Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

OC Housecalls, Inc.
Docket No. A-18-23
Decision No. 2893
September 12, 2018

REMAND OF ADMINISTRATIVE LAW JUDGE DECISION

OC Housecalls, Inc., (Petitioner, OC Housecalls) has appealed the October 30, 2017 decision by an administrative law judge (ALJ) sustaining on summary judgment the determination of the Centers for Medicare & Medicaid Services (CMS) to revoke Petitioner's Medicare enrollment and billing privileges. *OC Housecalls, Inc.*, DAB CR4961 (2017) (ALJ Decision). CMS determined that Petitioner had failed to comply with Medicare enrollment and participation requirements after its Medicare Administrative Contractor (MAC), Noridian Healthcare Solutions (Noridian), found Petitioner was no longer operational at its practice location of record and that Petitioner had failed to report a change of practice locations as required by the regulations. The ALJ sustained the revocation determination as to Petitioner's failure to notify CMS of a change in practice locations. However, the ALJ did not sustain CMS's determination that Petitioner was no longer operational at its practice location of record. Instead, the ALJ concluded that Petitioner had failed to satisfy a Medicare enrollment requirement, that being Petitioner's failure to notify CMS and its contractor of Petitioner's correct enrollment information. We have reviewed the administrative record and the arguments of the parties, and we conclude that the ALJ erred when he a) failed to consider whether a basis for revocation existed under 42 C.F.R. § 424.535(a)(5)(i); b) upheld on summary judgment CMS's reconsidered determination as to revocation based on 42 C.F.R. § 424.535(a)(5)(ii), and c) upheld on summary judgment revocation based on subsection 424.535(a)(9) of the regulation. For the reasons we further explain below, we vacate the ALJ Decision and remand this case, pursuant to the regulation at 42 C.F.R. § 498.88(a), for the ALJ to consider whether CMS had a basis under the regulation at 42 C.F.R. § 424.535(a)(5)(i) to revoke Petitioner's Medicare enrollment and billing privileges because Petitioner was no longer operational at its practice location of record.

Legal Background

The Medicare program is administered by CMS, which in turn delegates certain program functions to private contractors. Social Security Act (Act) §§ 1816, 1842, 1874A;[1] 42 C.F.R. § 421.5(b).

The Act provides for CMS to regulate the enrollment of providers and suppliers in the Medicare program. Act § 1866(j)(1)(A). The implementing regulations in 42 C.F.R. Part 424, subpart P[2], set out the enrollment process that CMS uses to establish eligibility for submitting claims to Medicare and to terminate such eligibility.

The enrollment requirements found in the subpart P regulations obligate a provider to submit – and keep current – a CMS-approved "enrollment application"[3] that identifies, among other things, the provider's "practice location." *Id.* §§ 424.502 (definition of "enroll/enrollment"), 424.510(a)(1), 424.510(d), 424.515, 424.516(d). Providers and suppliers must submit "[c]omplete, accurate, and truthful responses to all information requested within each section as applicable to the provider or supplier type." 42 C.F.R. § 424.510(d)(2)(i). To maintain Medicare billing privileges, a provider or supplier must resubmit, via a completed enrollment application, and recertify the accuracy of its enrollment information every 5 years. 42 C.F.R. § 424.515. The requirements for the resubmission, recertification and reverification of enrollment information include the following:

> (a) Submission of the enrollment application and supporting documentation. The provider or supplier must meet the submission, content, signature, verification, operational, inspection, and other requirements outlined in § 424.510.

42 C.F.R. § 424.515(a).

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[1] The current version of the Social Security Act can be found at http://www.socialsecurity.gov/OP_Home/ssact/ssact.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross-reference table for the Act and the United States Code can be found at https://www.ssa.gov/OP_Home/comp2/G-APP-H.html.

[2] We apply the regulations in effect as of the date of the notice of revocation, which in this case was November 14, 2016. The regulation had been revised via Federal Register notice on December 5, 2014. 79 Fed. Reg. 72,500, 72,524 (Dec. 5, 2014).

[3] The term "enrollment application" is defined in the regulations to mean the "CMS-approved paper enrollment application," the CMS-855, or "an electronic Medicare enrollment process approved by OMB [the Office of Management and Budget]." 42 C.F.R. § 424.502. In this instance, Petitioner submitted a paper form CMS-855I (07/11 version) application.

The regulations also require a provider or supplier be "*operational* to furnish Medicare covered items or services." *Id.* §§ 424.510(d)(6), 424.515(a) (italics added). "Operational" means that "the provider or supplier has a qualified physical practice location, is open to the public for the purpose 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." *Id.* § 424.502.

In addition to specifying Medicare's enrollment requirements, the subpart P regulations authorize CMS to take various actions to ensure compliance with those requirements. For example, CMS has the right to perform an "onsite review" or inspection of a provider in order "to verify that the enrollment information submitted to CMS or its agents is accurate and to determine compliance with Medicare enrollment requirements." *Id.* § 424.517(a); *see also id.* §§ 424.510(d)(8), 424.515(c).

Further, CMS may revoke a provider's Medicare enrollment for any of the "reasons" specified in paragraphs one through 14 of section 424.535(a). Relevant here are paragraphs five and nine, which state:

> §424.535 Revocation of enrollment 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:
>
> * * * *
>
> 5) *On-site review*. Upon on-site review or other reliable evidence, CMS determines that the provider or supplier is either of the following:
>
> (i) No longer operational to furnish Medicare-covered items or services.
>
> (ii) Otherwise fails to satisfy any Medicare enrollment requirement.
>
> * * * *
>
> (9) *Failure to report.* The provider or supplier did not comply with the reporting requirements specified in § 424.516(d)(1)(ii) and (iii) of this subpart.

Under subsections 424.516(d)(1)(ii) and (iii) of the regulation, a provider or supplier must report to their Medicare contractor within 30 days any adverse legal action or a change in practice location.

The Board has applied the regulation at 42 C.F.R. 424.535(a)(5)(i) in cases where the supplier's "*practice location of record . . .* was not operational *upon onsite review*." *Care Pro Home Health, Inc.*, DAB No. 2723, at 6 (2016) (citing *Viora Home Health, Inc*., DAB No. 2690, at 13 (2016) (italics in original)). The Board has rejected the argument that a physician supplier is operational for purposes of the regulation if, at the time of an on-site review, the supplier is operational at a location other than its practice location on record with the Medicare contractor.[4] *Jason R. Bailey, M.D., P.A.*, DAB No. 2855, at 9 (2018); *Foot Specialists of Northridge*, DAB No. 2773, at 8-9 (2017) (citing *Care Pro* at 5-6)).

Revocation becomes effective 30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier, except under certain circumstances, such as where "the practice location is determined by CMS or its contractor not to be operational," in which case revocation takes effect "the date that CMS or its contractor determined that the provider or supplier was no longer operational." 42 C.F.R. § 424.535(g).

A supplier's right of appeal is from the reconsidered determination, not the initial determination. 42 C.F.R. § 498.5(l)(2); *see also Benson Ejindu, d/b/a/ Joy Medical Supply*, DAB No. 2572, at 5 (2014).

Case Background[5]

Petitioner OC Housecalls is the corporate entity through which California physician Lynda Adrig, M.D., practices medicine and bills the Medicare program for services she supplies to Medicare beneficiaries. Decl. of Lynda M. Adrig, M.D., at 1-2, ¶ 3-6. In 2004, Dr. Adrig enrolled OC Housecalls in Medicare and listed her home address, 511 Newcastle, Irvine, California, on the enrollment application as its practice location. *Id.* at 2 ¶ 6; P. Ex. 3. In 2013, Noridian notified Dr. Adrig that Petitioner was required to revalidate its enrollment information. *Id.* at 2 ¶ 7. In October 2013, Petitioner submitted a revalidation application, form CMS-855I, to Noridian. CMS Ex. 2 at 4.

Because Petitioner had identified itself as a business entity (listing OC Housecalls as its legal business name) in Section 4A, Petitioner was also required to complete section 4C, as well as other portions of the application, with pertinent information.

[4] However, in *Adora Healthcare Services, Inc.*, DAB No. 2714, at 5 (2016), *recon. denied* DAB Rul. 2017-4 (2017), the Board affirmed the ALJ's decision reversing CMS's revocation determination based on 42 C.F.R. § 535(a)(5)(i), where it was undisputed that CMS failed to allow the home health services supplier 90 days to report a change in practice location prior to conducting a site visit, as the regulation at 42 C.F.R. § 424.516 (e)(2) provides.

[5] The information in this section is drawn from the undisputed facts in the ALJ Decision and in the record before the ALJ.

A Medicare supplier must follow several instructions to fully and accurately complete section 4C of application form CMS-855I, which include:

> **C. Practice location information**
> - If you completed Section 4A, complete Section 4C through Section 17 for your business.
>
> * * * *
>
> - Each practice location must be a specific street address as recorded by the United States Postal Service. Do not report a P.O. Box.
> - If you only render services in patients' homes (house calls), you may supply your home address in this section if you do not have an office. In Section 4H, explain that this address is for administrative purposes only and that all services are rendered in patients' homes.

CMS Ex. 2, at 16. Next, the instructions direct the applicant to list each location where the medical practice sees patients (if the physician or physician's organization sees patients in more than one practice location). *Id*. at 18. Further, the application directs suppliers, if they are changing, adding, or deleting information, to check the applicable box, furnish the effective date, and complete the appropriate fields in the section. *Id*. at 17.

On March 6, 2014, Noridian contacted Petitioner by facsimile seeking further information about Petitioner's practice for the revalidation application. Among the missing information Noridian cited was the practice location information required in section 4C of the application.[6] P. Ex. 2 at 1-2. Petitioner had provided Dr. Adrig's home address as the site where Petitioner stores medical records, and another address later revealed to be a commercial mailbox for OC Housecalls business correspondence, as the address where Petitioner would receive remittances.[7] Decl. of Lynda M. Adrig, M.D., at 3 ¶8; CMS Ex. 2, at 19-20.

In order to provide correct information in response to Noridian's request, Dr. Adrig said, she telephoned Noridian and spoke to G.O., the representative whose name appeared on the fax. Decl. of Lynda M. Adrig, M.D., at 3 ¶10. Dr. Adrig said she told G.O. that OC Housecalls had left section 4C of the application blank because Dr. Adrig had not

[6] Petitioner had listed elsewhere in section 4 the cities or towns where Dr. Adrig saw patients but left blank the practice location requested in section 4C. CMS Ex. 2 at 17-18; ALJ Decision at 8.

[7] In section 4E of the form, Petitioner entered the hand-written address thusly: "3943 Irvine Blvd #233, Irvine, Ca 92602", without indicating that it was a commercial mailbox facility, although the form provided for the use of post office boxes for remittances. *See* CMS Ex. 2 at 19.

changed practice locations and "therefore did not think it was necessary . . . to update that part of the application." *Id*. Dr. Adrig said that G.O. advised her to complete section 4C despite not having changed practice locations since submitting the 2003 enrollment application. *Id*.

The following day, on March 7, 2014, Petitioner faxed several documents responding to Noridian's information requests, including substitute form CMS-855I pages in which Dr. Adrig wrote the address 3943 Irvine Boulevard in the section of the form CMS-855I asking for practice locations. *See id*., at 4 ¶11; CMS Ex. 3, at 8. Subsequently, on March 18, 2014, Dr. Adrig received notice from Noridian that it had approved the revalidation application. Decl. of Lynda M. Adrig, M.D., at 4 ¶12; P. Ex. 3. Noridian sent the notice to 3943 Irvine Boulevard, yet Petitioner did not contact Noridian to ensure that Noridian's records reflected the correct practice location for its business.

Two years later, on March 22, 2016, a CMS inspector attempted to conduct an on-site inspection at the location Petitioner listed in the March 2014 revalidation application, without subsequent correction, as Petitioner's practice location: 3943 Irvine Boulevard. ALJ Decision at 8. The inspector recorded on a "site verification survey form" the attempt to inspect "OC Housecalls, Inc.," at "3943 Irvine BLVD STE 233", and finding the facility type a "Commercial Mailbox" in a building bearing the logo "Postal Annex" on the façade. CMS Ex. 1 at 11-12. Accordingly, the inspector determined that Petitioner did not operate a practice at 3943 Irvine Boulevard at the time of the inspection. ALJ Decision at 8.

On November 14, 2016, Noridian notified Petitioner of its initial determination to revoke Petitioner's Medicare enrollment and billing privileges, pursuant to the regulations at 42 C.F.R. §§ 424.535(a)(5) and (a)(9), effective March 22, 2016. ALJ Decision at 1. On February 21, 2017, CMS denied Petitioner's reconsideration request. CMS Ex. 1, at 1. In denying the reconsideration request, CMS stated:

> Revocation reason: 42 CFR § 424.535(a)(5)
>
> On-Site Review/Other Reliable Evidence that Requirements Not Met
>
> You are no longer operational to furnish Medicare covered items or services. A site visit conducted on March 22, 2016, at 3943 Irvine Blvd Ste. 233, Irvine, CA 92602-2400 confirmed that you are non-operational.
>
> Revocation reason: 42 CFR § 424.535(a)(9)
>
> Failure to Report Changes
>
> You are no longer operational to furnish Medicare covered items or services. A site visit conducted on March 22, 2016, at 3943 Irvine Blvd Ste. 233, Irvine, CA 92602-2400 confirmed that you are non-operational.

> You did not notify the Centers for Medicare & Medicaid Services of this change of practice location as required under 42 CFR § 424.516.
>
> * * * *
>
> Decision: OC Housecalls, Inc. had not provided evidence to show full compliance with the standards for which you were revoked. Therefore, Noridian Healthcare Solutions is not granting you access to the Medicare Trust Fund (by way of issuance) of a Medicare number.

CMS Ex. 1, at 1-2.

Petitioner then filed a request for hearing (RFH) with the ALJ. In its RFH, Petitioner argued, in sum, that Noridian's determination that Petitioner was not operational at its practice location on file with CMS was incorrect because it failed to take into account the nature of the medical practice, and that the revocation was not consistent with Medicare regulations and policy. RFH at 2. In response, CMS submitted a prehearing brief and motion for summary judgment in which it argued that the undisputed facts established that CMS had three bases to revoke Petitioner's Medicare enrollment: 1) Petitioner was not operational at its practice location of record[8]; 2) Petitioner failed to comply with other Medicare enrollment requirements; and 3) Petitioner had failed to notify CMS and Noridian that it moved its practice location. CMS Pre-Hearing Brief and Motion for Summary Judgment (CMS Br. and Mot.) at 6-8.

ALJ Decision

The ALJ sustained the revocation but departed from CMS's reconsidered determination as to the basis under 42 C.F.R. § 424.535(a)(5). The ALJ concluded that the record did not support summary judgment for CMS under subsection 424.535(a)(5)(i), on the basis that Petitioner was not operational at its practice location on file with CMS (in part, because the ALJ found that a dispute of material fact existed over whether Petitioner was operational at a location other than its practice location on file with the CMS contractor). ALJ Decision at 7. The ALJ concluded that summary judgment nonetheless was appropriate on two other bases. *Id*. The ALJ found undisputed evidence supported revocation under subsection 424.535(a)(5)(ii), reasoning that Petitioner failed to comply with Medicare enrollment regulations requiring providers and suppliers to provide accurate enrollment information to CMS and its contractors; and under subsection 424.535(a)(9), reasoning that Petitioner also failed to notify CMS or its contractor of a

[8] We note that, in its Reply to Petitioner's Prehearing Submission and Opposition to CMS's Prehearing Brief and Summary Judgment Motion, CMS counsel specified § 424.535(a)(5)(i) as the first basis for revocation, while the reconsidered determination refers only generally to §424.535(a)(5).

change in enrollment information because Petitioner had listed on its revalidation application a commercial mail drop, rather than its physical location, as its practice location. *Id*. at 6-9. The ALJ also upheld the effective date of revocation CMS had set based on its initial determination that Petitioner was not operational at its practice location on file with CMS. *Id*. at 10-11. This appeal followed.

Standard of Review

Whether summary judgment is appropriate is a legal issue that we address de novo, construing the facts in the light most favorable to Petitioner and giving Petitioner the benefit of all reasonable inferences. *See Livingston Care Ctr*., DAB No. 1871, at 5 (2003), *aff'd, Livingston Care Ctr. v. U.S. Dep't of Health & Human Servs*., 388 F.3d 168, 172-73 (6th Cir. 2004). Summary judgment is appropriate when there is no genuine dispute about a fact or facts material to the outcome of the case and the moving party is entitled to judgment as a matter of law. *Id.*; *Celotex Corp. v Catrett*, 477 U.S. 317, 322-25 (1986). The party moving for summary judgment has the initial burden to demonstrate that there is no genuine issue of material fact for trial and that it is entitled to judgment as a matter of law. *Celotex*, 477 U.S. at 323. If the moving party carries that burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial.'" *Matsushita Elec. Indus. Co., Ltd. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986) (quoting Rule 56(e) of the Federal Rules of Civil Procedure) (italics omitted). The Board's standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. *See Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program*, http://www.hhs.gov/dab/divisions/appellate/guidelines/prosupenrolmen.html.

Discussion

In deciding this appeal, we consider several factors stemming from the way the case below was decided and the way it has been presented to the Board. First we consider Petitioner's appeal of the ALJ's decision upholding revocation under section 424.535(a)(5)(ii) of the regulations, and why the ALJ erred when he failed to consider fully whether evidence in the administrative record supported revocation under subsection 424.535(a)(5)(i). In doing so, we conclude that we must address certain parts of the record not cited by the parties in order to decide this appeal and to decide whether that information provides a basis for reversing or remanding the ALJ Decision. Next we address whether substantial evidence in the record supports the ALJ Decision upholding on summary judgment revocation under section 424.535(a)(9).

We conclude for the reasons stated below that the ALJ erred when he ruled on summary judgment that CMS had legal bases for revocation under subsections 424.535(a)(5)(ii) and 424.535(a)(9). Evidence in the administrative record provides no basis for the ALJ to uphold the revocation under either provision of the regulations; moreover, the ALJ erred when he failed to consider further whether CMS had a basis for revocation under subsection 424.535(a)(5)(i), even if the record did not support summary judgment for CMS. Therefore, we reverse the ALJ Decision upholding revocation based on subsections 424.535(a)(5)(ii) and (a)(9). We remand for the ALJ to decide whether a basis for revocation exists under subsection 424.535(a)(5)(i), the sole remaining basis for revocation set forth in the reconsidered determination.

A. The ALJ erred in declining to consider fully whether revocation was appropriate under 42 C.F.R. § 424.535(a)(5)(i)[9] (based on questioning if Petitioner might be operational elsewhere) while upholding revocation under 42 C.F.R. § 424.535(a)(5)(ii) when CMS's reconsidered determination did not rely on that basis.

1. Any dispute between the parties over whether Petitioner was operational at a location other than its practice location on file with CMS at the time of the site visit was not material to the ALJ's review.

As discussed above, on reconsideration, CMS upheld the contractor's initial revocation determination because Petitioner was "no longer operational to furnish Medicare covered items or services." CMS Ex. 1. CMS explained its reasoning, stating:

> The revocation of OC Housecalls Inc. will be upheld due to the on-site (inspection) being performed at the practice location listed in the enrollment record and the requirement of keeping the Medicare enrollment record updated was not done. The revocation reasons 42 CFR § 424.535(a)(5) and (a)(9) are both valid revocation reasons[.]

[9] We note that CMS did not appeal the ALJ's decision rejecting 42 C.F.R. § 424.535(a)(5)(i) as the basis for revocation. *See* ALJ Decision at 7, 11. However, per the Board's Guidelines, we consider it necessary to address this aspect of the ALJ Decision in order to decide the appeal. We do not conclude that CMS waived the issue because the ALJ resolved the case on summary judgment alone. CMS may reasonably have concluded that, since it prevailed on summary judgment, it was unnecessary to identify error in the ALJ's not granting summary judgment on an additional basis for revocation that was set out in the reconsideration determination. Under these circumstances, we conclude that it is preferable for the ALJ on remand, and with our further guidance as set out in this decision, to take whatever actions are appropriate to develop the record on this issue.

Id. at 2. Although the contractor did not denote subsection 424.535(a)(5)(i) as the specific basis for revocation, it is apparent from the language the contractor quoted that this was the contractor's intention. By using the language "no longer operational to furnish Medicare covered items or services", the contractor quoted verbatim subsection 424.535(a)(5)(i)[10] even if it did not completely cite its alpha-numerical designation. By wording the basis for revocation this way, the contractor's reconsidered determination placed this basis, and not the "failure to satisfy any Medicare enrollment requirement", before the ALJ on appeal. Consequently, CMS argued that subsection 424.535(a)(5)(i) formed a basis for revocation in this case (and did not argue subsection (a)(5)(ii)). *See* CMS Br. and Mot. at 6-8.

The ALJ did not find summary judgment appropriate on whether Petitioner was operational because "[t]here are genuine disputes of material fact related to whether or not Petitioner was operational at *another* location at the time of the on-site review based on the written declaration of" Dr. Adrig and her patients. ALJ Decision at 7 (italics added).[11] The ALJ's reasoning is based on the flawed premise that a Medicare supplier can be "operational," as the term is defined in the regulations at 42 C.F.R. § 424.502, at any location other than its qualified physical practice location(s) on file with CMS (or CMS's contractor) at the time of the site visit. The Board has explained that a Medicare provider or supplier must be operational at its practice location of record upon onsite review, even where the supplier is mobile like Petitioner, or as in the case of a home health agency (HHA), or a mobile independent diagnostic testing facility (IDTF). *See Care Pro*, DAB No. 2723, at 6 (2016) (HHA) (citing *Viora Home Health, Inc.*, DAB No. 2690, at 13 (2016) (HHA)); *Vamet Consulting & Medical Services*, DAB No. 2778, at 7 (2017) (HHA); *AR Testing Corp.*, DAB No. 2679 (2016) (IDTF) ("Accordingly, [Petitioner's practice location of record], not any off-site location or mobile unit at which Petitioner's owner (or anyone else working for Petitioner) happened to be on [the date of the site visit], had to be found operational under section 424.535(a)(5) upon a site visit"). It is no defense that a provider or supplier may be operating elsewhere other than at their qualified physical practice location at the time of onsite review because CMS intended

[10] CMS revised the regulation in 2014 to list this basis for revocation in its own subparagraph, separately from the more general "otherwise fails to satisfy any Medicare enrollment requirement." *See* 79 Fed. Reg, 72,500, 72,524 (Dec. 5, 2014).

[11] We note that CMS argued to the Board mistakenly that the ALJ "ruled in favor of CMS, finding that Appellant was not operational at its listed practice location[.]" CMS Response to Petitioner's Request for Review at 2. Petitioner has argued that this mischaracterization of the ALJ Decision is grounds, at least in part, for reversal of the ALJ Decision. *See* Petitioner's Reply in Support of Request for Appellate Review (Pet. Reply) at 1-2. We address this more fully below in section C of this Decision.

site visits to be unscheduled and unannounced in order to ensure that appropriate standards are being met. *Care Pro* at 6 n. 4 (citing 76 Fed. Reg. 5862, 5870 (Feb. 2, 2011)). The fact that Petitioner may have been supplying services to Medicare beneficiaries from another practice location was immaterial. Only whether Petitioner was "operational" as defined by the regulation was material to the ALJ's review of revocation under subsection 424.535(a)(5)(i). Thus, the ALJ erred when he concluded that a material dispute existed over whether Petitioner was "operational" at a location other than its practice location on record with CMS.

Even if the ALJ concluded that the administrative record did not support summary judgment for CMS on revocation pursuant to subsection 424.535(a)(5)(i) (a conclusion with which we disagree), the ALJ did not further weigh the evidence and decide this issue on the merits. In view of the Board's prior decisions discussing the meaning of "operational" status under the regulation, this issue warranted further scrutiny. As the ALJ stated:

> There is no dispute that 3943 Irvine Boulevard is a commercial mailbox and not a location suitable for a medical practice location. There is no dispute that on March 22, 2016, a CMS inspector conducted an on-site inspection at 3943 Irvine, the location listed in the March 2014 CMS-855I as Petitioner's practice location. Petitioner does not dispute that the inspector determined that Petitioner did not operate a practice at 3943 Irvine at the time of the inspection. There is no dispute that Petitioner operated from the home of Dr. Adrig at 511 Newcastle and she saw patients at their residences. (Internal citations omitted).

ALJ Decision at 8-9.

As we discuss below, the ALJ subsequently upheld revocation under subsection 424.535(a)(5)(ii), a basis not set forth in the contractor's reconsidered determination. We conclude this also constituted legal error.

2. Revocation based on § 424.535(a)(5)(ii) was not at issue before the ALJ.

Petitioner argues on appeal to the Board that the ALJ erred because "the ALJ's Decision is predicated on reasoning not advanced previously by Noridian", an apparent reference to the ALJ analyzing revocation under 42 C.F.R. § 424.535(a)(5)(ii), despite CMS not citing that subsection in its reconsidered determination (and, we note, without affording the parties the opportunity to brief that issue). Pet. Reply at 1. Specifically, Petitioner argues:

> [T]he ALJ Decision was based on a different clause of one of the relevant regulations that Noridian did not [c]ite previously. [Citation omitted.] In effect, rather than deciding that [Petitioner] was not operational or failed to disclose a change of address, the ALJ found that it was appropriate for Noridian to revoke [Petitioner's] billing privileges because [Petitioner] mistakenly listed a correspondence address as a practice location in one section of a revalidation application. [Citation omitted.] That reasoning is different from the grounds [the contractor] gave for originally revoking [Petitioner's] billing privileges. CMS does not specifically address this distinction between Noridian and the ALJ decision in its response and therefore does not disprove [Petitioner's] claim of error with the ALJ's reasoning.

Id. at 2.

The ALJ analyzed CMS's reconsidered determination as applying subsection 424.535(a)(5)(ii), reasoning:

> The regulations grant CMS discretion to revoke enrollment and billing privileges if, upon on-site review or other reliable evidence, CMS determines that a provider or supplier fails to satisfy any Medicare enrollment requirement. 42 C.F.R. § 424.535(a)(5)(ii). In this case, Petitioner concedes that it failed to accurately report its practice location, violating the enrollment requirement of 42 C.F.R. § 424.510(d)(2). Petitioner also violated the Medicare enrollment requirement [of] 42 C.F.R. § 424.516(d)(1)(iii) to report its correct practice location within 30 days of having filed the incorrect information. Accordingly, I conclude Petitioner violated the requirements for maintaining enrollment in Medicare and there is a basis for revocation of Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. §§ 424.535(a)(5)(ii) and (9).

ALJ Decision at 10. However, the reconsidered determination did not specify subsection 424.535(a)(5)(ii) as the basis for revocation. Petitioner's right of appeal derives from the reconsidered determination, not the initial determination. 42 C.F.R. § 498.5(l)(2); *see also Neb Group of Ariz., LLC*, DAB No. 2573, at 7 (2014) (citing *Benson Ejindu, d/b/a/ Joy Medical Supply*, DAB No. 2572, at 5 (2014)). The regulations relating to reconsidered determinations further provide "[i]f the determination is adverse, the notice specifies the conditions or requirements of law or regulations that the affected party fails to meet, and informs the party of its right to a hearing." 42 C.F.R. 498.25(a)(3).

In explaining the contractor's reason for revocation, the reconsidered determination stated that "[y]ou are *no longer operational* to furnish Medicare covered items or services." CMS Ex. 1, at 1 (italics added). Moreover, the reconsidered determination stated the following rationale:

> [A]n on-site visit was performed . . . at 3943 Irvine Blvd., Ste. 233, Irvine, CA 92602, the practice location listed in the enrollment for OC Housecalls Inc. The on-site states that the provider/supplier is not open for business, does not have employees/staff present during the on-site, no customer activity during the on-site, and *the business did not appear to be operational*. As a result of the failed on-site visit, and *the failure to report changes to a valid practice location* a revocation letter was mailed to OC Housecalls Inc. revoking its Medicare billing privileges effective the date the on-site was performed, March 22, 2016.
>
> * * * *
>
> The revocation of OC Housecalls Inc. will be upheld due to the on-site being performed at the practice location listed in the enrollment record and the requirement of keeping the Medicare enrollment record updated was not done."

Id. at 2 (italics added). All of the factors Noridian cites in the reconsidered determination pertain to what the inspector observed about Petitioner's operational status at Petitioner's designated practice location upon on-site review. Noridian's use of the phrases "no longer operational" and "did not appear to be operational" invokes the language of, and evinces the intention to base revocation on, subsection 424.535(a)(5)(i). None of those factors directly referred to Petitioner's failure to accurately report the location on its Form CMS-855I or to revise or correct the documentation it submitted misidentifying its practice location.

While the ALJ found that Noridian provided adequate notice to Petitioner for revocation under subsection 424.535(a)(5)(ii), because the reconsidered determination referenced "the requirement of keeping the Medicare enrollment updated," we disagree. *See* ALJ Decision at 10, n.4. CMS did not individually cite any Medicare enrollment requirements on which a revocation under subsection 424.535(a)(5)(ii) could be based, or provide specific language to support the reasonable inference of such a basis. We conclude that CMS did not articulate subsection 424.535(a)(5)(ii) as a basis for revocation in the

reconsidered determination. Thus, the only issue properly before the ALJ was whether a legal basis existed for revocation of Petitioner's Medicare enrollment and billing privileges pursuant to subsections 424.535(a)(5)(i) and (a)(9), and not subsection 424.535(a)(5)(ii). Accordingly, the ALJ erred when he substituted his judgment as to the basis for revocation for the basis CMS had articulated in its reconsidered determination.

B. Revocation is not appropriate under *42 C.F.R. § 424.535(a)(9) because no evidence establishes that Petitioner failed to comply with the reporting requirements specified in 42 C.F.R. § 424.516(d)(1)(iii).*

A Medicare supplier's enrollment and billing privileges may be revoked pursuant to 42 C.F.R. § 424.535(a)(9) if the supplier fails to report to their Medicare contractor within 30 days a change in practice location, as required under subsections 424.516(d)(1)(iii) of the regulations. The evidence in the administrative record in this case, however, reflects that Petitioner never changed practice locations. It is undisputed that Petitioner originally enrolled in Medicare using Dr. Adrig's residence at 511 Newcastle, in Irvine, as its practice location. Decl. of Lynda M. Adrig, M.D., at 2 ¶ 6. Petitioner concedes that Dr. Adrig mistakenly entered the address of the Postal Annex commercial mailbox site as its practice location on Petitioner's Medicare enrollment revalidation application. Decl. of Lynda M. Adrig, M.D., at 4 ¶11. In his Decision, the ALJ accepted this admission as true for summary judgment purposes. ALJ Decision at 8 ("I accept as true for summary judgment Dr. Adrig's testimony that she listed 3943 Irvine as a practice location in error and she intentionally did not check a box to indicate a change of address for the practice location *because no change had been made*."). (Italics added). The ALJ also accepted the fact that OC Housecalls operated out of Dr. Adrig's home. *Id*. at 9 ("There is no dispute that Petitioner operated from the home of Dr. Adrig at 511 Newcastle and she saw patients at their residences.").

The ALJ reasoned that Petitioner was nonetheless subject to revocation pursuant to section 424.535(a)(9) because:

> Petitioner overlooks that Dr. Adrig admittedly reported incorrect information in March 2014, in violation of her certification that the information in the form filed was correct, and then she failed to change that incorrect information by giving CMS and the MAC notice of the correct information. Whether or not Dr. Adrig changed Petitioner's practice location is not the issue, the issue is whether Dr. Adrig gave CMS and the MAC notice of the changed information regarding Petitioner's practice location.

ALJ Decision at 12. This analysis was in error. Petitioner indeed may not have been in compliance with the other regulatory requirements to enter the correct site of its practice location on its revalidation application. However, CMS did not cite those other regulatory provisions as a basis for revocation. The contractor based the revocation determination on Petitioner's failure to notify CMS or its contractor of *a change in practice location* and CMS's reconsidered determination upheld revocation on that basis (42 C.F.R. § 424.535(a)(9)). Petitioner was entitled to defend against revocation by resenting facts, which it has, and which CMS does not dispute, that Petitioner never changed practice locations. Thus, the ALJ erred when he concluded that the legal issue presented was not "[w]hether . . . Dr. Adrig changed Petitioner's practice location[.]" As discussed above, Petitioner's right of appeal derives from the reconsidered determination, which expressly cited 42 C.F.R. § 424.535(a)(9) as a basis for revocation. Therefore, the correct question for the ALJ to consider was whether Petitioner changed practice locations without notifying CMS as required under the regulation. The evidence in the administrative record does not show that Petitioner changed practice locations. Accordingly, we reverse the ALJ's conclusion upholding revocation on that basis.

C. Petitioner's other arguments provide no further basis for reversal of the ALJ Decision, which we reverse and remand on other grounds.

Petitioner alleges the ALJ also erred in finding that Noridian processed Petitioner's revalidation correctly. Petitioner further argues that the revocation decision is inconsistent with Medicare policy. Pet. Reply at 4. Petitioner also contends that CMS mischaracterized the ALJ's Decision and Petitioner's arguments on appeal. *Id*. at 1-2. All of these arguments are unavailing.

First, the manner in which Noridian processed Petitioner's application is not a basis for appeal to the Board of the ALJ's Decision. The Board has held that the determination whether to revoke is a discretionary determination for CMS, and, if (as here) CMS chooses to proceed with revocation, on appeal, the inquiry for the ALJ and the Board is limited to whether CMS had a lawful basis to revoke. *Bailey* at 18 (citations omitted). The Board does not look behind the reconsidered determination to consider how CMS or its contractor carry out the administrative function of reviewing an enrollment application. Petitioner also argues that CMS policy, as expressed in the Medicare Program Integrity Manual, establishes that Medicare contractors are expected to provide the opportunity for Medicare participants to fix obvious mistakes in enrollment applications. Pet. Reply at 4. CMS policy as expressed through program manuals is not legally binding authority. The regulation at 42 C.F.R. § 424.535(a)(1) provides some

opportunity to correct mistakes in Medicare enrollment applications,[12] but does not require CMS to contact applicants about information included on the enrollment application which the applicant has certified as true, accurate and complete before making site visits.

Even if CMS mischaracterized the ALJ's Decision and Petitioner's arguments, our review is de novo. As such, the Board reviews the entire record and considers all of the arguments advanced on behalf of the parties when considering the Petitioner's request for review. We have addressed in section A of this decision the fact that CMS misstated the ALJ's conclusion as to revocation based on section 42 C.F.R. § 424.535(a)(5)(i); it is this issue upon which we base our decision to remand this case for further consideration of the evidence and arguments of the parties. However, the mere mischaracterization of the ALJ's conclusion, or of an opposing party's argument does not, in this instance, constitute an additional ground for outright reversal of the ALJ Decision in its entirety. These arguments provide no additional basis to reverse the ALJ Decision, and, in view of the foregoing discussion, have no bearing on our decision. The ALJ need not address them further on remand.

D. If, on remand, the ALJ upholds revocation pursuant to section 424.535(a)(5)(i), the effective date of revocation is March 22, 2016.

The effective date of revocation is determined by regulation. "Revocation becomes effective 30 days after CMS or the CMS contractor mails notice of its determination to the . . . supplier, except" under certain circumstances, one of them being where "the practice location is determined by CMS or its contractor not to be operational," in which case revocation takes effect "the date that CMS or its contractor determined that the . . . supplier was no longer operational." *Bailey* at 19 (citing 42 C.F.R. § 424.535(g)). Noridian determined Petitioner was "no longer operational" at 3943 Irvine Boulevard on March 22, 2016. ALJ Decision at 11. Therefore, if, on remand, the ALJ upholds revocation on the basis that Petitioner was found no longer operational upon site visit at its practice location of record, the effective date of revocation of Petitioner's Medicare enrollment and billing privileges will be March 22, 2016.

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[12] § 424.535(a)(1) provides:

> (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 to not be in compliance with the enrollment requirements described in this subpart P 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. The provider or supplier may also be determined not to be in compliance if it has failed to pay any user fees as assessed under part 488 of this chapter.
> (i) CMS may request additional documentation from the provider or supplier to determine compliance if adverse information is received or otherwise found concerning the provider or supplier.

Conclusion

We remand this case to the ALJ to decide whether a lawful basis exists under 42 C.F.R. § 424.535(a)(5)(i) to revoke Petitioner's Medicare enrollment and billing privileges. Before issuing a decision, the ALJ shall give the parties the opportunity to submit further argument on this issue, and to take any reasonable steps not inconsistent with this order.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Christopher S. Randolph
Presiding Board Member