Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

81 Home Health Care Corporation
(CCN: 05-8306),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-931

Decision No. CR3444

Date: November 5, 2014

DECISION

The Centers for Medicare & Medicaid Services (CMS) terminated Petitioner's provider agreement as a home health agency (HHA) effective May 28, 2013, because it found Petitioner in violation of multiple conditions of participation. Petitioner requested a hearing before an administrative law judge. The parties filed prehearing exchanges, which included briefs and proposed exhibits. Based on these submissions, I issued an order notifying the parties that I was considering whether to enter summary judgment and gave the parties an opportunity to respond whether summary judgment was appropriate. The parties responded and consented to summary judgment. Because the application of the law to the undisputed facts in this case supports CMS's termination of Petitioner's provider agreement, I affirm CMS's determination.

I. Background and Procedural History

Petitioner is a HHA that was enrolled as a provider of services to Medicare beneficiaries in the state of California. Following a March 27, 2013 survey, CMS terminated Petitioner's provider agreement based on a finding that Petitioner was deficient with regard to multiple conditions of participation requirements for HHAs including: 42 C.F.R. §§ 484.10 (patient rights), 484.14 (organization, services, and administration), 484.18 (acceptance of patients, plan of care, and medical supervision), and 484.30 (skilled nursing services). CMS Exhibit (Ex.) 1. CMS notified Petitioner that it

terminated its participation agreement effective May 28, 2013. CMS Ex. 2. Petitioner timely filed a request for hearing (RFH) before an administrative law judge. I issued a prehearing order and established a briefing schedule. The parties filed prehearing briefs (CMS Br. and P. Br.) and supporting exhibits (CMS Exs. 1-35 and P. Exs. 1-7).

II. Issue

Whether CMS's determination to terminate Petitioner's provider agreement should be affirmed because Petitioner has failed to contest several of the condition level deficiencies identified in CMS's determination.

III. Findings of Fact, Conclusions of Law, and Analysis[1]

The Social Security Act (Act) sets forth requirements for HHAs participating in the Medicare and Medicaid programs, and authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations implementing the statutory provisions. 42 U.S.C. §§ 1395x(m), (o), 1395bbb. The Secretary's regulations governing HHA participation in the Medicare program are found at 42 C.F.R. Part 484.

In order to participate in the Medicare program and obtain reimbursement for its services a HHA must be in compliance with all applicable conditions as specified in 42 C.F.R. Part 484. 42 C.F.R. § 488.3(a)(2). Periodic review of compliance with the conditions of participation is required and such reviews or surveys are generally conducted by the state agency. Based upon its survey, the state agency either certifies compliance or noncompliance of the surveyed provider. 42 C.F.R. §§ 488.20, 488.24, 488.26.

The state agency certifies that a HHA is not in compliance with the conditions of participation when the deficiencies are "of such character as to substantially limit the providers . . . capacity to furnish adequate care or which adversely affect the health and safety of patients." 42 C.F.R. § 488.24(b). Whether or not there is compliance with a condition of participation depends upon "the manner and degree to which the provider . . . satisfies the various standards within each condition." 42 C.F.R. § 488.26(b). Surveyors are required to "directly observe the actual provision of care and services to residents, and the effects of that care, to assess whether the care provided meets the needs of individual residents . . . ." 42 C.F.R. § 488.26(c)(2).

CMS is authorized to terminate a provider agreement when the provider no longer meets the requirements of the Act or fails to meet the conditions of participation, among other

[1] My findings of and conclusions of law are in bold and italics.

grounds listed in the regulation. 42 U.S.C. §§ 1395x(o)(6), 1395cc(b)(2)(B), 1395bbb(e); 42 C.F.R. § 489.53(a)(3). Notably, CMS is authorized to terminate a HHA's provider agreement if the HHA has a single condition level deficiency and such a decision is discretionary. *United Medical Home Care*, DAB No. 2194, at 13-14 (2008).

1. Summary judgment is appropriate because there are no disputed issues of material fact.

When appropriate, administrative law judges may decide a case arising under 42 C.F.R. pt. 498 by summary judgment. *See* Civil Remedies Division Procedures (CRDP) § 7; *Livingston Care Ctr. v. U.S. Dep't of Health & Human Servs.*, 388 F.3d 168, 172 (6th Cir. 2004) (citing *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743 (6th Cir. 2004). Summary judgment is appropriate and an in-person hearing is not required if the record shows that there is no genuine dispute of any material fact and the moving party is entitled to judgment as a matter of law. *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 3 (2010). To determine whether there are genuine issues of material fact for an in-person hearing, the administrative law judge must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. *Id*.

In considering summary judgment, I am procedurally and substantively guided by Rule 56 of the Federal Rules of Civil Procedure (FRCP). CRDP § 7; *see also Livingston Care Ctr.*, 388 F.3d at 172. Under paragraph (f) of Rule 56, I may consider summary judgment on my own motion if I identify the material facts not in dispute, and give the parties notice and an opportunity to respond.

In its request for hearing and prehearing exchange, Petitioner asserted that it is permitted to serve patients in the Blythe, California, area and disputed the condition of participation level citation at 42 C.F.R. § 484.10 regarding patient rights. RFH; P. Br. at 9-20. However, Petitioner did not dispute the condition level deficiencies at 42 C.F.R. §§ 484.14, 484.18, or 484.30 (organization, services, and administration; acceptance of patients, plan of care, and medical supervision; and skilled nursing services).

On June 18, 2014, I issued an order notifying the parties that I may consider summary judgment on my own motion in this case. I explained the material facts not in dispute and gave the parties an opportunity to respond. I explained that if I find that a legitimate basis exists for the termination, I must affirm CMS's determination to terminate Petitioner's agreement. *See Comprehensive Professional Home Visits*, DAB CR1097 (2003), *aff'd* DAB No. 1934, at 3-4 (2004). Specifically, because Petitioner did not dispute the conditional level deficiencies at 42 C.F.R. §§ 484.14, 484.18, and 484.30, I warned that summary judgment may be appropriate in this matter.

In its response, CMS argued that Petitioner failed to dispute the cited condition level deficiencies and that summary judgment in its favor is warranted. CMS Response (CMS Resp.) However, in Petitioner's response, rather than dispute the cited condition level deficiencies, Petitioner remained silent. Petitioner Response (P. Resp.) Instead, Petitioner responded that it agreed that summary judgment was appropriate. P. Resp.

2. The undisputed material facts support a finding that Petitioner failed to comply with a condition of participation.

On April 25, 2011, the state agency completed a complaint validation survey that found Petitioner not in compliance with seven conditions of participation: 42 C.F.R. §§ 484.12 (compliance with Federal, State, and local laws, disclosure and ownership information, and accepted professional standards and principles), 484.14 (organization, services, and administration), 484.18 (acceptance of patients, plan of care, and medical supervision), 484.30 (skilled nursing services), 484.32 (therapy services), 484.48 (clinical records), and 484.55 (comprehensive assessment of patients). The state agency conducted a follow-up survey on January 18, 2012, but found Petitioner out of compliance with one condition of participation: 42 C.F.R. § 484.14 (organization, services, and administration). The state agency conducted a second follow-up survey on May 27, 2013. The May 27, 2013 survey determined that Petitioner failed to comply with the following HHA conditions of participation:

1) 42 C.F.R. § 484.10: Patient rights;

2) 42 C.F.R. § 484.14: Organization, services, and administration;

3) 42 C.F.R. § 484.18: Acceptance of patients, plan of care, and medical supervision; and

4) 42 C.F.R. § 484.30: Skilled nursing services.

CMS Exs. 1-2.

Based on its review of the May 27, 2013 survey, CMS determined to terminate Petitioner's provider agreement, effective May 28, 2013. CMS Ex. 2.

Petitioner argues that the surveys were biased, that they were a result of a personal disagreement, and that it was unfairly targeted. Although the delays in conducting the follow-up surveys are peculiar, these contentions are not relevant to issues before me as described. As I explained to Petitioner in my notice, if I find Petitioner out of compliance with a single condition of participation, that noncompliance is a legitimate basis for termination, and I must uphold CMS's determination to terminate.

In this case, CMS has put forth evidence, and Petitioner does not contest the following condition-level deficiencies: 42 C.F.R. §§ 484.14, 484.18, or 484.30 (organization, services, and administration; acceptance of patients, plan of care, and medical supervision; and skilled nursing services); each citation a repeat violation.

A HHA needs to have proper coordination of patient services. 42 C.F.R. § 484.14. Petitioner's policy explains that "coordination of care is a critical element for improving the patient's health care and its delivery system." Petitioner's staff must communicate with the patient, the patient's family, the patient's doctors, and among each other. All of this must be documented in the patient's record. CMS Ex. 25 at 16-18. A HHA must assure that its plans of care are accurate, complete, up-to-date, and reflect the physician's orders. 42 C.F.R. § 484.18. The condition of participation at 42 C.F.R. § 484.30 requires that a HHA furnish skilled nursing services by or under the supervision of a registered nurse and in accordance with the plan of care. HHA's provide nursing care and act as the eyes and ears of their patients' physicians. The record reflects a number of circumstances that represent violations of more than one or all of these conditions of participation.

One example is evident in Petitioner's care of Patient 17. In this case, the diagnoses in the patient's plan of care did not match the corresponding nursing assessments. One of Patient 17's assessments listed the diagnoses as hypertension, general pain, and benign prostate hyperplasia. However, the plan of care did not reflect these diagnoses. Instead, the plan of care indicated a number of unlisted diagnoses, such as depression and obesity. Only in a different nursing assessment and plan of care for Patient 17 did it list a peptic ulcer in the assessment. In a different certification period, the plan of care listed Patient 17's primary diagnosis as a urinary tract infection (UTI). Yet the assessment makes no mention of a UTI and the clinical records did not reflect that Patient 17 was being treated for a UTI during that period. If Patient 17 did not have a UTI during that certification period, Patient 17 should have been reassessed to determine why he required home health services. CMS Ex. 21 at 12-18, 20, 23, 45-58, 73-89, 93-110, 122.

Patient 18's plan of care did not list congestive heart failure as a diagnosis, despite his hospital discharge papers listing it only two days earlier. Additionally, Patient 18's plan of care listed a diagnosis of bacterial pneumonia; however, Patient 18 did not have bacterial pneumonia. The nurse surveyor investigated and learned that Petitioner's staff was choosing the diagnosis based on his interpretation of the patient's medications. In this case, Petitioner's staff determined that Patient 18 was hypertensive because Patient 18 was on metoprolol. CMS Ex. 22 at 31-43; CMS Ex. 30. Petitioner's staff was diagnosing patients based on their medications, treating diseases they did not possess, and failing to treat diseases that they did. They were not reviewing the medical record or communicating with the physician.

Nursing notes from a visit with Patient 20 on February 18, 2013, described edema on both of her ankles and states that Patient 20's caregiver expressed concern about the swelling. The note, however did not describe the severity of the swelling or whether it was pitting or non-pitting edema. CMS Ex. 24 at 14. Petitioner's nursing OASIS assessment of February 25, 2013, documented pedal edema on both of Patient 20's ankles. Yet, the assessment, like the nursing note, did not describe the degree of edema that Patient 20 exhibited. CMS Ex. 24 at 74. In addition to the incomplete assessments, there is no evidence that Petitioner's nursing staff timely consulted Patient 20's physician regarding the edema. Nor did the nursing staff communicate his changes in condition to Patient 20's physician including fatigue, weakness, poor appetite, intolerance to cold, stomach pains, not taking medications as ordered, insomnia, hypotonic bowel sounds, low blood pressure, and assessments describing Patient 20 as pale and clammy. CMS Ex. 24; *see* CMS Ex. 32 (written declaration describing the importance of proper nursing assessments in relation to Patient 20's condition.).

These examples show a serious lacking in coordination of services, of care documented in medical records, plan of care, medical supervision, conformance with physician orders, skilled nursing services, duties of the registered nurse and appropriate counseling with patients and family, and all reflect a need for more effective governance. Petitioner does not dispute these assertions and has pointed to no evidence to the contrary. Accordingly, I conclude that Petitioner failed to meet the conditions of participation required that substantially limited Petitioner's capacity to furnish adequate care. Petitioner was not in substantial compliance with all required conditions of participation at the time of the March 27, 2013 survey.

3. CMS was authorized to terminate Petitioner's provider agreement because Petitioner no longer met the requirements of the Act for participation as a HHA.

CMS is authorized to terminate an HHA's provider agreement if the HHA has a condition level deficiency. 42 U.S.C. §§ 1395x(o)(6), 1395cc(b)(2)(B), 1395bbb(e); 42 C.F.R. § 489.53(a)(3). CMS's decision to terminate a provider agreement is discretionary. *United Medical Home Care*, DAB No. 2194, at 13-14. Petitioner simply does not dispute the condition level deficiencies at 42 C.F.R. §§ 484.14, 484.18, or 484.30 (organization, services, and administration; acceptance of patients, plan of care, and medical supervision; and skilled nursing services). Accordingly, I affirm CMS's determination to terminate Petitioner's provider agreement.

/s/
Scott Anderson
Administrative Law Judge