Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Profound Health Care,
(CCN: 05-8024),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-10-267

Decision No. CR2223

Date: August 18, 2010

DECISION

By this Decision I grant the pending Motion for Summary Disposition filed by the Centers for Medicare & Medicaid Services (CMS) on February 5, 2010, and thereby sustain its determination to terminate Petitioner Profound Health Care's Medicare provider agreement.

I. Procedural Background

Petitioner Profound Health Care (Profound) is located in Los Angeles, California and at one time was certified to participate in Medicare as a home health agency (HHA). On June 1, 2009, the California Department of Public Health (CDPH) completed a recertification survey of Profound and documented that it was not in substantial compliance with four Conditions of Participation (COPs) in the Medicare program. A follow-up survey was completed by CDPH on August 18, 2009, and revealed that Profound was not in substantial compliance with eight COPs, including the four COPs it failed to satisfy in June. CMS determined that Profound's failure to meet the eight COPs warranted the termination of Profound's Medicare provider agreement, and notified Profound of that determination by letter of October 22, 2009.

Profound sought review of CMS's action in its December 17, 2009 Request for Hearing. My Acknowledgment and Initial Docketing Order of January 7, 2010 required the parties to file any dispositive motions within 30 days, and CMS complied by filing its Motion for Summary Disposition on February 5, 2010. Profound filed its Rebuttal Brief on February 19, 2010. My Ruling of April 13, 2010 solicited additional briefing from the parties, and that cycle of briefing has been completed. Both CMS and Profound have proffered documents in support of their respective positions, and I have admitted all of them — CMS Exhibits 1-6 (CMS Exs. 1-6) and Profound's Exhibits 1-7 (P. Exs. 1-7) — to the evidentiary record.

I have reviewed the entire evidentiary record, and have carefully considered the parties' positions as articulated in all of their pleadings. Having done so, I find and conclude that there are no material questions of fact in dispute as to one COP, and that those settled material facts entitle CMS to judgment as a matter of law.

II. Issue

The sole legal issue before me in this case is whether CMS was authorized to terminate Profound's Medicare provider agreement.

III. Controlling Statutes and Regulations

The Social Security Act (Act) establishes requirements for HHAs participating in the Medicare and Medicaid programs, and authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations implementing the statutory provisions. Act, sections 1861(m) and (o), and 1891 (42 U.S.C. §§ 1395x(m) and (o); 1395bbb). The Secretary's regulations governing HHA participation in the Medicare program are found at 42 C.F.R. Part 484.

In order to participate in the Medicare program and obtain reimbursement for its services a HHA must be in compliance with all applicable COPs as specified in 42 C.F.R. Part 484. 42 C.F.R. § 488.3(a)(2). Periodic review of compliance with those COPs is required and such reviews or surveys are generally conducted by a state agency. Based upon its survey, the state agency certifies either compliance or noncompliance of the surveyed provider. 42 C.F.R. §§ 488.20, 488.24, 488.26.

The state agency certifies that a HHA is not in substantial compliance with the COPs when "the deficiencies are of such character as to substantially limit the provider's . . . capacity to furnish adequate care or which adversely affect the health and safety of patients." 42 C.F.R. § 488.24(b). Whether a provider is in substantial compliance with a COP depends upon the "manner and degree to which the provider . . . satisfies the various standards within each condition." 42 C.F.R. § 488.26(b); *CSM Home Health Services*, DAB No. 1622, at 6-7 (1997). Surveyors are required to "directly observe the actual

provision of care and services to residents, and the effects of that care, to assess whether the care provided meets the needs of individual residents . . . ." 42 C.F.R. § 488.26(c)(2).

CMS is authorized to terminate a provider agreement when the provider no longer meets the requirements of the Act or fails to meet the COPs, among other grounds listed in the regulation. 42 C.F.R. § 489.53. A provider's failure to meet even a single COP is sufficient to authorize CMS to terminate its provider agreement. If authorized, the choice to terminate a provider's agreement lies in CMS's discretion. *See United Medical Home Care*, DAB No. 2194 (2008).

IV. Findings and Conclusions

I find and conclude as follows:

1. In May, June, and July 2009, Petitioner participated in the Medicare program as a HHA.

2. In May, June, and July 2009, Petitioner was obliged, as a COP in the Medicare program, substantially to comply with the COP set out at 42 C.F.R. § 484.20, among other COPs set out at 42 C.F.R. Part 484, Subparts B and C.

3. Petitioner failed substantially to comply with the COP set out at 42 C.F.R. § 484.20 during May, June, and July 2009.

4. Because Petitioner failed substantially to comply with the COP set out at 42 C.F.R. § 484.20, a basis exists for termination of Petitioner's provider agreement and participation in the Medicare program, effective November 23, 2009.

V. Discussion

In considering motions for summary disposition, this forum is guided by FED. R. CIV. P. 56. Summary disposition is appropriate when, and only when, the record shows that there is no genuine issue as to any material fact, and that the moving party is entitled to judgment in its favor as a matter of law. A fact is "material" if, and only if, it is necessary to deciding a case's outcome. In evaluating whether there is a genuine issue as to a material fact, the administrative law judge must view the facts and the inferences reasonably to be drawn from the facts in the light most favorable to the nonmoving party. *See Pollock v. American Tel. & Tel. Long Lines*, 794 F.2d 860, 864 (3rd. Cir. 1986); *Madison Health Care, Inc.*, DAB No. 1927, at 5-7 (2004). This formulation of the summary-disposition principle — and of its corollary, that the administrative law judge must not assess the credibility or weight of conflicting evidence — has been emphasized repeatedly by the Departmental Appeals Board (Board), most notably in *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 (2010); *Ill. Knights Templar Home*, DAB No. 2274

(2009); *Kingsville Nursing & Rehab. Ctr.*, DAB No. 2234 (2009); *Brightview Care Ctr.*, DAB No. 2132 (2007). I have applied those principles in my analysis of the record before me in this matter.

In applying those principles, I have followed a similar approach with reference to each of the COPs identified immediately below. First, I have reviewed the assertions Profound made with reference to all of the COPs at issue in its Request for Hearing, and have specifically sought to identify the assertion of any material facts supporting Profound's claim of substantial compliance with any of the COPs at issue in this case. Next, I have reviewed CMS's Motion and its briefs, and CMS Exs. 1-6, to determine what material facts, if any, CMS contends are not in dispute with reference to the particular COPs at issue. Third, I have reviewed Profound's briefs and P. Exs. 1-7 to determine whether those pleadings and exhibits leave any material facts with reference to any of the COP at issue in genuine dispute. As I shall discuss in detail below, my review has demonstrated that, with reference to the individual COP set out at 42 C.F.R. § 484.20, no material facts remain in genuine dispute, and those undisputed material facts entitle CMS to summary disposition in its favor as to that COP. Since Profound's failure to meet even a single COP is sufficient to support CMS's decision to terminate its provider agreement, I need not discuss or rule on Profound's compliance vel non with the remaining COPs.

CMS's allegations of condition-level noncompliance by Profound are based on the revisit survey completed August 18, 2009. That survey determined that Petitioner failed to comply with eight conditions of participation for HHAs, as outlined in the following regulations:

- 42 C.F.R. § 484.10 (Patient rights);
- 42 C.F.R. § 484.14 (Organization, services, and administration);
- 42 C.F.R. § 484.18 (Acceptance of patients, plan of care, medical supervision);
- 42 C.F.R. § 484.20 (Reporting OASIS information);
- 42 C.F.R. § 484.30 (Skilled nursing services);
- 42 C.F.R. § 484.36 (Home health aide services);
- 42 C.F.R. § 484.48 (Clinical records); and
- 42 C.F.R. § 484.55 (Comprehensive assessment of patients).

Profound had been observed to be non-compliant with the COPs set out at 42 C.F.R. §§ 484.14, 484.18, 484.48, and 494.55 during the survey of June 1, 2009.

As I note above, failure by Profound to comply with even one condition of participation gives CMS grounds to terminate its participation in Medicare. In this decision I find and conclude that Profound failed substantially — indeed, failed completely — to comply with the COP established at 42 C.F. R. § 484.20, and failed to do so for a period of approximately three months. That COP requires HHAs to report timely and electronically certain data identified in 42 C.F.R. § 484.55 as the Outcome and

Assessment Information Set (OASIS), and establishes a comprehensive system by which the HHA must do so. The full terms of the COP are here set out:

> **§ 484.20 Condition of participation: Reporting OASIS information.**
>
> HHAs must electronically report all OASIS data collected in accordance with § 484.55.
>
> (a) Standard: Encoding and transmitting OASIS data. An HHA must encode and electronically transmit each completed OASIS assessment to the State agency or the CMS OASIS contractor, regarding each beneficiary with respect to which such information is required to be transmitted (as determined by the Secretary), within 30 days of completing the assessment of the beneficiary.
>
> (b) Standard: Accuracy of encoded OASIS data. The encoded OASIS data must accurately reflect the patient's status at the time of assessment.
>
> (c) Standard: Transmittal of OASIS data. An HHA must—
>
> (1) For all completed assessments, transmit OASIS data in a format that meets the requirements of paragraph (d) of this section.
> (2) Successfully transmit test data to the State agency or CMS OASIS contractor.
> (3) Transmit data using electronics communications software that provides a direct telephone connection from the HHA to the State agency or CMS OASIS contractor.
> (4) Transmit data that includes the CMS-assigned branch identification number, as applicable.
>
> (d) Standard: Data Format. The HHA must encode and transmit data using the software available from CMS or software that conforms to CMS standard electronic record layout, edit specifications, and data dictionary, and that includes the required OASIS data set.

42 C.F.R. § 484.20.

The facts of Profound's failure to comply with the regulation and the COP are plain and uncontested: in May, June, and July 2009 Profound simply did not transmit the required reports to CMS or to anyone else. Profound has never during the course of these proceedings suggested that it did in fact transmit the reports, or that the reports were transmitted but somehow not received by the appropriate agency. Indeed, Profound has conceded from the outset of this litigation what it admitted in its Request for Hearing, at

page 25, that "Due to Profound's computer problems reported to the (California) Department of Public Health, Profound was not able to timely transmit OASIS data." It is Profound's position now that its "computer problems" were actually the result of a "very serious burglary" (Pet. Rebuttal, at 12; P. Ex. 4) on July 21, 2009. While I accept Profound's assertion that its offices were burglarized and its computers stolen on that date, the burglary and theft do not explain or excuse its failure to file the required reports for May and June. The only OASIS reports provided to the surveyors were transmitted on June 1, 2009 and were for the months of March and April 2009. No OASIS report for July was transmitted even after the stolen computers had been replaced and the network restored. CMS Ex. 2, at 79-81. Profound's lapse was serious and prolonged, and carried with it the obvious potential of limiting substantially its capacity to furnish adequate care to, and to protect the health and safety of, its patients. The COP set out at 42 C.F.R. § 484.20 was breached by Profound's failure to transmit the reports for three months, and that breach warrants CMS's termination of Profounds's Medicare provider agreement.

VI. Conclusion

For all of the reasons recited above, I sustain CMS's determination that Petitioner was in condition-level violation of the Medicare COP set out at 42 C.F.R. § 484.20, and I find and conclude that a basis exists for termination of Petitioner's provider agreement and participation in the Medicare program, effective November 23, 2009.

/s/

Richard J. Smith
Administrative Law Judge