Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Neb Group of Arizona LLC,
(Supplier No.: 5340910002; NPI 1871551903),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-705

Decision No. CR2970

Date: October 25, 2013

DECISION

The Medicare enrollment and billing privileges of Petitioner, Neb Group of Arizona LLC, are revoked pursuant to 42 C.F.R. §§ 424.57(d) and 424.535(a)(5)(ii),[1] effective December 4, 2012.

I. Background

The Supplier Audit and Compliance Unit (SACU) of the National Supplier Clearinghouse, operated by Palmetto GBA (Palmetto),[2] a Medicare contractor, notified

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[1] References are to the 2012 revision of the Code of Federal Regulations (C.F.R.), unless otherwise indicated.

[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).

Petitioner by letter dated January 4, 2013, that Petitioner's DMEPOS supplier number[3] was revoked effective December 4, 2012. Palmetto advised Petitioner that its DMEPOS supplier number was revoked pursuant to 42 C.F.R. § 424.535(a)(1) and (5)(ii) based on noncompliance with supplier standard 42 C.F.R. § 424.57(c)(7). Palmetto advised Petitioner that, pursuant to 42 C.F.R. § 424.535(g), the effective date of revocation was December 4, 2012, the date on which CMS determined that Petitioner's practice location was not operational. Palmetto advised Petitioner that it was subject to a two year ban on re-enrollment pursuant to 42 C.F.R. § 424.535(c). Palmetto further advised Petitioner that it could request reconsideration of the revocation. CMS Exhibit (CMS Ex.) 1 at 30-35, 63-65.

Petitioner requested reconsideration on February 15, 2013.[4] CMS Ex. 1 at 37. The reconsideration decision dated March 22, 2013, upheld the revocation of Petitioner's billing privileges. The Medicare hearing officer concluded that Petitioner failed to show compliance with Supplier Standard 7 (42 C.F.R. § 424.57(c)(7)). CMS Ex. 1 at 1-5.

Petitioner timely filed a request for a hearing before an administrative law judge (ALJ) on April 29, 2013, and included evidence related to its CAP. On May 7, 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 combined prehearing brief and motion for summary judgment (CMS Br.) with CMS Exs. 1 and 2 on June 6, 2013. Petitioner filed a responsive pleading (P. Br.) with no exhibits on July 13, 2013. CMS advised me by letter dated August 5, 2013, that it waived filing a reply brief. Petitioner

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[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 or supplier 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).

[4] Petitioner submitted a Corrective Action Plan (CAP) on January 21, 2013. CMS Ex. 1 at 39-74. Palmetto notified Petitioner by letter dated February 4, 2013, that Petitioner's CAP was being returned because Petitioner failed to request reconsideration of the initial determination to revoke Petitioner's billing privileges. CMS Ex. 1 at 38. However, as discussed hereafter, no right of review is triggered by the rejection or denial of the CAP, and I have no authority to review the contractor's actions related to the CAP.

did not object to my consideration of CMS Exs. 1 and 2 which are admitted and considered as evidence. Evidence submitted by Petitioner with its request for hearing related to its CAP is not admitted and considered as evidence, as it is not relevant to any issue that I may decide or duplicates and is cumulative of CMS 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.[5] 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).

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[5] 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).

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 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 application and enrollment form 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). Revocation is also authorized when CMS determines, based on an on-site review, that a provider or supplier is no longer operational to furnish Medicare covered items or services or is not meeting Medicare enrollment requirements. 42 C.F.R. § 424.535(a)(5).

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; and

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 has 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* 373 F.3d at 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 a 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 in 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 the 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 & 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 response to CMS's motion for summary judgment. Nor did Petitioner challenge the sufficiency of the investigator's

declaration (CMS Ex. 1, at 20) and CMS's other evidence. In fact, Petitioner admitted in its response to the CMS motion that it was not in compliance with the Medicare requirements during the two site-visits. P. Br. at 1. I conclude, as discussed hereafter, that there is no dispute as to any material fact in this case 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 for a hearing.

2. There is a basis for revocation of Petitioner's billing privileges pursuant to 42 C.F.R. § 424.57(d) for noncompliance with 42 C.F.R. § 424.57(c)(7) (Supplier Standard 7[6]).

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

a. Facts

The facts are undisputed. On Monday, December 3, 2012, at approximately 9:10 a.m., a SACU inspector attempted to conduct an unannounced site inspection at Petitioner's facility located at 8260 E. Raintree Dr., Suite 119, Scottsdale, Arizona 85260-2516. CMS Ex. 1, at 15. The attempt was made during Petitioner's posted hours of operation, which were Monday through Wednesday, 9:00 a.m. to 5:00 p.m., Thursdays, 9:00 a.m. to 3:00 p.m., and closed Fridays and Saturdays. CMS Ex. 1 at 16. The inspector found that she could not enter Petitioner premises. The inspector concluded that no one was at the premises. CMS Ex. 1, at 20. On the entrance door was a sign stating:

Just Stepped Out
Be Back Soon!

If you need immediate attention

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[6] 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. § 424.57(c).

**please call 480.595.7272 ext.8 and
someone will be able to help you.**

CMS Ex. 1 at 20, 25, 28.

On Tuesday, December 4, 2012, at approximately 1:44 p.m., the SACU inspector made a second attempt to enter Petitioner's premises. She noticed that the same sign she observed on December 3 was posted on the door. The inspector took date-stamped photographs on both days of both the front door and the posted hours of operation with the posted out-of-office sign. CMS Ex. 1 at 20, 25, 28.

Palmetto notified Petitioner that its billing privileges were revoked by letter dated January 4, 2013.

b. Analysis

CMS argues that revocation is appropriate in this case on two grounds: (1) Petitioner was not in compliance with the supplier standards established by 42 C.F.R. § 424.57(c); and (2) Petitioner was not incompliance with the Medicare enrollment requirement established by 42 C.F.R. § 424.535(a)(5)(ii). CMS Br. at 2.

Supplier Standard 7 requires that a DMEPOS supplier maintain a physical facility that, among other things, is accessible and staffed during posted hours of operation. 42 C.F.R. § 424.57(c)(7)(i)(C). Pursuant to 42 C.F.R. § 424.57(d), CMS is required to revoke a DMEPOS supplier's billing privileges if the supplier is found not to meet the standards established by 42 C.F.R. § 424.57(b) or (c). The regulation provides that the revocation is effective 15 days after the supplier is sent notice of the revocation.[7] The language of the regulation indicates that revocation is mandatory when there is noncompliance with the supplier standards and there is no requirement that the supplier be given the opportunity to submit a CAP.

Pursuant to 42 C.F.R. § 424.535(a)(5), CMS may revoke a supplier's billing privileges if CMS determines that the supplier is no longer operational to furnish Medicare covered items or services, or has failed to satisfy any or all of the Medicare enrollment requirements. 42 C.F.R. § 424.535(a)(5)(ii). The regulation requires that a supplier or

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[7] The regulation states that "[t]he revocation is effective 15 days after the entity is sent notice of the revocation, as specified in § 405.875 of this subchapter." There is, however, no 42 C.F.R. § 405.875 and the regulatory reference is ignored. The requirements for notice of an initial determination are set forth at 42 C.F.R. § 498.20 and for a reconsideration determination at 42 C.F.R. § 498.25.

provider be given an opportunity to correct the deficient compliance before a final determination to revoke billing privileges, except when the basis for revocation is 42 C.F.R. § 424.535(a)(2), (a)(3), or (a)(5), which provide generally as follows: (a)(2) the provider or supplier or certain specified officers, owners, or employees are excluded, debarred or suspended from participating in Medicare, Medicaid, or other federal health care programs; (a)(3) the owner or the provider or supplier has a felony conviction within a specified period; or (a)(5) based upon an on-site review, CMS determines that a provider or supplier is no longer operational to furnish Medicare covered items and services, or has failed to meet Medicare enrollment requirements, or has failed to furnish Medicare covered items or services as required by law, which is the provision applicable in this case. 42 C.F.R. § 424.535(a)(1).

The effective date of revocation of billing privileges of suppliers and providers established by 42 C.F.R. § 424.535(g) is different from the effective date of revocation for DMEPOS suppliers under 42 C.F.R. § 424.57(d). Generally, revocation is effective 30 days after CMS or the contractor mails the notice of revocation except in those instances specified by 42 C.F.R. § 424.535(a)(2), (a)(3), and (a)(5). In the case of 42 C.F.R. § 424.535(a)(5), the revocation is effective the date the supplier is no longer operational as determined by CMS.

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:

> 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 Ex. 1 at 1-5, 30-35, 63-65. 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 focuses on the date of the revocation, i.e., the date on which a supplier no longer met state licensure requirements, which would necessarily be a date prior to any adverse determination by CMS or its contractor. The regulation specifically lists several grounds for revocation, such as license suspension or revocation, conviction of a felony, or ceasing operations, 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, the effective date of revocation is the date on which Petitioner was found to be closed or not operational and not the date of either the adverse initial or reconsideration determinations.

I conclude based on my review of the regulations and the regulatory history, that the regulatory history is incorrect in stating that "appeal rights are limited to provider or supplier eligibility at the time the Medicare contractor made the adverse determination." What is really at issue in this case is whether or not there was a basis for revocation of Petitioner's billing privileges on the effective date of the revocation. A related issue in this case is whether or not the effective date was determined consistent with the regulations. There is no challenge to the adequacy of the notice in this case and no assertion the notice failed to satisfy 42 C.F.R. § 498.20.

The undisputed facts in this case establish that Petitioner's practice location was not open and available to the public, or for the SACU inspector to conduct an inspection, on either December 3 or 4, 2012, during posted office hours. Petitioner concedes in its brief that its office was not open when the SACU inspector attempted to inspect Petitioner's facility on December 3, 2012 and again on December 4, 2012; and that it was not in compliance with Supplier Standard 7 on those dates. P. Br. at 1. Accordingly, I conclude that CMS has made a prima facie showing that Petitioner was not in compliance with Supplier Standard 7, specifically 42 C.F.R. § 424.57(c)(7)(i)(C), because it is admitted and undisputed that the Petitioner's practice location was not accessible and staffed during posted hours of operation. Petitioner has not rebutted the prima facie showing or presented an affirmative defense. Section 424.57(d) of Title 42 provides that "CMS will revoke" the billing privileges of a supplier that is found not to meet the standards established by 42 C.F.R. § 424.57(c). Thus, CMS has no discretion not to revoke Petitioner's billing privileges because there is an admitted violation of 42 C.F.R. § 424.57(c)(7)(i)(C).

Pursuant to 42 C.F.R. § 424.57(d), the effective date of the revocation based on the failure to comply with 42 C.F.R. § 424.57(c)(7)(i)(C) would be 15 days after notice of the revocation, i.e., approximately January 19, 2013. However, in this case CMS revoked Petitioner's billing privileges effective December 4, 2012, which would be an effective date authorized by 42 C.F.R. § 424.535(g) under the limited circumstances specified by that regulation. Therefore, it is necessary to consider whether there was a basis for CMS to conclude that Petitioner was not operational as of December 4, 2012.

> *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 (emphasis in original). Again, there is no dispute that the SACU investigator found on December 3 and 4, 2012, that Petitioner's practice location was not opened during posted hours of operation. Accordingly, CMS had a legitimate basis to determine that Petitioner was not operational within the meaning of 42 C.F.R. § 424.502 as of December 4, 2012, and there is a basis for revocation pursuant to 42 C.F.R. § 424.535(a)(5)(ii). Although Petitioner has argued that it implemented a CAP, and there is evidence that it did so, Petitioner has not presented evidence to permit me to determine when Petitioner was last operational prior to or after the times the surveyor visited on December 3 and 4, 2012. I conclude that Petitioner has not met its burden to rebut the prima facie case of a basis for revocation by showing that it was operational.

Accordingly, I conclude that CMS and Palmetto had legitimate bases to revoke Petitioner's billing privileges and participation in Medicare as a DMEPOS supplier based on a violation of both 42 C.F.R. §§ 424.57(c)(7)(i)(C) and 424.535(a)(5)(ii). I also conclude that revocation effective December 4, 2012, was correctly determined pursuant to 42 C.F.R. § 424.535(g), as there was a proper basis for revocation pursuant to 42 C.F.R. § 424.535(a)(5)(ii).

4. There is no regulatory requirement that a supplier be granted an opportunity to submit a CAP or correct deficient compliance prior to revocation pursuant to 42 C.F.R. § 424.57(d).

5. Petitioner had no right to review of the contractor's rejection or denial of Petitioner's CAP and I have no authority to grant such review.

6. I have no authority to grant equitable relief.

Petitioner argues in its request for hearing and brief, and there is evidence, that Petitioner created and implemented a CAP. In this case, the CAP has no impact on the decision.

Pursuant to 42 C.F.R. § 424.57(d), CMS is required to revoke a DMEPOS supplier's billing privileges if the supplier is found not to meet the standards established by 42 C.F.R. § 424.57(b) or (c). The language of the regulations indicates that revocation is mandatory when there is noncompliance with the supplier standards and there is no requirement that the supplier be given the opportunity to submit a CAP. When revocation is pursuant to 42 C.F.R. § 424.535(a)(5), the regulations specify that a provider or supplier need not be given an opportunity to correct deficient compliance prior to the final determination to revoke billing privileges. 42 C.F.R. § 424.535(a)(1). The Board has also determined in prior cases that no right to ALJ or Board review is triggered by the rejection or denial of a CAP. *DMS Imaging, Inc.*, DAB No. 2313, at 7-10 (2010) *citing* 72 Fed. Reg. 9,479, at 9,483 (March 2, 2007) (carrier's refusal to reinstate billing privileges based on the submission of a CAP is not an initial determination subject to ALJ review) and 73 Fed. Reg. 36,448, at 36,452 (June 27, 2008). Finally, neither an ALJ nor the Board have the authority to grant equitable relief but are limited to determining whether or not CMS had a legal basis to revoke a provider's or supplier's billing privileges. *Letania Bussell, M.D.*, DAB No. 2196, at 12-13 (2008). Therefore, Petitioner's request for probationary status and consideration of extenuating circumstances (P. Br. at 1-2), may not be granted.

III. Conclusion

For the foregoing reasons, Petitioner's Medicare enrollment and billing privileges were properly revoked effective December 4, 2012, due to noncompliance with 42 C.F.R. §§ 424.57(c)(7)(i)(C) and 424.535(a)(5)(ii).

/s/
Keith W. Sickendick
Administrative Law Judge