Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Anchor Home Healthcare Services, Inc.,
(NPI: 1164460846 / PTAN: 457846)

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-630

Decision No. CR4744

Date: November 28, 2016

DECISION

The enrollment and billing privileges of Petitioner, Anchor Home Healthcare Services, Inc., are revoked pursuant to 42 C.F.R. § 424.535(a)(5)(i), [1] effective June 13, 2014, for failure to comply with the enrollment requirement established by 42 C.F.R. § 424.516(d)(2).

I. Background

Palmetto GBA (Palmetto), a Centers for Medicare & Medicaid Services (CMS) Medicare Administrative Contractor, notified Petitioner by letter dated July 25, 2014, that its Medicare billing number and privileges were revoked effective June 13, 2014. CMS Exhibit (Ex.) 1 at 4-5. Palmetto cited 42 C.F.R. § 424.535(a)(5) as the basis for revocation. Palmetto alleged that Petitioner was no longer operational to furnish Medicare items or services and that Petitioner was not meeting Medicare enrollment requirements. Palmetto alleged that a site visit was attempted on June 13, 2014, and it

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[1] Citations are to the 2014 revision of the Code of Federal Regulations (C.F.R.), unless otherwise stated.

found Petitioner was no longer operating at 8035 East R.L. Thornton Freeway, Suite 320, Dallas, Texas (Thornton location). CMS Ex. 1 at 4. Palmetto also imposed a two-year re-enrollment bar. CMS Ex. 1 at 5.

On September 9, 2014, Petitioner requested reconsideration. CMS Ex. 3. On October 28, 2014, CMS issued a reconsidered determination upholding the revocation pursuant to 42 C.F.R. § 424.535(a)(5)(i). CMS Ex. 1 at 1-3. The hearing officer found, based on the site visit attempted on June 13, 2014, that Petitioner was no longer operational at the Thornton location and Petitioner failed to present evidence that CMS was notified of a change in practice location. CMS Ex. 1 at 2.

Petitioner requested a hearing before an administrative law judge (ALJ) on December 4, 2014. On December 11, 2014, the case was assigned to me to hear and decide, and an Acknowledgement and Prehearing Order (Prehearing Order) was issued at my direction.

On January 22, 2015, CMS filed a combined prehearing brief and motion for summary judgment with CMS Exs. 1 through 4. On February 23, 2015, Petitioner filed its combined prehearing brief and opposition to CMS's motion for summary judgment. Petitioner filed its corrected P. Exs. 1 and 2 on March 2, 2015. On March 23, 2015, I denied CMS's motion for summary judgment. CMS filed CMS Exs. 5 through 11 on April 30, 2015. Petitioner filed P. Exs. 3 through 9 on May 1, 2015. On September 4, 2015, the parties filed a joint motion to waive an oral hearing, which I granted by order dated September 8, 2015. Therefore, this decision is based upon the documentary evidence and the briefs of the parties.

On October 8, 2015, CMS filed its opening brief (CMS Br.) and proposed findings of fact and conclusions of law. Also on October 8, 2015, Petitioner filed its opening brief (P. Br.) and proposed findings of fact and conclusions of law. CMS waived its reply brief on November 9, 2015. Petitioner failed to file a reply brief and, thereby, waived the right to do so. Petitioner did not object to my consideration of CMS Exs. 1 through 11 and all are admitted as evidence. Petitioner filed Petitioner's exhibits 1 through 9. CMS did not object to P. Exs. 3 through 9 and they are admitted and considered as evidence.

CMS objected to my consideration of P. Exs. 1 and 2 on grounds that Petitioner failed to show good cause for the documents to be submitted for the first time in this proceeding. CMS cited 42 C.F.R. § 498.56(e). CMS Prehearing Reply Brief at 1-2; CMS Br. at 4. The regulation provides that in a provider or supplier case such as this, the ALJ must "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." 42 C.F.R. § 498.56(e)(1). If good cause is found, the evidence must be admitted and may be considered. 42 C.F.R. § 498.56(e)(2)(i). If good cause is not found, the evidence must be excluded and may not be considered. 42 C.F.R. § 498.56(e)(2)(ii). Good cause is not defined in the CMS regulations that are applicable.

The Departmental Appeals Board (the Board) has never definitively defined "good cause" in cases subject to 42 C.F.R. pt. 498, but has accepted ALJ rulings that cause beyond the control of a party may be good cause, without ruling out the possibility that other causes may also amount to "good cause." *See e.g., Hillcrest Healthcare, LLC,* DAB No. 1879 at 5 (2003); *cf. SSA Inspector General v. Karen Kay Parham*, DAB No.1600 at 3 (2007). It is not necessary to attempt to define "good cause" in this case. P. Ex. 1 is a form CMS-855A, a Medicare Enrollment Application. The form includes entries showing that Petitioner is a home health agency (HHA) reporting practice location information, payment address, and medical record storage information. P. Ex. 1 at 4-5. Petitioner completed section 4 of the form to show a "change" effective August 17, 2013, for Anchor Home Health Services at 310 Crooked Creek, Garland, Texas (Crooked Creek location). CMS does not challenge the authenticity or relevance of P. Ex. 1. Whether or not CMS objects, I may only admit and consider relevant and material evidence. 42 C.F.R. § 498.60(b). Evidence is relevant if it has any tendency to make a fact of consequence to my decision, more or less probable than it would be without the evidence. Fed. R. Evid. 401. Petitioner did not indicate by checking the available boxes on the form whether it was adding or deleting the location. P. Ex. 1 at 9. P. Ex. 1 does not bear the required signature or date and it is not possible to determine that the exhibit is relevant to any issue I may decide. Petitioner did not file an affidavit or declaration that explains the relevance of P. Ex. 1 and Petitioner waived the right to present testimony by waiving an oral hearing. I conclude that the relevancy of P. Ex. 1 has not been established and that document must be excluded for that reason.

P. Ex. 2 is a Texas Department of Aging and Disability Services Form 2021, License Application. The form is signed by Petitioner's purported Administrator and CFO and dated July 22, 2013. CMS does not challenge the authenticity or the relevance of the document. The document purports to report that Petitioner moved its operations to 310 Crooked Creek, Garland, Texas effective August 23, 2013. The fact that Petitioner moved and sent the state notice of a change of address does not have any tendency to show that it is more or less probable that Palmetto received a CMS-855A from Petitioner that advised Palmetto of Petitioner's change in practice location. I conclude that P. Ex. 2 is not relevant to prove or disprove any disputed issue of fact I must decide. Accordingly, P. Ex. 2 is not admitted.

Furthermore, the fact that Petitioner moved its operations to the Crooked Creek location on or about August 23, 2013, is not disputed. Therefore, P. Exs. 1 and 2 are not relevant to aid my finding of any facts of consequence. The issue of consequence in this case is not whether Petitioner moved; it is undisputed that it did. The issue of consequence is whether CMS or Palmetto received proper notice of the move.

II. Discussion

A. Applicable Law

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.[2] Act §§ 1834(j)(1) (42 U.S.C. § 1395m(j)(1)); 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395u(h)(1)). Petitioner, a home health agency, is a provider. Act § 1866(u).

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 denial or revocation of enrollment and billing privileges. Act § 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to 42 C.F.R. § 424.505, a provider such as Petitioner must be enrolled in the Medicare program and be issued a billing number to have billing privileges and to be eligible to receive payment for services rendered to a Medicare-eligible beneficiary.

Providers 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 provider'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. Subsection 424.510(d)(3) 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

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[2] 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.

applicable statutes, regulations, and program instructions. 42 C.F.R. § 424.510(d)(3). Providers must meet basic requirements depending on their type of service. 42 C.F.R. §§ 424.505, 424.516, 424.517. Providers are also subject to additional screening requirements depending upon the type of service they provide. 42 C.F.R. § 424.518.

The Secretary has delegated authority to CMS or its Medicare contractor to revoke an enrolled provider's Medicare enrollment and billing privileges and any provider agreement for any of the reasons listed in 42 C.F.R. § 424.535(a). Revocation becomes effective 30 days after CMS or one of its contractors mails the revocation notice to the provider, subject to some exceptions not applicable in this case. 42 C.F.R. § 424.535(g). A revoked provider is barred from re-enrollment for a minimum of one year, but no more than three years, depending on the basis for revocation. 42 C.F.R. § 424.535(c)(1).

A provider whose enrollment and billing privileges have been revoked may request reconsideration and review as provided by 42 C.F.R. pt. 498. 42 C.F.R. § 424.545(a). A provider submits a written request for reconsideration to CMS or its contractor. 42 C.F.R. § 498.22(a). CMS or its contractor must give notice of its reconsidered determination to the provider, giving the reasons for its determination and specifying the conditions or requirements the provider failed to meet, and advising the provider of its right to an ALJ hearing. 42 C.F.R. § 498.25. If the decision on reconsideration is unfavorable to the provider, the provider has the right to request a hearing by an ALJ and further review by the Departmental Appeals Board (the Board). CMS may also request a hearing by an ALJ if it disagrees with the reconsidered determination. Act § 1866(j)(8) (42 U.S.C. § 1395cc(j)(8)); 42 C.F.R. §§ 424.545, 498.3(b)(17), 498.5(*l*)(2). 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 provider bears the burden to demonstrate that it meets enrollment requirements with documents and records. 42 C.F.R. § 424.545(c).

B. Issue

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

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. There is a basis for revocation of Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(5)(i) because Petitioner failed to satisfy the requirement of 42 C.F.R. § 424.516(d)(2)

to give CMS or its contractor notice within 90 days of Petitioner's deletion of an old practice location and the addition of a new practice location.

2. Revocation is effective June 13, 2014, pursuant to 42 C.F.R. § 424.535(g).

a. Facts

There is no dispute that Petitioner was enrolled in the Medicare program as a home health agency in June 2005. CMS Ex. 10 at 1. In February 2006, Petitioner was at the Crooked Creek location. Petitioner notified CMS in February and March 2006 that it was changing its location to 8035 East R.L. Thornton Freeway, Suite 320, Dallas, Texas. P. Exs. 3, 5; CMS Ex. 10 at 2. In June 2012, Petitioner notified CMS that it was moving to the Thornton location, 8035 East R.L. Thornton Freeway, Suite 520. CMS Exs. 9; 10 at 3; 11 at 2; P. Ex. 5.

It is not disputed that on or about August 23, 2013, Petitioner moved back to the Crooked Creek location. CMS Ex. 3 at 2; P. Exs. 4, 6, 8, 9. By letter dated January 27, 2014, and addressed to Petitioner at the Crooked Creek location, Palmetto acknowledged that it received a notification from Petitioner that Petitioner had changed its address to the Crooked Creek location. However, Palmetto advised Petitioner that "(i)n order to update your information, you will need to submit the CMS Form 855A enrollment application." P. Ex. 6. Petitioner asserts that the CMS-855A was mailed to Palmetto. CMS Ex. 3 at 2. Petitioner has provided no registered or certified mail receipt or evidence to show that Palmetto received the CMS-855A documenting the move from the Thornton location to the Crooked Creek location.

On June 6, 2014, at about 1:50 p.m. and again on June 13, 2014, at about 11:30 a.m., a Palmetto inspector attempted to inspect Petitioner's facility at the Thornton location. The inspector found that Petitioner was no longer operating at the Thornton location. CMS Exs. 2, 5. CMS does not dispute that Petitioner was operating at the Crooked Creek location at the time of the attempted site inspections.

b. Analysis

The hearing officer on reconsideration upheld the revocation in this case pursuant to 42 C.F.R. § 424.535(a)(5)(i). CMS Ex. 1 at 1. The hearing officer stated that Petitioner was found to be "nonoperational" at the Thornton location, Petitioner presented no evidence that it was operational at the Thornton location, and Petitioner did not provide evidence that the required form showing a change of practice location was sent to CMS or

Palmetto. CMS Ex. 1 at 2. The hearing officer did not determine that Petitioner was not operational at some other location; however, that determination was not necessary to support her decision to uphold revocation.

CMS reserves the right to perform onsite reviews to determine whether or not providers and suppliers are complying with Medicare enrollment requirements. 42 C.F.R. § 424.517. If an onsite review determines a provider or supplier is not complying with Medicare enrollment requirements, revocation of enrollment is authorized by 42 C.F.R. § 424.535(a)(5). The regulation in effect at the time of the reconsidered determination provided:

> (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:
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> * * * *
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> (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—
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> > (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). The hearing officer determined that Petitioner, a provider, is subject to 42 C.F.R. § 424.535(a)(5)(i).[3] The subsection has two prongs. Revocation is authorized if: (1) the provider is no longer operational to furnish Medicare covered items or services; or (2) the provider fails to satisfy any of the Medicare enrollment requirements. In this case, the site inspector found that Petitioner was no longer operating at the Thornton location but his findings did not rule out the possibility that Petitioner was operating elsewhere. The reconsideration hearing officer found based on the attempted inspection that Petitioner was not operating at the Thornton location but did not make a finding that Petitioner was not operational at some other location. In fact, CMS does not dispute that Petitioner was operating at the Crooked Creek location at the time of the attempted inspections. Accordingly, I conclude that the first prong of 42 C.F.R. § 424.535(a)(5)(i) is not satisfied, and it is undisputed Petitioner was operational, albeit not at the Thornton location.

It is the second prong of 42 C.F.R. § 424.535(a)(5)(i) that is the basis for revocation in this case. One of the requirements for maintaining enrollment in Medicare is the requirement to give CMS or its contractor notice of certain changes involving an enrolled provider or supplier. Pursuant to 42 C.F.R. § 424.516(e)(2), Petitioner had 90 days to report its change of practice location from the Thornton location to the Crooked Creek location. Reporting must be done using the appropriate CMS enrollment application. 42 C.F.R. § 424.515. The provider or supplier is required to be able to demonstrate that it meets enrollment requirements and to produce the documents necessary to show it is in compliance with enrollment requirements. 42 C.F.R. § 424.545(c). Petitioner asserts it did mail a CMS Form 855A to Palmetto within 90 days to report the change from the Thornton location to the Crooked Creek location. However, Palmetto denies receiving the required CMS-855A from Petitioner until September 2, 2014, far more than 90 days after Petitioner's change in location and after the site inspections. CMS Ex. 11.

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[3] In the case of Medicare-eligible beneficiaries not enrolled in Medicare Part B, home health services are paid under Part A subject to the limitations specified in section 1812(a)(3) of the Act. Home health services are also covered under Medicare Part B for those enrolled. Act § 1832(a)(2)(A). Thus, home health agencies, which are defined as providers by section 1861(u) of the Act, may be reimbursed under Part A or Part B depending upon the facts of the particular case. In this case, the result would be no different if 42 C.F.R. § 424.535(a)(5)(ii) was applied. Under that subsection there are three prongs; neither the first nor third prong is factually present in this case; and the second prong is the same under both 42 C.F.R. § 424.535(a)(5)(i) and (ii).

The Board has made clear that under the regulations, the relevant issue is whether or not the Medicare contractor received the application, not whether the provider or supplier mailed the application. *Alexander C. Gatzimos, MD, JD, LLC*, DAB No. 2730 (2016). The Secretary has not provided in 42 C.F.R. pt. 498 for the allocation of the burden of persuasion or the quantum of evidence required to satisfy the burden. However, the Board has provided some persuasive analysis regarding the allocation of the burden of persuasion in cases subject to 42 C.F.R. pt. 498. *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd*, *Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 Fed. App'x 181 (6th Cir. 2005). Therefore, the burden is upon Petitioner to establish by a preponderance of the evidence that Palmetto actually received the CMS-855A advising of the change of location from the Thornton location to the Crooked Creek location within 90 days of that relocation. The evidence shows that by letter dated January 27, 2014, addressed to Petitioner at the Crooked Creek location, Palmetto acknowledged that it received a notification from Petitioner that Petitioner had changed its address to the Crooked Creek location, roughly five months before the site inspection. But, Palmetto advised Petitioner that "(i)n order to update your information, you will need to submit the CMS Form 855A enrollment application." P. Ex. 6. Petitioner has not offered evidence to show that Palmetto actually received the required CMS-855A within 90 days of the relocation as required by 42 C.F.R. § 424.516(e)(2). Accordingly, I conclude that Petitioner has failed to show compliance with the enrollment requirement established by 42 C.F.R. § 424.516(e)(2), and that is a basis for revocation pursuant to the second prong of 42 C.F.R. § 424.535(a)(5)(i).

Palmetto revoked Petitioner's Medicare billing number and privileges effective June 13, 2014, the date of the second failed attempt to do a site inspection of Petitioner's facility. CMS Ex. 1 at 4. The hearing officer that issued the reconsidered determination did not specifically address the issue of the effective date of the revocation. CMS Ex. 1 at 1-3. The determination of the effective date of revocation is controlled by 42 C.F.R. § 424.535(g), which provides:

> (g) *Effective date of revocation.* Revocation becomes effective 30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier, except if the revocation is based on Federal exclusion or debarment, felony conviction, license suspension or revocation, **or the practice location is determined by CMS or its contractor not to be operational**. When a revocation is based on a Federal exclusion or debarment, felony conviction, license suspension or revocation, **or the practice location is determined by CMS or its contractor not to be operational**, **the revocation is effective** with the date of exclusion or debarment, felony conviction, license suspension

> or revocation or **the date that CMS or its contractor determined that the provider or supplier was no longer operational.**

(Emphasis added.) There is no dispute that Petitioner was no longer operating at the Thornton location when the site inspections occurred. The second attempted inspection occurred on June 13, 2014, and the initial determination reflects that is the date that Palmetto determined Petitioner was no longer operational at the Thornton practice location. Accordingly, I conclude that Petitioner's Medicare enrollment and billing privileges are revoked effective June 13, 2014.

III. Conclusion

For the foregoing reasons, I conclude that there is a basis for revocation of Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(5)(i), effective June 13, 2014.

_____/s/_____
Keith W. Sickendick
Administrative Law Judge