Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

PSI Premier Specialties, Inc. d/b/a Medical Express PSI,
(Supplier No. 0653700001;
NPI No. 1831101848)

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-13-397

Decision No. CR2833

Date: June 18, 2013

DECISION

The Medicare enrollment and billing privileges of Petitioner, PSI Premier Specialties Inc. d/b/a Medical Express PSI (Supplier No. 0653700001; NPI No. 1831101848), are revoked pursuant to 42 C.F.R. § 424.535(a)(1)[1], effective September 2, 2012, for noncompliance with 42 C.F.R. §§ 424.57(c)(1), (2), and (22).

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[1] References are to the 2011 revision of the Code of Federal Regulations (C.F.R.), unless otherwise indicated.

I. Background

The Supplier Audit and Compliance Unit of the National Supplier Clearinghouse,[2] operated by Palmetto GBA (Palmetto), a Medicare contractor to the Centers for Medicare and Medicaid Services (CMS), notified Petitioner by letter dated August 3, 2012, that Petitioner's Medicare DMEPOS supplier number[3] was being revoked effective 30 days from the postmark of the August 3, 2012 letter. Palmetto advised Petitioner that its supplier number was being revoked for noncompliance with 42 C.F.R. § 424.57(c)(1) based on a violation of 42 C.F.R. § 424.57(b)(1); 42 C.F.R. § 424.57(c)(2); and 42 C.F.R. § 424.57(c)(22). CMS Exhibit (CMS Ex.) 2.

Palmetto notified Petitioner by letter dated September 19, 2012, that Petitioner's Corrective Action Plan was insufficient to permit reinstatement of Petitioner's billing number due to continued noncompliance with 42 C.F.R. § 424.57(c)(1), (2), and (22). CMS Exs. 3, 4. Petitioner requested reconsideration on October 1, 2012. The reconsideration decision dated December 10, 2012, upheld the revocation of Petitioner's billing privileges because Petitioner failed to show that it was in compliance with 42 C.F.R. § 424.57(c)(1), (2), and (22). CMS Ex. 1.

Petitioner timely filed a request for a hearing (RFH) before an administrative law judge (ALJ) on February 5, 2013. On February 8, 2013, the case was assigned to me for hearing and decision and an Acknowledgement and Prehearing Order (Prehearing Order) was issued at my direction. CMS filed a "Prehearing Brief and Motion for Summary Judgment" (CMS Br.) with CMS Exs. 1 through 9 on March 8, 2013. Petitioner filed a "Prehearing Brief and Response to Motion for Summary Judgment" (P. Br.) with no

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[2] The National Supplier Clearinghouse is the contractor responsible for enrollment and re-enrollment of Durable Medical Equipment, Orthotics, Prosthetics, and Supplies (DMEPOS) suppliers. 42 C.F.R. § 424.57(a).

[3] Palmetto referred to revocation of Petitioner's "supplier number," also known as a "billing number," but it is the revocation of Petitioner's billing privileges associated with its billing number that is at issue. A DMEPOS supplier must have a supplier number, which conveys billing privileges, in order to be paid by Medicare for the delivery of a Medicare-covered item to a Medicare eligible beneficiary. 42 C.F.R. § 424.57(b)(2). Revocation of a DMEPOS supplier's billing or supplier number is revocation of the supplier's billing privileges and ends the supplier's participation in Medicare until such time as the supplier can again qualify to participate. 42 C.F.R. §§ 424.57(d); 424.502; 424.535(a) and (c).

exhibits on April 8, 2013. CMS filed a Reply Brief (CMS Reply) on April 24, 2012 with CMS Ex. 10. Petitioner did not object to my consideration of any of CMS's proposed exhibits and CMS Exs. 1 through 10 are admitted and considered as evidence.

II. Discussion

A. Statutory and Regulatory Program Requirements

Section 1831 of the Social Security Act (the Act) (42 U.S.C. § 1395j) establishes the supplementary medical insurance benefits program for the aged and disabled known as Medicare Part B. Administration of the Part B program is through contractors such as Palmetto. Act § 1842(a) (42 U.S.C. § 1395u(a)). Payment under the program for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of services and suppliers.[4] Act §§ 1835(a) (42 U.S.C. § 1395n(a)), 1842(h)(1) (42 U.S.C. § 1395u(h)(1)). Petitioner is a DMEPOS supplier.

The Act requires the Secretary of Health and Human Services (Secretary) to issue regulations that establish a process for the enrollment in Medicare of providers and suppliers, including the right to a hearing and judicial review of certain enrollment determinations such as revocation of enrollment and billing privileges. Act § 1866(j) (42 U.S.C. § 1395cc(j)).

Pursuant to 42 C.F.R. §§ 424.57 and 424.505, a DMEPOS supplier such as Petitioner must be enrolled in the Medicare program to be reimbursed for DME or POS sold or rented to Medicare beneficiaries. Participation in Medicare imposes obligations upon a supplier. Suppliers must submit complete, accurate and truthful responses to all information requested in the enrollment application. 42 C.F.R. § 424.510(d)(2). Pursuant to 42 C.F.R.

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[4] A "supplier" furnishes services under Medicare and includes physicians or other practitioners and facilities that are not included within the definition of the phrase "provider of services." Act § 1861(d) (42 U.S.C. § 1395x(d)). A "provider of services," commonly shortened to "provider," includes hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, hospice programs, and a fund as described in sections 1814(g) (42 U.S.C. § 1395f(g)) and 1835(e) (42 U.S.C. § 1395n(e)) of the Act. Act § 1861(u) (42 U.S.C. § 1395x(u)). The distinction between providers and suppliers is important because they are treated differently under the Act for some purposes. A DMEPOS supplier generally sells or rents durable medical equipment (DME), prosthetics orthotics, or supplies (POS) as defined by section 1861(n) of the Act. 42 C.F.R. § 424.57(a).

§§ 424.502 and 424.510(d)(3), a supplier's application to enroll in Medicare must be signed by an authorized official, i.e., one with authority to bind the provider or supplier both legally and financially. The regulation provides that the signature attests to the accuracy of information provided in the application. The signature also attests to the fact that the provider or supplier is aware of and abides by all applicable statutes, regulations, and program instructions. 42 C.F.R. § 424.510(d)(3). DMEPOS suppliers have additional conditions imposed by 42 C.F.R. § 424.54(b) to be eligible for payment from Medicare for DMEPOS provided to Medicare-eligible beneficiaries: (1) the supplier must have submitted a completed applications and enrollment forms for each separate physical location it uses to furnish DMEPOS except those used solely as warehouses or repair facilities; (2) the DMEPOS item for which reimbursement is sought must have been furnished to the Medicare beneficiary on or after the date CMS granted the supplier billing privileges as reflected by the supplier number, with one supplier number issued for each of the supplier's locations; (3) billing privileges must not have been revoked and the supplier not excluded from Medicare during the period when the DMEPOS item was furnished; (4) the supplier has a state issued license to dispense drugs if the DMEPOS requires administration of a drug; and (5) the supplier provides CMS all information and documents necessary to process the claim. A DMEPOS supplier must also meet at the time of application and continue to meet thereafter the 30 supplier certification standards established by 42 C.F.R. § 424.57(c). Once enrolled, the supplier receives billing privileges and is issued the billing or supplier number that is required to receive payment for DMEPOS furnished to a Medicare beneficiary. There is no issue in this case that Petitioner was enrolled in Medicare as a DMEPOS supplier.

The Secretary has delegated authority to CMS or its Medicare contractor to revoke an enrolled provider or supplier's Medicare enrollment and billing privileges and any provider or supplier agreement for any of the reasons listed in 42 C.F.R. § 424.535. Noncompliance with enrollment requirements, such as those established by 42 C.F.R. § 424.57 for DMEPOS suppliers, is a basis for revocation of billing privileges and enrollment in Medicare. 42 C.F.R. § 424.535(a)(1).

A provider or supplier that has been denied enrollment or whose enrollment and billing privileges have been revoked has a right to request a hearing by an ALJ and further review by the Departmental Appeals Board (Board). 42 C.F.R. §§ 424.545, 498.3(b)(17), 498.5. A hearing on the record, also known as an oral hearing, is required under the Act. *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743, 748-751 (6th Cir. 2004). The provider or supplier bears the burden to demonstrate that it meets enrollment requirements with documents and records. 42 C.F.R. § 424.545(c).

B. Issues

Whether summary judgment is appropriate;

Whether there was a basis for revocation of Petitioner's billing privileges and enrollment in Medicare.

C. Findings of Fact, Conclusions of Law, and Analysis

My conclusions of law are set forth in bold text followed by my findings of fact and analysis.

1. Summary judgment is appropriate.

A provider or supplier denied enrollment in Medicare or whose enrollment had been revoked has a right to a hearing and judicial review pursuant to section 1866(h)(1) and (j) of the Act and 42 C.F.R. §§ 424.454(a), 498.3(b)(1), (5), (6), (8), (15), (17), 498.5. A hearing on the record, also known as an oral hearing, is required under the Act. Act §§ 205(b), 1866 (h)(1) and (j); *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743, 748-51. A party may waive appearance at an oral hearing, but must do so affirmatively in writing. 42 C.F.R. § 498.66. In this case, Petitioner has not waived the right to oral hearing or otherwise consented to decision based only upon the documentary evidence or pleadings. Accordingly, disposition on the written record alone is not permissible, unless the CMS motion for summary judgment has merit.

Summary judgment is not automatic upon request but is limited to certain specific conditions. The procedures established by 42 C.F.R. pt. 498 do not include a summary judgment procedure. However, appellate panels of the Board have long recognized the availability of summary judgment cases subject to 42 C.F.R. pt. 498, and the Board's interpretative rule has been recognized by the federal courts. *See, e.g.*, *Crestview*, 373 F.3d at 749-50. Furthermore, a summary judgment procedure was adopted as a matter of judicial economy within my authority to regulate the course of proceedings and made available to the parties in the litigation of this case by my Prehearing Order.

Summary judgment is appropriate and no hearing is required where either: there are no disputed issues of material fact and the only questions that must be decided involve application of law to the undisputed facts; or, the moving party must prevail as a matter of law even if all disputed facts are resolved in favor of the party against whom the motion is made. The Board follows the general approach of the federal courts in evaluating whether or not summary judgment in lieu of a hearing is appropriate. The movant bears the initial burden of demonstrating that there are no genuine issues of material fact for trial and that the movant is entitled to judgment as a matter of law. When confronted with a properly supported motion for summary judgment, the

nonmoving party "may not rest upon the mere allegations or denials of his pleading, but . . . must set forth specific facts showing that there is a genuine issue for trial." *Anderson v. Liberty Lobby, Inc*., 477 U.S. 242, 248 (1986) (quoting *First Nat'l Bank of Az. v. Cities Serv. Co.*, 391 U.S. 253, 249 (1968)); *see also* Fed. R. Civ. P. 56(c); *Venetian Gardens*, DAB No. 2286, at 10-11 (2009); *Ill. Knights Templar Home*, DAB No. 2274, at 3-4 (2009); *Garden City Med. Clinic*, DAB No. 1763 (2001), *Everett Rehab. & Med. Ctr.*, DAB No. 1628, at 3 (1997) (in-person hearing required where nonmovant shows there are material facts in dispute that require testimony); *Big Bend Hosp. Corp., d/b/a Big Bend Hosp. Ctr.*, DAB No. 1814, at 13 (2002) (in some cases, any factual issue is resolved on the face of the written record because the proffered testimony, even if accepted as true, would not make a difference).

In opposing a motion for summary judgment, the nonmovant bears the burden of showing that there are material facts that are disputed either affecting the movant's prima facie case or that might establish a defense. It is insufficient for the nonmovant to rely upon mere allegations or denials to defeat the motion and proceed to hearing. The nonmovant must, by affidavits or other evidence that sets forth specific facts, show that there is a genuine issue for trial. If the nonmovant cannot show by some credible evidence that there exists some genuine issue for trial, then summary judgment is appropriate and the movant prevails as a matter of law. *Anderson*, 477 U.S. at 247. A test for whether an issue is regarded as genuine is if "the evidence [as to that issue] is such that a reasonable jury could return a verdict for the nonmoving party." *Id.* at 248. In evaluating whether there is a genuine issue as to a material fact, an ALJ must view the facts and the inferences to be drawn from the facts in the light most favorable to the nonmoving party. *Pollock v. Am. Tel. & Tel. Long Lines*, 794 F.2d 860, 864 (3rd Cir. 1986).

The standard for deciding a case on summary judgment and an ALJ's decision-making in deciding a summary judgment motion differs from resolving a case after a hearing. On summary judgment, the ALJ does not make credibility determinations, weigh the evidence, or decide which inferences to draw from the evidence, as would be done when finding facts after a hearing on the record. Rather, on summary judgment the ALJ construes the evidence in a light most favorable to the non-movant and avoids deciding which version of the facts is more likely true. *Holy Cross Vill. at Notre Dame, Inc*, DAB No. 2291, at 5 (2009). The Board also has recognized that on summary judgment it is appropriate for the ALJ to consider whether a rational trier of fact could find that a party's evidence, i.e., the movant's evidence, would be sufficient to meet that party's evidentiary burden. *Dumas Nursing and Rehab., L.P.*, DAB No. 2347, at 5 (2010); *Ill. Knights Templar Home*, DAB No. 2274, at 8.

In deciding that summary judgment is appropriate in this case, I note that Petitioner offered no affidavit or declaration in support of its opposition to the motion for summary judgment. Furthermore, Petitioner advised me by its prehearing exchange filed on

April 8, 2013, that it intended to offer at hearing no documentary evidence and only one witness, Ed Stevens, who signed Petitioner's Corrective Action Plan, which is offered as evidence by CMS and is discussed in significant detail hereafter. I conclude, as discussed hereafter, that the material facts in this case are not in dispute and there is no genuine dispute as to any material fact that requires a trial. The issues in this case that require resolution are issues of law related to the interpretation and application of the regulations that govern enrollment and billing privileges in the Medicare program and application of the law to the undisputed facts of this case. The issues in this case must be resolved against Petitioner as a matter of law as discussed hereafter. Accordingly, I conclude summary judgment is appropriate and the decision on summary judgment is dispositive of all issues in this case obviating the need of a hearing.

2. Petitioner has not shown that it was in compliance with 42 C.F.R. § 424.57(c)(1) (Supplier Standard 1[5]).

3. There is a basis for revocation of Petitioner's billing privileges pursuant 42 C.F.R. § 424.535(a)(1).

Supplier Standard 1 requires that suppliers comply with federal regulatory requirements; state licensing and regulatory requirements; and local zoning requirements. 42 C.F.R. § 424.57(c)(1). The applicable federal regulations require that a DMEPOS "supplier must enroll separate physical locations it uses to furnish Medicare covered DMEPOS, with the exception of locations it uses solely as warehouses or repair facilities." 42 C.F.R. § 424.57(b)(1).

The parties were advised by my Prehearing Order § IIC that the issue before me is:

> Whether Petitioner met the requirements for participation in Medicare when the reconsideration decision was made. 73 Fed. Reg. 36,448, 36,452 (June 27, 2008).

The formulation of the issue is based on the discussion in the Federal Register of the scope of review available to a provider or supplier whose Medicare enrollment is denied or revoked. The pertinent discussion is as follows:

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[5] The regulation uses the phrase "application certification standards" rather than "supplier standards." 42 C.F.R. § 424.57(c). CMS uses the phrase "supplier standards" in its Medicare Program Integrity Manual, CMS pub. 100-08, § 15.24.9 (rev. 463, May 17, 2013). "Supplier Standard" as used in this decision refers to the 30 standards listed in 42 C.F.R. § 57(c).

> When a Medicare contractor makes an adverse enrollment determination (for example, enrollment denial or revocation of billing privileges), providers and suppliers are afforded appeal rights. **However, these appeal rights are limited to provider or supplier eligibility at the time the Medicare contractor made the adverse determination.** Thus, if a Medicare contractor determines that a provider or supplier does not meet State licensure requirements on June 1, 2007, it is the provider's responsibility to demonstrate during the appeals process that State licensure requirements were met on June 1, 2007. Conversely, if a provider only can demonstrate that State licensure requirements were met on a later date; such as, August 16, 2007, we believe that the contractor made the correct determination, and that the provider or supplier may reapply for Medicare billing privileges. Accordingly, a provider or supplier is required to furnish the evidence that demonstrates that the Medicare contractor made an error at the time an adverse determination was made, not that the provider or supplier is now in compliance. Thus, we believe that it is essential that providers and suppliers submit documentation that supports their eligibility to participate in the Medicare program during the reconsideration step of the provider enrollment appeals process. This will allow a hearing officer to review and make a decision using all applicable facts. Moreover, the early presentation of evidence will help to ensure an efficient and effective administrative appeals process.

Id. (emphasis added). This regulatory history could be interpreted to mean that a provider or supplier must show that it was in compliance with enrollment requirements as of the date of the initial determination by CMS or its contractor. But such specific language was not used by the drafters. Rather, the language chosen by the drafters refers to "the adverse determination." In this case the Medicare contractor Palmetto issued both an adverse initial determination and an adverse reconsideration determination. CMS Exs. 1, 2. The Federal Register discussion does not specify which adverse Medicare contractor decision should be the focus at hearing. It may also be argued that the focal point of a hearing should be the effective date of the revocation rather than the initial determination date. The example cited by the drafters is, if the contractor determined that the supplier did not meet state licensure requirements on June 1, on appeal the supplier has the burden to show that it did meet state licensure requirements on June 1. The regulation specifically lists several grounds for revocation, including license suspension or revocation, when the date of revocation may be earlier than the date of the initial

determination. 42 C.F.R. § 424.535(g). In this case, I do not need to resolve the possible inconsistency in what the drafters of the regulation intended. I consider the date of the initial determination (August 3, 2012), the effective date of the revocation (September 2, 2012), and the date of the reconsideration determination (December 10, 2012). The date chosen as the focal point does affect the conclusions as to specific issues, but not the ultimate decision in the case. Considering whether a provider or supplier was in compliance at the time of the adverse reconsideration decision by the contractor does, however, ensure that Petitioner's right to review is granted to the maximum extent possible.

I conclude that there is no genuine dispute as to any issue of material fact related to the Supplier Standard 1 and summary judgment is appropriate.

Petitioner admits in its August 30, 2012 Corrective Action Plan that it had patient facilities at 11886 Greenville Avenue, Suite 114, Dallas, Texas and 1825 Troup Highway, Tyler, Texas locations. Petitioner states that the facilities were not enrolled due to administrative oversight and that enrollment applications were submitted for both as soon as the oversight was recognized. Petitioner asserted in its Corrective Action Plan that it had applied to enroll both sites before receiving notification of revocation from Palmetto. CMS Ex. 4, at 2, 4. Thus, Petitioner clearly admitted in its Corrective Action Plan that it recognized that the Greenville Avenue site in Dallas and the Troup Highway site in Tyler were required to be enrolled in Medicare. Petitioner does not dispute that neither facility was enrolled prior to the notice of revocation, the effective date of revocation, or the reconsideration decision.

In the request for reconsideration, Petitioner's counsel concedes that the Greenville Avenue site in Dallas and the Troup Highway site in Tyler were licensed by the Texas Board of Orthotics and Prosthetics and applications for both to enroll in Medicare had been submitted to the National Supply Center in September 2011. Petitioner does not argue that the sites were enrolled prior to revocation. Rather, Petitioner argues that neither site was in the business of providing Medicare-covered DMEPOS. CMS Ex. 5. Petitioner makes a similar assertion in the request for hearing (RFH at 2) and in its opposition to the motion for summary judgment (P. Br. at 3-4). Petitioner's assertion that the Greenville Avenue and Troup Highway sites were not providing DMEPOS to Medicare-eligible beneficiaries is inconsistent with the Corrective Action Plan signed by Ed Stevens, who is listed as an authorized official of Petitioner. The Corrective Action Plan admits that both sites were required to be enrolled, a fact that Petitioner asserts it recognized before Palmetto gave notice of the revocation. CMS Ex. 4, at 2, 4. Petitioner's Corrective Action Plan satisfies the CMS evidentiary burden on summary judgment. Petitioner has offered no evidence to rebut the CMS evidence. Petitioner has failed to show, by affidavits or other evidence, that there is a genuine issue for trial. If the nonmovant cannot

show by some credible evidence that there exists some genuine issue for trial, then summary judgment is appropriate and the movant prevails as a matter of law. *Anderson*, 477 U.S. at 247.

Supplier Standard 1 also requires that a supplier meet state licensing and regulatory requirements. The August 3, 2012 Palmetto letter notified Petitioner that its billing privileges were being revoked because Petitioner did not have licenses in Illinois, Indiana, and Missouri, among other states. Petitioner's admitted in its Corrective Action Plan that it provided DMEPOS to physicians in Illinois, Indiana, and Missouri, though Petitioner asserts and I accept for purposes of summary judgment, that it had no physical locations in those states. Petitioner stated in the Corrective Action Plan that its failure to have state licenses in Illinois, Indiana, and Missouri was an administrative oversight. CMS Ex. 4, at 2. Petitioner stated in the Corrective Action Plan that a license was obtained from Indiana. The Indiana license was issued August 27, 2012, after the initial decision but before the effective date, and it is valid to December 31, 2013. CMS Ex. 5 at 32-25. Petitioner stated in the Corrective Action Plan that applications for licenses had been filed in Missouri and Illinois, but Petitioner does not assert that the licenses had been issued prior to reconsideration. CMS Ex. 4, at 2-4. Petitioner asserted in the request for reconsideration and the request for hearing that a license is not required in Missouri; that Petitioner had obtained an Indiana licensed; and that Petitioner was in the process of obtaining a license in Illinois. CMS Ex. 5, at 3; RFH at 3.The assertion that no license is required by Missouri is supported by evidence submitted with the request for reconsideration and request for hearing and, based on that evidence, I draw an inference in Petitioner's favor for purposes of summary judgment. However, Petitioner's Corrective Action Plan also satisfies the CMS burden on summary judgment as it contains the admission that Petitioner provided DMEPOS in Illinois without a license. Petitioner suggests in its brief in opposition to summary judgment that DMEPOS may have been provided by Petitioner to Medicare-eligible beneficiaries from Illinois when they were in Texas but Petitioner presented no evidence to support such a finding. Therefore, I conclude that Petitioner again failed to present credible evidence to show a genuine dispute as to a material fact and summary judgment is appropriate.

There is no genuine dispute of the material fact that Petitioner had two locations that were not enrolled in Medicare though Petitioner recognized they should have been. There is also no genuine dispute of the material fact that Petitioner provided DMEPOS in Indiana without a license. Accordingly, CMS has met its burden of making a prima facie showing of noncompliance and Petitioner was not shown it was in compliance with Supplier Standard 1 at the time of the initial determination, the effective date of revocation, or the date of reconsideration.

4.. Petitioner has not shown that it was in compliance with 42 C.F.R. § 424.57(c)(2) (Supplier Standard 2).

5. There is a basis for revocation of Petitioner's billing privileges pursuant 42 C.F.R. § 424.535(a)(1)..

Supplier Standard 2 requires that a supplier not make or cause to be made any false statement or misrepresentation of a material fact on its application for billing privileges. The regulation explains parenthetically that the supplier must provide complete and accurate information on its application for billing privileges and must report any changes to information on the application within 30 days. 42 C.F.R. § 424.57(c)(2).

The August 3, 2013 Palmetto notice-letter advised Petitioner that it was not in compliance with Supplier Standard 2 because it failed to report to the National Supplier Clearinghouse the "additional locations used to provide service to Medicare beneficiaries." Petitioner conceded in its August 30, 2012 corrective action plan that it had patient facilities at 11886 Greenville Avenue, Suite 114, Dallas, Texas and 1825 Troup Highway, Tyler, Texas that were not enrolled in Medicare as DMEPOS suppliers. In its request for hearing and brief, Petitioner simply refers to its arguments related to Supply Standard 1. RFH at 3; P. Br. at 4. Petitioner has not contested that information about locations used to provide DMEPOS services to Medicare beneficiaries is material to a determination as to whether or not a supplier should be enrolled and continue to be enrolled in Medicare.

I conclude that there is no genuine dispute as to any material fact and summary judgment is appropriate for the same reasons as discussed under Supplier Standard 1. CMS has met its burden of making a prima facie showing of noncompliance and Petitioner was not shown it was in compliance with Supplier Standard 2 at the time of the initial determination, the effective date of revocation, or the date of reconsideration.

6. Petitioner has not shown that it was in compliance with 42 C.F.R. § 424.57(c)(22) (Supplier Standard 22).

7. There is a basis for revocation of Petitioner's billing privileges pursuant 42 C.F.R. § 424.535(a)(1)..

Supplier standard 22 requires that:

> 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.

42 C.F.R. § 424.57(c)(22). Supplier Standard 22 states that a supplier of DMEPOS must be accredited but it does not specify that each location of a DMEPOS supplier be accredited. However, Supplier Standard 22 must be read in context with Supplier Standard 23 and Supplier Standard 24. Supplier Standard 23 provides that when a DMEPOS supplier opens a new location the supplier must notify its accreditation organization, which may accredit the new supplier location for three months before a site visit is conducted. 42 C.F.R. § 424.57(c)(23). Supplier Standard 24 specifically requires that all DMEPOS supplier locations must meet DMEPOS quality standards and be separately accredited. 42 C.F.R. § 424.57(c)(24). It is clear from considering Supplier Standard 22 in context with Supplier Standard 23 and 24 that the requirement is for each DMEPOS supplier location to be accredited for the type of DMEPOS services and equipment supplied to Medicare eligible beneficiaries.

The August 3, 2012 Palmetto notice-letter advised Petitioner that it was determined not in compliance with Supplier Standard 22 because accreditation for the company could not be verified. CMS Ex. 2, at 2. In its Corrective Action Plan, Petitioner states:

> We have been enrolled with Medicare since 1999 with the NPI # 06537000001. Our enrollment applications for all our locations were always truthful and the lack of accreditation by one of the approved Accreditation Organizations was apparent from our enrollment applications. This was never flagged as an issue by CMS, so we were operating under the assumption that we were in compliance with Medicare.

CMS Ex. 4, at 6.

The Corrective Action Plan concedes that there was a "lack of accreditation by one of the approved Accreditation Organizations" that was "apparent from . . . enrollment applications." The Corrective Action Plan also stated that Petitioner had begun the process of obtaining accreditation for facilities that were not currently accredited. CMS Ex. 4, at 6.

Petitioner submitted with its request for reconsideration a letter from the "American Board for Certification in Orthotics, Prosthetics & Pedorthics, Inc." dated September 26, 2012 addressed to Petitioner's 8800 Shoal Creek Boulevard, Austin, Texas, which states that that facility was accredited for three months effective from September 21, 2012 to December 21, 2012. CMS Ex. 5, at 14. Petitioner also submitted with its request for reconsideration two certificates from the American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc. but neither certificate shows that it was issued for a particular facility of Petitioner, except the indication that Petitioner was located in Austin. CMS Ex. 5 at 37, 39. One of the certificates dated October 6, 2010, bears an expiration date of April 1, 2014, and states that it is for a facility in Austin, Texas. CMS Ex. 15, at

37. The second certificate also states that it is for a facility in Austin, Texas, but the effective and expiration dates are unreadable. CMS Ex. 15, at 39. Petitioner also submitted on reconsideration a certificate issued by the Texas Board of Orthotics and Prosthetics that states that Petitioner, with the address of 8800 B Shoal Creek Boulevard, Austin, Texas, is credentialed in the State of Texas. The certificate bears an effective date of March 23, 2011. Petitioner does not argue that the certificate issued by the State of Texas is evidence of the accreditation required by Supplier Standard 22.

Petitioner argued on reconsideration that its evidence shows that Petitioner was accredited as an entity. Petitioner also argues that the fact it is accredited as an entity is shown by the fact that the American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc. had no trouble issuing an accreditation certificate for the facility at 8800 Shoal Creek Boulevard, which I note, was effective for only three months. CMS Ex. 5, at 3-4. Petitioner also argues in its brief in opposition to the CMS motion for summary judgment that Petitioner was accredited as a corporate entity. P. Br. at 4.

Petitioner's arguments and evidence fail to show that there is a genuine dispute as to a material fact regarding whether each of Petitioner's facilities was accredited as the regulation requires. Petitioner obtained a certificate of accreditation for the 8800 Shoal Creek facility effective September 21, 2012, which was after the August 3, 2012 notice of revocation and the September 2, 2012 effective date of revocation but prior to the reconsideration decision on December 10, 2012. However, Petitioner has offered no evidence and does not argue that it had received accreditation for its patient facilities at 11886 Greenville Avenue, Suite 114, Dallas, Texas and 1825 Troup Highway, Tyler, Texas, prior to the reconsideration decision.

Petitioner also argues that as a "technical matter" it is not required to be accredited citing the Medicare Program Integrity Manual, CMS pub. 100-08, § 15.21.6. P. Br. at 4-5; CMS Ex. 5, at 4. Section 15.21.6 was reserved for future use by revision 430 to the Medicare Program Integrity Manual, which was effective October 29, 2012, which was after the notice of revocation and the effective date of revocation in this case but before reconsideration in December 2012. Petitioner attached a copy of the section as it appeared prior to the October 2012 revision, which included the following language:

> Individual medical practitioners, inclusive of group practices of same, shall not currently require accreditation for enrollment. The practitioner types are those specifically stated in Section 1848(K)(3)(B) and 1842(b)(18)(C) of the Social Security Act as Amended. In addition, the practitioner categories of physicians, orthotists, prosthetists, optometrists, opticians, audiologists, occupational therapists, physical

> therapists and suppliers who provide drugs and pharmaceuticals (only) shall not currently require accreditation for enrollment.

CMS Ex. 5, at 41. Similar language is now found in section 15.21.1B of the Program Integrity Manual, which was effective October 29, 2012 under revision 430. Petitioner does not offer an explanation for how this provision applies in its case. There is no evidence that Petitioner is a practitioner or group of practioners as required for the exemption to apply. The credential issued by the State of Texas characterizes Petitioner as an Accredited Orthotic Facility and an Accredited Prosthetic Facility and does not suggest that Petitioner is a medical practitioner or group of practitioners. CMS Ex. 5, at 10. Accordingly, I conclude there is no genuine dispute as to a material fact related to the application of the exemption and I conclude it does not apply as a matter of law.

Petitioner's assertion in the Corrective Action Plan that it was apparent from its enrollment applications that it was not accredited but CMS never raised the issue, could be construed to be an argument that CMS should be estopped from requiring accreditation. CMS Ex. 4, at 6. As a general rule, the government cannot be estopped absent, at minimum, a showing that the traditional requirements for estoppel are present (i.e., a factual misrepresentation by the government, reasonable reliance on the misrepresentation by the party seeking estoppel, and harm or detriment to that party as a result of the reliance) and that the government's employees or agents engaged in "affirmative misconduct." *Office of Personnel Management v. Richmond*, 496 U.S. 414, 421 (1990); *Linkous v. United States*, 142 F.3d 271, 277-78 (5th Cir. 1998); *Oaks of Mid City Nursing and Reahab. Ctr.*, DAB No. 2375 at 30 (2011); *Pacific Islander Council of Leaders*, DAB No. 2091, at 12 & n.11 (2007). Petitioner does not allege and has presented no evidence that raises a genuine dispute as to the existence of the facts necessary to find that the elements of equitable estoppel are present in this case.

I conclude that there is no genuine dispute as to any material fact and summary judgment is appropriate . CMS has met its burden of making a prima facie showing of noncompliance and Petitioner was not shown it was in compliance with Supplier Standard 22 at the time of the initial determination, the effective date of revocation, or the date of reconsideration.

III. Conclusion

For the foregoing reasons, Petitioner's Medicare enrollment and billing privileges were properly revoked effective August 3, 2012, due to noncompliance with 42 C.F.R. §§ 424.57(c)(1), (2), and (22).

/s/
Keith W. Sickendick
Administrative Law Judge