Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

St. Catherine's Health Services,
(PTAN: 10-8201),
(NPI: 1811950934),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-175

Decision No. CR3151

Date: March 12, 2014

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to revoke the Medicare enrollment and billing privileges of Petitioner, St. Catherine's Health Services, Inc.

I. Background

Petitioner is a home health care agency that does business in the vicinity of Miami, Florida. It participated in the Medicare program. CMS revoked Petitioner's Medicare enrollment and billing privileges, finding that Petitioner had claimed reimbursement for Medicare services for individuals who had not been certified properly as needing home health services by a treating physician. That determination was affirmed on reconsideration and Petitioner requested a hearing before an administrative law judge.

CMS filed its pre-hearing exchange and with it a motion for summary judgment. Petitioner filed its exchange and opposed CMS's motion. CMS filed a reply brief.

I conferred with the parties and each advised me that it did not desire to cross-examine its opponent's witness. Additionally, I offered to Petitioner's counsel to subpoena the physician whose alleged certifications of Medicare beneficiaries for home health services are at issue in this case for the purpose of obtaining his testimony. Petitioner's counsel declined my offer.

I am electing to treat the motion for summary judgment and Petitioner's opposition to that motion as final briefs addressing the merits of the case given that neither party desires to offer testimony. I base my decision on the parties' arguments and the exhibits that they filed. CMS filed exhibits that it identified as CMS Exs. 1 – 8, 9a, 9b, and 10.[1] Petitioner filed exhibits that it identified as P. Exs. 1 – 93. I receive all of the parties' exhibits into the record.

II. Issue, Findings of Fact and Conclusions of Law

A. Issue

The issue is whether CMS properly revoked Petitioner's Medicare participation and its billing privileges.

B. Findings of Fact and Conclusions of Law

Providers and suppliers may participate in the Medicare program and receive reimbursement for their services to eligible beneficiaries only if they comply with all applicable laws and regulations governing their participation. CMS is authorized to revoke the Medicare enrollment and billing privileges of any participating provider or supplier that is not complying with enrollment requirements. 42 C.F.R. § 424.535(a)(1).

The application for participation in Medicare explicitly imposes on a home health care agency (or any provider or supplier) the obligation to comply with all Medicare participation requirements. An applicant signs a certification in which it expressly agrees that it is bound by these requirements. When Petitioner applied to participate in Medicare it not only subjected itself to applicable laws and regulations but it expressly agreed that it was doing so. CMS Ex. 2 at 49; CMS Ex. 3.

[1] CMS Ex. 9a and 9b are actually all part of one exhibit, CMS Ex. 9, with consecutively numbered pages, that was filed in two parts. When I cite the exhibit in this decision I cite it as "CMS Ex. 9 at (page)."

"Home health services" includes items or services furnished to an individual who is under the care of a physician, by a home health agency, "under a plan . . . established and periodically reviewed by a physician." Social Security Act (Act) § 1861(m). A physician must certify that home health services are necessary in order that they be reimbursable by Medicare. 42 C.F.R. § 424.22(a).

A written certification means more than a physician's signature on a form. "Certification" means that a physician has a treatment relationship with a patient, that he or she sees and evaluates that patient, and that he or she determines and attests in writing that the patient needs the services that are provided by a home health agency. Governing regulations envision that a physician will premise his or her certification on a face-to-face encounter with a beneficiary in which the physician evaluates the beneficiary's needs and determines that the beneficiary needs skilled nursing care or physical or speech therapy and that the beneficiary is confined to the home except when receiving outpatient services. 42 C.F.R. § 424.22(a)(1)(i), (ii). The physician must establish a comprehensive plan of treatment for the beneficiary. 42 C.F.R. § 424.22(a)(1)(iii). The physician must sign the certification at the time that the plan of treatment is established or as soon thereafter as is practicable. 42 C.F.R. § 424.22(a)(2).

Failure by a home health care agency to obtain the proper certification by a physician for home health services is a violation of participation requirements. It is a basis for CMS to revoke that agency's Medicare enrollment and its billing privileges. 42 C.F.R. § 424.535(a)(1). A single instance of failure to provide proper certification is sufficient grounds for revocation.

This case involves 26 Medicare beneficiaries who ostensibly were certified as being eligible for home health care services by a physician, Dr. Carlos Gonzalez. Petitioner submitted reimbursement claims for these beneficiaries listing Dr. Gonzalez as the "attending" (certifying) physician for each of them. CMS Ex. 5; CMS Ex. 7. In other words, Petitioner submitted reimbursement claims for the 26 beneficiaries in which they told Medicare that Dr. Gonzalez had certified each of them for home health care services.

CMS investigated the services that Dr. Gonzalez had ostensibly certified because he had not filed Medicare reimbursement claims for any of the 26 beneficiaries in question. CMS Ex. 6. CMS investigators showed Dr. Gonzalez medical records from Petitioner including plans of care for the 26 beneficiaries, all of which bore signatures purporting to be that of Dr. Gonzalez. When confronted with these records, Dr. Gonzalez denied signing any of them and signed statements confirming that the signatures on the records were not his. CMS Ex. 7; CMS Ex. 9 at 1 – 167. Additionally, Dr. Gonzalez denied ordering home health agency services, verbally or in writing, for any of the 26 beneficiaries. *Id.*

Medicare payment records corroborate Dr. Gonzalez' assertion to the investigators that he did not certify the 26 beneficiaries for home health care. CMS Ex. 5; CMS Ex. 6. The payment records do not show Dr. Gonzalez as having claimed reimbursement for services that he provided to any of the beneficiaries. CMS Ex. 5; CMS Ex. 7. The fact that Dr. Gonzalez – who does claim reimbursement for patients that he treats – did not file reimbursement claims for any of the 26 beneficiaries in question strongly supports his assertions that he did not certify any of the beneficiaries for home health care and that the signatures on Petitioner's records are not his. *See* CMS Ex. 6.

The inference that I draw from the evidence offered by CMS is that Petitioner filed claims for Medicare reimbursement based on invalid certifications that these individuals were eligible for home health care services and on equally invalid plans of care and treatment orders. Petitioner's failure to obtain valid certifications before claiming reimbursement for the services it allegedly provided to these beneficiaries is a violation of the regulations that govern home health care services and ample legal justification for CMS to revoke Petitioner's provider enrollment and Medicare billing privileges.

Petitioner makes several arguments to counter the evidence that CMS offered. First, it suggests that Dr. Gonzalez' denial that he signed the certifications and treatment plans for the 26 beneficiaries is not credible. However, Petitioner has offered no evidence that undermines Dr. Gonzalez' credibility. I afforded Petitioner the opportunity to take Dr. Gonzalez' testimony under oath and it declined that offer. It has offered no affirmative proof to challenge his statements. Furthermore, when the records that are at issue are looked at closely, they support – rather than contradict – Dr. Gonzalez' assertion that the signatures on the records are not his. Dr. Gonzalez' signature on the statements that he gave to CMS is clearly very different from his purported signature on some of Petitioner's records. Compare, for example, Dr. Gonzalez' signature on CMS Ex. 9 at 1 with his purported signature at the bottom of P. Ex. 28 at 2.

Petitioner's second argument is that even if Dr. Gonzalez may not have signed the certifications, individuals who worked for Dr. Gonzalez signed other documents relating to the beneficiaries and the care that they received. I find this argument to be unpersuasive. First, it is Dr. Gonzalez and only Dr. Gonzalez who was authorized to certify the beneficiaries for home health care. The regulations governing home health care services envision a treating relationship between a physician and a beneficiary. A home health agency may not accept a beneficiary for care unless *a physician* certifies that individual's need. 42 C.F.R. § 424.22(a)(1)(iii). Anything other than a physician's certification is unacceptable. Second, Petitioner has offered no evidence to show that the other signatures on the documents, signatures purporting to have been written by a

physician's assistant and a nurse practitioner, are authentic. Petitioner did not ask any of the purported authors of these statements to attest to the authenticity of their signatures. Moreover, Dr. Gonzalez denied working with either a physician's assistant or a nurse practitioner. CMS Ex. 7.

Petitioner also offers the affidavit of Brisaida Duarte, who is Petitioner's administrator. P. Ex. 92. Ms. Duarte avers that Petitioner "verified" the orders for home health care services ostensibly ordered by Dr. Gonzalez and also "verified" that all 26 of the beneficiaries in question were being cared for by Dr. Gonzalez. P. Ex. 92. I find these assertions to be not credible. Not only does Ms. Duarte not explain what she means by her assertion that she "verified" certain things, but she does not provide even a shred of explanation as to how this alleged verification occurred. She doesn't say, for example, that she or anyone on her staff ever spoke with Dr. Gonzalez.

Indeed, what is most striking about Petitioner's evidence is the singular lack of *any* evidence that anyone on Petitioner's staff every met with or spoke to Dr. Gonzalez. There is nothing in the welter of documents that Petitioner offered that shows a single phone call to Dr. Gonzalez or a consultation of any type at any time. Throughout the period when Petitioner allegedly provided care to all 26 of the beneficiaries, Dr. Gonzalez remains a phantom according to Petitioner's documents, a shadowy figure who remains in the background, never seen, never spoken to, never heard from.

And, yet, if Petitioner is to be believed, somehow Dr. Gonzalez managed to draft and sign dozens of Petitioner's records. Petitioner produced a host of treatment records for the 26 beneficiaries, many containing signatures that purportedly are that of Dr. Gonzalez. P. Exs. 54-57, 59-90. The signatures on these documents are plainly put there to make it look as if Dr. Gonzalez played an active role in ordering and treating the 26 beneficiaries. But, Petitioner offers no explanation at all as to how he allegedly came to sign these records. If Petitioner's staff was not contacting Dr. Gonzalez by phone – and Petitioner has provided no evidence that its staff did that – or meeting with him face to face – and Petitioner has provided no evidence that it did that either – then how was it that Dr. Gonzalez would be signing these documents as if he played an active role in the beneficiaries' care? Petitioner does not explain this mystery and the inference that I draw is that it cannot.

Petitioner's argues that even if all of these documents with Dr. Gonzalez' purported signature on them are false, it still operated within the regulatory requirements in claiming reimbursement for the services it provided for the 26 beneficiaries. That is because, according to Petitioner, it is not required by law to authenticate anyone's signature. It contends that it is allowed under Medicare

regulations to accept and rely on whatever paperwork that it receives and that it has no duty whatsoever to ascertain whether the paperwork is authentic. Indeed, it argues that it has no duty to *communicate at all* with a beneficiary's physician except in the case of a significant change in the beneficiary's medical condition. Thus, according to Petitioner, governing regulations permit it to receive written certification from a physician for home health care services, provide care for the beneficiary, and bill Medicare for that beneficiary, and never once speak to the physician or even communicate with the physician in writing about the beneficiary's care except where there is a significant change in the beneficiary's condition.

This argument contradicts both the letter and intent of the regulations governing home health agencies. Petitioner cannot rely solely on the paperwork that it receives from a beneficiary's physician without actively communicating with that physician about the beneficiary's condition. The regulations do not envision that a home health agency functions as an independent, free-standing provider of care, independent of a physician's overall supervision of a beneficiary's care. To the contrary, the regulations assume that any beneficiary who is provided care by a home health agency remains under the care and supervision of a treating physician. Any care plan that is established for a Medicare beneficiary while under the care of a home health agency must be established *and periodically reviewed* by the beneficiary's physician. 42 C.F.R. § 424.22(a)(1)(iii). The home health agency's services must be furnished while the beneficiary is *under the care* of a physician. 42 C.F.R. § 424.22(a)(1)(iv). By necessity the ongoing relationship between a beneficiary and his or her physician contemplated by the regulations must involve communication between the home health agency and the beneficiary's physician once the beneficiary is admitted to home health care. How can a physician possibly update a plan of care unless he or she is kept apprised of a beneficiary's condition by the home health agency? How can a physician provide care for any beneficiary if he or she is not in communication with the agency that is providing care on a day-to-day basis?

Indeed, Petitioner's care plans envision reporting to the beneficiaries' physician and these reports are not limited to circumstances where there are significant changes in a beneficiary's condition. *E.g.*, P. Ex. 27 at 4. Had Petitioner's staff been in communication with Dr. Gonzalez they would have learned immediately that he had not certified these beneficiaries for home health care.

The requirement that a home health agency remain in communication with a beneficiary's physician impliedly imposes on a home health agency the duty to verify that the physician is actually ordering the services that he or she purports to order. That does not mean that an agency must call a physician every time it receives a document purportedly signed by him or her and inquire whether the

physician's signature is authentic and whether the physician meant what he or she is purported to have said. But, it does mean that in the context of an ongoing treatment relationship the home health agency should learn whether the care was actually ordered by a physician.

Petitioner also asserts that it has statements from many of the 26 beneficiaries whose care is at issue that establish that each of them had a treating relationship with Dr. Gonzalez. P. Ex. 2 – P. Ex. 23. These statements – all of them verbatim identical except for the purported dates of service – do not prove that Dr. Gonzalez certified any of these individuals for home health care. First, they do not even mention Dr. Gonzalez. Secondly, none of the statements purports to prove that Dr. Gonzalez or anyone else certified the beneficiary as being eligible for home health care. Each statement merely avers that the beneficiary had "assist" (I infer that means "visited") a medical office that has the same address as Dr. Gonzalez' office on a particular date for a "follow up" with "a doctor." *E.g.*, P. Ex. 2. None of the statements specifies which doctor was seen or the reason for the visit.

It is Petitioner's burden to prove that the certifications for the 26 beneficiaries whose care is at issue are valid given the strong prima facie case presented by CMS showing that these individuals had not been certified by their (attending) treating physician, Dr. Gonzalez. Petitioner clearly failed to meet that burden.

/s/
Steven T. Kessel
Administrative Law Judge