Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Health Connect at Home
(Provider No. 28-7011),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-11-165

Decision No. CR2371

Date: May 18, 2011

DECISION

Petitioner, Health Connect at Home, appeals an October 28, 2010 reconsideration decision. 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

Petitioner is a home health agency located in Kearney, Nebraska, with a branch office located in Broken Bow, Nebraska. Around July 1, 2009, as part of a corporate restructuring, Petitioner underwent a change of ownership whereby the home health business of Good Samaritan Hospital was consolidated into a new entity, and Petitioner took over both the Kearney and Broken Bow offices. P. Br. at 1; P. Ex. 28, at 1 (Martin Aff.). Cahaba GBA (Cahaba), the Medicare contractor, received Petitioner's information update on form CMS-855A regarding this change of ownership on August 6, 2009, and Cahaba acknowledged the change of ownership request on April 13, 2010. CMS Ex. 1, at 1. On July 9, 2010, CMS informed Petitioner that it would send a new provider agreement following a determination that Petitioner met the ownership disclosure and civil rights requirements. CMS Ex. 1, at 3-4; P. Ex. 13, at 1.

According to Petitioner, until the week of April 20, 2010, Petitioner's Kearney office was located at 5 West 31st Street. P. Br. at 1; P. Ex. 29, at 1 (Jones Aff.). Petitioner claims that, during the change of ownership process, a reconstruction project began that involved the demolition of the building at 5 West 31st Street. P. Br. at 2; P. Ex. 30, at 2 (Surmeier Aff.). This construction project caused Petitioner to move to 1755 Prairie View Place in Kearney. *Id*. Petitioner began operating its Kearney office out of the 1755 Prairie View Place location in late April 2010. *Id*. Also, when Petitioner submitted the change of ownership request to the CMS contractor, Petitioner's Broken Bow branch office was located at 145 Memorial Drive in Broken Bow, Nebraska. P. Br. at 6. Petitioner claims that it moved this office location to 420 South 10th Avenue in Broken Bow around February 24, 2010 and reported this change of address to the State of Nebraska[1] but did not report the change to CMS until August 24, 2010. P. Br. at 6; P. Exs. 17 and 18.

On July 21, 2010, Petitioner's Director of Homecare, Marjorie Jones, received a phone call from Diana Moran, a nurse consultant for the division of survey and certification of CMS. P. Br. at 3. Ms. Moran explained that she had sent the July 9, 2010 letter regarding the reassignment of the provider agreement to Petitioner at its CMS address of record at 5 West 31st Street in Kearney, and the letter came back to CMS as undelivered with no forwarding address. *Id*. Ms. Moran then asked Ms. Jones where she should resend the letter, and, because Petitioner "had just moved to a new address and Ms. Jones was not sure if mail could be received at the 1755 Prairie View Place address yet, Ms. Jones explained to Ms. Moran that she should send her correspondence to 10 East 31st Street in Kearney, which is an address for Good Samaritan Hospital." P. Br. at 3-4; P. Ex. 29, at 2-3.

CMS then sent a letter to Petitioner at the 10 East 31st Street address stating that its previous letter was returned as not deliverable and informing Petitioner that it needed to submit a CMS-855A that includes a notification of the change in address. P. Ex. 14. Subsequently, on July 31, 2010, a Cahaba investigator attempted an on-site review of Petitioner's location at 5 West 31st Street in Kearney but found that the building had been demolished. CMS Ex. 4, at 1 (Gordon Aff.). The investigator also attempted to conduct the on-site review at the 10 East 31st St. address. In addition, the Cahaba investigator attempted to visit the two addresses for Petitioner in Broken Bow and found that Melham Medical Center occupied the 145 Memorial Drive address. In addition, the signage at the 420 South 10th St. address indicated Good Samaritan Hospital Homecare occupied it. P. Br. at 6; CMS Ex. 3, at 2; CMS Ex. 4, at 2.

After the unsuccessful attempts at site visits, on August 13, 2010, Cahaba sent Petitioner a notice of revocation of Medicare billing privileges and informed Petitioner of CMS's intent to terminate Petitioner's provider agreement. The notice letter stated that

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[1] Petitioner explains its lease erroneously shows the address as 404 South 10th Avenue, and this is the address it supplied to the State of Nebraska.

Petitioner was "no longer operational to furnish Medicare covered items or services" in violation of 42 C.F.R. § 424.535(a)(5), based on the fact that Petitioner's home health agency office in Kearney and branch office in Broken Bow were not located at the reported addresses during on-site visits, and Petitioner failed to submit CMS-855A forms for a change of address. P. Br. at 7; CMS Ex. 1, at 10.

Petitioner submitted a reconsideration request and corrective action plan (CAP) to CMS in response to the notice of revocation. P. Ex. 27. The CAP provided an explanation of the Kearney and Broken Bow office address changes. *Id*. The CAP stated that Petitioner provided Cahaba a letter and form CMS-855A informing CMS of the office location change to 1755 Prairie View Place, Kearney Nebraska on August 10, 2010. P. Br. at 4; P. Ex. 16; P. Ex. 27, at 2, 16-25. The CAP also indicated that, on August 24, 2010, Petitioner sent a CMS-855A to Cahaba, informing CMS of the change in location of the Broken Bow branch office. P. Br. at 6; P. Ex. 18; P. Ex. 27, at 2, 64-73.

On September 30, 2010, CMS issued a reconsideration decision, which denied the CAP and affirmed the decision to revoke Petitioner's Medicare billing privileges. CMS Ex. 1, at 12-14. CMS issued a corrected reconsideration decision on October 28, 2010. CMS Ex. 1, at 15-17.

Petitioner filed a timely hearing request with the Civil Remedies Division of the Departmental Appeals Board to appeal the reconsideration decision. I issued an Acknowledgment and Pre-hearing Order, and in accordance with that order, CMS filed a Brief and Motion for Summary Judgment (CMS Br.), accompanied by four exhibits (CMS Exs. 1-4). Petitioner filed its Pre-Hearing Brief and Response to CMS's Summary Judgment Motion (P. Br.), accompanied by 32 exhibits (P. Exs. 1-32). In the absence of objection, I receive into the record of this case CMS Exs. 1-4 and P. Exs. 1-32.

II. Applicable Law

Federal regulations articulate specific requirements regarding the reporting of any changes to enrollment with which certain providers, including home health agencies, must comply. 42 C.F.R. § 424.516(e). CMS requires that a home health agency must report to CMS any change to enrollment address within 90 days. *See* 42 C.F.R. § 424.516(e)(2).

Also, CMS may perform onsite review of a provider to verify that the enrollment information submitted to CMS or its agents is accurate and to determine compliance with Medicare enrollment requirements. 42 C.F.R. § 424.517(a). The regulation further states:

> Based upon the results of CMS's onsite review, the provider may be subject to denial or revocation of Medicare billing privileges as specified in . . .

§ 424.535 of this part.

(1) *Medicare Part A providers.* CMS determines, upon on-site review, that the provider meets either of the following conditions:

(i) Is unable to furnish Medicare-covered items or services.
(ii) Has failed to satisfy any of the Medicare enrollment requirements.

42 C.F.R. § 424.517(a).

Furthermore, 42 C.F.R. § 424.535 provides that a provider's Medicare enrollment and billing privileges may be revoked 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.

42 C.F.R. § 424.535(a)(5)(i).

III. Issue, Findings of Fact, Conclusions of Law

A. Issue

The sole issue in this case is whether CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(5).

B. Applicable Standard

The Departmental Appeals Board (Board) stated the standard for summary judgment:

> Summary judgment is appropriate when 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 genuine issues of material fact for trial and that it is entitled to judgment as a matter of

> law. . . . To defeat an adequately supported summary judgment 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 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.

Senior Rehab. & Skilled Nursing Ctr., DAB No. 2300, at 3 (2010) (citations omitted). 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 a hearing. The ALJ should not assess credibility or evaluate the weight of conflicting evidence. *Holy Cross Vill. at Notre Dame, Inc.*, DAB No. 2291, at 5 (2009). The Board has further stated, "[i]n addition, it is appropriate for the tribunal to consider whether a rational trier of fact could regard the parties' presentation as sufficient to meet their evidentiary burden under the relevant substantive law." *Dumas Nursing and Rehab., L.P.*, DAB No. 2347, at 5 (2010).

Neither party alleges that any material facts are in dispute, and they debate only whether CMS had the authority under those facts to revoke Petitioner's enrollment and billing privileges. Accordingly, summary judgment is appropriate.

C. Findings of Fact and Conclusions of Law

My sole finding and conclusion is in the italicized heading supported by the subsequent discussion below.

> ***CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges because Petitioner was not in compliance with the applicable regulations.***

Petitioner admits moving its Kearney office around April 20, 2010 but not reporting this change in location to CMS until August of 2010. P. Br. at 2-4; P. Ex. 16; P. Ex. 27, at 2, 16-25; P. Ex. 30. Petitioner concedes that "[f]rom its move in April 2010, up to and including the date of the site visit . . . on July 31, 2010, and thereafter, [Petitioner] operated out of its Kearney office located at 1755 Prairie View Place, Kearney Nebraska." *See* P. Br. at 4; *see also* P. Exs. 29, 31, 32. Yet, in July of 2010, Petitioner reported to the CMS contractor that it was unsure it could receive mail at the new Kearney address. P. Br. at 3-4; P. Ex. 29, at 2-3. Regarding the Broken Bow location, Petitioner claims it moved its office around February 24, 2010 and reported this change of address to the State of Nebraska but did not report the change to CMS until August 24, 2010. P. Br. at 6; P. Exs. 17 and 18. Petitioner also concedes it did not have a sign for the Broken Bow facility until August 26, 2010. P. Br. at 6-7; P. Exs. 20, 21, 28.

Petitioner concedes it did not report either address change within the 90 day regulatory deadline and was non-operational at the addresses on file with CMS at the time of the July 31, 2010 on-site review. Petitioner's defense is that it was precluded from reporting a change of address pending CMS's response and assignment of the Medicare provider agreement relating to Petitioner's change of ownership request. P. Br. at 14. Petitioner cites no legal authority for this proposition, and I am aware of no regulation or other authority that excuses the reporting requirements regarding changes to enrollment information pending the approval of a change of ownership request. In fact, the CMS State Operations Manual (SOM) instructs the Medicare contractor to specifically consider whether an address change or relocation is permissible with a concurrent change of ownership request depending on whether the provider is serving clients in the same geographical with the same employees. SOM § 3210.10B 5.

Petitioner supports its argument by referencing a portion of a CMS exhibit consisting of email exchanges between CMS and Cahaba employees (CMS Ex. 1, at 20-25). Petitioner did not learn of these emails until it received CMS's pre-hearing exchange in February of 2011 and clearly did not rely upon these emails before Petitioner's Medicare enrollment and billing privileges were revoked pursuant to 42 C.F.R. § 424.535(a)(5) for failure to comply with Medicare reporting and enrollment requirements. Despite an apparent intra-agency discussion of this issue, there is no indication in the record that the Medicare contractor advised Petitioner not to file a change of address pending the approval of a change of ownership request. And even if Petitioner were so advised, estoppel against the federal government, if available at all, is presumably unavailable absent "affirmative misconduct." *See, e.g., Pacific Islander Council of Leaders*, DAB No. 2091, at 12 (2007); *Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414, 421 (1990); *Huron Potawatomi, Inc.*, DAB No. 1889, at 5 (2003) (holding allegation that incorrect advice was provided was not to be evidence of affirmative misconduct).

Petitioner concedes that it was not operational at either office location on record with CMS on July 31, 2010, the time of the on-site review. P. Br. at 2-6. However, Petitioner maintains that it was operational at both locations at new addresses that it reported to the State of Nebraska Department of Health and Human Services. P. Br. at 3, 6, 8-9. For purposes of summary judgment, I will presume this information to be true. Petitioner still, however, was not in compliance with federal reporting requirements. 42 C.F.R. §§ 424.516(e)(2), 424.517(a)(1)(ii), and 424.535(a)(5)(i). CMS correctly determined that Petitioner failed to satisfy all of the Medicare enrollment requirements because Petitioner was not physically present at the addresses of record with CMS at the time of the on-site review, and Petitioner failed to report these changes in enrollment information within 90 days as is required by law.

IV. Conclusion

For the reasons explained above, I sustain CMS's determination to revoke Petitioner's Medicare billing privileges.

/s/

Joseph Grow
Administrative Law Judge