Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Adora Healthcare Services, Inc.
Docket No. A-16-119
Ruling No. 2017-4
May 18, 2017

RULING ON REQUEST FOR RECONSIDERATION

On June 20, 2016, the Departmental Appeals Board (Board) issued a decision affirming an administrative law judge (ALJ) decision reversing the Centers for Medicare & Medicaid Services' (CMS) reconsideration determination to revoke the Medicare enrollment and billing privileges of Adora Healthcare Services, Inc. (Adora). *Adora Healthcare Servs., Inc*., DAB No. 2714 (2016)(Decision). On July 20, 2016, CMS filed a Request for Reconsideration (Request) of the Decision, and on August 1, 2016, Adora filed a response opposing the Request.

We explain below that CMS has shown no error in our conclusion that the regulations do not authorize revoking a provider as "no longer operational" based only on a site visit to the practice location of record when the provider's operations have been relocated to a new practice location and the time for reporting the change of address has not expired.

The regulations at 42 C.F.R. Part 498 governing appeals to the Board[1] authorize the Board to reopen a decision where, as here, a party files a request to reopen within 60 days of the date of notice of the decision; the Board may also reopen on its own motion within that time period. 42 C.F.R. § 498.100. The Part 498 regulations do not specify a standard for granting a request to reopen, but procedures for deciding other types of appeals provide that the Board may reconsider a decision when a party promptly alleges a clear error of fact or law. 45 C.F.R. § 16.13. The Board has concluded this is a reasonable standard for a Part 498 reopening as well. *See Peter McCambridge, C.F.E.*, DAB Ruling No. 2010-1 (Feb. 2, 2010) (applying this standard to a request to reopen Board decision upholding denial of enrollment in Medicare program based on applicant's ineligibility). "Reopening a Board decision 'is not a 'routine step' in the process of appealing an ALJ decision . . . but '[r]ather, it is the means for the parties and the Board to point out and

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[1] These regulations appear at 42 C.F.R. § 498.100 et seq.

correct any errors that make the decision clearly wrong.'" *Mark B. Kabins, M.D.*, DAB Ruling No. 2012-1, at 3 (Oct. 14, 2011), quoting *Highland Pines Nursing Home, Ltd.*, DAB Ruling No. 2011-4, at 2 (Feb. 25, 2011). As we explain below, we conclude that CMS has not identified any error of law or fact and, accordingly, deny the Request.

Case Background and the Decision[2]

CMS, through its administrative contractor, made an initial determination to revoke Adora's Medicare billing privileges under 42 C.F.R. § 424.535(a)(5) based on Adora's having been found non-operational during a July 7, 2014 visit to Adora's duly enrolled practice location, 14405 Walters Road, Suite 340, Houston, Texas. Adora sought reconsideration by a contractor hearing officer, claiming it had timely notified CMS of its move to a new practice location at 14511 Falling Creek Drive, suite 100-12, Houston, TX 77014 effective July 1, 2014, and providing some evidence to support that claim including a change of address notice purportedly mailed to the contractor on June 26, 2014. The contractor hearing officer nevertheless upheld the revocation in a reconsideration decision stating, in part, that the CMS contractor had no record of having received a change of address notice from Adora. Decision at 2-3.

Adora requested a hearing before an ALJ. During the hearing, the parties essentially reiterated the positions they had taken before the contractor hearing officer with respect to notice of the move, and each party presented evidence to support its position. *See* Decision at 3. The ALJ reversed the reconsideration determination and, thus, the revocation. The ALJ cited the reporting requirement in 42 C.F.R. § 424.516(e)(2) ("All other changes to enrollment must be reported within 90 days.") and concluded that Adora had come forward with persuasive evidence demonstrating that it moved its operations to a new location prior to the onsite visit and timely mailed notice of that move to the Medicare contractor. *Id*. at 3-4.

CMS appealed to the Board which affirmed the reversal but for different reasons. The Board concluded that the revocation "was invalid because CMS's determination that Petitoner was 'no longer operational' rested solely on the inspector's visit to Petitioner's duly enrolled 14405 Walters Road location which occurred, as CMS does not dispute, before Petitioner's 90-day period for reporting its new Falling Creek Drive location had expired. The revocation determination, in effect, was premature." Decision at 4. For that reason, the Board said, it did "not need to decide the issue of whether and when Petitioner mailed the notice or whether CMS's receipt rather than the mailing date controls because those issues are not material to our decision." *Id*.

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[2] This section is intended to provide an abbreviated summary of the case background and the Decision for the convenience of the reader. It does not replace or modify any part of the Decision.

Discussion

1. The plain language of the regulation supports the Board's Decision.

CMS does not allege any clear error of fact in the Decision. However, CMS alleges a clear error of law, that "the Board's decision wholly disregards the Secretary's duly promulgated regulations and interpretive guidance." Request at 6. CMS begins by asserting that "the plain language of § 424.535(a)(5) . . . authorizes CMS to revoke a provider or supplier's billing privileges after it conducts an onsite visit and determines that the provider or supplier is not operating at the qualified practice location listed in its Medicare enrollment file." *Id*. at 7 (citations omitted). That is not an accurate statement of the regulation's language. The "plain language" of section 424.535(a)(5) authorizes revocation when CMS concludes based on an on-site visit that a provider or supplier "is no longer operational to furnish Medicare covered items or services . . . ." However, the regulation says nothing about the location of the onsite visit and, as the Board indicated in its Decision, the language "is no longer operational" actually lends support to the Board's analysis. *See* Decision at 5 (emphasizing "no longer" language and stating it "tends to suggest a cessation of existing operations, rather than merely a move to a new location, which . . . typically would not end them."). CMS's "plain language" argument does not address this point.

The Board has regularly upheld revocations where site visits to a provider or supplier's practice location of record disclosed that the provider or supplier was not operational at that location. *E.g. Vamet Consulting & Medical Services*, DAB No. 2778 (2017); *Care Pro Home Health, Inc*., DAB No. 2723 (2016). However, CMS points to no case upholding a revocation under section 424.535(a)(5) where the provider or supplier was able to demonstrate on reconsideration that it had moved to a new location where it was operating and had either provided notice of the change of address as required by the regulations or the time for reporting a change of address had not yet expired when the inspectors visited the old location.

CMS points to the definitions of "operational" and "enrollment" in section 424.502 as support for its asserted "plain language" argument with respect to section 424.535(a)(5) (Request at 7), but we find nothing in either of those definitions that supports its argument or would warrant reconsideration of our Decision. The definition of "operational", as CMS notes, includes, among other requirements, the provider's having a "qualified practice location" which is "open to the public for the purpose of providing health care related services . . . ." Indeed, our Decision rested, in large part, on that definition. *See* Decision at 5 (citing the definition of "operational" in holding that CMS's pointing only to evidence regarding the site visit to Adora's Walters Road location was insufficient to establish that Adora was no longer operational since the time for reporting the move had not expired). However, there is nothing in the definition of "operational,"

read alone or together with section 424.535(a)(5), that compels a conclusion that in situations where a provider has moved to a new location (which is not prohibited by the regulations) and the time for reporting the move has not expired, only the previous practice location then on file with CMS prior to the move can be the "qualified practice location."[3] CMS might determine based on further information or inspection (and is free to do so under our Decision) that an alleged new practice location is not "operational" or in some other way does not meet Medicare requirements and is, thus, not a qualified practice location, but CMS points to nothing in the regulations that would automatically disqualify the new location. It is also true, as CMS notes, that the definition of "enrollment" includes "[i]dentification and confirmation of the provider or supplier's practice location(s) and owner(s)." Request at 7, quoting section 424.502. However, that language does not preclude a provider or supplier's identifying, and CMS's confirming, a new practice location so long as the provider identifies the new location by the means and within the timeframe required by the regulations. Critically, here, the timeframe for the provider to do so had not expired so we have no basis to conclude that the new location was not qualified.

CMS cites two Board decisions as alleged support for its "plain language" argument (Request at 7), but neither decision addresses or supports that argument or CMS's arguments for reopening generally. The first decision, *Viora Home Health*, DAB No. 2690 (2016), involved an appeal from an ALJ decision upholding a revocation under section 424.535(a)(5) although the provider, like Adora here, argued that the revocation was invalid because it was still operational, albeit at a new location of which it allegedly had timely notified CMS. The Board affirmed the ALJ decision but did so because "Viora did not effectively inform the contractor of a change of practice location." *Id.* at 8. The Board did not hold that in circumstances where a move is alleged, CMS is authorized to revoke under section 424.535(a)(5) based solely on an investigation finding the provider is not operating at the pre-move location of record. *AR Testing Corp.*, DAB No. 2679 (2016), the second decision cited by CMS, did not involve an alleged move of the supplier's practice location; in fact, the supplier (an IDTF) denied it had moved.[4]

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[3] We note, as we did in the Decision, that while CMS denied receiving timely notice of Adora's move, it never disputed the move itself. *See* Decision at 5. We further note that CMS does not specifically challenge the Board's statement that the regulations "do not prohibit a provider from moving its operations from a previously enrolled location to a new location nor do they require that the Medicare contractor must be informed prior to the move." *Id.*

[4] CMS also cites an ALJ decision, *Trinity Bestcare Home Health Agency, LLC*, DAB CR4560 (2016). It is well established that an ALJ decision is not precedent or binding on the Board. *E.g. Willie Goffney, Jr., M.D.*, DAB No. 2763, at 8 (2017); *Aleader C. Gatzimos, MD, JD, LLC*, DAB No. 2730, at 16 (2016). Moreover, the ALJ decision cited by CMS was based on the ALJ's finding that the supplier had "not established by a preponderance of the evidence that it timely notified CMS of its change in location . . . ." DAB CR4560 at 8. The ALJ decision was not based on a conclusion that as a matter of law, the supplier could not be found operational at a new location just because it was not operating at the old location on the date of the onsite visit to the latter even though it still had time to lawfully report the change of address, as here.

Accordingly, the case is inapposite.

We conclude that the plain language of the regulation supports the Board's conclusions, not CMS's objections, and therefore do not find any clear error in our decision.

2. CMS misinterprets the Board decision as requiring some waiting period for revocation.

CMS next takes issue with what it characterizes as the Board's holding that CMS is required to "wait 90 days after the onsite visit . . . before revoking" a provider's Medicare billing privileges under 42 C.F.R. § 424.535(a)(5). Request at 8. CMS states,

> There is nothing in sections 424.535(a)(5) or 424.516(e)(2) that predicates a revocation under § 424.535(a)(5) [on] a finding of noncompliance under § 424.516(e)(2).
>
> CMS' authority to revoke a provider's billing privileges for its failure to be operational at a qualified practice location is separate and distinct from its authority to revoke billing privileges for failure to report a changed practice location [which exists under section 424.535(a)(1)].

Request at 8-9.

CMS appears to have misunderstood our Decision. The Decision does not hold or mean that CMS must wait 90 days to initiate a revocation action. Nor does it hold or mean that revocation under section 424.535(a)(5) is predicated on finding noncompliance under section 424.516(e)(2). CMS is free, under the Board's decision, to make an initial determination to revoke if and when an on-site inspection finds the provider or supplier non-operational at its currently listed practice location in the contractor's files; CMS does not need to wait 90 days or any period of time. However, where, as in this case, a provider or supplier seeks reconsideration of the initial determination on the ground that it was not at the site inspected because it moved its practice location to a new location where it continues to be "operational" within the meaning of the regulations, provides evidence establishing the move and claims it has timely notified CMS of the move or will do so within the required time, CMS may not then proceed with a revocation under section 424.535(a)(5) based solely on the fact that an on-site visit to the currently listed practice location found the provider or supplier not operational at that location.[5] At that

[5] In provider and supplier enrollment appeals, the appeal right is triggered by the reconsideration determination, not the initial determination. 42 C.F.R. §§ 424.545(a), 498.3(b)(17), 498.5(l)(1)-(3), 498.22(a). Accordingly, on reconsideration, CMS could either abandon an initial determination to revoke under section 424.535(a)(5) or reaffirm the initial determination to revoke under that regulation (as legally and factually appropriate) without disturbing appeal rights.

point, in order to continue with a revocation under section 424.535(a)(5), CMS must determine whether the provider or supplier is still operational within the meaning of sections 424.535(5)(a) and 424.502 at the new location. If CMS determines that the provider or supplier is not still operational at the new location (which may or may not require any additional investigation or site visit), CMS may issue a reconsideration decision revoking billing privileges under section 424.535(a)(5); otherwise it cannot revoke on that ground. Our Decision does not affect CMS's authority to make a new initial determination to revoke for failure (at either the old or new location) to meet any other regulatory requirement, including the provider or supplier's failure to timely notify CMS of the change in its practice location as required by section 424.516(e)(2).

CMS then argues that sections 424.535(a)(5) and 424.535(a)(1) "are separate and distinct requirements" and that what CMS calls the "90 day grace period"[6] for the reporting required under section 424.516(e)(2) does not apply to section 424.535(a)(5). Request at 10. The gist of this argument appears to be that the 90-day reporting requirement in section 424.516(e)(2) must be read exclusively as a ground for revocation under section 424.535(a)(1) and cannot be read as limiting CMS's authority under section 424.535(a)(5). This argument misses the point of our Decision. As we have already stated, our Decision does not mean CMS must wait 90 days before it can make an initial determination to revoke for being non-operational. We also recognize that section 424.535(a)(1) (which authorizes revocation for failure to meet the reporting requirements of section 424.516(e)(2)) and section 424.535(a)(5) (which authorizes revocation for being found non-operational) provide separate and distinct grounds for revocation of provider and supplier billing privileges. However, the mere fact that these regulations provide separate and distinct grounds for revocation does not mean, as CMS suggests (*see* Request at 10-11), that these and the other regulations in Part 424 should not be read as a whole in order to be in harmony or that the various regulations in Part 424 do not inform one another consistent with the purpose of the regulations, which is to assure that providers and suppliers meet and continue to meet enrollment requirements. *See* 2A Sutherland Statutory Construction § 46:5 (7th ed.)(discussing the "Whole statute" interpretation, as a cardinal rule of statutory construction).[7]

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[6] CMS does not explain the "grace period" characterization and points to no language in the regulation or its history to support that characterization. In any event, the characterization has no significance to our ruling to deny reconsideration.

[7] The Board has routinely applied rules of statutory construction to construe regulations. *See, e.g.*, *Ridgeview Hospital*, DAB No. 2593, at 8 (2014), citing 2A Norman J. Singer and J.D. Shambie Singer, Sutherland Statutes and Statutory Construction § 46:5 (7th ed.).

As previously indicated, we noted in our Decision that the phrase "no longer operational" in section 424.535(a)(5)(i) "tends to suggest a cessation of existing operations, rather than merely a move to a new location, which might cause some disruption in the existing operations during the move but typically would not end them." We then concluded,

> Thus, reasonably read, the regulations seem to anticipate that providers and suppliers, at least absent evidence to the contrary, may remain operational for up to 90 days during a change to a new location even if they are no longer practicing at the pre-move address. At least, CMS has no given us no reason to reach a contrary conclusion. In particular, CMS has not explained why the Secretary would have given providers 90 days to notify CMS of a change in operating location if CMS was authorized to revoke for being nonoperational based solely on a visit finding no operations at the previously approved location before the 90-day period had expired.

DAB No. 2714, at 5-6.

We do not find CMS's arguments here to be a persuasive explanation. CMS's alleged "plain language" reading of section 424.535(a)(5) and its compartmentalized reading of that regulation and section 424.535(a)(1) ignore the Secretary's choice of the words "no longer operational" as opposed to "not operational," a choice important to our Decision and not squarely addressed by CMS in its Request. Moreover, CMS's argument that sections 424.535(a)(1) and 424.535(a)(5) "are separate and distinct requirements" addresses only the fact that the two regulations provide separate bases for revocation. The mere fact that failure to report a change in enrollment information, including a change in practice location, within a specified timeframe provides an independent basis for revocation does not explain why a change in practice location, without more, would necessarily mean that a provider or supplier was "no longer operational to provide Medicare covered items or services" for purposes of section 424.535(a)(5).

CMS's final argument is that the Decision "[i]mproperly [p]laces the [b]urden on CMS to [p]rove the [i]mpossible." Request at 11. CMS states,

> At the time of the on-site visit, the only thing that CMS could verify was whether or not Adora was at its qualified practice location. When CMS conducted the on-site visit, Adora was required to be operational at the Walters address to furnish Medicare services. [citations omitted]

* * * * *

> Even if CMS were to wait 90 days after the on-site visit to take any action, it still would not know why Adora was not operational at its qualified practice location on the date of the on-site visit. Nor would CMS know when Adora stopped being operational at the qualified practice location or whether it was coming back.

CMS then asserts that the Board "previously adopted this same logic" in *I & S Healthcare Services, LLC*, DAB No. 2519 (2013). Request at 12.

This argument seems to be, in essence, a reiteration of CMS's argument that the Decision requires it to wait 90 days after the on-site inspection to take action to revoke. That argument, as we have already said, is based on a misunderstanding of the Decision, which, as explained, does not require CMS to wait any length of time to make an initial determination to revoke. Our Decision addresses situations, such as this one, where an initial determination that a provider or supplier is no longer operational is challenged on reconsideration on the ground that the provider or supplier had moved to a new practice location prior to the inspection underlying the non-operational determination and either has provided notice of the move or is still within the required timeframe for providing notice to the contractor. CMS does not explain why, in that situation, Adora "was required to be operational at the Walters address" (Request at 11) and cites no regulatory authority that requires a provider or supplier moving to a new location to operate at the former location until CMS has received notice of its move. As we have explained, indeed the regulations expressly require only that notice be provided within 90 days of the move. In this situation, as we indicated in our Decision, CMS's burden to make a prima facie case that the provider or supplier is "no longer operational" cannot be satisfied by merely relying on an on-site visit to the old location.

The Board's decision in *I & S Healthcare* does not support CMS's argument and is not even on point. That case did not involve a provider's move to a new location. In *I & S Healthcare*, the provider voluntarily suspended operations for approximately a year and a half and posted a sign to that effect on the door of its practice location of record with CMS. CMS concluded based on an inspection of that site during the suspension period that the provider was no longer operational. On appeal, the ALJ and Board rejected the provider's argument that the revocation was invalid because the provider had only temporarily ceased operations and would resume them at some point. It was in that factual context that the Board made the statement cited by CMS here that the regulations authorized CMS "to revoke billing privileges if a provider is not operational when an inspector visits its address during normal business hours, even though the provider had been operational at an earlier time and might resume operational status at some future

date." Request at 12-13, quoting DB No. 2519, at 6. Since *I & S Healthcare* did not involve a move at all, it did not raise the issue of whether a provider that had moved could be found to be no longer operational based on a visit to its old location without considering whether it continued its operations at its new location.

Conclusion

For the reasons stated above, we conclude that CMS has not shown a clear error of law or fact; accordingly, we decline CMS's request that we reconsider our decision in DAB No. 2714.

/s/

Leslie A. Sussan

/s/

Constance B. Tobias

/s/

Sheila Ann Hegy
Presiding Board Member