Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Hoyos Home Health Care, Inc.,
NPI: 1922280361),

Petitioner
v.

Centers for Medicare and Medicaid Services.

Docket No. C-12-1286

Decision No. CR2746

Date: April 9, 2013

DECISION

Petitioner, Hoyos Home Health Care, Inc., a home health agency, appeals a reconsideration decision dated July 26, 2012. The undisputed evidence establishes that Petitioner was not in compliance with Medicare program requirements involving proper home health care certification. As a consequence, I grant the motion of the Centers for Medicare and Medicaid Services (CMS) for summary judgment and uphold CMS's determination to revoke Petitioner's Medicare enrollment and billing privileges.

I. Background and Procedural History

By letter dated May 25, 2012, Palmetto GBA (Palmetto), a CMS contractor, informed Petitioner that CMS was revoking Petitioner's Medicare billing privileges and terminating Petitioner's Medicare provider agreement effective June 24, 2012, because Petitioner failed to comply with the Medicare enrollment requirements pursuant to 42 C.F.R. § 424.535(a)(1). CMS Exhibit (CMS Ex.) 3, at 1-2. Palmetto also informed Petitioner that it was establishing a Medicare re-enrollment bar for a period of three years. CMS Ex. 3, at 2. Specifically, the revocation letter stated that:

> Under 42 CFR 424.535(a)(1) CMS may revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement when the suppliers are not in compliance with the enrollment requirements specifically outlined in Section 15(a)5

> (Certification Statement for 855A application) that states: "I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and I will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity." The supplier submitted claims for payment that were based upon orders, treatment plans, or other documents some of which were created by the enrolled supplier that contain the altered or forged signature of the treating physician.

CMS Ex. 3, at 1.

Petitioner timely filed a request for reconsideration of CMS's decision to revoke Petitioner. CMS Ex. 3, at 3. On July 26, 2012, CMS issued a reconsidered determination that upheld the revocation based on Petitioner's noncompliance with Medicare enrollment requirements. CMS Ex. 3, at 3-5. In the reconsideration decision, CMS states that "[a]ll of the documentation in the file for this case has been reviewed and the decision has been made in accordance with Medicare guidelines as outlined in 42 CFR § 424.535(a)(1). Specifically, [Petitioner] has not provided evidence to show that it did not submit false or fraudulent claims . . ." CMS Ex. 3, at 4.

Petitioner then filed a hearing request (HR) and administrative subpoena request with the Civil Remedies Division of the Departmental Appeals Board on September 19, 2012, and the case was assigned to me for hearing and decision. I subsequently issued an order denying Petitioner's request for issuance of subpoenas because Petitioner did not comply with the requirements of 42 C.F.R. § 498.58. Petitioner filed a motion for reconsideration of that order, and CMS filed an opposition. I denied Petitioner's motion for reconsideration.

In accordance with my Acknowledgment and Pre-hearing Order issued on October 3, 2012, CMS filed its pre-hearing exchange, incorporating a Motion for Summary Judgment and brief (CMS Br.), with eight exhibits (CMS Exs. 1-8). In its brief, CMS stated that:

> This brief serves as notice of CMS' amendment of its basis for the revocation . . . . CMS is proceeding on the basis of the same regulation, 42 C.F.R. § 424.535(a)(1), and on the same theory, i.e., [Petitioner's] noncompliance with the requirements on the enrollment application. CMS amends its basis for the revocation only insofar as to characterize Petitioner's behavior as a failure to maintain the required conformance to the Medicare laws, regulations, and program instructions that apply to this provider . . . .

CMS Br. at 2 (internal quotation omitted).

Specifically, CMS claims that home health agencies may only receive Medicare reimbursement for services provided to beneficiaries who are under the care of a

physician and that the physician must have a face-to-face encounter with the beneficiary and certify the necessity of the home health services. 42 C.F.R. § 424.22(a); Medicare Benefit Policy Manual, 100-101, § 30.5.1.1. CMS claims that Petitioner did not meet these Medicare requirements with regard to the claims Petitioner submitted for 50 beneficiaries. CMS Br. at 9.

Petitioner then filed a Motion for Summary Judgment and brief (P. Br.), with three exhibits (P. Exs. 1-3). In Petitioner's Motion for Summary Judgment, Petitioner claims CMS "has wholly abandoned the theory upon which the revocation was based" and that Petitioner has been prejudiced by CMS's revocation of its provider number based on a new legal theory. P. Br. at 6. Also, Petitioner "proffer[ed] the submission of copies of the actual medical records for the 50 beneficiaries that CMS claims were not treated by [the certifying physician]." P. Br. at 8. Petitioner stated it was "offering this as a proffer rather than submitting them as exhibits because the records are extremely voluminous, contained protected health information, and CMS has not raised any issue outside of the billing issue." P. Br. at 8. CMS subsequently submitted a response in opposition to Petitioner's Motion for Summary Judgment (CMS Response).
On January 18, 2013, considering Petitioner did not come forward with any actual medical documentation, I gave Petitioner an opportunity to supplement the record in this case and to file as exhibits the records for the 50 beneficiaries, identified in CMS's Motion for Summary Judgment, whose care was allegedly certified in accordance with Medicare requirements at 42 C.F.R. § 424.22. On January 28, 2013, Petitioner filed nine "composite" exhibits. (P. Composite Exs. 1-9). CMS submitted a response to the additional documents that Petitioner submitted. (CMS Response to Additional Documents). Petitioner then submitted a reply to CMS's response. (P. Reply). In the absence of objection, I admit CMS Exs. 1-8, P. Exs. 1-3, and P. Composite Exs. 1-9 into the record.

II. Applicable Law

The Medicare statute defines "home health services" as "items and services furnished to an individual, who is under the care of a physician . . . under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician . . . ." 42 U.S.C. § 1395x(m). Home health services are covered by Medicare "only if . . . a physician certifies . . . that . . . home health services . . . are or were required because the individual is or was confined to his home . . . and needs or needed skilled nursing care . . . ." 42 U.S.C § 1395f(a)(2)(C); 42 U.S.C § 1395n(a)(2)(A).
A home health agency may receive Medicare payment for home health services for individuals only after the home health agency has obtained a valid certification from a physician that the individual is homebound and requires home health services. 42 U.S.C §§ 1395f(a)(2)(C), 1395n(a)(2)(A). Home health services must be furnished while the individual is under the care of a physician, and a physician must establish and periodically review a plan of care for furnishing the services. 42 C.F.R. § 424.22(a)(iii),(iv). Also, the certifying physician is required to know the Medicare beneficiary's medical status, and therefore there must be a face-to-face encounter with

the individual, 42 C.F.R. § 424.22(a); Medicare Benefit Policy Manual, CMS Publication 100-102, Ch. 7 (Home Health Services), § 30.5.1.1. The face-to-face encounter must be "related to the primary reason the patient requires home health services . . . ." 42 C.F.R. § 424.22(a)(1)(v).

A physician and the home health agency personnel must review a Medicare beneficiary's plan of care at regular intervals. 42 C.F.R. § 484.18(b). Also, the home health agency is required to "promptly alert the physician" to significant changes that suggest a need to alter the plan of care. 42 C.F.R. § 484.18(b). The home health agency consults with the individual's physician to obtain approval of any "additions or modifications to the original plan" of care. 42 C.F.R. § 484.18(a).

Section 424.535(a) of 42 C.F.R. authorizes CMS to "revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement or supplier agreement" for reasons including, as relevant here:

> (1) *Noncompliance*. The provider or supplier is determined not to be in compliance with the enrollment requirements described in this section, or in the enrollment application applicable for its provider or supplier type . . . .

III. Analysis

A. Issue

The issue in this case is whether CMS is entitled to summary judgment on the grounds that CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges.

B. Applicable Standard

Summary judgment is appropriate when a case presents no issue of material fact, and its resolution turns on questions of law. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-48 (1986); *Livingston Care Ctr. v. United States Dep't of Health and Human Servs.*, 388 F.3d 168, 173 (6th Cir. 2004); *see also Illinois Knights Templar Home*, DAB No. 2274, at 3-4 (2009) (*citing Kingsville Nursing Ctr.*, DAB No. 2234, at 3-4 (2009)).
The moving party may show the absence of a genuine factual dispute by presenting evidence so one-sided that it must prevail as a matter of law, or by showing that the non-moving party has presented no evidence "sufficient to establish the existence of an element essential to [that party's] case, and on which [that party] will bear the burden of proof at trial." *Livingston Care Ctr.,* 388 F.3d at 173 (*quoting Celotex Corp. v. Catrett,* 477 U.S. 317, 323-24 (1986)). To avoid summary judgment, the non-moving party must then act affirmatively by tendering evidence of specific facts showing that a dispute exists. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.,* 475 U.S. 574, 586 n.11 (1986); *see also Vandalia Park,* DAB No. 1939 (2004); *Lebanon Nursing and Rehab. Ctr.,* DAB No. 1918 (2004).

To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact. *Illinois Knights Templar*, DAB No. 2274, at 4; *Livingston Care Ctr.*, DAB No. 1871, at 5 (2003). In examining the evidence to determine the appropriateness of summary judgment, I must draw all reasonable inferences in the light most favorable to the non-moving party. *See Brightview Care Ctr.*, DAB No. 2132, at 2, 9 (2007); *Livingston Care Ctr.*, 388 F.3d at 168, 172; *Guardian Health Care Ctr.,* DAB No. 1943, at 8 (2004); *but see Cedar Lake*, DAB No. 2344, at 7; *Brightview*, DAB No. 2132, at 10 (noting entry of summary judgment upheld where inferences and views of non-moving party are not reasonable). However, drawing factual inferences in the light most favorable to the non-moving party does not require that I accept the non-moving party's legal conclusions. *Cedar Lake,* DAB No. 2344, at 7; *Guardian,* DAB No. 1943, at 11 ("A dispute over the conclusion to be drawn from applying relevant legal criteria to undisputed facts does not preclude summary judgment if the record is sufficiently developed and there is only one reasonable conclusion that can be drawn from those facts.").

The role of an ALJ in deciding a summary judgment motion differs from the ALJ's role in resolving a case after a hearing. The ALJ should not assess credibility or evaluate the weight of conflicting evidence. *Holy Cross Vill. at Notre Dame*, DAB No. 2291, at 4-5 (2009).

C. Findings of Fact and Conclusions of Law

1. *CMS was authorized to change its revocation basis because Petitioner had notice and opportunity to respond during this administrative proceeding.*

Petitioner argues that its revocation should be "rescinded because CMS could not prove the actual basis for the revocation" and that CMS "has wholly abandoned the theory upon which the revocation was based and replaced it with one that CMS believes it could actually prove." P. Br. at 5-6. Petitioner also contends that it did not attempt to submit a corrective action plan (CAP) because it was not reasonable that CMS would accept a CAP designed to correct CMS's original theory of the basis for revocation. P. Br. at 7. Therefore, Petitioner claims it has been prejudiced by CMS's amending of the basis for Petitioner's revocation at this level of review because CMS relies on a new legal theory for the revocation, and Petitioner did not have an opportunity to submit a CAP.

The Departmental Appeals Board (Board) has consistently held that after an administrative appeal has commenced, a federal agency may assert and rely on new or alternative grounds for the challenged action or determination as long as the non-federal party has notice of, and a reasonable opportunity to respond to, the asserted new grounds during the administrative proceeding. *Green Hills Enters.*, LLC, DAB No. 2199 (2008). *See also Abercrombie v. Clarke*, 920 F.2d 1351, 1360 (7th Cir. 1990), *cert. denied*, 520

U.S. 809 (1991) (holding that defects in formal notice may be cured during the course of an administrative proceeding, and due process is satisfied as long as the party is reasonably apprised of, and given opportunity to address, the issues in controversy); *St. Anthony Hosp. v. Sec'y, Dep't of Health and Human Servs.*, 309 F.3d 680, 708 (10th Cir. 2002) ("To establish a due process violation [in an administrative proceeding], an individual must show he or she has sustained prejudice as a result of the allegedly insufficient notice.") .

It is evident from CMS's many briefs in this matter that CMS chooses to revoke Petitioner's Medicare billing privileges under 42 C.F.R. § 424.535(a)(1) on the grounds that Petitioner failed to maintain the required conformance "to the Medicare laws, regulations, and program instructions that apply to this provider." CMS Br. at 2. During this stage of the proceeding, I provided Petitioner with ample opportunity to refute CMS's determination that it was found noncompliant based on failure to comply with Medicare laws and regulations and specifically the requirements of 42 C.F.R. § 424.22. I permitted Petitioner to respond to every submission CMS filed at this level of review and ordered Petitioner to supplement the record with evidence that could support Petitioner's position that its revocation was improper, the same type of opportunity that Petitioner would have if the contractor were to have offered Petitioner a CAP at the initial determination stage. Therefore, I do not find that Petitioner has been prejudiced, and I deny Petitioner's Motion for Summary Judgment.

2. The undisputed evidence shows CMS had a legitimate basis to revoke Petitioner's Medicare billing privileges because Petitioner was not in compliance with Medicare requirements for home health certifications involving five individuals.

Any home health agency which seeks to enroll as a provider in the Medicare program must complete a CMS 855A enrollment application. Petitioner completed a CMS 855A and signed the Certification Statement at Section 15 of the CMS 855A enrollment application. CMS. Ex. 2. Petitioner's signature "binds this provider to the laws, regulations, and program instructions of the Medicare program." CMS Ex. 2, at 6. CMS contends that Petitioner submitted claims for home health services which did not conform to "the Medicare laws, regulations, and program instructions that apply to this provider."[1] CMS Br. at 2. CMS argues that by signing a CMS 855A Certification Statement and enrolling in the Medicare program, Petitioner agrees to comport with all Medicare laws of general applicability and those that apply specifically to home health agencies. In addition, according to CMS, the text of the CMS 855A places Petitioner on notice that

[1] Specifically, CMS refers to the requirement that home health agencies may only receive Medicare reimbursement for services provided to individuals who are under the care of a physician, and the physician must have a face-to-face encounter with the individuals and certify the necessity of the home health services. CMS contends that these requirements were not met with respect to claims Petitioner submitted for 50 individuals. CMS Br. at 9.

failure to comply with Medicare laws may be a basis for the revocation of Petitioner's enrollment in the Medicare program in the future.

CMS determined to revoke Petitioner's Medicare billing privileges after an internal CMS inquiry revealed that the signature of Dr. Emilio Castaneda "was being used in conjunction with the certification of an enormous number of Medicare beneficiaries for home health services" and "Dr. Castaneda's NPI [National Provider Identifier] was coming up in the Medicare program's data as having been used by a number of home health agencies [in the south Florida area] with surprising frequency." CMS Ex. 6, at ¶¶ 8-9. CMS contends that Petitioner submitted Medicare home health claims on behalf of 50 individuals and named Dr. Castaneda as the certifying physician in each instance; however, CMS's Medicare reimbursement records for Dr. Castaneda do not indicate that Dr. Castaneda was involved in the care of those 50 individuals. CMS Br. at 10; CMS Exs. 4 and 5. Thus, CMS contends that Petitioner's submission of Medicare claims for individuals who were not under the care of a physician constituted noncompliance, and CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges.

Petitioner argues that the evidence CMS presents does not prove that these 50 individuals were not under the care of Dr. Castaneda. P. Br. at 4. Petitioner offers as evidence an affidavit of Andres Hernandez, R.N., who generally states that as the director of nursing for Petitioner, "I am familiar with the standard procedures and policies at Hoyos for obtaining and processing physician orders for home health services" and that when a new patient is referred for home health services, Petitioner receives a physician order faxed from the physician's office, and upon receipt of the order, a nurse is dispatched to the patient's home to conduct an initial evaluation and complete the plan of care. P. Ex. 2, at ¶¶ 3-6. Then, "[t]he plan of care is returned to the agency and I review all paperwork including the physician order for regulatory compliance" and "[t]he plan of care is then taken by a driver to the physician's office for review and signature. Once the plan of care has been signed by the physician, it gets picked up by the driver and returned to our office." P. Ex. 2, at ¶¶ 7-8. In addition, Petitioner includes an affidavit of Osmany Hoyos, Petitioner's owner, who attaches a list of "all of the patients who received home health services from [Petitioner] between January 1, 2011 and June 24, 2012 as a result of an order received from Emilio Castaneda, M.D." P. Ex. 1. Petitioner's owner also states that "[t]he patients whose names have a check mark next to them also appear on CMS' Exhibit 5 to its summary judgment motion. The exhibit is a list of all patients for whom Dr. Castaneda billed for services rendered between 2010 and October 16, 2012." P. Ex. 1, at ¶ 5. Petitioner also offers a variety of explanations for why Dr. Castaneda did not bill the Medicare program for services for the 50 individuals identified by CMS and why CMS's records do not show that Dr. Castaneda was ever involved in the care of these 50 individuals. P. Br. at 4-5. Petitioner also suggests that CMS should have come forward with other types of evidence to establish that Dr. Castaneda did not actually treat these 50 individuals. P. Br. at 5.

Petitioner did not initially come forward with any actual treatment records of its patients but instead filed a "proffer of home health records as evidence" and proffered the "submission of copies of the actual medical records for the 50 beneficiaries that CMS claims were not treated by Dr. Castaneda." Petitioner requested "the opportunity to include these as exhibits if either the ALJ or CMS has concerns as to whether appropriate medical records exist for these beneficiaries." P. Br. at 8. In its response brief, CMS argues that Petitioner has presented no evidence "from any of its home health patients to attempt to show that the patient was under the medical care of Castaneda or even knew Castaneda." CMS Response at 6. CMS also argues that "a home health agency is always responsible for ensuring that its own Medicare billing practices comply in full with Medicare law and policy, and so the home health agency is accountable for the integrity of the information contained in the claims by which it seeks Medicare funds." CMS Response at 6. CMS contends that Petitioner was obligated to timely present its case after CMS came forward with Medicare program records indicating that Dr. Castaneda was never involved in the care of 50 individuals for which Petitioner submitted claims for home health care services to Medicare and argues that Petitioner's proffer of unspecified voluminous home health records is inappropriate in this proceeding. CMS Response at 7.

In order to determine whether CMS had a legitimate basis for revoking Petitioner's Medicare billing privileges for submitting home health claims that allegedly had no physician certification, I determined Petitioner must submit copies of the medical records for the 50 individuals for whom CMS claims Dr. Castaneda did not certify. In response to my Order to Supplement the Record, which directed Petitioner to file as exhibits documentation for these 50 individuals, Petitioner provided nine "composite exhibits." These composite exhibits provide some documentation for 45 out of the 50 individuals CMS references in its Motion for Summary Judgment.[2] P. Composite Exs. 1-9; CMS Br. at 14-28.

However, Petitioner did not submit any documentation at all for individuals whom CMS identified as Beneficiary #1, #2, #3, #30 and #39. P. Composite Exs. 1-9; CMS Br. at 14, 22, 25. Petitioner presented nothing to suggest that these individuals were ever under Dr. Castaneda's care for home health services in accordance with 42 C.F.R. § 424.22. Petitioner does not dispute, however, that it billed Medicare for services Dr. Castaneda purportedly approved for these beneficiaries.

Petitioner argues that it has requested the issuance of subpoenas through which it could obtain medical records for patients Dr. Castaneda saw during his employment with C&M Physicians' Group, Inc., a Miami clinic which is no longer in business, and that "CMS must not be permitted to complain about [Petitioner's] inability to obtain medical records

[2] The documentation for the 45 of the 50 beneficiaries includes CMS forms for home health certification and plan of care, model verification forms for documentation of face-to-face encounters, verbal order forms, and other referral paperwork. P. Composite Exs. 1-9.

and at the same time oppose the only legal vehicle through which [Petitioner] might . . . obtain those records." P. Reply at 2-3. However, Petitioner has not provided any explanation as to why Petitioner must obtain medical records for these individuals from another source in order to prove Petitioner's clients were under the care of a physician.[3] Petitioner also provides no explanation as to why Petitioner did not have plans of care, face-to-face encounter documentation, and other certification paperwork indicating that all Petitioner's Medicare clients met the requirements of 42 C.F.R. § 424.22, prior to submitting claims for Medicare payment.

The law clearly requires that a physician must be involved in the certification of an individual for home health services and a physician's ongoing involvement in the care of that individual. 42 U.S.C § 1395f(a)(2)(C); 42 U.S.C § 1395n(a)(2)(A). Medicare program guidance echoes these statutory requirements: "[t]he patient must be under the care of a physician who is qualified to sign the certification statement and plan of care . . . A patient is expected to be under the care of the physician who signs the plan of care and the physician certification." Medicare Benefit Policy Manual, 100-101, § 30.3. The physician must base his certification of the need for home health services upon a face-to-face encounter with the patient and the encounter must be related to the primary reason the patient requires home health services. 42 C.F.R. § 424.22(a).

Because it is undisputed that Petitioner did not bring forth any evidence with regard to five individuals which could show that these individuals were under the care of Dr. Castaneda or that Dr. Castaneda certified the necessity of home health care services, I find Petitioner did not conform to "the laws, regulations, and program instructions of the Medicare program."[4] By signing the Certification Statement at Section 15 of the CMS 855A enrollment application, Petitioner was bound to comply with all applicable legal requirements. CMS Ex. 2, at 6. Thus, I find that CMS was authorized to revoke Petitioner's Medicare billing privileges for noncompliance with the enrollment application applicable for its provider or supplier type pursuant to 42 C.F.R. § 424.535(a)(1).

3. Petitioner's owner's affidavit, the affidavit of Petitioner's director of nursing, and the composite exhibits do not create a genuine dispute of material fact which could overcome CMS's Motion for Summary Judgment because Petitioner does not tender evidence of specific facts showing that a dispute exists for five individuals.

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[3] A proper subpoena request requires a party to specify the pertinent facts the party expects to establish by the witnesses or documents and indicate why those facts could not be established without the use of a subpoena. 42 C.F.R. § 498.58(c)(3).

[4] CMS also argues that Petitioner has presented only "referral paperwork" and no proper evidence of actual treatment, care, or medical monitoring of all 50 individuals. However, for purposes of summary judgment, considering Petitioner has come forward with some specific evidence, I will infer in Petitioner's favor that Dr. Castaneda provided appropriate certifications of the need for home health services for 45 beneficiaries.

To avoid summary judgment, the non-moving party must act affirmatively by tendering evidence of specific facts showing that a dispute exists regarding an essential element of the case. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 n. 11 (1986). A mere scintilla of supporting evidence is not sufficient to overcome a well-supported motion for summary judgment. "If the evidence is merely colorable or is not significantly probative, summary judgment may be granted." *Livingston Care Ctr. v. Dep't. of Health & Human Services,* 388 F.3d 168, 173 (6th Cir. 2004) (quoting *Anderson v. Liberty Lobby,* 477 U.S. 242, at 249-250 (1986)).

In order to dispute whether Dr. Castaneda provided the required treatment for the 50 home health clients CMS names, Petitioner came forward with an affidavit of Petitioner's owner with an attached list of "all of the patients who received home health services . . . between January 1, 2011 and June 24, 2012 as a result of an order received from Emilio Castaneda, M.D." P. Ex. 1. Petitioner also presented an affidavit of Petitioner's director of nursing generally describing the standard procedures and policies with regard to obtaining and processing physician orders for home health services, which does not mention any of the individual home health patients at issue.

Once I ordered Petitioner to supplement the record, Petitioner came forward with actual medical records for only 45 of the 50 home health clients that CMS named. Therefore, for five patients, the only evidence that Petitioner has ultimately come forward with to prove the disputed fact that Dr. Castaneda provided certification for care, is Petitioner's owner's affidavit.

Although I am required to draw all reasonable inferences in the light most favorable to Petitioner in deciding CMS's motion for summary judgment, Petitioner is required to come forward with specific evidence to show a genuine issue of material fact exists. However, Petitioner's owner's affidavit does not provide the specificity of facts needed to properly overcome CMS's motion for summary judgment. The affidavit, for example, does not describe the five patients, the type of care Dr. Castaneda allegedly provided to the five patients, when the care was provided, or why home health certifications and plans of care could not be produced for these five individuals. Therefore, without any supporting documentation, the owner's vague statement alone does not provide the specificity for me to draw an inference in Petitioner's favor that Dr. Castaneda provided the requisite certifications for those five patients. After careful review of the documentation that Petitioner provided, Petitioner has not presented evidence sufficient to establish the existence of a genuine factual dispute to an essential element of its case. Therefore, CMS is entitled to summary judgment.

IV. Conclusion

Petitioner has not shown a genuine issue of material fact exists with regard to CMS's challenge that a physician did not certify five of Petitioner's patients pursuant to Medicare home health care requirements. As a result, I must sustain CMS's determination to revoke Petitioner's Medicare enrollment and billing privileges because the undisputed evidence shows that Petitioner was not compliant with Medicare program requirements.

/s/

Joseph Grow
Administrative Law Judge