Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Prescribed Care, Inc.,	)	Date: September 16, 1997
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-96-234
	)	Decision No. CR492
Health Care Financing Administration.	)	
	)	

DECISION

For the reasons stated below, I conclude that Petitioner was not in compliance with Medicare conditions of participation governing home health agencies. Accordingly, the Health Care Financing Administration (HCFA) was authorized to terminate Petitioner's Medicare participation agreement.

I. Background

A. Applicable law and regulations

Petitioner is a home health agency that participated in the Medicare program. The services provided by home health agencies that are covered by the Medicare program are described in section 1861(m) of the Social Security Act (Act). The statutory requirements of participation for a home health agency are described in section 1861(o) of the Act.

The Secretary of the United States Department of Health and Human Services (Secretary) has published regulations which govern the participation in Medicare of home health agencies. These are contained in 42 C.F.R. Part 484. The regulations which define the Secretary's requirements for Medicare participation of home health agencies establish conditions of participation for these agencies. 42 C.F.R. §§ 484.10 - 484.52. The regulations express these conditions of participation as broadly stated participation criteria. The regulations also state standards of participation as subsidiary components of the conditions of participation.

The Secretary is required to determine whether a Medicare participant, including a home health agency, is complying substantially with the Medicare participation requirements established by the Act and regulations. Act, section 1866(b)(2). The Secretary may terminate the participation in Medicare of a provider which the Secretary finds not to be complying substantially with participation requirements. Act, section 1866(b)(2)(A).

The process and criteria for determining whether a provider is complying substantially with Medicare participation requirements are established by regulations contained in 42 C.F.R. Part 488.[1] Pursuant to the Act and regulations, the Secretary has entered into agreements with State survey agencies to conduct periodic surveys of providers, including home health agencies, in order to ascertain whether these providers are complying with Medicare participation requirements. Act, section 1864(a); 42 C.F.R. §§ 488.10, 488.11, 488.20.

HCFA may terminate the participation in Medicare of a provider when it determines, either on its own initiative or based on a survey report from a State survey agency, that the provider is not complying with one or more Medicare conditions of participation. See 42 C.F.R. §§ 488.20, 488.24, 488.26.[2] Failure to comply with a condition of participation occurs where deficiencies, either individually or in combination, are:

> . . . of such character as to substantially limit the provider's . . . capacity to furnish adequate care or which adversely affect the health and safety of patients;

42 C.F.R. § 488.24(b); see 42 C.F.R. § 488.28(b).

Where HCFA determines that there is a deficiency, but that the deficiency is not so severe as to constitute a condition-level deficiency, then HCFA may not terminate the provider's participation in Medicare without first affording the provider the opportunity to correct the deficiency. 42 C.F.R. § 488.28.

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[1] In July 1995, the Part 488 regulations were revised and amended substantially as they apply to long-term care facilities, including nursing facilities and skilled nursing facilities. 42 C.F.R. § 488.301 et seq. The revisions and amendments are not at issue in this case because Petitioner is not a nursing facility or a skilled nursing facility.

[2] The criteria which govern the circumstances under which HCFA may impose a remedy, including termination, against a nursing facility or a skilled nursing facility are stated at 42 C.F.R. §§ 488.402 - 488.456.

Termination of participation is a remedy intended to protect the health and safety of program beneficiaries and not a punishment. Termination of participation should be invoked in the circumstance where a provider's deficiencies establish that the provider is substantially incapable of providing care consistent with Medicare participation requirements. Termination should not be invoked unless the evidence proving a provider's failure to comply with participation requirements establishes that the provider cannot provide care consistent with that which is required by the Act and regulations.

Generally, a determination as to whether a provider is complying with a condition of participation depends on the extent to which that provider is found not to be complying with the standards that are components of the condition. 42 C.F.R. § 488.26(b). A provider may be found not to have complied with a condition of participation where it is shown that a provider has committed a pattern of failures to comply with the standards that comprise the condition. But, proof of a pattern of failures to comply with a standard or standards may not be the only basis to find that a provider has failed to comply with a condition of participation. The determinative issue in any case where noncompliance is demonstrated is whether the failure to comply is so egregious as to show that the provider is not capable of providing care consistent with that which is required by the Act and regulations.

B. History of this case

On November 10, 1995, the California Department of Health Services (CA DHS) completed a recertification survey of Petitioner. Transcript (Tr.) 193; HCFA Ex. 1. Based on that survey, Petitioner was found not to be complying with three conditions of participation. HCFA Ex. 1. The CA DHS conducted a second survey of Petitioner which was completed on January 12, 1996. HCFA Ex. 3. On February 7, 1996, HCFA notified Petitioner that, based on the second survey, HCFA had determined that Petitioner was not complying with three conditions of participation. HCFA Ex. 5. These conditions are:

> (1) 42 C.F.R. § 484.14 (Organization, services, and administration);
>
> (2) 42 C.F.R. § 484.18 (Acceptance of patients, plan of care, and medical supervision); and
>
> (3) 42 C.F.R. § 484.48 (Clinical records).

Id. HCFA terminated Petitioner's participation in Medicare, effective February 23, 1996.

Petitioner requested a hearing, and the case was assigned to me for a hearing and a decision. I held a hearing in Santa Ana, California, on October 15 - 16, 1996, and I heard testimony by telephone on November 5, 1996. I ordered the parties to submit posthearing briefs, response briefs, and reply briefs. On March 26, 1997, I afforded the parties time to brief the issues raised by the decision of an appellate panel of the Departmental Appeals Board in the case of Hillman Rehabilitation Center, DAB No. 1611 (1997).[3] HCFA did not avail itself of the opportunity. Petitioner submitted a one page response out of time (on May 16, 1997) and requested that, to respond to Hillman, I re-open the record to allow it to present additional evidence at an in-person hearing. I granted Petitioner's request and scheduled a hearing to commence on August 5, 1997. However, by letter of July 8, 1997, citing a lack of resources to go forward with the hearing, Petitioner requested that the hearing be cancelled and that I decide the case on the evidence of record. I granted Petitioner's request. However, I also afforded Petitioner one last opportunity to offer additional documentary evidence and briefing. Petitioner chose not to avail itself of the opportunity. I base my decision in this case on the governing

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[3] In my June 12, 1996 Order and Notice of Hearing, I placed on HCFA the burden of coming forward with evidence as to all issues and of proving, by a preponderance of the evidence, that Petitioner failed to comply with Medicare participation requirements. I placed on Petitioner the burden of proving, by a preponderance of the evidence, any affirmative defenses. I afforded the parties also the opportunity to brief the issue of which party had the burden of proof during their post-hearing briefing. Tr. 18. The Hillman decision, however, places on HCFA only the burden of coming forward with evidence to establish a prima facie case that it has a legally sufficient basis for termination, and imposes on a provider the burden of proving, by a preponderance of the evidence, that the provider was in substantial compliance with participation requirements. In its May 16, 1997 submission, Petitioner alleges that it would be very prejudicial and unfair to apply the Hillman decision retroactively. This argument is unpersuasive. First, the appellate panel never excluded from application of Hillman cases that were pending decision. Second, Petitioner was given the opportunity to offer additional proof under the guidelines of the Hillman case. In making my decision as to whether Petitioner met its burden of offering evidence demonstrating by a preponderance of the evidence that it was in substantial compliance with the conditions of participation, below I find repeatedly that HCFA not only established a prima facie case, but it also proved, by a preponderance of the evidence, that Petitioner failed to comply with Medicare participation requirements. Such a conclusion, by definition, means that Petitioner failed to meet its burden of proof under Hillman.

law, the evidence I received at hearing, and on the parties' arguments as expressed in their briefs.

II. Discussion

A. Petitioner was out of compliance with the condition of participation governing organization, services, and administration, 42 C.F.R. § 484.14.

HCFA is authorized to terminate Petitioner's Medicare provider agreement if Petitioner is out of compliance with any condition of participation. Petitioner's own statements demonstrate that, as of the date of the follow-up survey, Petitioner remained out of compliance with the condition of participation governing organization, services, and administration, codified at 42 C.F.R. § 484.14. Among other things, this regulation requires that a home health agency provide at least one of a list of qualifying services directly through agency employees. The service which Petitioner was to provide is skilled nursing.[4] HCFA alleged that Petitioner failed to comply with this requirement, in that Petitioner was providing skilled nursing services through contract nurses. The State surveyors testified that representatives of Petitioner present at the surveys admitted that Petitioner was providing skilled nursing services via contract nurses. Tr. 58, 119-20; HCFA Ex. 1 at 6; HCFA Ex. 3 at 2. I find credible the testimony that such admissions were made, because it is corroborated by Petitioner's own statements in its plans of correction. P. Ex. 14 at 2.

In its first plan of correction, Petitioner stated that it would recruit employee nurses by advertising in newspapers and nursing publications, to "gradually replace all registry nurses." HCFA Ex. 1 at 5. Petitioner undertook to complete this action by December 10, 1995. Based on this evidence, I find that there is no real dispute as to the fact that, as of the first survey, Petitioner was out of compliance with the requirement to furnish at least one service directly. Similarly, in its second plan of correction, Petitioner averred, "Contractual nursing agreements with individuals who are not employees of the Agency would be discontinued by the completion date [2/12/96]." P. Ex. 14 at 1.

Petitioner has nowhere contended that it was, in fact, in compliance with the requirement that it furnish at least one service directly. Instead, Petitioner argues that HCFA should have found credible its assertion that it would recruit and hire additional nursing staff at some time after the follow-up survey. Petitioner's Reply Brief at 5. Petitioner states that this deficiency "could not reasonably be remedied in just a short week

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[4] Petitioner never argued it would provide any service by its own employees other than skilled nursing.

or so." Id. This argument is unpersuasive for two reasons. First, Petitioner had notice that it was required to provide at least one service directly through employees as of its receipt of the CA DHS's letter of November 15, 1995, enclosing the statement of deficiencies from the November 10, 1995 survey.[5] The follow-up survey was completed on January 12, 1996. Thus, Petitioner had already been afforded approximately two months in which to come into compliance with this requirement. Second, the fact that Petitioner might have corrected its deficiencies at some time after the date of the second survey is irrelevant to my determination as to whether HCFA was authorized to terminate Petitioner's provider agreement. HCFA's termination decision must be evaluated based on conditions prevailing at Petitioner on the date of the survey. Carmel Convalescent Hospital, DAB CR389 (1995), aff'd in part and rev'd in part, DAB No. 1584 (1996).

In Carmel, the administrative law judge reasoned that, under the regulations, surveys are the means by which HCFA assesses providers' compliance with federal health, safety, and quality standards. 42 C.F.R. § 488.26(c)(1). Therefore, according to Carmel, the conditions which are relevant to HCFA's authority to terminate are those which prevail at a facility at the time of the survey, and not at some later time. Moreover, the administrative law judge ruled that no law or regulation compels HCFA to conduct another survey after finding deficiencies at a follow-up survey before actually effectuating its termination decision. I agree with the interpretation of the regulations set forth in the Carmel decision, and I adopt it here.

At the time of the follow-up survey, HCFA proved and Petitioner admitted that Petitioner remained out of compliance with the requirement that one of its services be provided directly by employees. It is not a defense to HCFA's finding of non-compliance that Petitioner submitted a plan of correction promising to hire additional direct employees at some future time. HCFA was under no obligation to conduct a second follow-up survey to determine whether Petitioner had, in fact, brought itself into compliance. Insuring that a home health agency provide one of its services directly through its employees rather than through contractors is necessary to protect Medicare beneficiaries and is basic to the operation of a home health agency.

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[5] Irrespective of this notice, Petitioner can be held to have notice of this requirement from the regulations themselves. When Petitioner commenced its operation of a home health agency, it assumed the responsibility to be in substantial compliance with the conditions of participation. That compliance includes knowledge of the regulatory requirements.

Petitioner's failure to provide at least one service directly through its employees seriously limits Petitioner's capacity to render adequate care, because a facility which does not satisfy this requirement fails to meet the basic definition of a home health agency. HCFA's nurse consultant, Ms. Patience, testified that to qualify as a home health agency, a provider must have control over at least one service, delivering that service through individuals employed by the provider. Tr. 262. If the provider does not have control over at least one service, then it does not meet the definition of a home health agency, but rather is operating more as a nursing registry. Id. at 262-63. That in January 1996, Petitioner was still unable to meet the threshold requirement to be certified as a home health agency, raises serious questions as to Petitioner's ability to render adequate care and fully justifies HCFA's determination to terminate Petitioner's provider agreement.

Thus, HCFA's decision to terminate Petitioner's provider agreement is authorized based on this deficiency alone. Consequently, I conclude that Petitioner's termination was authorized.

B. Petitioner was out of compliance with the condition of participation governing acceptance of patients, plan of care, and medical supervision, 42 C.F.R. § 484.18.

HCFA proved that Petitioner failed to comply with the condition of participation governing acceptance of patients, plan of care, and medical supervision, as of the date of the follow-up survey. Among other things, this condition of participation requires that a home health agency follow physician orders for each patient in a written plan of care.[6]

Following the initial survey of November 1995, and based on the clinical record review done by the CA DHS surveyors, HCFA determined that Petitioner failed to ensure that physician's orders in the written plan of care were followed, failed to notify physicians of changes in patients' conditions, and failed to ensure that drugs and treatments were administered only on physicians' orders. HCFA Ex. 1 at 14-17; Tr. 101-103. Specifically, HCFA determined that: a patient's physician was not notified when a patient with insulin dependent diabetes

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[6] An additional deficiency was cited in the follow-up survey based on the failure to obtain a physician's countersignature for orders given orally. This violated section 484.18(c), which was removed by technical changes to the regulation which had not been conveyed to the surveyors at the time of the follow up survey in January 1996. See Tr. 311. As a result, HCFA is not pursing this deficiency against Petitioner. HCFA Opening Memorandum at 28.

mellitus had blood sugar values that were too low on 20 different occasions during a one month period (HCFA Ex. 1 at 14; Tr. 102); skilled nursing instruction was not provided to a patient's caregiver as per physician's instructions (HCFA Ex. 1 at 15-16); a physical therapy evaluation was still not done two months after it was ordered (HCFA Ex. 1 at 15); medical social worker visits and skilled nursing visits were missed and the patients' physicians were not notified of the missed visits nor were the physicians notified of a change in the patients' conditions (HCFA Ex. 1 at 16-17; Tr. 76); and medicated eye drops and medication to treat pressure sores were administered by the staff without physician's orders for such medication. HCFA Ex. 1 at 17-18. Petitioner submitted no evidence to rebut HCFA's determinations.

Instead, Petitioner responded in a plan of correction that it would in-service its staff on the necessity of adherence to a plan of treatment, the importance of documentation, and the necessity of informing physicians of missed visits. Petitioner assured also that the Director of Patient Care Services would monitor compliance weekly. HCFA Ex. 1 at 13-16.

However, despite Petitioner's assurances, at the follow-up survey in January 1996, the surveyors found that, for 10 of 10 patients, the clinical records that were reviewed showed that home visits and other services were not furnished in accordance with the physicians' orders in the patients' plan of care. HCFA Ex. 3 at 4-8; Tr. 123, 126-127.

It was established by the testimony of Ms. Patience (the nurse consultant employed by HCFA who reviewed the survey findings) and Ms. Sabino (one of the home health evaluator nurses that surveyed Petitioner for the CA DHS) that there is an established nursing standard of practice that every action taken by nurses and other staff must be documented. Tr. 177-178, 264-265. They testified that if there is a lack of documentation, then the action is considered as not having been done. Id. The purpose of this nursing standard of practice is to show that what was ordered was indeed done and "to provide a record for other staff, to indicate the patients progress or lack thereof or stability. To document the condition of the patient. To assist the agency or to assist anybody in determining if there are further needs for that patient." Tr. 266.

Ms. Patience testified that it is also an established nursing practice that a physician's orders are to be "implemented as soon as possible" and "certainly within a few days." Tr. 266. Ms. Sabino confirmed this nursing practice by noting that a physician's orders should be carried out at least within 72 hours of their issuance. Tr. 129-130.

Based on the follow-up survey, HCFA proved that there were delays in following a physician's plan of care, in one instance by 13 days and in another instance by 17 days, which is well outside the established standard of practice. HCFA Ex. 3 at 4-5; Tr. 127. HCFA also proved that Petitioner repeatedly missed providing skilled nursing visits, home health aide visits, and therapy services, in direct violation of physicians' orders as stated on plans of care. HCFA Ex. 3 at 5-8; Tr. 130-134. In fact, eight patients out of the 10 reviewed missed services that they should have received under a physician's written plan of care in excess of 50 times. Since the missed visits and therapy services were nowhere documented in the patients' clinical records, under standard nursing practices, as noted by HCFA's witnesses, they have to be assumed to not have taken place. Indeed, nowhere has Petitioner claimed that the missing services were performed as ordered. No witnesses or records were offered to show that the services did, in fact, occur. Under Hillman, HCFA provided Petitioner with notice of the deficiencies which were the basis for citing this condition of participation. Petitioner, who provided the alleged deficient care, should have been in a position through its own medical records and testimony of caregivers to rebut the evidence offered by HCFA if such evidence was in existence. Since Petitioner chose to offer no such evidence, I must assume there is no such evidence.

HCFA also proved that, in the case of Patient #4, the physical therapy evaluation that was ordered on December 19, 1995 had not been received by this patient at the time of the follow-up survey of January 12, 1996, 24 days after the evaluation was ordered. HCFA Ex. 3 at 6. Not only were there repeated services entirely missed and delays in the implementation of physician's orders, but there was no notification to physicians of these failures to carry out orders both timely and as directed. HCFA Ex. 3 at 5-6.

In fact, in Petitioner's second plan of correction in response to the January 12th revisit survey, the Petitioner claims that it had conducted additional in-service training for its staff to address this deficiency, and that the training was completed on January 25, 1996. P. Ex. 14 at 4. Therefore, by Petitioner's own admission, it did not adequately address this deficiency until after the January 12, 1996 revisit survey.

Petitioner argues that HCFA relies on "assumptions and nebulous concepts like "standard nursing practices", that "if something is not written down it is thereby not actually done" and that the "72 hours standard" is "arbitrary and without basis in the regulations." Petitioner's Posthearing Response Brief at 5. I disagree. Standard nursing practices perform a necessary function to memorialize that physicians orders have been carried out so that different medical staff can be kept abreast of the current condition of the patient in order that the staff can continuously provide the best care possible. Ms. Sabino

testified that the "72 hours standard" is necessary so that a delay would not cause a patient to lose the progress the patient had gained during a hospital stay. Tr. 129. These are not assumptions, or nebulous concepts, nor are they arbitrary. Instead, they are necessary in order to provide adequate medical care. Although the witnesses could not point to a regulation that states these nursing practices, they were both firm in the existence of these practices. Their testimony is credible. Also, I note that Petitioner did not claim that such nursing practices do not exist. Nor did it offer any evidence to demonstrate that some other standard of care should be applied or that the standards referenced by HCFA's witnesses were invalid. Even though the specific standards are not contained in the regulations, HCFA can reasonably expect that home health agencies will apply and be in conformity with recognized nursing standards of care in meeting the specified regulatory standards.

Patients of home health agencies depend on the services they get from a home health agency. Repeatedly missing nursing, therapy and other services will adversely affect the health and safety of these vulnerable patients. Petitioner repeatedly missed providing its patients with a variety of services as required by physicians orders in a written plan of care. This is evidence of Petitioner's failure to comply with participation requirements and establishes that Petitioner cannot provide care consistent with that which is required by the Act and regulations.

C. Petitioner was out of compliance with the condition of participation governing clinical records, 42 C.F.R. § 484.48.

HCFA proved that, as of the date of the follow-up survey, Petitioner failed to comply with the condition of participation governing clinical records. The regulation, at 42 C.F.R. § 484.48, requires, generally, that a home health agency maintain clinical records "containing pertinent past and current findings in accordance with accepted professional standards." CA DHS initially found that Petitioner failed to comply with this condition of participation during the November 1995 recertification survey. HCFA Ex. 1 at 23; Tr. 113-15. At this survey, CA DHS surveyors found that 100 percent of the 16 clinical records sampled were incomplete. HCFA Ex. 1 at 24.

At the follow-up survey, the surveyors concluded that, far from being corrected, the state of Petitioner's clinical records had deteriorated further. Ms. Sabino testified that, during the January 1996 survey, the surveyors requested clinical records for certain patients, which were not immediately forthcoming from Petitioner's staff. Tr. 142-43. Upon investigating the reason for the delay, Ms. Sabino went to the area where records were kept and observed that there were stacks of loose papers that had

not been filed. Tr. 143.[7] Moreover, when the patient records were assembled and produced, the records were found to be incomplete. Tr. 145.

HCFA's nurse consultant, Ms. Patience, testified that the condition of participation governing clinical records is important to delivering adequate care to patients because:

> [The] clinical record is the documentation, the journal, if you will of what's happening with the patient and it's important that those records be maintained in a professional fashion so the information that's necessary for the care of the patient gets communicated to all staff and is kept.

Tr. 269. The witness testified further that maintaining clinical records completely and timely is necessary in order:

> To assess whether or not the patient is making progress or is regressing and also to determine that the physician's orders are being carried out . . . .

Tr. 270. When Petitioner's clinical record-keeping practices are measured against these goals, it is apparent that HCFA was justified in concluding that Petitioner failed to comply with the condition of participation governing clinical records.

The lack of order that prevailed in Petitioner's record keeping practices would seriously limit Petitioner's capacity to deliver adequate care to its patients. If caregivers cannot refer to a patient's clinical record and find current and complete information on the patient's condition, it would seem difficult, if not impossible, to coordinate the care being given by different disciplines. I take this to be what Ms. Patience was referring to when she testified that the clinical record should serve to communicate the information necessary for the care of the patient to all staff. In addition, lack of adequate record-keeping would also be detrimental to a home health agency's efforts to monitor the quality of services provided to its patients. See, 42 C.F.R. § 484.48, which imposes such an obligation on home health agencies.

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[7] Ms. Sabino's testimony is transcribed as follows: "I saw staff in front of files of loose papers." Tr. 143 (emphasis added). However, the context suggests that the word was "piles" rather than "files." For example, on page 144 of the transcript, counsel refers to "stacks" of paper. Similarly, the 2567 reports: "agency staff were attempting to retrieve clinical notes from stacks of paper for filing into the requested clinical records." HCFA Ex. 3 at 12.

Petitioner has argued, in general, that I should not rely on the testimony of HCFA's witnesses because they lack present recollection of the facts underlying the deficiencies noted in the HCFA form 2567. However, for me to resolve this case I need not decide whether HCFA failed to meet its burden of proof if its witnesses at hearing lacked present recollection of the facts reported in the HCFA form 2567. In the case of Ms. Sabino's testimony regarding the condition of Petitioner's record storage area, there is no such defect. Ms. Sabino's recollection as to the unfilled stacks of paper she observed was clear and dramatic. I have no difficulty in concluding that the conditions described do not comport with professionally recognized standards for record-keeping. For these reasons, I conclude that HCFA was justified in concluding that Petitioner failed to comply with the condition of participation governing clinical records. Even should I accept Petitioner's contention that HCFA's witness lacked specific recollection of the events to establish proof of the condition of participation, that would not overcome HCFA's responsibility under Hillman to provide notice only. Clearly, HCFA's witnesses, along with the 2567, provided Petitioner with notice of this condition. Again, Petitioner chose to offer no proof to rebut the evidence presented by HCFA or to show it was in substantial compliance with this condition of participation.

I have concluded that on the date of the follow-up survey, Petitioner was out of compliance with the conditions of participation governing organization, services, and administration (42 C.F.R. § 484.14); acceptance of patients, plan of care and medical supervision (42 C.F.R. § 484.18); and clinical records (42 C.F.R. § 484.48). Since providers that participate in Medicare are required to be in compliance with all conditions of participation, HCFA was fully justified in terminating Petitioner's Medicare participation agreement based on these findings.

Of particular significance in this case is Petitioner's failure to provide any evidence to rebut evidence presented by the surveyors relating to these conditions of participation. Petitioner had the opportunity at and subsequent to the hearing to present testimonial and documentary evidence challenging the testimony of the CA DHS surveyors. Despite repeated opportunities, no evidence was presented. Petitioner was in the best position to counter the testimony of the State surveyors. If such evidence was available, it was never presented.

D. HCFA is not estopped from terminating Petitioner's participation requirement.

Petitioner argues, essentially, that HCFA should be estopped from terminating its participation agreement because Petitioner was not given an opportunity to correct the deficiencies found after the CA DHS' 1/12/96 follow-up survey, which opportunity

Petitioner alleges was afforded it by the CA DHS in a letter of January 19, 1996. HCFA Ex. 4. Petitioner alleges that the letter afforded it 10 days in which to submit a response to the statement of deficiencies, which would be included in the public record of the survey and forwarded to HCFA for its "consideration." HCFA Ex. 4. Petitioner asserts that this is an "official promise ... made by respondent to petitioner inviting petitioner's reliance and action upon said promise." Petitioner's Initial Post-hearing Brief at 6.

As an initial matter, I note that it is not clear that estoppel will ever lie against the federal government. See, e.g., Colorado Dep't of Social Services, DAB QC6 (1991); Kansas Dep't of Social Services, DAB QC61 (1994); Virginia Dep't of Social Services, DAB QC75-R (1994). See also Wisconsin Dep't of Health and Social Services, DAB No. 1493 (1994). But even if estoppel could lie against HCFA, Petitioner has not proved the elements of estoppel in this case.

A party seeking to assert estoppel must prove that: 1) the party against whom estoppel is sought made false representations; 2) the party claiming estoppel relied on the false representations to the party's detriment; and 3) the reliance was reasonable, in that the party claiming the estoppel neither knew nor should have known that its adversary's conduct was misleading. Heckler v. Community Health Services, 467 U.S. 51, 59 (1984). Petitioner has not proved that these conditions exist here.

I do not read the January 19, 1996 letter from the CA DHS as inviting Petitioner to submit a second plan of correction or a credible allegation of compliance, nor does it promise Petitioner that it will be afforded a second follow-up survey, unlike the November 16, 1995 letter from the CA DHS which offered Petitioner the opportunity to submit evidence of correction and promised a follow-up survey if the evidence was found credible. See HCFA Ex. 2. The November 15, 1995 letter informed Petitioner also that if it was found out of compliance with any condition of participation after the follow-up survey, the CA DHS would be obliged to recommend termination to HCFA. In contrast, there were no false representations or official promises made to Petitioner in the January 19, 1996 letter stating that Petitioner had the right to submit further evidence of correction or the right to a second re-survey, and nowhere in the Act or regulations does such a right exist.

Moreover, even if Petitioner misled itself to believe that the response cited in the January 19, 1996 letter was an invitation to submit a second credible allegation and evidence of compliance, Petitioner's reliance on it to assert that HCFA was thus not authorized to terminate its provider agreement is not reasonable. In a situation such as this, where a provider has been found out of compliance with a condition of participation

and a follow-up survey has found it still out of compliance with that condition, HCFA is not required to review any more information prior to terminating that provider. HCFA is authorized to terminate the provider agreement of any provider if it concludes that, on balance, the deficiencies reasonably support a conclusion that a provider no longer meets any one condition of participation. 42 C.F.R. §§ 489.53(a)(1), (3), 488.24(b). Further, I note that the decision as to whether a follow-up survey should be performed is not an initial determination subject to review by me. 42 C.F.R. § 498.3.

III. Conclusion

For the reasons set forth above, I have concluded that HCFA was authorized to terminate Petitioner's Medicare participation agreement.

/s/

Edward D. Steinman
Administrative Law Judge