Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Care Pro Home Health, Inc.
(NPI: 1023278686;
PTAN: 74-7693),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-1362

Decision No. CR4321

Date: October 15, 2015

DECISION

The Centers for Medicare & Medicaid Services (CMS) revoked the Medicare enrollment and billing privileges of Care Pro Home Health, Inc. (herein "Petitioner") after it concluded that Petitioner was not operational at the practice location on file with CMS and its administrative contractor, Palmetto GBA. The CMS Provider Enrollment Oversight Group upheld the revocation in a reconsidered determination, and Petitioner requested a hearing to dispute the revocation. I affirm CMS's revocation of Petitioner's Medicare enrollment and billing privileges.

I. Background

Petitioner is a home health agency that was enrolled as a provider of services in the Medicare program. CMS Exhibit (Ex.) 1 at 1, 8. Palmetto GBA, in a November 4, 2014 letter, informed Petitioner that its Medicare billing privileges were revoked retroactively to July 16, 2014. CMS Ex. 3. Palmetto explained the following in its letter:

> CMS has determined, upon on-site review, that Care Pro Home Health Inc. is no longer operational to furnish Medicare covered items or services and is not meeting Medicare enrollment requirements under statute or regulation to supervise treatment of or to provide Medicare covered items or services for Medicare patients. On July 16, 2014 a site visit was conducted at 205 Oleander Dr. Desoto, TX 75115-1470. It was found that Care Pro Home Health Inc. is no longer operating from this location.

CMS Ex. 3 at 1.

On November 11, 2014, Petitioner requested reconsideration of the revocation, at which time Petitioner explained: "We are sorry that we forgot to notify Palmetto GBA/CMS of the change in facility address" and "we regret to realize that we failed to notify CMS of our change of address when we moved to a medical office building in [the] city of Lancaster on Nov[ember] 4, 2013." CMS Ex. 1 at 6. Petitioner sent the correspondence on letterhead containing the Desoto, Texas address, but Petitioner also included the new facility address in Lancaster at 2700 W. Pleasant Run Road, # 380, Lancaster, Texas. In its correspondence, Petitioner stated that it had notified the Texas Department of Aging and Disability Services (DADS) thirty days in advance of its relocation. CMS Ex. 1 at 6. Petitioner submitted with its reconsideration request a Notification of Change issued by DADS, dated November 14, 2014, showing that its change of address from the Desoto, Texas address to the Lancaster, Texas address, was effective October 25, 2013.[1] CMS Ex. 1 at 10. Petitioner also submitted a copy of its lease for the new location in Lancaster, Texas, along with a November 5, 2014 "Web Submission History Report" from the Provider Enrollment, Chain and Ownership System showing an activity description that "Provider is Reactivating a Deactivated Medicare Enrollment Record." CMS Ex. 1 at 11-14; P. Ex. 3.

CMS's Provider Enrollment Oversight Group issued a reconsidered determination on December 19, 2014, that determined that the Desoto, Texas location was "nonoperational" at the time of a site visit on July 16, 2014, and listed the basis for revocation as "42 C.F.R. § 424.535(a)(5): On-site Review." CMS Ex. 1 at 1. The reconsidered decision acknowledged that Petitioner contended that it had informed DADS of its new location, but explained that the provider did not attempt submission of a

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[1] The evidence regarding the precise date of the change of address is inconsistent. Petitioner submitted a declaration of Eucharia Pitts, the owner and chief financial officer of Petitioner, that indicates that Petitioner relocated on October 25, 2013. P. Ex. 1. However, in its reconsideration request, Petitioner contended that it relocated on November 4, 2013. P. Ex. 6. This slight discrepancy regarding the date Petitioner relocated is not material to the issue before me.

new form CMS-855A to Palmetto GBA until November 18, 2014, which is well after the failed attempt at an on-site visit and determination that the facility at the location of the on-site visit was not operational. CMS Ex. 1 at 1.

On February 17, 2015, Petitioner requested an administrative law judge hearing to dispute the revocation of its Medicare enrollment and billing privileges.

In an order dated March 9, 2015, Administrative Law Judge Keith W. Sickendick, who presided over this case prior to its reassignment to me on September 9, 2015, directed the parties to submit pre-hearing briefs addressing all issues of law and fact, along with any proposed exhibits. The order advised each party to provide a list of any witnesses it proposes to call at an oral hearing if oral hearing is not waived.

CMS submitted its pre-hearing brief, along with four proposed exhibits. Petitioner submitted twelve proposed exhibits with its pre-hearing brief and a motion for summary judgment.[2] CMS and Petitioner submitted several identical documents, and for identification purposes, duplicative exhibits will be referred to herein only by the exhibit numbers furnished by CMS.

CMS objects to the admission of a portion of P. Ex. 2 and the entirety of P. Exs. 5, 7, 8, and 10 as inadmissible new evidence. For reasons that will be discussed below, I exclude P. Ex. 2 in its entirety, and P. Exs. 5, 7, 8, and 10. Additionally, I find that P. Ex. 12 is not properly treated as evidence; I take judicial notice of but will not admit P. Ex. 12 as evidence. In the absence of further objections, I admit into evidence CMS Exs. 1-4 and P. Exs. 1, 3, 4, 6, 9, and 11.

CMS has not requested an in-person hearing to cross-examine any witnesses. Petitioner initially expressed a desire to cross-examine Tanesha Norman, a provider enrollment manager who supplied a declaration that was submitted by CMS at CMS Ex. 4. *See* Petitioner's May 8, 2015 Request to Cross Examine CMS's Witness. However, the parties subsequently and jointly reported, in a July 2, 2015, status report, that Petitioner waived a video teleconference hearing. The parties also requested that Administrative Law Judge Sickendick allow them an opportunity to submit additional briefing. Joint Status Report, submitted July 2, 2015. A July 9, 2015 Order by Administrative Law Judge Sickendick directed a briefing schedule and indicated that the case would be decided on the record if it was determined that an oral hearing is unnecessary. Petitioner and CMS filed their briefs (Pet. Br. and CMS Br.) on August 7 and 8, 2015, respectively.[3]

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[2] In a ruling dated June 5, 2015, Administrative Law Judge Sickendick denied Petitioner's motion for summary judgment.

[3] Along with its brief, Petitioner submitted Petitioner's Proposed Findings of Fact and Conclusions of Law.

On August 17, 2015, Petitioner filed an Objection to CMS's Evidence in which it objected to the Declaration of Tanesha Norman that was submitted on April 8, 2015.[4] Both parties filed reply briefs (CMS Reply and P. Reply) on September 4, 2015.

I consider the record in this case to be closed, and the matter is ready for a decision on the merits. *See* Civil Remedies Division Procedures (CRDP) §§ 19(c), (d).

II. Issue

Whether CMS has a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges because Petitioner was not operational at the practice location on file with CMS when an inspector attempted to conduct a site visit.

III. Jurisdiction

I have jurisdiction to decide this case. 42 C.F.R. §§ 405.803(a), 424.545(a)(1), 498.3(b)(17), 498.5(l)(2); *see also* 42 U.S.C. § 1395cc(j)(8).

IV. Findings of Fact, Conclusions of Law, and Analysis[5]

To participate in the Medicare program as a provider, a provider must complete a form CMS-855A enrollment application, which requires disclosure of the provider's address. *See* 42 C.F.R. § 424.510(a). Once enrolled, a provider must report, within 90 days, any changes in its enrollment information, including its address. 42 C.F.R. § 424.516(e)(2). CMS may require periodic revalidations and perform site visits to verify the provider's enrollment information, the provider's compliance with Medicare enrollment requirements, and that the provider is operational. 42 C.F.R. §§ 424.510(d)(8), 424.515(c), 424.517(a). If CMS determines that a provider is not operational, then CMS may revoke the provider's Medicare enrollment and billing privileges retroactive to the date that CMS determined that the provider was not operational. 42 C.F.R. §§ 405.800(b)(2), 424.535(a)(5)(i), (g).

1. Petitioner has not shown good cause for offering new documentary evidence that it did not submit at the initial

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[4] I observe that Petitioner, in its objection, incorrectly asserts that "CMS did not file an opening brief or additional evidence pursuant to [Judge Sickendick's July 9, 2015] order." This statement is patently incorrect, as CMS filed a timely opening brief on August 8, 2015.

[5] My numbered findings of fact and conclusions of law appear in bold and italics.

or reconsideration determination phases, and there is no basis to admit this evidence into the record.

Petitioner submitted five proposed documentary exhibits (P. Exs. 2, 5, 7, 8, and 10) that it did not previously submit at either the initial or reconsideration determination levels. In addition, Petitioner submitted another proposed exhibit (P. Exs. 12) that is not appropriately treated as "evidence."[6] These six proposed exhibits will not be admitted into the record.

Petitioner submitted the following documents that were not previously submitted: P. Ex. 2 (described as "DADS Change of Address License"); P. Ex. 5 (described as a "Notice of Overpayment"); P. Ex. 7 (described as "DADS Relocation CMS Approval Letter"); P. Ex. 8 (described as "Palmetto Update Address Letter"); and P. Ex. 10 (described as "Letter to CMS Deputy Regional Administrator David R. Wright").

CMS argues that Petitioner did not previously submit these documents and that Petitioner has not shown good cause for failing to present them earlier, as required by 42 C.F.R. § 498.56(e). CMS's Objections to Petitioner's Exs. I find the bases for the objections to be persuasive.

I must examine new documentary evidence that is offered by a provider or supplier and determine whether good cause exists for receiving that evidence. 42 C.F.R. § 498.56(e)(1). I must exclude any new documentary evidence at the administrative law judge level of appeal if I do not find good cause for Petitioner's failure to offer that evidence at the initial or reconsideration determination levels. 42 C.F.R. § 498.56(e)(2)(ii). While "good cause" is not defined in the regulations, the term has been interpreted to mean an event beyond a party's control that prevents the party from offering the evidence timely. *See, e.g., City Crown Home Health Agency, Inc.,* DAB CR3130 at 4 (2014). With regard to P. Ex. 2, CMS has objected to pages 2 through 4 of that proposed exhibit. As a preliminary matter, I observe that, page 1 of that proposed exhibit has been admitted into evidence as CMS Ex. 1 at 10. However, the copy of the document that has been admitted does not bear the handwritten markings that appear on page 1 of Petitioner's proposed exhibit. On its exhibit list, CMS described CMS Ex. 1 as "Reconsideration decision dated December 19, 2014 with evidence considered by the hearing officer." Petitioner did not object to this description. As such, page 1 of P. Ex. 2

[6] I do not consider P. Ex. 11 to constitute evidence. However, the excerpt from Chapter 15 of the Medicare Program Integrity Manual submitted as P. Ex. 11 differs from the current online version of the same manual, and therefore I have admitted it into evidence. The current online version of the Medicare Program Integrity Manual can be found at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads /pim83c15.pdf* (last visited October 9, 2015).

is not a verbatim copy of the document that was provided to CMS at the time of the request for reconsideration, and I will not admit it into evidence. With regard to pages 2 through 4 of P. Ex. 2, those pages pertain to a paperwork and payment submitted to DADS for a change of address that was reported on September 23, 2013, which pre-dates the date of the request for reconsideration by more than one year. Therefore, the dates of the documents clearly suggest that they were in existence at the time of the initial and reconsidered determinations. Petitioner has not alleged any factor amounting to good cause for why it did not submit pages 2 through 4 earlier, and I see no basis to find good cause to allow the submission of documents that were in existence prior to the initial and reconsidered determinations.

With respect to P. Exs. 2, 5, 7, 8, and 10, Petitioner argues that "[t]he evidence was not available at the time the request for reconsideration was filed, and only become [sic] relevant after the reconsideration decision was issued and during the federal district court litigation with CMS and Palmetto." Petitioner's Motion and Notice of Motion for Summary Judgment at 3. Petitioner alleges that these exhibits were submitted because "[o]nly recently and after the reconsideration request was submitted did CMS begin to allege the provider's noncompliance with 42 C.F.R. § 424.516(e) or the Petitioner's alleged failure to update address records with Palmetto."[7] *Id.* Noncompliance with 42 § 424.516(e) was not the basis for the revocation of Petitioner's billing privileges; rather, an inability by CMS to perform an unannounced on-site review, pursuant to 42 C.F.R. § 424.535(a)(5), was the basis for the revocation. Pursuant to 42 C.F.R. § 498.5(1) and (2), an entity that is dissatisfied with a reconsidered determination is entitled to a hearing before an administrative law judge, and the last determination of CMS or its agent, namely the reconsidered determination, is the determination that is subject to administrative law judge review. *See Neb Group of Arizona LLC,* DAB No. 2573 at 7 (2014); *Benson Ejindu, d/b/a Joy Medical Supply,* DAB No. 2572 at 5 (2014) (the reconsideration determination is the agency action that is subject to review). Thus, even if CMS now alleges, as Petitioner asserts, that Petitioner's billing privileges should be revoked on a different basis than was found in the reconsidered determination, I will limit

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[7] Petitioner's allegation that the issue of its failure to update its enrollment was not raised until *after* the reconsideration request is simply untrue. In its November 11, 2014 request for reconsideration, Petitioner brought this issue to the attention of CMS. Specifically, Petitioner informed CMS that it "failed to notify CMS" of its change of address and "forgot to notify Palmetto GBA/CMS of the change in facility address." CMS Ex. 1 at 6. Subsequently, the December 19, 2014 reconsidered determination explained that Palmetto GBA was not notified of the relocation until November 18, 2014, which is well after the site inspector determined that the Desoto location was not operational.

my review to the basis or bases for revocation that are provided in the December 19, 2014 reconsidered determination.[8]

As such, Petitioner has not asserted how there is good cause for the belated submission of these documents or how their inclusion in the record will have any relevance to my review of the reconsidered determination. Thus, even if I could accept these exhibits and admit them as evidence, Petitioner has not shown how they would support its appeal.

Additionally, Petitioner has submitted a decision by another administrative law judge from the Departmental Appeals Board's Civil Remedies Division (P. Ex. 12). I will take judicial notice of the decision; however, it is not properly classified as "evidence" and will not be admitted as an exhibit.[9]

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[8] The purported relevance of P. Exs. 5, 7, 8 and 10 is unclear to me. P. Ex. 5 references an overpayment that was created after Petitioner's billing privileges were revoked; however, the existence of an overpayment has no bearing on my review of the reconsidered determination. Likewise, P. Ex. 7 is a January 30, 2015 letter from DADS, but this correspondence does not in any way indicate that Petitioner was operational at the location of record with the CMS contractor at the time of the attempted site visit. P. Ex. 8 is dated May 21, 2013, and I am unable to discern this document's relevance to any issue that is presently before me. I reject Petitioner's citation to this document as authority for its proposition that it is the Medicare contractor's policy "to request that a provider update information when it learns the practice location reflected in the on-file enrollment application is not current." P. Br. at 9. Finally, Petitioner, at P. Ex. 10, has submitted a letter from its attorney to the CMS Deputy Regional Administrator in which the attorney expresses an intent to file a lawsuit. I am unable to glean any evidentiary significance from this correspondence.

[9] P. Ex. 12 is a copy of the administrative law judge decision in *Gibraltar Healthcare Services, LLC*, DAB CR3422 (2014). I observe that the *Gibraltar* decision is based on a dissimilar set of facts, in that Administrative Law Judge Carolyn Cozad Hughes found that CMS had improperly revoked a Medicare supplier number because the petitioner had "properly advised the Medicare contractor of its change in location." *Gibraltar Healthcare Services, LLC*, at 11. This decision is available on the Civil Remedies Division's website. *See http://www.hhs.gov/dab/decisions/civildecisions/2014/cr3422.pdf* (last visited October 9, 2015). Moreover, I reiterate that CMS did not revoke Petitioner's enrollment and billing privileges based on Petitioner's failure to timely notify CMS of its change of address. Instead, Palmetto GBA revoked Petitioner's enrollment and billing privileges based on a finding that Petitioner was not operational at the address on file. Accordingly, this decision is not relevant.

For the reasons stated above, I decline to admit P. Exs. 2, 5, 7, 8, 10, and 12.

> ***2. A Palmetto inspector attempted to conduct a site visit on July 16, 2014, at the address on file for Petitioner (205 Oleander Dr., Desoto, Texas); however, that location was not open to the public or staffed to allow the inspector to enter the office.***

Petitioner does not dispute that it was not operational at the location of the attempted site visit on July 16, 2014. P. Ex. 6; Petitioner's Proposed Findings of Fact and Conclusions of Law. Furthermore, Petitioner does not dispute that it had not notified CMS of its relocation until November 2014. CMS Ex. 1 at 11; Petitioner's Proposed Findings of Fact and Conclusions of Law (paragraph 14). Petitioner was enrolled in the Medicare program with its address listed as 205 Oleander Dr., Desoto, Texas. CMS Ex. 1 at 1; CMS Ex. 2 at 1; CMS Ex. 4 at 1-2. It is also undisputed that, on or about October 25, 2013, Petitioner moved its office to 2700 W. Pleasant Run Road in Lancaster, Texas. CMS Ex. 1 at 1, 6, 10. CMS does not challenge Petitioner's argument that it timely notified the Texas DADS of its relocation to Lancaster, Texas, and I see no evidence to refute that timely notice of such was provided to the Texas DADS. However, the issue before me is not whether the Texas DADS was notified of the relocation, or even whether Petitioner timely notified CMS of its change in address, but rather, whether the office location on file with Medicare was operational at the time of the July 16, 2014 on-site review. Petitioner has not disputed that, at the time of the July 16, 2014 on-site review, its Desoto, Texas, office was not operational.[10] Furthermore, Petitioner has acknowledged that it had relocated its office more than eight months prior to the unannounced on-site review and that the address on file with CMS as of July 16, 2014, was the then-closed Desoto location. CMS Ex. 1 at 6.

On July 16, 2014, between 3:30 pm and 4:30 pm, an inspector with Palmetto GBA attempted to conduct an unannounced site inspection of Petitioner's office at 205 Oleander Drive in Desoto, Texas. CMS Ex. 2 at 1. The inspector wrote in his inspection report that when he arrived at that location, which is a private residence, the homeowner told him that Petitioner had relocated to 2700 Pleasant Run Road, Suite 380, in Lancaster, Texas. CMS Ex. 2 at 1. The inspector noted in his report that Petitioner: was not open

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[10] A declaration of Eucharia Pitts, the owner and chief financial officer of Petitioner, was received and admitted as P. Ex. 1. The declarant reported that Petitioner relocated to its new location in Lancaster, Texas, on October 25, 2013. The declarant indicated that Petitioner's address was updated with the Texas DADS, but did not assert that the address on file with CMS or Palmetto was the new location in Lancaster. In addition, the declarant did not report that the location in Desoto, Texas, was open at the time of the on-site visit on July 16, 2014. P. Ex. 1.

for business; did not have employees/staff present; did not have customer activity; and did not appear to be operational. CMS Ex. 2 at 1.

3. CMS had a basis to revoke Petitioner's Medicare billing privileges pursuant to 42 C.F.R. § 424.535(a)(5) because the July 16, 2014 on-site visit showed that Petitioner was not operational at the location on file with CMS.

Petitioner acknowledges that it left the 205 Oleander Drive location on or about October 25, 2013, which was more than eight months prior to the inspector's attempted on-site visit. CMS Ex. 1 at 6, 10; Petitioner's Proposed Findings of Fact and Conclusions of Law. Petitioner argues that on July 16, 2014, it was operational at a different address in Lancaster, Texas. Petitioner stresses that it timely completed a change of location form for DADS. CMS Ex. 1 at 6; P. Br. (passim). Petitioner has also asserted that the inspector had knowledge of its new location at the time of the site visit, as the homeowner at the Oleander Drive location had shared that information with the inspector. *See* CMS Ex. 2 at 1; P. Ex. 1.

A provider is considered to be "operational" when it:

> 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.

42 C.F.R. § 424.502. CMS may revoke a currently enrolled provider's Medicare billing privileges, when upon on-site review, it determines that the provider is "[n]o longer operational to furnish Medicare-covered items or services." 42 C.F.R. § 424.535(a)(5)(i). Even if Petitioner was open and staffed at its Lancaster, Texas, location on July 16, 2014, the regulatory definition of the term "operational" refers to the "qualified physical practice location" of a provider. 42 C.F.R. § 424.502. The Medicare enrollment application directs that a provider report all practice locations and states that "the 'primary practice location' must be associated with the [National Provider Identifier] that the provider intends to use to bill for Medicare services" (*see* form CMS-855A), and a provider must provide "[c]omplete, accurate and truthful responses to all information requested within each section [of the enrollment application] as applicable to the provider or supplier type." 42 C.F.R. § 424.510(d)(2)(ii). CMS may perform on-site inspections to verify that the enrollment information submitted by a provider is accurate and to determine compliance with Medicare requirements. 42 C.F.R. § 424.517(a). This means that CMS will inspect the "qualified physical practice location" that has been provided by

the provider and is currently on file with CMS. *See, e.g.*, *JIB Enterprises, LLC*, DAB CR3010 at 9 (2013). As the regulatory drafters explained,

> when CMS or our contractor determines that a provider . . . is no longer operating *at the practice location provided to Medicare on a paper or electronic Medicare enrollment application* that the revocation should be effective with the date that CMS or our contractor determines that the provider or supplier is no longer operating at the practice location.

73 Fed. Reg. 69,725, 69,865 (Nov. 19, 2008) (emphasis added).

In the present matter, there is undisputed evidence that Petitioner was not open to the public or properly staffed and thus not operational at the 205 Oleander Drive, Desoto, Texas location, which was the address Petitioner had on file with CMS at the time of the July 16, 2014 attempted on-site visit. I conclude that CMS had a legal basis to revoke Petitioner's billing privileges pursuant to 42 C.F.R. § 424.535(a)(5)(i).

V. Conclusion

I affirm the revocation of Petitioner's Medicare enrollment and billing privileges effective July 16, 2014.

/s/

Leslie C. Rogall
Administrative Law Judge