

**Department of Health and Human Services**

**DEPARTMENTAL APPEALS BOARD**

**Civil Remedies Division**

Coral Home Care, Inc.,  
(PTAN: 10-7698),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-691

Decision No. CR3305

Date: July 22, 2014

**DECISION**

I grant summary judgment in favor of the Centers for Medicare & Medicaid Services (CMS) affirming the determination of a Medicare contractor to revoke the Medicare enrollment of Petitioner, Coral Home Care, Inc.

**I. Background**

Petitioner filed a request for hearing in order to challenge a reconsideration determination that affirmed revocation of Petitioner's Medicare enrollment. The case was assigned to me for a hearing and a decision. CMS moved for summary judgment. Petitioner's then-counsel submitted a notice withdrawing Petitioner's request for hearing. I dismissed the hearing request. Petitioner subsequently moved to have its hearing request reinstated and I granted that motion. Then, Petitioner replied to CMS's motion for summary judgment and cross-moved for summary judgment.

CMS filed six exhibits, identified as CMS Ex. 1 – CMS Ex. 6, with its motion for summary judgment. Petitioner filed seven exhibits, identified as

P. Ex. 1 – P. Ex. 7, with its opposition and cross-motion for summary judgment. I receive into the record CMS Ex. 1 – CMS Ex. 6. As for Petitioner’s exhibits there are grounds for excluding some of them inasmuch as P. Ex. 5 – P. Ex. 7 were clearly generated or obtained by Petitioner after the date of the reconsideration determination, January 9, 2014, and Petitioner has not shown good cause for my receiving these exhibits at this time.<sup>1</sup> 42 C.F.R. § 498.56(e). They also are irrelevant inasmuch as they are offered as evidence to support Petitioner’s contention that CMS unfairly refused to accept a corrective action plan from Petitioner. As I discuss below, CMS’s refusal to accept the corrective action plan is, as a matter of law, not reviewable. Therefore, I receive into evidence P. Ex. 1 – P. Ex. 4, and P. Ex. 7, at 15-16. I exclude P. Exs. 5, 6, and pages 1-14 and 17-24 of P. Ex. 7.

## **II. Issue, Findings of Fact and Conclusions of Law**

### **A. Issue**

The issue is whether there is a basis for CMS to revoke Petitioner’s Medicare enrollment.

### **B. Findings of Fact and Conclusions of Law**

The facts of this case are uncontroverted. Petitioner, a home health agency, had listed its business address with a Medicare contractor as 1149 SW 27<sup>th</sup> Avenue, Suite 303, Miami, Florida 33135. CMS Ex. 1. On August 27, 2013, an inspector visited this address on behalf of CMS and discovered that Petitioner was no longer at this location. CMS Ex. 3. CMS subsequently determined that Petitioner had moved in or about April 2012 to an address in Hialeah, Florida. CMS Ex. 3; CMS Ex. 4. In September 2013 a Medicare contractor confirmed that Petitioner had changed its business address to the Hialeah location. CMS Ex. 3.

These facts when read with applicable regulatory requirements establish a clear and irrefutable basis for CMS to revoke Petitioner’s Medicare enrollment. Petitioner failed to report to the Medicare contractor or to CMS its change of business address within 90 days of relocating. This is a violation of the reporting

---

<sup>1</sup> Pages 15 and 16 of P. Ex. 7 are an “Employer Account Change Form.” I note that CMS’s revocation determination dated January 9, 2014, provides a “Summary of Submitted Documentation” and one of the documents listed is “Employer Account Change Form.” Because it appears that pages 15 and 16 of P. Ex. 7 may have been supplied by Petitioner at the time it requested reconsideration, I will receive them into evidence, but not the remainder of P. Ex. 7.

requirements that apply to Petitioner at 42 C.F.R. § 424.516(e)(2). Failure to comply with these reporting requirements is grounds for CMS to revoke a provider or a supplier's participation in Medicare. 42 C.F.R. § 424.535(a)(9).

Petitioner does not deny any of the material facts nor does it argue that there was no legal basis to revoke its Medicare enrollment. Rather, it is Petitioner's contention that CMS unfairly rejected a plan of correction that Petitioner submitted after it had been notified about the revocation determination. Petitioner submitted that plan on October 23, 2013. CMS Ex. 2; P. Ex. 2. A Medicare contractor, acting on behalf of CMS, subsequently rejected the plan.

According to Petitioner, that rejection was arbitrary and unfair and I should overturn it. Petitioner argues that it had a right, pursuant to 42 C.F.R. § 424.535(a)(1) to "correct" its noncompliance. It asserts that it made the necessary correction by submitting a plan of correction that identified its new business address and that CMS was obligated to accept this plan in lieu of revoking Petitioner's Medicare enrollment.

I find Petitioner's argument to be unavailing for two reasons. First, the regulation relied on by Petitioner does not impose on CMS a duty to accept any plan of correction. An entity such as Petitioner may have a right to offer a plan of correction but CMS is under no obligation to accept that offer.

Second, and more important, there is nothing in the regulations that makes a refusal by CMS to accept a plan of correction reviewable. Initial determinations that may be challenged and reviewed on appeal are listed at 42 C.F.R. § 498.3(b). An action by CMS is not appealable unless it comprises one of the listed initial determinations. Refusal by CMS to accept a plan of correction is not one of the listed initial determinations and, therefore, it may not be challenged on appeal. *Conchita Jackson, M.D.*, DAB No. 2495 at 6 (2013); *DMS Imaging, Inc.*, DAB No. 2313 at 6 (2010).

Nor is CMS's refusal to reinstate a dis-enrolled provider such as Petitioner, after it has submitted a corrective action plan, reviewable. 42 C.F.R. § 405.874(e) makes it explicit that a contractor's refusal to reinstate on behalf of CMS is non-reviewable.

