Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Dallas Home Health Care, Inc.
(NPI: 1265594246 / PTAN: 74-7003)

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-1521

Decision No. CR4760

Date: December 13, 2016

DECISION

The Medicare enrollment and billing privileges of Petitioner, Dallas Home Health Care, Inc., are revoked pursuant to 42 C.F.R. § 424.535(a)(5)(ii)[1], for noncompliance with 42 C.F.R. § 424.516(e)(2). The revocation is effective July 16, 2014. 42 C.F.R. § 424.535(g).

I. Procedural History and Jurisdiction

Petitioner was enrolled in Medicare as a home health agency. Palmetto GBA (Palmetto), a Medicare administrative contractor, notified Petitioner by letter dated October 10, 2014, that Petitioner's Medicare billing privileges were revoked and its provider agreement terminated effective July 16, 2014. Centers for Medicare & Medicaid Services (CMS) Exhibit (Ex.) 1 at 8. Palmetto cited 42 C.F.R. § 424.535(a)(5) as the authority for revocation based on the fact that an on-site inspection determined that Petitioner was

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

not operational at 3635 Broadway Boulevard, Suite A, Garland, Texas. CMS Ex. 1 at 8. Palmetto notified Petitioner that it was subject to a two-year bar to re-enrollment pursuant to 42 C.F.R. § 424.535(c). CMS Ex. 1 at 9.

Petitioner requested reconsideration by letter dated November 4, 2014 that was received by Palmetto on or about November 10, 2014. CMS Ex. 1 at 5-6. Palmetto notified Petitioner by letter dated January 7, 2015, that the revocation of its enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(5), was upheld on reconsideration because Petitioner was no longer operational and not meeting Medicare enrollment requirements. CMS Ex. 1 at 1-2.

Petitioner requested a hearing before an administrative law judge (ALJ) on March 4, 2015 (RFH). On March 19, 2015, the case was assigned to me for hearing and decision and an Acknowledgement and Prehearing Order (Prehearing Order) was issued at my direction. Petitioner's request for hearing was timely; the parties have not challenged my authority to decide this case; and I have jurisdiction.

On April 20, 2015, CMS filed a prehearing brief, with CMS Exs. 1through 6. On May 19, 2016, Petitioner filed its prehearing brief with Petitioner's exhibits (P. Exs.) 1 through 12. On June 9, 2015, CMS filed its reply brief with CMS Exs. 7 through 13. CMS filed CMS Exs. 14 and 15 on September 3, 2015.

A hearing was convened on May 5, 2016, and a transcript (Tr.) was prepared. CMS Exs. 1 through 15 were offered and admitted as evidence. Tr. 20-21. Upon subsequent review I have determined that CMS Ex. 6 is not relevant, the prior ruling admitting that document is vacated, and the exhibit is not admitted or considered as evidence. Petitioner offered P. Exs. 1 through 13.[2] Tr. 21-50. P. Exs. 1, 3, and 6 through 15 were admitted as evidence at hearing. Tr. 51, 83-84. I deferred ruling on the admissibility of P. Ex. 2 and offered the parties the opportunity to address the question of admissibility in their post-hearing briefs. Tr. 47-50, 84-85. CMS elicited the testimony of Angela Holladay, a manager with Palmetto. Tr. 53-82. Petitioner called no witnesses.

CMS filed a post-hearing brief (CMS Br.) on August 2, 2016. Petitioner filed its reply brief (P. Br.) on August 8, 2016. On September 8, 2016, CMS filed its post-hearing reply brief (CMS Reply) and Petitioner waived its right to file a reply brief.

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[2] P. Ex. 13 is filed in the Departmental Appeals Board Electronic Filing System (DAB E-File) record as #23. The document was not properly marked as an exhibit but is treated as if marked P. Ex. 13 at Petitioner's request. Tr. 23-27.

CMS argued in its post-hearing briefs that Petitioner has not shown good cause for failing to offer P. Ex. 2 on reconsideration and offering it for the first time before me. CMS Br. at 7-9, CMS Reply at 1-2. Petitioner argues that P. Ex. 2 is a credit card receipt from the U.S. Postal Service (USPS). P. Br. at 1. It is clear from the face of P. Ex. 2 that it is a sales receipt issued by a USPS facility on April 17, 2014, in Garland South Station, Texas 75043 at 4:14:56 pm. The receipt reflects that five items were mailed, two to Columbia, South Carolina 29202; one to Austin, Texas 78751; one to Burleson, Texas 76028; and one to Garland, Texas 75043. The receipt does not reflect the contents of any of the envelopes or parcels. Petitioner implies without specifically asserting that P. Ex. 2 is the receipt for the mailing of a CMS-855A reporting Petitioner's change of address to Palmetto. P. Br. at 1-2. Petitioner submitted with its request for hearing the affidavit of Viju Mathew, Petitioner's chief financial officer, who attests that he completed and mailed a CMS-855 to Palmetto from Garland Station Texas 75043 on April 17, 2014 at about 2:50 pm. RFH Ex. A-2. Mr. Mathew does not identify the receipt depicted in P. Ex. 2 as the receipt he received. However, a copy of the same receipt was filed with Mr. Mathew's affidavit. RFH Ex. A-2. Mr. Mathew does not explain in his affidavit the discrepancy between the time he recalls mailing at about 2:50 pm and the time on the receipt, which is 4:14 pm. Mr. Mathew's affidavit was not offered as evidence at hearing and he was not called to testify subject to cross-examination despite being present at the hearing on May 5, 2016. Tr. 2, 6. CMS did not object to the authenticity of P. Ex. 2 or to its relevance. However, I may only admit and consider evidence that is relevant and material. 42 C.F.R. §§ 498.60(b), 498.66(d). Petitioner has failed to establish the relevance of P. Ex. 2. Petitioner failed to offer testimony at hearing that P. Ex. 2 is a receipt for the mailing of the CMS-855A in question to Palmetto. Even if, I consider Mr. Mathew's affidavit, he testifies that he mailed the packet at 2:50 pm but the receipt shows that the five items were actually mailed at 4:14 pm on April 17, 2014. Therefore, Mr. Mathew's affidavit does not support a finding that P. Ex. 2 is evidence of the mailing of the CMS-855A to which he refers. Accordingly, I conclude that P. Ex. 2 must be excluded because its relevance has not been established. Even if I accepted P. Ex. 2 on the basis that it shows that Petitioner mailed a CMS-855A to Palmetto, its relevance is minimal because it is receipt by Palmetto that satisfies the notification requirement, not the mailing of the CMS-855A. *See Alexander C. Gatzimos, M.D., J.D., LLC d/b/a Michiana Adult Medical Specialists* DAB No. 2730 at 1 (2016).

II. Discussion

A. Applicable Law

Sections 1811 through 1821 of the Social Security Act (the Act) (42 U.S.C. §§ 1395c-1395i-5) establish the hospital insurance benefits program for the aged and disabled known as Medicare Part A. Section 1831 of the Act (42 U.S.C. § 1395j) establishes the supplementary medical insurance benefits program for the aged and disabled known as

Medicare Part B.[3] Administration of both the Part A and B programs is through contractors, such as Palmetto. Act §§ 1816, 1842(a) (42 U.S.C. §§ 1395h, 1395u(a)). Payment under the programs for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of services and suppliers.[4] Act §§ 1815, 1817, 1834(j)(1) (42 U.S.C. §§ 1395g, 1395i, 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.

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 revocation of enrollment and billing privileges. Act § 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to 42 C.F.R. §§ 424.500 and 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 is aware of and abides by all applicable statutes,

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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.

[4] 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.

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. The provider bears the burden to demonstrate that it meets enrollment requirements with documents and records. 42 C.F.R. § 424.545(c). If CMS revokes a provider's Medicare billing privileges for not complying with enrollment requirements, then the revocation is effective 30 days after CMS or its contractor mails notice of its determination to the provider. 42 C.F.R. § 424.535(g). When CMS revokes a provider's billing privileges because the provider is not operational, the revocation is effective as of the date CMS determined the provider was no longer operational. 42 C.F.R. § 424.535(g). After a provider's Medicare enrollment and billing privileges are revoked, the provider is barred from re-enrolling in the Medicare program for one to three years. 42 C.F.R. § 424.535(c).

The Secretary has issued regulations that establish the right to a hearing and judicial review of certain enrollment determinations. Act § 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to section 1866(h)(1) and (j)(8), a provider or supplier whose enrollment application or renewal application is denied or whose Medicare enrollment is revoked and corresponding agreement, if any, is terminated is entitled to a hearing before an ALJ and Board review, followed by judicial review. Pursuant to 42 C.F.R. § 424.545(a), a provider or supplier denied enrollment in Medicare or whose Medicare enrollment and billing privileges are revoked has the right to administrative and judicial review in accordance with 42 C.F.R. pt. 498. Appeal and review rights are specified by 42 C.F.R. § 498.5.

The Secretary's regulations do not address the allocation of the burden of proof or the standard of proof. However, the Departmental Appeals Board (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. The standard of proof is a preponderance of the evidence. CMS has the burden of coming forward with the evidence and making a prima facie showing of a basis for revocation of Petitioner's enrollment. Petitioner bears the burden of persuasion to rebut the CMS prima facie showing by a preponderance of the evidence or to establish any affirmative defense. *Batavia Nursing & Convalescent Inn*, DAB No. 1911 (2004); *Batavia Nursing & Convalescent Ctr*., DAB No. 1904 (2004), *aff'd*, 129 F. App'x 181 (6th Cir. 2005); *Emerald Oaks*, DAB No. 1800 (2001); *Cross Creek Health Care Ctr.*, DAB No. 1665 (1998); *Hillman Rehab. Ctr*., DAB No. 1611 (1997) (*remand*), DAB No. 1663 (1998) (*aft. remand*), *aff'd*, *Hillman Rehab. Ctr. v. United States*, No. 98-3789 (GEB), 1999 WL 34813783 (D.N.J. May 13, 1999).

CMS makes a prima facie showing of noncompliance if the evidence CMS relies on is sufficient to support a decision in its favor absent an effective rebuttal. *Hillman Rehab. Ctr.*, DAB No. 1611 at 8 (1997). A provider can overcome CMS's prima facie case either by rebutting the evidence upon which that case rests or by proving facts that affirmatively show statutory or regulatory compliance. *Tri-County Extended Care Ctr.*, DAB No. 1936 (2004). "An effective rebuttal of CMS's prima facie case would mean that at the close of the evidence, the provider had shown that the facts on which its case depended (that is, for which it had the burden of proof) were supported by a preponderance of the evidence." *Id.* at 4 (quoting *Western Care Mgmt. Corp.*, DAB No. 1921 (2004)).

B. Issues

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

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

My conclusions of law are set forth in bold followed by the pertinent findings of fact and analysis. I have carefully considered all the evidence and the arguments of both parties, though not all may be specifically discussed in this decision. I discuss in this decision the credible evidence given the greatest weight in my decision-making.[5] I also discuss any evidence that I find is not credible or worthy of weight. The fact that evidence is not specifically discussed should not be considered sufficient to rebut the presumption that I considered all the evidence and assigned such weight or probative value to the credible evidence that I determined appropriate within my discretion as an ALJ. There is no requirement for me to discuss the weight given every piece of evidence considered in this case, nor would it be consistent with notions of judicial economy to do so. Charles H. Koch, Jr., *Admin. L. and Prac.* § 5:64 (3d ed. 2013).

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[5] "Credible evidence" is evidence that is worthy of belief. Black's Law Dictionary 596 (8th ed. 2004). The "weight of evidence" is the persuasiveness of some evidence compared to other evidence. *Id.* at 1625.

1. Pursuant to 42 C.F.R. § 424.516(e)(2), Petitioner was required to report to CMS or its contractor a change of address within 90 days of the change.

2. Providers and suppliers enrolling in Medicare or reporting changes to enrollment information must use the enrollment application – CMS-855 – of the type applicable to the provider or supplier. 42 C.F.R. § 424.510-.515.

3. Petitioner violated 42 C.F.R. § 424.516(e)(2) by not reporting its change of address to CMS or its contractor within 90 days of the change using the appropriate CMS-855.

4. There is a basis to revoke Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(5)(ii) for noncompliance with the requirement of 42 C.F.R. § 424.516(e)(2) to give notice of a change of enrollment information within 90 days.

5. Revocation is effective July 16, 2014, the date on which CMS or its contractor determined that Petitioner was no longer operational at the practice location on file with Palmetto. 42 C.F.R. § 424.535(g).

a. Facts

There is no dispute that prior to revocation Petitioner was enrolled in Medicare as a provider of home health services. In February 2012, Petitioner's revalidation application showed Petitioner's practice location to be 3635 Broadway Boulevard, Suite A, Garland Texas (the Broadway location). CMS Ex. 5. There is also no dispute that Petitioner moved its office from the Broadway location to 713 Gatewood Road, Suite C, Garland, Texas 75043 (the Gatewood location) sometime prior to July 16, 2014.[6] P. Br. at 1.

It is not disputed that on July 16, 2014, a Palmetto inspector attempted to conduct a site inspection of the Broadway location and found that Petitioner was not operational at that

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[6] There is a conflict in Petitioner's assertions about whether Petitioner moved on or about May 1, 2014 or on or about July 1, 2014. But it is not necessary for the purposes of this decision to decide the exact date on which Petitioner moved because I find that no notice of the change of address was received by Palmetto with 90 days of either date.

location. P. Br. at 1; CMS Exs. 2, 5 at 2 ¶ 11. It is also undisputed that Petitioner was operational at the Gatewood location on July 16, 2014. CMS Br. at 1, P. Br. at 1.

In its November 4, 2014, request for reconsideration, Petitioner represents that a CMS-855A was mailed to Palmetto on July 2, 2014 to update its address. CMS Ex. 1 at 5, 12. In the copy of the CMS-855A filed with the request for reconsideration, Petitioner completed the form to reflect a change of practice location to the Gatewood location effective July 1, 2014. CMS Ex. 1 at 38-39. In its request for hearing, Petitioner states that the move to the Gatewood location occurred on May 1, 2014, and that a CMS-855A was mailed to report the change of address on April 17, 2014. RFH at 1; RFH Ex. A-2. Petitioner argues before me that a CMS-855A was sent to Palmetto on April 17, 2014. Petitioner does not adequately explain the inconsistency between its representations on reconsideration and its representations before me. However, even if I accepted that Petitioner mailed a CMS-855A on either or both April 17, 2014 and July 2, 2014, those facts do not establish that Palmetto received either CMS-855A.

It is not disputed that Petitioner received correspondence from Palmetto addressed to its Gatewood location and postmarked May 29 and June 25, 2014. P. Exs. 4, 5. Petitioner argues that those undisputed facts establish that Palmetto knew of Petitioner's Gatewood location. Clearly, Palmetto did know of Petitioner's Gatewood location as early as May 29, 2014. However, the fact that Palmetto sent correspondence to Petitioner at its Gatewood location does not show that Petitioner complied with the Medicare enrollment requirement established by 42 C.F.R. § 424.516(e)(2) to notify CMS or its contractor of a change of address within 90 days using the applicable CMS-855. Ms. Holladay credibly testified that the letters postmarked May 29 and June 25, 2014, were mailed to Petitioner using an address provided by the USPS on returned mail and the fact those letters were mailed to Petitioner's correct address should not be accepted as evidence that Palmetto actually received a CMS-855A from Petitioner prior to the attempted onsite inspection in July 2014. Tr. 53-82; CMS Ex. 7. I also accept as credible Tanesha Norman's unrebutted declaration that Palmetto had no record of receiving a CMS-855A from Petitioner between April 1 and November 3, 2014. CMS Ex. 5 at 2 ¶ 13.

Petitioner has failed to meet its burden to show by a preponderance of the evidence that Palmetto received a CMS-855A reporting Petitioner's change of practice location to the Gatewood address within 90 days of either May 1, 2014 or July 1, 2014. Petitioner has not presented a certified or registered mail receipt, a courier service receipt, or other evidence that Palmetto received a CMS-855A reporting Petitioner's change of address within 90 days of either May 1, 2014 or July 1, 2014. Petitioner has not presented evidence that it notified CMS and Palmetto of the change of address within 90 days of the change using the CMS Provider Enrollment, Chain, and Ownership System (PECOS), which allows providers and suppliers to file a CMS-855 on-line.

b. Analysis

As a condition for maintaining Medicare enrollment, a provider or supplier is required to provide CMS notice of any change in its enrollment information, including a change of address of a practice location, using the appropriate CMS-855 enrollment application. 42 C.F.R. §§ 424.510-.515. A provider, such as Petitioner, is also required as a condition of enrollment to report a change of address to CMS or its contractor within 90 days of the change. 42 C.F.R. § 424.516(e)(2). A provider or supplier must 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).

Pursuant to 42 C.F.R. § 424.535(a)(5)(i),[7] CMS may revoke a provider's enrollment and billing privileges if CMS determines upon on-site review that:

> (1) The provider is no longer operational to furnish Medicare covered items or services; or
> (2) The provider has failed to satisfy any or all of the Medicare enrollment requirements.

In this case, there is no dispute that Petitioner moved from the Broadway location to the Gatewood location. The move probably occurred on about May 1, 2014, but Petitioner has also asserted that the move occurred on or about July 1, 2014. There is no dispute that an investigator attempted to conduct a site inspection on July 16, 2014 at the Broadway location, but Petitioner was not operational at that practice location. Palmetto has no record of receiving a CMS-855 from Petitioner reporting the change in practice location from the Broadway location to the Gatewood location until a CMS-855A was received in November 2014, more than 90 days after either May 1 or July 1, 2014. The reporting requirement is satisfied by Palmetto's receipt of the CMS-855, not the mailing of the CMS-855 by the provider or supplier. *See Gatzimos*, DAB No. 2730 at 1. Accordingly, I conclude that CMS has made a prima facie showing that Petitioner did not comply with 42 C.F.R. § 424.516(e)(2). I also conclude that there is a prima facie showing of a basis for revocation of Petitioner's enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(5)(i).

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[7] CMS may revoke a Medicare Part B supplier if on-site review determines the supplier is no longer operational; the supplier has failed to satisfy all Medicare enrollment requirements; or the supplier has failed to furnish Medicare covered items or services as required by the Act or regulations. 42 C.F.R. § 424.535(a)(5)(ii).

Petitioner has failed to meet its burden to rebut the CMS prima facie case or establish an affirmative defense by a preponderance of the evidence. Petitioner does not dispute that the Broadway location was not operational on July 16, 2014. Petitioner has not shown by a preponderance of the evidence that Palmetto received a CMS-855A reporting the change of address within 90 days of the date on which operations ceased at the Broadway practice location.

The effective date of revocation is determined pursuant to 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.**

42 C.F.R. § 424.535(g) (Emphasis added.) Although there is no dispute Petitioner was operational at the Gatewood location on July 16, 2014, there is also no dispute that Petitioner was not operational at the Broadway location when the site inspection was attempted at that practice location. Therefore, a conclusion that Petitioner was not operational at the Broadway location is shown by the evidence and constitutes grounds for retroactive revocation as of July 16, 2014, pursuant to 42 C.F.R. § 424.535(g).

III. Conclusion

For the foregoing reasons, I conclude that Petitioner's Medicare enrollment and billing privileges are revoked effective July 16, 2014, pursuant to 42 C.F.R. § 424.535(a)(5)(ii) for failure to comply with 42 C.F.R. § 424.516(e)(2).

/s/
Keith W. Sickendick
Administrative Law Judge