Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Rita Lemons d/b/a Experts Are Us Inc.,

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-11-226

Decision No. CR2398

Date: July 15, 2011

DECISION

Petitioner, Rita Lemons d/b/a Experts Are Us Inc., a durable medical equipment supplier, appeals three reconsideration decisions dated November 23, 2010. The undisputed evidence establishes that Petitioner was not in compliance with all Medicare program requirements. As a consequence, I grant the motion of the Centers for Medicare and Medicaid Services (CMS) for summary judgment and uphold CMS's determinations to deny Petitioner's three applications for reenrollment in the Medicare program.

I. Background and Procedural History

In September of 2009, the Civil Remedies Division received a set of documents from Petitioner. Petitioner's submission was docketed as C-09-724 and assigned to Administrative Law Judge (ALJ) Carolyn Cozad Hughes. Thereafter, Petitioner submitted additional arguments and documents. After reviewing the documents, ALJ Hughes concluded that Petitioner was seeking a review of a 2004 determination by a CMS contractor revoking Petitioner's Medicare billing privileges as a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) and review also of

dispositions of Petitioner's subsequent applications. *Experts Are Us, Inc.*, DAB CR2047, at 2-4 (2009). ALJ Hughes determined that Petitioner had no right to ALJ review of the 2004 revocation because it occurred before the effective date of the statutory provision that created this hearing right. *Id.* at 3. ALJ Hughes also concluded that Petitioner had no right to review the contractor's subsequent dispositions of Petitioner's applications because they were "applications for reinstatement" after revocation and, therefore, not reviewable under 42 C.F.R. Part 498. *Id.* at 4. ALJ Hughes consequently dismissed the case.

Petitioner appealed the dismissal to the Appellate Division of the Departmental Appeals Board (Board), and the appeal was assigned Docket No. A-10-38. In response to an Order to Develop the Record, CMS stated that the three CMS contractor determinations contained in Petitioner's documents were denials of reenrollment applications and that denials of reenrollment applications, like denials of enrollment applications, were within an ALJ's review authority. CMS's position was contrary to its prior position at the ALJ level, in which it had argued that these contractor determinations were rejections of requests for reinstatement after revocation. CMS suggested the case be remanded to ALJ Hughes. After upholding ALJ Hughes' conclusion that she lacked authority to review the 2004 revocation, the Board remanded the case for "further proceedings consistent with this decision" as to the remaining denials of reenrollment applications dated August 1, 2007, December 11, 2007, and May 30, 2008. *Experts Are Us, Inc.*, DAB No. 2322, at 12 (2010).

Thereafter, pursuant to 42 C.F.R. § 498.78(b), ALJ Hughes remanded the case to "CMS or its Medicare contractor to reconsider its . . . determinations denying [Petitioner's] applications for reenrollment in the Medicare program." *Experts Are Us, Inc.*, DAB CR2180, at 1 (2010). ALJ Hughes directed CMS or its contractor "to reconsider the contractor's initial determinations, dated August 1, 2007, December 11, 2007, and May 30, 2008, in accordance with 42 C.F.R. §§ 498.22 and 498.24." *Id.* at 2.

Then, on September 2, 2010, Petitioner submitted the following documents: a 14-page document titled "Appeal 2322"; a five-page document titled "Motion to Admit or Deny Appeal 2322"; a two-page document titled "Re: Appeal 2322"; a three-page document described as a "calculation table"; and 37 pages of attachments, such as phone and insurance records. After reviewing Petitioner's documents, the Board concluded that the documents were most reasonably and fairly understood to be: (1) a request to reopen the Board's decision in DAB No. 2322; (2) an appeal of the ALJ Remand Decision in DAB CR2180; (3) a request to file additional evidence; and (4) a request for admissions and subpoenas. *Experts Are Us, Inc.*, DAB No. 2342, at 3 (2010).

The Board declined to reopen DAB No. 2322 and upheld the ALJ Remand Decision. The Board also denied Petitioner's request to file additional evidence, request for admissions, and request for subpoenas. *Id*. at 1.

Upon remand, CMS referred its contractor's initial determinations dated August 1, 2007, December 11, 2007, and May 30, 2008 to a Hearing Officer. On November 23, 2010, the Hearing Officer issued reconsideration decisions on all three determinations upholding the contractor's initial denials. CMS Exhibits (Exs.) 1, 7, 12.

Petitioner timely appealed the three reconsideration decisions, and the case was then assigned to me for possible hearing and decision. I issued an Acknowledgment and Pre-Hearing Order, and in accordance with that order, CMS filed a Motion for Summary Judgment and Supporting Brief-in-Chief (CMS Br.) accompanied by seventeen proposed exhibits. I admit all CMS Exhibits into the record of this case. Petitioner submitted Plaintiff's Response and Supplement to Appeal (P. Br.) with multiple exhibits that were not numbered in accordance with my Pre-Hearing Order. Petitioner also submitted her own Motion for Summary Judgment; however, it contains no discernible argument relevant to a showing of summary judgment and cites to no evidentiary support. I have renumbered Petitioner's proposed exhibits as P. Ex. 1, Pages 1-256 and admitted all the documents Petitioner proposed into the record of this case. With this decision, I have provided both Petitioner and CMS with a copy of Petitioner's renumbered exhibits. I also note that Petitioner references many documents, such as the affidavits of several individuals (described as P. Exs. E-6 through E-10), which Petitioner did not include with her bound submissions of proposed exhibits.

Although Petitioner raises a variety of issues in her response similar to Petitioner's positions in previous appeals, the only issues raised in response to CMS's Motion for Summary Judgment relate to whether CMS had a legitimate basis to deny each of Petitioner's three Medicare reenrollment applications in its November 23, 2010 reconsideration decisions. Moreover, Petitioner's other arguments have been fully addressed in previous iterations of this matter. *See Experts Are Us, Inc.*, DAB No. 2342 (2010). Thus, I decline to address Petitioner's numerous other allegations and requests for relief in this decision.

II. Applicable Law

Section 1834(j)(1) of the Social Security Act, 42 U.S.C. § 1395m(j)(1), states the requirements for the issuance and renewal of a supplier number for suppliers of medical equipment and supplies. This section provides that "no payment may be made . . . for items furnished by a supplier of medical equipment and supplies unless such supplier obtains (and renews at such intervals as the Secretary may require) a supplier number."

To participate in Medicare as a medical equipment supplier and to maintain a supplier number and billing privileges, an entity must also meet the specific requirements, referred to as "supplier standards," set forth at 42 C.F.R. § 424.57(c) for suppliers of "durable medical equipment, prosthetics, orthotics, and supplies." 42 C.F.R. § 424.57(a). A

supplier seeking reenrollment must submit a new application and supporting documentation, which must be validated before the entity can become a Medicare supplier. *See* 42 C.F.R. § 424.505.

Regulations provide that CMS will deny a supplier's application for Medicare billing privileges, if it is found not to meet the supplier standards or other requirements in section 424.57(c). 42 C.F.R. § 424.57(d), (e). Supplier standard eight requires a supplier to allow CMS or CMS contractors to conduct on-site inspections to ascertain supplier compliance with Medicare requirements. 42 C.F.R. § 424.57(c)(8). Also, a supplier must maintain a physical facility on an appropriate site. 42 C.F.R. § 424.57(c)(7). Furthermore, CMS may deny a supplier's application for Medicare billing privileges if it determines, based on an on-site review, that the supplier: (1) is no longer operational to furnish Medicare covered items or services; or (2) otherwise fails to meet Medicare enrollment requirements. 42 C.F.R. § 424.530(a)(5).

The "clear intent of [42 C.F.R. § 424.57(c)] is that a supplier must comply with *each*, and not just some, of the enrollment standards in order to qualify for enrollment or re-enrollment. As a consequence, a supplier seeking re-enrollment that fails to demonstrate that it complies with even one of the regulatory standards will not qualify for re-enrollment . . . . A supplier must comply with the *letter* of the standards if it wishes to enroll or be re-enrolled." *Palmetto Pharmacy & Diagnostic, Inc.*, DAB CR1529 (2006).

III. Issue, Findings of Fact, Conclusions of Law

A. Issue

The issue in this case is whether CMS is entitled to summary judgment on the grounds that CMS had a legitimate basis to deny each of Petitioner's three reenrollment applications.

B. Applicable Standard

Summary judgment is appropriate when a case presents no issue of material fact, and its resolution turns on questions of law. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-48 (1986); *Livingston Care Ctr. v. United States Dep't of Health and Human Servs.*, 388 F.3d 168, 173 (6th Cir. 2004). *See Illinois Knights Templar Home*, DAB No. 2274, at 3-4 (2009) (*citing Kingsville Nursing Ctr.*, DAB No. 2234, at 3-4 (2009)).

The moving party may show the absence of a genuine factual dispute by presenting evidence so one-sided that it must prevail as a matter of law, or by showing that the non-moving party has presented no evidence "sufficient to establish the existence of an element essential to [that party's] case, and on which [that party] will bear the burden of

proof at trial." *Livingston Care Ctr.*, 388 F.3d at 173 (*quoting Celotex Corp. v. Catrett*, 477 U.S. 317, 323-24 (1986)). To avoid summary judgment, the non-moving party must then act affirmatively by tendering evidence of specific facts showing that a dispute exists. *See Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 n.11 (1986); *see also Vandalia Park*, DAB No. 1939 (2004); *Lebanon Nursing and Rehab. Ctr.*, DAB No. 1918 (2004).

To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact . . . . *Illinois Knights Templar*, DAB No. 2274, at 4; *Livingston Care Ctr.*, DAB No. 1871, at 5 (2003). In examining the evidence to determine the appropriateness of summary judgment, I must draw all reasonable inferences in the light most favorable to the non-moving party. *See Brightview Care Ctr.*, DAB No. 2132, at 2, 9 (2007); *Livingston Care Ctr.*, 388 F.3d at 168, 172; *Guardian Health Care Ctr.*, DAB No. 1943, at 8 (2004); *but see Cedar Lake*, DAB No. 2344, at 7; *Brightview*, DAB No. 2132, at 10 (noting entry of summary judgment upheld where inferences and views of non-moving party are not reasonable). However, drawing factual inferences in the light most favorable to the non-moving party does not require that I accept the non-moving party's legal conclusions. *Cedar Lake*, DAB No. 2344, at *7; Guardian*, DAB No. 1943, at 11 ("A dispute over the conclusion to be drawn from applying relevant legal criteria to undisputed facts does not preclude summary judgment if the record is sufficiently developed and there is only one reasonable conclusion that can be drawn from those facts.").

C. Analysis

My findings and conclusions are in the italicized headings and subsequent discussions below.

1) CMS had a legitimate basis to deny Petitioner's June 25, 2007 Medicare reenrollment application because Petitioner was not in compliance with supplier regulations.

On November 23, 2010, a hearing officer from Palmetto GBA, the Medicare contractor, issued a reconsideration decision based on an August 1, 2007 initial determination denying Petitioner's reenrollment application dated June 25, 2007. CMS Ex. 1; CMS Ex. 6, at 18. The hearing officer determined that the initial determination should be upheld and found Petitioner not in compliance with nine separate supplier standards. CMS Ex. 1, at 3-4. The hearing officer concluded Petitioner had not provided evidence to show she had fully complied with the standards for which she was considered non-compliant in the initial determination. The hearing officer did not identify any newly submitted documentation, so I presume the hearing officer relied on the evidence used in the initial determination. *Id*.

I must exclude any documentary evidence that is submitted for the first time at the ALJ level, unless Petitioner has established good cause for not submitting it previously. *See* 42 C.F.R. § 498.56(e). However, in this case, to fully consider the evidence in the light most favorable to the non-moving party, and because I am not certain whether there is new evidence due to the lack of any objection from CMS, I will not exclude any evidence Petitioner has submitted that might establish compliance with the supplier standards.

It is undisputed that on May 7, 2007, a fraud investigator from the Medicare contractor National Supplier Clearinghouse (NSC), attempted an on-site review at 6635 McCollum, Missouri City, TX. CMS Ex. 3. The fraud investigator reported he encountered a residence at Petitioner's address of record without a sign identifying the business. *Id*. at 1-2, 6-10. However, the 6635 McCollum, Missouri City, TX address is not listed as the official business location on Petitioner's reenrollment application. CMS Ex. 6, at 5. This address is listed instead as a medical record storage facility. CMS Ex. 6, at 8. Petitioner objects to the contention that Petitioner submitted a reenrollment application for this location. P. Br. at 3. There appears to be a genuine issue of disputed material fact as to whether this location was an official business address for Petitioner. Nonetheless, CMS also based its reconsideration decision on a July 18, 2007 on-site review at Petitioner's business location, which I need now also consider.

It is undisputed that on July 18, 2007, an NSC fraud investigator completed this on-site review of Petitioner's facility at 303 Ulrich Street, Ste. J, Sugarland, TX. CMS Ex. 4. This is the address that appears as the official business address on Petitioner's reenrollment application. CMS Ex. 6, at 5. The fraud investigator found Petitioner not in compliance with supplier standards: 1 (failure to comply with all licensure and regulatory requirements); 4 (failure to have its own inventory); 5 (failure to advise of rental/purchase option agreements); 6 (failure to have documentation of warranty coverage); 8 (failure to make its location accessible to beneficiaries); 10 (failure to have a comprehensive liability insurance policy); 12 (failure to have written instructions or information for beneficiaries on the use of equipment); 14 (failure to have a repair or service contract); and 20 (failure to maintain a complaint log). CMS Exs. 2 and 4.

The fraud investigator provided Petitioner written notice of each standard of non-compliance on a "Site Visit Acknowledgement" Form. CMS Ex. 4, at 6; P. Ex. 1, at 34. Petitioner signed that she received this information. *Id.* By signing this form, Petitioner acknowledged the following: Petitioner had been provided notice of the 21 supplier standards listed at 42 C.F.R. § 424.57; the NSC fraud investigator requested specific items listed on the "Site Visit Acknowledgement" form to be faxed to the fraud investigator within 2 business days; and notice that Petitioner's failure to provide the requested information could result in the denial or revocation of Petitioner's Medicare supplier billing number. CMS Ex. 4, at 6.

In her response, Petitioner claims that she faxed the fraud investigator nineteen pages that evidenced her compliance with the applicable regulations. P. Br. at 3, 25. However, Petitioner does not proffer the full fax response but rather a fax transmission sheet showing nineteen pages were faxed to the NSC fraud investigator on July 18, 2007. P. Ex. 1, at 35-36. A mere scintilla of supporting evidence is not sufficient to overcome a well-supported motion for summary judgment. "If the evidence is merely colorable or is not significantly probative, summary judgment may be granted." *Livingston Care Ctr. v. Dep't. of Health & Human Servs.*, No. 033489, 2004 WL 1922168, at 4 (6th Cir. 2004) (quoting *Anderson v. Liberty Lobby*, 477 U.S. 242, at 249-50 (1986)). Therefore, although I will consider and discuss other relevant exhibits from Petitioner that relate to the supplier standards, the mere production of a fax transmission sheet will not in itself be sufficient to establish a genuine issue of material fact for summary judgment purposes.

Clearly, a supplier must certify in its application for Medicare enrollment that it meets, and will continue to meet, all the supplier standards to obtain and maintain Medicare enrollment and billing privileges. 42 C.F.R. § 424.57(c). I will separately discuss Petitioner's purported compliance with each of the supplier standards CMS claims Petitioner did not satisfy. I note that the failure to comply with just *one* supplier standard would be a sufficient basis for the denial of Petitioner's Medicare enrollment application. *See 1866ICPayday.com*, DAB No. 2289, at 13 (2009). However, in the interests of clarity and completeness of the record, I have addressed every supplier standard noted in the November 23, 2010 reconsideration decision based on the August 1, 2007 initial determination denying Petitioner's reenrollment application.

Supplier Standard 1(failure to comply with all licensure and regulatory requirements)

Supplier standard 1 states that a Petitioner must operate its business and furnish Medicare-covered items in compliance with all applicable Federal and State licensure and regulatory requirements. 42 C.F.R. § 424.57(c)(1) (2006). The fraud investigator specifically requested Petitioner provide, within two business days: "TDH licenses, sales tax permit, and IRS Form w[ith] EIN." CMS Ex. 4, at 6. Petitioner provided CMS with a sales and use tax permit and a state medical device distributor license. CMS Ex. 4, at 9; CMS Ex. 6, at 21-25. There is no evidence in the record indicating that Petitioner provided the fraud investigator with an IRS Form with EIN. The investigator had previously noted that the Petitioner's sales tax permit was missing the suite identifier. CMS Ex. 4, at 3; CMS Ex. 4, at 9.

For purposes of summary judgment, I must review the evidence in the light most favorable to Petitioner and draw all reasonable inferences in Petitioner's favor. Because Petitioner has come forward with some proof that Petitioner met state licensure and regulatory requirements, and because it is unclear which specific laws CMS claims

Petitioner has not demonstrated compliance with, I conclude that CMS has not met its burden of showing that there are no genuine issues of material fact for hearing and that it is entitled to judgment as a matter of law with regard to Petitioner's non-compliance with supplier standard 1.

Supplier Standard 4 (failure to have its own inventory)

Supplier standard 4 requires that a supplier "[f]ills orders, fabricates, or fits items from its own inventory or by contracting with other companies for the purchase of items necessary to fill the order. If it does, it must provide, upon request, copies of contracts or other documentation showing compliance with this standard . . . ." 42 C.F.R. § 424.57(c)(4) (2006). The fraud investigator specifically requested credit agreements or invoices pursuant to supplier standard 4. CMS Ex. 4, at 6. Petitioner provided a list of supplies she claims were in her inventory, including items such as hoyer lifts, manual wheel chairs, motorized wheel chairs, speech generating devices, kangaroo pumps, suction pumps, dialysis equipment and supplies, C-PAP/Bi-PAP equipment, hospital beds, pressure reducing mattresses, stair lifter/climber, lymphedema pumps, portable commode, tens units, and diabetic supplies. CMS Ex. 4, at 19. Petitioner also provided access to diapers, expired diabetic supplies, surgical dressings, and a used hoyer. CMS Ex. 4, at 4.

In Petitioner's brief, Petitioner claims the business contracted with a wholesaler and private individual to purchase equipment and supplies as needed for a fee. P. Br. at 25. However, Petitioner did not come forward with any evidence of such credit agreements or invoices. I conclude that there is no genuine issue of disputed material fact regarding Petitioner's failure to have her own inventory because Petitioner has submitted no contracts or other documentation to show compliance with this supplier standard. Thus, CMS is entitled to summary judgment with regard to Petitioner's violation of supplier standard 4.

Supplier Standard 5 (failure to advise of rental/purchase option agreements)

Supplier standard 5 "[a]dvises beneficiaries that they may either rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental durable medical equipment, as defined in § 414.220(a) of this subchapter. (The supplier must provide, upon request, documentation that it has provided beneficiaries with this information, in the form of copies of letters, logs, or signed notices)." 42 C.F.R. § 424.57(c)(5) (2006).

The fraud investigator specifically requested, within 2 business days, rental/purchase option agreements and a "new policy with IRP notification" specifically pursuant to this supplier standard. CMS Ex. 4, at 6. I can find no evidence in the record indicating that Petitioner provided this documentation to the fraud investigator or other evidence that

would raise a genuine dispute of material fact with regard to whether Petitioner complied with this standard.

I conclude that it is undisputed that Petitioner was not in compliance with supplier standard 5, and CMS is entitled to summary judgment with regard to a violation of this supplier standard.

Supplier Standard 6 (failure to have documentation of warranty coverage)

In accordance with supplier standard 6 a supplier must honor "all warranties expressed and implied under applicable State law. A supplier must not charge the beneficiary or the Medicare program for the repair or replacement of Medicare covered items or for services covered under warranty. This standard applies to all purchased and rented items, including capped rental items, as described in § 414.229 of this subchapter. The supplier must provide, upon request, documentation that it has provided beneficiaries with information about Medicare covered items covered under warranty, in the form of copies of letters, logs, or signed notices." 42 C.F.R. § 424.57(c)(6) (2006).

The fraud investigator specifically requested that Petitioner provide proof of warranty coverage pursuant to this supplier standard. CMS Ex. 4, at 6. Petitioner provided a blank "Customer Briefing Form" where a customer was to check that he or she received detailed instruction on "Products and Warranty, Proof of Delivery and No Return policy." CMS Ex. 4, at 15. However, I can find no documentation indicating that Petitioner ever provided CMS with product and warranty information provided to beneficiaries in the form of letters, logs, or signed notices.

I therefore conclude that it is undisputed that Petitioner has not provided documentation that she has provided beneficiaries with information about Medicare covered items covered under warranty. I therefore find Petitioner is not in compliance with supplier standard 6, and CMS is entitled to summary judgment.

Supplier Standard 8 (failure to make its location accessible to beneficiaries)

Supplier standard 8 "[p]ermits CMS, or its agents to conduct on-site inspections to ascertain supplier compliance with the requirements of this section. The supplier location must be accessible during reasonable business hours to beneficiaries and to CMS, and must maintain a visible sign and posted hours of operation." 42 C.F.R. § 424.57(c)(8) (2006).

The fraud investigator specifically requested a receipt for a portable ramp or a protocol for assisting beneficiaries. CMS Ex. 4, at 6. The fraud investigator took pictures of Petitioner's business, including a visible sign, and the fraud investigator was able to enter Petitioner's location during reasonable posted hours to interact with management and to

ascertain supplier compliance. *Id*. at 1-4, 21. Petitioner has also provided a July 26, 2007 email from Petitioner to the fraud investigator regarding handicapped accessibility but provides no pictures allegedly attached to the email. P. Ex. 1, at 37.

I cannot conclude for purposes of summary judgment that Petitioner was in violation of this supplier standard. There is no evidence of any notice provided to Petitioner as to how the lack of a ramp specifically affected the accessibility of Petitioner's location. Further, Petitioner appears to dispute a genuine issue of material fact with regard to her compliance with signage and staffing requirements pursuant to this supplier standard. Thus, CMS has not met its burden and is not entitled to summary judgment with regard to supplier standard 8.

Supplier Standard 10 (failure to have a comprehensive liability insurance policy)

Supplier Standard 10 provides that a supplier must have "a comprehensive liability insurance policy in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. In the case of a supplier that manufactures its own items, this insurance must also cover product liability and completed operations. Failure to maintain required insurance at all times will result in revocation of the supplier's billing privileges retroactive to the date the insurance lapsed." 42 C.F.R. § 424.57(c)(10) (2006).

The fraud investigator specifically requested, within two business days, a "[c]omprehensive liability insurance policy and/or the Certificate of Insurance showing NSC as the certificate holder" pursuant to this supplier standard. CMS Ex. 4, at 6. The fraud investigator noted on his site investigation report that Petitioner's certificate contained an incomplete address. *Id.* at 3.

It appears that Petitioner provided the NSC investigator with a certificate of liability insurance, in the requisite amount, but it had an incomplete address. CMS Ex. 4 at 3; P. Ex. 1, at 44. On my inspection of the documents Petitioner submitted, I can determine that the suite number is missing from Petitioner's address on Petitioner's certificate of commercial general liability insurance. P. Ex. 1, at 44.

Thus, by coming forward with this evidence, Petitioner appears to raise a dispute as to a genuine issue of material fact with regard to her compliance with supplier standard 10. For purposes of summary judgment, I will not determine that Petitioner was in violation with this supplier standard, despite CMS's concerns about an incomplete address. I therefore determine that CMS is not entitled to summary judgment with regard to this supplier standard.

Supplier Standard 12 (failure to have written instructions or information for beneficiaries on the use of equipment)

In accordance with supplier standard 12 a supplier "must be responsible for the delivery of Medicare covered items to beneficiaries and maintain proof of delivery. (The supplier must document that it or another qualified party has at an appropriate time, provided beneficiaries with necessary information and instructions on how to use Medicare-covered items safely and effectively)." 42 C.F.R. § 424.57(c)(12) (2006).

The fraud investigator specifically requested "[d]ocumentation for written instruction/information on beneficiary use/maintenance of supply," including "educational material/training material" pursuant to this supplier standard. Petitioner appears to have provided a blank one-page "Customer Briefing Form" checklist and a one-page "Patient Post Education Form." CMS Ex. 4 at 15, 19. Both of the forms are totally devoid of any meaningful written instructions or information to assist Medicare beneficiaries with their supplies. *Id.*

Petitioner has not submitted more than a scintilla of supporting evidence on this issue, and I conclude that it is undisputed that Petitioner did not provide appropriate documentation with the necessary information and instruction on how to use Medicare covered items safely and effectively. Therefore, Petitioner is not in compliance with this supplier standard, and CMS is entitled to summary judgment.

Supplier Standard 14 (failure to have a repair or service contract)

To comply with Supplier Standard 14, a supplier "[m]ust maintain and replace at no charge or repair directly, or through a service contract with another company, Medicare-covered items it has rented to beneficiaries. The item must function as required and intended after being repaired or replaced." 42 C.F.R. § 424.57 (c)(14) (2006).

The fraud investigator specifically requested, within two business days, a repair contract/service agreement and a return policy. Petitioner has not provided any supporting evidence of such a repair contract/service agreement. Further, Petitioner provided proof of a blank "No Return Policy" (CMS Ex. 4, at 14) and a 2003 document signed by an apparent client certifying to the "No Return Policy" (P. Ex. 1, at 181), which does not comport with the requirements of this supplier standard. Petitioner cites to her exhibits "E" and "V" and CMS Ex. 4 to show she had the necessary inventory, credit agreements, and repair contracts to comply with this supplier standard. P. Br. at 22. However, after reviewing Petitioner's exhibits, I do not find any such agreements.

Thus, I conclude that Petitioner has not raised a genuine issue of fact as to whether

Petitioner was in compliance with this supplier standard, and CMS is entitled to summary judgment.

Supplier Standard 20 (failure to maintain a complaint log)

Supplier Standard 20 states that a supplier "[m]ust maintain the following information on all written and oral beneficiary complaints, including telephone complaints, it receives: (i) The name, address, telephone number, and health insurance claim number of the beneficiary. (ii) A summary of the complaint; the date it was received; the name of the person receiving the complaint, and a summary of actions taken to resolve the complaint. (iii) If an investigation was not conducted, the name of the person making the decision and the reason for the decision." 42 C.F.R. § 424.57 (c)(20) (2006).

The fraud investigator specifically requested that Petitioner provide him, within two business days, a complaint log pursuant to this supplier standard. Petitioner has provided an undated complaint from one of Petitioner's clients. P. Ex. 1, at 213. The nature of the complaint was apparently regarding the client's concern regarding a visit from a federal agent investigating his receipt of wheelchairs. *Id.*

I note that Petitioner only submitted one complaint, which does not comport with all the information collection requirements of Supplier Standard 20. However, for purposes of summary judgment, I will infer that Petitioner has raised a dispute as to a genuine issue of material fact with regard to whether Petitioner maintained a compliant log in compliance with this supplier standard. Thus, I do not find that CMS met its burden on summary judgment with regard to supplier standard 20.

In sum, based on the undisputed facts, I find Petitioner did not meet the requirements of multiple supplier standards. CMS clearly had a legitimate basis to deny Petitioner's June 25, 2007 Medicare reenrollment application because Petitioner was not in compliance with the applicable regulations and is thus entitled to summary judgment. *See 1866ICPayday.com*, DAB No. 2289, at 13 ("[F]ailure to comply with even one supplier standard is a sufficient basis for [denying] a supplier's [Medicare] billing privileges.").

2) CMS had a legitimate basis to deny Petitioner's August 22, 2007 Medicare reenrollment application because Petitioner was not in compliance with supplier regulations.

The Medicare hearing officer also issued a November 23, 2010 reconsideration decision based on a December 11, 2007 initial determination by the CMS contractor denying Petitioner's second reenrollment application dated August 22, 2007. CMS Exs. 7, 8, 11.

It is undisputed that on October 16, 2007, the same NSC fraud investigator attempted an

on-site inspection of a 6420 Richmond Avenue, Houston, TX address Petitioner listed on the second reenrollment application. CMS Ex. 9; CMS Ex. 11, at 8; P. Br. at 6. The fraud investigator found the office closed at 12:15 p.m. The fraud investigator left a notice with regard to the inspection attempt that stated in part:

> "[T]he visit was unsuccessful because the facility was closed or an authorized representative was not available. A second unannounced attempt will be made soon during your posted hours of operation. If we are unable to complete the inspection, it may be concluded that this company is not open for business. In addition, the company will be determined to be in non-compliance with the 21 Medicare DMEPOS Supplier Standards as listed in 42 C.F.R. 424.57(c), and it will be subject to denial or revocation of its Medicare DMEPOS supplier number."

CMS Ex. 10.

On October 17, 2007, the NSC fraud investigator made a second attempt at 11:40 a.m. to inspect the facility. CMS Ex. 9. Again, the fraud investigator found the office closed. He took pictures and completed a written report. *Id.* CMS has also provided written direct testimony to support the fraud investigator's report. CMS Ex. 17, at 4.

Petitioner does not dispute that the office was locked and unattended during the fraud investigator's on-site visit on October 16, 2007. P. Br. at 2. Petitioner questions the site visit the next day because she believes that the fraud investigator should have left notice at that time if he in fact attempted to conduct a site inspection. P. Br. at 2. Nonetheless, Petitioner argues that she was "locked out illegally" from the business during this timeframe. *Id.*

However, Petitioner cannot defeat CMS's summary judgment motion on this issue because Petitioner has not furnished any evidence of a dispute concerning a material fact that, if proven, would affect the outcome of the case under governing law. Petitioner does not support the claim that the office was illegally closed with any evidence. Petitioner merely makes statements that Petitioner previously complained about this issue to other governmental authorities. P. Br. at 2. Petitioner's statements alone, without supporting evidence or documentation, do not create a genuine issue of disputed material fact.

CMS contends that it attempted, and was unable to conduct, an on-site review of Petitioner's facility during Petitioner's posted hours of operation in October of 2007 because the facility was closed. In accordance with supplier standard 8, a Medicare supplier must permit "CMS, or its agents to conduct on-site inspections to ascertain supplier compliance with the requirements of this section. The supplier location must be accessible during reasonable business hours to beneficiaries and to CMS . . . ." 42 C.F.R.

§ 424.57(c)(8) (2007). The documentary evidence Petitioner has submitted does not demonstrate Petitioner's compliance with supplier standard 8 at the time of the on-site review. Instead, Petitioner acknowledges that the office was closed and does not produce any evidence to show why Petitioner was "locked out illegally."

Furthermore, a showing that Petitioner was operational at some time prior to, or after, the on-site review would not provide a basis for reversing the denial of Petitioner's enrollment application. CMS is authorized to deny a supplier's Medicare billing privileges based upon the failure to be accessible when the inspector attempted an on-site review, regardless of whether it may have been operational at some earlier or later time. *See Mission Home Health.*, DAB No. 2310 (2010). CMS and its contractors have limited resources and cannot be compelled to attempt multiple on-site inspections during a potential enrollee's posted business hours to determine if the facility complies with all Medicare requirements. Thus, I find the CMS decision to deny Petitioner's Medicare enrollment and billing privileges was justified based upon the unrefuted observations of the fraud investigator that Petitioner was not open and accessible during business hours during the attempted on-site review in October of 2007.

Therefore, CMS is entitled to summary judgment with regard to its denial of Petitioner's August 22, 2007 Medicare reenrollment application. Petitioner clearly was not in compliance with supplier standard 8, as it is undisputed that Petitioner did not permit CMS, or its agents, to conduct an on-site inspection to ascertain supplier compliance with applicable Medicare requirements.

3) CMS had a legitimate basis to deny Petitioner's April 4, 2008 Medicare reenrollment application because Petitioner was not in compliance with supplier regulations.

The Medicare hearing officer also issued a November 23, 2010 reconsideration decision based on a May 30, 2008 initial determination by a CMS contractor denying Petitioner's third reenrollment application dated April 4, 2008. CMS Exs. 12, 13, 16.

It is undisputed that on April 22, 2008 at 8:45 a.m., the same NSC fraud investigator attempted an on-site inspection at Petitioner's place of business at 6420 Richmond Avenue, Houston, TX. Petitioner's posted hours were 8:30 a.m. to 4:30 p.m. CMS Ex. 14, at 1, 7. The fraud investigator discovered that a property management company had placed a plaque on Petitioner's door. CMS Ex. 14, at 7; CMS Ex. 17, at 4. The plaque stated that the property management had changed the lock on Petitioner's door due to the delinquency of rent. *Id.* The notice further stated that Petitioner could obtain a key to the office only upon payment of all delinquent amounts. *Id.*

The fraud investigator left a notice of the attempted inspection. CMS Ex. 15. The notice warned:

> A representative of the National Supplier Clearing house attempted to conduct an inspection of your company, Experts Are Us, Inc. The first attempt was made today, 4/22/08; however, the visit was unsuccessful because the facility was closed or an authorized representative was not available. A second unannounced attempt will be made soon during your posted hours of operation. If we are unable to complete the inspection, it may be concluded that this company is not open for business. In addition, the company will be determined to be in non-compliance with the 21 Medicare DMEPOS Supplier Standards as listed in 42 CFR 424.47(c), and it will be subject to denial or revocation of its Medicare DMEPOS supplier number.

Id. The fraud investigator also provided written direct testimony to support his report. CMS Ex 17, at 4.

The fraud investigator reported making a second attempt at a site inspection on April 23, 2008 at 8:30 a.m. and found the same plaque on Petitioner's door. CMS Ex. 14; CMS Ex. 17, at 4. Further, the fraud investigator reported that the Petitioner's business phone number was no longer listed with directory assistance, which suggests a violation of supplier standard 9. CMS Ex. 14, at 10; CMS Ex. 17, at 4.

Petitioner disputes the second attempt at an on-site inspection on April 23, 2008 only. P. Br. at 8. In support of her contention, Petitioner cites to affidavits that she did not include with her submitted response brief and exhibits. *Id.* However, for purposes of summary judgment, even if I were to infer that the fraud investigator did not make a second attempt at an on-site inspection on April 23, 2008, it is immaterial to my decision.

Like the October 2007 site visit discussed above, CMS contends that it attempted, but was unable to conduct, an on-site review of Petitioner's facility on April 22, 2008 because the facility was closed. The documentary evidence Petitioner has submitted does not demonstrate Petitioner's compliance with all Medicare requirements at the time of the on-site inspection. Instead, Petitioner concedes that the office was closed on this date.

Again, CMS is authorized to deny a provider or supplier's Medicare billing privileges based upon the failure to be accessible when the inspector visited its address, regardless of whether it may have been operational at some earlier or later time. *See Mission Home Health*, DAB No. 2310. Only one attempted site visit is necessary during a potential enrollee's posted business hours, as CMS and its contractors have limited resources and cannot be compelled to attempt multiple on-site inspections to determine if the facility is in compliance with Medicare requirements. Thus, I find the CMS decision to deny Petitioner's Medicare enrollment and billing privileges was justified based upon the uncontested observations of the fraud inspector that Petitioner was not open during

business hours during the attempted on-site inspection on April 22, 2008. Therefore, CMS is entitled to summary judgment with regard to its denial of Petitioner's April 4, 2008 Medicare reenrollment application.

IV. Conclusion

I deny Petitioner's Motion for Summary Judgment. The undisputed facts establish that CMS is entitled to summary judgment as a matter of law with regard to all three reconsideration decisions dated November 23, 2010. I therefore grant summary judgment in favor of CMS and sustain the denials of Petitioner's Medicare reenrollment applications.

/s/
Joseph Grow
Administrative Law Judge