Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Trinity Bestcare Home Health Agency, LLC
(PTAN: 747569; NPI 1396975744),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-1204

Decision No. CR4560

Date: March 29, 2016

DECISION

The Centers for Medicare & Medicaid Services (CMS) revoked the Medicare enrollment and billing privileges of Trinity Bestcare Home Health Agency, LLC, (Petitioner) because CMS found that Petitioner was not operational at its Medicare-registered location at the time of a site visit on July 7, 2014. Petitioner requested a hearing to dispute the revocation. Petitioner concedes that it was not operational at the address visited by the site inspector on July 7, 2014, but asserts that it was operational at another location and had timely reported its address change to the Medicare contractor. After considering the full merits of the written record, and for the reasons explained below, I sustain CMS's determination.

I. Background

Petitioner, a provider[1] of home health services, participated in the Medicare program. In an October 27, 2014 initial determination, Palmetto GBA, a Medicare administrative

[1] A "provider of services," commonly shortened to "provider," includes hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation

contractor acting on behalf of CMS, revoked Petitioner's Medicare billing privileges and enrollment pursuant to 42 C.F.R. § 424.535(a)(5). CMS Ex. 1. Section 424.535(a)(5)(i) provides that CMS may revoke the Medicare enrollment and billing privileges of a currently enrolled provider if CMS determines, upon on-site review, that the provider is no longer operational to furnish Medicare covered items or services, or fails to satisfy any Medicare enrollment requirement. The October 27, 2014 initial determination stated that on July 7, 2014, a site inspector conducted a visit to 2000 Royal Crest Drive, Mansfield, Texas, Petitioner's location on file with Medicare, and found Petitioner was not operational. CMS Exhibit (CMS Ex.) 1. Consequently, Palmetto GBA revoked Petitioner's enrollment and billing privileges effective July 7, 2014. Palmetto GBA imposed a reenrollment bar on Petitioner for a period of two years. CMS Ex. 1 at 2; 42 C.F.R. § 424.535(c)(providing that the reenrollment bar is a minimum of one year but not greater than three years depending on the severity of the basis for revocation).

Petitioner requested reconsideration. CMS Ex. 8. Petitioner stated in its reconsideration request that 2000 Royal Crest Drive, Mansfield, Texas is Petitioner's Administrator's "home address, where the business originally started." CMS Ex. 8 at 1. Petitioner stated that the business moved in October 2012, and at that time Petitioner mailed and faxed a Form CMS-855A with its change of address information to the Medicare contractor. CMS Ex. 8 at 1. Petitioner included with its reconsideration request a fax cover sheet dated October 24, 2012 and Form CMS-855A with change of practice location information stamped "COPY," with a handwritten notation, "mailed 10/11/12." CMS Ex. 8 at 1-12. Petitioner also submitted copies of documents with change of address information that it alleged it concurrently sent to the Texas Department of Aging and Disability Services (state agency) and the Joint Commission. CMS Ex. 8 at 13-18.

CMS upheld the revocation and reenrollment bar in a reconsideration determination dated January 28, 2015. CMS Ex. 2. CMS stated that it had conferred with Palmetto GBA and that the Medicare contractor had no record of receiving Petitioner's change of address information. CMS noted that had Palmetto GBA received the change of address information, it would have sent an acknowledgment letter to Petitioner; such a letter was not provided by Petitioner or found in the contractor's records, however. CMS Ex. 2 at 2. CMS also observed that the evidence Petitioner submitted to show it had notified Palmetto GBA of its change of address did not include a fax receipt or any other documentation verifying that "the faxed information was actually either sent or received." CMS Ex. 2 at 2. CMS therefore sustained the revocation pursuant to 42 C.F.R. § 424.535(a)(5) based on the site visit, Petitioner's address information in the Medicare

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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 Social Security Act. Act § 1861(u) (42 U.S.C. § 1395x(u)).

Provider Enrollment, Chain, and Ownership System (PECOS), and the totality of evidence submitted for reconsideration.[2] CMS Ex. 2 at 2.

Petitioner filed a request for a hearing (RFH) by an administrative law judge to contest the reconsideration determination. Petitioner attached to its hearing request 20 supporting documents that it identified as P. Exs. 1-11, 15-17, and 21-26. RFH at 4. To avoid confusion, I refer to these documents as attachments to Petitioner's hearing request.

By my Acknowledgment and Pre-Hearing Order (Order) dated February 27, 2015, I set deadlines for the parties to file pre-hearing exchanges, including any motions for summary judgment, and I gave instructions for filing proposed exhibits. CMS filed a motion for summary judgment or in the alternative, prehearing brief (CMS Br.), accompanied by nine proposed exhibits (CMS Exs. 1-9). Petitioner, who is represented by counsel, filed a brief in opposition to CMS's motion for summary judgment or in the alternative, prehearing brief and a document tilted "Pre-hearing Exchange," which listed nine numbered, proposed exhibits and three witnesses, and set forth an objection to CMS Ex. 3. Petitioner, however, did not submit properly marked exhibits corresponding to the items it listed in its prehearing exchange as P. Exs. 1-5 because, Petitioner stated, these documents were already in the record. Complicating matters further, the item Petitioner listed as Exhibit 9 in its prehearing exchange is Petitioner's brief, to which it attached two additional proposed exhibits that it designated as P. Exs. A and B. CMS filed a motion objecting to P. Exs. A. and B. I rule on the admission of the proffered evidence below.

II. Evidentiary Rulings

My Order explained that each party's prehearing exchange must include a copy of each proposed exhibit, designated with a separate, unique, and whole identifying number and marked as specified in the Order. The Order also directed Petitioner not to file as proposed exhibits any documents that CMS had already filed. The Order stated that I may refuse to receive into evidence exhibits not filed in accordance with my instructions. Order ¶¶ 4, 6.

As noted, Petitioner did not file properly marked, proposed exhibits 1-5 corresponding to its prehearing exchange list of exhibits. Rather, Petitioner stated that these documents were already a part of the record either because Petitioner had filed them with its request for hearing or CMS had filed them as CMS exhibits. Because Petitioner did not file the documents it listed in its prehearing exchange as properly marked P. Exs. 1-5 in accordance with my Order, I do not recognize any documents in the record as P. Exs. 1-5. Petitioner submitted properly marked, proposed P. Exs. 6-8, which I admit into the record

[2] PECOS is an Internet-based enrollment tool that CMS established as an alternative to submitting paper enrollment documentation. CMS Ex. 9, ¶ 9.

absent objection. Petitioner identified its brief as P. Ex. 9. I do not recognize Petitioner's brief as an exhibit because it is not evidence.

CMS objects to the admission of the documents identified by Petitioner as P. Ex. A, an October 17, 2012 certified mail receipt for mail addressed to Palmetto GBA at a cost of $4.05, and P. Ex. B, a list of transactions showing an October 17, 2012 charge of $4.05 to "Cubesmart #686," which Petitioner offers as proof that it timely mailed its change of address information to the Medicare contractor. CMS's Objections to Petitioner's Exhibits and Response to Petitioner's Exhibit Objection. CMS argues that Petitioner did not have good cause for not submitting these documents at the reconsideration level of appeal. CMS further asserts that even if admitted into the record, the proposed exhibits would not prove that Palmetto GBA received the mailing because there is no corresponding return receipt. Petitioner asserts that the "reason why these documents were not submitted before is that Petitioner was just recently able to find them after a very thorough search of all agency records." P. Reply to CMS Objections to Petitioner's Exhibits and Response to Petitioner's Exhibit Objection at 1. Furthermore, Petitioner asserts, it is unfair to allow CMS to rely and use as a basis for actions against providers the delivery of notices through regular mail and not afford providers the same right.

The regulations that govern Medicare enrollment-related appeals are designed to promote an orderly and efficient process by requiring providers to submit all relevant and material documentary evidence relating to the matters at issue at the reconsideration level. 42 C.F.R. §§ 498.56(e)(2), 498.24; 42 C.F.R. § 424.545. Under the regulations, I must examine any new documentary evidence submitted by Petitioner to determine whether Petitioner had good cause for submitting the evidence for the first time at the ALJ level of review. If there is not good cause, I must exclude the evidence from the proceeding and may not consider it in reaching a decision. 42 C.F.R. § 498.56(e)(2)(ii).

While the regulations at 42 C.F.R. part 498 do not define "good cause," I conclude that Petitioner did not have good cause for submitting P. Exs. A and B for the first time at this level of review under any reasonable definition of the term. The initial determination expressly placed Petitioner on notice that the revocation was based on a site visit to Petitioner's address of record in the Medicare system and a finding that Petitioner was not operational at that location. CMS Ex. 1. Any evidence Petitioner wanted to present regarding its current location and whether it timely notified Medicare of its address change should have been submitted with its reconsideration request. The evidence that Petitioner submitted with its request for reconsideration indicates that Petitioner well understood the importance of submitting at the reconsideration stage any evidence that it timely notified Medicare of its change of location. Furthermore, Petitioner's explanation for the late submission makes clear that the delay was not caused by any factor beyond Petitioner's control. Rather, Petitioner had the documents in its possession at the time it requested reconsideration but had not conducted a "very thorough search" of its records.

Accordingly, I must exclude the evidence from this proceeding and may not consider it in reaching a decision.

Petitioner objects to CMS Exhibit 3, Palmetto GBA's Site Visit Report, on the ground that "the document was not dated by the surveyor and fails to comply with the requirements of sections 15.19.2.2, 20 and 20.1 of the Medicare Program Integrity Manual (MPIM) Chapter 15." P. Prehearing Exchange at 3. The MPIM requires the site visit contractor to document the date and time of the visit, write a report of findings, date all photographs and include a signed declaration stating the facts and verifying the completion of the site verification. MPIM §§ 15.19.2.2B., 15.20.1. The MPIM provides a sample declaration that includes a date field and instructs the user to attach the declaration to the report of the site visit. MPIM § 15.20.1.D.

Here, the Site Visit Report is a single document that includes the site visit findings, photos of the site and the site visit contractor's signed declaration. The first field in the document is the date of the survey, which is filled in "07/07/2014." CMS Ex. 3 at 1. Because the declaration, photos and survey findings are all included on this document, I consider it properly completed, signed and dated by the site visit contractor. Accordingly, I admit CMS Ex. 3 into the record.

III. Issues

This case presents two issues:

1. Whether CMS is entitled to summary disposition;

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

IV. Findings of Fact and Conclusions of Law

1. CMS is not entitled to summary judgment because Petitioner has furnished evidence of a dispute concerning a material fact.

Summary judgment is appropriate when the record shows that there is no genuine dispute of material fact, and the moving party is entitled to judgment as a matter of law. *18661CPayday.com, LLC.*, DAB No. 2289, at 2 (2009) (*citing Celotex Corp.* v. *Catrett, 477* U.S. 317, 322-25 (1986)). A party that moves for summary judgment bears the initial burden of showing that there are no disputed issues material to the outcome of the case. *Celotex,* 477 U.S. at 323. In determining whether there are genuine issues of material fact, the reviewer must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. *Senior Rehab. &*

Skilled Nursing Ctr., DAB No. 2300 at 3 (2010), *aff'd, Senior Rehab. & Skilled Nursing Ctr. v. Health & Human Srvcs*., 405 F. App'x 820 (5th Cir. 2010) (citations omitted).

To defeat a motion for summary judgment, the non-moving party must tender evidence of specific facts, in the form of affidavits or admissible discovery material, to support its assertion that a dispute exists. *Crestview Parke Care Ctr.*, DAB No. 1836 at 6 (citing *Matsushita Elec. Indus. Co. v. Zenith Radio Corp*., 475 U.S. 574, 586, n.11 (1986)). Here, by submitting the written testimony of three witnesses who challenge the dispositive issues in this case - whether Petitioner was operational and timely notified the Medicare contractor of its change of address - Petitioner has established that a material factual dispute exists. P. Exs. 6-8. CMS is therefore not entitled to summary judgment.

My Order advised the parties that they must submit written direct testimony for each proposed witness and that an in-person hearing would be necessary only if the opposing party affirmatively requested an opportunity to cross-examine a witness. Pre-Hearing Order ¶¶ 8-10; *Vandalia Park*, DAB No. 1940 (2004); *Pacific Regency Arvin*, DAB No. 1823, at 7-8 (2002) (holding that the use of written direct testimony for witnesses is permissible so long as the opposing party has the opportunity to cross-examine those witnesses). Neither party requested to cross-examine witnesses. Therefore, an in-person hearing in this case is unnecessary, and I proceed to issue my decision on the full merits of the written record.

2. CMS had a legal basis to revoke Petitioner's enrollment because Petitioner was not operational at its Medicare-registered location on July 7, 2014, the date of the attempted Medicare site inspection.

In order to participate in the Medicare program, a prospective provider must complete the applicable Form CMS-855 enrollment application, which requires, among other things, disclosure of the provider's practice location. 42 C.F.R. § 424.510(a). A provider in the Medicare program "must be operational to furnish Medicare covered items or services." 42 C.F.R. § 424.510(d)(6). A provider is "operational" when it has a "qualified physical practice location, is open to the public for the purpose of providing health care related services, is prepared to submit valid Medicare claims, and is properly staffed, equipped and stocked . . . to furnish these items or services." 42 C.F.R. § 424.502. CMS may perform on-site inspections to verify the accuracy of a provider's enrollment information and to determine the provider's compliance with Medicare enrollment requirements. 42 C.F.R. §§ 424.510(d)(8), 424.517(a).

CMS may revoke a provider or supplier's Medicare billing privileges for a variety of reasons including:

> (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 items or services for, Medicare patients. Upon on-site review, CMS determines that –
>
> > (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.

42 C.F.R. § 424.535(a)(5)(i).

When revocation is based on a determination that the provider is not operational at its practice location of record, the revocation is effective the date that CMS determined that the provider was no longer operational. 42 C.F.R. § 424.535(g).

Here, Petitioner's Medicare enrollment form on file showed 2000 Royal Crest Drive, Mansfield Texas to be Petitioner's practice location. CMS Ex. 4 at 9. The Site Visit Report establishes, and Petitioner does not dispute, that the property is a private residence which, on July 7, 2014, was not open for business and had no signs of customer activity. CMS Ex. 3. Petitioner also does not deny that it was not operating out of 2000 Royal Crest Drive, Mansfield, Texas on July 7, 2014, the date of the Medicare site inspection. Accordingly, I find that CMS had a legal basis to revoke Petitioner's enrollment pursuant to 42 C.F.R. § 424.535(a)(5)(i).

3. Petitioner has not provided persuasive evidence that it notified Palmetto about its address change prior to July 7, 2014.

As indicated above, Petitioner provided its practice location on its enrollment application, CMS Form-855A, which included a certification statement in which Petitioner agreed to adhere to all Medicare enrollment requirements and acknowledged that Petitioner's Medicare enrollment and billing privileges might be revoked if it failed to meet these requirements. CMS Ex. 4 at 22. Petitioner's duties included complying with the program's requirements for providing notice and information regarding its business location and change of address by filing an 855 Form or via PECOS within 90 days of the change. MPIM § 15.1.2; 42 C.F.R. § 424.516(e).

While Petitioner does not dispute that it was not operational at the Royal Crest Drive address at the time of the site inspection, Petitioner asserts that it had moved to a new location and reported to Palmetto GBA the change of address. In provider and supplier enrollment and revocation appeals, providers and suppliers must be able to demonstrate that they meet the enrollment requirements. 42 C.F.R. § 424.545(c). This responsibility is "consistent with the Board's conclusion in provider appeals under 42 C.F.R. Part 498 that a provider must prove substantial compliance by the preponderance of the evidence, once CMS has established a prima facie case that the provider was not in substantial

compliance with relevant statutory or regulatory provisions." *MediSource Corp.*, DAB No. 2011, at 2-3 (2006), *citing Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004); *aff'd, Batavia Nursing and Convalescent Center v. Thompson*, No. 04-3325 (6th Cir. April 15, 2005); *cf. Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd, Hillman Rehabilitation Ctr. v. U.S. Dep't of Health and Human Services*, No. 98-3789(GEB) (D.N.J. May 13, 1999).

I conclude that Petitioner has not shown by a preponderance of the evidence that it faxed or mailed the appropriate form to Palmetto GBA to change its Medicare-registered location prior to the on-site inspection. Petitioner filed no proof of fax receipt or delivery confirmation showing that Petitioner actually mailed to Palmetto GBA change of address information on October 11, 2014, as indicated on the copy of the form it allegedly faxed and mailed. While Petitioner submitted sworn declarations of its co-owner/Administrator and co-owner/Chief Financial Officer stating that each had personal knowledge that "on October 17, 2012 the 855-A notifying CMS of a change in . . . office location was delivered to the U.S. Post Office for delivery by certified mail to Palmetto GBA," neither stated that they had personally faxed, delivered or mailed the document. P. Ex. 6 at ¶ 4; P. Ex 7 at ¶ 4. Also, the declaration of Palmetto GBA Provider Enrollment Manager, Tanesha Norman, supports that Palmetto GBA reviewed its records and determined that it did not receive a Form CMS-855A from Petitioner notifying the contractor of a change of address from 2000 Royal Crest Drive. CMS Ex. 9 ¶ 10. Accordingly, I conclude that Petitioner has not established by a preponderance of the evidence that it timely notified CMS of its change in location, as required under the regulations governing Medicare provider enrollment.

V. Conclusion

Petitioner was not operational at its Medicare-registered location on July 7, 2014, and CMS had a legal basis to revoke Petitioner's enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(5)(i).

/s/
Joseph Grow
Administrative Law Judge