Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Care Time Home Health Services
(PTAN: 10-9194),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-10-972

Decision No. CR2349

Date: April 6, 2011

DECISION

Petitioner, Care Time Home Health Services, appeals a reconsideration decision issued on September 7, 2010. I sustain the determination of the Centers for Medicare and Medicaid Services (CMS) to revoke Petitioner's Medicare enrollment and billing privileges. I do so because Petitioner has failed to show that it met all Medicare enrollment requirements.

I. Background and Procedural History

On December 22, 2009, two inspectors from SafeGuard Services, LLC, a CMS contractor, attempted to conduct an on-site review of Petitioner's facility. CMS contends that the inspectors arrived at Petitioner's facility at 11:15 a.m., during Petitioner's listed hours of operation, and found the door to the facility locked, the blinds closed, and the lights turned off. CMS Ex. 1, at 4. Because the site review could not be completed, CMS could not verify Petitioner's compliance with Medicare enrollment requirements, and CMS therefore determined that the facility was found "no longer operational to furnish Medicare covered items or services . . ." in violation of 42 C.F.R. § 424.535(a)(5)(i). CMS Ex. 2. Petitioner contends that it was operational, and

"[n]umerous home health services were rendered to various beneficiaries by Care Time on the date in question, December 22, 2009 . . ." P. Br. at 4.

By letter dated May 13, 2010, CMS revoked Petitioner's Medicare billing privileges retroactive to December 22, 2009, the date of the attempted on-site review. CMS Ex. 2. Petitioner submitted a request for reconsideration on June 9, 2010, and included a Corrective Action Plan (CAP). CMS Ex. 3. Petitioner's CAP contained remedial measures including in-service training of all office staff, posting an "open/closed" sign, and installing a bell on the front door. *Id*. at 2. In its reconsideration request, Petitioner contends that the facility was operational on December 22, 2009, but states that:

> [o]n several occasions our office is been advised to keep doors closed to avoid assaults. Even though we keep the doors open most of the time, there is a possibility that on Dec 22, 2009 the door would be closed due the proximity of the Christmas and the increase rate of related crimes.

Id. at 1.

Petitioner also submitted a visitor log and treatment records from the date in question to prove Petitioner was open for business. *Id*. at 4. On September 7, 2010, CMS issued an unfavorable reconsideration decision. CMS Ex. 4. The decision states that:

> Although Care Time did provide justification for why the facility doors may have been locked on the day of the onsite visit, it is required that the facility remain open during their scheduled hours of operation. In addition, the observations made by the Investigators of the facility on the date of the onsite inspection, indicate that the facility was not open and operational during regular hours. Therefore, we are unable to determine if the facility was operational and meeting the requirements to qualify as a Home Health Agency. Accordingly, I am upholding Palmetto GBA's decision to revoke Medicare billing privileges for Care Time.

Id. at 2.

On September 13, 2010, Petitioner filed a hearing request with the Civil Remedies Division (CRD) of the Departmental Appeals Board (Board) to appeal the reconsideration decision. This case was initially assigned to Board Member Leslie A. Sussan pursuant to 42 C.F.R. § 498.44, which permits a Board Member to hear appeals under part 498. On October 25, 2010, this case was reassigned to me for hearing and decision.

In accordance with the Acknowledgment and Pre-hearing Order of September 20, 2010, CMS filed Respondent's Brief in Support of Revocation (CMS Br.), accompanied by 9 exhibits (CMS Ex. 1-9) on October 20, 2010. CMS provided a statement from the two inspectors that attempted to verify the operation of Petitioner's facility on December 22, 2009. CMS Ex. 6. On November 19, 2010, Petitioner filed its Reply Brief in Support of Reinstatement of PTAN 10-9194 (P. Br.), accompanied by 14 exhibits (P. Exs. 1-14). Petitioner did not list any proposed witnesses and accordingly did not include any written direct testimony. Petitioner did not request to cross-examine either of the CMS proposed witnesses. In the absence of objection, I receive into the record of this case CMS Exs. 1-9 and P. Exs. 1-14. Without the need for cross-examination, I do not need to conduct a hearing in this case, and I therefore make my decision based upon the written record.

II. Applicable Law

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 and services." 42 C.F.R. § 424.502. Thus, 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).

Federal regulations provide for revocation of 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 covered 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).

In provider and supplier appeals under 42 C.F.R. Part 498, CMS must make a prima facie showing that the provider or supplier has failed to comply substantially with federal requirements. *See Medisource Corp.*, DAB No. 2011 (2006). To prevail, the provider or supplier must overcome CMS's prima facie showing by a preponderance of the evidence.

Batavia Nursing and Convalescent Ctr., DAB No. 1904 (2004), *aff'd, Batavia Nursing and Convalescent Ctr. v. Thompson*, 129 Fed. Appx. 181 (6th Cir. 2005).

III. Issue

The issue in this case is whether CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges.

IV. Analysis

The issue in this case turns on the legal interpretation of 42 C.F.R. § 424.535 and other regulatory provisions that govern the revocation of Medicare billing privileges. CMS contends that it attempted and was unable to conduct an on-site review of Petitioner's facility during Petitioner's posted hours of operation because the facility was closed. A Medicare provider must be "*open to the public* for the purpose of providing health care related services . . .and [be] *properly staffed*. . . to furnish these services." 42 C.F.R. § 424.502 (emphasis added).

Petitioner submitted a CAP, as well as a reconsideration request containing remedial measures Petitioner would undertake to improve the facility's operations. CMS's decision whether or not to reinstate a provider based on a CAP is not an initial determination and not reviewable by an Administrative Law Judge (ALJ). 42 C.F.R. § 405.874(e).

The Board recently addressed the issue of an opportunity to correct through a CAP and explained how it is distinct from the contractor reconsideration process:

> After the initial notice of revocation, the supplier has two tracks to seek to avoid revocation and may elect to pursue either or both concurrently. [Medicare Program Integrity Manual (MPIM)], Ch. 10, § 19.A. The supplier, within 60 days, may request "reconsideration" of whether the basis for revocation is erroneous or, within 30 days, it may submit a CAP to demonstrate that it has corrected that basis. If the contractor accepts the CAP, it notifies the supplier, and any reconsideration request is withdrawn. If the contractor denies the CAP, the reconsideration process may proceed to a hearing before a hearing officer, who reviews "the Medicare contractor's reason for imposing a . . . revocation at the time it issued the action . . . ." *Id.* An unfavorable hearing officer decision is appealable to an ALJ, who reviews the basis for the revocation. *Id.* No provision is made for an appeal of the contractor's decision not to reinstate based on the CAP. *Id.* The hearing officer conducting the reconsideration (and the ALJ on appeal of the hearing officer decision) are limited to reviewing the basis for

> revocation set out in the initial notice, not the merits of any contractor decision that corrective action under a CAP was unacceptable.

DMS Imaging, Inc., DAB No. 2313, at 7-8 (2010) (footnote omitted).

Thus, the contractor's CAP evaluation is not an initial determination and not appealable. However, CMS's reconsideration decision arises from the contractor's initial determination to revoke Petitioner's Medicare billing privileges and is appealable through the administrative process, including the present review. *Emmanuel Brown M.D. and Simeon Obeng M.D.*, DAB CR2145, at 6-8.

Petitioner argues that the reconsideration decision was incorrect because the facility was open from 9:00 a.m. until 5:00 p.m. on December 22, 2009, the day of the attempted on-site review. P. Br. at 5. Petitioner alleges that, because it is located in a high crime area, the staff is advised to close the doors to the facility to avoid assaults. P. Ex. 5. However, Petitioner does not provide further explanation as to the circumstances in which it had closed the facility. Nor does Petitioner explain the inspectors' observations that the doors were not only locked, but also there was an absence of interior lighting and drawn blinds indicating that the facility was not open for business. CMS Exs. 6-9.

Petitioner also questions why the inspectors' report is dated approximately thirteen days after the date of the attempted on-site review on December 22, 2009. However, Petitioner did not request cross-examination of the inspectors to clarify or shed doubt on the accuracy of the inspector reports.[1] I find the inspectors' report and direct testimony credible and supportive of the CMS position that Petitioner was nonoperational and closed at the time of the site inspection. CMS Exs. 1 and 6.

On the other hand, Petitioner has not overcome its burden of showing by a preponderance of the evidence that it was in substantial compliance with Medicare requirements. The documentary evidence Petitioner has submitted, both at the reconsideration stage and at the ALJ level, does not demonstrate Petitioner's compliance with all Medicare requirements at the time of the on-site review. Instead, Petitioner concedes that "there is a possibility that on Dec 22, 2009 the door would be closed due the proximity of the Christmas and the increase rate of related crimes." CMS Ex. 3, at 1. Petitioner does not to explain why, in addition to closing its door; it also locked the door, closed the blinds, turned off the lights, and provided no alternative notice to the public.

Petitioner did submit a visitor log and nine pages of treatment records, which seem to be created throughout the day on the date in question to prove Petitioner was open for

[1] It is a reasonable assumption that the inspectors may have relied on contemporaneous notes at the time they completed the site report on January 4, 2010. However, CMS also does not explain the date discrepancy, and I weigh the inspectors' report accordingly.

business. P. Exs. 10-11. Petitioner does not offer witness testimony to explain who exactly was present at the facility on December 22, 2009 or to support its argument that someone advised Petitioner to keep its doors closed to avoid assaults. Although I admitted the visitor log and treatment records, they are unsupported hearsay evidence, and standing alone they do not afford CMS an opportunity to cross-examine the person who created them.

Furthermore, a showing that Petitioner has been operational at some time prior to, or after, the on-site review would not provide a basis for reversing the revocation. CMS is authorized to revoke a provider or supplier's Medicare billing privileges based upon the failure to be operational when the inspector visited its address, regardless of whether it may have been operational at some earlier or later time. *See Mission Home Health et al.*, DAB No. 2310 (2010). CMS and its contractors have limited resources and cannot be compelled to attempt multiple on-site inspections during an enrollee's posted business hours to determine if the facility complies with all Medicare requirements. Thus, I find the CMS decision to revoke Petitioner's Medicare enrollment and billing privileges was justified based upon the observations of the inspectors that Petitioner was not open during its business hours during the December 22, 2009 on-site review.

V. Conclusion

For the reasons explained above, I sustain CMS's determination to revoke Petitioner's Medicare billing privileges on the basis that it was not operational.

/s/
Joseph Grow
Administrative Law Judge