Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

UpturnCare Co., d/b/a/Accessible Home Health Care,
(NPI: 196272996),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-839

Decision No. CR3386

Date: September 24, 2014

DECISION

The Medicare enrollment of Petitioner, UpturnCare Co., d/b/a Accessible Home Health Care, is denied pursuant to 42 C.F.R. § 424.530(a)(10),[1] because a temporary moratorium pursuant to 42 C.F.R. § 424.570 applied to Petitioner's new home health agency practice location.

I. Procedural History and Jurisdiction

Palmetto GBA (Palmetto), a Medicare administrative contractor (MAC), notified Petitioner by letter dated February 3, 2014, that Petitioner's application to enroll in Medicare as a home health agency was denied. Palmetto advised Petitioner that its application was denied pursuant to 42 C.F.R. §§ 424.530(a)(10) and 424.570(c), because the Centers for Medicare & Medicaid Services (CMS) had imposed a six-month moratorium on enrolling new home health agencies and subunits in the area where

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[1] The 2013 revision of the Code of Federal Regulations (C.F.R.) is cited, unless otherwise stated.

Petitioner's practice was located. The notice advised that the moratorium began on July 30, 2013; that it may be extended in six-month increments; and that it applied to the county in which Petitioner was attempting to enroll a practice location. CMS Exhibit (Ex.) 4.

On March 3, 2014, Petitioner requested reconsideration of the enrollment denial. CMS Ex. 5. The reconsidered determination, dated April 1, 2014, concluded that Petitioner was subject to the moratorium and that Petitioner's application to enroll as a home health agency was properly denied. The reconsidered determination reflects that the moratorium was extended for six months effective January 31, 2014. CMS Ex. 7. An amended notice of reconsidered determination was issued on April 14, 2014. The amended notice added the information that Petitioner's application was denied based on the moratorium that took effect on January 31, 2014, for Tarrant County, Texas. CMS Ex. 8.

Petitioner filed a request for hearing before an administrative law judge (ALJ) on March 27, 2014, with six supporting documents (RFH).[2] The case was assigned to me for hearing and decision on April 2, 2014, and an Acknowledgement and Prehearing Order (Prehearing Order) was issued at my direction. No issue has been raised as to the timeliness of Petitioner's request for hearing; the parties do not challenge my authority to decide this case; and I conclude that I have jurisdiction.

On May 2, 2014, CMS file a combined prehearing brief and motion for summary disposition, which I construe to be a motion for summary judgment (CMS Br.), with CMS Exs. 1 through 9. On May 28, 2014, Petitioner submitted its brief (P. Br.) together with Petitioner's exhibits (P. Exs.) A through P and SM A through SM E.[3] On June 16, 2014, CMS filed its reply brief (CMS Reply) with an amended exhibit list and a second document marked CMS Ex. 9. I treat CMS's filing of a new document identified as CMS

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[2] Petitioner filed six documents with its request for hearing, identified on the Departmental Appeals Board (DAB) Electronic Filing (Efile) System as Items 1a-1f. On April 15, 2014, Petitioner filed additional documents designated in DAB Efile as Items 7, 7a-7c, apparently in response to my Order to Show Cause issued on April 2, 2014. On April 16, 2014, Petitioner submitted with its Notice of Appearance four additional documents listed as Items 9a - 9c and Item 10 and 11a in DAB Efile

[3] Petitioner's exhibits were not marked as required by the Prehearing Order and the Civil Remedies Division Procedures § 9. However, I did not require Petitioner to correct the exhibits, because to do so would further confuse the record and delay the decision. The documents are readily identifiable by the markings Petitioner used and there is little risk of confusion.

Ex. 9 as a substitution for and withdrawal of the offer of the document previously filed marked as CMS Ex. 9, which will remain with the record but not be considered as substantive evidence. On July 21, 2014, Petitioner filed a reply brief (P. Reply).[4] The parties have not objected to my consideration of the offered exhibits and CMS Exs. 1 through 9 and P. Exs. A through P and SM A through SM E are admitted as evidence. Documents filed by Petitioner that were not specifically marked as exhibits and not listed on Petitioner's exhibit list filed on May 28, 2014, are not considered as substantive evidence.

II. Discussion

A. Applicable Law

Section 1831 of the Social Security Act (the Act) (42 U.S.C. § 1395j) establishes the supplementary medical insurance benefits program for the aged and disabled known as Medicare Part B. Administration of the Part B program is through contractors, such as Palmetto. Act § 1842(a) (42 U.S.C. § 1395u(a)). Payment under the program for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of services and suppliers.[5] Act §§ 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395(u)(h)(1)). A home health agency enrolls in Medicare as a provider.

The Act requires the Secretary to issue regulations that establish a process for the enrollment of providers and suppliers, including the right to a hearing and judicial review in the event of denial or non-renewal. Act § 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to 42 C.F.R. § 424.505, a provider 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.

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[4] On August 11, 2014, Petitioner filed another copy of its reply in a different electronic format (Item 61) in DAB Efile. Item 61 is identical in all respects to Item 60, the copy of the reply filed on July 21, 2014.

[5] A "supplier" furnishes services under Medicare. The term supplier applies to 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) and 1835(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.

Congress authorized the Secretary to impose temporary moratoria on the enrollment of new Medicare and Medicaid providers and suppliers, including categories of providers and suppliers, if the Secretary determines such moratoria is necessary to prevent or combat fraud, waste or abuse under the programs. Act § 1866(j)(7)(A) (42 U.S.C. § 1395cc(j)(7)(A)). Under the applicable regulations, CMS may deny a supplier's enrollment in the Medicare program if the supplier submits an enrollment application for a practice location in a geographic area where CMS has imposed a temporary moratorium. 42 C.F.R. § 424.530(a)(10); 42 C.F.R. § 424.570. Congress has provided that there will be no judicial review of the Secretary's determination to impose a temporary moratorium. Act § 1866(j)(7)(B). The scope of review by an ALJ of denials related to a temporary moratorium is limited to the issue of whether the temporary moratorium applied to the denied provider. The basis for imposing a temporary moratorium is not subject to review by an ALJ. 42 C.F.R. § 498.5(l)(4).

B. Issues

Whether summary judgment is appropriate; and

Whether the temporary moratorium that was cited as the basis for denial of Petitioner's enrollment as a provider applied to Petitioner.

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

My conclusions of law are set forth in bold text followed by my findings of fact and analysis.

1. Summary judgment is appropriate.

CMS has requested summary judgment. A provider or supplier denied enrollment in Medicare or whose enrollment has been revoked has a right to a hearing and judicial review pursuant to section 1866(h)(1) and (j) of the Act and 42 C.F.R. §§ 498.3(b)(1), (5), (6), (8), (15), (17), 498.5. A hearing on the record, also known as an oral hearing, is required under the Act. Act §§ 205(b), 1866 (h)(1) and (j)(8); *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743, 748-51 (6th Cir. 2004). A party may waive appearance at an oral hearing, but must do so affirmatively in writing. 42 C.F.R. § 498.66. In this case, Petitioner has not waived the right to oral hearing or otherwise consented to decision based only upon the documentary evidence or pleadings. Accordingly, disposition on the written record alone is not permissible, unless the CMS motion for summary judgment has merit.

Summary judgment is not automatic upon request but is limited to certain specific conditions. The Secretary's regulations that establish the procedure to be followed in

adjudicating Petitioner's case are at 42 C.F.R. pt. 498. 42 C.F.R. §§ 424.545(a), 498.3(b)(5), (6), (15), (17). The regulations do not establish a summary judgment procedure or recognize such a procedure. However, the Board has long accepted that summary judgment is an acceptable procedural device in cases adjudicated pursuant to 42 C.F.R. pt. 498. *See, e.g.*, *Ill. Knights Templar Home*, DAB No. 2274, at 3-4 (2009); *Garden City Med. Clinic*, DAB No. 1763 (2001); *Everett Rehab. & Med. Ctr.*, DAB No. 1628, at 3 (1997). The Board also has recognized that the Federal Rules of Civil Procedure (Fed. R. Civ. Pro.) do not apply in administrative adjudications such as this, but the Board has accepted that Fed. R. Civ. Pro. 56 and related cases provide useful guidance for determining whether summary judgment is appropriate. Furthermore, a summary judgment procedure was adopted as a matter of judicial economy within my authority to regulate the course of proceedings and made available to the parties in the litigation of this case by my Prehearing Order. The parties were given notice by the Prehearing Order that summary judgment is an available procedural device and that the law as it has developed related to Fed. R. Civ. Pro. 56 will be applied.

Summary judgment is appropriate when there is no genuine dispute as to any issue of material fact for adjudication and/or the moving party is entitled to judgment as a matter of law. In determining whether there are genuine issues of material fact for trial, the reviewer must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. The party requesting summary judgment bears the burden of showing that there are no genuine issues of material fact for trial and/or that it is entitled to judgment as a matter of law. Generally, the non-movant may not defeat an adequately supported summary judgment motion by relying upon the denials in its pleadings or briefs but must furnish evidence of a dispute concerning a material fact, i.e., a fact that would affect the outcome of the case if proven. *Mission Hosp. Reg'l Med. Ctr.*, DAB No. 2459, at 4 (2012) (and cases cited therein); *Experts Are Us, Inc.*, DAB No. 2452, at 4 (2012) (and cases cited therein); *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 3 (2010) (and cases cited therein); *see also Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986).

The standard for deciding a case on summary judgment, and an ALJ's decision-making in deciding a summary judgment motion, differs from that used in resolving a case after a hearing. On summary judgment, the ALJ does not make credibility determinations, weigh the evidence, or decide which inferences to draw from the evidence, as would be done when finding facts after a hearing on the record. Rather, on summary judgment, the ALJ construes the evidence in a light most favorable to the non-movant and avoids deciding which version of the facts is more likely true. *Holy Cross Vill. at Notre Dame, Inc.*, DAB No. 2291, at 5 (2009). The Board also has recognized that on summary judgment it is appropriate for the ALJ to consider whether a rational trier of fact could find that the party's evidence would be sufficient to meet that party's evidentiary burden. *Dumas Nursing & Rehab., L.P.*, DAB No. 2347, at 5 (2010). The Secretary has not provided in 42 C.F.R. pt. 498 for the allocation of the burden of persuasion or the

quantum of evidence required to satisfy the burden. However, 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. *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd*, *Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 Fed. App'x 181 (6th Cir. 2005).

I conclude, after reviewing the evidence before me in the light most favorable to Petitioner and drawing all inferences in Petitioner's favor, that there is no genuine dispute as to any material fact in this case that requires a trial. The issues in this case that require resolution are issues of law related to the interpretation and application of the regulations that govern enrollment and billing privileges in the Medicare program and application of the law to the undisputed facts of this case. The issue in this case must be resolved against Petitioner as a matter of law because the undisputed evidence shows that the temporary moratorium did apply to Petitioner's application to enroll in Medicare. Accordingly, I conclude summary judgment is appropriate.

2. The temporary moratorium applies to Petitioner's enrollment application because the application was pending but not approved when the moratorium became effective.

3. There was a basis for denying Petitioner's Medicare enrollment pursuant to 42 C.F.R. § 424.530(a)(10).

There is no genuine dispute as to the pertinent facts.

On December 8, 2011, Petitioner's Owner and President, Zinaida Boltan, signed an application to enroll Petitioner in Medicare as a new home health agency. CMS Ex. 9. The practice location listed in the application was 803 Forest Ridge Drive, Suite 205, Bedford, Texas. CMS Ex. 9 at 29. Petitioner does not dispute that its practice location is in Tarrant County, Texas, and that it seeks to operate in Tarrant and Denton Counties, Texas. RFH at 1; P. Br. at 1. The application was received by Palmetto on December 12, 2011. Palmetto completed processing the application on August 9, 2012, and recommended approval of Petitioner to participate in Medicare as a provider. CMS Ex. 1. Petitioner was advised of the Palmetto recommendation on August 9, 2012, and that the application was forwarded to the state agency and CMS for further action, including a survey. CMS Ex. 2. The survey of Petitioner was completed and Petitioner received accreditation and a recommendation for Medicare certification by The Joint Commission effective October 1, 2013. CMS Ex. 3.

Effective January 30, 2014, CMS imposed a temporary moratorium on the enrollment of home health agencies in Dallas County, Texas (which includes the city of Dallas) and the six surrounding Texas Counties, which include Collin, Denton, Ellis, Kaufman, Rockwell, and Tarrant. The notice in the Federal Register specified:

> Beginning on the effective date of this document, no new HHAs will be enrolled into Medicare, Medicaid or CHIP with a practice location in the Texas Counties of Dallas, Denton, Ellis, Kaufman, Rockwall, and Tarrant unless their enrollment application has already been approved but not yet entered into PECOS or the State Provider/Supplier Enrollment System at the time the moratorium is imposed.

79 Fed. Reg. 6475, 6479 (Feb. 4, 2014); CMS Ex. 6 (press release). The regulation also provides that a "temporary enrollment moratorium does not apply to any enrollment application that has been approved by the enrollment contractor but not yet entered into PECOS at the time the moratorium is imposed." 42 C.F.R. § 424.570(1)(a)(iv).

Home health agencies are subject to a rigorous multi-tiered screening process for initial enrollment applications because CMS has designated these providers as high risk. 42 C.F.R. § 424.518(c); CMS Pub. 100-08, Medicare Program Integrity Manual (PIM), § 15.19.2.1C (May 7, 2012). Because of the potential for fraud, the enrollment process for new home health agency providers includes an additional step for a second review of enrollment criteria performed by either the Regional Home Health Intermediary or the MAC after the CMS regional office's review process is completed. CMS PIM § 15.26.3 (Jan. 7, 2014); CMS Survey and Certification Letter (S&C) 12-15-HHA, Revised Initial Certification Process for Home Health Agencies (HHA) (Dec. 23, 2011).[6] This review by the contractor occurs once CMS notifies the contractor by email to perform this second review. The contractor then re-reviews certain Medicare enrollment requirements, such as determining if the home health agency has the required amount of capitalization and checking to make sure that each entity and individual listed in the enrollment application is reviewed again against the Medicare Exclusion Database and the System for Award Management. The contractor then performs a site visit. It is only after successful completion of this final re-review by the contractor that the home health agency will be certified by CMS for enrollment and entered into PECOS.

Petitioner argues that it is not subject to the moratorium because all required steps had been completed in processing its enrollment; its enrollment application had been approved; and Petitioner was only waiting for the approval to be entered into PECOS and to receive its provider number from Palmetto. RFH at 1, 3; P. Br. at 1, 4; P. Reply at 2-3. CMS argues that Petitioner did not meet the exception to application of the moratorium,

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[6] CMS Survey and Certification letters are available at: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/.

because Petitioner's application had not received the second review by Palmetto. CMS Br. at 1; CMS Reply at 10. CMS states that Palmetto had not approved the enrollment application because it had not conducted its "re-review of Petitioner's Medicare enrollment requirements (e.g., site visit verification, capitalization requirements and Medicare exclusion checks)" prior to the moratorium being extended on January 30, 2014. CMS Reply at 10. The steps to which CMS refers are required by the PIM § 15.26.3 (Jan. 7, 2014).

Petitioner does not dispute and acknowledges that CMS did not notify Palmetto until January 8, 2014, that Palmetto should proceed with its "pre-tie-in review," that is, the final re-reviews and site visit. P. Br. at 2 ¶ 10; P. Ex. E. Petitioner also does not dispute that Palmetto had not yet performed the additional re-review required and had 45 days to do so. P. Br at 2; CMS Reply at 3-4. However, before the re-reviews and site visit could be performed by Palmetto, CMS announced the moratorium. Therefore, Petitioner's application was not "approved" because not every step required to be fully approved and accepted into the Medicare program had been completed prior to 12:00 a.m. on January 30, 2014, when the moratorium became effective.

To the extent Petitioner's arguments may be construed as a request for equitable relief, I have no authority to grant equitable relief. *US Ultrasound*, DAB No. 2302, at 8 (2010) ("[n]either the ALJ nor the Board is authorized to provide equitable relief by reimbursing or enrolling a supplier who does not meet statutory or regulatory requirements."). I am bound to follow the Act and regulations and have no authority to declare statutes or regulations invalid. *1866ICPayday.com, L.L.C.*, DAB No. 2289, at 14 ("[a]n ALJ is bound by applicable laws and regulations and may not invalidate either a law or regulation on any ground.").

There is no genuine dispute as to any material fact. Petitioner's application had not been processed through all required steps for approval prior to the moratorium going into effect. Accordingly, summary judgment is appropriate and Petitioner's application must be denied due to the moratorium.

III. Conclusion

For the foregoing reasons, I conclude that Petitioner's enrollment application was subject to the temporary moratorium imposed pursuant to 42 C.F.R. § 424.570(c), and the application is properly denied pursuant to 42 C.F.R. §§ 424.530(a)(10).

/s/
Keith W. Sickendick
Administrative Law Judge