Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Creative Orthotics & Prosthetics dba Marshall Labs
(PTAN: 0456230013)

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-11-290

Decision No. CR2407

Date: August 5, 2011

DECISION

For the reasons set forth below, I grant the Centers for Medicare and Medicaid Services' (CMS's) motion for summary judgment. The undisputed evidence establishes that Petitioner, Creative Orthotics & Prosthetics dba Marshall Labs, did not notify CMS that it moved to another location within the regulatory time period of 30 days, and CMS was therefore not able to conduct an on-site visit of Petitioner's facility. I thus sustain CMS's determination that Petitioner was not compliant with Medicare requirements and conclude that CMS had the authority to revoke Petitioner's Medicare enrollment and billing privileges with a two-year bar on re-enrollment.

I. Background

Petitioner, a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), requested an Administrative Law Judge (ALJ) hearing challenging CMS's determination to revoke Petitioner's enrollment in the Medicare program. With its hearing request, Petitioner submitted a timeline of events it created and several additional documents it labeled as attachments one through seven.

The case was assigned to me for a hearing and a decision. I issued a pre-hearing order in which I directed CMS and Petitioner to file pre-hearing exchanges of their proposed exhibits and briefs. On March 31, 2011, CMS filed its motion for summary judgment (CMS Br.) and six proposed exhibits (CMS Exs. 1 -6). I receive these CMS exhibits into the record. Petitioner filed its opposition to the CMS motion (P. Br.) on May 5, 2011.

CMS objects to the timeline and documentary evidence Petitioner submitted with its hearing request. CMS Br. at 8. CMS argues that I should exclude them pursuant to 42 C.F.R. § 498.56(e) because these documents constitute new evidence, and Petitioner failed to establish good cause for their submission. *Id*. I will admit these documents into the record considering that, even while admitted, they remain immaterial to my decision.

II. Applicable Law

Pursuant to section 1834(j)(1)(A) of the Social Security Act, Medicare may not pay a supplier of medical equipment for items provided to an eligible beneficiary unless the supplier has a supplier number that the Secretary of the Department of Health and Human Services issued. To participate in Medicare as a DMEPOS supplier and obtain a supplier number, an entity must meet the 26 supplier standards specified at 42 C.F.R. § 424.57(c)(1) through (26). Among these, the regulation provides that a supplier–

> (c)(2) . . . provide complete and accurate information in response to questions on its application for billing privileges. The supplier must report to CMS any changes in information supplied on the application within 30 days of the change.);
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> *** * ***
>
> (c)(7) Maintains a physical facility on an appropriate site. The physical facility must contain space for storing business records including the supplier's delivery, maintenance, and beneficiary communication records. For purposes of this standard, a post office box or commercial mailbox is not considered a physical facility. In the case of a multi-site supplier, records may be maintained at a centralized location; [and]
>
> (c)(8) Permits 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)(2), (c)(7), (c)(8).

The revocation of a supplier number is governed by 42 C.F.R. § 424.535. CMS may use an on-site review to determine whether a "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 supplier is operational when it "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 . . . to furnish these items or services." 42 C.F.R. § 424.502.

III. Issue

The issue is whether CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges.

IV. Discussion

My findings of fact and conclusions of law are set forth in italics and bold in the discussion captions of this decision.

A. Summary judgment is appropriate in this case.

CMS argues that it is entitled to summary judgment. The Departmental Appeals Board (Board) stated the standard for summary judgment:

> Summary judgment is appropriate when the record shows that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. . . . The party moving for summary judgment bears the initial burden of showing that there are no genuine issues of material fact for trial and that it is entitled to judgment as a matter of law. . . . To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact – a fact that, if proven, would affect the outcome of the case under governing law. . . . In determining whether there are genuine issues of material fact for trial, the reviewer must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor.

Senior Rehab. & Skilled Nursing Ctr., DAB No. 2300, at 3 (2010) (citations omitted). An ALJ's role in deciding a summary judgment motion differs from its role in resolving a case after a hearing. The ALJ should not assess credibility or evaluate the weight of conflicting evidence. *Holy Cross Vill. at Notre Dame, Inc*, DAB No. 2291, at 5 (2009).

I have accepted all of Petitioner's factual assertions as true and drawn all reasonable inferences in its favor. CMS argues that it is entitled to summary judgment because there is no genuine dispute as to any material fact. CMS Br. at 2. Indeed, Petitioner has not disputed the key material fact in this case, specifically, that it was not in compliance when it did not notify the Medicare contractor of its change in address within the required time period. P. Br. at 1-2; CMS Ex. 3, at 2 (setting forth Petitioner's request for reconsideration). I therefore agree with CMS that summary judgment is appropriate.

B. Petitioner did not inform CMS within the regulatory time period that it changed its address, which authorized CMS to revoke Petitioner's enrollment in Medicare.

CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges. It is undisputed that Petitioner did not comply with Medicare regulations when it moved its facility without reporting the change of address within the regulatory time period of 30 days. 42 C.F.R. § 424.57(c)(2). Without a valid address, CMS attempted, but was unable to complete, an on-site review to confirm whether Petitioner was meeting Medicare enrollment requirements. 42 C.F.R. § 424.535(a)(5). Petitioner's failure to comply with either of these requirements is grounds for revocation of its Medicare enrollment and billing privileges.

In its Medicare enrollment application, Petitioner certified that its business was located at 181 Intrepid Lane, Syracuse, N.Y. 13205. CMS Ex. 6, at 4. CMS asserts that, on August 19, 2010, a CMS contract investigator attempted to conduct a visit of Petitioner's facility. CMS Ex. 4. The investigator found that Petitioner's business was not operating at the enrolled address. Instead, the location contained physical therapy and physician offices. *Id*. The investigator spoke with an employee of the physician's office who stated that Petitioner's business had moved out of the space sometime before March 2010. The employee gave the investigator a new address for Petitioner's business and directions to the new site. *Id*.

Petitioner acknowledges that it closed its Intrepid Lane location of record and moved to a new location effective February 2, 2010. Hearing Request; CMS Ex. 3, at 2. Petitioner states that, "[d]ue to a simple administrative oversight," it failed to timely report its relocation. CMS Ex. 3, at 2. Petitioner concedes that it was out of compliance, but it argues that it has since "come into complete compliance." P. Br. at 1-2; *see also* Hearing Request; CMS Ex. 3, at 2. Petitioner further asserts that it intended nothing improper, and "while out of compliance at this single location for a brief time, [Petitioner] does not deserve to be revoked from the program." Hearing Request.

The fact that Petitioner may not have intended anything improper is not a viable defense. Petitioner was obligated to notify Medicare that it was no longer operational at the address it certified as its business location. Its failure to do so justifies revocation

of Petitioner's enrollment, even if Petitioner has later "come into complete compliance." *See Mission Home Health et al.*, DAB No. 2310 at 6 (2010) (finding CMS is authorized to deny 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). 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.

Additionally, I lack authority to invalidate or change an existing regulation or grant Petitioner an exemption from compliance with regulatory requirements, even if for a brief period. *1866ICPayday.com*, DAB No. 2289, at 14. I must sustain CMS's determination if a legitimate basis for revocation existed with facts establishing noncompliance with one or more of the regulatory standards. *Id.* at 13.

V. Conclusion

After reviewing the evidence in the light most favorable to Petitioner, I conclude that the regulatory language is plain, and there is no genuine issue of material fact. I therefore grant summary judgment to CMS because CMS acted within its regulatory authority to revoke Petitioner's enrollment and billing privileges for not notifying Medicare of its address change within the required timeframe.

/s/
Joseph Grow
Administrative Law Judge