Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: March 30, 2010
Mission Home Health, et al.,	
Petitioner,	Civil Remedies CR2007 App. Div. Docket No. A-10-13
	Decision No. 2310
- v. -	
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Mission Home Health, comprising 22 entities doing business under that name, requests review of the September 18, 2009 decision by Administrative Law Judge (ALJ) Carolyn Cozad Hughes granting summary judgment and affirming the determination of the Centers for Medicare & Medicaid Services (CMS) to deny their enrollment in the Medicare program as Home Health Agencies (HHAs). Mission Home Health, et al., DAB CR2007 (2009) (ALJ Decision). The ALJ determined that the undisputed facts established that none of these 22 entities were operational as required for enrollment as a Medicare provider.

Mission raises objections to CMS's evidence but concedes that its component entities were not in business at the time of the on-site inspection. Mission asserts they were forced to close because CMS failed to timely act on Mission's enrollment applications and argues that this delay violated its

constitutional due process rights. As we discuss below, none of these arguments allege any error in the ALJ Decision, which we affirm.

Legal Background

"Enrollment" is the process Medicare uses to establish a provider's eligibility to submit claims for Medicare-covered services and supplies, including validation of the provider's eligibility to provide items or services to Medicare beneficiaries. 42 C.F.R. § 424.502. CMS "uses on-site inspections," sometimes by Medicare contractors, "to determine compliance with Medicare enrollment requirements." 42 C.F.R. § 424.515(c); Renal CarePartners of Delray Beach, LLC, DAB No. 2271, at 2 (2009).

One requirement for enrollment is that a provider be "operational," meaning that 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 . . . to furnish these items or services." 42 C.F.R. §§ 424.502, 424.510(d)(6). CMS "may deny a provider's or supplier's enrollment in the Medicare program" for reasons including:

> *On-site review*. Upon on-site review or other reliable evidence, we determine that the provider or supplier is not operational, or is not meeting Medicare enrollment requirements to furnish Medicare covered items or services. Upon on-site review, CMS determines that—
>
> (i) A Medicare Part A provider is no longer operational to furnish Medicare covered items or services, or the provider fails to satisfy any of the Medicare enrollment requirements.

42 C.F.R. § 424.530(a)(5).

The ALJ Decision

The following summary is based on the ALJ's recitation of the evidence, which Mission does not dispute. The entities applying for enrollment under Mission's name were part of an enterprise to sell "turn key" HHAs that had provider numbers authorizing them to bill Medicare. ALJ Decision at 1, citing CMS Exhibit (Ex.) 30, at 2, and P. Br. at 3. Each entity listed the same street address and one of two suite numbers as its practice

location on its Medicare enrollment application, and all entities shared the same fax number and one of two telephone numbers and e-mail addresses. Id. at 3, citing CMS Exs. 1-22, and P. Ex. 1.

An on-site investigator visited the listed street address on May 27, 2008 to verify compliance. The investigator reported that Mission was no longer at one suite listed for four entities; at another suite listed for 18 entities, the door was locked, the space was dark and no one answered the door. ALJ Decision at 3, citing CMS Ex. 29, at 3 (investigator's affidavit), and CMS Ex. 24. He reported being told by the Senior Property Manager that Mission Home Health had been locked out of the two suites since March 2008 for non-payment of rent. Id. CMS's Medicare contractor, Palmetto Government Benefits Administrators, denied the entities' enrollment applications in notices dated June 12, 2008. Id. at 1, 2, citing P. Br. at 4, and CMS Exs. 23, 24. Mission requested reconsideration, and CMS upheld Palmetto's initial determinations in notices dated February 11, 2009. Id. at 2, citing CMS Ex. 27.

The ALJ found the evidence "sufficient to show 'an absence of evidence to support' Petitioner's claim that its entities are entitled to Medicare enrollment." ALJ Decision at 3, citing Celotex Corp. v. Carrett, 477 U.S. 317, 325 (1986). She found that Mission had come forward with "nothing to suggest" that its entities "were open to the public, had even one single employee, or had purchased any of the equipment or stock necessary for providing home health care services." ALJ Decision at 4. She rejected Mission's argument that CMS violated Mission's constitutional due process rights by failing to act on the applications within 45 days, on grounds including that she had no authority to review constitutional claims. She concluded that "CMS is entitled to summary judgment because the undisputed facts establish that none of these 22 entities doing business as Mission Home Health are operational, and CMS may deny Medicare enrollment if it determines that a potential provider is not operational." Id. at 2, citing 42 C.F.R. § 424.530(a).

Standard of review

Summary judgment is appropriate when the record shows that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. See Celotex, 477 U.S. at 322-25; Everett Rehabilitation and Medical Center, DAB No. 1628, at 3 (1997). 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 – a fact that, if proven, would affect the outcome of the case under governing law. 1866ICPayday.com, DAB No. 2289, at 2-3 (2009), citing Matsushita Elec. Industrial Co. v. Zenith Radio, 475 U.S. 574 at 586, n.ll (1986); Celotex, 477 U.S. at 322-23. The opposing party must do more than show that there is "some metaphysical doubt as to the material facts . . . ." Id., citing Matsushita, 475 U.S. at 587. If the non-moving party has either conceded all of the material facts or proffered evidence only on facts which, even if proved, clearly would not make any substantive difference in the result, summary judgment is appropriate. Dialysis Center at Moreno Valley, Inc., DAB No. 2193, at 8 (2008), citing Big Bend Hospital Corp., DAB No. 1814 (2002), aff'd, Big Bend Hospital Corp. v. Thompson, 88 F. App'x 4 (5th Cir. 2003).

Whether summary judgment is appropriate is a legal issue that we address de novo. 1866ICPayday.com, at 2, citing Lebanon Nursing and Rehabilitation Center, DAB No. 1918 (2004). Our standard of review on a disputed issue of law is whether the ALJ decision is erroneous. The standard of review on a disputed factual issue is whether the ALJ decision is supported by substantial evidence in the record as a whole. Guidelines -- Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program, http://www.hhs.gov/dab/divisions/appellate/guidelines/index.html .

Analysis[1]

1. The ALJ did not err in concluding that the undisputed facts established that none of Mission's entities were operational, authorizing CMS to deny their applications for Medicare enrollment.

Mission concedes that its entities "were no longer operational" and had "shut down," which it attributes to delay by CMS in acting on Mission's enrollment applications. Request for Review of ALJ Decision (RR) at 5. Nonetheless, Mission argues that CMS presented "no credible evidence" to support its motion for summary disposition (in the nature of summary judgment) and

[1] We have fully considered all arguments raised by Mission on appeal and reviewed the full record, regardless of whether we have specifically addressed particular assertions or documents in this decision.

"failed to establish a *prima facie* case that [Mission] was not in substantial compliance" with enrollment requirements. RR at 3. Specifically, Mission argues that the affidavit of the on-site investigator is "conclusory and establishes no facts" because it consists of what Mission characterizes as statements, allegations and claims. Id. at 4. Mission argues that CMS's other evidence, which includes site visit forms the investigator completed for each applicant describing his visit, and photographs he took of the premises, "lacks proper foundation" because the affidavit "fails to make specific reference to particular exhibits or authenticate the evidence cited by CMS in its motion." RR at 3, 4, citing Pfeil v. Rogers, 757 F.2d 850, at 859-60 (7th Cir. 1985).

Mission's arguments challenging the sufficiency of the investigator's affidavit and CMS's other evidence must fail, for several reasons. The court case Mission cites concerned requirements of Rule 56 of the Federal Rules of Civil Procedure, which apply by their own terms to federal court proceedings but not administrative proceedings under 42 C.F.R. Part 498.

In any event, the investigator's affidavit *does* refer to the site visit forms he completed, and to the photographs that he "personally took," during his visit in the ordinary course of his duties. CMS Ex. 29, at 2-3. We find these references adequate to provide foundation for the forms and photographs, at least in the absence of any assertion by Mission that the substance of the reports is inaccurate or that the photographs do not accurately depict the site of its alleged offices during the visit. Furthermore, we do not agree with Mission's dismissal of the investigator's statements in his affidavit as "conclusory" claims. The affidavit was made under oath, and in it the investigator recounts how he conducted his inquiry and describes in some detail what he observed and learned during the course of his on-site visit to Mission's offices. His statements are consistent with the on-site visit reports, which he prepared during the ordinary course of his duties. The ALJ thus did not err in admitting this evidence or in relying on the affidavit.

Finally, Mission's arguments, at most, challenge the form of CMS's evidence, not its substance. Mission does not actually take issue with any of the investigator's specific statements in his affidavit or in the on-site visit forms he completed, or in any of CMS's submissions in support of its motion. For example, Mission nowhere disputes that it was locked out of its offices, as the investigator reported that he learned from the Property Manager, or that its offices were not open for business, as the

investigator observed. Mission moreover concedes the substantive conclusion supported by the investigator's affidavit and CMS's other evidence, which is that Mission's entities were no longer "operational," as found during the on-site visit.

In discussing ALJ use of summary judgment in appeals of nursing home sanctions under Part 498, the Board has held that "if CMS in its summary judgment motion has asserted facts that would establish a prima facie case that the facility was not in substantial compliance, the first question is whether the facility has in effect conceded those facts." Lebanon Nursing and Rehabilitation Center, DAB No. 1918, at 5 (2004). That calculus is applicable here, where Mission has, in effect, conceded the facts that CMS presented. Given that evidence, and Mission's failure to have "furnishe[d] . . . evidence of its own suggesting a dispute concerning any material fact" (ALJ Decision at 3), the ALJ did not err in concluding that the undisputed facts established that none of Mission's entities were operational, authorizing CMS to deny their applications for Medicare enrollment.

2. Mission's allegations of prior compliance and its assertion of delays in processing its enrollment applications provide no basis to overturn the ALJ Decision.

Mission asserts that its entities had been operational at the time they submitted their enrollment applications but were forced to shut down because of delays in processing the applications. It accuses CMS of applying "a clandestine policy to illegally limit the number of [HHAs] that participate in Medicare." RR at 2. Mission thus "requests the opportunity to present evidence . . . that the providers were in compliance and operational at the time of their application." RR at 5.

A showing that Mission's entities had been operational at some time prior to the on-site visit would not provide a basis for reversing the denial of enrollment. CMS is authorized to deny enrollment when, among other reasons, it determines, "upon on-site review," that the provider "is no longer operational . . . ." 42 C.F.R. § 424.530(a)(5)(i) (emphasis added). CMS could thus deny enrollment based on Mission's undisputed failure to be operational when the inspector visited its address, regardless of whether its entities may have been operational at some earlier time.

Thus, evidence that Mission was operational when it submitted its applications was not material to the ALJ's decision and is not material to ours. However, we also note that Mission has

not accurately characterized the ALJ's conduct with respect to any such evidence. The ALJ did not prohibit Mission from introducing evidence of earlier compliance; indeed, Mission did not actually proffer such evidence to the ALJ.[2] The ALJ merely noted in a prehearing order that 42 C.F.R. § 498.56(e) requires that a provider have "good cause" for submitting "new documentary evidence . . . for the first time at the ALJ level" and subsequently instructed Mission to "identify that evidence and . . . provide good cause why that evidence is being submitted to me for the first time." Acknowledgment and Prehearing Order at 2 (Apr. 17, 2009); Ruling on P.'s Objection to Prehearing Order at 2 (May 20, 2009).

Mission also argues that a two year delay it alleges in processing its applications violated a requirement to process applications within 45 days and cited, before the ALJ, a section of the Medicare Program Integrity Manual (MPIM). RR at 1; P. ALJ Br. at 5. Current MPIM provisions state that contractors "shall process 90 percent of CMS-855 Web-based initial applications within 45 calendar days of receipt . . . 95 percent . . . within 60 calendar days of receipt, and . . . 99 percent . . . within 90 calendar days of receipt." MPIM Ch. 10, § 2.9.1.3 (Rev. 320, eff. Jan. 25, 2010). That provision (and a similar one CMS cites concerning written applications, both of which CMS characterizes as "merely guidance" and instructions to contractors, CMS Br. at 16-17) contains no deadline for processing *individual* applications and affords no remedies to applicants for a contractor's failure to meet the overall processing standards.[3] In any event, since Mission admits that

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[2] On appeal, Mission also did not proffer any evidence that it had been operational previously. Even if it had proffered such evidence, the regulations governing Board review of provider or supplier enrollment appeals do not permit the Board to admit evidence into the record in addition to the evidence introduced at the ALJ hearing. 42 C.F.R. § 498.86(a). Mission also proffered no evidence in support of its allegation of a CMS policy to limit the number of HHAs.

[3] CMS notes that a regulation requiring contractors to process new applications within 180 days of receipt became effective on August 26, 2008, after Palmetto denied the entities' enrollment applications. CMS Br. at 16-17, n.11, citing 42 C.F.R. § 405.874(h); see also 73 Fed. Reg. 36,460 (June 27, 2008). Since that regulation was not in effect during the relevant time period, we do not address it. We note also that while section 1866(j)(B) of the Act, which required the

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its entities were not operational as of the on-site visit, any failure by CMS or its contractor to have met the Manual's standards applicable to the universe of applications they process (which Mission did not demonstrate) would not establish that Mission was in compliance with the enrollment requirements, and would demonstrate no error in CMS's determination to deny enrollment. The regulation authorizing CMS to deny enrollment of providers who are no longer operational provides no exceptions to account for the reasons the provider ceased operations. 42 C.F.R. § 424.530(a)(5)(i). As the ALJ stated, any undue delay "would only entitle Petitioner to a response to its enrollment application; it would not create for these unqualified entities any right to participate in Medicare." ALJ Decision at 4.

Mission further argues that CMS failed "to properly extend[] appeal rights required by law, and in its failure to do so violated [the entities'] Due Process rights established by 42 C.F.R. § 424.545, and the Fifth and Fourteenth Amendments . . . ." RR at 3. Mission has not identified any appeal rights extended by law that were not provided in this case. As CMS points out, Mission's entities each received notices informing them of their right to request reconsideration of the denials of enrollment and then to appeal the reconsideration decisions to the ALJ. CMS Br. at 10. Mission also has identified no statute or regulations providing any appeal rights for enrollees (or prospective enrollees) with respect to delays in processing enrollment applications.

Thus, Mission' argument that its constitutional rights were violated by failure to extend legally-required appeal rights is groundless. It provides no basis to reverse a denial of enrollment that is fully supported by the applicable laws and regulations. See, e.g., Sentinel Medical Laboratories, Inc., DAB No. 1762, at 9 (2001) (finding it "well established that administrative forums, such as this Board and the Department's ALJs, do not have the authority to ignore unambiguous statutes or regulations on the basis that they are unconstitutional"),

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(Continued. . .)

Secretary to "establish by regulation procedures under which there are deadlines for actions on applications for enrollment," instructs the Secretary to "monitor the performance of Medicare administrative contractors in meeting the deadlines . . ."; it provides no remedy for enrollees (or prospective enrollees) if contractors fail to meet those deadlines.

aff'd, Teitelbaum v. Health Care Financing Admin., 32 F. App'x 865 (9th Cir. 2002). Furthermore, the Board has previously noted that "[c]ourts that have considered the issue have almost without exception concluded that a physician or other health care practitioner or entity does not have a protected interest in continuing eligibility for Medicare participation or reimbursement." Robert F. Tzeng, M.D., DAB No. 2169, at 13-14 n.16 (2009) (citations omitted).

As Mission notes, it asserted its constitutional arguments in a suit against CMS in a federal district court, which dismissed the suit on the ground that Mission had failed to exhaust its administrative remedies. See Home Health Licensing Specialists Inc., et al. v. Leavitt, Civil Action No. 3:07-CV-2150-B, at 4 2008 WL 4830543 (N.D. Tex. Nov. 7, 2008), citing Shalala v. Illinois Council on Long Term Care, Inc., 529 U.S. 1, 13 (2000) (holding that section 405(h) of the Act "demands the 'channeling' of virtually all legal attacks through the agency"); RR at 2. With the issuance of our decision, the Secretary's final decision, Mission is free to raise its constitutional arguments in another forum.

Conclusion

For the reasons stated above, we uphold the ALJ Decision.

_____/s/_____
Judith A. Ballard

_____/s/_____
Leslie A. Sussan

_____/s/_____
Sheila Ann Hegy
Presiding Board Member