Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Health Connect at Home
Docket No. A-11-97
Decision No. 2419
October 31, 2011

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Health Connect at Home (Petitioner), a home health agency, appeals the May 18, 2011 decision by Administrative Law Judge (ALJ) Joseph Grow, *Health Connect at Home,* DAB CR2371 (2011) (ALJ Decision). The ALJ granted summary judgment to the Centers for Medicare & Medicaid Services (CMS), holding that CMS had lawfully revoked Petitioner's Medicare enrollment and billing privileges because Petitioner was not "operational" at the addresses on file with CMS on the date of an onsite review, and because Petitioner failed to comply with the enrollment requirement that it report a change in its practice location within 90 days of the change. We affirm the ALJ Decision based on the undisputed facts which demonstrate that Petitioner did not comply with the 90-day reporting requirement.

Legal Background

In order to participate in Medicare, health care "providers" and "suppliers" – Petitioner is a "provider" for Medicare purposes – must enroll in the program. 42 C.F.R. § 424.500; *id.* § 400.202 (defining the term "provider" to include a home health agency). Enrollment confers program "billing privileges" – that is, the right to claim and receive Medicare payment for health care services provided to the program's beneficiaries. *Id.* §§ 424.502, 424.505.

CMS regulations in 42 C.F.R. Part 424, subpart P establish requirements for enrolling in Medicare and for securing and maintaining enrollment in the program.[1] CMS and its contractor relied on two such requirements here. The first states that a provider "must be operational to furnish Medicare covered items or services . . . ." 42 C.F.R. § 424.510(d)(6). The second obligates a provider to report changes to enrollment

[1] Unless otherwise indicated, the citations in this decision to 42 C.F.R. Part 424, subpart P are to the version of the regulations in effect from October 1, 2009 through September 30, 2010.

information – that is, information furnished in a Medicare enrollment application (form CMS-855), such as the provider's practice location – within 90 days of the change. *Id.* § 424.516(e)(2); *see also* 73 Fed. Reg. 69,726, 69,777, 69,915 (Nov. 19, 2008) (discussing enrollment-related reporting requirements for providers and suppliers); P. Ex. 18, at 6 (showing enrollment application's request for provider's practice location).

CMS may perform an "onsite review" of a provider "to verify that the enrollment information submitted to CMS or its agents is accurate and to determine compliance with Medicare enrollment requirements." 42 C.F.R. § 424.517(a). CMS may use the results of an onsite review to support a decision to deny or revoke a provider's enrollment. *Id.*

Section 424.535 authorizes CMS to revoke the Medicare enrollment and billing privileges of a provider under various enumerated circumstances. Section 424.535(a)(1), for example, authorizes CMS to revoke the enrollment of a provider that is found not to be in compliance with any "enrollment requirement." Section 424.535(a)(5) authorizes CMS to revoke a provider's enrollment if it "determines, upon on-site review, that the provider . . . is no longer operational to furnish Medicare covered items or services . . . ."

A determination by CMS or its contractor to revoke a provider's enrollment may be appealed in accordance with the procedures in 42 C.F.R. Part 498, subpart D. *See* 42 C.F.R. § 424.545(a). Under those procedures, a provider must first ask CMS for "reconsideration" of the revocation determination. *Id.* § 498.5(l). A provider dissatisfied with the reconsideration determination may request a hearing before an ALJ, then seek Board review of an unfavorable ALJ decision. *Id.* §§ 498.40, 498.80.

Case Background

The following facts, drawn from both the record and the ALJ Decision, are undisputed.

Petitioner, a home health agency, was formed as a result of a change-of-ownership (CHOW) transaction involving Good Samaritan Hospital (Good Samaritan). *See* P. Ex. 28 ¶ 4. Prior to the CHOW, Good Samaritan operated a home health business called Good Samaritan Hospital Home Care, whose primary office was located at 5 West 31st Street in Kearney, Nebraska, and whose branch office was located at 145 Memorial Drive in Broken Bow, Nebraska. *See id.* ¶¶ 4-5; P. Ex. 31 ¶ 6; P. Ex. 27, at 1, 115.

On or about July 1, 2009, Good Samaritan's home health business was "consolidated into" a new entity whose legal name is CHI Nebraska Health at Home, LLC d/b/a HealthConnect at Home (the Petitioner).[2] P. Ex. 28, at 1; CMS Ex. 1, at 1.

[2] The record shows Petitioner's business name as either "HealthConnect" or "Health Connect."

On August 6, 2009, Petitioner filed an application with CMS seeking Medicare approval of the CHOW. *See* CMS Ex. 1, at 1.

In a letter dated February 24, 2010, Petitioner notified the Nebraska Department of Health and Human Services (NDHHS), which licenses home health agencies, that the new address of its Broken Bow branch office was 404 South 10th Avenue as of February 18, 2010.[3] P. Ex. 27, at 115.

On April 13, 2010, CMS's contractor, Cahaba Government Benefit Administrators (Cahaba), recommended approval of Petitioner's CHOW application. CMS Ex. 1, at 1. The recommendation was ultimately forwarded to CMS for final action. *See* CMS Ex. 1, at 1-2.

On or about April 20, 2010, Petitioner moved its Kearney office from 5 West 31st Street to 1755 Prairie View Place because of a demolition and renovation project at or near the West 31st Street location. P. Ex. 28 ¶ 5; P. Ex. 29 ¶ 3-4.

On July 9, 2010, CMS sent a letter to Petitioner at its former Kearney, Nebraska address, 5 West 31st Street. P. Ex. 13. The July 9th letter acknowledged the July 1, 2009 CHOW; advised Petitioner that "[w]hen there is an ownership transfer of a Medicare provider of services," the prior owner's "provider agreement" is "assigned automatically to the new owner"; and informed Petitioner that CMS would forward the "reassigned [Medicare] provider agreement" once it determined that Petitioner had met applicable ownership disclosure and civil rights requirements. *Id.* The July 9th letter also referred to Petitioner's Broken Bow branch office as being located at 404 South 10th Avenue. *Id.*

The post office returned the July 9th letter to CMS as "not deliverable" with no forwarding address. CMS Ex. 2 ¶ 7; CMS Ex. 1, at 5. On July 21, 2010, Nurse Consultant Diana Moran, an employee of CMS's Division of Survey and Certification, telephoned Marjorie Jones, Petitioner's Director of Homecare, "to inquire about the correct address" for Petitioner's Kearney office. CMS Ex. 2 ¶ 8; P. Ex. 29 ¶ 2, 8. According to Ms. Moran's declaration, Ms. Jones stated during the July 21st telephone call that she was unsure about the correct address but asked Ms. Moran to send further CMS correspondence to 10 East 31st Street, an address

[3] The February 24, 2010 letter actually states that the address change was effective on February 18, ***2009***, but that date appears to be typographical error given the undisputed chronology of events.

for Good Samaritan Hospital. CMS Ex. 2 ¶ 8. (Both 5 West 31st Street and 10 East 31st Street are located on the campus of Good Samaritan Hospital. CMS Ex. 3, at 1.) In an affidavit, Ms. Jones explained that she had given CMS the 10 East 31st address because Petitioner "had just moved to a new address and I was not sure if mail could be received at 1755 Prairie View Place yet," and because Petitioner had previously received mail sent to that address. P. Ex. 29 ¶¶ 9-10.

On July 23, 2010, CMS memorialized the July 21st telephone conversation in a letter addressed to Petitioner at 10 East 31st Street in Kearney, Nebraska. CMS Ex. 1, at 7. The July 23rd letter stated in relevant part:

> CMS contacted [Petitioner] by phone on July 21, 2010, concerning the returned letter [dated July 9, 2010]. At that time [Petitioner's] administrator [Marjorie Jones] stated that the home health agency was located at the new address listed above [10 East 31st Street]. In order for our office [CMS] to complete the change of ownership and issue the provider agreements [Petitioner] will need to notify the state agency of your address change and file a CMS-855A with your Regional Home Health Intermediary (RHHI), Cahaba GBA. Until our office receives notification of the change of address from Cahaba we will be unable to proceed with the change of ownership.

Id.

On July 31, 2010, Diane Gordon, a Cahaba employee, attempted an unannounced onsite review of Petitioner at 5 West 31st Street in Kearney. CMS Ex. 3, at 1; CMS Ex. 4 ¶ 4. Ms. Gordon found that the building at that address had been torn down, and that there was no sign for Petitioner at that site. CMS Ex. 3, at 1; CMS Ex. 4 ¶ 5. In addition, Ms. Gordon visited 10 East 31st Street in Kearney but found no indication that Petitioner was operating from that address either. CMS Ex. 3, at 1; CMS Ex. 4 ¶ 5. According to Ms. Gordon, a Good Samaritan Hospital operator provided a telephone number for Petitioner, but that number was for an answering service that was unable to provide an address for Petitioner in Kearney. CMS Ex. 4 ¶ 5. Ms. Gordon also attempted an onsite review of Petitioner's branch office by going to the following two addresses in Broken Bow, Nebraska: 145 Memorial Drive; and 404 South 10th Street. CMS Ex. 3, at 2; CMS Ex. 4 ¶ 6. Ms. Gordon discovered another provider at 145 Memorial Drive and found a sign at 404 South 10th Street which indicated that that property was occupied by "Good Samaritan Hospital Homecare." CMS Ex. 3, at 2; CMS Ex. 4 ¶ 7.

In a letter dated August 10, 2010 and in an accompanying Medicare enrollment application signed on the same date, Petitioner notified Cahaba that its Kearney address had changed from 5 West 31st Street to 1755 Prairie View Place. P. Ex. 16, at 1, 5. The letter and application were stamped "received" by Cahaba on August 16, 2010. *Id.* at 1, 2.

In the meantime, on August 13, 2010, Cahaba issued an initial written determination that revoked Petitioner's enrollment on the ground that it was not operational at the Kearney and Broken Bow addresses visited by Cahaba's inspector on July 31, 2010. CMS Ex. 1, at 10. The initial determination also noted that Petitioner had not submitted an amended enrollment application (CMS-855A) notifying the Medicare program of the address changes for its primary and branch offices. *Id.* Cahaba advised Petitioner that the revocation would become effective on September 12, 2010 and that Petitioner could submit a "corrective action plan" (CAP) within 30 days from date of the initial determination showing that its "deficiencies" had been corrected and that it was eligible to participate in the Medicare program. *Id.*

On August 24, 2010, Petitioner notified Cahaba, via an updated Medicare enrollment application, that the address of its Broken Bow branch office had changed to 420 South 10th Avenue (instead of 404 South 10th Avenue). P. Ex. 18.

On August 26, 2010, Petitioner submitted a CAP. P. Ex. 27. Among other things, Petitioner asserted in its CAP that its Homecare Director had "misinterpreted" CMS's July 21st address request and, as a result, provided an incorrect current address for the Kearney office. *Id.* at 1. Petitioner also asserted that it became aware of its mistake when it received CMS's July 23, 2010 letter that "clarified the need for an update to the 855A information," further stating that "[a]pparently our [August 10] notice of address change and Cahaba's [August 13] notice of revocation crossed in the mail." *Id.* at 1-2. In addition, Petitioner explained that the branch office address supplied to NDHHS in February 2010 had been "incorrectly recorded" on the office lease as 404 South 10th Avenue, and that the post office had given notice that the correct address for that office was actually 420 South 10th Avenue. *Id.* In support of the CAP, Petitioner submitted evidence that it had erected a "temporary" sign at the Broken Bow office showing its current business name ("HealthConnect at Home"). *Id.* at 2. Petitioner also asserted that a permanent sign had been ordered for the branch office and would be installed "upon receipt." *Id.* Finally, Petitioner claimed that it had requested "internet based PECOS access" in order to "expedite future notification of enrollment information changes." *Id.*

On September 30, 2010, CMS notified Petitioner that it had declined to accept the CAP and denied the request for reconsideration on the ground that Petitioner had failed to notify Medicare of changes to existing enrollment information within "60 days" of the changes, as required by 42 C.F.R. § 424.516(e)(2).[4] CMS Ex. 1, at 13. (In fact, as indicated previously, section 424.516(e)(2) requires reporting within 90 days, not 60 days.)

During the subsequent ALJ proceeding, CMS moved for summary judgment, contending that the revocation of Petitioner's enrollment and billing privileges was legally justified because Petitioner was not operational at the Kearney and Broken Bow addresses that Cahaba sought to inspect on July 31, 2010, and because Petitioner did not timely notify CMS of changes in its practice locations. *See* Respondent's Brief and Motion for Summary Judgment at 1, 10 (stating that the evidence "supported the reasons behind [CMS's] decision" to revoke Petitioner's billing privileges).

Petitioner filed a response to the summary judgment motion, contending that "at all times relevant to this case," it was "operational to provide Medicare-covered services" at its new addresses in Kearney and Broken Bow (1755 Prairie View Place and 404 (or 420) South 20th Avenue); that it had "cured" any failure to timely report the February and April 2010 address changes for its two practice locations; and that genuine disputes of material fact existed about when that obligation arose (and about other issues). *See* Pet.'s Pre-Hearing Brief and Response to CMS's Summary Judgment Motion at 1, 13-17. Petitioner contended it did not notify Medicare about the changes to its practice locations until August 2010 "because it was waiting on CMS's response and assignment of the Medicare provider agreement relating to the CHOW" and suggested that its August 2010 notices should be considered timely because CMS could not, or would not, have accepted them prior to approving the CHOW. *Id.* at 14.

The ALJ Decision

The ALJ found Petitioner had "conceded" that: (1) it failed to report address changes for its Kearney and Broken Bow offices within the 90-day period prescribed in section 424.516(e)(2); and (2) it was "non-operational *at the addresses on file* with CMS at the time of the July 31, 2010 on-site review." ALJ Decision at 6 (italics added). (We presume that the ALJ used the term "addresses on file" to mean the following locations: 5 West 31st Street and 10 East 31st Street in Kearney, Nebraska; and 145 Memorial Drive and 404 South 10th Street in Broken Bow, Nebraska.)

[4] Although the revocation was sustained upon reconsideration, the September 30th determination states that CMS had overturned the initial determination. CMS Ex. 1, at 2. On October 28, 2010, CMS reissued the reconsideration determination to clarify that it had sustained (and not overturned) the initial determination. *Id.* at 15-16.

The ALJ also rejected Petitioner's claim that it was precluded from reporting the address changes until CMS had finally approved the CHOW. ALJ Decision at 6. For summary judgment purposes, the ALJ assumed that Petitioner was "operational" at its new addresses in Kearney and Broken Bow (1755 Prairie View Place and 420 South 10th Avenue) but nonetheless concluded:

> Petitioner still, however, was not in compliance with federal reporting requirements. . . . CMS correctly determined that Petitioner failed to satisfy all of the Medicare enrollment requirements because Petitioner was not physically present at the addresses of record with CMS at the time of the on-site review, and Petitioner failed to report these changes in enrollment information within 90 days as is required by law.

Id. (citing 42 C.F.R. §§ 424.516(e)(2), 424.517(a)(1)(ii), and 424.535(a)(5)(i)).

Standard of Review

Whether summary judgment is appropriate is a legal issue that we address de novo. *Lebanon Nursing and Rehabilitation Center,* DAB No. 1918, at 7 (2004). 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. *Kingsville Nursing and Rehabilitation Center,* DAB No. 2234, at 3 (2009) (*citing Celotex Corp. v. Catrett,* 477 U.S. 317, 322-25 (1986)).

Discussion

As indicated, the ALJ concluded that (1) Petitioner was not "operational" on July 31, 2010, the date of Cahaba's onsite inspections, and (2) Petitioner failed to report changes to its Medicare enrollment information – namely, the 2010 address changes for its two practice locations – within 90 days of the changes, as required by section 424.516(e)(2). Either conclusion, if established, is a legally sufficient basis for revocation. In our discussion below, we affirm the grant of summary judgment based on the undisputed facts that establish that Petitioner did not comply with the 90-day reporting requirement. Hence, we do not reach the issue of whether a provider must always be operational at the addresses on file with CMS.

1. *Undisputed facts demonstrate that Petitioner was noncompliant with the reporting requirement in 42 C.F.R. § 424.516(e)(2).*

Petitioner does not dispute that as a condition for securing or maintaining Medicare enrollment, section 424.516(e)(2) requires a provider to inform CMS of any change in the address of its practice location and to do so within 90 days of the change. Nor does

Petitioner challenge the ALJ's finding that it failed to report changes to the addresses of its practice locations in Kearney and Broken Bow, Nebraska within that time frame. The evidence of record confirms that failure. According to the affidavit of Petitioner's Director of Finance, the address change of its primary office in Kearney, Nebraska occurred on or about April 20, 2010. P. Ex. 28 ¶ 5. Thus, Petitioner was obligated to report that change by July 19, 2010. However, Petitioner proffered no evidence that it attempted to report the Kearney address change to CMS (or to its contractor) by that date. *See* P. Ex. 27, at 1-2. In addition, although CMS knew by late June or early July 2010 that Petitioner had moved its branch office in Broken Bow on February 18, 2010 (*see* CMS Ex. 1, at 2 and P. Ex. 13), Petitioner proffered no evidence that it notified Medicare of that address change within 90 days of the change (or by May 15, 2010).

As it did before the ALJ, Petitioner contends that it had no obligation to report the address changes because the pendency of its CHOW application "precluded" it from filing the required notices until CMS approved the CHOW. Request for Review (RR) at 13-15. According to Petitioner, the ALJ "incorrectly ignored evidence and regulatory authority that [Petitioner] was precluded from submitting an 855A [Medicare enrollment application] relating to the change of address until after CMS approved the pending CHOW, which did not happen until July 2010." RR at 13. In support of this argument, Petitioner points to section 5.5.2.5.1(B) of chapter 10 of the Medicare Program Integrity Manual (PIM), CMS Pub. 100-08.[5] That manual provision states:

> If – prior to the issuance of the tie-in notice – the contractor receives from the <u>buyer</u> a CMS-855 request to change any of the provider's existing enrollment information, the contractor shall return the application per section 3.2 of this manual. Until the tie-in is issued, the seller remains the owner of record; hence the buyer has no standing to submit CMS-855 changes on behalf of the provider.

(Emphasis in original.)

Claiming that its actions (or inaction) were consistent with these manual instructions, Petitioner asserts that it notified Cahaba of the address change of its Kearney and Broken Bow practice locations only after CMS's "approval" of the CHOW and "tie-in" (but prior to the initial revocation determination). RR at 14. Petitioner also cites the affidavit of its Director of Finance, who stated that Petitioner "did not file a CMS-855A for the change of address to 1755 Prairie View Place [in Kearney] because it was waiting for a response from [CMS] to the assignment of the provider number from Good Samaritan Hospital to

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[5] The PIM is available at https://www.cms.gov/Manuals/IOM/list.asp.

[Petitioner]." RR at 13; P. Ex. 28 ¶ 6. Finally, Petitioner points to an e-mail message in which a Cahaba employee informed CMS that Cahaba "technically cannot accept an 855A for a change of address before the CHOW has been approved." P. Ex. 1, at 23 (Aug. 2, 2010, 1:33 p.m. e-mail from P. Anderson to D. Moran).

We do not agree that the pendency of Petitioner's CHOW application operated to excuse, suspend, or otherwise nullify the 90-day reporting requirement in these circumstances. The 90-day reporting requirement is found in a duly promulgated program regulation, section 424.516(e)(2). That regulation on its face imposes the reporting obligation on any "provider," which Petitioner was at all relevant times.[6] The regulation makes no exception for a provider that happens to be the subject of a pending CHOW application.

To the extent that PIM § 5.5.2.5.1(B) – the authority cited by Petitioner – can be read as creating such an exception, it conflicts with the regulation's plain language. In that circumstance the legally binding regulation is controlling.[7] *Cf. Alden-Princeton Rehabilitation & Health Care Center*, DAB No. 1873, at 8 (2003) (holding that ambiguous language in a CMS manual could not be used to "impose on a [nursing home] participation requirement a limitation that is not supported under the plain language of the regulation").

We also disagree with Petitioner's reading of the PIM and e-mail messages. These materials indicate only that CMS's contractor could not or would not *accept* or *process* certain requests to change a provider's enrollment information. They do not state that a provider is barred or excused from reporting enrollment changes during the pendency of a CHOW application, and there is no evidence that CMS or Cahaba ever instructed Petitioner to postpone or delay notification of such changes.

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[6] As used in Medicare program's regulations, the term "provider" is defined to include a home health agency or other organization "that has in effect an agreement to participate in Medicare." 42 C.F.R. § 400.202. Petitioner had such an agreement beginning on July 1, 2009, the date of the relevant CHOW transaction. At that point, the Medicare provider agreement of Good Samaritan Hospital Home Care was automatically transferred to Petitioner. *See* 42 C.F.R. § 489.19(c) (providing that "[w]hen there is a change of ownership as specified in [section 489.19(a)], the existing provider agreement will automatically be assigned to the new owner"); *see also* State Operations Manual, CMS Pub. 100-07 (available at https://www.cms.gov/Manuals/IOM/list.asp) § 3210 ("When a provider undergoes a CHOW, the provider agreement is automatically assigned to the new owner unless the new owner rejects assignment of the provider agreement.").

[7] In appropriate circumstances, the Board may defer to a manual provision that interprets an ambiguous program regulation. *See Alaska Dept. of Health and Social Services*, DAB No. 1919, at 14 (2004). Even if section 424.516(e)(2) were ambiguous (which it is not), there is nothing in the manual provision cited by Petitioner which indicates that it was intended to interpret that regulation. Moreover, Petitioner proffered no evidence that it was previously aware of the cited manual provision and had relied on it.

In sum, there is no genuine dispute that Petitioner failed to comply with the applicable reporting requirement. For that reason, we conclude that CMS lawfully revoked Petitioner's enrollment and billing privileges pursuant to section 424.535(a)(1).

2. *Summary judgment was appropriate*

Petitioner contends that summary judgment was improper, asserting that there are genuine issues of material fact in this case – namely, (1) "whether [Petitioner] was required to or could have submitted an 855A change of address while its CHOW was still pending," and (2) "whether Cahaba could accept or process an 855A change of address from [Petitioner] before CMS approved the CHOW." RR at 16. Petitioner also contends that there are genuine issues of material fact regarding the following other topics:

- "the adequacy of the Cahaba's onsite visit and decision that [Petitioner] was 'no longer in operation'";

- "the credibility of CMS's investigation" following the July 31, 2010 onsite review; and

- "whether CMS's decision denying [Petitioner's] Corrective Action Plan [CAP] was arbitrary and capricious."

Id.; *see also* Pet.'s Pre-Hearing Brief and Response to CMS's Summary Judgment Motion at 13-17.

These issues do not raise genuine disputes of material fact. Whether Petitioner was "required to" notify CMS that its practice locations had changed "while its CHOW was still pending" is a legal issue that we discussed and resolved in the previous section. Whether, as a factual matter, CMS or Cahaba "could" or would have accepted and processed notice of an address change prior to CHOW approval is legally immaterial. Under section 424.516(e)(2) and section 424.535(a)(1), CMS has a legally sufficient basis for revocation if a provider does not give or attempt to give the Medicare program timely notice of a change in its practice location. In addition, the adequacy of Cahaba's onsite review and the credibility of CMS's investigation after the onsite review are immaterial because they concern the finding that Petitioner was not operational, a finding that we need not reach in order to affirm the grant of summary judgment.

Finally, CMS's rejection of Petitioner's CAP does not raise a genuine dispute of material fact because the rejection of a CAP is not reviewable in this proceeding. "While the regulations [in 42 C.F.R. Part 424, subpart P] require a contractor to provide a supplier

with an opportunity to submit a CAP, they nowhere indicate that a supplier may appeal a contractor's rejection of a CAP proffered after notice of revocation." *Pepper Hill Nursing & Rehabilitation Center, LLC,* DAB No. 2395, at 9-10 (2011).

Conclusion

For the reasons discussed, we affirm the ALJ's May 18, 2011 decision.

/s/
Sheila Ann Hegy

/s/
Constance B. Tobias

/s/
Judith A. Ballard
Presiding Board Member