Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

United Houston Homecare, Inc.,
(NPI: 1669457867)

Petitioner,

v.

Centers for Medicare & Medicaid Services

Docket No. C-16-770

Decision No. CR4787

Date: February 7, 2017

DECISION

The Centers for Medicare & Medicaid Services (CMS), through its Medicare administrative contractor, Palmetto GBA (Palmetto), revoked the Medicare enrollment and billing privileges of United Houston Homecare, Inc. (Petitioner) pursuant to 42 C.F.R. § 424.535(a)(1) because Petitioner failed to submit a complete fingerprint packet upon Palmetto's request as required by 42 C.F.R. § 424.518(d). The undisputed evidence shows that there is a basis for revocation of Petitioner's Medicare enrollment and billing privileges. Accordingly, I grant summary judgment for CMS and affirm CMS's determination to revoke Petitioner's Medicare enrollment and billing privileges.

I. Background and Procedural History

Petitioner was enrolled in the Medicare program as a home health agency. CMS Exhibit (Ex.) 8 at 2. CMS identified Petitioner as a "high categorical risk." CMS Ex. 11, ¶ 4; *see also* 42 C.F.R. § 424.518(c)(3). Because CMS designated Petitioner as a high categorical risk, the regulations required Palmetto to conduct a fingerprint-based criminal history record check on all individuals with a five percent or greater direct or indirect ownership interest in Petitioner. 42 C.F.R. § 424.518(c)(2)(ii)(B).

In a letter dated December 30, 2015, Palmetto notified Petitioner that Petitioner's owners with a five percent or greater ownership interest must submit fingerprints within 30 calendar days from the postmark of the letter pursuant to 42 C.F.R. § 424.518(d). CMS Ex. 1 at 1. Palmetto identified Walt Crowder as having five percent or greater ownership in Petitioner and required Petitioner to submit a set of fingerprints for Mr. Crowder. *Id.* The December 30 letter further informed Petitioner that its Medicare enrollment and billing privileges may be revoked if it did not submit Mr. Crowder's fingerprints. *Id.* In a letter dated March 16, 2016, Palmetto notified Petitioner that its Medicare enrollment and billing privileges were being revoked effective April 15, 2016. CMS Ex. 2. Palmetto cited 42 C.F.R. § 424.535(a)(1) as the basis for the revocation. Palmetto concluded that Petitioner was noncompliant with 42 C.F.R. § 424.518(d) because Petitioner failed to submit fingerprints for Mr. Crowder within 30 days, as Palmetto requested in its December 30, 2015 letter. CMS Ex. 2 at 1. Palmetto also notified Petitioner that it was subject to a one-year re-enrollment bar pursuant to 42 C.F.R. § 424.535(c). CMS Ex. 2 at 2.

In a letter to CMS's Provider Enrollment & Oversight Group dated March 24, 2016,[1] Petitioner requested an "appeal" and enclosed a copy of Mr. Crowder's fingerprints. CMS Exs. 4; 9. In the March 24 letter, Petitioner also represented that it was sending a copy of Mr. Crowder's fingerprints to Accurate Biometrics, the fingerprint processing contractor. CMS Ex. 9. In an email of April 13, 2016, CMS informed Petitioner that Accurate Biometrics had not yet received a copy of Mr. Crowder's fingerprints. CMS Ex. 7. CMS also stated that Petitioner had an additional 30 days to submit Mr. Crowder's fingerprint package to the contractor. *Id.* By letter dated April 18, 2016, Petitioner submitted another copy of the fingerprint package to CMS. CMS Ex. 10. A representative of CMS's Provider Enrollment & Oversight Group denied Petitioner's reconsideration request and corrective action plan (CAP) on June 1, 2016. CMS Ex. 5; 11. Petitioner filed its hearing request on July 28, 2016.

The case was assigned to me and I issued an Acknowledgment and Pre-Hearing Order (Pre-Hearing Order) on August 8, 2016. On September 22, 2016, CMS submitted its Motion for Summary Judgment (CMS Br.), along with 13 proposed exhibits (CMS Exs. 1-13). CMS submitted written declarations from Ms. Minisha Hicks and Ms. Tanesha Norman. CMS Exs. 11; 12. On October 24, 2016, Petitioner submitted its Opposition to CMS's Motion for Summary Judgment (P. Br.), along with three proposed exhibits (P. Exs. 1-3). Neither party objected to the exhibits offered by the opposing party. Accordingly, in the absence of objection, I admit CMS Exs. 1-13 and P. Exs. 1-3 into the record.

---

[1] I note that March 24, 2016 is 85 days after December 30, 2015.

In a document styled "United Houston Homecare, Inc.'s Pre-Hearing Exchange," Petitioner stated that it intended to call its owner, Mr. Crowder, to testify at a hearing and requested to cross-examine CMS's witnesses. However, Petitioner did not submit the written direct testimony of Mr. Crowder as required by ¶¶ 4.c.iv. and 8 of my Pre-Hearing Order and CMS did not request to cross-examine Mr. Crowder. As my Pre-Hearing Order informed the parties, a hearing is only necessary if a party files admissible written direct testimony and the opposing party asks to cross-examine. Pre-Hearing Order ¶ 10. Therefore, no hearing is required to receive the testimony of Mr. Crowder. Further, although Petitioner requested to cross-examine Ms. Hicks and Ms. Norman, I need not convene a hearing for that purpose because the undisputed facts establish a basis for CMS's revocation action without regard to the testimony of these witnesses.

II. Issues

1. Whether CMS is entitled to summary judgment; and

2. Whether CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges under 42 C.F.R. § 424.535(a)(1).

III. Jurisdiction

I have jurisdiction to hear and decide this case. 42 C.F.R. §§ 498.3(b)(17), 498.5(l)(2); *see also* 42 U.S.C. § 1395cc(j)(8).

IV. Discussion

A. Statutory and Regulatory Background

The Social Security Act (Act) authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations governing the enrollment process for providers and suppliers.[2] 42 U.S.C. §§ 1302, 1395cc(j). Under the Secretary's regulations, a provider or supplier seeking billing privileges under the Medicare program must "submit enrollment information on the applicable enrollment application. Once the provider or supplier successfully completes the enrollment process . . . CMS enrolls the provider or supplier into the Medicare program." 42 C.F.R. § 424.510(a)(1). CMS then establishes an effective date for billing privileges under the requirements stated in 42 C.F.R. § 424.520(d) and may permit limited retrospective billing under 42 C.F.R. § 424.521.

---

[2] As a home health agency, Petitioner is considered a "provider" for purposes of the Act and the regulations. *See* 42 U.S.C. § 1395x(u); 42 C.F.R. § 498.2; *see also* 42 C.F.R. § 400.202.

The Secretary has delegated the authority to revoke enrollment and billing privileges to CMS. 42 C.F.R. § 424.535. In order to maintain Medicare billing privileges after being enrolled, a provider or supplier must meet the requirements of 42 C.F.R. § 424.515 for revalidation and 42 C.F.R. § 424.516 for reporting changes, maintaining documents, and other requirements set forth in that regulation. CMS or its Medicare contractor may revoke an enrolled provider's Medicare enrollment and billing privileges and provider agreement for any of the reasons listed in 42 C.F.R. § 424.535. Pursuant to 42 C.F.R. § 424.535(a)(1), CMS may revoke a provider's enrollment and billing privileges if the provider is determined not to be in compliance with enrollment requirements. If CMS revokes a provider's Medicare billing privileges, the revocation becomes effective 30 days after CMS or one of its contractors mails the revocation notice to the provider, subject to some exceptions not applicable in this case. After a provider's Medicare enrollment and billing privileges are revoked, the provider is barred from reenrolling in the Medicare program for one to three years. 42 C.F.R. § 424.535(c).

Pursuant to sections 1124 and 1124A of the Act (42 U.S.C. §§ 1320a-3 and 1320a-3a) and 42 C.F.R. § 424.502, a provider or supplier is required to disclose to the Secretary full and complete information regarding any owner of the provider or supplier. An "owner" is defined as any individual or entity that has any partnership interest or a five percent or more direct or indirect ownership of the provider or supplier. Furthermore, the regulations require individuals or entities that have any partnership interest or a five percent or more direct or indirect ownership interest in the provider or supplier to submit fingerprints for a criminal background check:

> (d) *Fingerprinting requirements.* An individual subject to the fingerprint-based criminal history record check requirement specified in paragraph (c)(2)(ii)(B) of this section –
>
> > (1) Must submit a set of fingerprints for a national background check.
> >
> > > (i) Upon submission of a Medicare enrollment application; or
> > > (ii) Within 30 days of a Medicare contractor request.
> >
> > (2) In the event the individual(s) required to submit fingerprints under paragraph (c)(2) of this section fail to submit such fingerprints in accordance with paragraph (d)(1) of this section, the provider or supplier will have its billing privileges –

(i) Denied under § 424.530(a)(1); or
(ii) Revoked under § 424.535(a)(1).

42 C.F.R. § 424.518(d). Pursuant to 42 C.F.R. § 424.535(a)(1), CMS is authorized to revoke the Medicare enrollment and billing privileges of a supplier or provider for failure to comply with 42 C.F.R. § 424.518(d).

B. Conclusions of Law and Analysis

1. Summary judgment is appropriate in this case.

An administrative law judge may decide a case arising under 42 C.F.R. part 498 by summary judgment. *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)). "Matters presented to the administrative law judge for summary judgment will follow Rule 56 of the Federal Rules of Civil Procedure and federal case law . . . ." Civil Remedies Division Procedures § 19(a)(iii).

As stated by the United States Supreme Court:

> Rule 56(c) of the Federal Rules of Civil Procedure provides that summary judgment "shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." By its very terms, this standard provides that the mere existence of some alleged factual dispute between the parties will not defeat an otherwise properly supported motion for summary judgment; the requirement is that there be no genuine issue of material fact.

Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 247-48 (1986).

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 5 (2012) (and cases cited therein); *Experts Are Us, Inc.*, DAB No. 2452 at 5-6 (2012) (and cases cited therein); *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 at 3 (2010) (and cases cited therein); *see also Liberty Lobby, Inc.*, 477 U.S. at 248.

Viewing the evidence before me in a light most favorable to Petitioner and drawing all inferences in Petitioner's favor, I conclude that there is no genuine dispute as to any material fact pertinent to revocation under 42 C.F.R. § 424.535(a)(1) that would require a hearing in this case. Petitioner's contentions that CMS improperly revoked its Medicare enrollment and billing privileges must be resolved against it as a matter of law. The undisputed evidence shows that there is a basis for revocation of Petitioner's Medicare enrollment and billing privileges. Accordingly, summary judgment is appropriate.

2. CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges under 42 C.F.R. § 424.535(a)(1) because Petitioner failed to submit fingerprints as required by 42 C.F.R. § 424.518(d).

Petitioner does not dispute that it timely received the December 30, 2015 request for Mr. Crowder's fingerprints. Nor does Petitioner contend that it made any attempt to submit Mr. Crowder's fingerprints within 30 calendar days from the postmark of the December 30 letter. Instead, without exception, Petitioner's factual representations concern actions it took *after* Palmetto issued the revocation notice—78 days after the date of the initial request. Once the 30-day deadline set in 42 C.F.R. § 424.518(d) had elapsed without a response from Petitioner, CMS was authorized to revoke Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(1). Neither Petitioner's nor CMS's actions after the revocation determination are material to the question of whether CMS had authority to revoke Petitioner's Medicare enrollment and billing privileges.

Petitioner argues that it did not fail to comply with the requirements of 42 C.F.R. § 424.518(d) because the "statute does not provide a deadline or timeframe for CMS's contractor to process the documentation." P. Br. at 7. This argument is without merit. The regulation plainly states that individuals subject to the fingerprinting requirement must respond "within 30 days of a Medicare contractor request." 42 C.F.R. § 424.518(d)(1)(ii). Petitioner did not comply with the regulation because its response fell outside the 30-day window set forth in the regulation. Therefore, CMS had a legal basis to revoke Petitioner's Medicare enrollment and billing privileges as provided in 42 C.F.R. § 424.518(d)(2)(ii). Applying the law to the undisputed facts requires a judgment in favor of CMS as a matter of law.

Petitioner contends that revocation was inappropriate because Petitioner responded to CMS's fingerprinting requests but was hampered by a lack of guidance from the fingerprinting processing company. P. Br. at 7-8. Petitioner's argument does not raise a factual issue that would defeat summary judgment. As previously noted, the undisputed facts demonstrate that Petitioner made no response at all to the request for Mr. Crowder's fingerprints until after Palmetto issued the revocation notice. Furthermore, once Palmetto issued the revocation notice, Petitioner's actions in response represent its efforts to correct its noncompliance. In other words, these actions are part of Petitioner's CAP. As I explain below, CMS's actions on a CAP are not subject to my review.

3. Petitioner's efforts to cure its noncompliance are not material to my decision because an administrative law judge is not authorized to review CMS's rejection of a corrective action plan.

Petitioner argues that CMS may not revoke its Medicare enrollment and billing privileges because CMS failed to provide it a meaningful opportunity to correct its noncompliance. P. Br. at 6. Petitioner argues that 42 C.F.R. § 424.535(a)(1) provides for revocation only where a provider fails to comply with enrollment requirements *and* fails to submit a CAP. P. Br. at 6. Petitioner contends that, because it submitted a CAP, one of the required elements under section 424.535(a)(1) is not met and revocation is not authorized. P. Br. at 6. This argument misreads the applicable regulations because it fails to account for the interaction of section 424.535(a)(1) with section 405.809, which governs CMS action on a provider's CAP.

The regulation at 42 C.F.R. § 405.809 provides for "reinstatement" of a provider's billing privileges following corrective action. The regulation explains that, if CMS determines that a provider "provides sufficient evidence that it has complied fully with the Medicare requirements," CMS will reinstate the provider's billing privileges as of the date the provider demonstrates that it is in compliance. *See* 42 C.F.R. § 405.809(b). It is evident from this language that, where CMS has revoked a provider's billing privileges, the revocation may take effect without regard to whether the provider has submitted a CAP. As the regulation makes plain, only if the provider demonstrates compliance with the Medicare enrollment requirements does CMS reinstate the provider's billing privileges.

There would be no need to reinstate a provider's billing privileges if no revocation had taken place.[3] Thus, in the present case, CMS did not reinstate Petitioner's billing privileges because CMS determined that Petitioner did not submit an *acceptable* CAP.[4] Both Petitioner and CMS devote significant argument to the issue of whether Petitioner's attempts to complete its CAP by submitting Mr. Crowder's fingerprints were adequate to establish compliance with 42 C.F.R. § 424.518(d). For example, Petitioner asserts that it was unaware that the fingerprint submission was incomplete without Mr. Crowder's Social Security number and complains that neither CMS nor Palmetto explained why the submission was unacceptable. P. Br. at 8. In response, CMS argues that it (or its contractor) made numerous unsuccessful efforts to contact Petitioner regarding the fingerprint submission. *See, e.g.*, CMS Br. at 7-8. Ultimately, however, these contentions are not material to any issue before me. This is because CMS has discretion to accept or reject a CAP and that discretion is not subject to my review.

CMS did not approve Petitioner's CAP and issued an unfavorable reconsidered determination affirming the revocation of Petitioner's enrollment and billing privileges. CMS Ex. 5. I may presume CMS considered and rejected the CAP, or it would not have issued an unfavorable reconsidered determination.[5] *See, e.g., Douglas Bradley, M.D.*, DAB No. 2663 at 14 (2015) (a reviewing official may presume that "government officials have 'properly discharged their official duties' absent 'clear evidence to the contrary.'" (internal citations omitted)). Moreover, there is no requirement that CMS or its contractor explain its reasons for taking a discretionary action. *Brian K. Ellefsen, D.O.*, DAB No. 2626 at 9-10 (2015).

---

[3] To the extent Petitioner may be arguing that, had CMS accepted its initial CAP as submitted on March 24, 2016, the revocation would not have gone into effect on April 15, 2016, the argument nevertheless fails for the same reasons discussed in this section of my decision.

[4] Although not material to my decision that Petitioner failed to comply with 42 C.F.R. § 424.518(d) as of the date of the revocation notice, I note that CMS viewed Petitioner's subsequent submissions as incomplete because Petitioner failed to include Mr. Crowder's Social Security number. CMS Exs. 4; 10; 11; 12.

[5] The reconsidered determination is not a model of clarity. At one point the author states that the document responds to Petitioner's CAP (CMS Ex. 5 at 1), while at another point she states that it responds to Petitioner's reconsideration request (CMS Ex. 5 at 2). In any event, it is plain that the document intends to communicate that CMS has rejected the CAP and also ruled unfavorably on the reconsideration request.

Section 405.809 of the regulations explicitly precludes administrative law judge review of CMS's determination to reject a CAP: "The refusal of CMS or its contractor to reinstate a provider or supplier's billing privileges based on a corrective action plan is not an initial determination under part 498 of this chapter." 42 C.F.R. § 405.809(b)(2). Several appellate panels of the Departmental Appeals Board (DAB) have confirmed that administrative law judges have no authority to review CMS's (or a contractor's) decision to reject a proposed CAP. *See, e.g.*, *Conchita Jackson, M.D.*, DAB No. 2495 at 6 (2013); *DMS Imaging, Inc.*, DAB No. 2313 at 6 (2010). Thus, any actions (or inactions) of CMS or its contractor in reviewing Petitioner's CAP are not before me and cannot form a basis to reverse CMS's determination to revoke Petitioner's Medicare enrollment and billing privileges.

V. Conclusion

For the foregoing reasons, I grant CMS's motion for summary judgment and affirm CMS's revocation of Petitioner's Medicare enrollment and billing privileges.

/s/
Leslie A. Weyn
Administrative Law Judge