Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Courtney Home Care Services,

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-11-90

Decision No. CR2330

Date: March 2, 2011

DECISION

This matter is before me on the Centers for Medicare & Medicaid Services (CMS) "Motion for Dismissal and/or Summary Disposition" filed January 13, 2011. Below, I AFFIRM the termination of Petitioner, Courtney Home Care Services, from participation in the Medicare program as a home health agency.

I. Background

Petitioner is a provider of home health services and is located in Chatsworth, California. On April 23, 2010 (April survey), the California Department of Public Health (state agency) completed a recertification survey that found that Petitioner was not in compliance with five conditions of participation (CoPs) in the Medicare program, set out at 42 C.F.R. Part 484, specifically 42 C.F.R. §§ 484.14, 484.18, 484.30, 484.48, and 484.55. Following Petitioner's allegation that it had corrected the deficiencies and was in compliance with the CoPs, the state agency completed a follow-up survey on June 19, 2010 (June survey). The June survey found that Petitioner remained out of compliance with all five CoPs, and that it also had failed to correct deficiencies identified during the April survey. CMS determined that the deficiencies, when considered within the context

of the CoPs to which they related, either individually or in combination, substantially limited Petitioner's ability to render adequate care or adversely affected patient health and safety, establishing a basis under 42 C.F.R. § 488.24(b) to conclude the CoPs were not met. Documentation of the repeat deficiencies established a separate and distinct basis for termination. 42 C.F.R. §§ 488.28, 489.53. CMS Exhibits (CMS Exs.) 1-3.

Petitioner requested a hearing by letter dated November 8, 2010. Petitioner stated that it did not dispute the specific findings of the survey, but disagreed with the sampling method used by the state agency. Petitioner asserted that the "predominant findings and deficiencies" were from a review of patient charts where the patients identified were treated by only one of Petitioner's nurses, and that "while [Petitioner] do[es] not question the specific findings of the survey, we believe that to find an agency in substantial compliance should include the review of charts and cases of other patients under other nurses' care . . . ." Petitioner also noted:

> While it is not our contention that the agency would receive a deficiency free survey it is our contention that if the survey had been more balanced rather than focusing on one nurse primarily, the agency would have been found to be in substantial compliance and that the five conditions of participation would have been found to be more reasonably in substantial compliance.

The case was assigned to me for hearing and decision on November 15, 2010. CMS filed its motion to dismiss and/or motion for summary disposition on January 13, 2011, accompanied by four exhibits. Petitioner filed a response on February 14, 2011, unaccompanied by exhibits. In the absence of objection, I admit CMS Exs. 1-4.

II. Issues

The issues before me are:

> Whether Petitioner's hearing request should be dismissed pursuant to 42 C.F.R. § 498.40(b);
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> Whether Petitioner was in substantial compliance with Medicare participation requirements;
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> Whether summary disposition is appropriate; and
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> Whether there is a basis to terminate Petitioner's provider agreement.

III. Applicable Law

The Social Security Act (Act) defines a home health agency to be a public agency or private organization that provides skilled nursing and other health care services to patients in their homes. Act, § 1861(o). The Act sets forth requirements for home health agencies participating in Medicare and Medicaid. The Secretary of Health and Human Services (Secretary) is authorized to promulgate regulations implementing the statutory requirements. Act, §§ 1861(m) and (o), and 1891.

The regulations covering home health services are found in 42 C.F.R. Part 484, and set forth CoPs and subparts to the CoPs called standards of participation. A home health agency may provide services in the Medicare program if it meets the statutory definition and complies with the CoPs. Act, §§1861(o), 1891; 42 C.F.R. Part 484; 42 C.F.R. § 488.3. State agencies survey home health agencies to determine if they are in compliance with the CoPs. 42 C.F.R. §§ 488.10, 488.11, 488.12, 488.18-488.28. Compliance with a CoP is determined by the manner and degree to which the provider satisfies the standards within the condition. 42 C.F.R. § 488.26(b); *Aspen Grove Home Health*, DAB No. 2275 (2009); *CSM Home Health Services,* DAB No. 1622 (1997). If standard-level deficiencies are of such character as to substantially limit a provider's capacity to furnish adequate care or adversely affect the health and safety of patients, a provider is not in compliance with a CoP and that non-compliance is a basis for CMS to terminate a provider agreement. 42 C.F.R. § 488.24(b).

The regulations provide that a hearing request must "Identify the specific issues, and the findings of fact and conclusions of law with which the affected party disagrees; and . . . Specify the basis for contending that the findings and conclusions are incorrect." 42 C.F.R. § 498.40(b)(1)-(2). A hearing request may be dismissed if the party requesting the hearing does not have a right to a hearing or if the affected party did not file a timely hearing request and the time for filing a hearing request has not been extended. 42 C.F.R. § 498.70(b) and (c).

An appellate panel of the Departmental Appeals Board (Board) recited the standard for summary disposition or judgment in the case of *Senior Rehabilitation and Skilled Nursing Center*, DAB No. 2300, at 2 (2010), *aff'd, Senior Rehabilitation and Skilled Nursing Center v. Health & Human Services*, No. 10-60241 (5th Cir. Dec. 20, 2010). It stated that summary judgment is appropriate where the record shows that there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law. The party moving for summary judgment bears the initial burden of showing that there are no issues of material fact for trial and that it is entitled to judgment as a matter of law. To defeat an adequately supported 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 – a fact that, if proven, would affect the outcome of the case under governing law. In determining whether there are genuine issues of material fact,

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. In *Holy Cross Village at Notre Dame, Inc.*, DAB No. 2291, at 5 (2009), the Board stated that the role of an Administrative Law Judge (ALJ) in deciding a summary judgment motion differs from the ALJ's role in resolving a case after hearing. In that context, an ALJ should not assess credibility or evaluate the weight of conflicting evidence.

IV. Findings and Discussion

My findings are noted below, in bold, and are followed by my discussion of each finding.

1. Summary disposition is appropriate.

Below, I find no material facts in dispute and that summary disposition is appropriate.

Further, because I decide the case on CMS's motion for summary disposition and decide the case on the merits, I do not address CMS's argument that the case should be dismissed because Petitioner's hearing request does not meet the content requirements of 42 C.F.R. § 498.40(b).

2. CMS is authorized to terminate Petitioner's provider agreement.

CMS correctly points out that Petitioner does not dispute the findings of the April or June surveys. Instead, CMS notes that Petitioner argues only that it disagrees with the sampling method used by the state agency, because the survey focused primarily on the conduct of one of its many nurses. CMS asserts that Petitioner's argument is that had the surveyors reviewed other nurses' charts, Petitioner would have been found in substantial compliance. CMS argues that by making this argument, "In essence, Petitioner is alleging surveyor bias . . . ." CMS asserts that Petitioner has no evidence to support surveyor bias, nor could such a claim be relevant to the deficiencies Petitioner has not disputed. Because Petitioner admits that it does not dispute the specific findings of the surveys, and because Petitioner has failed to challenge or contradict any of the documented findings of non-compliance set forth in the April and June statements of deficiencies, CMS argues that summary disposition is appropriate.

In its response to CMS's motion, Petitioner states that it is not accusing the state agency of bias or asserting that the surveyors' actions constitute misconduct. It also states that it accepts CMS's representation that the sampling methods utilized by the state agency are

appropriate.[1] Petitioner admits that "specific clinical documentation was not available in the patient's chart during the time of survey." Petitioner admits that "documentation should have been readily available" and that "documentation was not available to the surveyors during their time of survey."[2] Petitioner admits that it "does not dispute that the conditions of participation that were not met **based solely upon eleven patients cared for by one single nurse could justify a finding that the conditions were not met.**" (emphasis in original). Petitioner acknowledges that it is not asserting that documentation is not important or not required by regulation or that it is not responsible for the actions of each of its employees. Petitioner admits that "the eleven patients that were cared for primarily by one nurse did create the indicated deficiencies." Petitioner's admissions fully support and confirm CMS's assertion that Petitioner has not contested the deficiency citations from the April and June surveys. Those admissions by Petitioner also support and confirm my finding that there are no disputed issues of material fact as to any of the citations before me.

Petitioner does offer reasons or explanations why it was deficient and also makes reference to its history of compliance. Petitioner notes it has been in business since before 1956; that it passed certification surveys without a complaint investigation from 1996 to 2010 (its last survey occurred in 2007); and that between 2007 and 2010 its 40 nurses provided care to more than 300 patients. It argues that, in contrast, the June survey sampled a total of 15 patients, 11 of whom were under the primary care of one nurse and that such a small sample does not provide an accurate picture of its agency. Petitioner asserts that the nurse in question was competent and qualified, that she saw Petitioner's patients for only a three-month period, and that her actions were "puzzling" to Petitioner. Petitioner touts the quality of its care, noting that it has provided care to patients with very complex needs and that it is referred patients by a local hospital, and by its other patients, because of the quality of care it is known to provide.

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[1] Petitioner does note that it believes that a policy that allows "such a limited and targeted review to determine the ultimate fate of an agency that has been in business for many years without incident or complaint . . . [is] ultimately unfair. . . ." Petitioner acknowledges that its dispute in this regard is with the Department's policies, not with the deficiency determination here. I have not been delegated authority to find invalid or review such policies. 42 C.F.R. Part 498; s*ee* 42 C.F.R. § 1005.4(c)(1).

[2] Petitioner notes that while it does not dispute that the documentation should have been readily available, its chart audits indicate that 24 hours before the survey "some" of the documents were present. Petitioner also states it "is not the purpose of this appeal to determine what did or did not happen" to the documents. As Petitioner does not explain the missing documentation, and admits that the documentation was not readily available during the survey, its argument does not rise to a disputed issue of material fact.

Petitioner argues that the issue here should be seen very broadly, and that the broad question should be whether it was in "substantial compliance" with the CoPs, not whether it was specifically deficient in complying with their particular terms and requirements. Petitioner notes the definition of "substantial compliance," set forth at 42 C.F.R. § 488.301, which is "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." Petitioner asserts such substantial compliance constitutes compliance with participation requirements and that since no harm occurred to its patients and there was no pattern of non-compliance (as the documentation errors were committed principally by one nurse) Petitioner was in compliance with the CoPs. Petitioner argues that given its compliance with the CoPs over a multi-year period, it should not be decertified solely based upon an "isolated sampling of the overall agency performance."

The definition of substantial compliance Petitioner refers to is found in the regulations governing the survey and certification of long-term care facilities, not home health agencies. Those regulations and that definition are inapplicable to home health agencies. A home health agency is no longer in compliance with the CoPs when a provider's deficiencies "are of such character as to substantially limit the provider's or supplier's capacity to furnish adequate care or which adversely affect the health and safety of patients." 42 C.F.R. § 488.24(b). In reviewing the April and June surveys, the content of which Petitioner does not dispute, I note that for the deficiency at 42 C.F.R. § 484.30 (skilled nursing services), CMS asserts that a registered nurse failed to prepare clinical progress notes for patients, a practice that could potentially cause non-communication or miscommunication among the agency staff involved in the care of a patient regarding the patient's current medical status. CMS Ex. 1, at 46; CMS Ex. 2, at 43. The failure to prepare such notes certainly affects Petitioner's capacity to furnish adequate care, as the patient's medical status and care needs would not be clear to anyone reviewing the patient's record. Moreover, even under the definition of "substantial compliance" relied on by Petitioner, there is certainly a risk of more than minimal harm in this one cited deficiency violation alone, among many other admitted deficiency citations.

Petitioner seeks the opportunity to reestablish itself as a Medicare provider and would like an "equitable solution" in order to become a Medicare provider again. My authority is limited to deciding whether CMS had a basis to terminate Petitioner's provider agreement. I have no authority over when, or how, Petitioner might reestablish itself as a Medicare provider.

V. Conclusion

For the reasons set forth above, CMS's motion for summary disposition must be, and it is, GRANTED. CMS was authorized to terminate Petitioner's participation in the Medicare program as a home health agency.

/s/
Richard J. Smith
Administrative Law Judge