Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Arkansas Health Group d/b/a Baptist Health Family Clinic Lakewood
Docket No. A-18-58
Decision No. 2929
February 14, 2019

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Petitioner Arkansas Health Group (d/b/a Baptist Health Family Clinic Lakewood) appeals the February 16, 2018 decision of an administrative law judge (ALJ). *Arkansas Health Group d/b/a Baptist Health Family Clinic Lakewood*, DAB CR5028 (2018) (ALJ Decision). The ALJ upheld on summary judgment a Centers for Medicare & Medicaid Services (CMS) Medicare Administrative Contractor's reconsidered determination, which assigned an effective date of May 22, 2017 for the reactivation of Petitioner's billing privileges. The Board affirms the ALJ Decision.

Legal authorities

A provider or supplier seeking billing privileges in the Medicare program must submit enrollment information to the appropriate CMS contractor on the applicable enrollment application for review. Upon successful completion of that process, CMS enrolls the provider or supplier. The regulations governing Medicare enrollment are found in 42 C.F.R. Part 424, subpart P. Enrollment is the process that CMS and its contractors use to identify the prospective provider or supplier, validate the provider's or supplier's eligibility to provide items or services to Medicare beneficiaries, identify and confirm a provider's or supplier's owner(s) and practice location(s), and grant Medicare billing privileges. *See* 42 C.F.R. § 424.502 (defining "Enroll/Enrollment").

The effective date of Medicare enrollment privileges for physicians, non-physician practitioners, physician and non-physician practitioner organizations, and ambulance suppliers is the later of:

> the date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor, or
>
> the date that the supplier first began furnishing services at a new practice location.

42 C.F.R. § 424.520(d); 79 Fed. Reg. 72,500, 72,531 (Dec. 5, 2014) (eff. Feb. 3, 2015). In the preamble to the final rule, CMS stated that the "date of filing" means "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); *accord Alexander C. Gatzimos, MD, JD, LLC d/b/a Michiana Adult Medical Specialists*, DAB No. 2730, at 5 (2016).

A supplier whose enrollment application has been approved "may retrospectively bill for services" when the supplier "has met all program requirements" and "services were provided at the enrolled practice location for up to" "[t]hirty days prior to [the] effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries." 42 C.F.R. § 424.521(a)(1); *see also* 79 Fed. Reg. at 72,531. A determination of the effective date of enrollment is an initial determination subject to appeal under 42 C.F.R. Part 498. 42 C.F.R. § 498.3(a)(1), (b)(15); *Victor Alvarez, M.D.*, DAB No. 2325 (2010).

"Deactivate" means that "the provider or supplier's billing privileges were stopped, but can be restored upon the submission of updated information." 42 C.F.R. § 424.502. Deactivation is considered an action to protect the provider or supplier from misuse of its billing number and to protect the Medicare Trust Funds from unnecessary overpayments. It has no effect on a provider's or supplier's participation agreement or any conditions of participation. *Id.* § 424.540(c). CMS may deactivate billing privileges if an enrolled provider or supplier does not furnish complete and accurate information and all supporting documentation within 90 calendar days of receipt of notification from CMS (or its contractor) to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information. *Id.* § 424.540(a)(3); 77 Fed. Reg. 29,002, 29,030 (May 16, 2012) (eff. July 16, 2012). If deactivated, a provider or supplier may reactivate billing privileges by meeting certain regulatory and CMS policy benchmarks. In order to reactivate billing privileges, the provider or supplier may be required to complete and submit a new enrollment application; or when deemed appropriate, the provider or supplier must, at a minimum, recertify that the enrollment information currently on file with Medicare is correct. 42 C.F.R. § 424.540(b)(1).

The deactivation of billing privileges is distinguishable from denial of enrollment of a prospective provider or supplier or revocation of billing privileges of an enrolled provider or supplier in important ways. Denial of enrollment and revocation of billing privileges may be appealed under Part 498, whereas deactivation may not be appealed. A deactivated provider or supplier "may file a rebuttal in accordance with § 405.374," which is "any statement (to include any pertinent information) as to why [the deactivation] should not be put into effect on the date specified in the notice," with the

contractor, generally within 15 days or less. 42 C.F.R. §§ 424.545(b), 405.374(a). Also, revocation terminates a provider agreement and requires the imposition of a re-enrollment bar of at least one year, neither of which occurs with deactivation. *Compare* 42 C.F.R. § 424.535(a), (b), (c) *with* § 424.540(c); *see also Willie Goffney, Jr., M.D.*, DAB No. 2763, at 3 (2017) (explaining the differences between deactivation and denial of enrollment or revocation), *reopening denied*, DAB Ruling 2017-5 (Sept. 15, 2017), *appeal docketed*, No. 2:17-cv-08032-MRW (C.D. Cal. Nov. 3, 2017).

Case background[1]

Petitioner represents that, on December 16, 2016, it received a letter from Novitas Solutions, Inc. (Novitas), a CMS Medicare Administrative Contractor, asking Petitioner to submit an application to revalidate its enrollment and billing privileges. CMS Ex. 11, at 4. In response Petitioner filed Form CMS 855B (enrollment form for "Clinics/Group Practices and Certain Other Suppliers"). CMS Ex. 2.

By letter dated February 23, 2017, Novitas asked Petitioner to submit additional information ("identification information" under section 6A and "authorized official signature" under section 15B of Form CMS 855B) in support of revalidation. CMS Ex. 3, at 1. The letter also stated, "Please complete a newly-signed and dated Section 15B Certification Statement. The new certification statement must be separate and distinct from the previous certification statement submitted. Multiple signatures and/or dates are not permitted." *Id.* at 2. Novitas informed Petitioner that if Petitioner does not respond with complete information "within **30 calendar days** from the postmarked date" of its letter, it "may reject" the application. *Id.* at 1 (Novitas's emphasis).

On May 2, 2017, Novitas wrote Petitioner, informing it that its billing privileges were deactivated because it did not "revalidate[]" its enrollment record and did not respond to the February 23, 2017 information request. CMS Ex. 4. Novitas specified that it "**stopped**" Petitioner's billing privileges on "05/02/2017." *Id.* at 1 (Novitas's emphasis).

On or around May 17, 2017, Petitioner submitted what appears to be a portion of Form CMS 855B intended to be responsive to Novitas's request for additional information. CMS Ex. 6. By letter dated June 1, 2017, Novitas acknowledged receipt of the submittal on May 22, 2017, but wrote:

[1] The background information is drawn from the ALJ Decision and the record before the ALJ and is not intended to substitute for his findings.

> We are withdrawing your application because our records indicate your file has been deactivated for non-response to revalidation and we are unable to process your request.
>
> Your Medicare file is due for revalidation
>
> In order to reestablish Medicare billing privileges, you must submit a new, fully completed Medicare CMS-855 enrollment application and annotate "Revalidation" in Section 1. We recommend you take action immediately because while you will maintain your original Provider Transaction Access Number (PTAN), an interruption in billing will occur during the period of deactivation resulting in a gap in coverage. After a period of deactivation, the reactivation date is the receipt date of the new, fully completed application. We cannot grant retroactive billing privileges. Services provided to Medicare patients during the period between deactivation and reactivation are the provider's liability.

CMS Ex. 7, at 1. Petitioner then submitted a new application on June 12, 2017, based on which Novitas issued an initial determination reinstating Petitioner effective that date. ALJ Decision at 4 n.1 (citing CMS Ex. 11, at 4).

After further exchanges between Petitioner and Novitas, Petitioner filed a request for reconsideration. On October 23, 2017, Novitas issued a reconsidered determination, reactivating Petitioner's billing privileges effective May 22, 2017, and informing Petitioner of the resulting "gap in coverage" [from] May 2, 2017 through May 21, 2017." CMS Ex. 1, at 3. Novitas added:

> The gap in coverage is applied when a provider/supplier is non-responsive to a revalidation request. The gap is between the deactivation and reactivation of billing privileges, with the reactivation effective date being based on the receipt date of the application. Therefore, the gap in coverage from May 2, 2017 through May 21, 2017 will remain due to being non-responsive to the February 23, 2017 development request.

Id. [2]

[2] Specifically, by a July 14, 2017 notice, Novitas informed Petitioner that its billing privileges were reinstated (CMS Ex. 10), but with a "gap in coverage from May 2, 2017 through June 11, 2017" (CMS Ex. 1, at 2-3). By its October 23, 2017 determination, Novitas informed Petitioner that it was "reducing the gap in coverage to May 2, 2017 through May 21, 2017." *Id.* at 3. Petitioner then requested a hearing before the ALJ on the October 23, 2017 determination that had resulted in a smaller, 19-day gap from May 2 through May 21, 2017.

ALJ proceedings and decision

Petitioner appealed the October 23, 2017 reconsidered determination, requesting a hearing before an ALJ. CMS moved for summary judgment in its favor, asserting that there was no genuine dispute of material fact because its contractor "properly determined Petitioner's gap in Medicare coverage based on the date it received a new validation application." CMS's motion for summary judgment and pre-hearing brief at 1. Petitioner filed an opposition to CMS's motion and a cross-motion for summary judgment, chiefly asserting that it did not receive Novitas's February 23, 2017 information request and Novitas (or CMS) "erroneously deactivated" its billing privileges based on a failure to respond to that request. Petitioner urged the ALJ to issue a summary judgment decision in its favor, "with a holding that there should be no gap in coverage; or, in the alternative, . . . [determine] there are undisputed facts as to receipt of notice that prohibit the grant of summary judgment in favor of CMS."[3] Petitioner's pre-hearing brief, response to CMS's motion, and motion for summary judgment at 1.

The ALJ first determined that a CMS contractor's decision to deactivate billing privileges is not an appealable determination. ALJ Decision at 2 (citing 42 C.F.R. § 498.3(b), (d)). "Consequently," the ALJ stated, "a provider or supplier whose Medicare billing privileges are deactivated may not challenge the contractor's decision to deactivate" and that he had no authority to decide that challenge. *Id.* Accordingly, the ALJ also stated, "the only question [he] may consider is whether the contractor (or, in this case, a reconsideration hearing officer) properly assigned a provider or a supplier whose billing privileges are deactivated an effective reactivation date," which is governed by 42 C.F.R. § 424.520(d). *Id.* at 3 (citing *Goffney*, DAB No. 2763).

The ALJ reasoned that the "*earliest possible* effective reactivation date" that could be assigned was the date on which Petitioner filed a new enrollment application with the contractor that the contractor subsequently approved. *Id.* (ALJ's emphasis). The ALJ stated that "[t]he contractor has no authority to assign a retroactive reactivation date"

[3] Both parties submitted exhibits. The ALJ determined that it was unnecessary to rule on the admissibility of exhibits because he was deciding this case on summary judgment based on undisputed material facts and the governing regulations. ALJ Decision at 1-2. The ALJ also stated that he would cite to "some" of the exhibits "only for the purpose of illustrating those facts that are undisputed." *Id.* at 2. An ALJ need not rule on admission of exhibits to resolve a motion for summary judgment, but, in that situation, the exhibits are "properly treated as an offer of proof, that may be evaluated if necessary to determine whether a genuine issue of material fact exists." *Illinois Knights Templar Home*, DAB No. 2274, at 6-7 (2009) (citation omitted). Although the ALJ's language is less than clear (and neither Petitioner nor CMS raises an issue about this aspect of the ALJ Decision), we will presume that the ALJ followed the long-standing requirement to consider all of the proffered exhibits, viewing them in the light most favorable to Petitioner in deciding to grant summary judgment for CMS. In any case, we review the ALJ's summary judgment decision de novo and have ourselves fully considered every exhibit.

where billing privileges were deactivated on a date before the date of submittal of a new enrollment application to reactivate billing privileges. *Id.* Moreover, the ALJ also stated, he was without authority "to order a contractor to assign a retroactive reactivation date." *Id.*

The ALJ wrote:

> The undisputed facts of this case are that on December 12, 2016, the contractor sent Petitioner a letter requesting that it revalidate its Medicare enrollment information. CMS Ex. 11 at 4. On January 3, 2017, Petitioner filed an application for revalidation of its billing privileges. CMS Ex. 2. The contractor concluded that the application lacked necessary information and, so, it sent a request to Petitioner on February 23, 2017, seeking additional information from it. CMS Ex. 3. Petitioner did not reply to the request. On May 2, 2017, the contractor deactivated Petitioner's billing privileges. CMS Ex. 4. Petitioner filed an application for reactivation of its billing privileges on May 22, 2017. CMS Ex. 6 at 26. That contractor initially determined that this application was ineffective; however, on reconsideration the application was accepted and Petitioner received a reactivation date of May 22, 2017, based on that application. As a consequence of these actions Petitioner's billing privileges were deactivated for a period that ran from May 2 through May 21, 2017, and Petitioner may not receive reimbursement from Medicare for otherwise covered items or services that it provided on those dates.
>
> May 22, 2017, is the *earliest* date on which Petitioner's billing privileges may be reactivated because that is the date on which the contractor received Petitioner's application for reenrollment that the reconsideration hearing officer subsequently directed be approved. Neither the contractor nor I may assign Petitioner a reactivation date that is retroactive to May 2, 2017, the date of deactivation of its billing privileges.

Id. at 3-4 (footnote omitted, ALJ's emphasis).

On Petitioner's argument that it was not at fault for failing to respond to the contractor's February 23, 2017 information request because it did not receive that request until after the deactivation, the ALJ stated that he had "no authority to hear and decide" that argument because "it effectively consists of a challenge to the contractor's decision to deactivate Petitioner's Medicare billing privileges." *Id.* at 4 (also noting that "a decision to deactivate is non-appealable").

The ALJ further determined that the facts concerning the question of whether Petitioner received the February 23, 2017 information request (which Petitioner asserted were material and disputed) were "not material inasmuch as they pertain to a question that [he had] no authority to hear or decide – the contractor's decision to deactivate Petitioner's participation." *Id.* The ALJ also stated that Petitioner's additional argument that the information Novitas requested by its February 23, 2017 letter is non-consequential and that Petitioner should not be penalized for not submitting information that is not material to its qualifications to participate in Medicare is a challenge to the decision to deactivate, too, which he had no authority to hear and decide. *Id.* at 4-5. Lastly, the ALJ noted that Petitioner's argument, which, in essence, was that it was being unfairly penalized for not responding to an information request that it never received, had an "equitable aspect" to it and stated that he could not hear and decide equitable challenges. *Id.* at 5 (citing *US Ultrasound*, DAB No. 2302, at 8 (2010)).

Standard of review

Whether summary judgment is appropriate is a legal issue that we address *de novo*. *1866ICPayday.com*, DAB No. 2289, at 2 (2009) (citing *Lebanon Nursing & Rehab. Ctr.*, DAB No. 1918 (2004)). Summary judgment is appropriate when the record shows that there is no genuine dispute of fact material to the result. *Id.* (citing *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986)).

The Board's standard of review on a disputed conclusion of law is whether the ALJ's decision is erroneous. *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program* (*Guidelines*), accessible at https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/enrollment/index.html.

Analysis

A. A decision to deactivate billing privileges is not appealable and is not reviewable; the issue on appeal is the date of reactivation of billing privileges.

Petitioner challenges the ALJ's determination that deactivation of billing privileges is not appealable. Citing 42 C.F.R. § 498.1(g), Petitioner asserts that deactivation is "appealable under 42 C.F.R. § 424.540(a)(3)" because it is an appealable initial determination consistent with sections 498.3(b)(5), 498.3(b)(6), and 498.3(b)(15) and is not otherwise among section 498.3(d)'s list of initial determinations that are not appealable under Part 498. Brief in support of request for review (RR) at 3. According to Petitioner, that section 424.545(b) permits a deactivated supplier to submit a "rebuttal"

indicates that deactivation is indeed an appealable determination. *Id.* Petitioner maintains, nevertheless, that the filing of such a "rebuttal" is not the "only recourse" a deactivated supplier has inasmuch as "the appeal relates to the request for restoration date that takes into account the circumstances of [the] case and permits retrospective billing." *Id.* (citing 42 C.F.R. § 424.521(a)).

Petitioner incorrectly invokes authorities concerning enrollment and revocation in service of its argument that deactivation is an appealable initial determination. Section 498.1(g), which Petitioner cites and which refers to section 1866(j) of the Social Security Act (Act) (headed "Enrollment process for providers of services and suppliers"),[4] does not provide that a determination to deactivate is an appealable determination under Part 498. Section 498.1(g) states that section 1866(j) of the Act "provides for a hearing and judicial review for any provider or supplier whose application for enrollment or reenrollment in Medicare is denied or whose billing privileges are revoked." In accordance with section 1866(j)(8), a provider or supplier "whose application to enroll (or, if applicable, to renew enrollment) . . . is denied" has hearing rights. Although section 1866(j) does not specifically refer to the hearing rights of providers and suppliers whose billing privileges have been revoked, CMS has interpreted the statute as providing hearing rights in revocation cases as in cases of denial of enrollment (or re-enrollment). 42 C.F.R. §§ 498.1(g), 498.3(b)(17); *Conchita Jackson, M.D.*, DAB No. 2495, at 2 (2013) (citing authorities). Nothing in these provisions extends hearing rights to those whose billing privileges have been deactivated but not revoked.

Moreover, the appealable initial determinations in section 498.3(b) to which Petitioner refers do not pertain to deactivation either. Section 498.3(b)(5) addresses whether a "prospective supplier" meets the conditions for coverage. *See* 42 C.F.R. § 498.2 (defining "prospective supplier" as any entity identified as a supplier in section 498.2 and which "seeks to be approved for coverage of its services under Medicare"). Only an existing, enrolled supplier, not a prospective supplier, could be subject to deactivation, so plainly that section is inapplicable here. Section 498.3(b)(6) provides that an initial determination of "[w]hether the services of a supplier continue to meet the conditions for coverage" is an appealable initial determination. No determination was made that Petitioner failed to meet the conditions for coverage and its provider agreement remained in effect. Section 498.3(b)(15) provides that an initial determination on "[t]he effective date of a Medicare provider agreement or supplier approval" (meaning enrollment or re-enrollment) is appealable. It is only under this provision that Petitioner may proceed and this provision speaks only to the effective date of approval, not the propriety of any prior deactivation.

[4] The current version of the Act can be found at http://www.socialsecurity.gov/OP_Home/ssact/ssact-toc.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Cross-reference tables for the Act and the United States Code can be found at http://uscode.house.gov/table3/1935_531.htm and https://www.ssa.gov/OP_Home/comp2/G-APP-H.html.

In short, as set out in the "Legal authorities" section above, the deactivation of billing privileges is different from denial of enrollment or revocation of billing privileges in a number of ways. As a result, and as the Board has repeatedly held, the decision to deactivate, unlike denial of enrollment or revocation, is not appealable. *See, e.g., Urology Group of NJ, LLC*, DAB No. 2860, at 6 (2018); *Frederick Brodeur, M.D.*, DAB No. 2857, at 12 (2018); *Richard Weinberger, M.D., and Barbara Vizy, M.D.*, DAB No. 2823, at 15 (2017); *Decatur Health Imaging, LLC*, DAB No. 2805, at 10 (2017); *Goffney* at 5. Petitioner correctly states that a deactivated supplier has an opportunity to submit a "rebuttal" (RR at 3 (citing 42 C.F.R. § 424.545(b))) in accordance with 42 C.F.R. §§ 424.545(b) and 405.374. However, a "rebuttal" to deactivation "is not itself an appeal." *Urology Group* at 6; *Goffney* at 5.

The only appealable issue where, as here, billing privileges were deactivated and then reactivated, is the effective date of reactivated billing privileges in accordance with section 424.520(d).[5] Our authority in this appeal is limited to reviewing the effective date of reactivation of billing privileges, which is May 22, 2017. *See Urology Group* at 6; *Goffney* at 5.

B. The effective date of reactivation of billing privileges was correctly assigned; we reject Petitioner's remaining arguments.

As set out above, in early 2017, Petitioner submitted a revalidation application. Novitas determined that it could not revalidate Petitioner's billing privileges based on the contents of that application and, by letter dated February 23, 2017, asked Petitioner to submit additional information. Receiving no response to that request, Novitas informed Petitioner by a May 2, 2017 notice that its billing privileges were deactivated, but eventually determined that Petitioner had met revalidation requirements as of May 22, 2017. A gap in billing privileges resulted from May 2, 2017, the date of deactivation, through May 21, 2017, the day before the effective date of reactivation.

[5] For purposes of sections 424.520(d) and 424.521(a), an application to revalidate billing privileges is treated as an initial enrollment application, which effectively means that a reactivated supplier will have a new effective date that is the later of the date of filing of the application or the date on which it first began providing services at a new practice location (if there were a change). *Arkady B. Stern, M.D.*, DAB No. 2329, at 4 n.5 (2010).

Petitioner asserts that there should have been no interruption in billing privileges because the only reason for deactivating on May 2, 2017, was the failure to respond to the February 23, 2017 information request. However, Petitioner represents, it did not receive that request until *after* the deactivation and therefore had no notice that its application, as submitted, was incomplete or insufficient for revalidation.[6] Petitioner maintains that it fully complied with revalidation requirements once informed that the contractor needed additional information. RR at 4-5.

Petitioner further asserts that Novitas not only failed to show that Petitioner received the February 23, 2017 information request, Novitas failed to comply with section 424.540(a)(3), which permits deactivation if the supplier does not furnish complete and accurate information and all supporting documentation "within 90 days of receipt of notification," because it deactivated Petitioner's billing privileges on May 2, 2017, only 68 days after February 23, 2017. *Id.* at 4. Petitioner also takes issue with deactivation for omitting information that it says was not material, but rather a mere failure to check a box for "Director/Officer" in the application. *Id.* Petitioner says that an "obviously active supplier" like Petitioner (*id.* at 5) that otherwise has met all program requirements and was continuously providing services that would be subject to coverage and payment (*id.* at 1-2) should not be deactivated for something as minor as "one missing checkmark" without "a second notice in some form" before deactivation. *Id.* at 5; Reply Br. at 2 (similar argument). Petitioner asks the Board to restore its billing privileges "with no gap," or permit retrospective billing for 30 days before May 22, 2017 (which would effectively eliminate the gap). RR at 5; *id.* at 1 and Reply Br. at 2 (invoking the retrospective billing provisions of section 424.521(a)).

To the extent Petitioner's reliance on the 90-day provision in section 424.540(a)(3) may be understood as an argument that a deactivation notice issued before the 90-day period is invalid as a matter of law, the Board is aware of no law or regulation that invalidates such a deactivation. In any case, as we have stated earlier, deactivation is not itself an appealable determination and therefore the validity of any such deactivation, whether the argument on validity is based on section 424.540(a)(3) or on the reason for deactivation (here, allegedly for omitting minor information), is not properly before us.

The dispositive question, as the ALJ correctly stated, is whether Novitas correctly assigned an effective date of reactivation. ALJ Decision at 3. That question turns on section 424.520(d). *Urology Group* at 7 (citing *Goffney* at 7 and *Arkady B. Stern, M.D.*, DAB No. 2329, at 4 (2010), and stating that "the policy of CMS to apply the regulation

[6] Petitioner maintains that it did not receive the February 23, 2017 information request until after it learned that its billing privileges had been deactivated, as communicated to Petitioner by the May 2, 2017 deactivation notice. Upon learning about the deactivation, an individual acting for Petitioner immediately contacted Novitas, which then sent Petitioner a copy of the February 23, 2017 request by fax. *E.g.*, P. Ex. 3.

found at 42 C.F.R. 424.520(d) to determine the effective date for the reactivation of Medicare billing privileges is proper"). As applied here, the effective date of reactivated billing privileges is the date of filing of the enrollment application that Novitas approved. It is undisputed that Novitas decided to approve Petitioner's May 22, 2017 submittal, together with the information previously submitted, as sufficient for revalidation effective that day. There is no evidence in the record of any such complete revalidation application that Novitas approved for revalidation between January 2017 and May 22, 2017. Because the undisputed evidence supports a finding that May 22, 2017 is the effective date of reactivated billing privileges, any factual disputes about whether Novitas in fact sent the February 23, 2017 information request and whether Petitioner received it and if so when (RR at 4) are, ultimately, immaterial here as they cannot have any effect on the outcome on the effective date.

Before the Board, Petitioner attempts to invoke the 30-day retrospective billing provision in section 424.521(a)(1), seeking to eliminate the gap in billing privileges from May 2 to May 21, 2017. However, we see no evidence that Petitioner invoked this specific regulation at the contractor level as it could have done when it had an opportunity to submit a rebuttal. As we have said, although deactivation itself is not appealable, a deactivated supplier is not without recourse. As Petitioner recognizes, a deactivated supplier may submit a "rebuttal" in accordance with section 405.374, generally within 15 days or less. 42 C.F.R. §§ 424.545(b), 405.374(a). We do not find any evidence that Petitioner availed itself of the opportunity to submit such a rebuttal within the permitted time period, asking Novitas to apply the section 424.521(a)(1) retrospective billing provision here. In any case, even before issuing the October 23, 2017 reconsidered determination that was appealed to the ALJ, in its June 1, 2017 letter acknowledging receipt of Petitioner's submittal on May 22, 2017, Novitas clearly informed Petitioner that it "cannot grant retroactive billing privileges." CMS Ex. 7, at 1.

On appeal before the ALJ, Petitioner merely cited section 424.521(a) in its request for hearing (at 2) without arguing why the regulation would apply under the circumstances of this case.[7] It did not specifically take issue with Novitas's June 1, 2017 statement that it "cannot grant retroactive billing privileges." Before the Board, Petitioner again cites the regulation (RR at 1), but, as with its request for hearing, its brief to the Board does not explain how section 424.521(a)(1), which provides that a supplier whose enrollment application has been approved may be permitted to "retrospectively bill for services" when the supplier "has met all program requirements" and "services were provided at the enrolled practice location for up to" "[t]hirty days prior to [the] effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries," has bearing here.

[7] Petitioner did not address section 424.521(a)(1) at all in its brief to the ALJ. It merely cited section 424.521(a) in its hearing request without argument as to its applicability here.

In any case, Petitioner does not squarely address the basic problem presented by its invoking section 424.521(a)(1) to eliminate the 19-day interruption in billing privileges, asserting instead that under the circumstances presented the regulation "should" be applied. Reply Br. at 2 (arguing that "reactivation should be set to the date of deactivation" by applying the 30-day retrospective billing provision because such an action would be "appropriate" where, as here, the contractor sent only one notice that was "lost in the mail" and where the application as submitted was "substantially and materially complete"). Such an application of the provision here would effectively undo the deactivation of billing privileges, a determination that is for CMS (or its contractor) to make and which is not appealable to the ALJ and the Board, and run counter to section 424.555(b), which provides that "[n]o payment may be made for otherwise Medicare covered items or services furnished to a Medicare beneficiary" when that supplier's billing privileges have been deactivated. Where, as here, the contractor deactivated Petitioner's billing privileges, the issue for us (and the ALJ) is the effective date of reactivation. Here, that date was correctly assigned as May 22, 2017, in accordance with section 424.520(d).

Conclusion

We affirm the ALJ Decision upholding the CMS contractor's determination that May 22, 2017, is the effective date of reactivation of Petitioner's billing privileges.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Susan S. Yim
Presiding Board Member