Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Therapy Management Services, Inc., d/b/a CompRehab, (CCN: 49-6641),	)	Date: January 26, 2009
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-08-301
	)	Decision No. CR1892
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

Petitioner, Therapy Management Services, Inc., d/b/a CompRehab (Petitioner or CompRehab), provided outpatient physical therapy (OPT) services in Woodbridge, Virginia. Until its termination on January 10, 2008, CompRehab was certified to participate in the Medicare program. However, following a survey completed on May 23, 2007, the Centers for Medicare & Medicaid Services (CMS) terminated CompRehab's program participation because it failed to maintain substantial compliance with six out of twelve conditions of participation. Petitioner here challenges its termination. CMS now moves for summary judgment.[1]

[1] CMS filed a Brief in Support of Summary Affirmance (CMS Br.), accompanied by 11 proposed exhibits (CMS Exs. 1-11). Petitioner, represented by Brenda M. Hunt, its owner/administrator, did not submit a separate brief, but responded with 12 proposed exhibits (P. Exs. 1-12). One of those exhibits, a written statement signed by Administrator Hunt, sets forth Petitioner's allegations of fact and legal arguments. P. Ex. 1. CMS filed a reply brief (CMS Reply).

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. CMS was therefore authorized to terminate its Medicare provider agreement.

Discussion

> ***CMS is entitled to summary judgment because the undisputed facts establish that CompRehab failed to maintain substantial compliance with all Medicare conditions of participation, and CMS is therefore authorized to terminate its 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*, *Inc.,* 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).

OPT services may be covered by the Medicare program if they are provided in accordance with statutory and regulatory requirements. The Social Security Act (Act) defines OPT services as physical therapy services furnished by, or under arrangement with, a provider of services, clinic, rehabilitation agency or public health agency to an individual who is under the care of a physician, and with respect to whom a physician or qualified physical therapist has established a care plan prescribing the type, amount and duration of services. A physician must review the plan periodically. Act § 1861(p). Pursuant to the Act, the Secretary of Health and Human Services has, by regulation, established additional health and safety requirements called "conditions of participation." Act § 1861(p)(4); 42 C.F.R. §§ 485.701; 488.1.

A "condition of participation" represents a broad category of OPT services. Each condition is contained in a single regulation, which is divided into subparts called standards. 42 C.F.R. Part 485. Compliance with a condition of participation is determined by the manner and degree to which the provider satisfies the standards within the condition. 42 C.F.R. §§ 488.1; 488.26(b). If 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," the provider is not in compliance with conditions of participation. 42 C.F.R. § 488.24(b).

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

CMS, acting on behalf of the Secretary, may terminate a provider agreement based on the provider's failure to comply with the provisions of section 1861 or its failure to comply with *all* applicable conditions of participation. Act § 1866(b)(2); 42 C.F.R. § 489.53(a); *Community Home Health*, DAB No. 2134, at 12 (2007). To monitor compliance, CMS contracts with state agencies that conduct periodic surveys. Act § 1864(a); 42 C.F.R. § 488.20. For facilities that are not skilled nursing facilities (SNFs), nursing facilities (NFs), or home health agencies, the State Agency must survey "as frequently as necessary to ascertain compliance. . . ." 42 C.F.R. § 488.20(b)(1).

Here, CompRehab apparently was not surveyed for more than eleven years – from February 1996 until May 2007. P. Ex. 1. On May 23, 2007, the Virginia Center for Quality Health Care Services and Consumer Protection (State Agency) completed a re-certification survey.[3] CMS Ex. 2. Based on the survey findings, CMS has determined that CompRehab was not in substantial compliance with six conditions: 42 C.F.R. § 485.709 (administrative management); 42 C.F.R. § 485.717 (rehabilitation program); 42 C.F.R. § 485.721 (clinical records); 42 C.F.R. § 485.725 (infection control); 42 C.F.R. § 485.727 (disaster preparedness); and 42 C.F.R. § 485.729 (program evaluation). CMS Exs. 1, 11.[4]

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[3] At the time of the survey, CompRehab was dually enrolled in the Medicare program as both a comprehensive outpatient rehabilitation facility (CORF) and an OPT provider, but, following the survey, it withdrew its CORF participation and continued only as an OPT provider. CMS Ex. 3, at 1, 2 (Thomas-Naarden Decl. ¶¶ 4, 6, 8); CMS Ex. 10, at 2.

[4] Among other deficiencies, CompRehab lacked by-laws; it had failed to disclose a change in ownership and control; it had no budget plan or cost report, no staff job descriptions, no performance evaluations, no evidence of continuing education. Policies were neither dated nor signed; no evidence suggested physician or physical therapist involvement in their development; CompRehab did not have a group of professional personnel to develop and review policies. The physician named in the emergency services policy was no longer on staff, and staff were instructed to call 911 in the event of an emergency if the patient's private physician could not be reached. Assessments for social and vocational adjustment were not conducted and those services were not provided. CompRehab had no contracts for outside services. Clinical records, stored offsite, could not be obtained in the Administrator's absence. Some clinical records were stored in an unlocked closet. Cleaning solutions were stored under a sink near the children's treatment area. Necessary repairs had not been made. The facility had no designated containers for contaminated linens or dressings; it had no process for

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Petitioner has not challenged the May 2007 survey findings. Its hearing request acknowledges that "there were deficiencies at the time of the survey." Nor do Petitioner's subsequent submissions suggest any dispute with the survey findings. In fact, in her written statement, Administrator Hunt does not allege that CompRehab achieved substantial compliance any earlier than "the time of the expected re-visit of the survey team in early December 2008." P. Ex. 1.

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

I recognize that the petitioner in *Carmel* was a long-term care facility (SNF or NF). I also recognize that care should be exercised when applying to other types of providers decisions involving a long-term care facility's participation in the Medicare program. Although long-term care facilities are "providers" and generally subject to the same procedural rules as other providers, the rules are not identical. *Compare*, *e.g.*, 42 C.F.R. § 488.28 *with* 42 C.F.R. § 488.402. Special rules allow for the ongoing certification of noncompliant SNFs and NFs. 42 C.F.R. §§ 488.24; 488.330. In applying a SNF or NF ruling to another type of provider, it is therefore important to examine the underlying reasoning to assure that the ruling is not based solely on rules peculiar to long-term care, but instead is based on principles applicable to all providers.

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[4](...continued)
identifying patients with open sores. It had no process for identifying, investigating, preventing and controlling causes of patient infection. To clean equipment, staff used germicidal wipes with an expiration date more than two years earlier. No evidence showed that the carpeting had been cleaned, and the facility had no cleaning schedule. No provisions were in effect to insure that the premises were maintained free of rodent and insect infestation. The facility's 11-year-old disaster plan did not designate how, where, or by whom patients would be relocated. No evidence showed staff drills or training in disaster preparedness. CMS Ex. 8. Remarkably, the State Agency must have determined that these deficiencies neither jeopardized patient health and safety nor seriously limited CompRehab's capacity to render adequate care, because it allowed the facility to continue its participation contingent on its submission of an acceptable plan of correction. CMS Ex. 6. And CMS subsequently acquiesced in that determination. CMS Exs. 7, 10; *see*, 42 C.F.R. § 488.28(a) and (b).

The Departmental Appeals Board's reasoning in *Carmel* applies here. The Board 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 – here, the Board cited 42 C.F.R. § 489.13(a), a rule applicable to all providers – 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 the parties agree that CompRehab 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.

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 an opportunity to correct. CMS Exs. 6, 7, 10. But, because CMS is not required to afford a provider the opportunity to correct a condition-level deficiency before terminating its program participation, Petitioner's assertion that it took corrective action prior to the termination date is irrelevant. *Community Home Health*, DAB No. 2134, at 14; *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), neither the State Agency nor CMS found them acceptable, so CompRehab was not afforded a follow-up survey. CMS Exs. 1, 8, 9, 11. Petitioner bases this appeal on CMS's refusal to accept its Plan of Correction, arguing that it could have demonstrated its substantial compliance during a follow-up survey. But, notwithstanding the considerable time the parties have dedicated to the merits of CMS's determination to reject CompRehab's plan of correction, that determination is wholly within CMS's discretion and I simply have no authority to review it.[5]

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[5] Even though CMS has defended, on the merits, its determination to reject the plans of correction and to decline a follow-up survey, its brief also argues that, based on the cited deficiencies, "CMS may immediately terminate participation and had no obligation to solicit a plan of correction or grant a reasonable period in which to correct the deficiencies." (Citing 42 C.F.R. §§ 488.24; 488.28.) CMS Br. at 10-11. Further,

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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 CR 1142, at 3-4; *see also*, *HRT Laboratory, Inc.*, 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 the uncontroverted evidence establishes that, at the time of its May 2007 survey, CompRehab 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 judgement.

/s/
Carolyn Cozad Hughes
Administrative Law Judge

[5](...continued)
CMS argues that its rejection of CompRehab's plan of correction is not reviewable. CMS Br. at 11-12. Thus, Petitioner had notice of these ultimately dispositive arguments.