Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Miami-Sunshine Health Care, Inc.,
(PTAN: 10-9379),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-495

Decision No. CR2849

Date: July 3, 2013

DECISION

Petitioner, Miami-Sunshine Health Care, Inc., a home health agency, appeals the reconsideration decision dated January 28, 2013, affirming the revocation of its Medicare enrollment and billing privileges effective August 19, 2012. The undisputed evidence establishes that Petitioner was not in compliance with Medicare program requirements for 10 Medicare beneficiaries for whom it submitted claims for home health care services. As a consequence, I grant the motion of the Centers for Medicare and Medicaid Services (CMS) for summary judgment and uphold CMS's determination to revoke Petitioner's Medicare enrollment and billing privileges effective August 19, 2012.

I. Background and Procedural History

By letter dated June 27, 2012, Palmetto GBA (Palmetto), a CMS contractor, informed Petitioner that CMS was revoking Petitioner's Medicare billing privileges and terminating Petitioner's provider agreement effective August 19, 2012, because Petitioner failed to comply with the Medicare enrollment requirements pursuant to 42 C.F.R.

§ 424.535(a)(1). CMS Exhibit (Ex.) 1; P Ex. B. Palmetto also informed Petitioner that it was establishing a Medicare re-enrollment bar for a period of three years. CMS Ex. 1 at 2; P. Ex. B at 2. Specifically, the revocation letter stated that:

> Under 42 CFR 424.535(a)(1) CMS may revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement when the suppliers are not in compliance with the enrollment requirements specifically outlined in Section 15(a)5 (Certification Statement for 855A application) that states: "I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and I will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity."

CMS Ex. 1 at 1.

Petitioner timely filed a request for reconsideration of CMS's decision. CMS Ex. 1 at 3. On January 28, 2013, CMS issued a reconsidered determination that upheld the revocation based on Petitioner's noncompliance with Medicare enrollment requirements. CMS Ex. 1 at 3-5. CMS found with respect to 10 beneficiaries that there was no evidence that Dr. Gonzalez was the treating physician; there was no claim for services from Dr. Gonzalez for these 10 patients even though Petitioner claimed there was a valid certification for home health services from Dr. Gonzalez for these beneficiaries.

Petitioner filed a hearing request (HR) with the Civil Remedies Division of the Departmental Appeals Board on March 4, 2013 and the case was assigned to me for hearing and decision.

In accordance with my Acknowledgment and Initial Docketing Order dated March 8, 2013, CMS filed on April 5, 2013, a Motion for Summary Judgment and brief (CMS Br.), with nine exhibits (CMS Exs. 1-9). In its brief, CMS stated that Petitioner obligated itself to full compliance with "the Medicare laws, regulations, and program instructions that apply to this provider" which include the standards governing Medicare-reimbursable home health services. CMS Br. at 1-2. CMS contends that such services may be provided only to a beneficiary who is under the care of a physician, and a physician must certify the necessity for home health services for the beneficiary, after a face-to-face encounter. CMS argues that Petitioner billed Medicare without valid certifications from a physician, who was involved in the treatment, care or monitoring of identified beneficiaries and this billing practice constituted noncompliance.[1] CMS Br. at 2.

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[1] In its brief, CMS stated that to the extent this constitutes a modification of the previously-articulated basis for the revocation, such a modification is permissible. CMS Br. at 2, n1 citing *Green Hills Enterprises, LLC*, DAB No. 2199 (2008)(it is permissible

Petitioner did not initially file its rebuttal response as directed by my order by April 25, 2013. On May 6, 2013, I issued an Order to Show Cause why I should not dismiss this matter as abandoned or for failure to follow my directives. Later that day, Petitioner filed its brief in opposition to CMS's motion (P. Br.) together with P. Exs. A-M and 1-20, and, later, at my directive, it filed on May 16, 2013, its showing of good cause for its failure to file its response by April 25, 2013. On June 3, 2013, I issued my ruling on Petitioner's good cause, indicating that while an error by counsel is generally not sufficient to show good cause for missing an important deadline, it was apparent from Petitioner's response that the circumstances here warranted my exercise of discretion in Petitioner's favor. I allowed Petitioner's May 6, 2013 response into the record.

CMS then filed its reply to Petitioner's motion in opposition to CMS' motion for summary judgment. CMS Reply.

II. Applicable Law

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), 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 Publication 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 the home health agency personnel must review a Medicare beneficiary's plan of care at regular intervals. 42 C.F.R. § 484.18(b). Also, the home health agency is required to "promptly alert the physician" to significant changes that suggest a need to alter the plan of care. 42 C.F.R. § 484.18(b). The home health agency consults with the

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for CMS to state alternative grounds for its determination provided the petitioner has the opportunity to respond to those grounds during the administrative proceeding).

individual's physician to obtain approval of any "additions or modifications to the original plan" of care. 42 C.F.R. § 484.18(a).

Section 424.535(a) of 42 C.F.R. authorizes CMS to "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 . . . .

III. Analysis

A. Issue

The issue in this case is whether CMS is entitled to summary judgment on the grounds that CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges.

B. Applicable Standard

Summary judgment is appropriate when a case presents no issue of material fact, and its resolution turns on questions of law. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-48 (1986); *Livingston Care Ctr. v. United States Dep't of Health and Human Servs.*, 388 F.3d 168, 173 (6th Cir. 2004); *see also Illinois Knights Templar Home*, DAB No. 2274, at 3-4 (2009) (*citing Kingsville Nursing Ctr.*, DAB No. 2234, at 3-4 (2009)). The moving party may show the absence of a genuine factual dispute by presenting evidence so one-sided that it must prevail as a matter of law, or by showing that the non-moving party has presented no evidence "sufficient to establish the existence of an element essential to [that party's] case, and on which [that party] will bear the burden of proof at trial." *Livingston Care Ctr.,* 388 F.3d at 173 (*quoting Celotex Corp. v. Catrett*, 477 U.S. 317, 323-24 (1986)). To avoid summary judgment, the non-moving party must then act affirmatively by tendering evidence of specific facts showing that a dispute exists. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.,* 475 U.S. 574, 586 n.11 (1986); *see also Vandalia Park,* DAB No. 1939 (2004); *Lebanon Nursing and Rehab. Ctr.,* DAB No. 1918 (2004).

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. *Illinois Knights Templar*, DAB No. 2274, at 4; *Livingston Care Ctr.*, DAB No. 1871, at 5 (2003). In examining the evidence to determine the appropriateness of summary judgment, I must draw all reasonable inferences in the light most favorable to the non-moving party. *See Brightview Care Ctr.*, DAB No. 2132, at 2,

9 (2007); *Livingston Care Ctr.*, 388 F.3d at 168, 172; *Guardian Health Care Ctr.,* DAB No. 1943, at 8 (2004); *but see Cedar Lake*, DAB No. 2344, at 7; *Brightview*, DAB No. 2132, at 10 (noting entry of summary judgment upheld where inferences and views of non-moving party are not reasonable). However, drawing factual inferences in the light most favorable to the non-moving party does not require that I accept the non-moving party's legal conclusions. *Cedar Lake,* DAB No. 2344, at 7; *Guardian,* DAB No. 1943, at 11 ("A dispute over the conclusion to be drawn from applying relevant legal criteria to undisputed facts does not preclude summary judgment if the record is sufficiently developed and there is only one reasonable conclusion that can be drawn from those facts.").

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*, DAB No. 2291, at 4-5 (2009).

C. Findings of Fact and Conclusions of Law

1. *CMS was authorized to change its revocation basis because Petitioner had notice and opportunity to respond during this administrative proceeding.*

Petitioner admits that CMS was legally authorized to amend its initial basis for revocation.

The Departmental Appeals Board (Board) has consistently held that after an administrative appeal has commenced, a federal agency may assert and rely on new or alternative grounds for the challenged action or determination as long as the non-federal party has notice of, and a reasonable opportunity to respond to, the asserted new grounds during the administrative proceeding. *Green Hills Enters.*, LLC, DAB No. 2199 (2008). *See also Abercrombie v. Clarke*, 920 F.2d 1351, 1360 (7th Cir. 1990), *cert. denied*, 520 U.S. 809 (1991) (holding that defects in formal notice may be cured during the course of an administrative proceeding, and due process is satisfied as long as the party is reasonably apprised of, and given opportunity to address, the issues in controversy); *St. Anthony Hosp. v. Sec'y, Dep't of Health and Human Servs.*, 309 F.3d 680, 708 (10th Cir. 2002) ("To establish a due process violation [in an administrative proceeding], an individual must show he or she has sustained prejudice as a result of the allegedly insufficient notice.").

It is evident from CMS's many briefs in this matter that CMS chooses to revoke Petitioner's Medicare billing privileges under 42 C.F.R. § 424.535(a)(1) on the grounds that Petitioner failed to maintain the required conformance "to the Medicare laws, regulations, and program instructions that apply to this provider." CMS Br. at 1; CMS

Ex. 2 at 38. I provided Petitioner with ample opportunity to refute CMS's determination that it had been found noncompliant based on failure to comply with Medicare laws and regulations.

2. ***The undisputed evidence shows CMS had a legitimate basis to revoke Petitioner's Medicare billing privileges effective August 19, 2012 because Petitioner was not in compliance with Medicare requirements for home health certifications for 10 Medicare beneficiaries.***

Any home health agency that seeks to enroll as a provider in the Medicare program must complete a CMS 855A enrollment application. Petitioner completed a CMS 855A and signed the Certification Statement at Section 15 of the CMS 855A enrollment application. CMS Ex. 3. Petitioner's signature "binds this provider to the laws, regulations, and program instructions of the Medicare program." CMS Ex. 3 at 4. CMS contends that Petitioner submitted claims for home health services which did not conform to "the Medicare laws, regulations, and program instructions that apply to this provider."[2] CMS Br. at 2. CMS argues that by signing a CMS 855A Certification Statement and enrolling in the Medicare program, Petitioner agrees to comport with all Medicare laws of general applicability and those that apply specifically to home health agencies. In addition, according to CMS, the text of the CMS 855A places Petitioner on notice that failure to comply with Medicare laws may be a basis for the revocation of Petitioner's enrollment in the Medicare program in the future.

CMS determined to revoke Petitioner's Medicare billing privileges after an internal CMS inquiry revealed that the signature of Dr. Gonzalo Gonzalez and his National Provider Identifier (NPI) appeared as the certifying physician on an extraordinarily high number of home health claims for Medicare beneficiaries submitted by a number of home health agencies in the Miami area.[3] CMS Br. at 8; CMS Ex. 7. CMS contends that Petitioner submitted Medicare home health claims on behalf of 30 individuals and named Dr. Gonzalez as the certifying physician in each instance; however, CMS's Medicare reimbursement records for Dr. Gonzalez do not indicate that he was involved in the care

[2] Specifically, CMS refers to the requirement that home health agencies may only receive Medicare reimbursement for services provided to individuals who are under the care of a physician, and the physician must have a face-to-face encounter with the individuals and certify the necessity of the home health services. CMS contends that these requirements were not met with respect to claims Petitioner submitted for 30 individuals. CMS Br. at 9.

[3] CMS found that for calendar year 2011, nearly 1,000 Medicare beneficiaries were allegedly certified as requiring home health services with Dr. Gonzalez identified by the home health agency as the alleged certifying physician. In calendar 2012, more than 1,200 beneficiaries were so certified as requiring home health services with Dr. Gonzalez identified by the home health agency as the certifying physician. CMS Ex. 7 at 2.

of those 30 individuals. CMS Br. at 9-10; CMS Exs. 5 and 6; CMS Ex. 7 at 2. Thus, CMS contends that Petitioner's submission of Medicare claims for individuals who were not under the care of a physician constituted noncompliance, and that CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges. Finally, CMS notes that Petitioner voluntarily relinquished its license to operate a home health agency to Florida's Agency for Health Care Administration, effective February 20, 2013, and, therefore, Petitioner cannot be enrolled in the Medicare program because under applicable Medicare requirements a home health agency must satisfy state licensure requirements. CMS Br. at 12-13; 42 C.F.R. § 424.516(a)(2). CMS also points out that under the Medicare certification requirements a cessation of business is deemed to be a voluntary termination of the provider's Medicare provider agreement. 42 C.F.R. § 489.52(b)(3). Thus CMS contends that Petitioner's relinquishment of its license and the cessation of operation as a home health agency constitutes an additional basis for the revocation of Petitioner's enrollment and billing privileges.

Petitioner argues that the evidence CMS presents does not prove that these 30 individuals were not under the care of Dr. Gonzalez. P. Br. at 2. Petitioner contends that it has no legal or contractual authority as a home health agency over Dr. Gonzalez and therefore has no way of knowing anything about the Medicare Part B claims Dr. Gonzalez or his employer clinic, Vortex Medical Center, submits for services he renders to his or its patients. P. Br. at 2. Petitioner then contends it possessed, and offered as evidence, all the legally required home health documents necessary to submit a claim for the home health services it argues it rendered to 20 beneficiaries.[4] P. Br. at 2, P. Exs. 1-20.[5] Petitioner contends that based on this documentation it would have no reason to know or doubt that a valid and ongoing patient/physician relationship existed between Dr. Gonzalez and these 20 beneficiaries. Petitioner also argues that CMS is holding Petitioner to a strict liability standard in that because Dr. Gonzalez or his employer clinic did not submit a Part B claim for the patients at issue, Petitioner should have its enrollment and billing privileges revoked. Petitioner contends that it can comply only with its own standards of conduct and those it has contractual privity with or control over, and that it has no privity or control over Dr. Gonzalez or his employer clinic. P. Br. at 6-

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[4] Petitioner makes no mention and presents no evidence whatsoever with respect to 10 beneficiaries specifically named by CMS, as early as the reconsideration determination, for whom Dr. Gonzalez did not bill for services and for whom CMS determined Dr. Gonzalez was not the treating physician who could certify the necessity for home health services. *See* Palmetto notice letter dated January 28, 2012 attached to RFH as Exhibit 2 at 4; CMS Reply at 4.

[5] These 20 exhibits contain what purport to be the proper certifying physician records for 20 beneficiaries. They consist of the initial prescription, the Plan of Care, Verbal Orders, a signed Face-to-Face Encounter form, and Discharge Orders all allegedly signed by Dr. Gonzalez. P. Exs. 1-20.

7. Petitioner contends it has no independent legal obligation to speak with the certifying physician directly unless one of the enumerated obligations listed at 42 C.F.R. § 484.18(b) is present, such as if there is a significant change in the patient's condition. P. Br. at 8. Finally, Petitioner contends that summary judgment is inappropriate here as there are numerous facts in dispute. P. Br. at 9.

In order to determine whether CMS had a legitimate basis for revoking Petitioner's billing privileges for submitting home health claims that allegedly had no physician certification, Petitioner would have to submit at least documentary evidence such as medical records or sworn testimonial evidence from the Medicare beneficiaries which reasonably establish that Dr. Gonzalez had actually treated them and appropriately certified them as in need of home health agency services for all the 30 of the beneficiaries questioned by CMS. However, even though Petitioner was on notice from January 28, 2012 of 10 named beneficiaries for whom CMS alleged no valid physician certification, Petitioner did not and has not submitted any documentation for these 10 identified patients. Thus, Petitioner has presented no evidence whatsoever to suggest that these 10 patients were under Dr. Gonzalez's care for home health services in accordance with 42 C.F.R. § 424.22. And, Petitioner does not dispute that it billed Medicare for services Dr. Gonzalez purportedly approved for these beneficiaries. Petitioner suggests that CMS should have requested medical records from Dr. Gonzalez or from his employer, Vortex Medical Center. However, Petitioner has not provided any explanation as to why this should be necessary. It does not explain why Petitioner did not submit for these 10 patients the prescriptions, plans of care, face-to-face encounter documentation, and other certification paperwork that it submitted for the other 20 patients. The only inference I can make is that the documentation does not exist. It should: Petitioner should have this information in its own medical records if Petitioner was submitting claims for payment to Medicare for home health services for these 10 patients. Also, if Petitioner did not have this information available, despite its obligation to have these records in its possession, it could have provided sworn declarations from the 10 beneficiaries stating that Dr. Gonzalez was their treating physician. No such documentation was presented.

The law clearly 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.[6] 42 U.S.C §§ 1395f(a)(2)(C), 1395n(a)(2)(A). Medicare program

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[6] Petitioner argues that it is being held to a strict liability standard on the basis that Dr. Gonzalez or his employer did not submit a Part B claim for services for the patients at issue and they do not have authority or control over Dr. Gonzalez. P. Br. at 7. However, tort concepts such as "imputed liability" and "strict liability" are irrelevant to federal administrative enforcement proceedings against noncompliant suppliers and providers. The Departmental Appeals Board has made clear that a strict liability standard is not being applied simply because a facility is held to "standards enunciated in the relevant

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, 100-101, § 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 failed to provide any evidence with respect to 10 patients which would show that these patients were under the care of Dr. Gonzalez and that Dr. Gonzalez certified the necessity of home health care services for them, 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 CMS 855A enrollment application, Petitioner was bound to comply with all applicable legal requirements. CMS Ex. 3 at 4. Thus, I find that CMS was authorized to revoke Petitioner's Medicare billing privileges effective August 19, 2012 for noncompliance with the enrollment application applicable for its provider or supplier type pursuant to 42 C.F.R. § 424.535(a)(1).

3. *There is no genuine dispute of material fact which could overcome CMS's motion for summary judgment because Petitioner did not present any evidence* of *specific facts showing a dispute exists with respect to 10 patients.*

To avoid summary judgment, the non-moving party must act affirmatively by tendering evidence of specific facts showing that a dispute exists regarding an essential element of the case. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 n. 11 (1986). A mere scintilla of supporting evidence is not sufficient to overcome a well-supported motion for summary judgment. "If the evidence is merely colorable or is not significantly probative, summary judgment may be granted." *Livingston Care Ctr. v. Dep't. of Health & Human Services,* 388 F.3d 168, 173 (6th Cir. 2004) (quoting *Anderson v. Liberty Lobby,* 477 U.S. 242, at 249-250 (1986)).

While Petitioner did present arguably relevant evidence with respect to 20 of the Medicare beneficiaries who were allegedly certified by Dr. Gonzalez as in need of those services as the treating physician and for which Petitioner claimed payment for home

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participation requirements. *Tri-County Extended Care Center*, DAB No. 2060, at 5 (2007); *see also Martha & Mary Lutheran Services*, DAB No. 2147 (2008); *Lake Mary Health Care*, DAB No. 2081 (2007). Here Petitioner is merely being held to Medicare requirements to which it agreed to when it applied to enroll in the Medicare program.

health care services, it failed to present any evidence whatsoever for 10 patients even though it was on notice of the names of the disputed patients since January 28, 2012.

Although 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 a genuine issue of material fact exists. Petitioner has presented no evidence with respect to specific facts showing that a dispute exists as to these 10 patients. Therefore, without any such evidence, I cannot draw an inference in Petitioner's favor that Dr. Gonzalez provided the requisite certifications for these 10 patients. In fact, Petitioner has not presented any evidence sufficient to establish the existence of a genuine factual dispute. Thus, CMS is entitled to summary judgment.

4. *While CMS had a legitimate basis to revoke Petitioner's enrollment and billing privileges effective August 19, 2012, the fact that Petitioner no longer has a valid license from the State of Florida to operate a home health agency is an additional basis for revoking Petitioner's Medicare enrollment and billing privileges.*

Petitioner does not dispute that it voluntarily relinquished its license to operate a home health agency as of February 20, 2013. CMS Ex. 9. In order to satisfy Medicare enrollment requirements, a home health agency must be in compliance with state licensure requirements at C.F.R. §§ 424.516(a)(2) and 484.12(a). Petitioner's relinquishment of its license and cessation of business amounts to a voluntary termination of its Medicare provider agreement and constitutes a separate and additional basis for the revocation of Petitioner's Medicare enrollment and billing privileges effective as of February 20, 2013.

IV. Conclusion

Petitioner has not shown that a genuine issue of material fact exists with regard to CMS's challenge that a physician did not certify 10 of Petitioner's patients pursuant to Medicare home health care requirements. As a result, I must sustain 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/
Richard J. Smith
Administrative Law Judge