Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Malou Home Health Inc., d/b/a Dignity Home Health, Inc.,
(NPI: 1982936316),

Petitioner

v.

Centers for Medicare and Medicaid Services.

CRD Docket No. C-12-1224

ALJ Ruling No. 2013-4

Date: February 15, 2013

ORDER OF DISMISSAL

I dismiss the hearing request of Petitioner, Malou Home Health Inc., d/b/a Dignity Home Health, Inc. Because Petitioner did not request that the Centers for Medicare and Medicaid Services (CMS) reconsider its initial determination denying Petitioner's Medicare enrollment application, Petitioner has no right to a hearing to challenge that determination.

I. Background

Petitioner submitted a Medicare enrollment application to Palmetto GBA (Palmetto), a Medicare contractor, to participate as a Home Health Agency (HHA) provider in the Medicare program. On February 4, 2011, Palmetto faxed Petitioner a notice letter, requesting that Petitioner submit updated Initial Reserve Operating Funds (IROF) documentation within 30 days to demonstrate that Petitioner "maintains sufficient funds to operate for a current three month period subsequent to the effective date of your Medicare provider agreement." CMS Ex. 1, at 1. Petitioner submitted some of the requested IROF documentation and over the course of the following year Palmetto processed Petitioner's enrollment application. CMS Ex. 1, at 3-5. On April 9, 2012,

Palmetto faxed Petitioner another notice letter requesting that Petitioner submit within 30 days IROF documentation to show that Petitioner maintained "sufficient funds to operate for a current three month period . . . ." CMS Ex. 1, at 3. Petitioner did not submit the requested documentation to Palmetto within 30 days of the April 9, 2012 notice letter. CMS Ex. 1, at 4.

On May 24, 2012, Palmetto sent Petitioner a letter indicating that Palmetto was denying Petitioner's Medicare enrollment application based on Petitioner's failure to submit the requested IROF documentation. CMS Ex. 1, at 4-5. The May 24, 2012 letter entitled "RE: Notice of Denial" states in pertinent part that:

> In accordance with 42 CFR § 498.28, an HHA must have available sufficient "Initial Reserve Operating Funds" (IROF) to operate the HHA for the three month period after its Medicare provider agreement becomes effective, exclusive of actual or projected accounts receivables from Medicare or other health care insurers. On April 9, 2012, Palmetto GBA requested you submit IROF documentation that shows that your home health agency maintains sufficient funds to operate. Based upon visit projections submitted with your enrollment application, and upon review of data for comparable agencies, we determined the minimum need of $138,037.33. Palmetto GBA did not receive the requested documentation showing that your home health agency meets the IROF requirements set forth above.
>
> Consistent with regulations found at 42 CFR § 424.530(a)(5), your application is denied for failure [to] satisfy the IROF requirement.
>
> If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, you may submit a corrective action plan (CAP) within 30 calendar days after the postmark date of this letter. The CAP should provide evidence that you are in compliance with Medicare requirements.
>
> . . .
>
> If you believe that this determination is not correct, you may request reconsideration before a contractor hearing officer. The reconsideration is an independent review and will be conducted by a person who was not involved in the initial determination. You must request the reconsideration in writing to this office within 60 calendar days of the postmark date of this letter. The request for reconsideration must state the issues, or the findings of fact with which you disagree and the reasons for disagreement. . . .

> Failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.
>
> . . .

CMS Ex. 1, at 4-5.

By letter dated June 28, 2012, Petitioner filed a corrective action plan (CAP). CMS Ex. 2. Petitioner's CAP stated:

> CAP for 42 CFR § 489.28(a)(5)
>
> The administrator/owner will ensure that Dignity Home Health agency have available sufficient "Initial Reserve Operating Funds" to operate the HHA for three month period after its Medicare provider agreement becomes effective, exclusive of actual or projected accounts receivables from Medicare or other health care insurers. The owners of Malou Home Health Inc. d/b/a Dignity Home Health sold 20% of the stocks, and had funds in their corporate savings, which total the amount required. The administrator will attest that Dignity Home Health, NPI #1982936316, has $138,037.33 reserved for capitalization purposes and none of the funds will be used for operating purposes.

CMS Ex. 2, at 1.

Petitioner included a "Stock Sales Contract" with the CAP request. CMS Ex. 2, at 2-3.

On August 16, 2012, CMS sent a letter entitled "Re: Request for Corrective Action Plan (CAP) Malou Home Health, Inc," which denied Petitioner's CAP request. CMS Ex. 1, at 6-8. In this letter, CMS stated that "[t]his decision letter is in response to your CAP requested [sic] received . . . . The CAP request is based on the above referenced provider or suppliers denial." CMS Ex. 1, at 6. The letter also stated that Petitioner's "request, to reopen their Medicare enrollment" was denied based on [Petitioner's] failure to provide "additional evidence to show they have met the capitalization standard of the $138,037.33 minimum for which they were denied." CMS Ex. 1, at 6. However, CMS incorrectly informed Petitioner that it had the right to an administrative law judge (ALJ) hearing on this unfavorable CAP determination. CMS Ex. 1, at 7.

Pursuant to this misinformation, on August 25, 2012, Petitioner filed a hearing request. I was assigned to the case and issued an Acknowledgement and Pre-Hearing Order that established a briefing schedule for the parties. Accordingly, CMS filed a Motion for Summary Judgment and Prehearing Brief and three proposed exhibits (CMS Exs. 1 – 3). In its submission, CMS requests that I grant summary judgment in CMS's favor.

Petitioner responded to the CMS Motion for Summary Judgment and submitted a Prehearing Brief, but filed no exhibits. Petitioner did not object to CMS's exhibits. Therefore, I receive CMS Exs. 1 - 3 into the record.

II. Discussion

A determination by CMS to deny a provider enrollment in the Medicare program is an appealable "initial determination." 42 C.F.R. § 498.3(b)(17). A provider may request reconsideration of an initial determination denying enrollment. 42 C.F.R. §§ 498.5(l)(1), 498.22(a). To do so, a provider must file a request for reconsideration with CMS within 60 days from receipt of the initial determination, and must state in the request the issues or the findings of fact with which the provider disagrees, and the reasons for the disagreement. 42 C.F.R. § 498.22(b)-(c). Although a provider who is "dissatisfied with a reconsidered determination . . . is entitled to a hearing before an ALJ," 42 C.F.R. § 498.5(l)(2), an initial determination is "binding" unless it is first reconsidered. *See* 42 C.F.R. § 498.20(b)(1). Therefore, if a provider does not receive a reconsidered determination from CMS, then that provider does not have a right to a hearing before an ALJ. *Denise Hardy*, DAB No. 2464, at 4-5 (2012); *Hiva Vakil*, DAB No. 2460, at 4-5 (2012); *see also Better Health Ambulance*, DAB No. 2475, at 4 (2012).

Palmetto's May 24, 2012 letter was an appealable initial determination. CMS Ex. 1, at 4-5. However, Petitioner's June 28, 2012 letter states that it is a "CAP for 42 CFR § 489.28(a)(5)". CMS Ex. 2. The letter addresses how Petitioner intends to correct deficiencies and establish Petitioner's eligibility to participate in the Medicare program and also provides evidence that Petitioner is currently in compliance with Medicare requirements. CMS Ex. 2. The June 28, 2012 letter neither states nor suggests that it is also meant to serve as a request for reconsideration. In this letter, Petitioner did not contend that the May 24, 2012 initial determination was incorrect and Petitioner did not state the issues or the findings of fact with which Petitioner disagreed. CMS Ex. 2. Thus, Petitioner's June 28, 2012 letter did not meet the requirements for a request for reconsideration under 42 C.F.R. § 498.22(c). CMS construed Petitioner's June 28, 2012 letter as a CAP request (CMS Br. at 2-4; CMS Ex. 1, at 6) and Petitioner does not claim in its brief that it requested reconsideration. Therefore, I find that Petitioner did not file a request for reconsideration in this matter and that Petitioner's June 28, 2012 letter constituted a CAP request.

I further find that CMS's August 16, 2012 letter is a denial of Petitioner's CAP request. The letter indicates at the top that it relates to a CAP request and the first two sentences of the letter make it clear that it is sent in response to Petitioner's CAP request. CMS Ex. 1, at 6.

I do not have jurisdiction to review the August 16, 2012 letter because it is a determination denying a CAP request. The process under which CMS considers a CAP

is separate from the process to reconsider an initial determination. *See DMS Imaging, Inc.*, DAB No. 2313, at 7 (2010). The denial of a CAP is not an appealable initial determination under 42 C.F.R. Part 498; therefore, a provider does not have the right to a hearing before an ALJ based on such a denial.[1] *See* 42 C.F.R. § 405.874(e) (2011); *Pepper Hill Nursing & Rehab. Ctr.*, DAB No. 2395, at 9-10 (2011); *DMS Imaging*, DAB No. 2313, at 5-10.

An ALJ may, on his own motion, dismiss a hearing request when the party requesting the hearing is either not a proper party or "does not otherwise have a right to a hearing." 42 C.F.R. § 498.70(b). In the present matter, Petitioner has no right to a hearing based on the denial of a CAP; therefore, this case will be dismissed.

III. Conclusion

Petitioner did not timely request reconsideration and it has no right to appeal the Medicare contractor's determination regarding its CAP under 42 C.F.R. Part 498. Petitioner's request for hearing is hereby dismissed, 42 C.F.R. § 498.70(b), and the May 24, 2012 initial determination denying Petitioner's Medicare enrollment application is binding. 42 C.F.R. § 498.20(b)(1).

It is so ordered.

/s/
Scott Anderson
Administrative Law Judge

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[1] CMS's August 16, 2012 letter erroneously notified Petitioner that it could appeal the CAP denial to an ALJ. CMS Ex. 1, at 7. Although it is regrettable that CMS included this incorrect information in the letter, such an error does not create a right to a hearing where one does not exist. *See Vakil*, DAB No. 2460, at 5 n.3.