke a supplier's Medicare billing privileges where the supplier has failed to comply with standards governing its participation or where the supplier is not operational.

In order to participate in Medicare a supplier must meet all of the application certification standards that are set forth at 42 C.F.R. § 424.57(c)(1) – (25). CMS will revoke the supplier's Medicare billing privileges if the supplier fails to meet any of these standards. 42 C.F.R. § 424.57(d).

The regulatory language is plain. A supplier must comply with the letter of all standards or CMS will revoke its billing privileges. And, I must sustain CMS's determination where the facts establish noncompliance with one or more of the regulatory standards. There is nothing in the regulation that establishes a good cause exception to the requirement that a supplier comply with all certification standards. Nor is there any language to suggest that I have the authority to waive the compliance requirement in cases of extenuating circumstances or where a supplier asserts that, as a matter of equity, I should not hold it strictly accountable for compliance.

A supplier must also be "operational" within the meaning of 42 C.F.R. § 424.535(a)(5)(ii), and CMS will revoke a supplier's Medicare enrollment if it determines the supplier not to be operational. The term "operational":

> means the provider or supplier has a qualified physical practice location, is open to the public for the purposes of providing health care related services, is prepared to submit valid Medicare claims, and is properly staffed, equipped, and stocked . . . to furnish these items or services.

42 C.F.R. § 424.502.

2. The undisputed facts establish that Petitioner was not complying with enrollment standards and was not operational. Therefore, CMS was authorized to revoke Petitioner's Medicare enrollment.

The following facts are undisputed. On August 1, 2008, at about 9:45 a.m., an inspector working on behalf of CMS attempted to make a site visit inspection at Petitioner's office. CMS Ex. 2, at 2, 7; CMS Ex. 10, at ¶ 2. When the inspector arrived at the office he found the office to be closed. CMS Ex. 10, at ¶ 2. There was a sign on the office door which listed office hours as "By Appointment Only Please Call 1-810-606-0801." No other signs or notes were present on the office door. CMS Ex. 10, at ¶ 5; CMS Ex. 3, at 1-2. The inspector attempted to call the phone number listed on the office door. However, that attempt failed because the call connected him to a facsimile machine. CMS Ex. 10, at ¶ 2.

The inspector returned to Petitioner's office on August 4, 2008, at 2:00 p.m. to attempt another site inspection. CMS Ex. 2, at 2, 7; CMS Ex. 10, at ¶ 3. Again, the office was closed. There was no sign on the office door other than the sign which told the public that visits were by appointment only. CMS Ex. 10, at ¶ 5; CMS Ex. 3, at 3.

Another inspector attempted to call Petitioner multiple times on August 11, 2008. CMS Ex. 11, ¶ 3. Once again, the calls were not answered because the calls connected to a facsimile machine. *Id.*

These undisputed facts establish three grounds for revocation of Petitioner's Medicare enrollment. First, they establish that Petitioner failed to comply with the requirements of 42 C.F.R. § 424.57(c)(8), one of the enrollment standards that a supplier must comply with to remain eligible for Medicare participation. The standard states that a supplier:

> must be accessible during reasonable business hours to beneficiaries and to CMS, and must maintain a visible sign and posted hours of operation.

Petitioner was not accessible during reasonable business hours. Petitioner's facility was closed to the public during normal business hours on the two dates when site inspections were attempted.

Second, Petitioner did not comply with the requirements of 42 C.F.R. § 424.57(c)(9). This section directs a supplier to maintain:

> a primary business telephone listed under the name of the business locally or toll-free for beneficiaries. . . . The exclusive use of a beeper number, answering service, pager, facsimile machine, car phone, or an answering machine may not be used as the primary business telephone for purposes of this regulation.

Petitioner failed to comply with this requirement in that it was relying exclusively on the use of a facsimile machine during the period that ran from August 1 through August 11, 2008. On at least three occasions during this period inspectors attempted to call Petitioner and each time they were connected to a facsimile machine.

Third, Petitioner failed to comply with the requirement that it be operational. 42 C.F.R. § 424.535(a)(5)(ii); *see* 42 C.F.R. § 424.502. Petitioner plainly was not open to the public for the purpose of providing health care related services during the period when the inspectors attempted to perform site visits at Petitioner's facility. Moreover, Petitioner admits that, as of the first week of August 2008 it was not operational:

> [A]s of August, 2008 . . . [Petitioner] was still not yet selling to patients. It was still waiting to obtain its BlueCross/Blue Shield number. *It did not start selling to patients until October, 2008 when it hired . . .[a] new employee*.

Petitioner's response (Response) to CMS's motion for summary disposition and pre-hearing brief at 3 (emphasis added).

Petitioner makes a number of arguments and fact assertions to counter the undisputed facts. I find them to be irrelevant because, assuming the truth of Petitioner's assertions, they do not, as a matter of law, amount to viable defenses. Some of Petitioner's assertions rest on facts that were not before CMS at the time that reconsideration was made. Were this case to go to a hearing I would not consider these assertions given that Petitioner has failed to show good cause for not making them at an earlier date. However, even these assertions, assuming them to be true, fail to support legally relevant arguments.

Petitioner's principal fact assertion is that its proprietor, Wade T. McDermaid, was on vacation during the first week of August 2008. From this it contends that CMS acted unfairly to penalize Petitioner because Petitioner should be allowed to give its proprietor reasonable time off.

Nothing in the regulations prohibits a supplier from taking a vacation. But, that is not at issue here. The issue is whether Petitioner maintained a business that complied with regulatory requirements, including the requirement that it be open to the public during normal business hours. That is a requirement with which Petitioner failed to comply. It was incumbent on Mr. McDermaid to make whatever reasonable arrangement that was necessary in order to keep his business operational while he was on vacation. That might have included hiring temporary help. But, what Petitioner was not allowed to do – and what he admittedly did – was simply to lock his business' doors and walk away from it while he was on vacation.

Petitioner argues that "the . . . regulations do not indicate that a supplier cannot shut down for a short period of time to take a vacation." Response at 5. In fact, the regulations do not allow a supplier to "shut down" during normal business hours for any reason. Maintaining operations during normal business hours is a condition for enrollment and a supplier must comply with that requirement if it wishes to remain enrolled.

CMS has a right to require that a supplier – if it wishes to remain enrolled – not act like a strictly private business. That requirement is plainly stated in regulations and suppliers, therefore, are on notice that they must comply with it. The prohibition on a supplier coming and going from its business as he or she pleases is one of many that distinguish a

Medicare supplier from a strictly private business. 42 C.F.R. § 424.57(c)(1) - (25). 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.

Moreover, Petitioner's assertion that he was on vacation does not address the fact that, as of August 2008, Petitioner was by its own admission not operational. Petitioner admits that it was not providing any services to the public as of August 2008, and did not begin to do so until October of that year.

Petitioner argues that its admission that it was not doing business as of August 2008, and at no time prior to October 2008, should not be a basis for holding it not to be operational. According to Petitioner, it was in "start up mode" as of August 2008. Response at 6. But, a "start up mode" as described and admitted to by Petitioner fails to comply with the regulatory definition of an operational supplier. Planning or preparing to do business with the public is not equivalent to the requirement that a supplier be: open to the public for the purposes of providing health care related services; prepared to submit valid Medicare claims; and properly staffed, equipped, and stocked to furnish Medicare items or services to the public. 42 C.F.R. § 424.502.

Petitioner contends that its telephone service complied with the requirements of 42 C.F.R. § 424.57(c)(9) because CMS has adduced no facts to show that it made exclusive use of a beeper number, answering service, pager, facsimile machine, car phone, or an answering machine as its primary business telephone. Response at 7; *see* 42 C.F.R. § 424.57(c)(9). However, the undisputed facts establish that Petitioner used a facsimile machine as its exclusive telephone service on August 1 and 4, 2008, and subsequently on August 11, 2008. There is no dispute that the only vehicle for electronic communication with Petitioner existing on these dates was Petitioner's facsimile machine.

Petitioner also asserts that Petitioner's telephone routed calls to a facsimile machine by accident and not by design during the period of time when Mr. McDermaid was away on vacation. Response at 8. Petitioner argues that it should not be penalized for what it characterizes as an accident. This argument is not relevant even if I assume to be true for the purposes of this decision Petitioner's contention that the calls were routed to a facsimile machine by accident and not intentionally. Petitioner would have not had a telephone service that complied with regulatory requirements during the period when Mr. McDermaid was away *even if* during that period calls had been routed to an answering machine. That is because use of an answering machine even for a brief period of time in lieu of a live response is not permitted during normal business hours.

I am not suggesting here that an answering machine would be prohibited as a back up to a live response. It is a fact of modern life that callers get routed to answering machines when lines are tied up by other calls and I do not read the regulation as being blind to that reality. But, and assuming Petitioner's depiction of the facts to be true, it intended its answering machine to serve as its *sole call response* during the first week of August 2008. That is plainly prohibited by the regulations.

Furthermore, Petitioner's assertion that it relied on an answering machine in lieu of a live response only for the period during the first week of August 2008 is unsupported by any facts. The uncontested facts are that Petitioner's telephone still routed calls to a facsimile machine as late as August 11, 2008.

Finally, Petitioner argues that revocation is not authorized in this case because it submitted a plan for corrective action to CMS. Response at 9. Petitioner relies on the language of 42 C.F.R. § 424.535(a)(1) as support for its argument. According to Petitioner the regulation requires CMS to afford a supplier the opportunity to file a corrective action plan to address any failure to comply with enrollment requirements before finally determining to revoke the supplier's Medicare enrollment.

However, Petitioner was not denied the opportunity to file a corrective action plan. Assuming Petitioner's assertions to be true, it filed a corrective action plan on February 18, 2009 with its request for reconsideration of CMS's determination to revoke Petitioner's enrollment. CMS's agent then denied reconsideration. Thus, CMS complied with the letter of 42 C.F.R. § 424.535(a)(1) because it allowed Petitioner to file a corrective action plan before finally determining to revoke enrollment.

There is nothing in the regulation that requires CMS to *accept* a corrective action plan. At most, the regulation gives a supplier an opportunity to file one before CMS makes its final determination to revoke the supplier's enrollment. Acceptance or rejection of a corrective action plan by CMS is an act of discretion. I have no authority to decide whether CMS properly exercised that discretion.

/s/
Steven T. Kessel
Administrative Law Judge