Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Miller's Merry Manor – Rockport, et al.,

Petitioners,

v.

Centers for Medicare & Medicaid Services.

Docket Nos. C-10-558 through C-10-570

Decision No. CR2228

Date: August 27, 2010

DECISION

For the reasons set forth below, I grant the Centers for Medicare & Medicaid Services' (CMS's) motion for summary judgment (MSJ) in each of these consolidated cases. A complete list of Petitioners, along with the corresponding docket numbers and provider transaction access numbers (PTANs) is appended to this decision. The undisputed evidence establishes that Petitioners were not in compliance with Medicare program requirements, and, as a consequence, CMS has the authority to revoke Petitioners' Medicare supplier PTAN numbers.

I. Applicable Law and Regulations

Section 1834(a)(16)(B) of the Social Security Act (Act), 42 U.S.C. § 1395m(a)(16)(B), states that the Secretary of Health and Human Services (Secretary) "shall not provide for the issuance (or renewal) of a provider number for a supplier of durable medical equipment, for purposes of payment . . . for durable medical equipment furnished by the supplier, unless the supplier provides the Secretary on a continuing basis . . . with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000."

CMS's regulations implement statutory requirements through the "supplier standards" at 42 C.F.R. § 424.57(c) that suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) must meet to maintain Medicare billing privileges. As relevant

here, section 424.57(c) provides:

> (c) *Application certification standards.* The supplier must meet and must certify in its application for billing privileges that it meets and will continue to meet the following standards.
>
> * * * *
>
> (22) All suppliers of DMEPOS and other items and services must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment for those specific products and services. [supplier standard 22]
>
> * * * *
>
> (26) [The supplier m]ust meet the surety bond requirements specified in paragraph (d) of this section. [supplier standard 26]

The surety bond requirements at 42 C.F.R. § 424.57(d) referenced in supplier standard 26 state, as relevant here, that "beginning October 2, 2009, each Medicare-enrolled DMEPOS supplier must meet the requirements of paragraph (d) . . . ." These include maintaining "a bond that is continuous," which "meet[s] the minimum requirements of liability coverage ($50,000)," and provides that "[t]he surety is liable for unpaid claims, CMPs [civil money penalties], or assessments that occur during the term of the bond." 42 C.F.R. § 424.57(d)(1)(ii), (4), (5). "The term of the initial surety bond must be effective on the date that the application is submitted to the NSC [National Supplier Clearinghouse, a Medicare contractor]." 42 C.F.R. § 424.57(d)(2). CMS may at any time require a DMEPOS supplier to show compliance with the surety bond requirement. 42 C.F.R. § 424.57(d)(12).

The regulations provide that failure to submit a surety bond as required is grounds for revocation of a supplier's billing privileges. 42 C.F.R. § 424.57(d)(4)(ii)(B); *see also* 42 C.F.R. § 424.57(d)(11) ("CMS revokes the DMEPOS supplier's billing privileges if an enrolled supplier fails to obtain, file timely, or maintain a surety bond as specified in this subpart and CMS instructions."). Section 1834(a)(20)(F)(i) of the Act imposed the requirement to become accredited by October 1, 2009, implemented by supplier standard 22. The regulations also provide that CMS "will revoke a supplier's billing privileges if it is found not to meet" the supplier standards or other requirements in section 424.57(c). 42 C.F.R. § 424.57(e) (formerly § 424.57(d)).[1]

[1] Paragraph (e) of section 424.57 was previously designated paragraph (d) and was redesignated by the rulemaking that imposed the surety bond requirements at paragraph (d); however, the redesignations have not yet been incorporated into the Code of Federal Regulations. *See* 42 C.F.R. Ch. IV § 424.57, Editorial Note (Oct. 1, 2009). References are to the regulation as redesignated.

A supplier that has had its billing privileges revoked is "barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar. The re-enrollment bar is a minimum of 1 year, but not greater than 3 years depending on the severity of the basis for revocation." 42 C.F.R. § 424.535(c).

II. Background

Petitioners in this appeal consist of 13 DMEPOS suppliers owned by Miller's Health Systems, Inc., d/b/a Miller's Merry Manor (Miller's), operating at 13 locations. NSC revoked the supplier numbers of each location. CMS Exs. 1, at 7 (October 9, 2009 revocation notice in C-10-569); 2, at 7 (October 9, 2009 revocation notice in C-10-565); 3, at 7 (November 9, 2009 revocation notice in C-10-564); 4, at 7 (October 9, 2009 revocation notice in C-10-568); 5, at 7 (October 9, 2009 revocation notice in C-10-566); 6, at 7 (October 9, 2009 revocation notice in C-10-559); 7, at 7 (October 9, 2009 revocation notice in C-10-563); 8, at 7 (November 9, 2009 revocation notice in C-10-558); 9, at 7 (October 9, 2009 revocation notice in C-10-560); 10, at 7 (October 9, 2009 revocation notice in C-10-562); 11, at 7 (November 9, 2009 revocation notice in C-10-561); 12, at 7 (October 9, 2009 revocation notice in C-10-570); and 13, at 7 (October 9, 2009 revocation notice in C-10-567).[2]

By a single letter dated November 6, 2009, Petitioners sought reconsideration of all the revocations, as well as of additional supplier numbers not presently before me. *See*, *e.g.*, CMS Ex. 1, at 5. An NSC hearing officer upheld the revocations in decisions issued over two days. CMS Exs. 1, at 1 (January 15, 2010 reconsideration decision in C-10-569); 2, at 1 (January 15, 2010 reconsideration decision in C-10-565); 3, at 1 (January 15, 2010 reconsideration decision in C-10-564); 4, at 1 (January 14, 2010 reconsideration decision in C-10-568); 5, at 1 (January 14, 2010 reconsideration decision in C-10-566); 6, at 1 (January 14, 2010 reconsideration decision in C-10-559); 7, at 1 (January 14, 2010 reconsideration decision in C-10-563); 8, at 1 (January 15, 2010 reconsideration decision in C-10-558); 9, at 1 (January 15, 2010 reconsideration decision in C-10-560); 10, at 1 (January 15, 2010 reconsideration decision in C-10-562); 11, at 1 (January 14, 2010 reconsideration decision in C-10-561); 12, at 1 (January 15, 2010 reconsideration

[2] CMS Exhibits 1-13 consist of the decisional documents relating to each Petitioner, including each reconsideration decision, acknowledgment, reconsideration request, and revocation notice. CMS organized the exhibits in order of PTANs assigned to the suppliers (rather than by the docket numbers assigned to the cases on appeal). CMS Motion for Summary Judgment and/or Dismissal (MSJ) at 1-2 n.2. Where the corresponding documents in these exhibits are identical or the distinctions are immaterial, I may cite only to a document in CMS Exhibit 1. CMS Exhibit 14 consists of 266 pages of materials submitted by Petitioners. The same material accompanied Petitioners' hearing requests but without consecutive numbering. In order to assist the reader in following the discussion, I cite only to the numbered CMS exhibit for these duplicative submissions.

decision in C-10-570); and 13, at 1 (January 14, 2010 reconsideration decision in C-10-567).

By letter dated March 18, 2010 (HR), Petitioners requested hearings on appeal of the listed reconsideration decisions. The material attached to the hearing request is, as noted, contained in CMS's numbered exhibits, which are admitted without objection. The cases were assigned to me as a member of the Departmental Appeals Board (Board) pursuant to 42 C.F.R. § 498.44. I issued a pre-hearing order (PHO) on March 30, 2010 and ordered the cases consolidated on April 27, 2010 at CMS's request and without objection from Petitioners.

Petitioners failed to respond timely to CMS's MSJ or to a letter sent by fax from this office inquiring as to whether Petitioners intended to submit a response, so I ordered the record closed on July 7, 2010. Thereafter, new counsel appeared for Petitioners and requested an opportunity to file a "very brief response" to CMS's motion, which I permitted. Order Reopening Record at 1 (July 16, 2010). After determining that Petitioners' response (P. Br.), accompanied by an affidavit of Lori Haug, Chief Financial Officer of the Petitioners' parent corporation (Haug Aff.), contained new arguments not reflected in the hearing request, I permitted CMS to file a reply which it did on August 6, 2010 (CMS Br.), accompanied by a declaration of Barry Bromberg, CMS's Project Officer overseeing NSC's enrollment activities (Bromberg Decl.).

CMS objects to the admission of the Haug affidavit based on section 498.56(e) which bars admission of "any new documentary evidence" before the ALJ absent a good cause determination. CMS Br. at 5. CMS argues that I should treat the affidavit as "new documentary evidence," even if testimonial in nature, because it "is also literally a document . . . ." *Id*. CMS suggests that this reading harmonizes section 498.56(e) with section 405.874(c)(3),(5) which requires suppliers to "submit all evidence that they want to be considered" on reconsideration and precludes the supplier from "introducing new evidence at higher levels of the appeals process." CMS Br. at 5-6. CMS goes even further and suggests that the "good cause" exception applies only to documentary evidence whereas all testimonial evidence is completely barred by section 405.874(c)(3),(5). *Id*.

I disagree. To read the requirement that all supportive evidence be submitted on reconsideration as precluding any later testimony would make a mockery of the ALJ hearing process. The fundamental unfairness of CMS's position is highlighted by CMS's proffer of its own witness testimony, illustrating that such a reading would result in hearings in which only one party may offer testimony. The regulations afford no right to an oral hearing during reconsideration or at any time prior to the ALJ hearing phase of the appeal process. Reconsideration is not a hearing and the regulations addressing reconsideration make no provision for convening an oral hearing. While section 405.874 refers to reconsideration being handled by the CMS regional office or "a contractor hearing officer," it has no hearing procedures and nowhere empowers or requires CMS or the contractor to convene an oral hearing, take sworn testimony, preserve an accurate

transcript, or provide for cross-examination. On the contrary, more specific regulations governing reconsideration at subpart B of part 498 (§§ 498.20 - 498.25) state that the reconsideration will be performed based on written submissions. Thus, section 498.24(a) states that, in conducting reconsideration, CMS (or its contractor) receives "*written evidence and statements* that are relevant and material" and "[c]onsiders . . . the evidence considered in making the initial determination, and any other *written* evidence submitted under paragraph (a) . . . ." (Emphasis added). That a hearing officer may, as was apparently done here, have unrecorded oral communication with a petitioner or their representative does not convert the reconsideration process into an oral hearing. As suppliers have no right to an oral hearing on reconsideration, barring testimony offered "for the first time" at the ALJ level would have the absurd effect of denying suppliers the right to oral hearings. In discussing the ALJ hearing process available to providers and suppliers, subpart C of part 498 clearly provides evidentiary hearings at which witnesses may be presented to provide sworn testimony and may be cross examined. CMS points to nothing in the regulatory history evincing any intent that these procedures would not apply to supplier/provider enrollment appeals under part 498. In the absence of clear language to the contrary, I do not read a restriction on new documentary evidence to constitute a bar to testimonial evidence in the context of an ALJ hearing.

The next question is whether, by complying with my order to submit direct examination testimony in written form, Petitioners lost the ability to have that evidence considered in their ALJ-level appeal. I find that they did not. That the testimony may be embodied in a written form is an efficient option for reserving scarce and costly hearing time for confrontation of witnesses whose credibility or accuracy is challenged. I decline to accept the literalism of CMS's argument which would simply result in burdening the entire administrative system by forcing in-person hearings for oral testimony in supplier/provider enrollment cases.

Finally, the two provisions cited by CMS are best reconciled, to the extent reconciliation is required at all, by reading them as precluding appellants from withholding documents at the reconsideration level only to proffer them on appeal unless an ALJ makes a determination that good cause exists for the late submission. The requirement that a petitioner submit all evidence that they wish considered at the reconsideration level cannot reasonably be read to refer to sworn testimony or cross-examination since no provision is made for receipt of such evidence at that level. Based on my analysis, I therefore admit the Haug affidavit.

CMS also argues that Ms. Haug discusses documents which were not mentioned or submitted on reconsideration and that Petitioners "should not be allowed to end-run the limits on new evidence set forth in § 498.56(e) by submitting a declaration that claims the existence and contents of documents when the documents themselves could not be considered." CMS Br. at 6, citing Haug Aff. at ¶¶ 15-16. The documents at issue were never even submitted on appeal but merely proffered as available for some future hearing, nor was any showing of good cause for any eventual late submission offered. I agree that Petitioners may not rely on testimony about the documents after failing to

submit the documents themselves and explain why they could not have been submitted below. I discuss this conclusion further in ruling on the motion for summary judgment.

After receipt of the CMS reply brief, Petitioners asked to respond to the arguments therein and the declaration relating to Medicare law and policy on consolidating supplier numbers. Over CMS's objection, I permitted a 5-page surreply which Petitioners submitted on August 20, 2010 (P. Surreply).

III. Issues

The issues in this case are

> (1) whether CMS is entitled to summary judgment on the ground that the undisputed facts demonstrate that the revocation of Petitioners' Medicare billing privileges was legally authorized;
>
> (2) whether Petitioners' concerns about deactivation of certain supplier numbers are properly before me; and
>
> (3) whether Petitioners' arguments that their multiple supplier numbers should be consolidated into a single number or that past claims which have been "held" should be paid are properly before me.

IV. Applicable Standard

The Board stated the standard for summary judgment as follows.

> 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 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).

V. Findings of Fact, Conclusions of Law, and Discussion

I make findings and conclusions set out below in the bold, italicized headings, each followed by my supporting discussion.

A. CMS was authorized as a matter of law to revoke Petitioners' billing privileges based on undisputed evidence that Petitioners had not obtained surety bonds as required by 42 C.F.R. § 424.57(c)(26) and (d).

Petitioners state that their parent company operates 35 long-term care (LTC) facilities in Indiana which are serviced by its DMEPOS supply operations out of a central location in Warsaw, Indiana, from which enteral/parenteral products and services are delivered to residents in the LTC facilities. P. Br. at 2; Haug Aff. at 1. Miller's obtained DMEPOS supplier numbers many years ago for the LTC facility locations at which it delivered those DMEPOS products and services. *Id*. Petitioners began to pursue revalidation of the supplier numbers in 2007 by submitting "approximately thirty applications, many of which were processed without any further requests for information and some of which were processed successfully after receiving additional information. HR. Petitioners assert that they were told that the remaining numbers "were not reactivated in error" even though the applications were "essentially identical for all locations . . . ." HR.

In seeking reconsideration, Petitioners indicated that they sought only to get the supplier numbers "reactivated so as to be able to process payments, and then inactivated as of September 30, 2009." *See, e.g.*, CMS Ex. 1, at 2. The hearing officer reported that, in writing and in oral presentations, Ms. Haug, on behalf of Petitioners, represented that, on the one hand, "the company was not interested in retaining their supplier numbers after the October 1, 2009 deadline" but only wanted to get reimbursed for services provided prior to that date, and, on the other hand, that once the supplier numbers were reactivated for that prior period, the company "would look at proceeding with the proper documentation being completed for the supplier numbers that may not be accredited." *Id*. The hearing officer found these two positions to be in conflict and, in any case, inconsistent with applicable procedures for revalidation. *Id*.

Similarly, Petitioners assert to me that they "are simply requesting that these numbers be reactivated for the period since inactivation through October 1, 2009" but acknowledge their understanding that "a surety bond and accreditation would be necessary to bill under these numbers after October 1, 2009." HR. In short, Petitioners do not assert that they were in compliance with surety bond requirements at any point. I discuss in the next section Petitioners' contentions about reactivation of their supplier numbers for the pre-October 1, 2009 period. In this section, I consider whether the revocations (all of which took effect 30 days after the issuance of the applicable revocation notice well after October 1, 2009) are authorized as a matter of law based on the undisputed facts.

As noted above, the statute states that the Secretary shall not issue or renew a DMEPOS supplier number "unless the supplier provides the Secretary **on a continuing basis** . . .

with a surety bond . . . ." 42 U.S.C. § 1395m(a)(16)(B) (emphasis added). This requirement for continuous compliance is implemented in the regulations that the Secretary issued. The introductory language of 42 C.F.R. § 424.57(c) states, in pertinent part, "[t]he supplier must meet and must certify in its application for billing privileges that it meets **and will continue to meet**" the supplier standards listed within. (Emphasis added.) Those standards include section 424.57(c)(26) (supplier standard 26), which states that a supplier "[m]ust meet the surety bond requirements specified in paragraph (d) of this section." It follows that a supplier must meet the surety bond requirements specified in paragraph (d) on a continuing basis.

Consistent with this, the preamble to the final rule on appeals of CMS determinations when a provider or supplier fails to meet the requirements for Medicare billing privileges states that CMS believes that "all providers and suppliers must meet and maintain all Federal and State requirements for their provider or supplier type to enroll or maintain their enrollment in the Medicare Program." 73 Fed. Reg. 36,448, 36,452 (June 27, 2008).

The regulation at 42 C.F.R. § 424.535 plainly authorizes CMS to revoke a supplier's Medicare enrollment whenever the supplier fails to maintain compliance with enrollment requirements. Thus, section 424.535 provides:

> **Revocation of enrollment and billing privileges in the Medicare program.**
>
> (a) *Reasons for revocation.* CMS may revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement or supplier agreement for the following reasons:
>
> (1) *Noncompliance.* The provider or 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, and has not submitted a plan of corrective action as outlined in part 488 of this chapter. . . .

It is an enrollment requirement that "[t]he supplier must meet and must certify in its application for billing privileges that it meets and will continue to meet" the supplier standards in 42 C.F.R. § 424.57(c), which includes the surety bond requirement of section 424.57(c)(26). 42 C.F.R. § 424.57(c). 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(e); *1866ICPayday.com*, DAB No. 2289, at 13 (2009) ("[F]ailure to comply with even one supplier standard is a sufficient basis for revoking a supplier's billing privileges.").

Section 424.57(d)(11) further makes abundantly clear the consequences of a failure to obtain a compliant surety bond, as follows:

> CMS revokes the DMEPOS supplier's billing privileges if an enrolled supplier fails to obtain, file timely, or maintain a surety bond as specified in this subpart and CMS instructions. Notwithstanding paragraph (e) of this

> section, the revocation is effective the date the bond lapsed and any payments for items furnished on or after that date must be repaid to CMS by the DMEPOS supplier.

42 C.F.R. § 424.57(d)(11); *see also* 42 C.F.R. § 424.57(c)(26).

The regulatory language is plain. A supplier must comply with 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. Petitioners here make no claim to have complied with the additional requirement of supplier standard 22 to become accredited by October 1, 2009.

I therefore conclude that CMS acted within its regulatory authority to revoke Petitioners' Medicare supplier numbers, because Petitioners were not compliant with the surety bond requirements of 42 C.F.R. § 424.57(c)(26) and (d) by October 2, 2009 and did not voluntarily terminate their enrollments before the requirement went into effect.

Petitioners assert that "Miller's believes that there are numerous facts in dispute in this matter" so that summary judgment should be denied (P. Br. at 7), but the standard for summary judgment is that the non-movant must show that **material** facts are in dispute. The facts that Petitioners refer to are not material. For example, Petitioners assert that Miller's "has never had a compliance problem with CMS (for which the surety bond is intended to protect)" and that it obtained a single accreditation in anticipation of consolidating its supplier numbers. P. Br. at 6 (emphasis in original). The requirements for each supplier enrolled in Medicare to obtain a surety bond and become accredited do not depend on whether that supplier has had past compliance problems nor whether the supplier's number may later be consolidated with that of another enrolled supplier that is accredited. *See infra* for further discussion of the consolidation issue. Similarly, Petitioners allege that CMS has not raised "any concerns regarding Miller's submission of claims for covered Medicare DME . . . ." *Id*. at 4 (emphasis in original). Petitioners' uncontested noncompliance with the accreditation and surety bond requirement is unrelated to whether any concerns have arisen about its claims.

Petitioners also contend that Miller's is suffering "financial hardship" because the "inconsistent processing of enrollment applications" has forced it "to hold and not seek payment for many Medicare claims in excess of $170,000. *Id.* at 7. I cannot address the status of other supplier numbers which have been approved or deactivated and are not before me. To the extent that some unsubmitted claims related to the revoked supplier numbers, the issue before me is whether the revocations are supported by law, not whether Petitioners incurred costs for services performed after revocation. Petitioners do not deny that they had 30 days notice of the impending revocation so it is not clear why Miller's would have provided services thereafter for which they are holding claims. To the extent that Petitioners are seeking equitable relief based on hardship or equitable estoppel based on confusion about its communications with NSC (*see* Haug Aff. passim), this forum cannot offer relief from legal requirements on such grounds. Such arguments

essentially seek estoppel against the federal government, which, if available at all, is presumably unavailable absent "affirmative misconduct," such as fraud. *See, e.g.*, *Pac. Islander Council of Leaders*, DAB No. 2091 (2007); *Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414, 421 (1990). Petitioners allege nothing that could be characterized as affirmative misconduct. Furthermore, I would not find even the basic requirements of estoppel to be present since Petitioners have not shown that they reasonably relied on any misrepresentation in incurring costs which are not reimbursable.

Finally, Petitioners state that Miller's "is prepared to demonstrate at the hearing, that it possessed a surety bond and accreditation which fully covered the Company's DME supplier business which included any locations where the Company delivered products for beneficiary use." P. Br. at 6-7. Petitioners had ample opportunity to proffer evidence of compliant surety bond and accreditation documentation at the reconsideration but did not do so. *See* CMS Ex. 14 (representing Petitioners' entire submission at the reconsideration level in each case).[3] The regulations require that I exclude any documentary evidence not submitted on reconsideration unless good cause exists for the late submission. 42 C.F.R. § 498.56(e). Despite my advising Petitioners of this requirement in my initial order, they offer no explanation for late submission. *See* PHO at 2. Indeed, they still do not proffer the purported evidence now, but merely suggest that they are "prepared" to do so at an eventual hearing even though I instructed Petitioners to submit all proposed exhibits with their exchange and response to the MSJ, and advised them that an in-person hearing would be necessary only if a party requested to cross-examine a witness whose written direct testimony was admitted. PHO at 2-3. Petitioners had no basis to withhold documentary evidence on the assumption that yet another opportunity would be provided to them to produce this documentation. While I draw all reasonably inferences in Petitioners' favor in ruling on CMS's summary judgment motion, I cannot infer a good cause showing that Petitioners fail to even allege.

I conclude that CMS is entitled to summary judgment on the issue properly before me of whether Petitioners' revocations were authorized under the applicable law.

B. Deactivation is not subject to review before me.

The revocation notices sent to Petitioners informed them that NSC was revoking their supplier numbers effective 30 days from the date of the notices. *See, e.g.*, CMS Ex. 1, at 7. They also asked Petitioners to contact NSC immediately if they had timely obtained required accreditation and/or surety bonds or if they had submitted a request for

[3] Ms. Haug avers that Miller's "submitted applications to notify the NSC on our recent accreditation and attainment of the surety bond" but no such application was submitted on appeal. Haug Aff. at 4. Nothing in the Haug affidavit suggests that these documents covered the multiple supplier numbers for different service locations, as opposed to the centralized supplier distribution center. Since Petitioners chose not to provide me or the hearing officer with the actual terms of the surety bond or accreditation documentation, I cannot reasonably infer coverage of the Petitioners' supplier numbers.

voluntary termination of their supplier numbers prior to October 1, 2009. *Id*. Voluntary termination of a supplier number before the accreditation or surety bond requirements went into effect would mean that the supplier was not out of compliance and therefore would not be revoked. *See Sherye Epps d/b/a Sunshine Shoes*, DAB CR2215, at 10 (2010) (citing CMS information letter advising suppliers of option to voluntarily terminate enrollment before new surety bond and accreditation requirements took effect); 74 Fed. Reg. 166, 180 (Jan. 2, 2009) (CMS believed "that some DMEPOS suppliers will make the decision to withdraw from the Medicare program due to the additional costs associated with the surety bond"). Voluntary termination, unlike revocation, carries no re-enrollment bar and therefore such a supplier could re-apply immediately once they achieved compliance. Petitioners do not assert, and the record does not show, that they ever requested voluntary termination despite the statements cited above from the reconsideration decisions and the hearing request to the effect that Petitioners were only seeking retroactive reinstatement in order to submit past claims but was not attempting to meet the accreditation and surety bond requirements until some later point.

Petitioners argue that some of their supplier numbers were deactivated in error and should have been reactivated, as were other supplier numbers. HR. CMS, however, points out that Petitioners themselves submitted a chart showing the action dates for 30 supplier locations for which it sought revalidation. CMS MSJ at 10-11; CMS Ex. 14, at 6-7. Eleven of the 13 supplier numbers that were revoked and are at issue on appeal are listed as having been among those that were reactivated in 2007. CMS Ex. 14, at 6-7. Further, all the supplier numbers at issue in the present case are listed in the chart as active as of June 10, 2009. *Id*.

In their response to CMS's motion, Petitioners do not dispute CMS's reading of the chart as it applies to the numbers at issue. Instead, Petitioners simply state that 22 of the 30 revalidation applications "were ultimately processed to completion and 8 were deactivated by NSC due to an enrollment-related documentation issue . . . ." P. Br. at 4. Petitioners suggest that deactivation amounted to a constructive revocation since NSC would not either consolidate those numbers under a single supplier number (a new contention which I address below) or reactivate them. Petitioners nowhere indicate that any of the deactivated supplier numbers are among those presently before me. I therefore have no jurisdiction to take any action as to those numbers.

In any case, Petitioners are mistaken in equating deactivation and revocation. The actions differ significantly in their consequences. Deactivation, like voluntary termination, does not involve any re-enrollment bar, so that a deactivated supplier number may be reactivated upon submission of whatever information is necessary (as happened with most of the supplier numbers in the chart). *Compare* 42 C.F.R. § 424.535(c) *with* 42 C.F.R. § 424.540(b). Furthermore, suppliers whose numbers are revoked have appeal rights, whereas the only provision to challenge a deactivation permits submission of a rebuttal statement but does not mention any right to reconsideration or to further administrative review. *Compare* 42 C.F.R. § 424.545(a) *with* 42 C.F.R. § 424.545(b); *see also* 42 C.F.R. §§ 405.374, 405.375(c).

C. Petitioners' additional arguments regarding consolidation of their multiple supplier numbers and about payment for past services are not properly before me.

In responding to CMS's motion, Petitioners suggest that neither the deactivations nor the revocations that affected its multiple supplier numbers would have happened if "the entire Miller's Part B supplier business would have been consolidated into a single Medicare Part B supplier number." P. Br. at 1-2. Petitioners contend that this approach would have been appropriate because Miller's DMEPOS operations are provided to patients in its 35 LTC facilities but are run by a "single, centralized company under a single corporate tax ID . . . ." *Id.* at 2. According to Petitioners, no one at Miller's or NSC apparently knows why Miller's received 30 separate supplier numbers when it enrolled in Medicare more than 22 years ago. *Id*; Haug Aff. at 2.

Petitioners do not dispute that, when they received re-enrollment applications for the 30 separate supplier number, they sought to re-enroll each of them separately. P. Br. at 3. Nor do Petitioners allege that they ever filed an application to enroll as a single supplier.

In fact, Petitioners assert that the idea of consolidating supplier numbers occurred to Ms. Haug only in 2009 when she became aware of the requirement that each supplier submit proof of a compliant surety bond by October 1, 2009. *Id.*; Haug Aff. at 3. Ms. Haug alleges that she then had conversations with accreditation companies and with unnamed NSC representatives that led her to conclude that they "could operate the business under a single Medicare Part B supplier number," whereupon Miller's obtained a single accreditation and surety bond. Haug Aff. at 3-4. She states that they did so based on "the representations from the NSC that we would be able to consolidate our Medicare supplier numbers . . . ." *Id*. at 4. Ms. Haug contends, based on these assertions, that the revocations at issue were "inconsistent with our prior conversations with the NSC . . . ." *Id*.

To begin with, I fail to see the alleged inconsistency. Accepting for purposes of summary judgment that some representative of NSC did indicate that Miller's could enroll a single consolidated supplier number, I still find no representation by Petitioners that Miller's ever filed an application seeking to enroll as a consolidated supplier. Petitioners accuse CMS of failing to understand Miller's business structure, but do not explain why Miller's sought to maintain all 30 supplier numbers and, as late as the hearing request in this case, sought to reactivate those which had been deactivated. *See* P. Br. at 1. Since Petitioners never filed an application for a consolidated number, no such application was ever denied. As mentioned above, appeal rights extend to denials of applications, but Petitioners do not provide any basis for me to review an inchoate dispute prior to any actual application or denial. In short, even assuming NSC would approve consolidation, Petitioners do not show that Miller's could simply proceed as if consolidation had been sought and granted without ever requesting a new consolidated supplier number.

Secondly, I agree with CMS that no initial determination has been made about consolidating Miller's supplier numbers, and therefore I have no basis to reach this issue in the present case. CMS Br. at 3-4. In essence, Petitioners are saying that their supplier numbers should not be revoked because they did not need to have so many numbers to start with. I can find no support for the position that a revocation is improper if the underlying number was superfluous. As I have already pointed out, Petitioners were free to terminate the numbers voluntarily but I see no basis to preclude CMS from revoking them when the supplier standards are not met. I further agree with CMS that no regulation provides authority for me to rule in the first instance on whether supplier numbers should be consolidated. *Id.* at 4 n.4.

CMS also argues on the merits that the multiple supplier numbers reflecting multiple LTC facility locations where the supplies are delivered cannot properly be collapsed into a single consolidated supplier number because a number of supplier standards can only be met and monitored by treating the locations as separate suppliers. CMS Br. at 6-8; Bromberg Decl. passim. Petitioners strongly contest CMS's position as inconsistent with CMS practice and unsupported by Medicare law or policy. P. Surreply at 1. According to Petitioners, all applicable requirements can be met from a centralized location from which supplies are furnished rather than requiring a physical location within each nursing home at which they are delivered to beneficiaries. *Id.* at 2-5. I do not resolve the propriety of consolidating some or all of Miller's various DMEPOS supplier numbers since I have concluded that the question is not properly before me. I disagree with Petitioners that a finding that Medicare law permits a centralized location with a consolidated number would legally moot the present dispute. As I have explained, the permissibility of an alternative arrangement does not mean that CMS cannot revoke the current supplier numbers for those Petitioners that have not complied with applicable supplier standards. Although Petitioners assert that it is "unnecessary if not impossible, in today's Medicare enrollment system, to obtain separate supplier numbers" based on each location serviced, Petitioners do not explain how they then found it possible to do so for 22 years until they were required to comply with accreditation and surety bond standards. *Id*. at 5.

Finally, I note that Petitioners request that I waive "the timely filing limit for the claims involved with these provider numbers that were never processed accurately," on the grounds that some claims are "just past the filing limit" and that Petitioners have been "very diligent about our communication and attempts to get all paperwork in appropriately and in a timely fashion." HR. Petitioners nowhere propose any source of authority for me to waive timely claims limits and the reference to numbers that were "never processed accurately" suggests to me that Petitioners are referring to the deactivated numbers which are not, as I discussed above, before me in this appeal. Petitioners do not indicate whether they have ever made such a request to NSC or CMS. I decline Petitioners' invitation to instruct CMS and NSC to work with them to treat unsubmitted claims as timely. P. Br. at 7.

VI. Conclusion

For the reasons explained above, I grant summary judgment in favor of CMS, and sustain the revocation of Petitioners' Medicare supplier numbers.

/s/
Leslie A. Sussan
Board Member