Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Todd G. Anderson, O.D., PLLC
(PTAN: R153390),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-17-652

Decision No. CR4990

Date: December 14, 2017

DECISION

Noridian Healthcare Solutions, Inc. (Noridian), an administrative contractor for the Centers for Medicare & Medicaid Services (CMS), reactivated the Medicare billing privileges of Todd G. Anderson, O.D., PLLC (Petitioner or Dr. Anderson) effective November 1, 2016. Petitioner requested a hearing before an administrative law judge to dispute this effective date. Because Noridian approved Petitioner's revalidation enrollment application that it received on November 1, 2016, it correctly determined that the effective date for Petitioner's reactivated billing privileges is November 1, 2016. Therefore, I affirm the effective date determination.

I. Background

By letter dated May 12, 2016, Noridian informed Dr. Anderson that he must revalidate his Medicare enrollment by July 31, 2016. CMS Exhibit (Ex.) 1. In response, Dr. Anderson submitted an online application to revalidate his enrollment information via the

Provider Enrollment, Chain and Ownership System (PECOS).[1] On August 4, August 26, and August 31, 2016, Noridian emailed Dr. Anderson to request that he provide additional information in support of the application. CMS Ex. 2 at 1-6. Dr. Anderson represents that he was unable to upload the requested information to PECOS. Petitioner's Brief (P. Br.) at 1.[2] Dr. Anderson further represents that Noridian employees assured him that the deadline to revalidate would be extended. *Id.* Nevertheless, Noridian rejected Dr. Anderson's revalidation application because Noridian did not receive the requested information. CMS Ex. 2 at 7, 10. Further, in a letter emailed to Dr. Anderson on September 15, 2016, Noridian informed him that it had stopped his billing privileges as of that date because he had failed to complete the revalidation process. CMS Ex. 2 at 8-9.

Dr. Anderson submitted a second online application to revalidate his Medicare enrollment, which Noridian received on September 16, 2016. *See* CMS Ex. 3 at 3. In an email dated September 30, 2016, Noridian asked Dr. Anderson to submit additional information. CMS Ex. 3 at 1. By email on October 31, 2016, Noridian informed Dr. Anderson that it was rejecting the September application because Noridian did not receive the information within 30 days. CMS Ex. 3 at 3.

Dr. Anderson submitted a third revalidation application that Noridian received on November 1, 2016. Noridian approved the application and reactivated Dr. Anderson's Medicare enrollment and billing privileges effective November 1, 2016. CMS Ex. 4. The effect of this determination was to leave a gap in Dr. Anderson's billing privileges from September 15, 2016 through October 31, 2016.

Dr. Anderson timely requested reconsideration of the effective date and Noridian issued a reconsidered determination dated March 13, 2017. CMS Ex. 6. The reconsidered determination concluded that "[t]he gap in coverage cannot be removed due to the provider not revalidating on time." CMS Ex. 6 at 2.

Petitioner requested a hearing before an administrative law judge and the case was assigned to me. I issued an Acknowledgement and Pre-Hearing Order, dated May 11, 2017 (Pre-Hearing Order), that required each party to file a pre-hearing exchange

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[1] Neither CMS nor Dr. Anderson offered as exhibits printouts of the revalidation applications Dr. Anderson submitted via PECOS. CMS represents that Noridian received the first revalidation application on July 21, 2016, the second application on September 16, 2016, and the third application on November 1, 2016. CMS Brief (Br.) at 4-5. Because it does not appear that Dr. Anderson disputes the dates on which Noridian (or PECOS) received the applications, I accept these dates as the dates of receipt. P. Br.

[2] I refer to Petitioner's letter to me, dated June 26, 2017, and uploaded to the DAB E-File System on June 27, 2017 (item 6 in the E-File for this case) as Petitioner's Brief.

consisting of a brief and any supporting documents. Pre-Hearing Order ¶ 4. CMS filed its brief (CMS Br.), which incorporated a motion for summary judgment, and six proposed exhibits (CMS Exs. 1-6). Petitioner filed a letter in which he presented his arguments. P. Br. Petitioner did not offer any proposed exhibits; nor did he object to the exhibits offered by CMS. Therefore, in the absence of objection, I admit CMS Exs. 1-6. Neither party offered the written direct testimony of any witness as part of its pre-hearing exchange. As stated in my May 11, 2017 Pre-Hearing Order, "[a]n in-person hearing to cross-examine witnesses will be necessary only if a party files admissible, written direct testimony, and the opposing party asks to cross-examine." Pre-Hearing Order ¶ 10. Therefore, an in-person hearing is not necessary and I decide this case based on the parties' written submissions, without regard to whether the standards for summary judgment are satisfied.

II. Issue

The issue in this case is whether Noridian, acting on behalf of CMS, properly established November 1, 2016, as the effective date of reactivation of Petitioner's Medicare enrollment and billing privileges.

III. Jurisdiction

I have jurisdiction to decide this case. 42 C.F.R. §§ 498.3(b)(15), 498.5(*l*)(2); *see also* 42 U.S.C. § 1395cc(j)(8).

IV. Discussion

A. Applicable Legal Authority

The Social Security Act (Act) authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations governing the enrollment process for providers and suppliers. 42 U.S.C. §§ 1302, 1395cc(j). A "supplier" is "a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services" under the Medicare provisions of the Act. 42 U.S.C. § 1395x(d); *see also* 42 U.S.C. § 1395x(u).

A supplier must enroll in the Medicare program to receive payment for covered Medicare items or services. 42 C.F.R. § 424.505. The regulations define "*Enroll/Enrollment*" as "the process that Medicare uses to establish eligibility to submit claims for Medicare-covered items and services." 42 C.F.R. § 424.502. A provider or supplier seeking billing privileges under the Medicare program must "submit enrollment information on the applicable enrollment application. Once the provider or supplier successfully completes the enrollment process . . . CMS enrolls the provider or supplier into the Medicare program." 42 C.F.R. § 424.510(a). CMS then establishes an effective date for billing

privileges under the requirements stated in 42 C.F.R. § 424.520(d) and may permit limited retrospective billing under 42 C.F.R. § 424.521.

To maintain Medicare billing privileges, providers and suppliers must revalidate their enrollment information at least every five years. 42 C.F.R. § 424.515. However, CMS reserves the right to perform revalidations at any time. 42 C.F.R. § 424.515(d), (e). When CMS notifies providers and suppliers that it is time to revalidate, the providers or suppliers must submit the appropriate enrollment application, accurate information, and supporting documentation within 60 calendar days of CMS's notification. 42 C.F.R. § 424.515(a)(2). CMS can deactivate an enrolled provider's or supplier's Medicare billing privileges if the enrollee fails to comply with revalidation requirements. 42 C.F.R. § 424.540(a)(3). When CMS deactivates providers' or suppliers' Medicare billing privileges "[n]o payment may be made for otherwise Medicare covered items or services furnished to a Medicare beneficiary." 42 C.F.R. § 424.555(b). If CMS deactivates a provider's or supplier's billing privileges due to an untimely response to a revalidation request, the enrolled provider or supplier may apply for CMS to reactivate its Medicare billing privileges by completing a new enrollment application or, if deemed appropriate, recertifying its enrollment information that is on file. 42 C.F.R. § 424.540(b)(1).

B. Findings of Fact and Conclusions of Law[3]

1. Noridian received Dr. Anderson's application to revalidate his Medicare billing privileges on November 1, 2016, and approved that application.

2. The effective date of reactivation for Dr. Anderson's Medicare billing privileges is November 1, 2016.

The effective date for Medicare billing privileges for physicians, non-physician practitioners, and physician or non-physician practitioner organizations is the later of the "date of filing" or the date the supplier first began furnishing services at a new practice location. 42 C.F.R. § 424.520(d). The "date of filing" is the date that the Medicare contractor "receives" a signed enrollment application that the Medicare contractor is able to process to approval. 73 Fed. Reg. 69,726, 69,769 (Nov. 19, 2008); *Donald Dolce, M.D.*, DAB No. 2685 at 8 (2016).

CMS represents, and Dr. Anderson does not dispute, that Noridian received a revalidation application from Dr. Anderson on November 1, 2016. *See* CMS Ex. 4 at 1. Noridian approved that application. *Id*. Accordingly, as required by regulation, the effective date of reactivation of Dr. Anderson's Medicare enrollment is November 1, 2016.

[3] My findings of fact and conclusions of law appear as numbered headings in bold italic type.

3. I have no authority to review the deactivation of Dr. Anderson's Medicare billing privileges on September 15, 2016, or the rejection of his prior revalidation applications in September and October 2016.

Dr. Anderson represents that Noridian employees assured him that he would be given additional time to submit the information required to revalidate his Medicare enrollment. P. Br. at 1. Even though Dr. Anderson did not submit his statement in the form of an affidavit or declaration,[4] I find the statement credible. Nevertheless, the fact that Dr. Anderson may have received assurances that he would have additional time to submit his revalidation application before Noridian deactivated his billing privileges does not change the outcome in this case. That is because whatever assurances Dr. Anderson may have received are only relevant, if at all, to whether Noridian acted properly in deactivating Dr. Anderson's billing privileges. I do not have jurisdiction to review CMS's deactivation of Petitioner's Medicare billing privileges because deactivation is not an "initial determination" and deactivation decisions have a separate review process. *See* 42 C.F.R. §§ 424.545(b), 498.3(b); *see also Willie Goffney, Jr., M.D.*, DAB No. 2763 at 4-5 (2017).

Moreover, to the extent Dr. Anderson contends that Noridian should have continued to work with him so that he could complete (and Noridian could approve) the revalidation application he submitted prior to the revalidation deadline in July 2016, this amounts to an argument that Noridian should not have rejected the application. As is true for review of deactivations, administrative law judges are not authorized to review a contractor's decision to reject an enrollment application. 42 C.F.R. § 424.525(d); *see also James Shepard, M.D.*, DAB No. 2793 at 3 (2017). Therefore, even if Noridian should not have rejected Dr. Anderson's July (or September) revalidation application, this would not be a basis to grant him an earlier effective date. As an appellate panel of the Departmental Appeals Board (DAB) observed in *Shepard*, the supplier's argument that the Medicare contractor did not provide sufficient information for him to submit an approvable application "is an implicit request that we assess the reasonableness or legality of [the contractor's] decision to reject the . . . application. However, section 424.525(d) plainly prohibits [administrative law judge] or Board review of that decision . . . ." DAB No. 2793 at 8. As was the case in *Shepard*, Dr. Anderson's arguments in the present case amount to a backdoor challenge to the contractor's rejection of his revalidation applications and deactivation of his billing privileges—determinations for which there are no administrative appeal rights. *Id.*

[4] My Pre-Hearing Order required the parties to submit the testimony of any proposed witness in writing, in the form of an affidavit made under oath or a declaration signed under penalty of perjury. Pre-Hearing Order ¶ 8.

4. Dr. Anderson's arguments in equity are not a basis to change the effective date of his Medicare enrollment and billing privileges.

Finally, Petitioner's argument that CMS should be bound by the statements made by its representatives (P. Br. at 1) appears to raise a claim of equitable estoppel. However, many DAB decisions have held that neither administrative law judges nor appellate panels have authority to overturn a legally valid agency action on equitable grounds or otherwise grant equitable relief. *See, e.g.*, *Richard Weinberger, M.D. and Barbara Vizy, M.D.*, DAB No. 2823 at 18 (2017) (and cases there cited). Further, even if I could adjust Dr. Anderson's effective date of reactivation based on equitable grounds, I would not find a basis to invoke estoppel here. The appellate panel in *Weinberger* endorsed the view that equitable estoppel does not lie against the government absent proof of affirmative misconduct. *Id.* at 19. In the present case, as in *Weinberger*, the communications with Noridian that Dr. Anderson describes suggest "misunderstandings, miscommunications, or confusion" rather than affirmative misconduct. *Id.*

V. Conclusion

For the reasons explained above, I affirm CMS's determination that the effective date of Dr. Anderson's Medicare enrollment and billing privileges is November 1, 2016.

/s/
Leslie A. Weyn
Administrative Law Judge