Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Briarwood Community Mental Health Center
Docket No. A-11-64
Decision No. 2414
September 23, 2011

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Briarwood Community Mental Health Center (BCMHC) appeals the March 11, 2011 decision by Administrative Law Judge (ALJ) Keith W. Sickendick, *Briarwood Community Mental Health Center,* DAB CR2338 (2011) (ALJ Decision). The ALJ held that the Centers for Medicare & Medicaid Services (CMS) lawfully denied BCMHC's application for enrollment in the Medicare program because BCMHC did not meet the program's definition of a "community mental health center" (CMHC). We affirm the ALJ Decision with the modifications discussed below.

Legal Background

The Medicare program, established under title XVIII of the Social Security Act (Act), pays for covered health care items and services furnished to program beneficiaries by qualified "providers" and "suppliers." *See* Act §§ 1811-1812, 1832-1833, 1866; 42 C.F.R.§ 424.500 *et seq.* (requirements for providers and suppliers to obtain Medicare billing privileges). The benefits covered by Medicare are described under Parts A through D of the Act.

In order to receive payment from Medicare (or from a Medicare beneficiary) for covered items or services, a provider or supplier must be approved by CMS for "enrollment" in the program. 42 C.F.R. §§ 424.500, 424.505. Regulations in 42 C.F.R. Part 424, subpart P (§§ 424.500-565) specify the requirements that a provider or supplier must meet in order to enroll. Those requirements include the submission of an appropriate enrollment application and documentation establishing the provider's or supplier's "eligibility to furnish Medicare covered items or services" to program beneficiaries. *Id.* § 424.510(d)(1), (d)(2)(iii).

The Medicare statute expressly provides that a CMHC may participate in Medicare as a "provider" but only for the purpose of furnishing "partial hospitalization services." [1] Act § 1866(a)(1), (e)(2); *see also* 42 C.F.R. 400.202 (defining the term "provider" to include a CMHC "that has in effect [an agreement to participate in Medicare] but only to furnish partial hospitalization services"). Partial hospitalization services, as covered by Medicare Part B, constitute an intensive outpatient program of psychiatric and related services provided to mentally ill patients as an alternative to inpatient psychiatric care. *See* 42 C.F.R. §§ 410.2, 410.43; 72 Fed. Reg. 66,580, 66,670 (Nov. 27, 2007). The section of the Medicare statute that delineates the scope of Part B coverage states that when certain criteria (not relevant to this decision) are met, Part B covers partial hospitalization services "provided by a community mental health center (as described in section 1861(ff)(2)(B))." Act § 1832(a)(2)(J) (emphasis added). (We note that the definition of a CMHC is actually in section 1861(ff)(3)(B), not section 1861(ff)(2)(B).)

Section 1861(ff)(3)(B) defines a CMHC in relevant part as an entity that "provides the mental health services described in section 1913(c)(1) of the Public Health Service Act [PHSA]." The mental health services described in section 1913(c)(1) of the PHSA include:

- "Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility",
- "24-hour-a-day emergency care services";
- "Day treatment or other partial hospitalization services, or psychosocial rehabilitation services"; and
- "Screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission."

42 U.S.C. § 300x-2(c)(1)(B)-(E). Consistent with section 1861(ff)(3)(B), Medicare regulations at 42 C.F.R. § 410.2 define a CMHC as an entity that provides these four types of services.

[1] According to a CMS program manual, a mental health facility that does not provide partial hospitalization services may enroll in Medicare as a "clinic." *See* Medicare Program Integrity Manual (CMS Pub. 100-08), § 15.4.1.1(A), available at http://www.cms.gov/Manuals/IOM/list.asp. In this case, however, BCMHC seeks to participate in Medicare as a "provider" that furnishes partial hospitalization services. CMS Ex. 3, at 1, 4.

In sum: (1) an entity may participate in Medicare as a CMHC only for the purpose of providing partial hospitalization services; (2) Medicare does not cover or pay for partial hospitalization services performed by a CMHC unless it meets Medicare's definition of a CMHC; and (3) the Medicare statute and regulations define a CMHC as an entity that provides the four types of services specified in section 1913(c)(1) of the PHSA.[2] Sections 2250 and 2252 of CMS's State Operations Manual (SOM) explain the requirements for Medicare coverage and payment of CMHC services.[3] They also describe the process by which CMS approves or denies a request by an entity to participate in Medicare as a CMHC. The process begins with a review by a CMS contractor of the prospective CMHC's Medicare enrollment application (CMS-855A). SOM §§ 2252A, 2252D. If the contractor recommends approval of the application, the appropriate CMS Regional Office visits the applicant to ensure that it is providing – or, with respect to 24-hour-a-day emergency care services, is capable of providing – all of the "required core services," the label used to identify the services that an entity must perform in order to meet Medicare's definition of a CMHC in section 1861(ff)(3)(B). *Id.* §§ 2252A, 2252F, 2252G.

In an appeal of a determination to deny Medicare enrollment, "[t]he provider or supplier must be able to demonstrate that it meets the enrollment requirements and it must be able to make available any documents and records that support the provisions of this regulation and the Medicare enrollment application if requested by CMS or its agents." 42 C.F.R. § 424.545(c).

<u>Case Background</u>

The following facts, drawn from both the record and the ALJ Decision, are undisputed.

In January 2006, BCMHC filed an application (form CMS-855A) to enroll in the Medicare program as a CMHC. CMS Ex. 3, at 1, 4; ALJ Decision at 2. The application identified Shalaish Pathak, L.S.W. (licensed social worker) as BCMHC's sole owner, chief executive officer, and "program director." CMS Ex. 3, at 4, 6, 17, 20 (identifying the organization as a "sole proprietorship"). The application also listed BCMHC's "practice location" as 7633 Bellfort, Houston, Texas 77061. *Id.* at 5. The facility located at 7633 Bellfort is, in fact, a nursing home that the record refers to by various names,

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[2] *See also* 42 C.F.R. §§ 410.110 (stating that Medicare covers partial hospitalization services furnished by or under arrangement made by a CMHC "if they are provided by a CMHC as defined in § 410.2 that has in effect a provider agreement in effect under part 489") and 410.172 (providing that Medicare pays for partial hospitalization services furnished in a CMHC to a Medicare beneficiary only if the CMHC files an appropriate claim for payment, and the services are furnished in accordance with the coverage requirements in section 410.110).

[3] The parties submitted copies of these manual provisions to the ALJ. *See* P. Ex. 4 and CMS Ex. 13. The SOM (CMS Pub. 100-07) is also available on CMS's website at https://www.cms.gov/Manuals/IOM/ list.asp.

including Briarwood Health Care Center, Briarwood Nursing Home, Briarwood Nursing & Rehabilitation, and Briarwood Nursing & Rehabilitation Center.[4] *See* ALJ Decision at 12 n.6.

In late February 2006, a CMS contractor recommended approval of the application and informed BCMHC that the "next step of the enrollment process" would involve a site visit to verify its compliance with program participation requirements. P. Ex. 2, at 1. On December 15, 2008, CMS employee Thomas Scheidel, R.N. inspected the nursing home where BCMHC was reportedly providing services for the purpose of verifying that BCMHC was a CMHC as defined in the Medicare statute and regulations. CMS Ex. 4. Mr. Scheidel outlined his findings in an affidavit that CMS submitted for the record. *Id.* at 2-3.

Mr. Scheidel reported in his affidavit that BCMHC did not (upon inspection) present itself to the public or other health care professionals as an organization that offered partial hospitalization services, noting that there were no "signs, posters, advertisements, or handouts" on the nursing home's walls, doors, or counters indicating the existence of an operational CMHC, and that staff at the nursing home's front desk were unable (over a three-hour period) to identify the location of the CMHC. CMS Ex. 4, at 2-3. According to Mr. Scheidel, BCMHC's representative (presumably Mr. Pathak) identified a single conference room in the nursing home as the place where BCMHC provided its services, but there were, in fact, no signs, posters, or other evidence that the conference room had been designated for BCMHC's use. *Id.* at 3. In addition, Mr. Scheidel found no evidence that BCMHC "was serving the community" or had scheduled regular operating hours. *Id.* He also could find no "discrete CMHC clinical records" and noted that the only clinical records available for his inspection were records generated or kept by the nursing home. *Id.* Mr. Scheidel further stated that "[c]linical review and planning for health care issues, including nursing, dietary, and medication were contained in the CMS Certified Nursing Home's clinical records." *Id.*

On March 6, 2009, CMS issued an initial determination letter which notified BCMHC that it did not meet the requirements "for certification to participate in the Medicare program as a [CMHC]." CMS Ex. 1, at 1. In support of that determination, CMS stated that BCMHC was not providing "day treatment or other partial hospitalization service or psychosocial rehabilitation services as listed in Section 1913(c)(1) of the PHSA and

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[4] According to Medicare's online nursing home directory ("Nursing Home Compare," found at www.medicare.gov), the nursing home located at 7633 Bellfort is presently called Briarwood Nursing & Rehabilitation and certified to participate in both Medicare and Medicaid.

required by Section 1861(ff)(3)(B) of the Social Security Act." *Id.* at 2. CMS provided the following factual grounds for that statement in a Statement of Findings attached to the March 6 letter:

> During the on-site visit conducted on December 15, 2008, the federal surveyor determined through observation and staff interview that Briarwood CMHC did not meet the requirements of a PHP program [partial hospitalization program]. Specifically, treatment goals were not developed for PHP patients that were measurable, functional, time-framed, medically necessary or directly related to the reason for admission; PHP services were not provided through a multi-disciplinary team approach to patient care under the direction of a physician; . . .
>
> The CMHC is located inside a nursing home and staff stated they had no knowledge of the location of the CMHC on the premises or any group meetings being held. The CMHC is staffed by one Licensed Social Worker (LSW) and has entered into an agreement for a Medical Director who is a physician licensed in the State of Texas. There are no other disciplines involved to provide a multi-disciplinary approach to patient care. All counseling and therapeutic sessions are under the leadership of the single LSW. Admission history and physical was the same as the admission history and physical for the nursing home. While this physical was timely, it was for the admission to the nursing home and not admission to the appropriate program within the CMHC and did not demonstrate the ability of the patient, based on their physical status, to participate in the CMHC therapeutic programs. . . .[5]

Id. at 3-4 (footnote added).

On April 18, 2009, BCMHC requested reconsideration of CMS's initial determination, claiming that it had provided "CMHC required services since [December 2005]" and that its services were "provided under the supervision of a Board Certified Psychiatrist and Physicians when it is medically necessary while following all" relevant state and federal requirements. CMS Ex. 2, at 14.

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[5] We assume that the terms "admission history" and "physical" refer to patient services that were documented in clinical records obtained or reviewed by CMS during (or as a result of) its December 15, 2008 site visit. *See* CMS Ex. 4, at 2 n.1 (Mr. Scheidel's statement that "medical records, facility documents and interviews acquired from the facility" during the site visit "are accurately reflected in CMS's Exhibits Nos. 1-12)." The patient records submitted by CMS are contained in CMS Exhibits 5 through 12.

On July 8, 2009, CMS issued a "reconsideration" determination which affirmed its initial determination that BCMHC did not meet Medicare's definition of a CMHC as an entity that provides "day treatment or other partial hospitalization services, or psychosocial rehabilitation services." CMS Ex. 2, at 26 (citing 42 C.F.R. § 410.2).

BCMHC then requested a hearing before the ALJ, contending that it had always provided CMHC core services. CMS Ex. 2, at 28. BCMHC also alleged that CMS had unreasonably delayed the processing of its enrollment application and ultimately denied the application in retaliation for complaints it made to the Vice President and Secretary of Health and Human Services. *Id.*

BCMHC later waived its right to an in-person evidentiary hearing and consented to a decision by the ALJ based on the written record.

The ALJ Decision

As a preliminary matter, the ALJ held that he could not legally consider any documentary evidence dated on or after the date of CMS's reconsideration determination (July 8, 2009). *See* ALJ Decision at 4. Applying that limitation, the ALJ did not admit or consider pages 18 and 32 through 34 of Petitioner's Exhibit 12. *Id.*

Turning to the dispositive legal issue, the ALJ held that BCMHC was "qualified to be enrolled in Medicare as a CMHC" only if it satisfied Medicare's definition of a CMHC as an entity that provides (either directly or by contract) all of the mental and other health care services (the "core services") specified in section 1913(c)(1) of the PHSA. ALJ Decision at 10-11. Noting that the evidence supported an inference that BCMHC "never operated as a CMHC," the ALJ concluded that BCMHC failed to prove that it provided all of the core services. *Id.* at 11-13. In support of that conclusion, the ALJ found that BCMHC did not provide outpatient services to children or 24-hour-a-day emergency care services during the relevant period. *Id.* at 13. He also found that BCMHC had failed to prove that it screened patients being considered for admission to state mental health facilities. *Id.* In addition, the ALJ stated that although "[BCMHC] may have provided partial hospitalization services" to eleven patients, none of those services were "compensable by Medicare" because the patients were residents of the nursing home. *Id*. at 13 & n.7. The ALJ also found that BCMHC's own actions contributed to any delay in processing its enrollment application and that he had no authority in any event to fashion a remedy for any delay. *Id.* at 13 n.8. Finally, the ALJ held that he had "no authority or jurisdiction" to review BCMHC's allegations of retaliation. *Id.*

Board's Standard of Review and Decisional Authority

The Board's standard of review on factual issues is whether the hearing decision is supported by substantial evidence in the whole record. The standard of review on issues of law is whether the hearing decision is erroneous. *See Guidelines — Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program* at http://www.hhs.gov/dab/divisions/appellate/guidelines/prosupenrolmen.html; *Experts Are Us, Inc.*, DAB No. 2322, at 2 (2010).

Applying the relevant review standards, the Board may modify or supplement an ALJ's factual findings and legal conclusions and may, in appropriate circumstances, make findings and conclusions on issues that the ALJ did not address. 42 C.F.R. § 498.88(f): *Spring Meadows Health Care Center*, DAB No. 1966, at 15 n.6 (2005) (holding that the Board may modify an ALJ decision in whole or in part); *Ross Healthcare Center*, DAB No. 1896, at 12-13 (2003) (noting that the Board had the authority to address a compliance issue that was properly before – but not addressed by – the ALJ or, alternatively, to remand the case to the ALJ for further adjudication).

Discussion

In its request for review, BCMHC objects to the ALJ's findings that it failed to provide outpatient services to children, 24-hour-a-day emergency care services, and screening services, asserting that such findings were not the basis for CMS's initial and reconsideration determinations. BCMHC maintains that it did, in any event, "always" provide all of the core services necessary for Medicare designation as a CMHC.[6] BCMHC attached to its request for review documents that it claims were submitted to CMS prior to, or during, the December 15, 2008 site visit.

We agree with BCMHC that the ALJ's discussion of certain core services (such as outpatient services to children and 24-hour-a-day emergency care) went beyond the issue directly stated by CMS in its initial and reconsideration determinations. The issue addressed in those determinations is whether BCMHC was engaged in providing "day treatment or other partial hospitalization services, or psychosocial rehabilitation services." The ALJ did not make a clear or definite finding about whether BCMHC provided those core services. He stated on the one hand that BCMHC "may have provided partial hospitalization services" to certain individuals, although none "compensable by Medicare as the individuals are residents of nursing facilities."[7] ALJ Decision at 13. On the other hand, the ALJ stated that he was

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[6] BCMHC does not take issue with any other aspect of the ALJ Decision, including the exclusion of a portion of Petitioner's Exhibit 12 and the ALJ's rejection of BCMHC's due process and retaliation claims.

[7] The term "partial hospitalization services" is defined, in part, to mean a "distinct and organized intensive ambulatory treatment service offering less than 24-hour-daily care other than in an individual's home or in an inpatient or residential settings." Act § 1961(ff)(3)(A) (emphasis added).

making "no judgment regarding the quality of any services provided by [BCMHC] or whether those services actually satisfy the requirements for partial hospitalization services under the Act and regulations." *Id.* at 13 & n.7. In our view, however, a finding that BCMHC was not providing those core services is implicit in the ALJ's overarching and dispositive finding that BCMHC "never operated as a CMHC." That overarching finding is, as we discuss later, supported by substantial evidence. Nonetheless, to the extent there is ambiguity or lack of clarity about whether or how the ALJ resolved the issue of whether BCMHC was providing partial hospitalization or psychosocial rehabilitation services, we modify the ALJ Decision to find that BCMHC did not provide those core services (either directly or under arrangement) during the period relevant to this decision. We outline the bases for our conclusions in sections two and three below but first address a procedural issue.

1. *Certain documents submitted by BCMHC with its request for review are inadmissible and hereby excluded from the record.*

BCMHC attached to its request for review three exhibits, labeled Exhibits A, B, and C. The documents in Exhibit A were submitted by one or both parties during the ALJ proceeding and are already part of the record of this case. However, Exhibits B and C were not submitted to the ALJ by either party. Those documents are inadmissible because the regulations governing an appeal of a provider enrollment determination prohibit the Board from admitting any evidence in addition to that which was introduced in the ALJ proceeding. 42 C.F.R. § 498.86(a) (giving the Board authority to admit evidence in certain circumstances "except for provider and supplier enrollment appeals"); *1866ICPayday.com, L.L.C.*, DAB No. 2289, at 3-4 (2009). Hence, our review is limited to the evidence admitted into the record by the ALJ. In any event, the documents we have ruled inadmissible, which relate to emergency care services and inpatient screening, are irrelevant to the factual issue we focus on below – that is, whether BCMHC provided partial hospitalization or psychosocial rehabilitation services during the period relevant to this decision.

2. *Pursuant to section 42 C.F.R. § 424.530(a), CMS may deny an entity's application for Medicare enrollment as a CMHC if the entity does not meet the definition of a CMHC in section 1861(ff)(3)(B) of the Act.*

Before reviewing the ALJ's conclusion that BCMHC did not meet Medicare's definition of a CMHC, we clarify the legal context in which this dispute is being resolved. Although the initial and reconsideration determinations do not use the term "enrollment," the ALJ properly treated the determinations as Medicare enrollment denials because they

directly resulted from an administrative process – described in sections 2250 and 2252 of the SOM – that CMS initiated in order to approve or deny BCMHC's January 2006 application for Medicare enrollment as a CMHC.[8] Although the ALJ did not specify which of the enrollment regulations in 42 C.F.R. Part 424 he relied on to uphold the enrollment denial, the substance of his legal analysis supports the application of section 424.530(a)(1).

Section 424.530(a)(1) of CMS's enrollment regulations provides that CMS may deny enrollment if the provider "at any time is found not to be in compliance with the Medicare enrollment requirements described in this section" (emphasis added). "Enrollment requirements" are found in sections 424.510 and 424.516. Relevant here, section 424.510(d)(2)(iii) requires a provider to furnish "all documentation, including all applicable Federal and State licensure and regulatory requirements that apply to the specific provider or supplier type that relate to providing health care services . . . to establish the provider or supplier's eligibility to furnish Medicare covered items or services to beneficiaries in the Medicare program" (emphasis added). In addition, sections 424.516(a)(1) and 424.516(a)(2) indicate that a condition for Medicare enrollment is CMS's verification that the applicant is compliant with the Medicare statute and regulations, including federal certification and regulatory requirements "based on the type of services or supplies the provider or supplier type will furnish and bill Medicare" (emphasis added).[9] These requirements plainly indicate that an entity seeking enrollment as a particular type of Medicare provider must satisfy the legal conditions which render the provider eligible to furnish covered items or services to the program's beneficiaries, and to receive Medicare payment for those covered items and services. *See also* 42 C.F.R. § 424.502 (defining "enrollment" as the process that Medicare uses to establish eligibility to submit claims for Medicare covered services and supplies); *id.* § 424.505 (stating that a provider must be enrolled in the program to receive Medicare payment for "covered services"); *Peter McCambridge, C.F.A.*, DAB No. 2290 (2009), reopening denied, Ruling No. 2010-1 (Feb. 2, 2010) (holding that CMS was authorized to deny the supplier's application for enrollment because Medicare did not cover the services for which he sought to claim Medicare payment).

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[8] Although the initial determination did not cite the enrollment regulations in 42 C.F.R. Part 424, the determination stated that CMHC did not meet "the requirements for certification to participate" in Medicare and indicated that its decision was an appealable "initial determination" under 42 C.F.R. § 498.3. CMS Ex. 1, at 1. Enrollment denials pursuant to 42 C.F.R. § 424.530 are considered "initial determinations" subject to appeal under the procedures in 42 C.F.R. Part 498. *See* 42 C.F.R. § 498.3(b)(17). The reconsideration determination, on the other hand, indicates that it was issued pursuant to 42 C.F.R. § 489.12(a)(4), which authorizes CMS to deny a Medicare provider agreement to a prospective provider if the provider "is unable to give satisfactory assurance of compliance with the requirements of title XVIII of the Act." CMS Ex. 2, at 26. However, CMS did not rely on section 489.12(a)(4) in its arguments to the ALJ or on appeal, and the ALJ makes no mention of that regulation in his decision.

[9] Section 424.516(a), which was promulgated in November 2008 and became effective on January 1, 2009, contains provisions formerly found in section 424.520. *See* 73 Fed. Reg. 69,726, 69,777 (Nov. 19, 2008).

As outlined above, BCMHC sought to enroll in Medicare as a CMHC, meaning that it was seeking enrollment solely for the purpose of providing Medicare-covered "partial hospitalization services." *See* Act § 1866(e)(2). BCMHC must meet the statutory definition of a CMHC in order to enroll in Medicare because (1) it is a requirement for enrollment that a provider be eligible to furnish and receive payment for Medicare-covered services, *see* 42 C.F.R. § 424.510(d)(2)(iii), and (2) a CMHC is eligible to furnish or receive Medicare payment for partial hospitalization services only if it meets the statutory definition of a CMHC, *id.* §§ 410.110 and 410.172.

In deciding whether the ALJ correctly resolved the enrollment issue, we confine our review (as the ALJ did) to facts and circumstances that existed on or before July 8, 2009, the date of the reconsideration determination from which BCMHC took its appeal. *See Pepper Hill Nursing & Rehabilitation Center*, LLC, DAB No. 2395, at 6-7 (2011) (holding that, in accord with the preamble to the Part 424's enrollment regulations, the proper inquiry in a provider or supplier enrollment appeal is to ascertain the applicant's eligibility for enrollment at the time CMS or its contractor makes the relevant adverse determination).

3. *Substantial evidence supports the ALJ's conclusion that BCMHC did not meet Medicare's definition of a CMHC.*

As BCMHC concedes, an entity cannot be considered a CMHC for Medicare purposes unless it is providing all of the core services specified in Medicare's definition of a CMHC. We agree with the ALJ that BCMHC failed to establish that it provided all of those services during the 42 months between the submission of its enrollment application (in January 2006) and the issuance of CMS's reconsideration determination (on July 8, 2009).

The findings of CMS's December 2008 site inspection, which BCMHC did not refute, severely undercut BCMHC's claim that it was engaged in providing all of a CMHC's core services. Those findings show that BCMHC was not a functioning health care organization distinct from the nursing home where it purportedly provided services.

During the site visit, CMS found no indication that BCMHC had advertised its existence as a CMHC, either to the public or, it appears, to the nursing home or the health care community at large.[10] CMS also found that BCMHC did not have a schedule of

[10] Inspector Scheidel stated in his affidavit that BCMHC's name did not appear in the results of his internet search of that name. CMS Ex. 4, at 3. During the ALJ proceeding, BCMHC produced a document showing a Google search result that turned up its name ("Briarwood CMHC") on several web pages. P. Ex. 22, at 13. However, BCMHC did not indicate when it performed the search. The only date on the document suggests that the search was performed in April 2010, nine months after the end of the period relevant to this decision. *Id.* (URL line at bottom of page). BCMHC did not submit an affidavit or declaration to contradict the inspector's sworn statement about his internet search.

appointments for any of the services it allegedly provided and – most revealing – did not generate or keep patient records.

During the ALJ proceeding, BCMHC produced no substantial or credible evidence of its day-to-day operations, such as patient rosters, employee timesheets, work schedules, treatment records identifying it as the service provider, or documentation that it billed patients or their insurers for its services. BCMHC did submit to the ALJ a brochure listing its address, hours of operation, telephone numbers, and menu of services, P. Ex. 3, at 29-30, but as the ALJ noted, there is no evidence that the brochure was produced for or actually disseminated to the public or to the local health care community. And although BCMHC claimed in a November 4, 2009 email to a Civil Remedies Division staff attorney that it had furnished CMS with a copy of a lease that permitted use of the nursing home's conference room, there is no such lease in the record.

Clinical records obtained by CMS during the site visit (and submitted as CMS Exhibits 5 through 12) reflect mental health treatment furnished to nine patients. BCMHC submitted clinical records of eleven patients. P. Exs. 10-20. In several instances, the clinical records show involvement by Mr. Pathak, BCMHC's owner, in the patient's care. That involvement included participating in treatment plan development, serving as a patient's "case manager," or providing or overseeing individual or group therapy. *See, e.g.,* P. Ex. 15, at 14, 15-26, 45. However, none of the clinical records identify Mr. Pathak's affiliation with "Briarwood CMHC" or indicate that the patients had been admitted to an outpatient treatment program managed by BCMHC. *See, e.g.,* P. Ex. 11, at 45, 47 (admission and discharge summaries, neither of which identify BCMHC as the service provider).

We also find it significant, as CMS did (*see* CMS Exhibit 1, at 3-4), that BCMHC's staff appeared to consist solely of Mr. Pathak. BCMHC's enrollment application identified two individuals as employees: Lakesia Smith, a licensed vocational nurse (identified as a "managerial employee"); and Mark Moeller, M.D. (identified as a "medical director"). CMS Exhibit 3, at 7-8. BCMHC did not point to any evidence of health care services provided by these two individuals during the relevant period, nor did BCMHC submit evidence (such as contracts, timesheets, or wage or salary records) confirming that those persons were, in fact, employees of BCMHC. CMS's Statement of Findings states that BCMHC "entered into an agreement for a Medical Director," CMS Exhibit 1, at 4, but the nature of that agreement (and the identity of the other party to the agreement) is unclear, and neither party produced a copy.

The clinical records show that Mr. Pathak sometimes worked in concert with health care professionals other than Nurse Smith and Dr. Moeller (including a registered nurse and social worker) to formulate treatment plans and provide therapy. *See, e.g.*, P. Ex. 13, at 17 (identifying Mr. Pathak as one of four "participants" in the formulation of the patient's Master Treatment Plan"). However, none of these other professionals was alleged to be an employee of BCMHC.[11]

Viewed in its totality, the evidence of record indicates that BCMHC's operation consisted of little more than the services personally furnished by Mr. Pathak on behalf of nursing home residents. That being true, BCMHC cannot plausibly claim that it was providing – or was even institutionally capable of providing – all of a CMHC's core services, especially "day treatment or other partial hospitalization services, or psychosocial rehabilitation services."

According to CMS's State Operations Manual, partial hospitalization and psychosocial rehabilitation services "are structured day programs (less than 24 hours per day) that use a multidisciplinary team approach to develop treatment plans that vary in intensity of services and the frequency and duration of services provided based on the needs of the patient." SOM § 2250F (emphasis added). Partial hospitalization is "more intense than outpatient day treatment or psychosocial rehabilitation," *id.*, and is defined in the Medicare statute as a "distinct and organized intensive ambulatory treatment service" – involving diagnosis, treatment (that may included individual, group, and drug therapy), family counseling, and patient education and training – furnished under an individualized plan of treatment established and periodically reviewed by a physician, Act § 1861(ff)(1), (2), (3)(A) (emphasis added). The State Operations Manual further explains that a partial hospitalization program (PHP): (1) is "[s]imilar to that of a highly structured, short-term hospital inpatient program"; (2) is "[a]ctive treatment that incorporates an individualized treatment plan which describes a coordination of services wrapped around the particular needs of the patient"; (3) is "[p]rovided through a multi-disciplinary team approach to patient care under the direction of a physician, who certifies the patient's need for PHP services"; and (4) "reflects a high degree of structure and scheduling." SOM § 2250F (emphasis added); *see also* 72 Fed. Reg. 66,580, 66,673 (Nov. 27, 2007) (noting that "[b]ecause partial hospitalization is provided in lieu of inpatient care, it should be a highly structured and clinically-intensive program, usually lasting most of the day").

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[11] In a letter supporting the request for reconsideration, BCMHC's attorney asserted that "[w]hile it is true Mr. Pathak is the lone case manager/owner of CMHC[,] he is assisted by KD Nguyen, M.D., Melinda Smith (social worker), and registered nurse, Roxann Hart . . . ." CMS Ex. 2, at 23. BCMHC also stated that its charts show that patients were "initially evaluated by Dr. Rubashkin, psychiatrist . . . ." *Id.* at 24. However, BCMHC produced no evidence that these professionals were its employees. An April 2009 letter purportedly signed by Dr. Nguyen, and a similar letter from Dr. Moeller, state merely that they had been "associated with" BCMHC for more than three years. CMS Ex. 2, at 15, 17.

The clinical records in this case indicate that some of the patients on whose behalf Mr. Pathak provided services had a physician order to receive a PHP. *See, e.g.,* P. Ex. 11, at 14. The clinical records also show that those patients received some of the types of services (individual and group therapy, for example) ordinarily provided under a PHP. *Id.* at 26-29 (daily therapy notes). However, the clinical records do not show that BCMHC – rather than the nursing home where it purportedly operated – organized, implemented, and assumed ultimate responsibility for any physician-ordered PHP. As discussed, there is no credible evidence that BCMHC's operation amounted to anything more than services personally rendered by its sole owner, who was licensed in just one discipline (social work). It is thus implausible to claim that BCMHC was, by itself, providing or orchestrating a "multidisciplinary team approach" to patient care, a hallmark of partial hospitalization and psychosocial rehabilitation.[12]

In sum, BCMHC did not meet its burden to show that it provided partial hospitalization or psychosocial rehabilitation services during the relevant period. Accordingly, we affirm, pursuant to section 424.530(a)(1), the ALJ's conclusion that CMS lawfully denied BCMHC's January 2006 application for Medicare enrollment.

We note, moreover, that based on the facts of record, CMS could also have denied enrollment under section 424.530(b)(5), which authorizes denial if CMS "determine[s] that the provider or supplier is *not operational*, or is not meeting Medicare enrollment requirements to furnish Medicare covered items or services." The regulations define the term "operational" as follows:

> Operational means the provider or supplier has a qualified physical practice location, is open to the public for the purpose of providing health care related services, is prepared to submit valid Medicare claims, and is

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[12] According to CMS's State Operations Manual, a core service may be provided "under arrangements made by" the CMHC; that is, a CMHC may arrange to have an outside vendor perform the service. SOM § 2250F. Such an arrangement must be evidenced by a "written agreement or contract between the two parties that specifies services to be rendered, and the manner in which the CMHC exercises its legal, professional and administrative responsibility for those services." *Id.* BCMHC did not allege before the ALJ that it was providing partial hospitalization or psychosocial rehabilitation services under arrangement, and we find no evidence that it did so during the relevant period. In making this finding, we considered documents that purport to be contracts between BCMHC and two other health care organizations, Vericare and Senior Connections. *See* P. Ex. 3, at 2; P. Ex. 4, at 15, 37. These alleged contracts are not reliable evidence of actual agreements in part because they do not clearly identify the names or positions of the individuals who signed them on behalf of Vericare and Senior Connections. Even if they were reliable evidence, the contracts are insufficient under Medicare program guidelines to establish that BCMHC was providing services under arrangement because they fail to specify that BCMHC bore ultimate legal and professional responsibility for the services provided by Vericare and Senior Connections under the contracts. CMS's exhibits include additional agreements with Vericare and Senior Connections, but the contents of those agreements make it clear that they were executed by the nursing home, not by BCHMC. *See* CMS Ex. 3, at 21-28 (March 1, 2006 and April 15, 2006 agreements by "Briarwood Healthcare Center").

> properly staffed, equipped, and stocked (as applicable, based on the type of facility or organization, provider or supplier specialty, or the services or items being rendered), to furnish these items or services.

42 C.F.R. § 424.502. In a recent decision, the Board emphasized that "[t]he word 'operational' is a term of art specific to Medicare, and it means that a provider or supplier must have a qualified physical practice location and actually be furnishing the types of covered Medicare services that it holds itself out as furnishing." *CompRehab Wellness Group, Inc.*, DAB No. 2406, at 7 (2011). Furthermore, as CMS indicated in its initial determination, being "fully operational" to perform core services is an implicit requirement of the statutory definition of a CMHC:

> The statute also requires that an applicant CMHC be providing the services listed in the PHSA at the time of certification, not at some future point in time. Accordingly, CMS looks for evidence that the applicant is already providing the core services as a pre-condition for certification as further stated in the [SOM] . . . . For example, CMS looks to see if the applicant has been <u>fully operational</u> for one business quarter . . . .

CMS Ex. 1, at 1-2 (citing SOM § 2250G) (emphasis added).

As CMS's initial determination and our discussion illustrate, BCMHC was not fully operational as a CMHC during the relevant period. It was not open to the public for providing core services and not visibly distinct from the nursing facility where it allegedly operated. BCMHC also lacked an identifiable physical practice location within the nursing facility, the only evidence of that location being Mr. Pathak's uncorroborated assertion to CMS's inspector. In addition, the record before us contains no evidence of BCMHC's regular, day-to-day administrative functioning: CMS's inspector found no posted schedule of operations for BCMHC and confirmed that its owner (and only employee) had not planned to be at the alleged practice location on the day of the site visit. CMS Ex. 4, at 3. Finally, with only one apparent employee, BCMHC was not staffed to provide Medicare-covered partial hospitalization services (or prepared to submit valid Medicare claims for those services) and other CMHC core services, such as psychosocial rehabilitation and outpatient services (including specialized services for children and individuals with a "serious mental illness").

Conclusion

For the reasons discussed, we modify the ALJ Decision to find that BCMHC was not engaged in providing partial hospitalization or psychosocial rehabilitation services during the period relevant to this decision. In addition, we clarify that CMS's determination to deny BCMHC's January 2006 application for Medicare enrollment was lawful under 42 C.F.R. § 424.530(a)(1). With these modifications, the ALJ Decision is hereby affirmed.

/s/

Leslie A. Sussan

/s/

Constance B. Tobias

/s/

Sheila Ann Hegy
Presiding Board Member