Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Bono Home Health Care, LLC
(NPI: 1003138322)

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-12-771

Decision No. CR2588

Date: August 17, 2012

DECISION DISMISSING APPEAL FOR CAUSE

The request for hearing of Petitioner, Bono Home Health Care, LLC, is dismissed pursuant to 42 C.F.R. § 498.70(b).

I. Procedural History

Palmetto GBA, the Medicare contractor, mailed Petitioner a letter dated July 8, 2011, notifying Petitioner that its Medicare billing privileges were revoked and its provider agreement terminated effective April 21, 2011. Palmetto cited as grounds for the revocation and termination that a site visit revealed that Petitioner was no longer operational to furnish Medicare covered items or services. The notice informed Petitioner that it had a right to reconsideration by a contractor hearing officer and that a request for reconsideration had to be made in writing within 60 calendar days of the postmark date of the Palmetto letter. The letter also advised Petitioner that it was subject to a two-year bar to reenrollment in Medicare. CMS Exhibit (Ex.) 1.

It is undisputed that Petitioner did not request reconsideration of the revocation until March 5, 2012, 244 days after the July 8, 2011 date on the Palmetto notice of revocation and termination. CMS Ex. 7. On May 7, 2012, Palmetto notified Petitioner by email that its appeal rights had expired because no reconsideration request had been received within

60 days of the July 8, 2011 notice of revocation. Palmetto informed Petitioner that the failure to timely request reconsideration was deemed a waiver of all rights to further administrative review. CMS Ex. 7. No reconsideration decision was issued by the contractor.

On May 29, 2012, my office received Petitioner's request for hearing dated May 25, 2012. Petitioner also requested a stay of the revocation of its billing privileges and the termination of its provider agreement. The case was assigned to me for hearing and decision. I issued an Acknowledgment and Prehearing Order on June 4, 2012, and an amendment to that order dated June 22, 2012.

On June 29, 2012, CMS filed a response to Petitioner's request for a stay of the revocation and a motion to dismiss Petitioner's hearing request with supporting brief (CMS Motion) and CMS Exs. 1 through 9. On July 19, 2012, Petitioner filed its response (P. Response) together with Petitioner Exhibits (P. Exs.) A through E. Petitioner also filed documents with its request for hearing marked P. Exs. A through J, which I refer to as Request for Hearing (RFH) Exs. A through J. No objection has been made to my consideration of the offered exhibits and CMS Exs. 1 through 9, P. Exs. A through E, and RFH Exs. A through J are admitted.

II. Applicable Law

A provider or supplier may request reconsideration of an initial determination by CMS that affects the provider's or supplier's ability to participate in the Medicare program. 42 C.F.R. § 498.5 (a), (b), (d) and (l). The request for reconsideration must be filed with CMS; either directly by the provider/supplier or through the provider's or supplier's designated representative, within 60 days of receipt of the notice of the initial determination. 42 C.F.R. § 498.22(b). The date of receipt of the initial determination is presumed to be five days after the date on the notice from CMS or its contractor, unless there is a showing that it was received earlier or later. 42 C.F.R. § 498.22(b).

III. Findings of Fact and Conclusions of Law

My conclusions of law are set forth followed by the pertinent findings of fact and analysis.

A. Petitioner has no right to a hearing before an ALJ because there has been no reconsideration determination.

B. Dismissal is required as Petitioner has no right to a hearing.

CMS moved to dismiss Petitioner's request for hearing on grounds that I lack jurisdiction because Petitioner failed to timely request reconsideration of the initial determination

which is now final pursuant to 42 C.F.R. § 498.20(b). CMS argues that Palmetto notified Petitioner by letter dated July 8, 2011, that its billing privileges were revoked and its provider agreement terminated effective April 21, 2011.[1] CMS Ex. 1. The notice letter informed Petitioner of its right to reconsideration; that the reconsideration request must be received within 60 calendar days of the postmark date of the notice letter; and that the reconsideration request must be signed and dated by the authorized or delegated official within the entity. The notice also informed Petitioner that failure to timely request reconsideration would be treated as a waiver of all rights to further administrative review. CMS Motion at 1-2.

Petitioner asserts, based on the declaration of its owner, that it did not receive the notice of revocation and termination dated July 8, 2012, until January 23, 2012. P. Ex. C. Petitioner has presented evidence showing that it continued to have repeated interactions with Palmetto and CMS throughout the remainder of the calendar year 2011, consistent with Petitioner being enrolled in Medicare, and Petitioner argues, inconsistent with Petitioner's enrollment being revoked July 8, 2011. RFH at 1; P. Response at 4-8; P. Ex. C; RFH Exs. B-E. Petitioner notes that it did receive a notice from Palmetto dated July 8, 2011, which welcomed Petitioner to the Medicare program and included information for Petitioner as a new provider. RFH at 2; P. Ex. C, at 2-3; RFH Ex. B.

Petitioner enrolled in Medicare effective February 8, 2011, as a home health agency within the meaning of section 1861(o) of the Social Security Act (the Act) (42 U.S.C. § 1395x(o)). CMS Ex. 3; CMS Ex. 4 at 2. A home health agency is a provider of services pursuant to section 1861(u) of the Act (42 U.S.C. § 1395x(u)).[2] The regulations are

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[1] CMS asserts it is undisputed that Palmetto GBA mailed Petitioner a notice revoking its enrollment on July 8, 2011. Petitioner does not concede that the notice was mailed and disputes that the notice was received prior to January 23, 2012. CMS has presented no evidence to show that the notice letter was actually placed in the mail on July 8, 2011, by producing a certified or registered mail receipt. Rather, CMS relies, as it is entitled to, upon the rebuttable presumption that the letter was deposited in the ordinary course of government business and the rebuttable presumption that the letter was received within five calendar days. I conclude as discussed hereafter that I have no jurisdiction to review whether or not Petitioner rebutted the presumptions relied upon by CMS.

[2] A "supplier" furnishes services under Medicare and the term supplier applies to physicians or other practitioners and facilities that are not included within the definition of the phrase "provider of services." Act § 1861(d) (42 U.S.C. § 1395x(d)). A "provider of services," commonly shortened to "provider," includes hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, hospice programs, and a fund as described in sections 1814(g) and 1835(e) of the Act.
(Footnote continued next page.)

potentially confusing regarding the appeal rights of a provider that has its billing privileges revoked and its provider agreement terminated. CMS and its contractor are authorized to revoke enrollment and billing privileges for the reasons listed in 42 C.F.R. § 424.535. Pursuant to 42 C.F.R. § 424.545(a) a provider whose Medicare enrollment and billing privileges have been revoked may appeal in accordance with 42 C.F.R. Part 498. Termination of a provider agreement is governed by 42 C.F.R. § 489.53. The regulation provides that a provider may appeal the termination of its provider agreement in accordance with 42 C.F.R. Part 498. 42 C.F.R. § 489.53(e). The procedures for appealing determinations that affect participation in Medicare are found in 42 C.F.R. Part 498. The termination of a provider agreement pursuant to 42 C.F.R. § 489.53 is an initial determination subject to review by an administrative law judge (ALJ) and appeal to the Departmental Appeals Board (the Board). 42 C.F.R. § 498.3(b)(8). A determination to revoke enrollment in Medicare is also an initial determination of CMS subject to review by an ALJ and appeal to the Board. 42 C.F.R. § 498.3(b)(17). Pursuant to 42 C.F.R. § 498.5(b), a "provider dissatisfied with an initial determination to terminate its provider agreement is entitled to a hearing before an ALJ." Section 498.5 of Title 42 imposes no requirement for there to be reconsideration by CMS or its contractor. However, 42 C.F.R. § 498.5(l)(1) provides that if an existing provider, such as Petitioner, is dissatisfied with an initial determination to revoke Medicare billing privileges, the provider may request reconsideration pursuant to 42 C.F.R. § 498.22. The regulation provides that a provider is entitled to a hearing before an ALJ if dissatisfied with the reconsideration decision. 42 C.F.R. § 498.5(l)(2). Thus, pursuant to 42 C.F.R. § 498.5(b) Petitioner arguably may request that an ALJ review the initial determination to terminate its provider agreement, while pursuant to 42 C.F.R. § 498.5(l) Petitioner must obtain reconsideration of the initial determination to revoke billing privileges and enrollment prior to requesting review by an ALJ. This apparent conflict is resolved by 42 C.F.R. § 424.545(a)(1)(ii) which provides:

> When a provider appeals the revocation of billing privileges and the termination of its provider agreement, there will be one appeals process which will address both matters. The appeal procedures for revocation of Medicare billing privileges will apply.

Petitioner seeks review of the revocation of its billing privilege and the resulting termination of its provider agreement. Accordingly, the provisions related to review of revocation of billing privileges and enrollment in Medicare apply in this case.

(Footnote continued from preceding page.)

Act § 1861(u) (42 U.S.C. § 1395x(u)). The distinction between providers and suppliers is important because they are treated differently under the Act for some purposes.

I am bound by the regulations and I can only hear a matter if I have jurisdiction. Petitioner does not have a right to an ALJ hearing in this case. Petitioner failed to timely request reconsideration regarding the revocation of its billing privileges and enrollment in Medicare, and no reconsideration decision was issued by CMS or its contractor. I have no authority to consider whether or not the request for reconsideration to Palmetto was timely or to grant specific relief in the form of an order to CMS or its contractor to conduct reconsideration.[3] Because there was no reconsideration decision, Petitioner has no right to a hearing by an ALJ. Dismissal is required. 42 C.F.R. § 498.70(b).

III. Conclusion

For the foregoing reasons, Petitioner's request for hearing is dismissed. I may vacate a dismissal if either party files such a request within 60 days of receipt of this dismissal and states good cause for such action. 42 C.F.R. § 498.72.

/s/
Keith W. Sickendick
Administrative Law Judge

[3] I considered remanding this case to CMS for clarification of whether or not the contractor hearing officer properly considered whether the time for requesting reconsideration should have been extended. However, there is no evidence before me that Petitioner requested that CMS or the contractor extend the time for Petitioner to file its request for reconsideration pursuant to 42 C.F.R. § 498.22(d) for good cause. Furthermore, I have concluded that I also have no jurisdiction to remand to CMS in this case as there was no reconsideration decision.