Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Vamet Consulting & Medical Services
(PTAN: 74-7265; NPI: 1073781738),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-16-285

Decision No. CR4677

Date: August 10, 2016

DECISION

The Centers for Medicare & Medicaid Services (CMS), through an administrative contractor, revoked the Medicare billing privileges of Vamet Consulting & Medical Services (Petitioner), a home health agency (HHA), because CMS determined Petitioner was not operational in violation of 42 C.F.R. § 424.535(a)(5). Specifically, an inspector twice attempted to conduct an on-site review of Petitioner's office during Petitioner's posted business hours, but on both occasions, Petitioner's office was locked and no one responded to the inspector's knocks on the door. Petitioner requested a hearing before an administrative law judge (ALJ) to dispute CMS's determination, asserting that Petitioner's owner and a staff member were present in a back room of Petitioner's office on the dates and at the times of the inspector's attempted site visits and, in any event, Petitioner is operational because it has been providing home health services regardless as to whether the inspector could gain entry to Petitioner's office. CMS moved for summary judgment, which Petitioner opposes. Because there is no dispute that the inspector was unable to conduct a site visit on two occasions and, even when accepting the facts in this case in the light most favorable to Petitioner, there is a sufficient basis to conclude that Petitioner was not operational, I grant summary judgment for CMS and affirm CMS's determination to revoke Petitioner.

I. Background and Procedural History

Petitioner was enrolled as an HHA in the Medicare program.[1] *See* CMS Exhibit (Ex.) 7 at 11; CMS Ex. 8. In March 2012, Petitioner timely informed CMS that as of April 21, 2012, the address of its practice location would be 8600 West Airport Blvd., #B, Houston, Texas 77071-2315. CMS Ex. 9 at 1, 19; CMS Ex. 10 at 2.

On July 14, 2014, at approximately 1:40 p.m., an inspector with a CMS administrative contractor attempted to conduct a site visit at Petitioner's office located at the 8600 West Airport address; however, the door to Petitioner's office was locked and no one answered the door after the inspector knocked. CMS Ex. 4 at ¶¶ 3-4; CMS Ex. 5. The inspector returned to Petitioner's office on July 15, 2014, at approximately 11:45 a.m., and again the door to Petitioner's office was locked and the inspector's knocks at the door went unanswered. CMS Ex. 4 at ¶¶ 3-4; CMS Ex. 5. During the attempted site visits, the inspector took a number of photographs of the exterior of Petitioner's office, including a paper sign posted to the door indicating that Petitioner's business hours were 9:00 a.m. to 5:00 p.m., Monday to Friday. CMS Ex. 4 at ¶¶ 5-6; CMS Ex. 6. In his report, the inspector noted that: Petitioner was not open for business; Petitioner's office did not appear to have staff present; Petitioner's office did not have any customer activity present; Petitioner did not appear to be operational; and Petitioner had posted hours of operation from 9:00 a.m. to 5 p.m. CMS Ex. 5.

In an October 21, 2014 initial determination, a CMS contractor revoked Petitioner's Medicare enrollment and billing privileges effective July 14, 2014, because a July 14, 2014 site visit found that Petitioner was no longer operating from its 8600 West Airport address. CMS Ex. 1. Petitioner requested reconsideration of the initial determination, stating that Petitioner: "has never closed nor moved but continues to operate from the [8600 West Airport] location as evidenced by the attached pictures." Petitioner (P.) Ex. 1. The CMS contractor issued a reconsidered determination upholding Petitioner's revocation. CMS Ex. 2. In pertinent part, the reconsidered determination stated:

> [The site inspector] conducted two separate site visits to verify whether the provider was operational, first on 7/14/14, at 1:40 PM, and again on 7/15/14 at 11:45 AM. Both times were reasonable, in that the business should have been operational during those times. Instead, the [site inspector] found that the provider was not open for business on both occasions, that no employees or staff were present, that there was no customer activity at the location, and that the location did not appear to be operational. "The provider was closed," stated the [site inspector.] "I knocked and there was no

[1] An enrolled HHA is a Medicare "provider of services." 42 U.S.C. § 1395x(u).

> answer . . . . the location was closed on both visits." [The Site inspector's] photographs show a paper sign on the location's door, but no evidence of business activity, particularly in contrast to businesses located immediately adjacent, who display permanent signage on the outside of the building and advertising in the windows.
>
> In its reconsideration package, the provider submitted photographs of the office to evidence operational status. However, while photographs may provide evidence of an office's existence, they do not evince that office being operational. In consideration of the totality of the evidence, therefore, CMS cannot reasonably conclude from the evidence submitted that the business location is operational.

CMS Ex. 2 at 1-2

Petitioner requested a hearing to further dispute the revocation. On February 8, 2016, I issued an Acknowledgment and Pre-hearing Order (Order). In response to the Order, CMS filed a motion for summary judgment and prehearing brief (CMS Br.), and ten proposed exhibits (CMS Exs. 1-10), one of which was a declaration serving as the written direct testimony of the site inspector (CMS Ex. 4). Petitioner filed a pre-hearing brief opposing summary judgment (P. Br.) and ten proposed exhibits (P. Exs. 1-10), three of which were declarations serving as the written direct testimony from three witnesses (P. Exs. 3-5). Petitioner requested to cross-examine the site inspector. P. Br. at 11. CMS did not request to cross-examine any of Petitioner's witnesses.

II. Petitioner's new evidence

CMS's initial determination stated that Petitioner "may submit additional information with the reconsideration request that [Petitioner] believe[s] may have a bearing on the decision [to revoke]." CMS Ex. 1 at 1. Petitioner's reconsideration request states that Petitioner attached pictures to the request as evidence that Petitioner was operational. P. Ex. 1.[2] The reconsideration request makes no mention of any other substantive evidence, and the reconsidered determination confirms that Petitioner only submitted "[p]hotographs of office." CMS Ex. 2 at 1. The reconsidered determination addresses the photographs in a section titled Evaluation of Submitted Documentation. CMS Ex. 2 at 1-2.

[2] Although Petitioner submitted the reconsideration request as an exhibit, it did not submit the pictures that Petitioner had originally attached to the reconsideration request.

With its hearing request and again with its brief, Petitioner submitted a number of new substantive exhibits: Hearing Request, Exhibit E at 4-5 and P. Ex. 6 (an employee time and attendance sheet for July, and record of payment to the employee for $336.00 for July 14 through August 1); Hearing Request, Exhibit E at 6 and P. Ex. 7 (Bank of America checking account statement for check cashed for $336.00); Hearing Request, Exhibit E at 7-9 and P. Ex. 8 ("Final Report" and "Face-to-Face Home Health Order Entered On: 07/12/2014"); Hearing Request, Exhibit E at 10 and P. Ex. 9 (AT&T monthly statement – mostly illegible); and Hearing Request, Exhibit E at 11-12 and P. Ex. 10 (Nursing Visit Notes dated July 10, 2014, and July 17, 2014).

In my Order, I warned that:

> Petitioner may not offer new documentary evidence in this case absent a showing of good cause for failing to present that evidence previously to CMS. If Petitioner offers such evidence, the evidence must be specifically identified as new, and Petitioner's brief must explain why good cause exists for me to receive it. I must exclude any new evidence for which a showing of good cause has not been made pursuant to 42 C.F.R. § 498.56(e).

Order ¶ 6.

Although Petitioner has a right to submit evidence following the revocation of enrollment and billing privileges, Petitioner needed to submit that evidence with its reconsideration request. 42 C.F.R. § 405.803(c). Because Petitioner submitted new evidence to me, I must consider whether there is good cause for this late submission. *Id*. § 498.56(e)(1).

Petitioner did not discuss in its brief why there is good cause for submitting new evidence at the ALJ level of appeal in this case. Petitioner obviously understood that it could submit evidence with the reconsideration request because it did so. CMS Ex. 2 at 1; P. Ex. 1. Further, because Petitioner submitted evidence with its reconsideration request, the CMS administrative contractor was not under an obligation to contact Petitioner to see if Petitioner had additional relevant evidence to submit. *See* 42 C.F.R. § 405.803(d). Therefore, I conclude that Petitioner did not have good cause to submit new evidence and, by regulation, I am precluded from considering that evidence (i.e., P. Exs. 6-10) when rending this decision. *Id*. §§ 405.803(e), 498.56(e)(2).

III. Issues

1. Whether CMS is entitled to summary judgment; and

2. Whether CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges under 42 C.F.R. § 424.535(a)(5).

IV. Jurisdiction

I have jurisdiction to hear and decide this case. 42 C.F.R. §§ 498.3(b)(17), 498.5(*l*)(2); *see also* 42 U.S.C. § 1395cc(j)(8).

V. Findings of Fact, Conclusions of Law, and Analysis

To participate in the Medicare program, an HHA must enroll as a provider by meeting all enrollment requirements stated in the regulations and in the applicable enrollment application. 42 C.F.R. §§ 424.500, 424.510, 424.516, 424.530. One enrollment requirement is that a provider "must be operational to furnish Medicare covered items or services . . . ." *Id.* § 424.510(d)(6). During the enrollment process, CMS may conduct an on-site review (also called a site visit) to ascertain compliance with enrollment requirements and to determine whether the prospective provider is operational. *Id.* § 424.510(d)(8). Once enrolled, a provider has "billing privileges," which is the right to file claims to receive Medicare payment for services provided to Medicare beneficiaries. *See id.* §§ 424.502 (definition of *Enroll/Enrollment*), 424.505.

Enrolled providers must maintain compliance with enrollment requirements in order to maintain billing privileges. *Id.* § 424.500. CMS may conduct an on-site review "when deemed necessary . . . to verify that the enrollment information submitted to CMS or its agents is accurate and to determine compliance with Medicare enrollment requirements." *Id*. § 424.517(a). Providers and suppliers are responsible for demonstrating that they meet enrollment requirements and must be able to provide documentation or records upon CMS's request. *Id*. § 424.545(c). The results of the on-site inspection may be used to support revocation of billing privileges. *Id.* CMS may revoke a provider's Medicare enrollment and billing privileges if it violates any provision of 42 C.F.R. § 424.535(a).

A. *Summary judgment is appropriate in this case.*

An ALJ may decide a case arising under 42 C.F.R. part 498 by summary judgment. *Livingston Care Ctr. v. U.S. Dep't of Health & Human Servs.*, 388 F.3d 168, 172 (6th Cir. 2004) (citing *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743 (6th Cir. 2004)). "Matters presented to the ALJ for summary judgment will follow Rule 56 of the Federal Rules of Civil Procedure and federal case law . . . ." Civil Remedies Division Procedures § 19(a)(iii).

As stated by the United States Supreme Court:

> Rule 56(c) of the Federal Rules of Civil Procedure provides that summary judgment 'shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.' By its very terms, this standard provides that the mere existence of *some* alleged factual dispute between the parties will not defeat an otherwise properly supported motion for summary judgment; the requirement is that there be no *genuine* issue of *material* fact.

Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 247-48 (1986) (emphasis in original). To determine whether there are genuine issues of material fact for an in-person hearing, the ALJ 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). However, in order to defeat a well-pleaded motion for summary judgment, the non-moving party must come forward with some evidence of a dispute concerning a material fact; mere denials in its pleadings are not sufficient. *Id*.

In the present case, there are no material facts in dispute. Petitioner did not dispute that a site inspector attempted site visits on July 14 and 15, 2014, at Petitioner's office location on file with CMS (i.e., 8600 West Airport Blvd.), or that on both occasions, Petitioner's office was locked and no one answered the door when the inspector knocked. Petitioner has also not disputed that its posted business hours were Monday to Friday from 9 a.m. to 5 p.m. or that July 14 and 15, 2015, were a Tuesday and Wednesday, respectively.

Petitioner affirmatively states the following facts are in dispute:

1. CMS's conclusion that [Petitioner] was "**no longer operational** to furnish Medicare covered items or services, or failed to satisfy any Medicare enrollment requirement" on July 14 and 15, 2014, under the provisions of 42 C.F.R. § 424.535(a)(5), when it was visited by [the CMS administrative contractor].

2. CMS's conclusion that on July 14 and 15, 2014 [Petitioner] did not appear to have employees/staff present.

3. CMS's conclusion that on July 14 and 15, 2014 [Petitioner] did not appear to be prepared to submit valid Medicare claims, to be properly staffed, equipped and stocked based on the type of provider.

P. Br. at 4 (emphasis in original).

For purposes of summary judgment, I draw all reasonable inferences in favor of Petitioner. Therefore, I accept as true that Petitioner's owner and a staff member were working in the filing room of Petitioner's office on July 14 and 15, 2014, during the time of the attempted site visits, and that Petitioner was adequately staffed and occupied the 8600 West Airport Blvd. location during the dates of the attempted site visit. P. Ex. 3 ¶¶ 3-5; P. Ex. 4 ¶¶ 3-5; P. Ex. 5 ¶¶ 3-5. I will also accept as true that Petitioner was prepared to submit claims, and was properly stocked and equipped.[3]

I do not accept as true Petitioner's assertion that it was operational because that is the ultimate conclusion I must make by applying the law to the undisputed facts in this case.

B. *CMS had a legitimate basis to revoke Petitioner's Medicare enrollment under 42 C.F.R. § 424.535(a)(5) because Petitioner has not shown that its qualified physical practice location was open to the public on July 14 and 15, 2014.*

CMS may revoke a provider if, upon an on-site review, CMS determines that the provider is no longer operational to provide Medicare covered items or services, or the provider fails to meet enrollment requirements. 42 C.F.R. § 424.535(a)(5)(i) (2013). The term "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 (definition of *Operational*). In order "[t]o be 'operational' in accordance with the definition in section 424.502, a provider, among other things, must have a 'qualified physical practice location' that is 'open to the public for the purpose of providing health care related services." *Viora Home Health, Inc*., DAB No. 2690 at 7 (2016). A provider's "qualified physical practice location" is the provider's address that

[3] These facts are material generally to whether Petitioner was operational. However, they are not directly at issue because the site inspector was not able to conduct a site visit of Petitioner's office to verify compliance with those requirements.

is on file with CMS at the time of a site visit. *Care Pro Home Health, Inc.*, DAB No. 2723 at 5-6 (2016) (footnote omitted).

In the present case, it is undisputed that the site inspector attempted to conduct a site visit, on two different days, of Petitioner's qualified physical practice location, but that he was unable to complete the site visit because Petitioner's qualified physical practice location was locked and no one answered the door when the inspector knocked. Both attempted site visits occurred during the business hours that Petitioner posted on its door. These facts are sufficient for me to conclude that Petitioner was not open to the public, and therefore, not operational. In making this conclusion, I am mindful "that the proper inquiry is to assess the [provider's] operational status *at the time of the onsite review* because the intent of the applicable regulations 'is that a supplier must maintain, and be able to demonstrate, continued compliance with the requirements for receiving Medicare billing privileges.'" *Viora*, DAB No. 2690 at 7 n.7 (emphasis added), quoting *A to Z DME, LLC*, DAB No. 2303 at 7 (2010). Petitioner's failure to be open to the public on either of the days that the inspector attempted site visits prevented the inspector from determining whether Petitioner continued to be compliant with enrollment requirements.

Petitioner asserts that it has always been operational and that it submitted evidence to show that "it was open for business, receiving communications for other healthcare facilities referring patients, paying employees, performing skilled nursing visits, paying for telephone services, and performing duties in the back room of the company's Medicare approved location." P. Br. at 8. Petitioner asserts that because an HHA provides its services away from its qualified physical practice location, its qualified physical practice location need not be physically open to the public so long as it is open to provide services. P. Br. at 8-10.

Although I had to exclude from consideration much of the evidence Petitioner submitted to prove that it was open to provide services, my conclusion that Petitioner was not operational does not rest on Petitioner's failure to provide evidence that Petitioner was providing services. Rather, Petitioner's qualified physical practice location needed to be open to the public and open for a site inspector to conduct a site visit. If, as Petitioner asserts, its owner and staff were present at its office on the days and at the times of the attempted site visits, but the owner and staff were in a filing room with the front door to the office locked (P. Br. at 7), this still provides no defense to revocation because Petitioner's owner or staff needed to answer the door when the inspector knocked. *Cf. Benson Ejindu, d/b/a Joy Medical Supply*, DAB No. 2572 at 7-8 (2014) (holding that a Medicare supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) was not accessible because, in part, "Petitioner needed to provide a customer who encountered a locked door during regularly scheduled hours with a reliable and effective means to overcome that barrier and obtain prompt entry."). Although, unlike DMEPOS suppliers, HHAs do not have required hours during which their qualified physical practice location must be open to the public, they must be open for some periods

of time and, in this case, the site inspector came during Petitioner's posted business hours.

In another case, an ALJ responded as follows to the same argument Petitioner has made:

> Petitioner seems to argue that its business activities as a home health agency do not require its office staff to come into face-to-face contact with members of the public since home health services are provided to Medicare beneficiaries at their residences. It appears to contend that the requirement that it be open to the public shouldn't apply to its operations. I disagree. The regulatory language is explicit and does not suggest that there are exceptions to the rule that a provider or a supplier has an office that is accessible to the public. Moreover, Petitioner has offered no facts to show that members of the public would have no reason to visit its office. To the contrary, there are reasons why members of the public would want to visit Petitioner's office directly. The fact that a home health agency delivers care at locations other than its office premises does not mean that there wouldn't be times when either beneficiaries or members of their families would have need to talk to Petitioner's office staff in person. They might wish to visit in person to ask questions about what home health care consists of and their eligibility for such care. They might do so to seek instructions about care to be given to relatives or to ask questions about that care.

Guardian Care Servs., Inc., DAB CR4195 at 4 (2015) (citation omitted). I agree with this analysis. Therefore, I reject Petitioner's argument that, because it is an HHA, its qualified physical practice location does not need to be open to the public.

VI. Conclusion

I grant CMS's motion for summary judgment and affirm CMS's revocation of Petitioner's Medicare enrollment and billing privileges.

/s/
Scott Anderson
Administrative Law Judge