Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Freedom Allied Medical Supply Corp.
(Supplier No. 5768790001),

Petitioner

v.

Centers for Medicare & Medicaid Services.

Docket No. C-10-125

Decision No. CR2118

Date: April 23, 2010

DECISION

I grant summary judgment in favor of the Centers for Medicare and Medicaid Services (CMS) and sustain CMS's determination to revoke the Medicare supplier number of Petitioner, Freedom Allied Medical Supply Corp. (Petitioner).

I. Background

Petitioner was enrolled in the Medicare program as a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). *See* 42 C.F.R. § 424.57. In a letter dated April 9, 2009, the Medicare contractor, Palmetto GBA National Supplier Clearinghouse (contractor), notified Petitioner that its supplier number would be revoked 30 days from the postmark of the letter, pursuant to 42 C.F.R. §§ 405.874, 424.57(d), and 424.535(a)(5)(ii). CMS Ex. 3. The letter stated that a contractor representative (i.e., an inspector) had attempted to conduct an inspection of Petitioner's facility, but the facility had been closed during the posted hours of operation on four separate occasions. In response to the letter, Petitioner submitted a corrective action plan and sought reconsideration. In a reconsideration decision, dated September 28, 2009, the Medicare hearing officer found that Petitioner had failed to provide proof of liability insurance for

the period of July 20, 2008 through July 30, 2009, and affirmed the revocation of Petitioner's supplier number. CMS Ex. 12.

Petitioner requested a hearing before an administrative law judge (ALJ) by letter dated November 9, 2009. I held a prehearing conference by telephone on December 14, 2009. My December 23, 2009 Amended Order Following Prehearing Conference summarizes the discussions held in the conference and contemplated that this case could be resolved by summary disposition on the parties' briefs and documentary exhibits.[1]

CMS filed a Motion for Summary Judgment and proffered twelve proposed exhibits, CMS Exs. 1-12. Petitioner filed a response entitled "Motion for Judgment" (P. Response), accompanied by the proffer of nine proposed exhibits that were marked as P. Exs. 1-7, P. Ex. 7a, and P. Ex. 9. CMS filed a Reply Brief. In the absence of objection from either party, all proffered exhibits have been admitted to the record on which I decide this case. My decision is based on the record before me, which includes the documentary evidence admitted and the parties' pleadings.

II. Controlling Statutes and Regulations

Section 1861(n) of the Social Security Act (Act) defines medical and other health services that are eligible for Medicare reimbursement for DMEPOS suppliers. To receive Medicare payments for items furnished to a Medicare-eligible beneficiary, a DMEPOS supplier must have a supplier number issued by the Secretary of Health and Human Services (Secretary). Act § 1834(j)(1)(A). A supplier may not obtain a supplier number unless it meets the standards prescribed by the Secretary. Act § 1834(j)(1)(B). A prospective DMEPOS supplier must meet all of the standards specified at 42 C.F.R. § 424.57(b) and (c) to be issued supplier billing privileges. Once billing privileges are issued, CMS or the CMS contractor may revoke a supplier's billing privileges for failure to meet all of the standards specified. 42 C.F.R. §§ 424.57(c)(1), (d); 42 C.F.R. § 424.535(a)(1); 42 C.F.R. § 405.874.

Among other requirements, a supplier must permit CMS, or its agents, to conduct on-site inspections to ascertain its compliance with governing regulations. Its location must be accessible during reasonable business hours, and it must maintain a visible sign and post its hours of operation. 42 C.F.R. § 424.57(c)(8).

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[1] Following the prehearing conference, I issued an Order Following Prehearing Conference, dated December 15, 2009. However, because the Order did not contain the correct briefing deadlines, I issued an Amended Order Following Prehearing Conference on December 23, 2009.

A supplier must also have a comprehensive liability insurance policy in place that covers its place of business as well as all customers and employees. Specifically, the supplier must have and maintain:

> a comprehensive liability insurance policy in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. In the case of a supplier that manufactures its own items, this insurance must also cover product liability and completed operations. Failure to maintain required insurance at all times will result in revocation of the supplier's billing privileges retroactive to the date the insurance lapsed.

42 C.F.R. § 424.57(c)(10).

III. Issues, Findings of Fact, and Conclusions of Law

A. Issue

The issue before me in this case is whether Petitioner satisfied the requirements necessary to participate in the Medicare program as a DMEPOS supplier. To do so, an entity or individual must meet the standards set forth in 42 C.F.R. § 424.57(c)(10).

B. Findings of Fact and Conclusions of Law

CMS is entitled to summary judgment because the undisputed facts establish that Petitioner did not satisfy the requirements necessary to participate in the Medicare program as a supplier of services.[2]

In *Senior Rehab. and Skilled Nursing Ctr.*, DAB No. 2300 (2010), the Departmental Appeals Board (Board) stated the standards 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. *Kingsville Nursing and Rehabilitation Center*, DAB No. 2234, at 3 (2009), citing *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986). While the Federal Rules of Civil Procedure (FRCP) are not binding in this administrative appeal, we are guided by those rules and by judicial decisions on summary judgment in determining whether the ALJ properly granted summary judgment. *See Thelma Walley*, DAB No. 1367 (1992) . . . . 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. *Kingsville* at 3, citing *Celotex*, 477 U.S. at 323. If the moving party carries its

[2] I make this one finding of fact/conclusion of law.

> initial burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial.'" *Matsushita Elec. Industrial Co. v. Zenith Radio*, 475 U.S. 574, 587 (1986) (quoting FRCP 56(e)). 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. *Id*. at 586, n.11; *Celotex*, 477 U.S. at 322. 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. *U.S. v. Diebold, Inc.*, 369 U.S. 654, 655 (1962). . . . Whether summary judgment is appropriate is a legal issue that we address de novo. *Lebanon Nursing and Rehabilitation Center*, DAB No. 1918 (2004). In reviewing whether there is a genuine dispute of material fact, we view the proferred evidence in the light most favorable to the non-moving party. *Kingsville* at 4, and cases cited therein.

Senior Rehab., DAB No. 2300 at 3. The Board has also noted that 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 engage in assessing credibility or evaluating the weight of conflicting evidence. *Holy Cross Vill. at Notre Dame*, DAB No. 2291 at 4-5 (2009).

I find that summary judgment is appropriate because there are no material facts in dispute, and because this case turns entirely on questions of law. I conclude that CMS's position is correct as a matter of law.

Here, the basic and dispositive facts are not in dispute. Petitioner was a DMEPOS supplier that participated in the Medicare program. Its posted hours of operation were 9:00 a.m. to 5:00 p.m. Monday through Friday, and 10:00 a.m. to 2:00 p.m. on Saturday. CMS Ex. 1 at 3. On October 22, 2008, a site inspector from the contractor's Supplier Audit and Compliance Unit attempted to inspect Petitioner's facility but found the facility closed during posted hours of operation, with the shutters up and the door locked. There was no answer when the inspector rang the doorbell and knocked repeatedly. *Id.* at 1-2. On October 27, 2008, the inspector made a second attempt to inspect Petitioner's facility. Again, the facility was closed. *Id.* The inspector returned to the facility two more times during posted hours of operation on December 30, 2008, and January 5, 2009. CMS Ex. 2 at 1-2. On both these succeeding occasions, the facility was closed, and no one responded to his knocks. *Id*.

In a letter dated April 9, 2009, the contractor notified Petitioner that because an inspection of its facility could not be completed, it concluded that Petitioner was not operational. Therefore, the contractor revoked Petitioner's supplier number, effective 30 days from the postmark of the letter. CMS Ex. 3. The letter advised Petitioner that it had the right to appeal the revocation decision within 60 days of the letter's postmark and/or

submit a corrective action plan within 30 days of the letter's postmark. *Id*. On May 28, 2009, Petitioner sent a letter to the contractor "requesting for [sic] a corrective action plan or hearing," accompanied by copies of letters showing that one employee had been terminated, and another employee had been hired. CMS Ex. 4.

On June 15, 2009, the inspector made a fifth attempt to inspect Petitioner's facility. However, again, the door was locked, and no one answered the doorbell. CMS Ex. 5 at 1-2. The inspector returned to the premises the next day, June 16, 2009, and Petitioner's representative, Ambrose Ezemma, answered the doorbell after about ten minutes. CMS Ex. 5 at 2. The inspector was able to conduct an on-site inspection, during which he asked Mr. Ezemma for proof of insurance coverage. Mr. Ezemma provided the inspector with a copy of Petitioner's certificate of liability insurance from Nationwide Mutual Insurance Company. The certificate listed the policy effective date as July 20, 2006, and the policy expiration date as July 20, 2007. CMS Ex. 5 at 8. Mr. Ezemma agreed to provide the contractor with additional documentation within two business days, including proof of a comprehensive liability insurance policy and/or "the Certificate of Insurance showing [the contractor] as the certificate holder." CMS Ex. 5 at 10.

By facsimile, dated June 30, 2009, the contractor informed Mr. Ezemma that Petitioner's corrective action plan was being processed and advised Mr. Ezemma that he still needed to submit a certificate of insurance that listed the contractor as a certificate holder. The facsimile stated — as I have noted above — that the insurance certificate on file with the contractor had expired on July 20, 2007. CMS Ex. 6 at 1.

On June 26, 2009, Mr. Ezemma submitted a completed Medicare Enrollment Application (form CMS-855S), which the contractor received on July 10, 2009, in which Mr. Ezemma requested a voluntary termination of Petitioner's enrollment in the Medicare program effective August 15, 2009. CMS Ex. 7 at 4, 15, 32.

By letter, dated July 30, 2009, the contractor informed Petitioner that it had received its request for a corrective action plan and reconsideration. CMS Ex. 8. The letter advised Petitioner further that it was "unable to reinstate/issue [its] DMEPOS billing number," because the information submitted did not establish that Petitioner was in compliance with all failed standards. The letter stated that Petitioner's reconsideration request had been forwarded to a Medicare hearing officer for review. *Id*.

On July 31, 2009, Mr. Ezemma faxed to the contractor a copy of a certificate of insurance from Nationwide Mutual Fire Insurance Co. that listed the policy's effective date as July 31, 2009 and the policy's expiration date as July 31, 2010. CMS Ex. 9.

The contractor notified Mr. Ezemma on August 10, 2009, via facsimile, that Petitioner's corrective action plan and reconsideration request were being processed and that Petitioner still needed to provide a "Certificate of Insurance with [the contractor] (and

address) listed as a certificate holder for the periods of July 21, 2007- July 21, 2008 and July 22, 2008 – July 30, 2009." CMS Ex. 10.

On August 11, 2009, Mr. Ezemma faxed to the contractor two certificates of insurance from Nationwide Mutual Insurance Company. One certificate that covered the period July 20, 2006 through July 20, 2007, and another certificate covered the period July 31, 2009 through July 31, 2010 (he had previously provided this latter certificate to the contractor). Mr. Ezemma also faxed a policy declaration from the insurance company indicating coverage for the period July 20, 2007 to July 20, 2008. CMS Ex. 11.

A Medicare hearing officer issued a reconsideration decision, dated September 28, 2009. CMS Ex. 12. The Medicare hearing officer recited the inspector's five unsuccessful attempts to inspect Petitioner's facility, stated that the contractor had revoked Petitioner's supplier number on May 9, 2009, for noncompliance with Medicare Supplier Standards, and noted that, on July 30, 2009, the contractor upheld the revocation of Petitioner's supplier number for noncompliance with Medicare Supplier Standard #10 (42 C.F.R. § 424.57(c)(10)), which requires a supplier to have a comprehensive liability insurance policy in place that covers its place of business as well as all customers and employees. In explaining the rationale for the decision, the Medicare hearing officer described the contractor's requests in June and August 2009 for proof of up-to-date insurance from Petitioner and noted what documents Petitioner had furnished in response. The Medicare hearing officer found that Petitioner had failed to provide any documentation "to verify that insurance was up-to-date and in place for the July 20, 2008 – July 30, 2009 time frame." CMS Ex. 12 at 2.

Petitioner asserts that it maintained a comprehensive liability insurance policy of at least $300,000 but acknowledges that a "lag" occurred in its insurance coverage because of "communications issues" with its insurance company, Nationwide Mutual Insurance. P. Response at 2. Petitioner claims that because of a change of its insurance agent, the premiums it paid for its business liability policy were incorrectly applied to its auto insurance policy. Petitioner admits that it was unaware that its liability insurance policy was "ineffective" until the on-site inspection occurred. *Id.* Petitioner asserts that it renewed its policy immediately.

Petitioner notes further that, because of the "bad economy," it submitted an application to voluntarily terminate its enrollment in the Medicare program, effective August 15, 2009. However, the application was returned, and it was "directed to do a [corrective action plan]." P. Response at 1. Petitioner states that it operated the business from July 2006 through August 2009, when "the business was shut down." *Id*. at 2. In this context of summary judgment analysis, I accept as true Petitioner's assertions that it did have a liability insurance policy in place and that the lapse in insurance coverage was due to premiums being credited to the wrong account. I also accept that Petitioner's business closed in August 2009.

Although Petitioner's request for hearing stated that the facts set forth in the September 28, 2009 reconsideration decision are "not accurate," Petitioner has not disputed any of the facts set forth in CMS's briefs. The record shows that, at the time of the June 16, 2009 on-site inspection, Petitioner produced an expired certificate of insurance and failed to provide proof of current comprehensive liability insurance coverage for its business, customers, and employees. Following the inspection, in response to the contractor's specific requests for proof of insurance coverage, Petitioner was only able to provide certificates of insurance and/or a policy declaration covering the following periods: July 20, 2006 to July 20, 2007; July 20, 2007 to July 20, 2008; and July 31, 2009 to July 31, 2010. The contractor specifically requested that Petitioner provide a certificate of insurance with the contractor listed as a certificate holder for the time period "July 22, 2008 – July 30, 2009." CMS Ex. 10. However, Petitioner failed to provide any proof that it had an active comprehensive liability insurance policy for the period July 20, 2008 to July 30, 2009.

By its own admission, Petitioner did not have a valid comprehensive liability insurance policy in effect at the time of the June 16, 2009 on-site inspection. Petitioner acknowledges that it was unaware of any lapse in its insurance coverage, until the inspector inquired about its insurance policy, but then took immediate steps to renew its policy. Petitioner has made no attempt to show that it had a valid insurance policy in effect at the time of the June 16, 2009 on-site inspection.

Petitioner's claim that its failure to maintain an active liability insurance policy was due to a miscommunication with its insurance company is irrelevant. To the extent that Petitioner may be seeking relief on equitable grounds, it is beyond my authority to consider or grant such relief. *See Oklahoma Heart Hosp.*, DAB No. 2183 (2008); *Community Hosp. of Long Beach*, DAB No. 1938 (2004). Further, the fact that Petitioner submitted an application requesting voluntary termination of its enrollment in the Medicare program, effective August 15, 2009, has no bearing on my analysis. On the date its facility was inspected, June 16, 2009, Petitioner was enrolled in the Medicare program as a DMEPOS supplier, and, as such, was required to be in compliance with all of the standards set forth in 42 C.F.R. § 424.57(c).

Based on these facts, I find that Petitioner failed to maintain a comprehensive liability insurance policy of at least $300,000 covering its place of business, as well as all customers and employees, at all times, and was therefore out of compliance with the standard set forth in 42 C.F.R. § 424.57(c)(10). CMS therefore properly revoked its billing privileges. 42 C.F.R. § 424.57(d).

IV. Conclusion

Because the undisputed facts establish that Petitioner violated 42 C.F.R. § 424.57(c)(10), I grant CMS's motion for summary judgment and sustain the revocation of Petitioner's supplier number.

/s/
Richard J. Smith
Administrative Law Judge