Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

I & S Healthcare Services, LLC
Docket No. A-13-42
Decision No. 2519
June 24, 2013

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

I & S Healthcare Services, LLC, (I & S), a home health agency, appeals the March 5, 2013 decision by an administrative law judge (ALJ), *I & S Healthcare Services, LLC*, DAB CR2715 (2013) (ALJ Decision). The ALJ affirmed the determination by the Centers for Medicare & Medicaid Services (CMS) to revoke I & S's enrollment in Medicare effective March 23, 2012. The ALJ determined that CMS had a legal basis to revoke I & S's enrollment because I & S was not "operational" to furnish Medicare items or services within the meaning of the applicable regulations.

For the reasons discussed below, we affirm the ALJ Decision.

Legal Background

To participate in Medicare, a home health agency must enroll in the program. 42 C.F.R. § 424.500; 42 C.F.R. § 400.202 (defining Medicare "provider" to include a home health agency). Once enrolled, a home health agency has "billing privileges" — that is, the right to claim and receive Medicare payment for services provided to Medicare beneficiaries. 42 C.F.R. §§ 424.502, 424.505.

CMS regulations in 42 C.F.R. Part 424, subpart P, set out the requirements for establishing and maintaining Medicare billing privileges. Section 424.510(d)(6) states that a provider "must be operational to furnish Medicare covered items or services . . . ." CMS may perform an "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). CMS may use the results of an onsite review to support a decision to revoke a provider's enrollment. *Id.*

Section 424.535 lists the bases on which CMS may revoke a provider's Medicare billing privileges and provider agreement. 42 C.F.R. § 424.535(a). Section 424.535(a)(5)(i) provides that "CMS may revoke" a provider's Medicare billing privileges and provider

agreement when "CMS determines, upon on-site review" that the provider "is no longer operational to furnish Medicare covered items or services . . . ." Section 424.502 defines the term "operational" to mean--

> the provider or supplier has a qualified physical practice location, is open to the public for the purpose of providing health care related services, is prepared to submit valid Medicare claims, and is properly staffed, equipped, and stocked (as applicable, based on the type of facility or organization, provider or supplier specialty, or the services or items being rendered), to furnish these items or services.

Revocation results in the termination of the Medicare provider agreement as well as a bar on re-enrollment for a minimum of one year, but no more than three years. Section 424.535(b)-(c).

A provider may appeal a determination by CMS to revoke its Medicare enrollment using the procedures in 42 C.F.R. Part 498. A provider must first ask CMS for "reconsideration" of the initial revocation determination. 42 C.F.R. §§ 498.5(1), 498.22. A provider dissatisfied with the reconsideration determination may request a hearing before an ALJ, then seek Board review of an unfavorable ALJ decision. 42 C.F.R. §§ 498.40, 498.80.

Case Background

The following facts, drawn from the record and the ALJ Decision, are undisputed. In February 2012, CMS suspended I & S's Medicare billing privileges based on a suspicion of fraud. In response, I & S submitted a corrective action plan (CAP).[1] CMS approved I & S's CAP and reinstated its billing privileges in April 2012.

On Thursday, June 7, 2012, at 12:00 p.m., an inspector from a Medicare contractor, Palmetto GBA (Palmetto), arrived at I & S's offices at 2646 South Loop West #370, Houston, Texas, to conduct an onsite visit. CMS Ex. 3. The inspector found the office closed and two posted signs. One sign read: "I & S Healthcare Services, LLC, 713-838-2005, Business Hours: 9am – 5pm, Mon – Fri, Closed All Holidays, Closed Sat & Sun, No Soliciting." CMS Ex. 5. The other sign read:

I & S HEALTHCARE SERVICES LLC
THIS IS NOTICE OF VOLUNTARY
SUSPENSION OF NORMAL BUSINESS OPERATIONS

[1] Under section 424.535(a)(1), a provider has an opportunity to correct a deficient compliance requirement before a final determination to revoke billing privileges is issued, except where the revocation is for the reasons described in paragraphs (a)(2), (a)(3), or (a)(5). The revocation here is under paragraph (a)(5).

EFFECTIVE
MARCH 23, 2012
TO OCTOBER 1, 2013
ADMINISTRATION

Id. The inspector filled out a "site verification survey form" indicating that I & S was not open for business and did not appear to have employees or staff present. The completed form also indicated that there did not appear to be signs of customer activity present and the facility did not appear to be operational – that is, it did not appear to be open to the public for the purpose of providing health care related services, did not appear to be prepared to submit valid Medicare claims, and did not appear to be properly staffed, equipped, and stocked to furnish health care services. CMS Ex. 3.

On July 24, 2012, CMS, through Palmetto, issued an initial determination to revoke I & S's Medicare billing privileges and provider agreement pursuant to section 424.535(a)(5)(i), effective March 23, 2012, on the ground that I & S was "non operational." CMS Ex. 4.

On September 11, 2012, I & S submitted a request for reconsideration of the initial determination. I & S stated in its reconsideration request, "Due to the suspension of billing privileges [in February of 2012, I & S] stopped admitting patients or in any other way providing services to Medicare beneficiaries. All contracts with providers were suspended as well." P. Ex. 2, at 1. I & S further explained, "The suspension of services prompted [it] to place the notice . . . indicating the timeframe during which the agency would be closed." *Id.* I & S also stated that "even though the billing privileges had been reinstated" in April 2012, its "owners concentrated their efforts in complying with their obligations under the approved [CAP] to conduct an audit of all the medical and billing records for the time period originally called into question[] in CMS' letter of February 2012." *Id.* at 2.

In addition, I & S stated in its reconsideration request that it "had been unable to reinitiate operations by the time of the on-site visit" and that its "inability to provide services [was] not the result of its own doing or operational decisions, but of the actions [it] had to take" to comply with the CAP. *Id.* I & S added that it was "ready to start again, as soon as the billing privileges are reinstated and Palmetto GBA finishes the revalidation process." *Id.*

On September 18, 2012, CMS issued a decision sustaining the revocation under section 424.535(a)(5)(i) based on the site visit finding that I & S "was still in a voluntary self-imposed non-operational status." Notice of Unfavorable Decision at 1.

The ALJ Decision

The ALJ found on review of the evidence that "[d]uring the June 7, 2012 site visit, [I & S's] office displayed a sign indicating it had voluntarily suspended operations from March 23, 2012, through October 1, 2013, and that the site inspector observed that [I & S] did not otherwise appear operational." ALJ Decision at 3, *citing* CMS Exs. 3, 5. That is, when Palmetto's inspector conducted the site visit of I & S's offices at noon on Thursday, June 7, 2012, during I & S's posted business hours, the office "was not staffed, was not open to the public, and was not providing services . . . ." ALJ Decision at 3.

Next, applying the language of the governing regulations to the factual findings, the ALJ concluded that I & S "was not operational pursuant to 42 C.F.R. § 424.535(a)(5)." ALJ Decision at 4. Specifically, the ALJ determined that "the undisputed facts indicate that [I & S] neither held itself out as a [home health agency] that was providing services on June 7, 2012, nor was it capable on that date of doing so." *Id.* Consequently, the ALJ determined, CMS had a "legitimate basis to revoke [I & S']s enrollment in the Medicare program. . . ." *Id.*

In affirming the revocation, the ALJ rejected I & S's argument that the Palmetto inspector incorrectly concluded "that I & S was no longer operational, because the notice posted on the agency's window specifically indicated the suspension of operations was temporary." P. Prehearing Br. at 8-9. The ALJ also rejected I & S's assertion that CMS's position erroneously required personnel to be present at a provider's offices "every day, of every week, of every year, without considering circumstances like, vacations, holidays, or other circumstances . . . known to CMS." *Id.* at 10. The ALJ determined that I & S's suspension of operations for approximately a year and a half was not analogous to a temporary closing due to a holiday or emergency. ALJ Decision at 4. The ALJ also concluded that the fact that I & S "had been operational at an earlier time and might be operational in the future is not a basis for reversing a revocation." *Id.* at 4-5, *citing Mission Home Health, et al.,* DAB No. 2310, at 6, 8 (2010).

Standard of Review

We review a disputed finding of fact to determine whether the finding is supported by substantial evidence in the record as a whole and a disputed conclusion of law to determine whether it is erroneous. *See Guidelines — Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program* at http://www.hhs.gov/dab/divisions/appellate/guidelines/prosupenrolmen.html.

Discussion

1. The ALJ did not err in concluding that I & S was no longer operational to furnish Medicare covered items or services within the meaning of the applicable regulations.

On appeal to the Board, I & S asserts that the ALJ erred in finding that it was "no longer operational to furnish Medicare covered items or services" under section 424.535(a)(5)(i). According to I & S, the ALJ "conclu[ded] that a temporary cessation of operations is not a valid legal defense" to rebut a CMS determination that a provider was "no longer operational" within the meaning of the regulations. P. Br. at 3. I & S also contends, "The ALJ failed to consider or indicate whether the term 'operational,'" as defined in the regulations, "requires the provider to be open to the public for the purpose of providing health care related services 24 hours a day, 7 days a week, 52 weeks a year . . . ." *Id.* I & S argues that the ALJ failed to consider whether "CMS' expansion of the definition of 'operational'" under the regulations "has the effect of amending the statute[[2]] to require every Medicare certified provider to remain open for business 24 hours a day, 7 days a week, 52 weeks a year." *Id.*

I & S's legal arguments are directed against mischaracterizations of the ALJ Decision and CMS's position. The ALJ did not conclude that a provider may never cite a temporary cessation of operations to disprove a determination by CMS that the provider was "no longer operational" within the meaning of section 424.530(a)(5)(i). Rather, the ALJ applied the regulatory requirements to the facts presented in this case, concluding that I & S was "no longer operational" when, as of March 23, 2012, it closed to the public, admittedly ceased providing home health services for a period expected to last over 18 months, and indicated that it intended to resume normal operations after that prolonged period. ALJ Decision at 3-4. Indeed, the ALJ stated that characterizing this lengthy period as analogous to a temporary holiday closing was "a strained argument in the extreme." ALJ Decision at 4. Thus, the ALJ concluded, I & S's argument that it had temporarily ceased operations did "not provide a legal defense to [its] failure to be operational during the June 7, 2012 site visit." *Id.* at 5.

We see no error in the ALJ's analysis. We additionally note that the term "no longer," used to modify the term "operational" in section 424.535(a)(5)(i), "is used when something happened or was true in the past but is not true now." *See Macmillan Dictionary, http://www.macmillandictionary.com/us/dictionary/american/long_34#no-longer.* Thus, consistent with the Board's decision in *Mission Home Health*, we read the

[2] I & S's brief repeatedly uses the term "statute" to refer to 42 C.F.R. §§ 424.535(a)(5)(i) and 424.505. These provisions are regulations, not statutes.

regulation (as the ALJ did) to authorize CMS to revoke billing privileges if a provider is not operational when an inspector visits its address during normal business hours, even though the provider had been operational at an earlier time and might resume operational status at some future date.

Moreover, we agree with CMS that I & S's position that a provider may close to the public, stop providing Medicare-covered services for 18 months and still be considered "operational" under the regulations would permit entities that are closed to the public and not providing any beneficiary services to circumvent the enrollment regulations by "merely declaring [an] intent to be open at some point in the near or distant future." CMS Br. at 8-9. Such an intent-based standard is inconsistent with the Secretary's specific requirement that providers remain open, staffed, and equipped to provide health care services to beneficiaries to maintain their billing privileges. *Id.*

We also note that when CMS issued the regulations for establishing and maintaining Medicare billing privileges, it explained that a General Accountability Office report had concluded: "Weaknesses in CMS' current provider enrollment process have made Medicare vulnerable to dishonest providers. To protect the integrity of Medicare, CMS and its contractors must have effective practices for reviewing applicants to verify that they are eligible for enrollment in the program, as well as the authority to deny or revoke enrollment to those that are not." 71 Fed. Reg. 20,754, at 20,774 (April 21, 2006), *citing* GAO/T-HEHS-94-124. The report also concluded, "Periodic revalidation of provider enrollment data should be a valuable means of ensuring that we have current, useful data on active providers and that providers no longer eligible to participate in Medicare are dropped from the program." *Id.* CMS further explained that "past experience has demonstrated that in many cases site visits are the only method we have to ensure that providers and suppliers actually exist and meet the requirements to participate in the Medicare program . . . . Left unchecked, Medicare program resources and the health of Medicare beneficiaries may be vulnerable." *Id*. at 20,754-55.

I & S further mischaracterizes the issue presented here by arguing that CMS expanded the definition of "operational" under the regulations "to require every Medicare certified provider to remain open for business 24 hours a day, 7 days a week, 52 weeks a year" and that the ALJ "failed to consider" whether the regulations require the "continuous and uninterrupted operation of the business." P. Br. at 3. CMS did not revoke I & S's billing privileges because of a vacation, holiday, or emergency situation, or because of a failure to remain open 24 hours per day, 365 days per year. Thus, the question whether the regulations require such continuous operations was not before the ALJ.

Moreover, as the ALJ noted, the Palmetto inspector assessed whether I & S was operational during the "normal business hours" that I & S itself had posted. Specifically, the ALJ stated that the "inspector conducted his site visit . . . at 12:00 PM on Thursday June 7, 2012. . . during Petitioner's posted business hours." ALJ Decision at 3, citing

CMS Exs. 3, 5. The timing of this inspection was consistent with CMS Medicare Program Integrity Manual instructions on site verification visits, which read: "Site verifications should be done Monday through Friday (excluding holidays) during [the provider's] posted business hours. If there are no hours posted, the site verification should occur between 9 a.m. and 5 p.m." MPIM § 15.20.1, available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf. Thus, contrary to I & S's mischaracterizations, CMS policy recognizes that to be "operational," a provider need not be open on weekends, holidays, or other times outside of its normal business hours.

I & S also points out that CMS's manual addresses various matters that an inspector should document during an on-site visit, such as whether the facility is vacant and free of all furniture and whether an eviction notice was posted at the facility. P. Br. at 6. I & S argues that all of these examples "suggest situations in which the person conducting the onsite visit could infer that the cessation of operations was permanent" and that "Palmetto GBA's employee could not make such inference in this case." *Id.* As I & S concedes, however, the manual also directs an inspector to determine whether the facility is open, personnel are at the facility, customers are at the facility (if applicable to that provider or supplier type), and the facility appears to be operational. *Id.* at 5. These types of observations are relevant to whether a provider is operational, even if they do not constitute evidence of a permanent cessation of operations equivalent to the examples that I & S cites. Nothing in the manual precludes a finding that a provider is no longer operational merely because the inspector does not find the circumstances given in the examples I & S cites.

I & S also states that even though its billing privileges had been reinstated in April 2012, its owners had not resumed providing services as of the time of the site visit (June 2012) because they had "concentrated their efforts in complying with their obligations under the approved" CAP. P. Br. at 2. This argument also has no merit. The Board previously has explained that the language of section 424.535(a)(5)(i), which authorizes CMS to revoke the billing privileges of providers who are no longer operational "provides no exceptions to account for the reasons the provider ceased operations." *Mission Home Health* at 8.

Accordingly, we conclude that the ALJ correctly determined that I & S was no longer operational to furnish Medicare covered items or services within the meaning of section 424.535(a)(5)(i).

2. The ALJ did not refuse to review whether CMS had authority to revoke I & S's Medicare enrollment and billing privileges under the regulations.

I & S argues that the "ALJ's refusal to review whether CMS's authority to revoke was appropriate under the scope of 42 C.F.R. § 424.535(a)(5)(i) and 42 C.F.R. [§ 424.]502

rendered I & S's . . . appeal an exercise in futility." P. Br. at 3. According to I & S, "The ALJ was not called upon to substitute [his] discretion about whether or not to revoke, but to review whether CMS had gone beyond the plain language of the statute and misapplied it to the facts of this case." *Id.* Furthermore, I & S asserts, "Even if the statute provides CMS with a legal basis to revoke, that does not mean the statute has been correctly applied or that CMS has not overextended its authority by requiring more than the plain language of the statute requires." *Id.*

Again, I & S misconstrues the ALJ Decision. The ALJ applied the plain meaning of the regulatory language to the facts as established by the record before him, concluding that the revocation was authorized. Thus, the ALJ viewed I & S's arguments about aspects of its situation that he found irrelevant to whether the regulations authorized the revocation as going instead to whether CMS abused the discretion accorded to it under the regulations. In this context, the ALJ determined that he had no authority to review CMS's discretionary act to revoke a provider and could not substitute his discretion for that of CMS. ALJ Decision at 5. I & S now clarifies that it was not, in fact, asking the ALJ to review CMS's exercise of discretion. Thus, we need not address this issue further.

Conclusion

For the reasons discussed above, we affirm the ALJ Decision.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Judith A. Ballard
Presiding Board Member