Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Miracle Mile Community Mental Health Center,

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-11-239

Decision No. CR2390

Date: June 27, 2011

DECISION

I sustain the determination of the Centers for Medicare and Medicaid Services (CMS) to revoke the Medicare billing privileges of Petitioner, Miracle Mile Community Mental Health Center. Considering Petitioner has not come forward with any treatment records to show that it was actively providing screening for patients being considered for admission to state mental facilities, I find Petitioner was not providing a required core service of a community mental health center (CMHC) necessary for its Medicare provider enrollment.

I. Background

Petitioner is a CMHC in Miami, Florida. On March 19, 2010, SafeGuard Services (SGS) conducted an on-site review on behalf of CMS at Petitioner's facility. During the review, Petitioner's clinical director and Petitioner's owner reportedly stated to the SGS investigators that Petitioner was not providing children services but was planning to provide such services once it was approved for Medicaid. CMS Exs. 5-7; CMS Ex. 14. Further, Petitioner was also unable to produce any evidence that it screened patients for possible admission to state mental health facilities, either directly or through a contract with another facility. CMS Ex. 7, at 3; CMS Ex. 14, at 2-3; CMS Ex. 5. Thereafter, SGS recommended that First Coast Service Options (FCSO), a CMS contractor, revoke

Petitioner's Medicare provider number. On April 21, 2010, FCSO sent a letter notifying Petitioner that FCSO was revoking its Medicare provider number and billing privileges, effective the date of the on-site review, with a two-year reenrollment bar. CMS Ex. 3. The revocation letter notified Petitioner that the basis for the revocation was due to noncompliance with regulations and standards as specified at 42 C.F.R. § 424.535(a)(1). The revocation letter specifically noted that Petitioner was not providing outpatient specialized children services and screening for patients being considered for admission to state mental health facilities. *Id.* The revocation letter also informed Petitioner that it could request a reconsideration decision by sending the request to CMS at an address in Baltimore, Maryland. CMS Ex. 3, at 2.

Petitioner submitted its reconsideration request to FCSO in Florida on or about May 26, 2010. CMS Ex. 2, at 6. FCSO does not perform reconsiderations determinations and informed Petitioner on July 29, 2010 that Petitioner needed to send the reconsideration request to CMS in Baltimore, Maryland. *Id.* Eventually, CMS received Petitioner's reconsideration request at the Baltimore address on or about August 26, 2010. *Id.* at 12. In its reconsideration request, Petitioner: stated that Dr. Carmen Bruno, a child psychiatrist, was on staff prior to the site inspection; denied reported statements made by its clinical director and owner to SGS investigators; and provided two outpatient treatment records for children from October and December 2009. CMS Ex. 2. Also, Petitioner attached two "Citrus Health Network, Inc. Screening Services Agreement[s]" to its reconsideration request. CMS Ex. 2, at 29, 46.

On December 20, 2010, CMS sent an unfavorable decision letter to Petitioner confirming FCSO's decision to revoke Petitioner's billing privileges. CMS Ex. 1. The decision letter found that Petitioner was not in compliance with the requirements of a CMHC at 42 C.F.R. § 410.2 at or around the time that FSCO performed the on-site review. The decision letter stated that SGS had determined that Petitioner was not providing two of the four core services that would qualify it as a CMHC. Specifically, it found that SGS had determined that Petitioner did not have a contract with another agency or facility for patient screening services for state mental facilities and that both Petitioner's owner and Petitioner's clinical director stated that Petitioner was not going to provide children's outpatient services until Petitioner received a Medicaid number. In addition, the decision letter concluded that Petitioner did not timely submit its reconsideration request to CMS.

On January 24, 2011, Petitioner filed a hearing request with the Civil Remedies Division of the DAB to appeal the decision. In accordance with a prehearing order I sent, CMS filed a motion to dismiss and supporting brief (CMS Br.), accompanied by 15 exhibits (CMS Ex. 1-15), and CMS provided written direct testimony for one proposed witness. Petitioner thereafter filed its brief (P. Br.), accompanied by seven attachments that I have

labeled as exhibits (P. Exs. 1-7).[1] Petitioner did not list any proposed witnesses and accordingly did not include any written direct testimony. In accordance with the prehearing order, a hearing in this matter was not necessary, as Petitioner did not request to cross-examine CMS's proposed witness. Therefore, I decide this case based on the written record.

II. Applicable Law

A CMHC must be certified to participate in the Medicare program to be able to receive reimbursement for services that it provides to Medicare beneficiaries. For Medicare purposes, a CMHC is defined as an entity that:

> (1) Provides outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and residents of its mental health service area who have been discharged from in-patient treatment at a mental health facility;
>
> (2) Provides 24-hour-a-day emergency care services;
>
> (3) Provides day treatment or other partial hospitalization services, or psychosocial rehabilitation services;
>
> (4) Provides screening for patients being considered for admission to State mental health facilities to determine the appropriateness of this admission; and
>
> (5) Meets applicable licensing or certification requirements for CMHCs in the State in which it is located.

42 C.F.R. § 410.2; *see* 42 U.S.C. § 300x-2(c)(1)(B)-(E).

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[1] Petitioner did not label its attachments. I have labeled Petitioner's attachments as:

P. Ex. 1 – Approval letter dated April 16, 2010 from Florida Medicaid to Dr. Bruno
P. Ex. 2 – Dr. Carmen Bruno's attestation
P. Ex. 3 – Dr. Mario Aguado's attestation
P. Ex. 4 – January 24, 2011 hearing request to the DAB
P. Ex. 5 – 2010 screening agreement with Citrus Health Network, Inc.
P. Ex. 6 – 2009 screening agreement with Citrus Health Network, Inc.
P. Ex. 7 – August 9, 2010 Request for Reconsideration

CMS may revoke a provider's Medicare billing privileges if it determines, based on an on-site review, that the provider is no longer operational to furnish Medicare covered items or services, or is not otherwise meeting Medicare enrollment requirements. 42 C.F.R. § 424.535(a)(5)(i). Section 1866(j)(2) of the Social Security Act (Act) (42 U.S.C. § 1395cc(j)(2)) provides administrative and judicial hearing rights to providers or suppliers whose Medicare billing privileges are revoked. CMS implemented section 1866(j) of the Act by providing for administrative hearing rights for revoked providers or suppliers in 42 C.F.R. §§ 424.545, 405.874, and Part 498. These procedures provide for a hearing before Administrative Law Judges (ALJs) of this forum and for review of the resulting ALJ decisions by the appellate division of the DAB.

In provider appeals under section 1866(j)(1) of the Act and 42 C.F.R. Part 498, CMS must make a prima facie showing that the provider or supplier has failed to comply substantially with federal requirements. *See Medisource Corp.*, DAB No. 2011 (2006). To prevail, the provider must overcome CMS's prima facie showing by a preponderance of the evidence. *Batavia Nursing and Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd, Batavia Nursing and Convalescent Ctr. v. Thompson*, 129 Fed. Appx. 181 (6th Cir. 2005).

III. Issues

The issues in this case are whether:

1. Petitioner's hearing request is properly before me, and

2. CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges.

IV. Discussion

My findings of fact and conclusions of law are set forth in italics and bold in the discussion captions of this decision.

1. I decline to dismiss Petitioner's hearing request.

CMS moved to dismiss Petitioner's hearing request, arguing Petitioner requested an untimely reconsideration decision, and therefore the hearing request is not properly before me. CMS Br. at 2-3. A Petitioner must file with CMS a request for reconsideration from an initial determination within 60 days of its receipt. *See* 42 C.F.R. § 498.22. Petitioner's notice of revocation from FSCO was dated April 21, 2010. CMS Ex. 2, at 14. Initially, Petitioner submitted its reconsideration request to FCSO on or about May 26, 2010, well-within the required 60 days of receipt of the initial determination. *Id.* at 6. However, FSCO instructed Petitioner to submit its

reconsideration request to CMS at an address in Baltimore, Maryland in the initial determination letter. *Id.* at 15. Had Petitioner sent its reconsideration request to the specified address, the request would have clearly been timely filed. Nonetheless, FSCO did not forward Petitioner's reconsideration request to CMS. Instead, by letter dated July 29, 2010, after the appeal period expired, FSCO notified Petitioner that it needed to send its reconsideration request to CMS in Baltimore, Maryland. *Id.* at 6. CMS ultimately received the reconsideration request, sent from the Petitioner, on or about August 26, 2010. *Id.* at 12.

A December 20, 2010 response letter from CMS concluded that Petitioner had failed to submit a timely reconsideration request to CMS and that, even if it assumed the reconsideration request was timely, Petitioner had failed to provide outpatient specialized children services and screening services for patients being considered for admission to state mental health facilities. CMS Ex. 1.

As an extension of CMS, FSCO should have made an effort to forward Petitioner's reconsideration request to CMS, or at least notify Petitioner earlier, before the appeal period had expired. Considering Petitioner's good faith efforts to file a timely appeal to its initial determination, and considering the December 20, 2010 CMS letter to Petitioner still addressed the case's substantive issues, I will recognize the CMS letter as a reconsideration decision issued in response to a timely appeal. Petitioner's January 24, 2010 hearing request to the DAB is thus filed timely within 60 days of the date of the reconsideration decision. *See* 42 C.F.R. § 498.40. Under these circumstances, I decline to dismiss Petitioner's hearing request.

2. Petitioner was not providing screening for patients being considered for admission to state mental health facilities, a required core service for a CMHC to be enrolled in Medicare.

A CMHC must provide all four core services to meet the definition of a CMHC for Medicare reimbursement. 42 C.F.R. § 410.2; *see* 42 U.S.C. § 300x-2(c)(1)(B)-(E). Among other requirements, a CMHC must provide screening services, either directly or through a contract with another entity, for patients being considered for admission to state mental health facilities to determine the appropriateness of this admission. CMS determined, on its on-site review, that Petitioner was not meeting this Medicare enrollment requirement to provide Medicare covered services for Medicare patients. Petitioner did not produce any evidence that it actively provided any screening services. CMS Ex. 7, at 3; CMS Ex. 14, at 2-3; CMS Ex. 5. During the on-site review, Petitioner's owner reportedly told the SGS investigators that she had "transfer" agreements with Citrus Health and Jackson Memorial, but she provided no documentation of these agreements and reportedly offered no explanation regarding what she meant by "transfer" agreements. CMS Ex. 14, at 3. Petitioner has now provided two "Citrus Health Network Screening Services Agreement[s]." P Ex. 5; P. Ex. 6; CMS Ex. 2

at 29, 46.[2] The 2010 agreement provided that it was "effective on the 1st day of March, 2010," however, it was signed and dated May 3, 2010, by the notary who attested to the signatures of Petitioner's clinical director and Petitioner's president and owner. CMS Ex. 2, at 30-45. At no point has Petitioner come forward with any patient screening records to show CMS or me that it provides the required screening services.

Prior ALJ decisions have held that a CMHC will not qualify to participate in Medicare if it only establishes that it has the capability to provide the necessary services but fails to establish that it actually provides such services. *See, e.g., Grandview Behavioral Health Ctr.*, DAB CR998 (2003); *Psychstar of America*, DAB CR645 (2000), *Counseling and Therapeutics Ctr.*, L.L.C., DAB CR696 (2000). A CMHC must provide all of the services required in the regulation. Allowing facilities that claim to have the capacity to provide the services of a CMHC to participate in Medicare, without actually proving that they are providing the services, would allow nonqualified entities to participate in Medicare. *Grandview Behavioral Health Ctr.*, DAB CR998, at 9. A facility must provide "active, consistent, and ongoing patient services" to receive Medicare certification as a CMHC. *Comprehensive Behavioral Healthcare*, DAB CR890 (2002).

These requirements are consistent with the State Operations Manual (SOM), CMS's guidance to surveyors and contractors. The SOM provides that a CMHC must provide the core services at the same time of certification, not at some future time. SOM § 2250G. As a precondition to certification, in a three-month period, the CMHC must have served at least ten non-Medicare patients, and, for a minimum of three patients, the records must show that the CMHC provided the core services of screening services for admission to state mental health facilities and day treatment, or other partial hospitalization or psychosocial rehabilitation services. *Id*. Further, a CMHC is expected to continue to provide the core services once it has been approved for Medicare participation. "Providing the [core services] . . . is ongoing and not a one time qualifying event for Medicare participation." *Id*.

The May date of the notary's signature on the 2010 screening agreement with Citrus Health Network places the validity of the March 2010 effective date in doubt. I find it notable that the agreement appears to be backdated to the month of the SGS on-site review. Even if the 2010 screening agreement with Citrus Health Network was indisputably valid, however, I find it is not enough for Petitioner to meet its burden by only showing an agreement to provide this service without showing any patient treatment records. Absent these records, I see no reason to make any judgment on the validity of the screening agreement itself.

[2] Petitioner also provided these two Citrus Health Network agreements with its request for reconsideration that it filed with CMS.

CMS's brief also contends that Petitioner does not meet state certification requirements for a CMHC in Florida[3] and that Petitioner does not provide outpatient services for children. Considering Petitioner has not shown that it actively provided the core CMHC service of screening patients for admission to state mental hospitals, a requirement for Medicare enrolment and billing privileges, I decline to address these other arguments because they would be immaterial to the outcome of this decision.

V. Conclusion

I sustain CMS's determination to revoke Petitioner's Medicare billing privileges on the basis that it was it was not actually providing all the required core services of a CMHC that are necessary for Medicare enrollment.

/s/
Joseph Grow
Administrative Law Judge

[3] For Medicare enrollment, a CMHC must meet applicable licensing or certification requirements for CMHCs in the state in which it is located. *See* 42 C.F.R. § 410.2. Florida law defines a CMHC as a "publicly-funded, not-for-profit center which contracts with the [Florida Department of Children and Family Services] for the provision of inpatient, outpatient, day treatment, or emergency services." Fla. Stat. Ann § 394.455(6) (2010). CMS argues that Petitioner was incorporated as a for-profit corporation and therefore it should not be certified as a CMHC due to this noncompliance with the Florida statute. CMS Exs. 11, 12, and 14.