Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Gilberto Acosta Podiatrist, Inc.,
(NPI: 1891781332)

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-12-523

Decision No. CR2807

Date: May 30, 2013

DECISION

Petitioner Gilberto Acosta Podiatrist, Inc. appeals the determination by the Centers for Medicare & Medicaid Services (CMS) to revoke his Medicare enrollment and Medicare billing privileges. After reviewing the written record in this case, I sustain CMS's determination to revoke Petitioner's enrollment in the Medicare program.

I. Background

Petitioner submitted a Medicare enrollment application (form CMS-855I) dated January 14, 2009. CMS Exhibit (Ex.) 14. In the enrollment application, Petitioner listed one practice location, 801 West 48th Street, Suite B, Hileah, Florida 33012. CMS Ex. 14, at 13. On March 16, 2011, SafeGuard Services LLC, a Medicare contractor, conducted an unannounced site visit of Petitioner's practice location. During this site visit, Petitioner admitted that approximately 60% of his patients are seen outside of this practice location in day care centers, assisted living facilities, rehabilitation facilities, skilled nursing facilities, and private homes. CMS Exs. 1, 9, 10, 13. The majority of Petitioner's patients receive Medicare benefits, and for that reason Petitioner should have previously disclosed these additional locations to CMS. *See* CMS Exs. 9, 10, 13, 14.

On April 13, 2011, CMS, through its contractor First Coast Service Options (FCSO), determined that Petitioner's Medicare enrollment should be revoked effective March 16, 2011, based upon Petitioner's failure to report additional practice locations. CMS Ex. 1. FCSO also informed Petitioner that he could submit a corrective action plan (CAP) within thirty days, and include all supporting documentation.

On May 13, 2011, Petitioner's attorney, Michael Lowe,[1] sent a letter to FCSO indicating that the letter was a CAP. In the CAP, Petitioner did not contend that he notified CMS of all his practice locations prior to the site visit and subsequent revocation. CMS Ex. 2. Instead, the letter stated that Petitioner was still unable to disclose all of Petitioner's practice locations to CMS. CMS Ex. 2, at 2.

Then, in a letter dated May 17, 2011, Mr. Lowe stated that "[Petitioner] needs to update a significant number of locations of service on his provider enrollment information and profile with FCSO." CMS Ex. 3. FCSO allowed for additional time to complete the process of updating Petitioner's enrollment application.

In a subsequent letter dated June 17, 2011, Mr. Lowe indicated that Petitioner still had not completed the process of updating his enrollment application to include all the locations where Petitioner saw patients. CMS Ex. 4.

Finally, in a letter dated August 9, 2011, Mr. Lowe indicated that he was submitting additional documentation in support of Petitioner's CAP and provided another CMS-855I form listing many practice locations. CMS Ex. 5. Nevertheless, Mr. Lowe stated that "we are not certain that the locations of service for which [Petitioner] and the Corporation have provided updated provider enrollment information on the enclosed pages and forms constitute a complete set of all of those locations of service at which Dr. Acosta has provided podiatric medical services to Medicare program beneficiaries since his initial enrollment with the program." CMS Ex. 5, at 2. The letter also provided that "for many of the locations of service [Petitioner] has had to estimate the add or delete date for those locations of service as he is not able to completely reconstruct those exact dates for each location of service." CMS Ex. 5, at 3.

FCSO notified Petitioner by letter dated August 31, 2011 that Petitioner could not be enrolled in the Medicare program based upon the CAP. CMS Ex. 7. Petitioner requested reconsideration and on February 2, 2012, CMS issued a reconsideration decision finding that the revocation of Petitioner's Medicare enrollment was authorized. CMS Ex. 8.

On March 29, 2012, Petitioner filed a hearing request (HR), challenging the CMS determination to revoke Petitioner's Medicare enrollment and billing privileges. In

[1] Mr. Lowe is not representing Petitioner in this appeal.

accordance with my Order Establishing Procedures and Schedule for Pre-Hearing Exchanges dated May 11, 2012, the parties filed proposed exhibits (CMS Exs. 1-13 and P. Exs. 1-16) and pre-hearing memoranda. After review of the materials submitted, I convened a pre-hearing conference in order to determine if a hearing would be necessary in this matter. At the pre-hearing conference, the parties stated that this case may be amenable to resolution without the need for a full evidentiary hearing and they believed that the merits of the case may be best addressed through the summary-disposition mechanism. Accordingly, I set a schedule for the filing of briefs and CMS timely submitted a Motion for Summary Disposition and a brief in support of its motion (CMS Br.) on October 12, 2012. Petitioner filed Petitioner's Opposition to the CMS Motion and a Cross Motion for Summary Disposition (P. Br.) on November 7, 2012.

The first attempt at resolving the case by summary disposition was unsuccessful: on December 21, 2012, I issued a Ruling Denying Cross Motions for Summary Disposition and Order Establishing Procedures and Schedule for Pre-Hearing Exchanges. This Order established new deadlines for any supplements or amendments to the exhibit lists, witness lists, and pre-hearing memoranda previously submitted, in light of my ruling denying the cross motions for summary disposition. On February 8, 2013, CMS submitted an amended exhibit list with a supplemental exhibit (CMS Ex. 14) and on March 1, 2013, CMS submitted an amended pre-hearing brief (CMS Am. Br.). Petitioner did not submit an amended pre-hearing brief or respond to the CMS amended pre-hearing brief and supplemental exhibit.

On March 20, 2013, a letter was issued at my direction stating that when I considered the supplemented evidentiary record, the case did not at that point reflect any genuine disputes as to any material facts and I would proceed to evaluate the case *sua sponte* for decision. I provided until April 5, 2013 for the parties to submit written comments, objections, or additional arguments. Neither party responded. Thus, as I indicated, I have evaluated the written record in this matter and have determined that it would be appropriate to render a written decision based upon the documentary evidence submitted by the parties. In the absence of objection, I admit CMS Exs. 1-14 and P. Exs. 1-16 into the record.

II. 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. Payment under the program for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of services and suppliers.[2] When

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[2] A "supplier" furnishes services under Medicare and the term supplier applies to physicians and other non-physician practitioners and facilities that are not included within the definition of the phrase "provider of services." Act § 1861(d) (42 U.S.C.

applying for enrollment in the Medicare program, a supplier is required to provide complete, accurate, and truthful responses to all information requested within each section on the enrollment application applicable to the supplier type. 42 C.F.R. § 424.510 (d)(2)(i). Also, a supplier is obligated to report within 30 days any changes in the supplier's practice location and other changes to the supplier's enrollment must be reported within 90 days. 42 C.F.R. § 424.516(d).

CMS has a right to perform on-site inspections to verify the accuracy of a supplier's enrollment information and to determine the provider's compliance with Medicare enrollment requirements. 42 C.F.R. § 424.510(d)(8); *see also* 42 C.F.R. § 424.517(a)(1). CMS may revoke a supplier's enrollment if the supplier "is determined not to be in compliance with the enrollment requirements described in this section, or in the enrollment application applicable for its provider or supplier type . . . ." 42 C.F.R. § 424.535(a)(1).

III. Issue

The issue in this case is whether CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges.

IV. Analysis

My findings of fact and conclusions of law are set forth in italics and bold in the discussion captions of this decision.

1. This case is appropriate for summary judgment

The Departmental Appeals Board (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

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§ 1395x(d)). The term "physician," includes a doctor of podiatric medicine, but only with respect to functions he is legally authorized to perform by the State in which he performs them. Act § 1861(r) (42 U.S.C. § 1395(x)(r)); 42 C.F.R. § 410.20(b)(3). Podiatrists and other practitioners are considered suppliers under the relevant regulations. *See* 42 C.F.R. § 400.202; 42 C.F.R. § 424.502.

> 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 Rehabilitation & Skilled Nursing Center, DAB No. 2300, at 3 (2010) (citations omitted).

The Board has further explained that the role of an Administrative Law Judge (ALJ) in deciding a summary judgment motion differs from its role in resolving a case after a hearing. The ALJ should not assess credibility or evaluate the weight of conflicting evidence. *Holy Cross Village at Notre Dame, Inc*., DAB No. 2291, at 5 (2009).

I have accepted all of Petitioner's factual assertions as true and drawn all reasonable inferences in Petitioner's favor. Therefore, I accept Petitioner's claim that after the unannounced site visit in 2011, Petitioner attempted to update his enrollment information on file with CMS. HR; P. Br. I further accept Petitioner's assertion that he submitted a CAP to the CMS contractor dated May 13, 2011, disclosing all of Petitioner's current practice locations to the best of his knowledge and belief. P. Br. at 2-3. Finally, I accept Petitioner's assertion that he timely provided all information to the CMS contractor in support of his CAP. For the purposes of summary judgment, I accept Petitioner's description and chronology of these events as true. However, this depiction remains unsupportive of a favorable outcome for Petitioner. Petitioner has not disputed any fact material to my resolution of the case. Accordingly, summary judgment is appropriate in this case.

2. CMS was authorized to revoke Petitioner's Medicare enrollment and billing privileges because Petitioner did not supply complete and accurate information on Petitioner's Medicare enrollment application

CMS contends that Petitioner failed to file a complete and accurate Medicare enrollment application and failed to notify CMS in a timely manner of additional practice locations. CMS argues it was therefore authorized to revoke Petitioner's Medicare enrollment after an unannounced site visit revealed that Petitioner was not in compliance with the applicable regulations. Petitioner was required to provide practice location information "for each location" in Section 4C of his CMS-855I enrollment application. CMS Ex. 14, at 13. The enrollment application form provides spaces to provide such information as the practice location name, practice location address, telephone number, Medicare identification number, the date the first Medicare patient was seen at this location, and the type of practice location. CMS Ex. 14, at 13. Petitioner does not dispute that his Medicare enrollment application submitted in 2009 contained information for only one practice location under Section 4C. CMS Ex. 14, at 13; CMS Exs. 1-5. Also, Petitioner

does not dispute that under Section 4D of the Medicare enrollment application, a section designated for information regarding “Rendering Services in Patients’ Homes,” Petitioner indicated that the section was “N/A” [not applicable] . CMS Ex. 14, at 14.

On March 16, 2011, a Medicare contractor conducted a site visit at the practice location named on Petitioner’s Medicare enrollment application. CMS Ex. 11. During this site visit, Petitioner stated that he saw 60% of his patients at locations other than his private office. CMS Ex. 10, at 2. Petitioner stated that he saw patients at adult day care centers, alternative living facilities, rehabilitation facilities, skilled nursing facilities, and private homes. CMS Ex. 10, at 1-2. Petitioner estimated a patient population of 1700, 90% of which were Medicare patients. CMS Ex. 10, at 2; CMS Ex. 13, at 2. After the March 16, 2011 site visit, in the spring and summer of 2011, Petitioner provided a CAP and supporting documentation. P. Exs. 5, 6, 9. During this time period, Petitioner attempted to disclose all additional practice locations to CMS and provide updated supplier enrollment information regarding Petitioner’s enrollment with the Medicare program. P. Exs. 5, 6, 9, 11. On August 31, 2011, CMS determined that Petitioner could not be enrolled in the Medicare program based upon Petitioner’s CAP.

Petitioner does not dispute the facts as recited above and does not argue that Petitioner notified CMS of all additional practice locations or changes to Petitioner’s enrollment information prior to the March 16, 2011 site visit. Instead, Petitioner states that all oversights and failures to provide complete and accurate information were corrected by providing this information to the CMS contractor after the March 16, 2011 site visit, in Petitioner’s attempts to file documentation in support of a CAP. P. Br. at 2-3; P. Ex. 9. Clearly, Petitioner argues that he corrected his noncompliance after CMS issued the notice of revocation, not before, and his attempts to update his Medicare enrollment information were made during the CAP process. *See* P. Br. at 2-4. Thus, it is undisputed that Petitioner failed to provide complete information in a timely fashion and was not in compliance with 42 C.F.R. § 424.510 (d)(2)(i) and 42 C.F.R. § 424.516(d) at the time of the revocation.

I do not have the authority to review CMS’s discretionary act to revoke a supplier’s Medicare status. *Letantia Bussell*, DAB No. 2196, at 13 (2008). I must sustain CMS’s revocation determination if a legitimate basis exists for that determination and where the facts established noncompliance with one or more of the relevant regulations. *1866ICPayday.com,* DAB No. 2289, at 13 (2009). As the Board has stated, “the right to review of CMS’s determination by an ALJ serves to determine whether CMS had the authority to revoke [the supplier’s] Medicare billing privileges, not to substitute the ALJ’s discretion about whether to revoke.” *Bussell*, DAB No. 2196, at 13. Based upon the undisputed facts, I find that CMS has established a legitimate basis for its determination and CMS had the authority to revoke Petitioner after the March 16, 2011 site visit revealed Petitioner’s noncompliance with Medicare regulations. Therefore, the

revocation of Petitioner's Medicare enrollment and billing privileges was authorized. 42 C.F.R. § 424.535(a)(1).

3. Petitioner's CAP is not reviewable in this forum

Petitioner contends that he disclosed all current practice locations, to the best of his knowledge and belief, and made full disclosure of all current facilities where he rendered medical services in his CAP. P. Br. at 2-3. Petitioner also states that all information requested by the CMS contractor in the CAP denial was in fact timely provided by Petitioner to the CMS contractor. P. Br. at 3. Essentially, Petitioner asks me to set aside the revocation because Petitioner eventually identified, to the best of his knowledge, all of Petitioner's practice locations through the CAP process. Petitioner suggests I should review Petitioner's CAP and decide at what time Petitioner corrected Petitioner's deficient compliance. *See* P. Br. at 2-4.

However, I lack the authority to review Petitioner's CAP and the CMS contractor's refusal to reinstate Petitioner's Medicare billing privileges. Revocation of enrollment is a discretionary act by CMS, *see* 42 C.F.R. § 424.535(a), and through the reconsideration process, CMS can decide to exercise its discretion not to revoke a supplier should the circumstances warrant such action. *See* 42 C.F.R. § 498.24. Further, suppliers subject to revocation may submit a CAP and CMS may accept that CAP and reinstate a provider. 42 C.F.R. § 405.809; 42 C.F.R. § 405.874(e) (2011). However, I do not have authority to review CMS's decision to deny a CAP. CAP decisions are not initial determinations subject to appeal under 42 C.F.R. Part 498. 42 C.F.R. § 405.874(e) (2011); *Pepper Hill Nursing & Rehab. Ctr.*, DAB No. 2395, at 9-10 (2011); *DMS Imaging, Inc.*, DAB No. 2313, at 5-10 (2010).

Therefore, I have no authority to decide whether Petitioner corrected his deficiencies through the CAP process. *DMS Imaging, Inc.*, DAB No. 2313, at 8. The undisputed evidence shows that as of March 16, 2011, Petitioner had only notified CMS of one practice location when he had been seeing patients at numerous practice locations. *See* P. Br. at 2-3; P. Exs. 5 and 6. In fact, Petitioner never stated why he disagreed with the revocation, but instead promised to provide updated information regarding his practice locations in the near future. P. Ex. 5, at 3. I have no authority to review CMS's decision to reject Petitioner's CAP based on the subsequent information Petitioner provided to CMS and CMS contractors. My authority is limited to determining whether a basis existed to revoke Petitioner's enrollment in the Medicare program as of the date of the revocation, March 16, 2011.

V. Conclusion

Petitioner has not shown a genuine issue of material fact exists with regard to the basis for Petitioner's revocation. As a result, I must sustain CMS's determination to revoke

Petitioner's Medicare enrollment and billing privileges because the undisputed evidence shows that Petitioner did not supply complete and truthful responses to all information requested on Petitioner's Medicare enrollment application. Therefore, I find CMS acted within its regulatory authority to revoke Petitioner's Medicare enrollment and billing privileges.

/s/

Richard J. Smith
Administrative Law Judge