Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Advanced Medical Services, PLLC,
(PTAN: MI4731, NPI: 1619275583),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-691

Decision No. CR3284

Date: July 2, 2014

DECISION

Petitioner, Advanced Medical Services, PLLC, was operational during the period February 23, 2011 to October 2012, and there is no basis for the revocation of Petitioner's Medicare enrollment and billing privileges.

I. Background and Procedural History

Advanced Medical Services, PLLC, owned by Zakiya O. Antoine, D.O., was initially enrolled as a supplier of medical services under the Medicare program effective February 23, 2011. Centers for Medicare & Medicaid Services (CMS) Exhibit (Ex.) 3. The Medicare contractor, Wisconsin Physicians Service Insurance Corporation (WPS), notified Petitioner by letter dated October 8, 2012, that its Medicare billing privileges were revoked effective February 23, 2011. WPS cited 42 C.F.R. § 424.535(a)(1) and (5) as the basis for revocation.[1] WPS also notified Petitioner that it was subject to a two-year

[1] The 2012 revision of the Code of Federal Regulations (C.F.R.) is cited, unless otherwise indicated.

bar to reenrollment pursuant to 42 C.F.R. § 424.535(c). CMS Ex. 3 at 1; CMS Ex. 1 at 7-8.

Petitioner requested reconsideration of the initial determination to revoke by letter dated November 20, 2012. CMS Ex. 1 at 4-5. WPS notified Petitioner by letter dated February 20, 2013, that the revocation was upheld on reconsideration. CMS Ex. 1 at 1-2.

Petitioner requested review by an administrative law judge (ALJ) by letter dated April 8, 2013. On April 29, 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 motion for summary judgment, a memorandum in support of the motion, and CMS Exs. 1, 2, and 3, on May 29, 2013.[2] Petitioner filed its prehearing brief, which included its opposition to the CMS motion for summary judgment, with Petitioner's exhibits (P. Exs.) 1 through 7,[3] on June 28, 2013. On July 15, 2013, CMS filed a reply brief. On August 2, 2013, Petitioner filed a motion for leave to file a sur-reply accompanied by its sur-reply. Petitioner filed an amended sur-reply on August 4, 2013. The motion for leave to file the sur-reply was granted and the amended sur-reply was accepted and considered. On October 22, 2013, I issued my ruling denying CMS's motion for summary judgment and ordering the parties to file a joint status report advising me of their availability for hearing and requesting subpoenas for witnesses. CMS did not request any subpoenas. Petitioner requested subpoenas for G. Kemoli

---

[2] On November 8, 2013, CMS filed a substitute CMS Ex. 1 (Departmental Appeals Board electronic filing system (DAB e-File) #27), which included color rather than black and white copies of pictures taken by the investigator. CMS also filed on November 8, 2013, a motion for leave to file an amended CMS Ex. 1, which included more photographs than either CMS Ex. 1 or the substituted CMS Ex. 1, and an amended exhibit list (DAB e-File #28). The amended CMS Ex. 1 (DAB e-File #28) was the document admitted as evidence at hearing and considered in this decision and CMS Ex. 1 (DAB e-File #6) and substituted CMS Ex. 1 (DAB e-File #27) were not admitted or considered. Transcript (Tr.) 26-27, 30-34, 136-48.

[3] The documents Petitioner filed as proposed exhibits were not properly marked as required by the Prehearing Order and the Civil Remedies Division Procedures (CRDP). However, the exhibits were not returned to Petitioner for correction because there was no potential for confusion due to the absence of correct markings. Petitioner's exhibits are listed in DAB e-File as AMS Ex. 1 through AMS Ex. 7 (DAB e-File #9-15), but they are referred to as P. Ex. 1 through 7 in this decision as they were at hearing. Tr. 35-36.

Sagala, DC; Marion Armstrong; Jerry Whitehead, and Brenda Wright. Petitioner's request for subpoenas for these witnesses was granted.[4]

A hearing was convened by video teleconference on December 11, 2013, and a transcript was prepared. CMS offered CMS Exs. 1 (amended) through 3 that were admitted as evidence. Tr. 24-27, 30-34, 136-48. Petitioner offered P. Exs. 1 through 7. P. Exs. 1 through 4 and 6 and 7 were admitted over CMS's objection, which is discussed in more detail hereafter. Tr. 34-66. CMS called as witnesses Adam Barnett, an investigator for Cahaba Safeguard Administrators, LLC, and Special Agent (SA) James Grzeszczak with the U.S. Department of Health and Human Services, Office of the Inspector General. Petitioner elicited the testimony of three Medicare beneficiaries who were patients of Dr. Antoine: Jerry Whitehead, Brenda Wright, and Marion Armstrong. Dr. Antoine also testified as the owner and operator of Advanced Medical Services, PLLC.

CMS's post-hearing brief (CMS Br.) was filed February 28, 2014, and its post-hearing reply (CMS Reply) and Proposed Findings of Fact and Conclusions of Law were filed on March 30, 2014. Petitioner's post-hearing brief[5] (P. Br.) was filed on March 1, 2014; its post-hearing reply (P. Reply) on March 30, 2014; and its Proposed Findings of Fact and Conclusions of Law on March 31, 2014.

The CMS objection to Petitioner's documentary evidence warrants some discussion in this decision. CMS objected to the admission of P. Exs. 1 through 4 and 6 and 7, citing 42 C.F.R. §§ 405.874(c)(3) and 498.56(e)(5). The CMS argument is that the evidence was not submitted before the reconsideration determination was issued and Petitioner is precluded from introducing new evidence before me. The objection was overruled at hearing for the reason stated on the record. Tr. 37-66. CMS raises a similar objection in its post-hearing brief. CMS argues that because Petitioner did not file documents with its

---

[4] Petitioner also requested subpoenas to compel the testimony of Shirley Kuhl, a WPS employee, who issued the notice assigning Petitioner's provider transaction number (PTAN); Paul Bamrah, an employee of WPS who signed the initial determination to revoke Petitioner's enrollment in Medicare; and Shawn Cook, a WPS employee who issued the unfavorable reconsideration determination. Petitioner failed to identify any relevant testimony that these witnesses could offer at hearing and the requests for subpoenas for those individuals were denied. Ruling Upon Requests for Subpoena and Notice of Hearing, dated November 5, 2013.

[5] Petitioner's post-hearing brief is incorrectly titled "Advanced Medical Services PLLC's Pre-Hearing Brief."

reconsideration request, "as a matter of law, Petitioner's Exhibits 1-7[6] should be excluded." CMS erroneously cites 42 C.F.R. §§ 405.874(c)(3) and 498.56(e)(5) as authority supporting its position. CMS Br. at 10 n.1. The initial determination was made on October 8, 2012, and the reconsideration determination was made on February 20, 2013. Based on the dates of the initial and the reconsideration determinations, the 2012 revision of the C.F.R., which was issued on October 1, 2012, was in effect when those determinations were made. The 2012 revision of the C.F.R. does not include 42 C.F.R. § 405.874(c)(3), which last appeared in the 2011 revision. The regulatory language found in 42 C.F.R. § 405.874(c)(3) (2011 revision) is found in 42 C.F.R. § 405.803 in the 2012 revision of the C.F.R. The CMS reference to 42 C.F.R. § 498.56(e)(5) is also in error as there is no such subsection in either the 2011 or 2012 revision of the C.F.R. Furthermore, the language CMS quotes as if from 42 C.F.R. § 498.56(e)(5) does not appear in 42 C.F.R. § 498.56(e)(5) (2012 revision). More importantly, the CMS position is unsupported by the regulations actually in effect.

Pursuant to 42 C.F.R. § 405.803(a), the procedures applicable in this case are those established by 42 C.F.R. pt. 498. The following regulation applies in provider and supplier-related cases:

> (e) *Provider and supplier enrollment appeals: Good cause requirement—*
> (1) *Examination of any new documentary evidence*. After a hearing is requested but before it is held, the ALJ will examine any new documentary evidence submitted to the ALJ by a provider or supplier to determine whether the provider or supplier has good cause for submitting the evidence for the first time at the ALJ level.
> (2) *Determining if good cause exists—*
> (i) *If good cause exists*. If the ALJ finds that there is good cause for submitting new documentary evidence for the first time at the ALJ level, the ALJ must include evidence and may consider it in reaching a decision.
> (ii) *If good cause does not exist*. If the ALJ determines that there was not good cause for submitting the evidence for the first time at the ALJ level, the ALJ must exclude the evidence from the

---

[6] P. Ex. 5 was excluded at hearing because it was not relevant and that document is not considered in the decision of this case. Tr. 62-66.

> proceeding and may not consider it in reaching a decision.
>
> (2) *Notification to all parties*. As soon as possible, but no later than the start of the hearing, the ALJ must notify all parties of any evidence that is excluded from the hearing.

42 C.F.R. § 498.56(e) (emphasis and incorrect numbering of subsections as in original). The regulation is clear on its face that it applies only to documentary evidence and that "new documentary evidence" is evidence offered for the first time at the ALJ-level. No definition of good cause was established by CMS when it promulgated this regulation on behalf of the Secretary of Health and Human Services (Secretary). The regulation requires that the ALJ examine any new documentary evidence to determine if good cause exists for submission of the evidence for the first time at the ALJ-level. I am bound to follow the Secretary's regulations and apply them harmoniously and consistently with the Constitution, the Social Security Act (the Act), and the Secretary's other regulations.

I consider the adequacy of the notice that Petitioner received regarding the submission of evidence on reconsideration, in determining whether Petitioner should be barred from presenting evidence for the first time before me. Fundamental notions of due process suggest that Petitioner should not be deprived of an opportunity to submit evidence for consideration if Petitioner was not informed when to submit evidence in support of its request for reconsideration or be barred from doing so subsequently. In this case, the regulations, the WPS notice of initial determination, and the hearing officer's failure to comply with the regulations, all operated to deprive Petitioner of the opportunity to submit evidence at reconsideration. The October 8, 2012 notice of revocation from WPS advised Petitioner that it could request reconsideration before a contractor hearing officer; that reconsideration is an independent review by an individual not involved in the initial determination; that reconsideration had to be requested within 60 calendar days of the postmark on the October 8 notice letter; that Petitioner must state the issues and facts with which it disagreed and the reasons for the disagreement; and that Petitioner "may" submit additional information that may have a bearing on the decision. CMS Ex. 1 at 8. There is no description of the procedures that would be followed on reconsideration; whether the additional information had to be submitted with the request for reconsideration or at some later point in the reconsideration process; or a warning that failure to submit more information at a specific time in the reconsideration stage could serve to bar submission of the evidence to the ALJ. The regulations that control reconsideration do not specify when evidence must be submitted to the hearing officer on reconsideration. The regulations provide that when a request for reconsideration is properly filed, then CMS receives written evidence and statements relevant to the matters at issue and submitted within a reasonable time after the request for reconsideration is filed. 42 C.F.R. §§ 498.22 and 498.24(a). Further, 42 C.F.R. § 405.803(d) provides that "[i]f supporting evidence is not submitted with the appeal request, the contractor contacts the provider or supplier to try to obtain the evidence." Petitioner's reconsideration

request was received by WPS on November 28, 2012. The reconsideration hearing officer acknowledged Petitioner's request for reconsideration by letter dated December 7, 2012. The letter contained only two sentences − the first acknowledging the request and noting the date it was received, and the second noting that the reconsideration would be conducted and a determination issued within 90 days of the date of Petitioner's request. The acknowledgment letter does not advise Petitioner that additional evidence had to be submitted or that failure to do so would preclude submission of evidence in any future proceedings. The reconsideration hearing officer failed to request in his letter that Petitioner provide any evidence supporting the reconsideration request as required by 42 C.F.R. § 405.803(d). CMS Ex. 1 at 3. The initial determination letter, the letter acknowledging receipt of Petitioner's reconsideration request, and the reconsideration determination do not show that Petitioner was ever advised of a date by which additional evidence had to be submitted for reconsideration or that failure to timely submit evidence during the reconsideration process could bar future consideration of such evidence. CMS Ex. 1 at 1-3, 7-8. The regulations controlling reconsideration at 42 C.F.R. §§ 498.22 and 498.24 do not clearly establish a procedure for submission of evidence on reconsideration. The WPS notice letters did not clearly establish a procedure for submitting evidence on reconsideration. Additionally, the regulation establishing the right to request reconsideration clearly states that if a provider or supplier fails to submit evidence with the reconsideration request, the reconsideration hearing officer would request that evidence be submitted, thereby giving the provider or supplier another opportunity to submit evidence on reconsideration. 42 C.F.R. § 405.803. In this case, the hearing officer failed to provide Petitioner with an opportunity to submit evidence prior to issuance of the reconsideration determination. The hearing officer failed to comply with 42 C.F.R. § 405.803(d), despite the fact that Petitioner's request for reconsideration clearly stated that there was other evidence that could support Petitioner's assertion that it was "operational" at the time of the site visits (CMS Ex. 1 at 4-5). The hearing officer's failure to comply with the regulations and the failure to give Petitioner notice of when evidence had to be submitted on reconsideration are both a legally sufficient basis and beyond Petitioner's control and constitute good cause for the submission of new documentary evidence to me. The CMS objection is overruled.

II. Discussion

A. Applicable Law

Section 1831 of the Act (42 U.S.C. § 1395j) establishes the supplementary medical insurance benefits program for the aged and disabled known as Medicare Part B. Payment under the program for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of services and suppliers. Act §§ 1835(a) (42 U.S.C. § 1395n(a));1842(h)(1) (42 U.S.C. § 1395(u)(h)(1)).

Administration of the Part B program is through contractors such as WPS. Act § 1842(a) (42 U.S.C. § 1395u(a)). The Act requires the Secretary to issue regulations that establish a process for the enrollment of providers and suppliers, including the right to a hearing and judicial review in the event of denial or non-renewal. Act § 1866(j) (42 U.S.C. § 1395cc(j)).

Pursuant to 42 C.F.R. § 424.505, a supplier such as Petitioner must be enrolled in the Medicare program to be reimbursed for services provided 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. §§ 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 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 supplier is aware of and agrees to abide by all applicable statutes, regulations, and program instructions. 42 C.F.R. § 424.510(d)(3). Suppliers must meet basic requirements depending on their type of service. 42 C.F.R. §§ 424.505, .516, .517. Suppliers are also subject to additional screening requirements depending upon the type of service they provide. 42 C.F.R. § 424.518.

Once enrolled, the supplier receives billing privileges and is issued a billing number that is required to receive payment for services rendered to a Medicare beneficiary. 42 C.F.R. § 424.505. The supplier is subject to a five-year revalidation of enrollment cycle and CMS is authorized to perform off-cycle revalidations for a number of reasons. CMS has the right to perform on-site inspections of a provider or supplier to verify that the enrollment information submitted to CMS or its agents is accurate and to determine compliance with Medicare enrollment requirements. 42 C.F.R. § 424.510(d)(8).

CMS or its Medicare contractor has been delegated authority 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(a). In this case Petitioner was notified that its enrollment and billing privileges were being revoked pursuant to 42 C.F.R. § 424.535(a)(1) and (5), because CMS determined Petitioner was not in compliance with Medicare enrollment requirements and, upon site review, Petitioner was not operational to furnish Medicare covered items or services. A revocation based on a determination that a provider or supplier is not operational is effective on "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 provider whose Medicare enrollment or billing privileges has been revoked may ask for reconsideration of that revocation by CMS or its contractor. 42 C.F.R. §§ 424.545(a), 498.5(1), 498.22(a). A provider or supplier dissatisfied with the reconsideration

determination may request a hearing before an ALJ and further review by the Departmental Appeals Board (the 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, 748-51 (6th Cir. 2004).

The Secretary's regulations do not address the allocation of the burden of proof or the standard of proof. However, the Board has addressed the allocation of the burden of proof in many decisions. The standard of proof is a preponderance of the evidence. CMS has the burden of coming forward with the evidence and making a prima facie showing of a basis, in this case, for revocation of Petitioner's enrollment. Petitioner bears the burden of persuasion to rebut the CMS prima facie showing by a preponderance of the evidence or to establish any affirmative defense. *Batavia Nursing & Convalescent Inn*, DAB No. 1911 (2004); *Batavia Nursing & Convalescent Ctr*., DAB No. 1904 (2004), *aff'd,* 129 F. App'x 181 (6th Cir. 2005); *Emerald Oaks*, DAB No. 1800 (2001); *Cross Creek Health Care Ctr.*, DAB No. 1665 (1998); *Hillman Rehab. Ctr*., DAB No. 1611 (1997) (*remand*), DAB No. 1663 (1998) (*aft. remand*), *aff'd*, *Hillman Rehab. Ctr. v. United States*, No. 98-3789 (GEB), 1999 WL 34813783 (D.N.J. May 13, 1999).

"Prima facie" means generally that the evidence is "[s]ufficient to establish a fact or raise a presumption unless disproved or rebutted." *Black's Law Dictionary* 1228 (8th ed. 2004). Thus, CMS has the initial burden of coming forward with sufficient evidence to show that its decision to revoke Petitioner's Medicare participation and billing privileges is legally sufficient under the statute and regulations. CMS makes a prima facie showing of noncompliance if the credible evidence CMS relies on is sufficient to support a decision in its favor absent an effective rebuttal by Petitioner.

B. Issues

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

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. The findings of fact are based on the exhibits admitted and testimony obtained at the hearing. I have carefully considered all the evidence and the arguments of both parties, though not all may be specifically discussed in this decision. I discuss in this decision the credible evidence given the greatest weight in my decision-making. I also discuss any evidence that I find is not credible or worthy of weight. The fact that evidence is not specifically discussed should not be considered sufficient to rebut the presumption that I considered all the evidence and assigned such weight or probative value to the credible evidence that I determined appropriate within my discretion as an ALJ. There is no requirement for me to discuss the weight given every piece of evidence

considered in this case, nor would it be consistent with notions of judicial economy to do so. *Charles H. Kock, Jr., Admin L. and Prac.* § 5:64 (3d ed. 2013).

1. Petitioner was operational within the meaning of 42 C.F.R. § 424.502.

2. There is no basis for the revocation of Petitioner's billing privileges and enrollment in Medicare pursuant to 42 C.F.R. § 424.535(a)(1) and (5).

3. I have no authority to grant equitable relief.

a. Facts

On March 9, 2011, Zakiya O. Antoine, D.O., signed an application to enroll Petitioner, her new corporation, in Medicare. CMS Ex. 2. The address for Petitioner was listed in the application as 23300 Greenfield Road, Suite 205C, Southfield, Michigan, 48037 (Greenfield Road). CMS Ex. 2. WPS notified Petitioner by letter dated August 23, 2011, that Petitioner's application to enroll in Medicare was approved with the effective billing date of February 23, 2011. CMS Ex. 3.

There is no dispute that Adam Barnett, an investigator for Cahaba Safeguard Administrators, a Medicare program integrity contractor, requested that SA Grzeszczak do a site visit of Petitioner's practice location. Tr. 109-10. There is also no dispute that SA Grzeszczak attempted to conduct site visits at Petitioner's address on Greenfield Road on August 10, September 12, and September 21, 2012. CMS Ex. 1 at 9-11; Tr. 109. The first site visit occurred on August 10, 2012, at approximately 11 a.m. when SA Grzeszczak went to Greenfield Road to see if Petitioner was physically at that location. He went to the first floor of the building to view the building directory, he did not find Advanced Medical Services listed on the building directory, and he took a photo of the directory. He then went to the second floor of the building to locate suite 205C but did not find it. During the August 10 site visit, he took four photos – two of the exterior of the building and two of the building directory. He returned to Greenfield Road for a second site visit on September 12, 2012, between 10 a.m. and 11 a.m., at the request of Mr. Barnett because the photos that were taken by him on August 10 were not "legible," in particular the photo of the building directory. On September 12, he took a series of photos that were submitted to Mr. Barnett. Tr. 110-13; CMS Ex. 1 at 10-11. He was then contacted by Mr. Barnett to go back a third time to see if there was any foot traffic at suite 205C, and to check whether the door of suite 205C would open. His third site visit was on September 21, 2012, at approximately 10 a.m. During the third site visit, he did not find a door for suite 205C. He did observe a sign "205 Northland Chiropractic Centre" and a sign "200/205 Dr. G. Kemoli Sagala." He monitored the area for foot traffic and then attempted to enter suite 200/2005, but the door was locked. He knocked

on the door to suite 205 but there was no response. He then spoke with people at other businesses on the same floor but none recognized Petitioner's name. He then telephoned the building leasing manager, Tom Kadoo, and asked if he had heard of Petitioner. Mr. Kadoo stated he had not heard of Petitioner and that suite 200/205 was leased to Northland Chiropractic.[7] Tr. 114-17; CMS Ex. 1 at 9-11. On cross-examination, he testified that he did not ask other tenants if they knew Petitioner's owner, Zakiya Antoine. Tr. 128-29. Because Tom Kadoo was not present to testify at hearing and not available for cross-examination, I will not infer based on the statement recorded by and testified to by SA Grzeszczak that Tom Kadoo did not know Zakiya Antoine or that she did not use office space in his building. Tr. 143-47. The testimony of SA Grzeszczak is credible; however, the hearsay statements of Tom Kadoo lack sufficient indicia of reliability to be accepted as credible and as a basis for drawing inferences adverse to Petitioner.

Adam Barnett testified that it was determined to revoke Petitioner's enrollment and billing privileges as of the effective date of enrollment because SA Grzeszczak was told by the leasing manager, Tom Kadoo, that he never heard of Petitioner. Tr. 89; CMS Ex. 1 at 9.

Petitioner called three witnesses to testify. The witnesses were Medicare beneficiaries who testified that they had received medical treatment from Dr. Antoine during 2011 and 2012 at the Greenfield Road location.

Jerry Whitehead testified that he was referred to Dr. Antoine in April 2011. He testified that he received medical treatment from Dr. Antoine at the Greenfield Road location beginning in the summer of 2011, twice per month, every second Wednesday of the month, for approximately eight months. He identified the photos in CMS Ex. 1 at 10 and 11, as the exterior of the Greenfield Road building, doorway, and building directory. P. Ex. 3; Tr. 166, 169, 170, 177-78, 180-84. He testified that he did not recall seeing a sign with Petitioner's name. He testified that there were several rooms in the suite; there was an office and waiting area with a secretary, a table and chairs; and he would receive medical treatment from Dr. Antoine in an examination room that had an examining bed.

---

[7] In response to my questioning, SA Grzeszczak testified that he entered suite 200/205 in December 2012 when executing a search warrant in another case. He recalled that there were six offices in the suite but with no numbers on or at the doors. He testified that some of the rooms were examination rooms with chiropractic equipment and one room had x-ray equipment. Tr. 124-27. Except to the extent his description of suite 200/205 is consistent with and corroborates the testimony of Petitioner's witnesses, I give no weight to this testimony as his observations occurred well after the end of the period in question.

Tr. 207-09. He stated in his June 12, 2013 affidavit that he saw Dr. Antoine at the Greenfield Road location in suite 205, examination room C, and that he was still a patient of hers. P. Ex. 3.

Brenda Wright testified for Petitioner that she recognized the photos marked as CMS Ex. 1 at 10 and 11; that she had been receiving medical treatment from Dr. Antoine on a monthly basis beginning in October 2011at the Greenfield Road location; that she saw Dr. Antoine for approximately one year at the Greenfield Road location before Dr. Antoine moved to her current location. She testified that at the Greenfield Road location she would enter suite 205 which had a sign for Northland Chiropractic; there was a girl sitting at a desk with whom she would check in; and she would sit in the waiting area until she was called to the examination room where she saw Dr. Antoine. Tr. 218-19, 221-22, 226-28. She stated in her June 13, 2013 affidavit that she saw Dr. Antoine at the 23300 Greenfield Road address in suite 205, examination room C, and that she was still a patient of hers. P. Ex. 4.

Marion Armstrong identified the photographs admitted as CMS Ex. 1 at 10 and 11 as the location where she would see Dr. Antoine. She testified that she received medical treatment from Dr. Antoine at that location, twice a month beginning in December 2011; that upon entering the suite there was a lady at the desk and that Megan was Dr. Antoine's assistant; and the suite consisted of different rooms where she would be examined by Dr. Antoine. Tr. 233-34; 236-39, 245-49. In her June 12, 2013 affidavit, Ms. Armstrong stated that she saw Dr. Antoine at the Greenfield Road location in suite 205, examination room C, and that as of June 12, 2013, she was still a patient of hers. P. Ex. 2.

Dr. Antoine testified that Advanced Medical Services had a practice location at 23300 Greenfield Road, suite 205C. She testified she had an agreement with Dr. Sagala to use the space which was within his office space. She testified that she saw patients in the space one to two days per week between about February 23, 2011 and sometime in October 2012. She testified that her patients were given the business phone number of Dr. Sagala's office so that they could call the office scheduling staff to make an appointment with her, or ask a question about their treatment or medication. Office staff called her cell phone number to relay any message or inquiry. Dr. Antoine also had her own scheduling staff that she hired directly, Megan and Mandy, which is consistent with the testimony of Ms. Armstrong. Dr. Antoine testified that she also saw patients at their homes based on referrals from home health agencies and also from a visiting physician's organization. P. Ex. 1; Tr. 234, 264-79. She testified that from February 23, 2011 through the end of October 2012, she had a desk, chairs, a file cabinet with a lock, paper shredders, trash cans, exam tables, stethoscopes, sphygmomanometers, a scale, and a printer at Greenfield Road, suite 205. Tr. 283-85. P. Ex. 1 reflects that the arrangement with Dr. Sagala was an oral agreement. Dr. Antoine's statement at P. Ex. 1 and her testimony at hearing that she had a practice location at 23300 Greenfield Road, suite

205C, are consistent with and supported by the CMS evidence, CMS Exs. 2 and 3, Petitioner's enrollment application signed March 9, 2011 and the August 23, 2011 CMS determination enrolling Petitioner in Medicare.

b. Analysis

WPS revoked Petitioner's enrollment and billing privileges retroactive to the date of Petitioner's enrollment in Medicare, because WPS determined that Petitioner was never operational at the address on Greenfield Road listed in the enrollment application. WPS cited 42 C.F.R. § 424.535(a)(1) and (5) in the initial determination, but it is clear that the factual basis for the revocation was the conclusion that Respondent was not operational at the Greenfield Road location. CMS Ex. 1 at 7-8. In fact, the ZPIC Revocation Request Form (ZPIC Form) clearly shows that Mr. Barnett requested revocation based on 42 C.F.R. § 424.535(a)(5) and his conclusion that Petitioner was not operational from the effective date of Petitioner's enrollment. CMS Ex. 1 at 9-10; Tr. 89. It is also clear from the reconsideration determination that revocation was approved based on the determination that Petitioner was not operational at the Greenfield Road location since the date of her enrollment. CMS Ex. 1 at 2. The pertinent regulation 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:
>
> * * * *
>
> (5) *On-site review*. CMS determines, upon on-site review, that the provider or supplier is no longer operational to furnish Medicare covered items or services, or is not meeting Medicare enrollment requirements under statute or regulation to supervise treatment of, or to provide Medicare covered items or services for, Medicare patients. Upon on-site review, CMS determines that—
>
> > (i) A Medicare Part A provider is no longer operational to furnish Medicare covered items or services, or the provider fails to satisfy any of the Medicare enrollment requirements.
> >
> > (ii) A Medicare Part B supplier is no longer operational to furnish Medicare covered items or services, or the supplier has failed to satisfy any or all of the Medicare enrollment requirements, or has failed

> to furnish Medicare covered items or services as required by the statute or regulations.

42 C.F.R. § 424.535(a)(5). Petitioner was a physician practice, which makes Petitioner a Medicare Part B supplier subject to 42 C.F.R. § 424.535(a)(5)(ii). In this case the only basis cited for revocation under 42 C.F.R. § 424.535(a)(5)(ii) was that Petitioner was not operational to furnish Medicare covered items or services. There is no allegation, finding, or conclusion that Petitioner failed to satisfy any other Medicare enrollment requirement or failed to furnish Medicare covered items or services as required by Medicare. The term "operational" has a specific definition under the regulations:

> *Operational* means 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 (as applicable, based on the type of facility or organization, provider or supplier specialty, or the services or items being rendered), to furnish these items or services.

42 C.F.R. § 424.502.

There is no dispute regarding the law to be applied or that the case turns on whether Petitioner met the definition of operational during the period February 23, 2011 to October 2012. The regulations and CMS policy applicable to physicians and physician practices do not establish specific requirements for a physician's physical practice location, except that the definition of "operational" requires that it be a physical location, open to the public, and properly staffed, equipped, and stocked to deliver the type of services the physician is licensed and enrolled to provide. The regulations and CMS policy do not require that a physician's practice location be open to the public at specific times or have signs identifying the location of the practice or the hours the location is open to the public. The regulations and policies also do not specify requirements that must be satisfied for a physician to be found prepared to submit valid Medicare claims, other than the requirements for licensure, Medicare enrollment, and the ability to deliver covered items or services to a qualified Medicare beneficiary. 42 C.F.R. §§ 410.20, 410.26; Medicare Program Integrity Manual, CMS Pub. 100-08 (MPIM), ch. 15, §15.4.4.10.

My review of whether or not CMS had a basis to revoke Petitioner's participation in Medicare is *de novo*. The decision in this case turns on issues of fact, including the credibility of documentary and testimonial evidence, and not issues of law. I conclude that the CMS evidence – specifically CMS Exs. 1 at 9-12; 2; and 3; and the testimony of SA Grzeszczak – is credible and sufficient to establish a prima facie case that Petitioner

was not operational within the meaning of 42 C.F.R. §§ 424.502 and 424.535(a)(5)(ii). However, I further conclude, that Petitioner's evidence is credible and unrebutted and amounts to a preponderance of the evidence showing Petitioner was, in fact, operational within the meaning of the regulations.

The CMS position is that revocation was appropriate because Petitioner had no qualified physical practice location at the Greenfield Road location, which is the location listed in the enrollment form, and there was no evidence presented to show that Petitioner was ever operational at that location. CMS Br. at 8. The CMS position is based on the investigation of SA Grzeszczak as reported in the ZPIC Form prepared by Mr. Barnett. There is no question that the ZPIC form provided the factual basis for WPS and CMS to revoke Petitioner's Medicare enrollment and billing privileges. CMS Br. at 6, 7-8; CMS Ex. 1 at 1-2, 9-11. It is clear from his testimony that Mr. Barnett completed the ZPIC form based upon the information of SA Grzeszczak. Tr. 75-81, 86-88; CMS Ex. 1 at 9. The ZPIC form and SA Grzeszczak's testimony are sufficient evidence, without consideration of Petitioner's evidence, to constitute a prima facie showing that Petitioner was not operational at the Greenfield Road location. There is no dispute that SA Grzeszczak visited the correct building, and the correct floor in the building; there were no signs indicating the presence of Petitioner in that building or on that floor; and the people he interviewed were not aware of an entity with Petitioner's name operating in that building or on that floor. However, SA Grzeszczak's evidence is weak and readily subject to rebuttal.

SA Grzeszczak admittedly had limited information to work with when he went to the Greenfield Road location on three occasions. Furthermore, he testified that he conducted a visit rather than an investigation. Tr. 113. SA Grzeszczak did not know, for example, that Petitioner was solely owned and operated by Dr. Antoine and he admitted in testimony that he never asked other tenants or the leasing manager about their knowledge of Dr. Antoine. Tr. 128-30. SA Grzeszczak's testimony was credible. However, both his investigation and the facts he gathered were limited. He made three trips to the building where Petitioner reportedly operated on August 10, September 12 and September 21, 2012. During the first site visit on October 12, he observed the external activity of the office building, went to look at the building directory on the first floor, and took four photos (two of the exterior of the building and two of the building directory), all of which were indiscernible. He did not attempt to enter suite 205 during this visit. Because he did not find Petitioner's name on the building directory, he concluded on minimal evidence that Petitioner was not operational at that location. On September 12, 2012, he returned to the Greenfield Road location at the request of Mr. Barnett for additional information. SA Grzeszczak took additional photos and observed external activity of the office building, but, again, he did not attempt to enter suite 205. Tr. 111-12, 113, 114. On September 21, 2012, SA Grzeszczak returned to the Greenfield Road location a third time at the request of Mr. Barnett to make additional observations and to attempt to enter room 205C. Tr. 114. He could not locate room 205C and when he

attempted to enter suite 205 the door was locked. Tr. 114-15. He spoke with some of the other building tenants, asking if they knew of Advanced Medical Services, and they could only confirm that suite 205 was a chiropractic office. Tr. 116. At hearing he was unable to provide the names of the tenants he spoke with because he did not take any contemporaneous notes or make any written report of these discussions. Tr. 117, 118. He interviewed the building leasing manager by phone but mentioned only the name of Advanced Medical Services and not Dr. Antoine as its owner and operator. He failed to establish the leasing manager's basis for knowledge and, thus, the information is entitled to little weight. He did not ask Mr. Kadoo how long he had been the building leasing manager but inferred it had been several years based only on Mr. Kadoo's tone. Tr. 116-17. He also did not ask Mr. Kadoo how long he had been handling the lease for Northland Chiropractic; if he knew of any other business operating out of suite 205; or whether there were any subleases. Tr. 119, 120. Mr. Kadoo was not called as a witness to corroborate SA Grzeszczak's testimony, nor was he available for cross-examination. SA Grzeszczak did not ask the other building tenants on the same floor if they knew Dr. Zakiya Antoine because he was not aware that she was listed on the Medicare enrollment application as the sole owner and operator of Petitioner. Tr. 128-30; CMS Ex. 2 at 3, 7. He did not attempt to call the telephone number listed under the practice location in the enrollment application in an attempt to locate the correct office. CMS Ex. 2 at 8. SA Grzeszczak did not interview Dr. Sagala, the owner and operator of Northland Chiropractic, which had offices in suite 200/205 even though his photographs clearly show that Dr. Sagala operated in suites 200 and 205. Therefore, he did not ask Dr. Sagala about any office arrangements with Advanced Medical Services or Dr. Antoine. Tr. 127.

Although the evidence developed by SA Grzeszczak is sufficient to make a prima facie showing, the evidence he developed is not conclusive or determinative of the issue of whether Petitioner was not operational. Rather, the CMS prima facie case is subject to rebuttal by evidence presented by Petitioner that shows it is more likely than not that she was, in fact, operational within the meaning of the regulations.

Petitioner focused her case on showing that she had an arrangement to use an office at the Greenfield Road location to deliver qualified services to qualified Medicare beneficiaries and that she was, therefore, operational. Petitioner presented credible testimony from patients that Petitioner was in fact operational. Petitioner's witnesses testified under oath, and all three witnesses were able to credibly identify the photos contained in CMS Ex. 1 and were able to identify them as photos of the Greenwood Road practice location where they were treated by Dr. Antoine. Tr. 169; 218; 233. Although the witnesses' memories were not strong regarding the exact dates of their medical appointments that occurred up to three years prior, they credibly testified that Petitioner's Greenfield Road location was where they received medical treatment from Dr. Antoine on a regular basis during the relevant period. Dr. Antoine credibly testified at hearing as the owner and operator of Advanced Medical Services. She stated that suite 205 was occupied by Northland

Chiropractic Centre PC and operated by Dr. Sagala, a chiropractor. She explained why there was no listing of Advanced Medical Services in the building directory for suite 205C. In her reconsideration request she stated that the office space for Advanced Medical Services at the Greenfield Road location was subleased from Northland Chiropractic Centre since February 23, 2011; she explained that her office was sometimes closed when there were no scheduled patients or when care was being delivered by Dr. Antoine at other medical offices or patient homes; and she stated in her reconsideration request that the locations where she delivered services were reflected on her claims. CMS Ex. 1 at 4-5; Tr. 270, 272. Petitioner's enrollment application notes "23300 Greenfield Road" as its practice location and Dr. Antoine's contact phone number was listed in the application. CMS Ex. 2 at 3, 8.

I find that the testimony of Dr. Antoine and her patients show Petitioner was in fact operational at the Greenfield Road location during the period February 2011 through October 2012. The fact Petitioner had no sign or posted hours of operation is evidence but not determinative of the issue of whether Petitioner was open to the public. Whether a facility is open to the public for the purpose of providing health care-related services is only one of the criteria established by 42 C.F.R. § 424.502 for deciding whether a supplier is operational. An analysis of whether a facility is "operational" within the meaning of 42 C.F.R. § 424.502 also requires consideration of evidence related to the other factors listed in the regulatory definition of "operational," such as whether or not Petitioner was prepared to submit valid Medicare claims, and whether the facility was properly staffed, equipped, and stocked to furnish items or services the supplier was authorized to furnish by its Medicare enrollment. Petitioner provided credible testimonial evidence from four witnesses, including Dr. Antoine, that Petitioner was open to the public; the office was staffed and furnished to provide medical services; and Petitioner was prepared to and submitting claims to Medicare during the relevant period. Although CMS argues that Petitioner never presented evidence of a lease for the Greenfield Road location covering the relevant period (CMS Br. at 7, 9, 12; CMS Reply at 5), CMS cites no law or policy that requires that a physician or physician's practice have a written lease. Further, Petitioner presented evidence that she had a verbal sublease agreement with Dr. Sagala. Tr. 264, 267; P. Ex. 1. The evidence of an oral sublease is unrebutted.

I conclude that Petitioner met its burden of showing by a preponderance of the credible evidence that it had a practice location at 23300 Greenfield Road, suite 205 room C, that was operational between February 23, 2011 and October 2012, including the dates of the site visits. The sole basis for Petitioner's revocation was its failure to be "operational." The preponderance of the evidence shows that Petitioner was, in fact, operational. Accordingly, CMS did not have a legal basis to revoke Petitioner's Medicare enrollment and billing privileges.

Petitioner requests payment for unpaid claims plus interest and compensation for financial losses due to the revocation of Petitioner's enrollment and billing privileges. P.

Br. at 16; P. Reply at 26. I express no opinion as to whether CMS may owe Petitioner any money as that is not a matter within my jurisdiction. Further, neither an ALJ nor the Board has the authority to grant equitable relief but is limited to determining whether or not CMS had a legal basis to revoke a provider's or supplier's billing privileges. *US Ultrasound*, DAB No. 2302, at 8 (2010). Therefore, Petitioner's request for money may not be granted in this forum.

III. Conclusion

For the foregoing reasons, I conclude that CMS has failed to establish a basis for the revocation of Petitioner's Medicare enrollment and billing privileges.

/s/
Keith W. Sickendick
Administrative Law Judge