

Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Adora Healthcare Services, Inc.
Docket No. A-16-20
Decision No. 2714
June 20, 2016

**FINAL DECISION ON REVIEW OF
ADMINISTRATIVE LAW JUDGE DECISION**

The Centers for Medicare and Medicaid Services (CMS) requests review of an administrative law judge decision reversing CMS’s determination to revoke the Medicare enrollment and billing privileges of Adora Healthcare Services, Inc. (Petitioner) based on having found Adora nonoperational at the location stated in its enrollment application. *Adora Healthcare Services, Inc.*, DAB CR4229 (September 18, 2015) (ALJ Decision). The ALJ reversed the revocation after concluding that Petitioner had come forward with persuasive evidence demonstrating that it moved its operations to a new location on July 1, 2014 and on June 26, 2014, timely mailed notice of the move to the Medicare contractor. We affirm the ALJ Decision to reverse the revocation, but, as explained below, do so for different reasons.

Legal Background

To participate in Medicare, a home health agency must enroll in the program. 42 C.F.R. §§ 424.500, 400.202 (defining Medicare “provider” to include a home health agency). Once enrolled, a home health agency has “billing privileges” — that is, the right to claim and receive Medicare payment for services provided to Medicare beneficiaries. 42 C.F.R. § 424.505. A provider must report to CMS certain enrollment information changes, including a change in the location of its practice, within 90 days of the change. 42 C.F.R. § 424.516(e)(2).

The regulations in 42 C.F.R. Part 424, subpart P set out the requirements for establishing and maintaining Medicare billing privileges. Section 424.510(d)(6) states that a provider “must be operational to furnish Medicare covered items or services” 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 revoke a provider’s enrollment. *Id.*

Section 424.535(a) sets out the bases on which CMS may revoke a provider's Medicare billing privileges and provider agreement. Section 424.535(a)(5) provides that "CMS may revoke" a provider's Medicare billing privileges and provider agreement when CMS determines "upon on-site review" that the provider is "no longer operational to furnish Medicare covered items or services. . . ." Section 424.502 defines the term "operational" to mean that—

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.

Revocation results in the termination of the Medicare provider agreement as well as a bar on re-enrollment for a minimum of one year, but no more than three years. 42 C.F.R. § 424.535(b), (c).

A provider may appeal a determination by CMS to revoke its Medicare enrollment under the procedures in 42 C.F.R. Part 498. A provider must first ask CMS for "reconsideration" of the initial revocation determination. 42 C.F.R. §§ 498.5(1), 498.22. A provider dissatisfied with the reconsidered determination may request a hearing before an ALJ. 42 C.F.R. § 498.40. Either party may seek Board review of an unfavorable ALJ decision. 42 C.F.R. § 498.80.

Case Background

Petitioner is a home health agency that was enrolled as a provider in the Medicare program. ALJ Decision at 1. Petitioner stated on its Medicare enrollment applications dated June 20, 2011 and December 26, 2013 that its location was 14405 Walters Road, Suite 340, Houston, Texas. *Id.* at 3, citing CMS Exhibit (Ex.) 7, at 2. On July 7, 2014, a CMS contractor attempted to conduct an inspection of Petitioner at that address but was unable to gain access. *Id.* at 3, citing CMS Exs. 6, at 1; 7, at 2; 8. The inspector reported that Petitioner's name was listed on the building directory but that she was unable to find Petitioner's office suite of record and also received no response when calling Petitioner's "listed number." *Id.*, citing CMS Ex. 6, at 1; 8, at 2. The inspector confirmed that this was Petitioner's phone number of record. *Id.*, citing CMS Ex. 8, at 2. Based on the inspector's report, CMS concluded that Petitioner was no longer operational to furnish Medicare covered items or services. ALJ Decision at 1-2, citing CMS Ex. 1 (revocation notice); 42 C.F.R. § 424.535(a)(5); 42 U.S.C. §§ 1302, 1395cc(j), 1395hh.

Petitioner asked for reconsideration of the revocation determination, asserting that it had moved its practice location to 14511 Falling Creek Drive, suite 100-12, Houston, TX 77014 effective July 1, 2014 and had notified CMS of this change in a letter mailed to the CMS contractor on June 26, 2014. ALJ Decision at 2, citing CMS Ex. 2. Petitioner attached to its reconsideration request copies of the CMS Form 855-A purportedly sent to the contractor, as well as a September 22, 2014 Notification of Change from the Texas Department of Aging and Disability (TDADS) that cited Petitioner's change of address, effective July 14, 2014, for purposes of Medicaid. CMS Exs. 3, 4. On December 4, 2014, CMS affirmed the revocation determination, stating that the contractor had no record of Petitioner's notice of a change of address. ALJ Decision at 2, citing CMS Ex. 5; *see also* CMS Ex. 7, at 2 (affidavit claiming that CMS received no change of address notification from Petitioner between December 27, 2013 and December 17, 2014).

Petitioner submitted a request for hearing on the reconsidered determination; its request included four exhibits marked A-D. ALJ Decision at 2. CMS moved for summary judgment. *Id.* Petitioner filed a brief opposing the motion and two affidavits of direct testimony denominated Petitioner's Exhibits (P. Exs.) 1 and 2. *Id.* CMS did not object to any of Petitioner's exhibits, and the ALJ overruled Petitioner's objection to CMS Exs. 6-8. *Id.* Neither party asked to cross-examine the other party's witnesses; accordingly, the ALJ concluded an in-person hearing was unnecessary, and he decided the case on the written record, reversing the revocation. *Id.* CMS then filed the request for review addressed in this decision.

Standard of Review

We review a disputed finding of fact to determine whether the finding is supported by substantial evidence in the record as a whole and a disputed conclusion of law to determine whether it is erroneous. *See Guidelines — Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program (Guidelines)*. The *Guidelines* are available at <http://www.hhs.gov/dab/divisions/appellate/guidelines/prosupenrolmen.html>.

Analysis

The ALJ reversed the revocation based on his conclusion that Petitioner had timely mailed the CMS 855-A form notifying CMS of Petitioner's move from its Walters Road address to its new Falling Creek Drive address. The ALJ correctly noted that a provider has 90 days to notify CMS of a change in address by sending notice of same to the CMS contractor. ALJ Decision at 4, citing 42 C.F.R. § 424.516(e)(2). The ALJ stated that, although he found "no reason to discredit CMS's assertion that Palmetto [the CMS contractor] did not receive notification of Petitioner's move," he was "persuaded that Petitioner provided CMS with the requisite notification of change of address by

mailing the form to CMS in a timely manner.” ALJ Decision at 5. CMS, the ALJ noted, had not challenged the statements by Petitioner’s witnesses that Petitioner had mailed the CMS 855-A on June 26, 2014, and the ALJ found those statements credible and consistent with TDADS’s verification of Petitioner’s move in July 2014. *Id.* The ALJ then concluded, “Because [CMS] concluded Petitioner was no longer operational based on its on-site review of a former address, there was no legal basis for CMS to revoke Petitioner’s Medicare enrollment.” *Id.*

We agree that CMS had no legal basis to revoke Petitioner’s Medicare enrollment for being non-operational based on the on-site review that occurred at Petitioner’s former address, 14405 Walters Road, Suite 340, Houston, Texas, on July 7, 2014. However, unlike the ALJ, we reach this conclusion regardless of whether Petitioner timely informed CMS of its move to its new location at 14511 Falling Creek Drive, suite 100-12, Houston, TX 77014 and regardless of whether CMS received notice from Petitioner of the change of address between December 27, 2013 and December 17, 2014. We do not need to decide whether and when Petitioner mailed the notice or whether CMS’s receipt rather than the mailing date controls because those issues are not material to our decision. Our decision focuses on the timing of the on-site inspection on which CMS based its determination that Petitioner was non-operational rather than on whether Petitioner timely mailed and CMS received notice of Petitioner’s change of address.¹ We conclude that the revocation was invalid because CMS’s determination that Petitioner was “no longer operational” rested solely on the inspector’s visit to Petitioner’s duly enrolled 14405 Walters Road location which occurred, as CMS does not dispute, before Petitioner’s 90-day period for reporting its new location had expired. The revocation determination, in effect, was premature.

As context for our decision, we find it necessary to address the parties’ respective burdens of proof since CMS’s statement on that issue is not entirely accurate. CMS asserts that “[a]s a provider enrolled in the Medicare program, Adora had the burden to demonstrate that it was operational and to ensure that [the Medicare contractor] was provided with complete and current information regarding its practice location.” CMS Reply at 4. The Board applies to provider and supplier enrollment appeals the same burden of proof that it applies to other cases subject to the appeal procedures in Part 498. *See Promptcare New England Respiratory, LLC*, DAB No. 2673, at 7-8 (2016); *Ronald J. Grason, M.D.*, DAB No. 2592, at 5 (2014). Applying that burden to appeals of

¹ This is not a case like *Donald Dolce, M.D.*, DAB No. 2685 (2016). There, the Board had to decide whether the “filing of a Medicare enrollment application that was subsequently approved . . .” occurred on the date the supplier mailed the application or on the date CMS’s contractor received it because the answer determined the effective date of the supplier’s enrollment under 42 C.F.R. § 424.520(d). The Board decided in that circumstance that the filing of the application occurred when CMS’s contractor received it because only then did CMS have an application it could process to approval (or disapproval).

enrollment revocations, CMS has the burden of coming forward with evidence that establishes a prima facie case that the cited basis for the revocation exists. If CMS meets this burden, a petitioning provider then has the burden to prove its case, that is, to rebut the basis for the revocation, by a preponderance of the evidence. *Id.*

In this case, CMS was required to make a prima facie case that Petitioner was no longer operational, the basis for its revocation determination under section 424.535(a)(5)(i). To do that, CMS needed to point to evidence in the record developed before the ALJ showing that Petitioner no longer “had a qualified physical practice location,” and was not “open to the public for the purpose of providing health care related services, . . . prepared to submit valid Medicare claims [or] properly staffed, equipped, and stocked . . . to furnish these items or services.” 42 C.F.R. §424.502. The only evidence CMS pointed to was the evidence related to the July 7, 2014 inspection at Petitioner’s old location of record on Walter’s Road. We conclude that this evidence was insufficient to make a prima facie case that Petitioner was no longer operational in light of Petitioner’s undisputed move to a new location prior to the inspection and the fact that Petitioner’s 90-day period for notifying CMS of that move had not elapsed.

The record contains undisputed evidence that Petitioner was operational while at its old Walter’s Road location; indeed, CMS itself put into evidence the enrollment applications showing that Petitioner was operational at the Walters Road address at least as late as December 26, 2013. Petitioner said it moved to its new Falling Creek Drive location effective July 1, 2014, and although CMS presented affidavit testimony that it did not receive notice of the move until December 2014, CMS did not dispute that Petitioner moved from the Walters Road location. The regulations do not prohibit a provider from moving its operations from a previously enrolled location to a new location nor do they require that the Medicare contractor must be informed prior to the move. The only requirement is that the provider notify CMS of the change of location **within 90 days**. 42 C.F.R. § 424.516(e)(2).

Furthermore, CMS’s authority to revoke in section 424.535(a)(5)(i) is based on finding that the provider is “no longer operational” (emphasis added), language which tends to suggest a cessation of existing operations, rather than merely a move to a new location, which might cause some disruption in the existing operations during the move but typically would not end them. Thus, reasonably read, the regulations seem to anticipate that providers and suppliers, at least absent evidence to the contrary, may remain operational for up to 90 days during a change to a new location even if they are no longer practicing at the pre-move address. At least, CMS has not given us any reason to reach a contrary conclusion. In particular, CMS has not explained why the Secretary would have given providers 90 days to notify CMS of a change in operating location if CMS was authorized to revoke for being nonoperational based solely on a visit finding no

operations at the previously approved location before the 90-day period had expired. Absent any such explanation, we do not find persuasive CMS's position that it was authorized to revoke based on a determination that Petitioner was no longer operational based on nothing more than the contractor's July 7, 2014 inspection of the practice location listed in Petitioner's most recently approved CMS 855-A, when at the time of the inspection, the 90-day period for Petitioner to notify CMS of its July 1, 2014 move to a new practice location had not yet expired.

CMS asserts that its receipt of a provider's 855-A showing a change of practice location is important because receiving that information allows CMS to then verify that the provider is operational at the new location. RR at 8-9. We do not disagree, and our decision does nothing to undercut that important regulatory concern. Nor does our decision preclude CMS's revoking for no longer being operational based on an inspection that occurs at a prior location after the provider's 90-day window for reporting the change of address has closed or if the window has not closed at the time of the inspection but CMS has other evidence that the provider is no longer operational. We are merely holding that in this case, where CMS cited no evidence that Petitioner had ceased operating other than the results of the inspection at its Walter's Road location – which showed only that Petitioner was not operating at that location, not that it had ceased operating altogether and which took place before the 90-day notice period for a change of address had elapsed – CMS could not make a valid determination that Petitioner was non-operational. Had CMS relied on and presented evidence of other information indicating that Petitioner was no longer operational at the time of the July 7, 2014 inspection, our decision might be different. CMS, however, did not do so.

In addition, the ALJ cited and credited evidence of record, consisting of completed Home Health Certification and Plan of Care forms, as tending to show Petitioner remained operational at its new location following its move in early July:

Finally, Petitioner offers the "Home Health Certification and Plan of Care" for multiple patients for care services it provided during July 2014. Each of these certifications contains Petitioner's Falling Creek address. RFH [Request for Hearing] Ex. D. This information helps persuade me that Petitioner was, in fact operating at a new location.

ALJ Decision at 4-5.

CMS argues, “The record . . . does not support the ALJ’s finding that Adora was operational at the Falling Creek location.” RR at 16. CMS acknowledges that the certification forms the ALJ relied on are, in fact, record evidence but takes the position that as a matter of law they could not establish that Petitioner was operational at the new location because only CMS can make that determination “following an on-site review or other reliable evidence.” *Id.* CMS cites no authority for this assertion other than the definition of the term “operational” in section 424.502 and CMS’s authority to revoke for being non-operational in section 424.535(a)(5)(i). Neither regulation, however, states that a provider ceases to be operational simply because it moves its practice location, and to conclude otherwise would mean, in essence, that the regulations do not permit providers to continue to be enrolled in and bill Medicare while moving to a new practice location pending an inspection of the new location by CMS. This is not a reasonable reading of the regulations cited by CMS, and CMS cites no other authority for this proposition. Moreover, CMS’s position that only it may determine that a provider is non-operational overlooks that fact that the whole purpose of giving providers appeal rights for such determinations – or more precisely the reconsidered determinations – is to allow an ALJ to determine whether the record supports revocation on that basis.

The record also includes the TDADS letter confirming that Petitioner had notified it of Petitioner’s change of address and assigning a July 14, 2014 effective date for that change. CMS Ex. 4; RFH Ex. C, at 1-2. The ALJ found that evidence consistent with and thus supportive of the affidavit testimony of Petitioner’s witnesses that Petitioner had mailed notices of its change of address to both CMS and TDADS on June 26, 2014. ALJ Decision at 4, 5. CMS argues that “TDADS was not the contractor responsible for processing change of information applications for CMS” and that for that and other reasons the “TDADS notice does not constitute evidence of Adora’s compliance with CMS’s reporting requirement.” RR at 16. However, as explained above, unlike the ALJ, our decision is not based on whether Petitioner timely mailed a change of address notice or whether CMS received the notice but, rather, on our conclusion that CMS’s determination that Petitioner was nonoperational was premature since Petitioner’s 90-day window for notifying CMS of that change had not closed at the time of the inspection on which CMS based its determination. We find that the TDADS notice provides at least some additional evidence (additional to the Home Health Certification and Plan of Care forms) that Petitioner was, in fact, operating at its new Falling Creek location in early July.

Of course, our decision does not preclude CMS from conducting an onsite inspection at Petitioner’s new location and taking any action appropriate to the findings of such a site visit. Based on the current record, however, we cannot conclude that Petitioner was no longer operational at the time of the site visit on which CMS relies.

Conclusion

For the reasons stated above, rather than those stated by the ALJ, we affirm the ALJ Decision reversing CMS's revocation of Petitioner's Medicare enrollment and billing privileges under 42 C.F.R. § 424.535(a)(5).

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Sheila Ann Hegy
Presiding Board Member