Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Improving Life Home Care, LLC,

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-512

Decision No. CR3076

Date: January 13, 2014

DECISION

Petitioner, Improving Life Home Care, LLC, a home health agency, appeals a reconsideration decision dated January 8, 2013, upholding the revocation of Petitioner's Medicare enrollment and billing privileges. The undisputed evidence establishes that Petitioner was not in compliance with Medicare program requirements for home health care certification. Consequently, I grant the Centers for Medicare & Medicaid Services' (CMS) motion for summary judgment and affirm CMS's determination to revoke Petitioner's Medicare enrollment and billing privileges.

I. Background

Petitioner is a home health agency located in Miami, Florida. CMS Ex. 2, at 4-7. Petitioner completed and signed an application (Form CMS-855A) to enroll as a provider in the Medicare program on January 13, 2009. CMS Ex. 2. The Form CMS-855A was signed by Petitioner's authorized officials, Eduardo Cabrera (CFO/Owner) and Miranda Ibrahim (Owner/Manager). CMS Ex. 2, at 15-17.

On October 17, 2012, Palmetto GBA (Palmetto), a Medicare administrative contractor, notified Petitioner that its billing number and provider agreement were being revoked for noncompliance with enrollment requirements under 42 C.F.R. § 424.535(a)(1). Palmetto stated that the Form CMS-855A requires applicants, including Petitioner, to sign and thus certify that the applicant:

> agree[s] to abide by the Medicare laws, regulations and program instructions that apply to this contractor. The Medicare laws, regulations, and program instructions are available through the Medicare contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the supplier's compliance with all applicable conditions of participation in Medicare.

Palmetto alleged that Petitioner failed to abide by Medicare laws, regulations, and program instructions by failing to provide valid physician orders when submitting claims for Medicare payment, specifically those of two physicians: Ana P. Orozco, M.D. (18 Medicare beneficiaries); and Olivia Graves, M.D. (three Medicare beneficiaries). In addition, Palmetto alleged that Petitioner submitted these claims for services certifying that Drs. Orozco and Graves signed orders for the services when they did not (Drs. Orozco and Graves reviewed the documentation submitted by Petitioner and disputed that they signed the documents). Palmetto notified Petitioner it could file a corrective action plan (CAP) and/or reconsideration request. CMS Ex. 3, at 1-2.

On December 4, 2012, Petitioner filed a timely request for reconsideration. On January 8, 2013, CMS's Center for Program Integrity issued a reconsideration determination on behalf of CMS. The determination states that CMS reviewed 74 home health services claims submitted by Petitioner on which Drs. Orozco and Graves are identified as the certifying physicians. CMS reviewed Drs. Orozco and Graves billing records and determined that they did not bill for treatment for a total of 23 beneficiaries for which Petitioner submitted claims for home health services. Based on this, CMS determined that Drs. Orozco and Graves were not the treating physicians certifying the necessity for home health services for these 74 sampled claims. CMS noted that it had the authority to revoke the enrollment of a provider or supplier who is out of compliance with enrollment requirements, citing 42 C.F.R. § 424.535(a)(1). CMS noted that Petitioner certified in its Form CMS-855A that it would abide by Medicare laws, regulations, and program instructions and that it understood payment of a claim was conditioned on such compliance. CMS determined that Petitioner failed to obtain a valid physician order when it submitted beneficiaries' claims for payment and falsely certified that a physician signed an order for the services. CMS notified Petitioner of its right to request a hearing before an administrative law judge. CMS Ex. 3, at 4-6.

Petitioner filed a timely request for an administrative law judge hearing on February 28, 2013. In its hearing request, Petitioner asserts that Drs. Orozco and Graves where employed by C & M Physicians' Group (C & M) at the time the 23 beneficiaries were referred to Petitioner. Petitioner argues that irrespective of whether Drs. Orozco or Graves billed Medicare for their treatment, the doctors saw the 23 beneficiaries and were under their care when referred to Petitioner for home health services.

The case was originally assigned to another administrative law judge. The parties filed pre-hearing exchanges pursuant to the administrative law judge's Acknowledgment and Initial Docketing Order dated March 14, 2013. On April 15, 2013, CMS filed a Motion for Summary Judgment and Brief (CMS Br.), accompanied by ten exhibits (CMS Exs. 1-10). On May 6, 2013, Petitioner filed its response, accompanied by 25 exhibits it lists as Petitioner's exhibits (P. Exs.) 1, 2 A Part 1, 2 A Part II, 2 B Part 1, 2 B Part 2, two documents titled 2C Part II, 2 D Part I, 2 D Part II, 2 E Part I, 2 E Part II, 2 F Part I, 2 F Part II, 2 G Part I, 2 G Part II, 2 H Part I, 2 H Part II, 2 I Part I, 2 I Part II, 2 two documents titled 2J Part II, 3 A Part I, 3 A Part II, and two documents titled 3 B Part II. CMS filed a reply on May 28, 2013 (CMS Reply). Petitioner filed a sur-reply on June 11, 2013 (P. Reply). In the absence of objection, I admit all submitted exhibits.

On July 31, 2013, the parties were informed that the case had been transferred to me. In a letter to the parties dated September 16, 2013, I reserved judgment on the motion for summary judgment and ordered the parties to make full pre-hearing submissions. I required the parties to submit written direct testimony for all proposed witnesses and to notify me if the parties wanted to cross-examine any of the proposed witnesses at a hearing.[1] On October 1, 2013, CMS filed a statement indicating that it had no additional pre-hearing documents to offer and that it was incorporating the exhibits previously

[1] In this letter I also denied Petitioner's subpoena request. In its hearing request, Petitioner requested subpoenas to obtain documents from C & M and the contractor in order to show that the 23 beneficiaries were treated by one or both physicians at C & M. On April 12, 2013, Petitioner renewed its subpoena request, but only for C & M records to show that Drs. Orozco and Graves did treat patients and referred them to Petitioner for home health services. On April 15, 2013, CMS filed its motion for summary judgment. On April 16, 2013, the previously assigned administrative law judge reserved ruling on the subpoena request pending his decision on CMS's motion for summary judgment. In denying Petitioner's subpoena request, I held that Petitioner failed to show that it met the stringent regulatory requirements for issuance of a subpoena. Petitioner did not: identify the specific documents to be produced; describe the location or address where the documents were to be found (only providing the former address for the now closed C & M Physician Group); and did not identify why the facts it intended to establish by the subpoenaed documents could not be established without use of a subpoena. *See* 42 C.F.R. § 498.58.

submitted in conjunction with its pending motion for summary judgment. By letter dated October 15, 2013, Petitioner's counsel withdrew as legal counsel to Petitioner, citing "irreconcilable differences." Petitioner's counsel stated that "all future filings should be forwarded to Petitioner," and provided Petitioner's address. In a letter to the parties dated November 6, 2013, I gave Petitioner until November 25, 2013, to file its pre-hearing exchange and to let me know the name and contact information for its representative. I warned Petitioner that if it did not respond, I would proceed to decision based on the existing record. Petitioner did not respond. Accordingly, I am issuing this decision.

II. Rulings

A. CMS's New Issues

In its brief, CMS now asserts that Drs. Orozco and Graves did not bill Medicare for treatment of 93 beneficiaries for whom Petitioner submitted claims. Petitioner notes that CMS originally supported revocation by stating that Drs. Orozco and Graves had reviewed the underlying documentation for the claims and determined that the signatures on the documents were not theirs. Petitioner questions why CMS is not now relying on this basis and notes that CMS has not offered any signed statements from these physicians, or other evidence related to the physicians, and that the failure to do so raises due process and evidentiary concern. P. Reply at 3.

The reconsidered determination stated the following: "[Petitioner] failed to obtain a valid order from a physician when it submitted beneficiaries' claims for payment. In addition, it submitted these claims for services certifying that a doctor signed an order for services, but that was not true." CMS Ex. 3, at 5. CMS's brief still maintains that the primary basis for revocation was a failure to comply with enrollment requirements pursuant to 42 C.F.R. § 424.535(a)(1), specifically discussing improper certifications concerning doctors' alleged orders for beneficiaries related to the need for home health care services. CMS Br. at 10-14. This is consistent with the reconsidered determination. Therefore, CMS has not raised a legal basis for revocation that was not the subject of a reconsidered determination, and Petitioner had notice of this basis.

However, CMS has significantly increased the number of beneficiaries for which it alleges Petitioner filed claims without a physician's order. CMS now alleges 93 beneficiaries when the reconsidered determination only identified 23. CMS Br. at 10. CMS indicated that it was allowed to modify its basis for revocation, citing *Green Hills Enterprises, LLC*, DAB No. 2199 (2008). CMS Br, at 2 n.1. The claims for the 70 new beneficiaries identified in CMS's brief constitute a change in the factual basis for the revocation that would require Petitioner to submit evidence for those beneficiaries to me in order to present a defense in this case. Therefore, each new beneficiary raises an issue that was not the subject of an initial or reconsidered determination.

Provider and supplier enrollment appeals are governed by 42 C.F.R. pt. 498. 42 C.F.R. §§ 405.800(a)(2), 405.800(b)(1)(ii), 424.545(a), 498.1(g), 498.3(c)(17), 498.5(l), 498.40(a)(1). Although proceedings under 42 C.F.R. pt. 498 generally allow the parties to request that an administrative law judge adjudicate "new issues that impinge on the rights of the affected party" even if "CMS . . . has not made an initial or reconsidered determination on them," provider and supplier enrollment cases are expressly excepted from this rule. *Id.* § 498.56(a)(1)-(2). This limitation on new issues is consistent with the special rule prohibiting providers and suppliers from submitting new evidence to administrative law judges in enrollment cases, 42 C.F.R. § 405.803(e), although there is a good cause exception to rule. *Id.* § 498.56(e).

As indicated above, CMS relied on *Green Hills Enterprises, LLC* for the proposition that CMS could modify the basis for revocation. However, neither this case nor *Fady Fayad, M.D.*, DAB No. 2266 at 9-11 (2009), cited or discussed the regulatory exception to new issues in provider/supplier enrollment hearings in 42 C.F.R. § 498.56(a)(2).

Because all of the issues that impinge the rights of an affected party in a provider or supplier enrollment case must have been decided in an initial or reconsidered determination, remand to CMS for a new determination appears to be the proper course of action when CMS wants to add a basis for revocation in a provider or supplier enrollment case. 42 C.F.R. §§ 498.56(d), 498.78. However, because I am affirming Palmetto's determination to revoke Petitioner's Medicare billing privileges based the beneficiaries identified in the reconsidered determination, there is no need to remand this case for a new determination.

B. Summary Judgment

When appropriate, administrative law judges may decide a case arising under 42 C.F.R. pt. 498 by summary judgment. *See* Civil Remedies Division Procedures § 7; *Livingston Care Ctr. v. U.S. Dep't of Health & Human Srvcs.*, 388 F.3d 168, 172 (6th Cir. 2004) (citing *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743 (6th Cir. 2004)). Summary judgment is appropriate if "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." *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 3 (2010) (citations omitted).[2] The moving party must show that there are no genuine issues of material fact requiring an evidentiary hearing and that it is entitled to judgment as a matter of law. *Id.* If the moving party meets its initial burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial . . . .'" *Matsushita Elec. Industrial Co. v. Zenith Radio*, 475 U.S. 574, 587 (1986); *see also Vandalia Park*, DAB No. 1939 (2004). "To defeat an adequately supported summary judgment motion, the

[2] Administrative decisions cited in this decision are accessible on the internet at: http://www.hhs.gov/dab/decisions/index.html.

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." *Senior Rehab.*, DAB No. 2300, at 3. To determine whether there are genuine issues of material fact for hearing, an ALJ must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. *Id.* When ruling on a motion for summary judgment, an ALJ may not assess credibility or evaluate the weight of conflicting evidence. *Holy Cross Vill. at Notre Dame, Inc.*, DAB No. 2291, at 5 (2009).

In the present case, CMS has moved for summary judgment to uphold a revocation based on 42 C.F.R. § 424.535(a)(1) for noncompliance with Medicare enrollment requirements. Petitioner's revocation under section 424.535(a)(1) turns on the interpretation and application of the regulations that govern revocation of enrollment in the Medicare program and no genuine issues of material fact exist. Therefore, summary judgment in favor of CMS on this issue is appropriate.

III. Issue

Whether CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges. I have jurisdiction to decide this issue. 42 C.F.R. §§ 498.3(b)(17), 498.5(l)(2); *see also* 42 U.S.C. § 1395cc(j)(8).

IV. Discussion

The Medicare statute defines "home health services" as "items and services furnished to an individual, who is under the care of a physician . . . under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician . . ." 42 U.S.C. § 1395x(m). Home health services are covered by Medicare only if "a physician . . . certifies . . . that . . . home health services . . . are or were required because the individual is or was confined to his home . . . and needs or needed skilled nursing care . . . ." 42 U.S.C. § 1395f(a)(2)(C); 42 U.S.C. § 1395n(a)(2)(A). A home health agency may receive Medicare payment for home health services for individuals only after the home health agency has obtained a valid certification from a physician that the individual is homebound and requires home health services. 42 U.S.C. §§ 1395f(a)(2)(C); 1395n(a)(2)(A). Home health services must be furnished while the individual is under the care of a physician, and a physician must establish and periodically review a plan of care for furnishing the services. 42 C.F.R. § 424.22(a)(iii), (iv). Also, the certifying physician is required to know the Medicare beneficiary's medical status, and therefore there must be a face-to-face encounter with the individual. 42 C.F.R. § 424.22(a); Medicare Benefit Policy Manual, CMS Pub. 100-102, Ch. 7 (Home Health Services), § 30.5.1.1. The face-to-face encounter must be "related to the primary reason the patient requires home health services . . . ." 42 C.F.R. § 424.22(a)(1)(v).

A physician and home health agency personnel must review a Medicare beneficiary's plan of care at regular intervals. 42 C.F.R. § 484.18(b). Also, a home health agency is required to "promptly alert the physician" to significant changes that suggest a need to alter the plan of care. *Id*. The home health agency consults with the individual's physician to obtain approval of any "additions or modifications to the original plan" of care. *Id.* § 484.18(a).

1. Petitioner did not tender evidence of specific facts showing that a dispute of material fact exists.

Any home health agency which seeks to enroll as a provider in the Medicare program must complete a Form CMS-855A enrollment application. Petitioner completed a Form CMS-855A and signed the certification statement at section 15. CMS Ex. 2, at 14-17. The signatures of Petitioner's CFO/Owner, Eduardo Cabrera, and its Owner/Manager, Miranda Ibrahim, bind "this provider to the laws, regulations, and program instructions of the Medicare program." CMS Ex. 2, at 15-17. CMS asserts that when Petitioner signed its Form CMS-855A, it obligated itself to compliance with Medicare laws, regulations, and program instructions, including the standards governing Medicare-reimbursable home health services. CMS asserts that such services may only be provided to a beneficiary who is under the care of a physician, and the physician must certify the necessity of home health services for the beneficiary after a face-to-face encounter. CMS argues that Petitioner submitted Medicare claims lacking the requisite valid physician certification from a physician involved in the care, treatment or monitoring of the beneficiary, and that Petitioner's failure to submit claims with valid physician certifications constitutes noncompliance with the regulations. CMS Br. at 2.

CMS specifically identifies Petitioner as a home health agency that submitted a number of claims in 2012 identifying Drs. Orozco or Graves as the examining physician. After reviewing the claims, CMS found that for 23 beneficiaries for whom Petitioner submitted a Medicare home health claim, and where either Dr. Orozco or Dr. Graves was identified as the certifying physician, the respective beneficiary's Medicare payment history showed no indication that either Dr. Orozco or Dr. Graves had treated, evaluated, monitored, or cared for the beneficiary or been involved in the beneficiary's care. CMS Br. at 9-10; CMS Exs. 3; 5; 7, at ¶¶ 12, 13.

Petitioner does not assert that Drs. Orozco or Graves actually filed a Medicare claim for payment for treating any of the 23 beneficiaries. P. Reply at 1-2. Instead, Petitioner argues that all CMS's billing records show is that Drs. Orozco and Graves did not bill Medicare for the care or treatment of the 23 beneficiaries. Petitioner argues that CMS's billing records are only circumstantial evidence as to whether Drs. Orozco or Graves actually saw the 23 beneficiaries. Petitioner asserts that to make its case that the two physicians did not have the respective beneficiaries under their care or treatment, CMS should have offered patient statements, physician statements, medical records, or other

direct proof that Drs. Orozco or Graves did not see the beneficiaries. P. Br. at 2; P. Reply at 2-3. Although Petitioner submitted significant documentation from its file regarding two of the 23 beneficiaries named by CMS, Petitioner offers no evidence of its own, however, to show that Drs. Orozco or Graves actually had a face-to-face encounter with or treated the 21other beneficiaries in question.

In provider revocation cases, CMS must come forward with sufficient evidence to show a basis for the revocation. Because CMS's evidence concerning its billing records related to Drs. Orozco and Graves meets this standard, Petitioner now has the burden of showing compliance with Medicare enrollment requirements. 42 C.F.R. § 424.545(c) ("The provider . . . must be able to demonstrate that it meets the enrollment requirements and it must be able to make available any documents and records that support the provisions of this regulation and the Medicare enrollment application if requested by CMS or its agents."). Although for purposes of summary judgment I am required to draw all reasonable inferences in the light most favorable to Petitioner in deciding CMS's motion for summary judgment, Petitioner is required to come forward with specific evidence to show that a genuine issue of material fact exists. Petitioner fails to do so.

Petitioner offers the affidavit of Andros Miranda, Petitioner's Administrator (P. Ex. 1), to assert that Petitioner was aware, through Mr. Miranda's discussions with Petitioner's Director of Nursing (DON), that Drs. Orozco and Graves were employed at C & M and saw patients at that location. Mr. Miranda also states that although he never personally spoke with either Dr. Orozco or Dr. Graves, he understood that Petitioner's DON typically contacted a referring physician's office when an order for home health services was received in order to verify the details of the order.[3] Mr. Miranda's affidavit does not raise an issue of material fact with regard to the 21 specific beneficiaries cited by CMS for which no documentation has been submitted. Nothing in Mr. Miranda's affidavit shows that either Dr. Orozco or Dr. Graves had a face-to-face encounter with or treated any of the 21 beneficiaries in question.

Petitioner also references CMS Ex. 6 to argue that Drs. Orozco and Graves did submit Medicare claims for 10 of Petitioner's Medicare patients between January 1, 2010 and March 4, 2013, although acknowledging that these 10 were not among the 21 beneficiaries in question. P. Br. at 3. Petitioner argues that its records, at P. Exs. 2A through 2J, show that Drs. Orozco and Graves did at times bill Medicare for seeing beneficiaries they referred to Petitioner. Petitioner asserts that its records, at P. Exs. 3A and 3B, are for two of the beneficiaries on the list of 23 beneficiaries for whom Petitioner billed for services, but for whom Drs. Orozco and Graves did not submit a Medicare claim. Petitioner argues that the documentation, signatures, and orders for these two

[3] Mr. Miranda also states that many of Dr. Orozco's patients were seen by the nurse practitioner under her supervision. This is irrelevant to the issues before me because, as stated below, a physician must order the home health services.

beneficiaries are not significantly different than for the 10 beneficiaries for whom Drs. Orozco and Graves did file a Medicare claim. Based on this, Petitioner insists that it would have had no reason to know or question whether the two physicians filed Medicare claims for payment for the care or treatment of the other 21 beneficiaries or have any reason to doubt that these beneficiaries were properly referred to Petitioner. P. Br. at 2-4. Petitioner also makes a proffer of evidence, stating that it will submit records for the remaining 21 beneficiaries, but noting that the exhibits are voluminous. P. Br. at 4: P. Reply at 1-2. Petitioner's proffer of evidence does not, however, go to whether or not Drs. Orozco or Graves actually treated the other 21 beneficiaries in question.

In my September 16, 2013 communication to the parties, I ordered Petitioner to file with its pre-hearing exchange all documents that Petitioner believes show that it was in full compliance with Medicare program requirements for the remaining beneficiaries for whom Petitioner had not yet provided any documentation. I told Petitioner to tailor its selection to those documents that address the specific reasons that CMS revoked Petitioner's billing privileges. Petitioner filed nothing in response. Moreover, and most important to my decision, at no time in this proceeding has Petitioner ever filed any evidence to show that it was in compliance, such as filing testimony from the beneficiaries it cared for that they were in fact cared for, treated, and referred to Petitioner by Dr. Orozco or Dr. Graves; or filed plans of care, face-to-face encounter documentation, or other certification paperwork indicating that all the beneficiaries identified by CMS met the requirements of 42 C.F.R. § 424.22 prior to Petitioner's submission of claims for Medicare payment (documents that are or should be in Petitioner's possession).

2. The undisputed evidence shows CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges because Petitioner was not in compliance with Medicare requirements for home health certifications.

The law requires that a physician must be involved in the certification of an individual for home health services and a physician's ongoing involvement in the care of that individual. 42 U.S.C. § 1395f(a)(2)(C); 42 U.S.C. § 1395n(a)(2)(A). Medicare program guidance echoes these statutory requirements: "[t]he patient must be under the care of a physician who is qualified to sign the certification statement and plan of care . . . A patient is expected to be under the care of the physician who signs the plan of care and the physician certification." Medicare Benefit Policy Manual, CMS Publication 100-101, Ch. 7, § 30.3. The physician must base his certification of the need for home health services upon a face-to-face encounter with the patient and the encounter must be related to the primary reason the patient requires home health services. 42 C.F.R. § 424.22(a).

Because Petitioner did not bring forth any evidence concerning 21 of the 23 beneficiaries identified by CMS as under Dr. Orozco's or Graves' care, or for whom Dr. Orozco or Dr. Graves allegedly ordered home health care services, I find Petitioner did not conform to

"the laws, regulations, and program instructions of the Medicare program." By signing the certification statement at section 15 of the Form CMS-855A enrollment application, Petitioner bound itself to comply with all applicable legal requirements. CMS may "revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement or supplier agreement" for reasons including, as relevant here:

> (1) *Noncompliance*. The provider or supplier is determined not to be in compliance with the enrollment requirements described in this section, or in the enrollment application applicable for its provider or supplier type . . . .

42 C.F.R. § 424.535(a).

Accordingly, I find that CMS was authorized to revoke Petitioner's Medicare enrollment and billing privileges for noncompliance with the enrollment application applicable for its provider type pursuant to 42 C.F.R. § 424.535(a)(1). *Hoyos Home Health Care Inc.*, DAB CR2746, at 8-9 (2013); *IFA Universal Home Care, Inc.*, DAB CR2745, at 8-9 (2013).

V. Conclusion

Petitioner has not shown a genuine issue of material fact exists with regard to CMS's challenge that a physician did not certify 21 of Petitioner's patients pursuant to Medicare home health care requirements. As a result, I must affirm CMS's determination to revoke Petitioner's Medicare enrollment and billing privileges because the undisputed evidence shows that Petitioner was not compliant with Medicare program requirements.

/s/
Scott Anderson
Administrative Law Judge