Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
TEHC, LLC,	)	Date: April 14, 2009
(CCN: 10-7790),	)	
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-08-719
	)	Decision No. CR1941
Centers for Medicare & Medicaid	)	
Services.	)	
	)	

DECISION

Petitioner, TEHC, LLC (Petitioner or TEHC), is a home health agency (HHA) located in Fort Lauderdale, Florida. Until its termination on August 6, 2008, TEHC was certified to participate in the Medicare program. Following a survey completed May 8, 2008, the Centers for Medicare and Medicaid Services (CMS) terminated TEHC's program participation because it failed to maintain substantial compliance with five conditions of participation. Petitioner here challenges its termination, and CMS moves for summary judgment.[1]

For the reasons discussed below, I find that summary judgment is appropriate. Petitioner does not challenge CMS's determination that it was not in substantial compliance with all Medicare conditions of participation at the time of its survey, and CMS was therefore authorized to terminate its Medicare provider agreement.

[1] With its motion CMS filed a brief (CMS Br.) and eight proposed exhibits (CMS Exs. 1-8). Petitioner has filed a response (P. Response), brief (P. Br.) and ten proposed exhibits (P. Exs. 1-10).

Discussion

A. CMS is entitled to summary judgment because the undisputed facts establish that TEHC failed to maintain substantial compliance with all Medicare conditions of participation, and CMS is therefore authorized to terminate is program participation.[2]

Summary judgment is appropriate here because this case turns on a question of law and presents no genuine dispute as to any material fact. *Anderson v. Liberty Lobby*, 477 U.S. 242, 247-48 (1986); *Livingston Care Center v. United States Department of Health and Human Services*, 388 F. 3d 168, 173 (6th Cir. 2004).

An HHA is a public agency or private organization that "is primarily engaged in providing skilled nursing services and other therapeutic services" to patients in their homes. Social Security Act (Act) section 1861(o). It may participate in the Medicare program as a provider of services if it meets that statutory definition and complies with certain requirements, called conditions of participation. Act, sections 1861(o), 1891; 42 C.F.R. Part 484; 42 C.F.R. § 488.3. On the other hand, CMS, acting on behalf of the Secretary of Health and Human Services, may terminate a provider agreement based on the provider's failure to comply with provisions of section 1861 or the regulations governing its program participation. Act, section 1866(b)(2); 42 C.F.R. § 489.53(a)(1).

Here, on May 8, 2008, the Florida Agency for Health Care Administration (State Agency) completed a recertification survey. CMS Ex. 1. Based on the survey findings, CMS determined that TEHC was not in substantial compliance with five conditions: 42 C.F.R. § 484.10 (patient rights); 42 C.F.R. § 484.18 (acceptance of patients, plan of care, and medical supervision); 42 C.F.R. § 484.30 (skilled nursing services); 42 C.F.R. § 484.48 (clinical records); and 42 C.F.R. § 484.55 (comprehensive assessment of patients).

Petitioner has not challenged the May 2008 survey findings. Its hearing request focuses solely on the HHA's efforts to complete and submit an acceptable plan of correction and to make "substantial changes to its operation in order to comply with federal requirements." CMS Ex. 7; *see also*, P. Ex. 8 (Nord Decl.).

When a provider's Medicare participation is terminated because of alleged noncompliance, "the critical date for establishing compliance is the survey date, not the subsequent effective date of the termination." *Carmel Convalescent Hospital*, DAB No. 1584, at 12 (1996); *Rosewood Living Center*, DAB No. 2019, at 11 (2006). A provider's efforts to bring itself into compliance after the date of the resurvey are "completely

[2] My findings of fact and conclusions of law are set forth, in italics and in bold, in the discussion captions.

irrelevant to the facility's appeal of [CMS's] determination to terminate." *Carmel*, DAB No. 1584, at 13.[3]

The Board in *Carmel* noted that a provider's participation is determined by means of a state survey. Inasmuch as a facility entering the program may participate no earlier than the date on which the onsite survey establishes compliance (42 C.F.R. § 489.13(a)), its participation is terminated based on the findings at the time of the survey. The regulations require CMS to rely on the survey agency's finding which "necessarily relate to the status of the facility as of the date of the survey." The Board also pointed out that, as a practical matter, relying on a date after the survey "could cause a never-ending cycle of resurveys based on unsubstantiated claims of compliance by a facility as of the later date." *Carmel*, DAB No. 1584, at 13.

Because Petitioner does not dispute that it was not in substantial compliance with all conditions of participation on the date of the survey, CMS had the authority to terminate its Medicare participation, and is entitled to summary judgment.

B. Petitioner is not entitled to an opportunity to correct.

In reaching this decision, I recognize CMS's discretion to afford providers an opportunity to correct deficiencies prior to termination. *See*, 42 C.F.R. § 488.28 (A deficient provider may continue to participate only if the facility has "submitted an acceptable plan of correction for achieving compliance within a reasonable time.") Here, CMS afforded Petitioner such an opportunity. However, because CMS is not required to afford a provider the opportunity to correct a condition-level deficiency before terminating its program participation, Petitioner's claims to have submitted an acceptable plan of correction are simply irrelevant.[4] *See, Community Home Health*, DAB No. 2134, at 14 (2007); *Excelsior Health Care Services, Inc.*, DAB No. 1529, at 6-7 (1995).

Finally, I note that, although Petitioner submitted two plans of correction (a plan and a revised plan), CMS rejected the first as unacceptable and the second (submitted the day after termination) as untimely, so TEHC was not afforded a follow-up survey. CMS Exs. 2, 4, 5. Petitioner bases this appeal on CMS's refusal to accept its revised plan of

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[3] *Carmel* involved a long-term care facility (SNF/NF), whose governing rules are not completely identical to those of other providers (*compare, e.g*. 42 C.F.R. § 488.28 *with* 42 C.F.R. § 488.402). However, as I explained in an earlier decision, the Board based its conclusions on rules applicable to all providers. *Therapy Management Services, Inc. d/b/a CompRehab*, DAB CR1892, at 4-5 (2009).

[4] I note that Petitioner has not even alleged that it achieved substantial compliance prior to the termination date; it only claims to have submitted a corrective action plan that CMS should have considered. P. Br. at 5.

correction. But, notwithstanding the considerable time the parties have dedicated to the merits of CMS's determination to reject TEHC's revised plan, that determination is wholly within CMS's discretion and I simply have no authority to review it.

A provider dissatisfied with an initial determination – which includes the termination of a provider agreement in accordance with section 489.53 – may request a hearing, and hearings are conducted in accordance with procedures set forth in 42 C.F.R. Part 498. 42 C.F.R. §§ 498.5, 489.53(e). Only initial determinations are appealable. The regulations list actions that are initial determinations and thus subject to appeal. The determination to reject a provider's plan of correction is not listed as an initial determination and is therefore not reviewable in this forum. 42 C.F.R. § 498.3(b); *On-Call Nursing of Alaska*, DAB CR1142, at 3-4 (2004); *see also*, *HRT Laboratory*, DAB No. 2118, at 11 (2007) (same reasoning applied to a clinical laboratory); *Hermina Traeye Memorial Nursing Home*, DAB No. 1810, at 13 (2002) (In affirming the termination of a SNF, "ALJ properly concluded that he lacked authority to adjudicate the question of whether [CMS] abused its discretion in deciding to reject the POC.")

Conclusion

Because no one disputes that, at the time of its May 2008 survey, TEHC was not in substantial compliance with Medicare conditions of participation, CMS was authorized to terminate its provider agreement. I therefore grant CMS's motion for summary judgment.

/s/
Carolyn Cozad Hughes
Administrative Law Judge