Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Hanover Home Health Care, LLC,

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-13-264

Decision No. CR2823

Date: June 12, 2013

DECISION

The Centers for Medicare and Medicaid Services (CMS) denied the application of Hanover Home Health Care, LLC, Petitioner, for enrollment in the Medicare program as a home health agency (HHA). Petitioner appealed. For the reasons stated below, I affirm the determination to deny Petitioner's enrollment.

I. Background and Procedural History

On May 3, 2010, Petitioner submitted a Medicare enrollment application (CMS Form 855A) to CGS Administrators, LLC (CGS), a CMS contractor. CMS Exhibit (Ex.) 1. In a June 29, 2010 letter, CGS informed Petitioner that it was recommending approval of Petitioner's application, but advised Petitioner that it could still take "6 to 9 months (or longer) for [Petitioner] to obtain its billing number." CMS Ex. 2. Apparently the enrollment process lasted significantly longer than nine months. On June 7, 2012, CGS sent a letter to Petitioner stating that "[i]n order to proceed with the enrollment process, [CGS] must verify that the initial reserve operating funds that were calculated during the review of [Petitioner's] CMS-85[5]A application are still available." CMS Ex. 4, at 1. The capitalization amount that CMS determined would satisfy the initial reserve operating funds requirement was $39,939.00. CMS Ex. 4, at 2. CGS included with the

letter an Information Request Attachment (Attachment). The Attachment listed the documentation that Petitioner was required to submit to confirm the availability of sufficient initial reserve operating funds. CMS Ex. 4, at 2. The Attachment also stated that "[a]t least half of the [initial reserve operating] funds must be the HHA's own funds; the rest may be borrowed, including a line of credit, from an unrelated lender." CMS Ex. 4, at 2. The June 7, 2012 letter advised that all required information confirming the availability of funds must be received by July 6, 2012. CMS Ex. 4, at 1. According to the letter, if Petitioner failed "to furnish adequate proof of capitalization by submitting the requested information within 30 days from the date of this letter, [CGS's] previous approval recommendation will be revised and the State and the CMS Regional Office will be notified that [Petitioner's] enrollment in the Medicare program is now denied." CMS Ex. 4, at 1.

On July 3, 2012, Petitioner faxed CGS a letter from Essex Bank dated June 26, 2012, approving a line of credit for Petitioner in the amount of $40,000. CMS Ex. 6; Petitioner's Request for Hearing (RFH), Supporting Documents at 9, 17-18. However, Petitioner did not submit any information regarding non-borrowed funds. Petitioner did not submit a current bank statement or an attestation that at least 50% of the initial reserve operating funds were Petitioner's own funds, as requested by CGS in the Attachment to the June 7, 2012 letter. On July 19, 2012, CMS denied Petitioner's Medicare enrollment application based on Petitioner's failure to meet the initial capitalization requirements of 42 C.F.R. § 489.28(a). CMS Ex. 3.

On August 10, 2012, Petitioner requested reconsideration and submitted proof that Petitioner met the initial reserve operating funds requirement. Petitioners Exhibits (P. Exs.) 1, 3. On October 22, 2012, CMS issued an unfavorable reconsidered determination stating that Petitioner had not submitted proper initial reserve operating funds documentation in the 30-day time period provided. CMS Ex. 5.

Petitioner timely filed an RFH and supporting documents with the Departmental Appeals Board, Civil Remedies Division. In response to my January 7, 2013 Acknowledgment and Pre-hearing Order (Order), CMS filed a Motion for Summary Judgment and supporting brief (CMS Br.) and six proposed exhibits. Petitioner also filed a Motion for Summary Judgment (P. Br.) and four proposed exhibits. Because neither party objected to any of the proposed exhibits, I admit CMS Exs. 1 through 6 and P. Exs. 1 through 4 into the record. Further, because neither party proposed any witnesses, I will issue this decision based on the written record. *See* Order ¶ 11.

II. Discussion

An HHA is a "provider" under the Medicare program. 42 C.F.R. § 400.202. In order to be a "provider," individuals and entities must enroll and meet certain criteria to receive billing privileges. *Id*. §§ 424.505, 424.510. One requirement is that an HHA have

sufficient "initial reserve operating funds." *Id*. § 424.510(d)(9). This means an HHA must "have available sufficient funds . . . at the time of application submission and at all times during the enrollment process up to the expiration of the 3-month period following the conveyance of Medicare billing privileges . . . ." *Id.* § 489.28(a). CMS determines the amount of initial reserve operating funds. *Id.* § 489.28(b), (c). An HHA seeking Medicare enrollment must be able to provide proof that it meets the initial reserve operating funds requirement within 30 days of a request from CMS or one of its contractors. *Id.* § 424.530(a)(8). The regulations indicate the type of documented proof that is acceptable and, significantly, that 50 percent of the required initial reserve operating funds must be non-borrowed funds. *Id.* § 489.28(d). The remainder of the initial reserve operating funds may be secured through borrowing or a line of credit from an unrelated lender. *Id*. § 489.28(d),(e),(f).

A. Issue

Whether CMS has a legal basis to deny Petitioner's enrollment as an HHA provider in the Medicare program based on Petitioner's failure to timely submit information pertaining to its initial reserve operating funds. *See id*. § 424.530(a)(8).

B. Findings of Fact, Conclusions of Law, and Analysis[1]

1. Between June 7, 2012, and July 7, 2012, Petitioner only submitted to CGS a letter indicating that Petitioner had a line of credit of $40,000, as proof that it had initial reserve operating funds in the amount of $39,939.00.

CGS stated in its June 7, 2012 letter that Petitioner must provide documented proof of capitalization in the amount of $39,939.00 by July 6, 2013.[2] CMS Ex. 4. The Attachment included with the June 7, 2012 letter from CGS specifies acceptable proof. CMS Ex. 4, at 2. In response, Petitioner submitted a letter dated June 26, 2012, from Essex Bank indicating that Petitioner received a $40,000 revolving line of credit. CMS Ex. 6; RFH, Supporting Documents at 9. Petitioner submitted no further documentation to CGS in advance of the July 7, 2012 deadline.

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[1] My findings of fact and conclusions of law are set forth in italics and bold font.

[2] Petitioner must provide proof that it meets the initial reserve operating funds requirement within 30 days of CGS's letter. *See* 42 C.F.R. § 424.530(a)(8). Thirty days from the June 7, 2012 letter requesting such proof was July 7, 2012, a Saturday. Thus, CGS apparently required Petitioner to submit all documented proof within 29 days. However, it is undisputed that Petitioner did not submit all required proof until August 10, 2012, well after the 30-day time period had expired. P. Exs. 1-3.

Petitioner's owner states that on June 6, 2012, she spoke with a CGS representative who told her that she needed additional funds. RFH, Supporting Documents at 1. Based on that conversation, Petitioner's owner set up two accounts at her bank, one of non-borrowed personal savings in the amount of $20,000 and another line of credit in the amount of $20,000. RFH, Supporting Documents at 1. However, Petitioner has provided no proof that these accounts were in existence by July 7, 2012, or that Petitioner provided proof of these accounts to CGS within 30 days of the request for such proof.[3]

2. CMS has a legal basis to deny Petitioner's enrollment in the Medicare program as an HHA because Petitioner was not able to provide documented proof to CGS that it met the initial reserve operating funds requirement within 30 days of CGS's request for such proof.

Petitioner does not dispute the facts as recited above and Petitioner has not provided any evidence showing that it provided proof that it met the initial reserve operating funds requirement within 30 days of CGS's June 7, 2012 request. Petitioner's proof of a $40,000 line of credit did not prove it was sufficiently capitalized. 42 C.F.R. § 489.28(d), (e), (f). Petitioner did not provide a bank statement or an attestation that at least 50% of Petitioner's initial reserve operating funds were non-borrowed funds by July 7, 2012. *Id.* § 489.28(d). Petitioner may have met the initial reserve operating funds requirement on August 10, 2012. P. Exs. 1-3. However, this documentation was not timely submitted and does not show that Petitioner met the initial reserve operating fund requirement by July 7, 2012. Therefore, Petitioner did not provide sufficient proof to satisfy the initial reserve operating funds requirement within 30 days. *Id.* § 424.530(a)(8).

CMS may deny enrollment to an HHA that does not provide proof that it meets the initial reserve funds requirement within the 30-day time period. *Id.* § 424.530(a)(8); *see also id.* § 489.28(g)(1). I must sustain CMS's denial determination if a legal basis exists for that determination. *See Letantia Bussell*, DAB No. 2196, at 10, 13 (2008). Based on the evidence of record, I conclude that CMS has established a legal basis for its determination because Petitioner failed to submit the documented proof requested by a CMS contractor within 30 days.[4] 42 C.F.R. § 424.530(a)(8).

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[3] The only document that might be from the relevant period, dated June 30, 2012, does not support Petitioner's assertion concerning the funds in Petitioner's bank account. RFH, Supporting Documents at 15.

[4] A CGS employee apparently advised Petitioner to submit a corrective action plan (CAP) by August 10, 2012. P. Br. at 1. This is consistent with the denial notice CGS issued on July 11, 2012, and with the fact that Petitioner appears to have submitted proof of corrective action by August 10, 2012. P. Exs. 1-3; RFH, Supporting Documents at 9. In fact, Petitioner expressly refers to her request for reconsideration (P. Ex. 1) as a CAP and that she filed evidence of her corrective action (P. Ex. 3). P. Br. at 1. However, it is

III. Conclusion

CMS provided evidence, which is undisputed, that Petitioner did not timely submit sufficient documentation relating to its initial reserve operating funds. I conclude based on the evidence of record that CMS had a legal basis to deny Petitioner's enrollment under 42 C.F.R. § 424.530(a)(8). Therefore, CMS's denial of Petitioner's enrollment in the Medicare program is affirmed.

/s/
Scott Anderson
Administrative Law Judge

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understandable why CMS interpreted Petitioner's August 10, 2012 submission as a request for reconsideration because Petitioner asks for reconsideration in the first sentence of its letter. P. Ex. 1. My jurisdiction in this case is limited to reviewing CMS's determination on reconsideration to deny Petitioner's enrollment application. *See* 42 C.F.R. §§ 405.809, 498.3(b)(17) 498.5(l). However, in the interest of justice, CMS should review Petitioner's August 10, 2012 submission to determine whether Petitioner's pro se reconsideration request should have been construed as a timely filed CAP.