Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Suitable Homehealth Care, Inc.,

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-11-704

Decision No. CR2488

Date: January 11, 2012

DECISION

Petitioner, Suitable Homehealth Care, Inc., appeals a reconsideration decision issued on June 29, 2011. I grant summary judgment and sustain the determination of the Centers for Medicare and Medicaid Services (CMS) to revoke Petitioner's Medicare enrollment and billing privileges. I do so because Petitioner did not show that it met Medicare enrollment requirements as an operational home health agency upon CMS's unsuccessful attempts to conduct on-site reviews of its premises.

I. Background and Procedural History

Petitioner submitted an enrollment application for eligibility to submit claims to the Medicare program for covered services it provided to beneficiaries. Palmetto GBA (Palmetto), a CMS contractor, received the application in February of 2010. On August 6, 2010, Palmetto sent a letter to Petitioner indicating the completion of the processing of its enrollment application. The letter also stated that Petitioner would be subject to a future site visit to determine compliance with Medicare requirements. CMS Ex. 1.

On February 24, 2011, Palmetto attempted to conduct a site inspection survey at the business location address identified on Petitioner's enrollment application. The site

inspection report states that Petitioner's facility was a private residence, there was no visible signage with Petitioner's business name and hours of operation posted at the business address, Petitioner was not open for business, and there were no customers present. CMS Ex. 4. The inspector knocked on the door and rang the doorbell. There was no response, and no person was present at Petitioner's place of business to provide entry to continue the site visit. CMS Ex. 8. On March 31, 2011, Palmetto attempted another site inspection survey. Again, the site inspection report states that Petitioner's facility was a private residence, there was no visible signage with Petitioner's business name and hours of operation posted at the business address, Petitioner was not open for business, and there were no customers present. CMS Ex. 5. The inspector rang the doorbell twice and waited, but no person was present at Petitioner's place of business to provide entry to continue the site visit.

On April 11, 2011, Palmetto sent Petitioner a letter stating that Petitioner's Medicare billing number was revoked effective February 24, 2011. CMS Ex. 3. The notice letter also advised Petitioner that CMS was imposing a re-enrollment bar from participation in the Medicare program for a period of two years. *Id.* Petitioner was notified that it could submit a Corrective Action Plan (CAP) within thirty days. *Id.* On April 20, 2011, Petitioner timely submitted a CAP and stated that Petitioner's signage has been unstable and often blew away. Petitioner submitted pictures showing that another sign had been posted at Petitioner's place of business. CMS Ex. 6. On June 29, 2011, CMS issued an unfavorable decision regarding Petitioner's CAP, which CMS also considered to be a request for reconsideration, and determined that Petitioner did not provide adequate evidence to correct the deficiency for which Petitioner was revoked. CMS Ex. 7. The reconsideration decision provided Petitioner with appeal rights for review by an Administrative Law Judge (ALJ). *Id.* Petitioner then filed a hearing request (HR) with the Civil Remedies Division of the Departmental Appeals Board, and the case was originally assigned to ALJ Steven T. Kessel. The matter was subsequently transferred to me for hearing and decision.

In accordance with the Acknowledgment and Pre-hearing Order issued on August 22, 2011, CMS filed a Motion for Summary Judgment and Pre-Hearing Brief (CMS Br.), accompanied by eight exhibits (CMS Exs. 1-8). Petitioner then filed its Response in Opposition to CMS's Motion for Summary Judgment and Pre-Hearing Brief (P. Br.), accompanied by three exhibits (P. Exs. 1-3). CMS subsequently filed a Motion for Leave to Supplement Exchange (CMS Motion), and Petitioner filed a Response to CMS's Motion for Leave to Supplement Exchange (P. Response) accompanied by one exhibit (P. Ex. A). CMS also filed a Reply to Petitioner's Response to CMS's Motion for Summary Judgment (CMS Reply), and Petitioner filed a Sur-Reply to CMS's Reply to Petitioner's Response in Opposition to CMS's Motion for Summary Judgment (P. Sur-Reply).

Petitioner objects to all of CMS's proposed exhibits and requested that none of CMS's submitted documents be considered as part of my determination. Petitioner noted that

CMS did not file a list of exhibits, as the Pre-Hearing Order required, with its Motion for Summary Judgment and Pre-Hearing Brief. Petitioner argues therefore that the CMS documents submitted as exhibits were not properly identified and should be stricken from the record. Shortly after receiving Petitioner's Brief, CMS filed its Motion for Leave to Supplement Exchange along with a Proposed List of Exhibits and Witnesses. CMS stated that it "inadvertently omitted its Exhibit & Witness List from its pre-hearing exchange . . . [and] now seeks to supplement the record accordingly." CMS Motion. CMS noted that "Petitioner was provided with the copies of the labeled exhibits, which identified them as CMS exhibits, and the surveyor whose observations were the basis for the revocation was identified in CMS' Motion for Summary Judgment and Pre-Hearing Brief, as well as the affidavit submitted." *Id*. CMS argues that its omission of a formal Exhibit and Witness List was harmless error and requests that I grant its Motion for Leave to Supplement the CMS Pre-Hearing Exchange. I agree that CMS's failure to include an Exhibit and Witness List was harmless error and grant leave to CMS to supplement its prehearing exchange. I find Petitioner was not prejudiced by CMS's failure to submit a list of exhibits considering that CMS timely submitted the exhibits themselves, including an affidavit of the direct testimony for the only CMS witness.

Petitioner also objects to CMS's proposed witness testifying as an expert witness in addition to a fact witness. The inspector's affidavit, representing his direct-testimony, consists of factual observations made during the course of two attempted on-site inspections he conducted of Petitioner's premises. There is no basis for me to exclude this fact-based testimony based on the actual inspections, especially considering the reports of the inspector that no one was present at the premises during the on-site visits is uncontested. Therefore, in the absence of further objections, I admit all of CMS's exhibits and Petitioner's exhibits into the record.

II. Applicable Law

CMS will enroll a provider into the Medicare program only when the provider "successfully completes the enrollment process including, if applicable, a State survey and certification or accreditation process . . ." 42 C.F.R. § 424.510(a). CMS has a right to perform on-site inspections to verify the accuracy of a provider's enrollment information and to determine the provider's compliance with Medicare enrollment requirements. 42 C.F.R. § 424.510(d)(8); *see also* 42 C.F.R. § 424.517(a)(1). A provider in the Medicare program "must be operational to furnish Medicare covered items or services." 42 C.F.R. § 424.510(d)(6). A provider is "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 . . . to furnish these items and services." 42 C.F.R. § 424.502.

CMS is authorized to revoke a provider's Medicare billing privileges when the provider is determined not to be in compliance with Medicare enrollment requirements. 42 C.F.R. § 424.535(a). Federal regulations provide for revocation of a provider or supplier's Medicare billing privileges for a variety of reasons including:

> (5) *On-site review.* CMS determines, upon on-site review, that the provider or supplier is no longer operational to furnish Medicare covered items or services, or 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. Upon on-site review, CMS determines that –
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> > (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. § 424.535(a)(5)(i).

III. Issue, Findings of Fact, Conclusions of Law

A. Issue

The issue in this case is whether CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges.

B. Applicable Standard

The Board stated the standard for summary judgment:

> 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. . . . The party moving for summary judgment bears the initial burden of showing that there are no genuine issues of material fact for trial and that it is entitled to judgment as a matter of law. . . . 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. . . . In determining whether there are genuine issues of material fact for trial, the reviewer must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor.

Senior Rehab. & Skilled Nursing Ctr., DAB No. 2300, at 3 (2010) (citations omitted).

The role of an 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, Inc*, DAB No. 2291, at 5 (2009). The Board has further stated, "[i]n addition, it is appropriate for the tribunal to consider whether a rational trier of fact could regard the parties' presentation as sufficient to meet their evidentiary burden under the relevant substantive law." *Dumas Nursing and Rehab., L.P.*, DAB No. 2347, at 5 (2010).

C. Findings of Fact and Conclusions of Law

My findings and conclusion are in the italicized heading supported by the subsequent discussion below.

CMS had a legitimate basis to revoke Petitioner's billing privileges because Petitioner was not operational pursuant to 42 C.F.R § 424.535(a)(5)

CMS moves for summary judgment asserting that no material facts are in dispute. CMS contends that it was unable to conduct an on-site inspection of Petitioner's business on two separate occasions because no person was present at Petitioner's place of business. CMS Br. at 4. Because the evidence does not reflect that a genuine dispute as to a material fact exists, summary judgment is appropriate. The issue in this case turns on the legal interpretation of 42 C.F.R. § 424.535 and other regulatory provisions that govern the revocation of Medicare billing privileges.

It is undisputed that no one was present at Petitioner's business during its posted hours of operation[1] when a site inspector arrived at the place of business on February 24, 2011 and March 31, 2011. HR, CMS Ex. 4 and CMS Ex. 5, P. Br. at 3-4, P. Sur-Reply at 2. Petitioner never disputed that no person was available, during its hours of operation, to allow the inspectors access to its place of business for an on-site inspection. P. Br. at 6. Petitioner admits that "on the occasions Palmetto's inspector visited in February and March 2011, [Petitioner's] employees were providing services to patients and conducting marketing efforts. This is the reason no one was in its offices to receive Palmetto's inspector." *Id.*, P. Ex. 3 at 2-3. Petitioner also admits that a sign was missing from Petitioner's place of business at the time of the attempted site inspections. P. Br. at 6. Petitioner contends that a sign holder demonstrates that a sign was supposed to be in

[1] Petitioner's Corrective Action Plan (CAP) indicates that it has since posted a sign indicating Petitioner's hours of operation are Monday to Friday from 9:00 a.m. to 5:00 p.m. CMS Ex. 6. Thus, the site inspections conducted on February 24, 2011, (Thursday) at 2:22 p.m. and March 31, 2011, (Thursday) at 11:00 a.m. would be during Petitioner's hours of operation. *See* CMS Ex. 4 and CMS Ex. 5.

place and "[i]ntermittently, the sign was blown down by wind during bad or severe weather . . ." *Id*. at 6-7. Petitioner states that when this would occur it re-posted the sign immediately. *Id*. at 7. For purposes of summary judgment, I will draw all reasonable inferences in the light most favorable to the non-moving party. Specifically, I will accept as true Petitioner's claims that Petitioner provided services to patients on the dates of the attempted on-site inspections. I will also accept as true Petitioner's explanation for the lack of signage on the dates of the site inspections and infer that the winds must have blown away the signs that posted Petitioner's hours of operation.

Petitioner originally submitted a CAP containing remedial measures Petitioner would undertake with regard to Petitioner's signage. CMS's decision whether or not to reinstate a provider based on a CAP is not an initial determination and not reviewable by an ALJ. 42 C.F.R. § 405.874(e). However, Petitioner also argues that CMS's reconsideration decision was incorrect because it "was open for business to the public at the times the inspector came. By the nature of its business, [Petitioner] must be out at clients' homes to be open for business and that is where its representatives were. . . . Furthermore, being open for business within the meaning of the law does not require a person to be at the company's offices." P. Br. at 2. Petitioner further states that its "business is largely based upon referrals with virtually no walk-in traffic. . . . With just four employees, three of which are part-time, and all of whom are involved in patient care, [Petitioner] does not often have down time in its offices." P. Br. at 6. Petitioner also questions whether the absence of a representative at the facility to receive an inspector can establish that Petitioner was non-operational. P. Br. at 7-8. Petitioner claims it is not required to have a representative physically present at its offices to allow a site inspector access in order to be "operational" within the meaning of the law. P. Br. at 8. However, Petitioner does not cite any case law or regulatory authority that would tend to support its position.

A Medicare provider must be "*open to the public* for the purpose of providing health care related services . . . and [be] *properly staffed* . . . to furnish these services." 42 C.F.R. § 424.502 (emphasis added). Petitioner contends that it was operational at the time of the site inspections because Petitioner saw patients on these dates. Petitioner argues that it was open to the public and properly staffed at the time of both site visits, even though all of Petitioner's staff was seeing patients outside of its business location. I find a provider can be neither "open to the public" nor "properly staffed," if the provider's business location is closed and no staff is present to allow a CMS site inspector access to the facility.

CMS policy supports the interpretation that a home health agency, like a durable medical equipment supplier, must have an employee physically present at the business location during its posted hours of operation to allow the public access to the facility and to allow CMS investigators to conduct site inspections and monitor compliance with relevant federal regulations. The Medicare Program Integrity Manual (MPIM), CMS Pub. 100-08. Section 15.19.2.1 states that "newly-enrolling and existing providers and suppliers

will, beginning on March 25, 2011, be placed into one of three levels of categorical screening: limited, moderate, or high. The risk levels denote the level of the contractor's screening of the provider when it initially enrolls in Medicare . . . ." Newly enrolling durable medical equipment suppliers and newly enrolling home health agencies are characterized at a "high" level of categorical screening and the CMS contractor shall "[p]erform a site visit to the extent that this is not already required by CMS. If a site visit is currently required, the contractor shall continue this activity in accordance with existing instructions." MPIM § 15.19.2.1 (C).

The MPIM also outlines the scope of the site visit for providers other than durable medical equipment suppliers. Section 15.19.2.2 (B) states:

> In terms of the extent of the visit, the contractor shall determine whether the following criteria are met:
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> • The facility is open
> • Personnel are at the facility
> • Customers are at the facility (if applicable to that provider or supplier type)
> • The facility appears to be operational
>
> This will require the site visitor(s) to enter the provider or supplier's practice location/site, rather than simply conducting an external review. **If any of the 4 elements listed above are not met**, the contractor shall, as applicable - and using the procedures outlined in Pub. 100-08, Chapters 10 and 15 - deny the provider's enrollment application pursuant to §424.530(a)(5)(i) or (ii), **or revoke the provider's Medicare billing privileges under §424.535(a)(5)(i) or (ii).**

MPIM § 15.19.2.2 (B) (emphasis added). CMS has categorized home health agencies as a high risk for fraud requiring additional unannounced site visits as a type of screening that requires staff to be present at the site. Congruent with its policy, CMS had a basis to revoke Petitioner's Medicare billing privileges for being non operational when, after visits to Petitioner's business location, no employee was present to allow the inspector access. And even if a home health agency may not expect to have a customer presence based on the nature of its business, CMS still reasonably expects personnel to be present at the business premises. Considering the serious concerns for maintaining the integrity of the Medicare program, and considering the potential for fraud inherent in the home heath area, I do not find CMS's policies unreasonable or that they are inconsistent with the regulatory requirements.

Additionally, a showing that Petitioner has been operational at some time prior to, or after, a site visit would not provide a basis for reversing the revocation. CMS is

authorized to revoke a provider or supplier's Medicare billing privileges based upon the failure to be operational when the inspector visited its address, regardless of whether it may have been operational at some earlier or later time. *See Mission Home Health et al.*, DAB No. 2310 (2010). CMS and its contractors have limited resources and cannot be compelled to attempt multiple on-site inspections to determine if the facility complies with all Medicare requirements.

I must sustain CMS's determination if a legitimate basis exists and where the facts established noncompliance with one or more of the relevant regulations. *1866ICPayday.com*, DAB No. 2289, at 13. Thus, I find the CMS decision to revoke Petitioner's Medicare enrollment and billing privileges was justified based upon the undisputed facts that Petitioner did not have staff at its facility during its business hours on February 24, 2011 and March 31, 2011, the dates of the attempted site visits.

IV. Conclusion

After reviewing the evidence in the light most favorable to Petitioner, I conclude there is no genuine issue of material fact at issue here. By virtue of having no staff at its location, Petitioner was not operational and not able to allow CMS to conduct on-site reviews of its business. I therefore grant summary judgment to CMS because CMS acted within its regulatory authority to revoke Petitioner's billing privileges and implement a two year re-enrollment bar.

/s/
Joseph Grow
Administrative Law Judge