Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Kamran Hamidi, M.D.,
(PTAN (Individual) – CB239543, WA85217A)
and
Sina Infectious Diseases Medical Associates, Inc.
(PIN: 1992815047 / PTAN (Group) – CB238262, CB238263, W19940),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Respondent

Docket No. C-16-186

Decision No. CR4577

Date: April 8, 2016

DECISION REMANDING AND DISMISSING CASE

This case is remanded to the Centers for Medicare & Medicaid Services (CMS) pursuant to 42 C.F.R. § 498.56(d).[1] This case is dismissed pursuant to 42 C.F.R. § 498.70(b) to permit action by CMS in accordance with current regulations. This dismissal is without prejudice to any right of Petitioner to request a hearing as to a determination by CMS on remand that triggers such a right. Either party may request in writing that I vacate, for

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[1] References are to the revision of the Code of Federal Regulations (C.F.R.) in effect at the time of the initial and reconsideration determinations, unless otherwise stated for processing of Petitioner's application for reactivation of its billing privileges in accordance with 42 C.F.R. § 424.540.

good cause, the dismissal within 60 days of the date of this Order. 42 C.F.R. § 498.72. Any other objection to this Order must be filed within ten days of the date of this Order.

I. Procedural History and Findings of Fact

Noridian Healthcare Solutions (Noridian) is a Medicare contractor. Petitioner is Kamran Hamidi, M.D., Sina Infectious Diseases Medical Associates, Inc. On July 7, 2014, Noridian sent Petitioner a letter requesting that Petitioner revalidate its Medicare enrollment information and stating that if Petitioner failed to submit a complete enrollment application and all supporting documentation within 60 days, Petitioner's Medicare billing privileges may be deactivated. CMS Exhibit (Ex.) 1 at 5-7. On February 11, 2015, Noridian notified Petitioner by letter that its Medicare billing privileges were deactivated because Petitioner failed to timely submit a complete Medicare enrollment application in response to the July 7, 2014 Noridian revalidation request. CMS Ex. 1 at 8-9. The February 11, 2015 Noridian deactivation letter states:

> The deactivation of Medicare billing privileges is considered an action to protect from the misuse of your billing number and to protect the Medicare Trust Funds from unnecessary overpayments. **This deactivation does not have any effect on your participation agreement and/or any conditions of participation.**

CMS Ex. 1 at 9 (emphasis added).

On July 2, 2015, Noridian electronically received an enrollment application from Petitioner. CMS Ex. 1 at 10-36. Noridian notified Petitioner by letter dated August 12, 2015, that Petitioner's enrollment application was approved with a period for retroactive filing of claims beginning July 2, 2015. CMS Ex. 1 at 37-39.

Petitioner requested reconsideration of Noridian's initial determination and requested that its enrollment be made retroactive to December 1, 2005. CMS Ex. 1 at 40-63. On October 22, 2015, an unsigned reconsidered determination was issued by an unidentified contractor hearing officer. The reconsidered determination stated that Petitioner's request for an earlier effective date was denied. The reconsidered determination cited Medicare Program Integrity Manual (MPIM) section 15.27.1.2 and 42 C.F.R. § 424.520 as the basis for its decision and stated that Petitioner's effective date of Medicare enrollment could be no earlier than Noridian's receipt on July 2, 2015, of Petitioner's application that could be processed to completion. CMS Ex. 1 at 1-4. The reconsidered determination reflects that the unidentified contractor hearing officer recognized that Petitioner submitted the CMS-855I application received by Noridian on July 2, 2015, not for the purpose of enrollment as it was already enrolled in Medicare and its enrollment was never revoked. Rather, the CMS-855I was submitted by Petitioner to reactivate its

billing privileges that had been deactivated by letter dated July 7, 2014. However, as explained hereafter, the reconsidered determination is based on an error of law and cannot be upheld or enforced.

Petitioner requested a hearing before an administrative law judge (ALJ) on November 30, 2015. The case was assigned to me for hearing and decision on December 28, 2015, and an Acknowledgment and Prehearing Order (Prehearing Order) was issued at my direction.

On January 27, 2016, CMS filed a motion for summary judgment with CMS exhibit (CMS Ex.) 1. On February 26, 2016, Petitioner filed a response in opposition to the CMS motion for summary judgment with Petitioner's exhibits (P. Exs.) 1 through 2. On March 14, 2016, CMS filed a reply brief. The parties have not objected to my consideration of the offered exhibits and all are admitted and considered.

II. Discussion

A. Applicable Law

Section 1831 of the Social Security Act (the Act) (42 U.S.C. § 1395j) establishes the supplementary medical insurance benefits program for the aged and disabled known as Medicare Part B. Payment under the program for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of services and suppliers[2]. Administration of the Part B program is through contractors such as Noridian. Act § 1842(a) (42 U.S.C. § 1395u(a)).

The Act requires the Secretary of Health and Human Services (the Secretary) to issue regulations that establish a process for the enrollment of providers and suppliers,

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[2] Petitioner is a "supplier" under the Act and the regulations. 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, critical access 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. 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. Act §§ 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395(u)(h)(1)).

including the right to a hearing and judicial review of certain enrollment determinations. Act § 1866(j) (42 U.S.C. § 1395cc(j)).

Pursuant to 42 C.F.R. § 424.505, a provider or supplier must be enrolled in the Medicare program and be issued a billing number to have billing privileges and to be eligible to receive payment for services rendered to a Medicare-eligible beneficiary. The effective date of enrollment in Medicare of a physician, nonphysician practitioner, and physician and nonphysician practitioner organizations is governed by 42 C.F.R. § 424.520(d). The effective date of enrollment for a physician or nonphysician practitioner may only be the later of two dates: the date when the physician filed an application for enrollment that was subsequently approved by a Medicare contractor charged with reviewing the application on behalf of CMS; or the date when the physician first began providing services at a new practice location. *Id.* An enrolled physician or nonphysician practitioner may retrospectively bill Medicare for services provided to Medicare-eligible beneficiaries up to 30 days prior to the effective date of enrollment, if circumstances precluded enrollment before the services were provided. Retrospective billing for up to 90 days prior to the effective date of enrollment is permitted only in case of a Presidentially-declared disaster pursuant to 42 U.S.C. §§ 5121-5206. 42 C.F.R. § 424.521.

The Secretary has authorized CMS to deactivate a provider's or supplier's Medicare billing privileges if the provider or supplier does not submit any Medicare claims for 12 consecutive calendar months. 42 C.F.R. § 424.540(a)(1). CMS may also deactivate a provider's or supplier's billing privileges if the provider or supplier does not report certain changes of information, such as a change in practice location or change of any managing employee, within 90 calendar days of when the change occurred, or does not provide complete and accurate information within 90 days of CMS's request for such information. 42 C.F.R. § 424.540(a)(2), (3). A provider or supplier "deactivated for any reason other than nonsubmission of a claim" is required to "complete and submit a new enrollment application to reactivate its Medicare billing privileges or, when deemed appropriate, at a minimum, recertify that the enrollment information currently on file with Medicare is correct." 42 C.F.R. § 424.540(b)(1). A provider or supplier who is "deactivated for nonsubmission of a claim" for 12 months is "required to recertify that the enrollment information currently on file with Medicare is correct and furnish any missing information as appropriate. The provider or supplier must meet all current Medicare requirements in place at the time of reactivation, and be prepared to submit a valid Medicare claim." 42 C.F.R. § 424.540(b)(2). Deactivation of Medicare billing privileges is to protect the provider or supplier from misuse of their billing privileges and the Medicare Trust Funds. Deactivation does not have any effect upon the provider's or supplier's participation in Medicare. 42 C.F.R. § 424.540(c).

B. Analysis

The CMS evidence shows that on about July 7, 2014, Noridian requested that the Petitioner revalidate its Medicare enrollment. Noridian also advised Petitioner that if it failed to submit the requested information in 60 days, its Medicare billing privileges may be deactivated. CMS Ex. 1 at 5-7. Noridian then notified Petitioner by letter dated February 11, 2015, that its billing privileges were deactivated on that date because Petitioner had not submitted the requested revalidation information. CMS Ex. 1 at 8-9. There is no evidence that Noridian advised Petitioner that its enrollment in Medicare would be revoked if it failed to timely submit the requested information.

Petitioner submitted the information requested by Noridian using a CMS-855I, which Noridian received on July 2, 2015. CMS Ex. 1 at 10-36. I infer from the fact that Noridian requested Petitioner to revalidate its Medicare enrollment information in July 2014, that Petitioner was enrolled at that time and I find no evidence to support a contrary inference. There is no evidence that CMS ever revoked Petitioner's Medicare enrollment or was authorized to do so under 42 C.F.R. § 424.535 or any other provision of the Act or regulations. Because Petitioner's enrollment and billing privileges were deactivated and not revoked, the issue that must be decided is the effective date for the reactivation of Petitioner's billing privileges. The effective date of the reactivation of Petitioner's billing privileges must be determined in accordance with the Secretary's regulation, 42 C.F.R. § 424.540(c), not a CMS policy contrary to the regulation.

CMS's policy in effect at the time of Petitioner's July 2, 2015 application for reactivation provides that, if a CMS contractor such as Noridian approves a supplier's reactivation application, "the reactivation effective date shall be the date the contractor received the application . . . that was processed to completion." MPIM, ch. 15, § 15.27.1.2 (rev. 561, iss'd Dec. 12, 2014, eff. Mar. 18, 2015).[3] On its face, CMS's policy in effect at the time of Petitioner's July 2, 2015 application is inconsistent with and violates the Secretary's regulation, which provides that deactivation of Medicare billing privileges is to protect the provider or supplier from misuse of their billing privileges and the Medicare Trust

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[3] S*ee also* MPIM, ch. 15, § 15.29.4.3 (rev. 578, iss'd Feb. 25, 2015, eff. May 15, 2015) (instruction that if a revalidation is received more than 120 days after deactivation, a new effective date will be issued to the supplier consistent with the effective date requirements of section 15.17 of chapter 15, which applies 42 C.F.R. § 424.520(d), pertaining to the effective date of a new enrollment by a physician, nonphysician practitioner, or organizations of either).

Funds and **does not have any effect upon the provider's or supplier's participation in Medicare**. 42 C.F.R. § 424.540(c) (emphasis added).[4] If the current version of MPIM, ch. 15, § 15.27.1.2 is given effect, it potentially prevents the filing of claims for covered services rendered to Medicare-eligible beneficiaries during the period of the deactivation and before the contractor receives the CMS-855I filed for purposes of reactivation. This effect is clearly contrary to the Secretary's regulation that provides deactivation "**does not have any effect upon the provider's or supplier's participation in Medicare**." 42 C.F.R. § 424.540(c) (emphasis added).

The current version of MPIM, ch. 15, § 15.27.1.2 in effect at the time of Petitioner's July 2, 2015 application for revalidation applied by Noridian may not be enforced to the extent the policy is inconsistent with the Secretary's regulation. CMS policy statements such as those set forth in the MPIM do not have the force and effect of law, *i.e.*, the statutes or regulations. *Perex v. Mortgage Bankers Ass'n*, __ U.S. ___, 135 S.Ct. 1199 at 1204 (2015) (Convenience of issuing an interpretive rule or policy rather than a legislative rule using the Administrative Procedure Act (APA) notice and comment procedure "comes at a price: **Interpretive rules** 'do not have the force and **effect** of **law** and are not accorded that weight in the adjudicatory process.'" (citation omitted) (emphasis in original)); *Ind. Dep't. of Pub. Welfare v. Sullivan*, 934 F.2d 853 (7th Cir. 1991) (substantive rules promulgated under the APA notice and comment rulemaking procedures as regulations are enforceable as law; agency interpretative rules or policy statements are not subject to notice and comment rulemaking requirements but are not enforceable as law); *Nw. Tissue Ctr. v. Shalala*, 1 F.3d 522 (7th Cir. 1993). Furthermore, as an ALJ I am bound to follow the Constitution, the Act, and the Secretary's regulations, and I give effect to the policies of the Secretary and CMS to the extent not inconsistent with the law. *1866ICPayday.com, L.L.C.*, DAB No. 2289 at 14 (2009) ("[a]n ALJ is bound by applicable laws and regulations and may not invalidate either a law or regulation on any ground.").

Pursuant to 42 C.F.R. § 498.56(d), I may remand a case to CMS for consideration of a new issue and a new determination. In this case, the new CMS policy for determining the effective date of a reactivation of Medicare billing privileges set forth in MPIM, ch. 15, § 15.27.1.2 is inconsistent with 42 C.F.R. § 424.540(c). The application of that policy by

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[4] The prior CMS policy provided that if the contractor approves a provider or supplier's reactivation application, the reactivation effective date shall be the provider or supplier's date of deactivation. MPIM, ch. 15, § 15.27.1 (C) (rev. 462, iss'd May 16, 2013, eff. Mar. 18, 2013); MPIM, ch. 15, § 15.27.1.2(D) (rev. 474, iss'd Jul. 5, 2013, eff. Oct. 8, 2013).

the contractor hearing officer was legal error. This case is remanded to permit a new reconsidered determination that determines the effective date of the reactivation of Petitioner's Medicare billing privileges consistent with the Act and the Secretary's regulations.

Accordingly, this case is remanded to CMS and dismissed. The parties may request that an order dismissing a case be vacated within 60 days for good cause shown pursuant to 42 C.F.R. § 498.72. If CMS completes its action on this case more than 60 days from the date of this Order and Petitioner desires my further review, Petitioner will file a request for hearing referring to this case with a copy of this Order attached.

III. Conclusion

For the foregoing reasons, this case is remanded and dismissed.

/s/
Keith W. Sickendick
Administrative Law Judge