Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

West Miami CMHC, Inc.,
(NPI No. 1588765226),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-10-875

Decision No. CR2315

Date: January 23, 2011

DECISION

I sustain the determination of the Centers for Medicare and Medicaid Services (CMS) to revoke the Medicare billing privileges of Petitioner, West Miami CMHC, Inc. I do so because Petitioner has failed to show that it met Medicare enrollment requirements to supervise treatment of, or to provide Medicare covered items or services for, Medicare patients as required for all Community Mental Health Centers (CMHCs).

I. Background

Petitioner is a CMHC in Miami, Florida. On February 18, 2010, SafeGuard Services (SGS) conducted an on-site investigation on behalf of CMS at Petitioner's facility. Thereafter, SGS recommended that First Coast Service Options (FCSO), a CMS contractor, revoke Petitioner's Medicare provider number. On March 27, 2010, FCSO sent a letter notifying Petitioner that its Medicare provider number and billing privileges had been revoked effective February 18, 2010. CMS Ex. 16; P. Ex. 6. The March 27, 2010 revocation letter provided specific findings that Petitioner moved, or changed its address, without providing proper notification to Medicare. P. Ex. 6.

On June 22, 2010, a Hearing Officer affirmed FCSO's decision to revoke Petitioner's provider number. CMS Ex. 17; P. Ex. 9. This reconsideration decision, based on 42 C.F.R. § 424.535(a)(5)(i), held that Petitioner was not operational and not furnishing services to Medicare beneficiaries. Specifically, it found that SGS determined that Petitioner was not operational because no employees, except the owner, were present during the on-site inspection, and no patients were receiving, or had received, Medicare covered services since January 2010.[1] Further, it found Petitioner was not providing core services that would qualify it as a CMHC. The reconsideration decision also explained that Petitioner had not provided evidence that it employed the appropriate staff to furnish Medicare covered services to Medicare beneficiaries on an ongoing basis. It further stated that Petitioner's owner had told the SGS investigators that she could not afford to operate, and she had stopped providing services. *Id.*

On July 28, 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. An Acknowledgment and Pre-hearing Order was sent to the parties on August 4, 2010. On August 25, 2010, the parties jointly requested a thirty-day extension of time from the pre-hearing deadlines, which was granted, to explore possible settlement. The parties could not reach a settlement agreement and proceeded to file submissions.

On October 4, 2010, CMS filed a prehearing brief (CMS Br.), accompanied by 26 exhibits (CMS Ex. 1-26) and provided written direct testimony for two proposed witnesses. On November 17, 2010, Petitioner filed its brief (P. Br.), accompanied by 42 exhibits (P. Exs. 1-42). Petitioner did not list any proposed witnesses and accordingly did not include any written direct testimony. On October 25, 2010, this case was reassigned to me for hearing and decision.

On December 2, 2010, I convened a telephone conference. During the conference, I noted that neither Petitioner nor CMS had requested cross-examination of any witnesses. Thus, in accordance with Board Member Sussan's Acknowledgment and Pre-Hearing Order, this case would typically be ready for my decision on the written record without an in-person hearing. However, I also noted that during the course of my review of the materials submitted, certain issues required clarification.

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[1]The date of January 2010 is an apparent typographical error. CMS provided evidence that, at the time of the February 18, 2010 on-site visit, no patients had received Medicare covered services since January 23, 2009, not 2010. CMS Ex. 23, at 11.

I first inquired of CMS counsel whether the revocation of Petitioner's Medicare billing privileges on the specific basis that Petitioner moved its practice location without proper notification to CMS, as stated in the original revocation notice letter, remained at issue in this case. CMS counsel verified that Petitioner's change of address was no longer at issue. I also stated it was necessary to ensure that both parties were reasonably apprised of, and given an opportunity to address, all of the remaining issues in controversy. I noted that the June 22, 2010 reconsideration decision set forth CMS's argument that Petitioner was not operational because Petitioner failed to provide the core services required to qualify as a CMHC. However, it appeared that Petitioner did not receive clarification that the basis of its revocation was not an address change until it received the reconsideration decision. To ensure a complete and accurate record, I directed CMS to submit a supplemental brief explaining how each requirement to provide core services as a CMHC applies in this case, especially with regard to the new evidence that Petitioner presented after the reconsideration decision. Accordingly, I gave Petitioner an opportunity to respond. Order Following Telephone Conference and Order for Supplemental Brief, December 3, 2010.

On December 17, 2010, CMS filed its supplemental brief (CMS Supp. Br.). On December 29, 2010, Petitioner filed its response (P. Supp. Br.), accompanied by a witness list and two additional exhibits, labeled P. Ex. 1 and 2. I have relabeled Petitioner's first exhibit, P. Ex. 1, as P. Ex. 43, and I have relabeled P. Ex. 2 as P. Ex. 44 to avoid confusion with Petitioner's initial submission of exhibits. In its response, Petitioner made a late request to cross-examine one of the SGS investigators, Rebekah Paone. P. Supp. Br. at 3.

II. Applicable Law

A CMHC must be certified to participate in the Medicare program to be able to claim, and to receive reimbursement for, services that it provides to Medicare beneficiaries. A CMHC is defined as an entity that:

> (1) Provides outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and residents of its mental health service area who have been discharged from in-patient treatment at a mental health facility;

> (2) Provides 24-hour-a-day emergency care services;
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> (3) Provides day treatment or other partial hospitalization services, or psychosocial rehabilitation services;
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> (4) Provides screening for patients being considered for admission to State mental health facilities to determine the appropriateness of this admission; and
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> (5) Meets applicable licensing or certification requirements for CMHCs in the State in which it is located.

42 C.F.R. § 410.2; *see* 42 U.S.C. § 300x-2(c)(1)(B)-(E).

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 –
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> > (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.
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> 42 C.F.R. § 424.535(a)(5)(i).

III. Issue

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

IV. Discussion

My findings of fact and conclusions of law are set forth in italics and bold in the discussion captions of this decision.

1. Petitioner has received due process despite the defective revocation notice.

The specific findings of CMS's March 27, 2010 revocation letter based the revocation of Petitioner's Medicare billing number and billing privileges on Petitioner's failure to report its change of address to CMS within 30 days. CMS's June 22, 2010 reconsideration decision, instead, focused its determination on Petitioner's non-operational status pursuant to 42 C.F.R. § 424.535(a)(5)(i).

CMS now argues that Petitioner was not providing any of the four core CMHC services since January 2009, and therefore it was no longer operational to furnish Medicare covered services. CMS Br. at 1. In response, Petitioner asserted that it met the definition of operational. 42 C.F.R. § 424.502; P. Br. at 2, 4. Further, Petitioner explains that a CMHC need not render "CMHC-PHP (partial hospitalization program) services at an ever constant pace and timing" but that federal law "requires the facility only to be 'operational' and be ready willing and able to render CMHC Medicare covered services." P. Br. at 2. In addition, Petitioner expressly denied its failure to report its change of address within 30 days and provided CMS's August 24, 2009 letter approving Petitioner's change of address. P. Ex. 7. Petitioner argued that the issue of Petitioner's operational status was raised for the very first time in CMS's June 22, 2010 Reconsideration decision. P. Br. at 3.

During the December 2, 2010 telephone conference, CMS explained that it no longer based the revocation on Petitioner's alleged failure to notify CMS of its change of address within thirty days. In its supplemental brief, CMS argued that Petitioner's procedural due process rights were not violated and cited persuasive authority for the proposition that, after an administrative appeal has been commenced, a federal agency may assert and rely on new or alternative grounds for the challenged action or determination as long as the non-federal party has notice of, and a reasonable opportunity to respond to, the asserted new grounds during the administrative proceeding. *See Green Hills Enters., LLC*, DAB No. 2199 (2008). *See also Abercrombie v. Clarke*, 920 F.2d 1351, 1360 (7th Cir. 1990), *cert. denied*, 520 U.S. 809 (1991) (holding that defects in formal notice may be cured during the course of an administrative proceeding, and due

process is satisfied as long as the party is reasonably apprised of, and given opportunity to address, the issues in controversy); *St. Anthony Hosp. v. Sec'y, Dep't of Health and Human Servs.*, 309 F.3d 680, 708 (10th Cir. 2002) ("To establish a due process violation [in an administrative proceeding] , an individual must show he or she has sustained prejudice as a result of the allegedly insufficient notice.").

Petitioner responded that it was "not contending that CMS deprived Petitioner of its due process rights" based on the faulty revocation letter. Petitioner's Supp. Br. at 2. I am now satisfied that CMS has provided Petitioner with proper notification of its revocation, and, now that Petitioner is not objecting that it had a reasonable opportunity to respond, Petitioner has received due process in this matter.

2. I will accept Petitioner's exhibits into the record before me.

Petitioner has submitted 44 exhibits that may not have been offered to the Hearing Officer during the reconsideration process. The regulation at 42 C.F.R. § 405.874(c)(5) provides that if a provider or supplier fails to provide evidence before the contractor's Hearing Officer issues a decision, the provider or supplier is precluded from introducing new evidence at higher levels of the appeal process. However, an Administrative Law Judge (ALJ) may consider new evidence if the supplier demonstrates good cause for the late submission of the evidence. 42 C.F.R. § 498.56(e). Although Petitioner does not argue due process issues before me, I find that good cause exists to give Petitioner a reasonable opportunity to respond to the asserted new grounds during this administrative proceeding.

Petitioner's exhibits are relevant to my determination of whether a legitimate basis exists to support CMS's determination to revoke Petitioner's Medicare billing privileges. In its supplemental brief, CMS objected to the authenticity of Plaintiff's Exhibits 13, 19, 20, 21, 22, and 24 because Petitioner did not provide these exhibits to the SGS investigators at the time of the on-site investigation, even though the investigators requested them. CMS Supp. Br. at 5-6. CMS also objected to Plaintiff's Exhibit 15 and Plaintiff's Exhibits 25-42 on relevance and materiality grounds because the exhibits are dated after the date of the on-site visit and because the exhibits demonstrate other types of services not included in the four core areas required to qualify as a CMHC. CMS Supp. Br. at 6-7. Considering the defects involving CMS's original revocation notice to Petitioner, I will accept all of Petitioner's exhibits as relevant to the showing of the nature of services Petitioner may have provided. Nevertheless, I may only consider what CMHC core services Petitioner may have been providing up until CMS's on-site visit, and effective

date of revocation, February 18, 2010. Accordingly, I admit P. Exs. 1-44 and CMS Exs. 1-26 into the record.

3. Petitioner was not operational because it was not actively providing all CMHC core services to patients on an ongoing basis.

42 C.F.R. § 424.535 provides:

> (a) *Reasons for revocation*. CMS may revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement or supplier agreement for the following reasons:
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> ***
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> (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.

The parties dispute the interpretation of this regulation. CMS argues that this regulation requires that a CMHC must continue to provide the four cores services listed in 42 U.S.C. § 300x-2(c)(1)(B)-(E) and 42 C.F.R. § 410.2 on an ongoing basis. Petitioner chose not to address its recent dearth of patient care and, instead, asserts that it is enough for a CMHC to be ready and willing to render these four core services, even if it is not providing them currently. P. Br. at 2.

CMS has made a prima facie case that Petitioner was not operational and provided the written direct testimony of SGS Investigators Marisela Garrido and Rebekah Paone that the owner of Petitioner, Ms. Nancy Saavedra, reportedly admitted that the facility had not provided CMHC services since January 2009. CMS Ex. 14, at 3; CMS Ex. 15, at 2.

Ms. Garrido stated that all the medical records she had reviewed were old, dating back to 2008. CMS Ex. 15, at 2. When Ms. Saavedra was specifically asked for more recent records, Ms. Garrido reported that Ms. Saavedra responded that there were no records beyond January 2009 because no services were rendered since that time. *Id.*

Petitioner has not provided the written direct testimony of any of its witnesses, including Ms. Saavedra, to dispute Ms. Garrido's testimony. Also supportive of the investigator's testimony is the fact that Petitioner has not submitted any Medicare reimbursement claims with a date of service to a beneficiary after January 2009. CMS Exs. 23-25. The most recent date of Medicare service that Petitioner provided was January 23, 2009, according to the provider reimbursement database. CMS Ex. 23, at 11.

Petitioner's exhibits also confirm this clear lack of recent patient care with regard to two of the specific CMHC core services. Petitioner Exhibit 23, which is a chart entitled "Claims Billed and Appealed," shows that Petitioner has not provided any partial hospitalization or psychosocial rehabilitation services since January 23, 2009. Petitioner Exhibit 13 entitled "Billing Summary 2009-2010" also shows that the last date of services for partial hospitalization services prior to the February 18, 2010 on-site visit was January 23, 2009, a period of approximately thirteen months before Petitioner's on-site visit and effective revocation date. Petitioner submitted only one exhibit as evidence of actually providing partial hospitalization services. P. Ex. 32. However, it does not assist Petitioner because it is a medical record of purported partial hospitalization services rendered after the on-site visit date of February 18, 2010. The only evidence that Petitioner submitted to show that it provides the core service of screening for patients being considered for admission to State mental health facilities is a screening services agreement with Citrus Health Network. P. Ex. 24.

Prior ALJ decisions have held that a CMHC will not qualify to participate in Medicare if it only establishes that it has the capability to provide the necessary services but fails to establish that it actually provides such services. *See e.g., Grandview Behavioral Health Ctr.*, DAB CR998 (2003); *Psychstar of America*, DAB CR645 (2000), *Counseling and Therapeutics Ctr., L.L.C.*, DAB CR696 (2000). A CMHC must provide all of the services required in the regulation. Allowing facilities that claim to have the capacity to provide the services of a CMHC to participate in Medicare, without actually proving that they are providing the services, would allow entities that are not CMHCs to participate in Medicare. *Grandview Behavioral Health Ctr.*, DAB CR998, at 9 (2003). A facility must provide "active, consistent, and ongoing patient services" to receive Medicare certification as a CMHC. *Comprehensive Behavioral Healthcare*, DAB CR890 (2002).

These requirements are consistent with the State Operations Manual (SOM), CMS's guidance to surveyors and contractors. The SOM provides that a CMHC must provide the core services at the same time of certification, not at some future time. SOM § 2250G. As a precondition to certification, in a three-month period, the CMHC must have served at least ten non-Medicare patients, and, for a minimum of three patients, the records must show that the CMHC provided the core services of screening services for admission to State mental health facilities and day treatment, or other partial hospitalization or psychosocial rehabilitation services. *Id.* Further, a CMHC is expected to continue to provide the core services once it has been approved for Medicare participation. "Providing the [core services] . . . is ongoing and not a one time qualifying event for Medicare participation." *Id.* CMS considers an on-site inspection that reveals the failure of a CMHC to provide two or more of the core services a "most egregious" CMHC program offender suitable for termination. SOM § 2252O.

Considering all of the interpretative guidance from prior ALJ decisions and the SOM, I find it reasonable for CMS to have concluded, when CMS decided to uphold Petitioner's revocation, that Petitioner was not operational with regard to the CMHC core service of partial hospitalization services, or psychosocial rehabilitation services, because it had not provided any relevant patient treatment within approximately thirteen months of the on-site visit. Further, with regard to the other required CMCH core service of patient screening, I find it is not enough to establish operational status by only showing agreements to provide this service without showing any recent patient treatment, or any patient treatment at all, as the case was here. I see no need to make any judgment on the efficacy of the agreements themselves without any treatment records. Considering Petitioner has not made an acceptable showing that it provided the other core CMHC services, and considering that a CMHC is required to provide all four core areas of service, I decline to determine whether Petitioner was providing outpatient services[2] and 24-hour a day emergency care services, as it would be immaterial to the outcome of this decision. Further, I deny Petitioner's request to cross-examine one of the SGS investigators. Despite her testimony, the undisputed and determinative fact remains that, at the time of the on-site visit, Petitioner had not provided patient services in two of the four CMHC core service areas since, at latest, January 2009.

[2]This was the one CMHC core service area for which Petitioner appears to have provided actual treatment records within a relevant time period. P. Exs. 19-20.

V. **Conclusion**

I sustain CMS's determination to revoke Petitioner's billing privileges on the basis that it was not operational as a CMHC because it was not actually providing all required core services to patients.

/s/
Joseph Grow
Administrative Law Judge