Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Ultra Care, LLC,
(NPI: 1386061638),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-17-355

Decision No. CR4886

Date: July 10, 2017

DECISION

Petitioner, Ultra Care, LLC, applied for enrollment in the Medicare program as a home health agency in the State of Texas. The Centers for Medicare & Medicaid Services (CMS) denied its application because CMS has imposed a moratorium on enrolling new home health agencies in Texas. Petitioner appeals the denial, arguing that it was enrolled in the program before the moratorium began. The parties agree that no material facts are in dispute and have filed cross-motions for summary judgment.

For the reasons set forth below, I find that Petitioner was not enrolled in the Medicare program when the moratorium took effect, and that the moratorium precludes Petitioner's enrollment. I therefore grant CMS's motion and deny Petitioner's.

Background

Petitioner, Ultra Care, LLC, applied to enroll in the Medicare program as a provider of services. CMS Exhibit (Ex.) 1. In a letter dated August 19, 2016, the Medicare contractor, Palmetto GBA, denied the application, explaining that CMS had imposed a

temporary moratorium on home health agency enrollments for the state in which Petitioner has its practice location (Texas). CMS Ex. 9. Petitioner sought reconsideration.

In a reconsidered determination, dated December 15, 2016, a CMS hearing officer affirmed the denial. She found that Petitioner was not in "approved" status prior to July 29, 2016, when the state-wide moratorium took effect. She pointed out that that there are no exceptions for newly-enrolling home health agencies in moratorium areas and that administrative review of those denials is limited to the question of whether the moratorium applies to the provider or supplier type or the geographic location. CMS Ex. 10 at 3.

Petitioner timely appealed, and the matter is now before me. The parties have filed cross-motions for summary judgment (CMS MSJ and P. MSJ). Along with its motion, CMS submits 19 exhibits (CMS Exs. 1-19).[1] With its motion, Petitioner submits three exhibits (P. Exs. 1-3).

Discussion

CMS properly denied Petitioner's Medicare enrollment application because CMS had not finally approved that application before a moratorium on enrolling new home health agencies in Texas went into effect.[2]

Enrollment. To participate in the Medicare program, an entity must be enrolled. 42 C.F.R. § 424.505. Enrollment means the process Medicare uses to establish that a provider or supplier is eligible to submit claims for covered services and supplies. The process includes: 1) identifying the provider or supplier; 2) validating the provider/supplier's eligibility to provide items or services to Medicare beneficiaries; 3) identifying and confirming the provider/supplier's practice location(s) and owner(s); and 4) *granting the provider/supplier Medicare billing privileges*. 42 C.F.R. § 424.502.

Screening levels for home health agency applicants. Medicare contractors must screen all initial applications for Medicare enrollment based on CMS's assessment of the risk the applicant poses to program integrity. 42 C.F.R. § 424.518. Home health agencies fall into the "high-risk" category and are thus subject to more stringent enrollment procedures than limited or moderate risk applicants. 42 C.F.R. § 424.518(c); *see* Program Integrity Manual (PIM) § 15.19.2.1C (eff. 12-29-14).

[1] In error, CMS submitted a second copy of CMS Ex. 3 instead of CMS Ex. 2. When we brought this to CMS's attention, it promptly substituted the appropriate document.

[2] I make this one finding of fact/conclusion of law.

The moratorium. CMS, acting on behalf of the Secretary of Health and Human Services, may impose a temporary moratorium on the Medicare enrollment of new providers and suppliers if "necessary to prevent or combat fraud, waste, or abuse . . . ." Social Security Act (Act) § 1866(j)(7)(A); 42 C.F.R. § 424.570(a). CMS must deny a supplier's enrollment in the Medicare program if (among other reasons) its application is for a practice location in a geographic area where CMS has imposed a temporary moratorium. 42 C.F.R. §§ 424.530(a)(10); 424.570(c). The moratorium applies to all pending applications.

A home health agency may appeal the denial of its billing privileges based on CMS's imposing a moratorium on new enrollments, but the regulations limit my authority to review such appeals. My review is limited to "whether the temporary moratorium applies to the provider or supplier appealing the denial." CMS's basis for imposing the temporary moratorium is not reviewable. 42 C.F.R. § 498.5(*l*)(4); *see* 81 Fed. Reg. 51,120-21 (August 3, 2016); *see* CMS Ex. 11 at 2.

In a Federal Register notice dated July 31, 2013, CMS imposed moratoria on the enrollment of new home health agencies in Miami-Dade County, Florida and Cook County, Illinois, in order "to prevent and combat fraud, waste, and abuse." The moratoria became effective July 31, 2013. 78 Fed. Reg. 46,339-40 (July 31, 2013); *see* CMS Ex. 11 at 2; CMS Ex. 15. CMS has extended and expanded the moratoria multiple times since originally imposed. 79 Fed. Reg. 6475 (February 4, 2014); 79 Fed. Reg. 44,702 (August 1, 2014); 80 Fed. Reg. 5551 (February 2, 2015); 80 Fed. Reg. 44,967 (July 28, 2015); 81 Fed. Reg. 5444 (February 2, 2016); *see* CMS Ex. 13.

In a Federal Register notice published August 3, 2016, CMS expanded the moratoria to include all newly enrolling home health agencies in the State of Texas (as well as the entire states of Florida, Illinois, and Michigan). CMS explained that a "high risk of fraud, waste, and abuse" exists in these areas. Effective **July 29, 2016**, no new Texas home health agencies would be enrolled "unless their enrollment application has already been approved but not yet entered into PECOS . . . ."[3] 81 Fed. Reg. 51,123 (August 3, 2016); *see* 42 C.F.R. § 424.570(a)(1)(iv); CMS Ex. 11 at 4. By notice dated January 9, 2017, CMS extended the Texas moratorium. 82 Fed. Reg. 2363-2366 (January 9, 2017); *see* CMS Ex. 12.

Petitioner Ultra Care's enrollment status. Petitioner maintains that it was enrolled in Medicare before the moratorium took effect. In fact, it was not.

[3] PECOS – Provider Enrollment, Chain and Ownership System – is the electronic system through which providers and suppliers may enroll in the Medicare program.

Step 1: Apply.[4] To enroll in Medicare, a prospective provider must complete and submit an enrollment application. 42 C.F.R. § 424.510(d)(1).

Here, Petitioner submitted an application, dated April 18, 2014, and post-marked April 22, 2014. CMS Ex. 1. The application's date stamp indicates that the contractor received it on April 28, 2014.[5]

By email dated May 30, 2014, the Medicare contractor asked Petitioner to complete missing or incomplete sections of the application. The omissions were significant: the application did not indicate the locations (state, county, and city/town) where services would be provided; it omitted ownership interests and other important information for the individuals listed as delegated officials. The entire section 15 of the application – the certification statement – was missing. The contractor also asked for a copy of the home health agency's current state license and some critical banking information – a pre-printed voided check, or letter from a bank official. Petitioner had not signed nor dated its electronic funds transfer agreement, so it needed to submit a signed and dated copy. CMS Ex. 2; *see* 42 C.F.R. § 424.518(a)(2) (requiring license verification); 42 C.F.R. § 424.518(c)(2) (requiring fingerprints and FBI background checks on individuals with 5% or greater ownership interest in the home health agency).

Petitioner apparently provided the requested information because, on July 14, 2014, the contractor forwarded its application to the Texas Department of Aging & Disability Services (state agency) and the Dallas Regional Office of CMS for the next step of the process: the survey. CMS Ex. 3.

Step 2: Survey. To participate in the Medicare program, a home health agency must demonstrate that it meets the statutory definition and complies with certain requirements called conditions of participation. Act §§ 1861(o), 1891; 42 C.F.R. Part 484; 42 C.F.R.

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[4] The Medicare enrollment process can obviously be described in any number of ways. In an effort to keep this explanation relatively simple and understandable, I break the complicated process down into steps, each step representing – in my view – a major component of the process.

[5] The Medicare contractor stamps paper applications with a "Julian date stamp," which counts the days of the year consecutively. In this case, a number is stamped in the upper left-hand corner of each page of Petitioner's application: "14118C25100168." The first five digits indicate the date of receipt. The first two digits indicate the year – 2014. The next three digits indicate the date – the 118th day of 2014 or April 28, 2014. P. Ex. 1. For reasons it has not explained, CMS maintains that the contractor received the application on May 16, 2014 and Petitioner has not challenged that. CMS MSJ at 5. Although puzzling, the discrepancy does not affect the outcome so the specific date of filing is not material to this decision.

§ 488.3. To determine its compliance, a state survey agency or an approved accrediting organization must survey the applicant. Act §§ 1864(a), 1865(a); 42 C.F.R. § 488.10; *see* Act § 1891; 42 C.F.R. pt. 488, subpt. I.

Here, an accrediting organization surveyed Petitioner and determined that it met program participation requirements as of December 17, 2015; the accrediting organization recommended that Petitioner be certified effective that date. CMS concurred and, in a letter dated July 1, 2016, so advised Petitioner, enclosing a copy of a signed Medicare agreement. CMS Ex. 5; P. Ex. 2.

Prior to December 2011, this would have completed the enrollment process. *See* CMS Ex. 18 at 1 (CMS Survey & Certification (S & C) Letter, S&C: 12-15-HHA, Revised Initial Certification Process for Home Health Agencies (HHAs)). However, in order to "reduce the Medicare program's vulnerability to fraud," on December 23, 2011, CMS added additional safeguards to the process: following the certification survey, the Medicare contractor must verify the applicant's financial situation (to assure that it has remained solvent); verify its enrollment eligibility (i.e., assure that neither the home health agency nor its principals have been excluded); and conduct a site visit (to assure that it remains operational). *See UpturnCare Co.*, DAB No. 2632 at 12 (2015) (holding that "a successful accreditation outcome . . . does not mean that CMS (through its contractor) has in fact determined that [the home health agency] has met all of the requirements for enrollment. . . .").

Step 3: Contractor review and site visit. After CMS has reviewed the survey findings and determined that the home health agency is in substantial compliance with Medicare conditions of participation, it sends a "tie-in notice" or approval letter to the contractor. The contractor must then verify that the home health agency meets capitalization requirements; it must check the Medicare exclusion database to insure that neither the home health agency nor its owners nor principals have been excluded from program participation; it must order a site visit – which is not the same as the certification survey. CMS PIM §§ 15.19.2.1C (eff. 12-29-14); 15.26.3 (eff. 01-07-14); CMS Ex. 17 at 2 (S & C: 13-53-HHA); CMS Ex. 18 at 2 (S & C: 12-15-HHA); *see* 42 C.F.R. § 489.28; *UpturnCare Co.*, DAB No. 2632 at 2 (2015).

Here, the CMS Regional Office issued its tie-in notice on July 12, 2016. CMS Ex. 6.

In a letter dated July 20, 2016, the contractor asked Petitioner to submit updated "initial reserve operating funds" documentation showing that the home health agency maintains sufficient funds to operate for three months after the effective date of its provider agreement. The letter warned that CMS may deny the application if the information were not furnished within 30 calendar days. CMS Ex. 7 at 2. Petitioner responded on July 27, 2016. CMS Ex. 7 at 4-11.

The CMS contractor also ordered the site visit, which occurred on **August 8, 2016**, after the effective date of the moratorium. CMS Ex. 8.

Thus, because the enrollment process was not completed prior to the date the moratorium went into effect, CMS properly denied Petitioner's enrollment application. *UpturnCare Co.* at 13 ("The term 'approved' . . . contemplates a determination to allow enrollment following successful completion of the *entire* review process." (emphasis added))

Petitioner, however, points to CMS's July 1, 2016 notice letter, which includes a Medicare certification number (CCN) and a Medicare agreement. CMS Ex. 5; P. Ex. 2. CMS characterizes the letter as "a preliminary approval letter" but does not explain why the Dallas Regional Office of CMS assigned the CCN or sent the provider agreement. CMS MSJ at 5-6. This was plainly an error. The regional office is supposed to:

> **hold** the issuance of a CCN and provider agreement until the [contractor] has re-reviewed certain Medicare enrollment requirements (e.g., site visit verification, capitalization requirements and Medicare exclusion checks) and has notified the [regional office] that the prospective [home health agency] continues to be in compliance with the criteria.
> . . .
>
> It is critical that the [contractor] be given the opportunity to re-review the information submitted on the [application] to ensure that the specific enrollment requirements . . . continue to be met <u>before</u> CMS enters into an agreement with the [home health agency]. Criteria for a successful site visit include a determination that the facility is open, staffed with personnel . . . and appears operational.

CMS Ex. 18 at 2 (S&C: 12-15-HHA).

Nevertheless, the regional office's error does not change the outcome here. As CMS points out, it did not confer a billing number (PTAN) but advised Petitioner that it would notify the Medicare contractor, via a tie-in notice, of its ultimate decision. CMS MSJ at 8; CMS Ex. 5. When the moratorium went into effect, the contractor had not conducted a site visit; Petitioner was not yet eligible for a billing number and had not been granted billing privileges. It was therefore not enrolled in the Medicare program. 42 C.F.R. § 424.502; *UpturnCare Co*. at 13-14.

Conclusion

Petitioner was not enrolled in the Medicare program before CMS imposed its moratorium on enrolling home health agencies in the State of Texas. CMS therefore properly denied its enrollment application. I therefore grant CMS's motion for summary judgment and deny Petitioner's.

/s/
Carolyn Cozad Hughes
Administrative Law Judge