Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Mission Home Health, et al.,	)	Date: September 18, 2009
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-09-389
	)	Decision No. CR2007
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

The Centers for Medicare and Medicaid Services (CMS) has denied Medicare enrollment applications for twenty-two entities, each "doing business as" Mission Home Health, the petitioner in this case.[1] Petitioner appeals, and CMS has moved for summary judgment.

For the reasons discussed below, I grant CMS's motion.

Background

A business enterprise called Home Health Licensing Specialists, Inc. has been offering for sale what it characterizes as "turn key" home health agencies (HHAs). According to its literature, customers who want to avoid the "bureaucratic red tape" required to set up a licensed and Medicare-certified HHA could instead purchase from this enterprise an HHA that has "already passed the initial survey and [has] its provider number ready to go." CMS Ex. 30, at 2; P. Br. at 3.

Apparently, Home Health Licensing, Inc. obtained licensing and certification for eleven such HHAs before CMS noticed anything amiss. In letters dated June 12, 2008, CMS's Medicare contractor, Palmetto Government Benefits Administrators, denied twenty-two subsequent Medicare enrollment applications that were filed under the auspices of Home

[1] The entities are: Twelve LAC, Inc.; Fourteen LAC, Inc; Fifteen LAC, Inc.; Sixteen LAC, Inc.; Seventeen, LAC, Inc.; Eighteen, LAC, Inc.; Nineteen, LAC, Inc.; Twenty, LAC, Inc; 21 HHA, Inc.; 22 HHA, Inc.; 23 HHA, Inc.; 24 HHA, Inc.; 25 HHA, Inc.; 26 HHA, Inc.; 28 HHA, Inc.; 29 HHA, Inc.; 30 HHA, Inc.; 31 HHA, Inc.; 32 HHA, Inc.; 33 HHA, Inc.; 34 HHA, Inc.; 35, HHA, Inc. CMS Ex. 27.

Health Licensing, Inc. P. Br. at 4; CMS Exs. 23, 24. Those twenty-two, each ostensibly doing business as Mission Home Health, sought reconsideration. In a notice dated February 11, 2009, CMS upheld Palmetto's initial determinations. CMS Ex. 27. Petitioners now seek review by an administrative law judge.[2]

CMS has moved for summary judgment, which Petitioner opposes. With its motion and brief (CMS Br.), CMS initially submitted 29 exhibits (CMS Ex. 1-29). Petitioner responded with its "answer in opposition" to summary judgment (P. Br.), accompanied by one exhibit (P. Ex. 1). CMS filed a reply with one additional exhibit (CMS Ex. 30).

Discussion

CMS is entitled to summary judgment because the undisputed facts establish that none of these 22 entities doing business as Mission Home Health are operational, and CMS may deny Medicare enrollment if it determines that a potential provider is not operational. 42 C.F.R. § 424.530(a).[3]

Summary judgment is appropriate if a case presents no genuine issue of material fact. "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 . . . ." *Livingston Care Center*, DAB No. 1871 (2003). The moving party may show the absence of a genuine factual dispute 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 Center v. Dep't of Health and Human Services*, 388 F.3d 168, 173 (6th Cir. 2004). 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 Rehabilitation Center*, DAB No. 1918 (2004).

A provider applying for enrollment 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 and services." 42 C.F.R. § 424.502.

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[2] Although Petitioner's request for review is dated March 31, 2009, it was not post-marked until April 8, 2009. The Civil Remedies Division received it on April 14, 2009.

[3] I make this one finding of fact/conclusion of law.

CMS has a right to 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). Based on an on-site review or other "reliable evidence" that the provider is not operational or otherwise not meeting reenrollment requirements to furnish covered items or services, CMS may deny a provider's enrollment. 42 C.F.R. § 424.530(a)(1) and (5).

In this case, CMS alleges – and presents evidence sufficient to establish – that none of these 22 entities are operational. CMS Exs. 1-22. Although Petitioner complains about the quality of CMS's evidence, it furnishes no evidence of its own suggesting a dispute concerning any material fact. CMS first points to portions of these entities' enrollment applications, which, on their faces, raise significant questions as to whether they were properly staffed operations, open to the public, able to furnish home health services, and to submit Medicare claims. As Palmetto noted in its June 5, 2007 letters recommending denial, the multiple program applications all list the "exact same practice location." P. Ex. 1. The entities also share incorporation dates (four were incorporated on May 19, 2006; four were incorporated on July 14, 2006; five were incorporated on September 15, 2006, and nine were incorporated on October 23, 2006). They all have the same fax number and one of two telephone numbers and e-mail addresses. While no one of these factors would necessarily preclude enrollment, the mass production quality of the applications justifiably calls for careful scrutiny from CMS, which must guard against trafficking in Medicare provider numbers.

Next, CMS submits evidence establishing that, on May 27, 2008, an on-site investigator, Larry Seals, visited 13759 San Pedro Avenue, San Antonio, Texas, the practice location listed on the applications. CMS Exs. 28, 29. The address was a multi-story office building. Mission Home Health was not listed in the tenant directory. Investigator Seals went to Suite 600, the suite number listed in the address for four of the entities (Twelve Lac, Inc; Fourteen LAC, Inc; Fifteen LAC, Inc.; and Sixteen LAC, Inc.). He learned that Suite 600 "is the business address for several companies that rent one of the small office spaces located within the suite," but that Mission Home Health was no longer there. CMS Ex. 29, at 2 (Seals Affidavit); *See* CMS Ex. 23. He then went to Suite 710, the suite number listed in the address for the remaining 18 entities. The door was locked; the space was dark; no one answered the door. He spoke to Senior Property Manager Susan Sweet, who told him that Mission Home Health had been locked out of Suites 600 and 710 since March 2008 for non-payment of rent. CMS Ex. 29, at 3; *See* CMS Ex. 24.

I find CMS's submissions sufficient to show "an absence of evidence to support" Petitioner's claim that its entities are entitled to Medicare enrollment. *See Celotex Corp. v. Carrett*, 477 U.S. 317, 325 (1986). To avoid summary judgment, Petitioner needed to present evidence "of evidentiary quality" (such as admissible documents, attested

testimony) demonstrating the existence of a genuine issue of material fact, as required by Rule 56. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 252 (1986).[4] But Petitioner came forward with no such evidence. It provided nothing to suggest its entities were ever operating as HHAs, e.g., that they were open to the public, had even one single employee, or had purchased any of the equipment or stock necessary for providing home health care services.

Thus, the undisputed evidence establishes that these 22 entities purportedly doing business as Mission Home Health are not operational, and CMS is entitled to summary judgment.

Petitioner also charges that its due process rights were violated because the Medicare contractor failed to process its enrollment applications "within 45 days of receipt." Of course, I have no authority to review any Constitutional claims. Further, any undo delay would only entitle Petitioner to a response to its enrollment application; it would not create for these unqualified entities any right to participate in Medicare. Moreover, Petitioner has not established any contractor delay, undo or otherwise. Based on the record before me, I cannot determine how long it took Palmetto to process these applications because Petitioner has not told me when they were submitted. (I note, however, that the two year delay Petitioner alleges seems highly unlikely inasmuch as the last of the entities were only incorporated on October 23, 2006, and Palmetto's recommendation to CMS was dated June 5, 2007).

Conclusion

The undisputed evidence establishes that the entities doing business as Mission Home Health are not operational, and therefore may not enroll in the Medicare program as HHAs. I therefore grant CMS's motion for summary judgment, and affirm its reconsidered determination.

/s/ Carolyn Cozad Hughes
Administrative Law Judge

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[4] Petitioner incorrectly asserts that it "must only *allege* facts which, if they are true, would dispute those facts relied on by CMS in support of its motion." (Emphasis added). P. Br. at 6. In fact, mere allegations are not sufficient to defeat an adequately supported summary judgment motion. The non-movant "*must furnish evidence* of a dispute concerning a material fact." (Emphasis added). *Vandalia Park*, DAB No. 1939, at 6 (2004), *citing Matsushita Elec. Indus.* at 586 n. 11.