

Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Universal Health Provider Corp.,
(PTAN: 10-9572),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-12-1296

Decision No. CR2747

Date: April 9, 2013

DECISION

Petitioner, Universal Health Provider Corp., a home health agency, appeals a reconsideration decision dated August 29, 2012. The undisputed evidence establishes that Petitioner was not in compliance with Medicare program requirements involving proper home health care certification. As a consequence, I grant the motion of the Centers for Medicare and Medicaid Services (CMS) for summary judgment and uphold CMS's determination to revoke Petitioner's Medicare enrollment and billing privileges.

I. Background and Procedural History

By letter dated May 25, 2012, Palmetto GBA (Palmetto), a CMS contractor, informed Petitioner that CMS was revoking Petitioner's Medicare billing privileges and terminating Petitioner's Medicare provider agreement, effective June 24, 2012, because Petitioner failed to comply with the Medicare enrollment requirements pursuant to 42 C.F.R. § 424.535(a)(1). CMS Exhibit (CMS Ex.) 3, at 1-2. Palmetto also informed

Petitioner that it was establishing a Medicare re-enrollment bar for a period of three years. CMS Ex. 3, at 2. Specifically, the revocation letter stated that:

Under 42 CFR 424.535(a)(1) CMS may revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement when the suppliers are not in compliance with the enrollment requirements specifically outlined in Section 15(a)5 (Certification Statement for 855A application) that states: "I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and I will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity." The supplier submitted claims for payment that were based upon orders, treatment plans, or other documents some of which were created by the enrolled supplier that contain the altered or forged signature of the treating physician.

CMS Ex. 3, at 1.

Petitioner timely filed a request for reconsideration of CMS's decision to revoke Petitioner's Medicare enrollment and billing privileges. CMS Ex. 3, at 3. On August 29, 2012, CMS issued a reconsidered determination that upheld the revocation based on Petitioner's noncompliance with Medicare enrollment requirements. CMS Ex. 3, at 3-5. In the reconsideration decision, CMS states that "[a]ll of the documentation in the file for this case has been reviewed and the decision has been made in accordance with Medicare guidelines as outlined in 42 CFR § 424.535(a)(1). Specifically, [Petitioner] has not provided evidence to show that it did not submit false or fraudulent claims." CMS Ex. 3, at 4.

Petitioner then filed a hearing request (HR) with the Civil Remedies Division of the Departmental Appeals Board on September 27, 2012, and the case was assigned to me for hearing and decision. In accordance with my Acknowledgment and Pre-hearing Order issued on October 3, 2012, CMS filed its pre-hearing exchange, incorporating a Motion for Summary Judgment and brief (CMS Br.), with eight exhibits (CMS Exs. 1-8). In its brief, CMS stated that:

This brief serves as notice of CMS' amendment of its basis for the revocation CMS is proceeding on the basis of the same regulation, 42 C.F.R. § 424.535(a)(1), and on the same theory, *i.e.*, [Petitioner's] noncompliance with the requirements on the enrollment application. CMS amends its basis for the revocation only insofar as to characterize Petitioner's behavior as a failure to maintain the required conformance to the Medicare laws, regulations, and program instructions that apply to this provider

CMS Br. at 2 (internal quotation omitted).

Specifically, CMS claims that home health agencies may only receive Medicare reimbursement for services provided to beneficiaries who are under the care of a physician and that the physician must have a face-to-face encounter with the beneficiary and certify the necessity of the home health services. 42 C.F.R. § 424.22(a); Medicare Benefit Policy Manual, 100-101, § 30.5.1.1. CMS claims that Petitioner did not meet these Medicare requirements with regard to the claims Petitioner submitted for 43 beneficiaries. CMS Br. at 9.

Petitioner then filed a Motion for Summary Judgment and brief (P. Br.), with 44 exhibits (P. Exs. 1-25; P. Exs. A-F, F1, F2, and G-Q). In Petitioner's Motion for Summary Judgment, Petitioner claims CMS has made a "complete 180° change from its initial basis for revocation" and that CMS has not put forth a prima facie case against Petitioner. P. Br. at 1, 6-7. CMS subsequently submitted a response in opposition to Petitioner's Motion for Summary Judgment (CMS Response). In the absence of objection, I admit CMS Exs. 1-8, P. Exs. 1-25, and P. Exs. A-F, F1, F2, and G-Q into the record.

On January 9, 2013, Petitioner filed a Motion for the Issuance of Subpoena in order to obtain medical records for 21 beneficiaries (P. Motion). CMS then submitted a response in opposition to Petitioner's Motion for the Issuance of Subpoena, stating that the request was untimely and the record was closed in this case. CMS also argued that Petitioner's motion did not meet the requirements of 42 C.F.R. § 498.58, and specifically that Petitioner did not show that the documents requested were reasonably necessary for the full presentation of its case.

Then, on March 5, 2013, CMS filed a Notice (CMS Notice) with an attachment (CMS Attachment A) and stated that "CMS has recently learned Petitioner . . . voluntarily relinquished its license to operate a home health agency as of November 19, 2012" and that Petitioner's "voluntary relinquishment of its license has not been disclosed in [Petitioner's] filings in the instant appeal." CMS contends that a license issued by the State of Florida is required for Petitioner to operate. CMS Notice at 1. CMS also contends that "[f]or Medicare purposes, the relinquishment of a license means that the home health agency can no longer satisfy the enrollment regulation at 42 C.F.R. § 424.516(a)(2), which calls for continuing compliance with 'State licensure . . . requirements.'" CMS Notice at 1. CMS also argues that under Medicare certification regulations, a cessation of business is deemed to be a voluntary termination of the provider's Medicare provider agreement, effective as of the date the provider stopped providing services. 42 C.F.R. § 489.52(b)(3). CMS's position is that Petitioner's relinquishment of its state license and cessation of operations as a home health agency would be a separate and additional basis for the revocation of Petitioner's Medicare enrollment and billing privileges. CMS Notice at 2. Petitioner did not respond to the CMS Notice.

II. Applicable Law

The Medicare statute defines “home health services” as “items and services furnished to an individual, who is under the care of a physician . . . under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician” 42 U.S.C. § 1395x(m). Home health services are covered by Medicare “only if . . . a physician certifies . . . that . . . home health services . . . are or were required because the individual is or was confined to his home . . . and needs or needed skilled nursing care” 42 U.S.C § 1395f(a)(2)(C); 42 U.S.C § 1395n(a)(2)(A).

A home health agency may receive Medicare payment for home health services for individuals only after the home health agency has obtained a valid certification from a physician that the individual is homebound and requires home health services. 42 U.S.C §§ 1395f(a)(2)(C), 1395n(a)(2)(A). Home health services must be furnished while the individual is under the care of a physician, and a physician must establish and periodically review a plan of care for furnishing the services. 42 C.F.R. § 424.22(a)(iii),(iv). Also, the certifying physician is required to know the Medicare beneficiary’s medical status, and therefore there must be a face-to-face encounter with the individual, 42 C.F.R. § 424.22(a); Medicare Benefit Policy Manual, CMS Publication 100-102, Ch. 7 (Home Health Services), § 30.5.1.1. The face-to-face encounter must be “related to the primary reason the patient requires home health services” 42 C.F.R. § 424.22(a)(1)(v).

A physician and the home health agency personnel must review a Medicare beneficiary’s plan of care at regular intervals. 42 C.F.R. § 484.18(b). Also, the home health agency is required to “promptly alert the physician” to significant changes that suggest a need to alter the plan of care. 42 C.F.R. § 484.18(b). The home health agency consults with the individual’s physician to obtain approval of any “additions or modifications to the original plan” of care. 42 C.F.R. § 484.18(a).

Section 424.535(a) of 42 C.F.R. authorizes CMS to “revoke a currently enrolled provider or supplier’s Medicare billing privileges and any corresponding provider agreement or supplier agreement” for reasons including, as relevant here:

- (1) *Noncompliance*. The provider or supplier is determined not to be in compliance with the enrollment requirements described in this section, or in the enrollment application applicable for its provider or supplier type

III. Analysis

A. Issue

The issue in this case is whether CMS is entitled to summary judgment on the grounds that CMS had a legitimate basis to revoke Petitioner’s Medicare enrollment and billing privileges.

B. Applicable Standard

Summary judgment is appropriate when a case presents no issue of material fact, and its resolution turns on questions of law. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-48 (1986); *Livingston Care Ctr. v. U. S. Dep't of Health and Human Servs.*, 388 F.3d 168, 173 (6th Cir. 2004); *see also Illinois Knights Templar Home*, DAB No. 2274, at 3-4 (2009) (*citing Kingsville Nursing Ctr.*, DAB No. 2234, at 3-4 (2009)).

The moving party may show the absence of a genuine factual dispute by presenting evidence so one-sided that it must prevail as a matter of law, or by showing that the non-moving party has presented no evidence “sufficient to establish the existence of an element essential to [that party’s] case, and on which [that party] will bear the burden of proof at trial.” *Livingston Care Ctr.*, 388 F.3d at 173 (*quoting Celotex Corp. v. Catrett*, 477 U.S. 317, 323-24 (1986)). To avoid summary judgment, the non-moving party must then act affirmatively by tendering evidence of specific facts showing that a dispute exists. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 n.11 (1986); *see also Vandalia Park*, DAB No. 1939 (2004); *Lebanon Nursing and Rehab. Ctr.*, DAB No. 1918 (2004).

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. *Illinois Knights Templar*, DAB No. 2274, at 4; *Livingston Care Ctr.*, DAB No. 1871, at 5. In examining the evidence to determine the appropriateness of summary judgment, I must draw all reasonable inferences in the light most favorable to the non-moving party. *See Brightview Care Ctr.*, DAB No. 2132, at 2, 9 (2007); *Livingston Care Ctr.*, 388 F.3d at 168, 172; *Guardian Health Care Ctr.*, DAB No. 1943, at 8 (2004); *but see Cedar Lake Nursing Home*, DAB No. 2344, at 7 (2010); *Brightview Care Ctr.*, DAB No. 2132, at 10 (noting entry of summary judgment upheld where inferences and views of non-moving party are not reasonable). However, drawing factual inferences in the light most favorable to the non-moving party does not require that I accept the non-moving party’s legal conclusions. *Cedar Lake*, DAB No. 2344, at 7; *Guardian*, DAB No. 1943, at 11 (“A dispute over the conclusion to be drawn from applying relevant legal criteria to undisputed facts does not preclude summary judgment if the record is sufficiently developed and there is only one reasonable conclusion that can be drawn from those facts.”).

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*, DAB No. 2291, at 4-5 (2009).

C. Findings of Fact and Conclusions of Law

1. *CMS was authorized to change its revocation basis because Petitioner had notice and opportunity to respond during this administrative proceeding.*

Petitioner argues that its revocation should be rescinded because CMS has made a “complete 180° change from its initial basis for revocation.” P. Br. at 1. The Departmental Appeals Board (Board) has consistently held that after an administrative appeal has commenced, a federal agency may assert and rely on new or alternative grounds for the challenged action or determination as long as the non-federal party has notice of, and a reasonable opportunity to respond to, the asserted new grounds during the administrative proceeding. *Green Hills Enters., LLC*, DAB No. 2199 (2008). *See also Abercrombie v. Clarke*, 920 F.2d 1351, 1360 (7th Cir. 1990), *cert. denied*, 520 U.S. 809 (1991) (holding that defects in formal notice may be cured during the course of an administrative proceeding, and due process is satisfied as long as the party is reasonably apprised of, and given opportunity to address, the issues in controversy); *St. Anthony Hosp. v. Sec’y, Dep’t of Health and Human Servs.*, 309 F.3d 680, 708 (10th Cir. 2002) (“To establish a due process violation [in an administrative proceeding], an individual must show he or she has sustained prejudice as a result of the allegedly insufficient notice.”).

It is evident from CMS’s briefs in this matter that CMS chooses to revoke Petitioner’s Medicare billing privileges under 42 C.F.R. § 424.535(a)(1) on the grounds that Petitioner failed to maintain the required conformance “to the Medicare laws, regulations, and program instructions that apply to this provider.” CMS Br. at 2. During this stage of the appeal, I provided Petitioner with ample opportunity to refute CMS’s determination that it was found noncompliant based on failure to comply with Medicare laws and regulations and specifically the requirements of 42 C.F.R. § 424.22. Therefore, I do not find that Petitioner has been prejudiced.

2. *The undisputed evidence shows CMS had a legitimate basis to revoke Petitioner’s Medicare billing privileges because Petitioner was not in compliance with Medicare requirements for home health certifications involving 32 individuals.*

Any home health agency that seeks to enroll as a provider in the Medicare program must complete a CMS 855A enrollment application. Petitioner completed a CMS 855A and signed the Certification Statement at Section 15 of the CMS 855A enrollment application. CMS Ex. 2. Petitioner’s signature “binds this provider to the laws, regulations, and program instructions of the Medicare program.” CMS Ex. 2, at 6. CMS contends that Petitioner submitted claims for home health services which did not conform to “the Medicare laws, regulations, and program instructions that apply to this provider.” CMS Br. at 2. Specifically, CMS refers to the requirements that home health agencies may only receive Medicare reimbursement for services provided to individuals who are

under the care of a physician and that the physician must have a face-to-face encounter with the individuals and certify the necessity of the home health services. CMS contends that these requirements were not met with respect to claims Petitioner submitted for 43 individuals. CMS Br. at 9.

CMS argues that by signing a CMS 855A Certification Statement and enrolling in the Medicare program, Petitioner agrees to comport with all Medicare laws of general applicability and those that apply specifically to home health agencies. In addition, according to CMS, the text of the CMS 855A places Petitioner on notice that failure to comply with Medicare laws may be a basis for the revocation of Petitioner's enrollment in the Medicare program in the future.

CMS determined to revoke Petitioner's Medicare billing privileges after an internal CMS inquiry revealed that the signature of Dr. Emilio Castaneda "was being used in conjunction with the certification of an enormous number of Medicare beneficiaries for home health services" and "Dr. Castaneda's NPI [National Provider Identifier] was coming up in the Medicare program's data as having been used by a number of home health agencies [in the south Florida area] with surprising frequency." CMS Ex. 6, at ¶¶ 8-9. CMS contends that Petitioner submitted Medicare home health claims on behalf of 43 individuals and named Dr. Castaneda as the certifying physician in each instance; however, CMS's Medicare reimbursement records for Dr. Castaneda do not indicate that Dr. Castaneda was involved in the care of those 43 individuals. CMS Br. at 10; CMS Exs. 4 and 5. Thus, CMS contends that Petitioner's submission of Medicare claims for individuals who were not under the care of a physician constituted noncompliance, and CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges.

Petitioner argues that the evidence CMS presents does not prove that these 43 individuals were not under the care of Dr. Castaneda. P. Br. at 6-8. Petitioner includes an affidavit of Dr. Castaneda with an attached spreadsheet. P. Ex. G. Petitioner offers a variety of explanations for why Dr. Castaneda did not bill the Medicare program for services for these 43 individuals and why CMS's records do not show that Dr. Castaneda was ever involved in the care of these 43 individuals. P. Br. at 7-8. Petitioner also suggests that CMS should have come forward with other types of evidence to establish that Dr. Castaneda did not actually treat the patients at issue. P. Br. at 6.

Petitioner did not come forward with any actual treatment records for the 43 individuals in its challenged claims, but it instead submitted documents in reference to a smaller group of patients, only 11 of whom are among the 43 individuals CMS names. P. Br. at 4; P. Exs. 1-25. In its response brief, CMS argues that if Petitioner "believed that either Castaneda or his employer possessed patient records that would show that the 43 beneficiaries were actually treated or monitored medically by Castaneda, it would have been [Petitioner's] responsibility to obtain those records and come forward with them . . . It is . . . [Petitioner] and Castaneda who allegedly had a significant patient-referral

relationship and (more importantly) who allegedly shared responsibility for the health care needs of the 43 beneficiaries” CMS Response at 6.

Petitioner has requested the issuance of subpoenas through which it could obtain medical records for patients Dr. Castaneda saw during his employment with C&M Physicians’ Group, Inc., a Miami clinic which Petitioner states is no longer in business. However, Petitioner has not provided any explanation as to why Petitioner must obtain medical records for these individuals from another source in order to prove Petitioner’s clients were under the care of a physician for services it alleges it provided. Petitioner’s motion for the issuance of subpoenas does not meet the requirements of 42 C.F.R. § 498.58 because it does not show that the documents requested are reasonably necessary for the full presentation of its case. Further, it does not specify the pertinent facts Petitioner expects to establish by the witnesses or documents nor does it indicate why those facts could not be established without the use of a subpoena. 42 C.F.R. § 498.58(c)(3). Accordingly, I have denied Petitioner’s request for subpoenas. Finally, Petitioner provides no explanation as to why Petitioner did not have plans of care, face-to-face encounter documentation, and other certification paperwork indicating that these Medicare clients of Petitioner’s met the requirements of 42 C.F.R. § 424.22, prior to Petitioner submitting claims for Medicare payment.

A physician must be involved in the certification of an individual for home health services and a physician’s ongoing involvement in the care of that individual. 42 U.S.C § 1395f(a)(2)(C); 42 U.S.C § 1395n(a)(2)(A). Medicare program guidance incorporates these statutory requirements: “[t]he patient must be under the care of a physician who is qualified to sign the certification statement and plan of care . . . A patient is expected to be under the care of the physician who signs the plan of care and the physician certification.” Medicare Benefit Policy Manual, 100-101, § 30.3. The physician must base his certification of the need for home health services upon a face-to-face encounter with the patient and the encounter must be related to the primary reason the patient requires home health services. 42 C.F.R. § 424.22(a).

Because Petitioner did not bring forth any specific evidence with regard to 32 individuals that could show that these individuals were under the care of Dr. Castaneda or that Dr. Castaneda certified the necessity of home health care services, despite the undisputed fact that Petitioner billed Medicare for these individuals as receiving care that Dr. Castaneda approved, I find Petitioner did not conform to “the laws, regulations, and program instructions of the Medicare program.” By signing the Certification Statement at Section 15 of the CMS 855A enrollment application, Petitioner was bound to comply with all applicable legal requirements. CMS Ex. 2, at 6. Thus, I find that CMS was authorized to revoke Petitioner’s Medicare billing privileges for noncompliance with the enrollment application applicable for its provider or supplier type pursuant to 42 C.F.R. § 424.535(a)(1).

Additionally, CMS has presented evidence that Petitioner voluntarily relinquished its license to operate a home health agency in Florida as of November 19, 2012. CMS

Notice, Attachment A. Petitioner did not respond to the CMS Notice regarding the voluntary relinquishment of its home health agency license. Pursuant to 42 C.F.R. § 424.516(a)(2), a provider must maintain an active enrollment status and continue to meet Medicare requirements including “State licensure, certification, and regulatory requirements” Also, “[a] cessation of business is deemed to be a termination by the provider, effective with the date on which it stopped providing services to the community.” 42 C.F.R. § 489.52(b)(3). Therefore, this undisputed evidence suggests CMS has an additional legitimate basis to revoke Petitioner’s Medicare billing privileges, as of November 19, 2012, because Petitioner is not in compliance with applicable Medicare requirements.

3. *Dr. Castaneda’s affidavit does not create a genuine dispute of material fact necessary to overcome CMS’s Motion for Summary Judgment because Petitioner has not tendered evidence of specific facts showing that a dispute exists for 32 individuals.*

To avoid summary judgment, the non-moving party must act affirmatively by tendering evidence of specific facts showing that a dispute exists regarding an essential element of the case. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 n.11 (1986). A mere scintilla of supporting evidence is not sufficient to overcome a well-supported motion for summary judgment. “If the evidence is merely colorable or is not significantly probative, summary judgment may be granted.” *Livingston Care Ctr. v. U.S. Dep’t of Health & Human Servs.*, 388 F.3d 168, 173 (6th Cir. 2004) (quoting *Anderson v. Liberty Lobby*, 477 U.S. 242, at 249-50 (1986)).

In order to dispute whether Dr. Castaneda provided the required treatment for the 43 home health clients CMS names, Petitioner came forward with an affidavit of Dr. Castaneda generally stating that “I hereby attest that I conducted the Face-to-Face evaluation and signed all home health ordering documentation (such as Plan of Care, Verbal Orders, Certification Orders, etc.) for all beneficiaries attached here to.” P. Ex. G, at 1. The affidavit includes several documents that are difficult to decipher, including several lists of patients, many of whom are not among the 43 individuals CMS identifies in its Motion for Summary Judgment. P. Ex. G, at 3-5. The affidavit also includes a “Home Health Claims Review Overpayment Spreadsheet” for Petitioner showing claims that were denied because “[S]ervices not ordered.” Both the spreadsheet and the list of patients reference some, but not all, of the 43 individuals CMS identified and include individuals not identified in the CMS Motion for Summary Judgment. *Compare* P. Ex. G, at 3-8 and CMS Br. at 14-26. However, for 32 of the 43 individuals, the only evidence that Petitioner has ultimately come forward with to prove the disputed fact that Petitioner met the Medicare requirements for home health certification is Dr. Castaneda’s sparse affidavit.

Although I am required to draw all reasonable inferences in the light most favorable to Petitioner in deciding CMS’s motion for summary judgment, Petitioner is required to come forward with specific evidence to show a genuine issue of material fact exists.

However, Dr. Castaneda's affidavit does not provide the specificity of facts needed to properly overcome CMS's motion for summary judgment. The affidavit, for example, does not specifically describe the 32 individuals, when Dr. Castaneda allegedly certified that care was provided to the 32 individuals, where Dr. Castaneda saw these individuals, or attach any documentation required by 42 C.F.R. § 424.22(a). Therefore, without attaching any actual medical certifications or other specific records, Dr. Castaneda's vague statement alone does not provide the specificity for me to draw an inference in Petitioner's favor that Dr. Castaneda provided the requisite certifications for these 32 individuals. Therefore, after careful review of the documentation that Petitioner provided, I cannot conclude that Petitioner has presented evidence sufficient to establish the existence of a genuine factual dispute to an essential element of its case. Therefore, CMS is entitled to summary judgment.

IV. Conclusion

Petitioner has not shown a genuine issue of material fact exists with regard to CMS's challenge that a physician did not certify 32 of Petitioner's patients pursuant to Medicare home health care requirements. As a result, I must sustain CMS's determination to revoke Petitioner's Medicare enrollment and billing privileges because the undisputed evidence shows that Petitioner was not compliant with Medicare program requirements.

/s/

Joseph Grow
Administrative Law Judge