**Department of Health and Human Services**

**DEPARTMENTAL APPEALS BOARD**

**Civil Remedies Division**

Anjali Sahai, M.D.,
(CCN: 09295014100100),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-10-347

Decision No. CR2172

Date: July 1, 2010

# DECISION DENYING CMS'S MOTIONS TO DISMISS AND FOR SUMMARY JUDGMENT, DISMISSING WITHOUT PREJUDICE, AND REMANDING TO CMS FOR FURTHER ACTION

I deny the motion of the Centers for Medicare and Medicaid Services (CMS) to dismiss the hearing request of Petitioner, Anjali Sahai, M.D. I also deny CMS's Motion for Summary Disposition. I dismiss the appeal without prejudice and remand this matter to CMS with instructions that CMS further develop the factual record of this case and issue a new determination.

## I. Background

Petitioner filed a hearing request (HR) dated January 11, 2010 accompanied by two attachments: a letter from the provider enrollment unit at CMS dated October 27, 2003, and a reconsideration decision letter dated January 4, 2010. I have marked the accompanying attachments as Petitioner's Exhibits 1 and 2, respectively, for reference in this decision.

This case was originally assigned to Administrative Law Judge (ALJ) Carolyn Cozad Hughes for hearing and decision. On January 27, 2010, an Acknowledgment and Initial Pre-Hearing Order (Pre-Hearing Order) was issued at her direction. On February 24, 2010, CMS filed a Motion to Dismiss Petitioner's request for a hearing and also filed two

exhibits, CMS Exhibits A and B. On March 25, 2010, this case was transferred to me for hearing and decision, pursuant to 42 C.F.R. § 498.44.

Petitioner failed to file a response to the CMS Motion to Dismiss, and, on April 16, 2010, I issued an Order to Show Cause. Petitioner responded to the Order to Show Cause by letter dated May 3, 2010. That letter mentioned documents not included with the HR but did not include copies of them. Neither party complied with the deadlines set in the Pre-Hearing Order for exchanging all exhibits, written direct testimony, and pre-hearing briefing. On April 26, 2010, I issued another Order directing both parties to submit all material they wished me to consider, including all materials that the Pre-Hearing Order required.

On May 6, 2010, Petitioner's submitted a letter with additional documents including most of those documents referenced in Petitioner's May 3, 2010 letter. I have marked Petitioner's documents that accompanied the letter as Petitioner's Exhibits 3, 4, 5, and 6 and numbered the pages consecutively for reference in this decision. On May 7, 2010, CMS filed a Motion and Memoranda for Summary Disposition. Neither party has objected to any document or exhibit, so I admit both parties' exhibits as evidence.

A brief description of the relevant facts underlying my decision is as follows: Petitioner submitted an enrollment application and received an "effective date"[1] for that enrollment application of August 17, 2009 from Palmetto GBA (Palmetto), a CMS contractor. CMS Ex. B. Petitioner then filed a reconsideration request challenging the effective date Palmetto provided and requested an effective date retroactive to July 1, 2009. P. Ex. 5. On January 4, 2010, the Palmetto hearing officer denied Petitioner's reconsideration request, citing 42 C.F.R. §§ 424.520(d) and 424.521(a)(1) as the basis of the decision.

In this appeal, Petitioner's representative argues that Petitioner was enrolled with Medicare in 2003 and never should have been required to submit a new provider enrollment application in the fall of 2009. HR. Petitioner's representative states that for "some unknown and unspecified reason" Petitioner became "unlinked" from her medical group, whereupon the contractor requested that Petitioner submit a new CMS 8551 and CMS 855R application. P. Letter of May 3, 2010. Petitioner contends that CMS erred in requesting a new provider enrollment application and requests that Petitioner's original effective date be reinstated. HR. Thus, Petitioner essentially argues that, due to CMS's error in instructing Petitioner to resubmit a new enrollment application, Petitioner's effective date was incorrectly determined. *See* P. Letter of May 3, 2010.
Neither party proffered any testimonial evidence. Petitioner stated in her May 3, 2010 letter that her position was that she had "submitted ample evidence that the root of the problem is the fact that CMS inexplicably and without warning unlinked Dr. Anjali Sahai

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[1] The date that Palmetto identified (August 17, 2009) is not Petitioner's "effective" date; however, since it is not the date of receipt of Petitioner's application but, instead, is most likely the date CMS determined that Petitioner could retroactively bill for services in accordance with 42 C.F.R. § 424.521. This issue is discussed in greater detail infra.

from Altos Oaks Medical Group" and that Petitioner hopes "for a quick and favorable outcome." I conclude that neither party seeks an in-person evidentiary hearing. I have reviewed all the materials that the parties submitted, as well CMS's motions, and proceed to decide this case based upon the current record.

## II. Issues, Findings of Fact, and Conclusions of Law

### 1. Issues

The issues in this case are as follows:

1. Whether I should dismiss Petitioner's hearing request on the ground that she has no right to appeal; and

2. Whether CMS is entitled to summary judgment that its contractor properly determined Petitioner's effective date of enrollment.

### 2. Findings of Fact and Conclusions of Law

My findings of fact and conclusions of law are set forth in bold and italics below.

***A. The effective date of a Medicare provider agreement or supplier approval is an initial determination reviewable in this forum; thus, Petitioner has a right to a hearing.***

i. Applicable Standard

Pursuant to 42 C.F.R. § 498.70(b), I may dismiss a hearing request where a party requesting a hearing "does not otherwise have a right to a hearing."

ii. Analysis

CMS argues that the Medicare regulations "do not give appeal rights to a Medicare provider or supplier dissatisfied with the effective date of Medicare enrollment" and that I must therefore dismiss the appeal. CMS Motion to Dismiss at 2.

In several prior decisions, I have explained why I do not agree with CMS and the decisions it cites. *See Michael Majette, D.C.*, DAB CR 2142 (2010); *see also Eugene Rubach, M.D.,* DAB CR2125 (2010); *Mobile Vision, Inc.*, DAB CR2124 (2010). I adopt the reasoning explained in my prior decisions, which I summarize briefly here.
The wording of section 498.3(b)(15) appears straightforward in providing that the "effective date of a Medicare provider agreement or supplier approval" is an appealable initial determination and includes no qualifying or limiting language. None of the administrative actions identified in section 498.3 as *not* subject to appeal under Part 498

include the determination of an effective date for a provider or supplier to participate in Medicare.

While subpart P of part 424 unquestionably does grant appeal rights from denials and revocations, as CMS notes, it does so by reference to the provisions of subpart A of Part 498, stating that a prospective provider or supplier whose enrollment is denied or revoked "may appeal CMS' decision in accordance with part 498, subpart A of this chapter." 42 C.F.R. § 424.545(a). Subpart A of Part 498 includes section 498.3(b)(15), yet CMS did not exclude section 498.3(b)(15) or otherwise indicate that effective date determinations would not be proper subjects for these Medicare hearings. When CMS published subpart P of Part 424 in 2006 (71 Fed. Reg. 20,753, 20,776 (Apr. 21, 2006)), it was well-aware of the longstanding provision in section 498.3(b)(15), which it had described in 1997 as granting "appeal rights and procedures for entities that are dissatisfied with effective date determinations." 62 Fed. Reg. 43,931-32 (Aug. 18, 1997). Yet, section 424.545(a) incorporated section 498.3 without limitation. Hence, the plain language of section 424.545(a) reinforces the plain language of section 498.3(b)(15).

The history of section 498.3(b)(15) shows CMS's recognition that: (1) approving participation at a date later than that sought amounts to a denial of participation during the intervening time; (2) effective date appeals generally involves the same kind of compliance issues that arise from initial denials; and (3) the right to appeal an effective date determination, while not previously codified, had already been confirmed by court decisions. 62 Fed. Reg. at 43,933-34 (final rule); 57 Fed. Reg. 46,362, 46,363 (Oct. 8, 1992) (proposed rule). While rules for determining effective dates adopted at the same time as section 498.3(b)(15) applied only to providers and suppliers subject to certification or accreditation, the rulemaking addressing section 498.3(b)(15) contains no language parallel to that addressing determining effective dates, limiting its application to only providers and suppliers that are subject to survey and certification or accreditation. 62 Fed. Reg. at 43,934; 57 Fed. Reg. at 46,363.

CMS argues nonetheless that the plain language of section 498.3(b)(15) is inapplicable here. CMS argues that this provision is meant to apply only to those suppliers or providers subject to survey and certification (or accreditation by a CMS-approved accrediting organization) as a basis for determining their participation in Medicare and whose effective dates are governed by 42 C.F.R. § 489.13, but not to suppliers, such as Petitioner, whose Medicare enrollment is approved under Part 424, subpart P. CMS points out that section 498.3(b)(15) was adopted "long before" the Medicare statute was amended (by section 936(a)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (codified at 42 U.S.C. § 1395cc(j))) to permit suppliers not subject to survey and certification or accreditation to appeal denials of applications for enrollment (CMS Motion to Dismiss at 3) and that the regulations in Part 424 implementing the 2003 amendment permit such suppliers to appeal only denials and revocations of enrollment.

CMS's argument is not persuasive. A later statute does not elucidate the intended meaning of a prior regulation, especially one unambiguous on its face. While regulatory history and other sources of guidance are relevant in interpreting language, which is ambiguous, unclear in its application, or which leaves gaps, courts do not resort to such interpretive tools when the wording is clear on its face. *See, e.g., Connecticut Nat'l Bank v. Germain*, 503 U.S. 249, 253-54 (1992) ([T]he "cardinal canon" of construction is that a statute means what it says and, when unambiguous, "this first canon is also the last: 'judicial inquiry is complete.'"). CMS has not identified in what respect the wording of section 498.3(b)(15) is ambiguous or unclear, or where the language leaves a gap requiring interpretation to give it meaning. I thus find little room for the interpretation CMS advances.

iii. Conclusion

Based on the foregoing, I deny CMS's Motion to Dismiss.

***B. CMS is not entitled to summary judgment on the record before me.***

i. Standard of Review

CMS's Motion for Summary Disposition seeks relief in the nature of summary judgment. The Departmental Appeals Board stated the standard of review for summary judgment as follows:

> Summary judgment is appropriate when the record shows that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. *Kingsville Nursing and Rehabilitation Center*, DAB No. 2234, at 3 (2009), citing *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986). While the Federal Rules of Civil Procedure (FRCP) are not binding in this administrative appeal, we are guided by those rules and by judicial decisions on summary judgment in determining whether the ALJ properly granted summary judgment. *See Thelma Walley*, DAB No. 1367 (1992). . . . The party moving for summary judgment bears the initial burden of showing that there are no genuine issues of material fact for trial and that it is entitled to judgment as a matter of law. *Kingsville* at 3, citing *Celotex*, 477 U.S. at 323. If the moving party carries its initial burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial.'" *Matsushita Elec. Industrial Co. v. Zenith Radio*, 475 U.S. 574, 587 (1986) (quoting FRCP 56(e)). To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact – a fact that, if proven, would affect the outcome of the case under governing law. *Id.* at 586, n.11; *Celotex*, 477 U.S. at 322. In determining whether there are genuine issues of material fact for trial, the reviewer must view the evidence in the light

> most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. *U.S. v. Diebold, Inc.*, 369 U.S. 654, 655 (1962).

*Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 3 (2010).

ii. Analysis

The core of Petitioner's argument appears to be that she has been continuously enrolled in Medicare as a member of the same group (Altos Oaks Medical Group, Inc.) since 2003. HR; P. Exs. 1 and 5. According to Petitioner, her claims as a group member were paid through June 2009, when, without notice, they ceased to be paid. P. Letter of May 3, 2010; P. Ex. 6. Palmetto wrote to Petitioner's group on August 13, 2009 asking that it provide a spreadsheet within 72 hours listing all its physicians and their locations, because it had been "identified as a billing provider who does not have certain rendering/performing providers attached to your group or billing provider indicated on recently submitted claims." P. Ex. 4, at 1. It appears that the group faxed the requested spreadsheet, including Petitioner's name and entry date of 2003, with a coversheet the next day. *Id.* at 3-5. Palmetto sent another letter dated September 2, 2009 stating that the spreadsheet had been received and reviewed and that it had determined that "[a]t this time" that Petitioner was "not attached" to the group. P. Ex. 3, at 1. Attached to the letter was an annotated copy of the spreadsheet on which Petitioner's name is circled, along with other markings. *Id.* at 2. The letter instructed the group that, "[i]n order to correct this issue we are requesting a CMS 855I and CMS 855R applications" for Petitioner, but that no CMS 855B was needed to "revalidate" the group's information. *Id.*

Petitioner evidently followed these instructions. In a letter dated October 14, 2009, Palmetto stated that Petitioner's Medicare enrollment applications CMS-855I and CMS-855R had been processed. Palmetto informed Petitioner's representative that Petitioner had been assigned a Provider Transaction Access Number (PTAN) (which was different than her preexisting PTAN) and that the PTAN "is linked to" the Altos Oaks' group PTAN number. CMS Ex. B at 1. The effective date for this action was given as August 17, 2009, citing 42 C.F.R. § 424.21(a)(1). *Id.*

Petitioner filed a reconsideration request challenging the August 17, 2009 effective date Palmetto provided in the October 14, 2009 decision and requested an effective date retroactive to July 1, 2009. P. Ex. 5. Petitioner's reconsideration request stated that, "Dr. Sahai has been a Medicare provider since 2003 and has been getting paid up until June 2009 when her claims were denied and provider enrollment contacted me she was not attached to our group. . . . would like effective date retro to July 1, 2009 or what date, after review, Palmetto <u>unlinked</u> Dr. Sahai with Altos Oaks Medical Group." P. Ex. 5 (emphasis in original).

On January 4, 2010, the Palmetto hearing officer denied Petitioner's reconsideration request. The reconsideration decision provides no facts upon which the hearing officer based the decision and merely concludes that "[p]er Title 42 CFR § 405.874 does not afford a physician or non-physician practitioner with the right to appeal the effective date made by a Medicare contractor, a physician can always raise their concerns to the contractor management." P. Ex. 2. The rationale for denying a change to the effective date is given as "30 days from the Receipt Date of the application," but the decision does not state when the application was received or respond to Petitioner's concern about why correcting the "unlinking" of Petitioner involved establishing a new effective date of enrollment.

In its terse motion for summary disposition, CMS does not clarify either point. CMS provides a letter from Palmetto dated September 16, 2009 acknowledging receipt of Petitioner's application, but the letter does not state the actual date of receipt. CMS Ex. A. In its motion to dismiss, CMS states that Palmetto received Petitioner's enrollment application "on or about September 16, 2009." CMS Motion to Dismiss at 1. CMS does not provide Petitioner's enrollment application that Palmetto received (as it does in many other cases in which each page of an application shows a stamp with the date and time of receipt).

The date upon which Palmetto received Petitioner's application is integral to the correct determination of Petitioner's effective date of Medicare billing privileges. Section 424.520 provides in pertinent part:

> (d) *Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations.* The effective date for billing privileges for physician, nonphysician practitioners, and physician and nonphysician practitioner organizations is the later of <u>the date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor</u> or the date an enrolled physician or nonphysician practitioner first began furnishing services at a new practice location.

(Emphasis added). The "date of filing" is the date that the Medicare contractor **receives** a signed provider enrollment application that the Medicare contractor is able to process to approval. 73 Fed. Reg. 69,725, 69,769 (Nov. 19, 2008) (emphasis added).

It is evident that the date assigned by Palmetto as the "effective date," August 17, 2009, is not consistent with section 424.520(d), since CMS described it as "thirty days from the date [the application] was received by the contractor." CMS Motion for Summary Disposition at 1. Given the citation to section 424.521(a)(1), I might presume that CMS and Palmetto intended to assign an effective date based on the receipt date sometime on or prior to September 17, 2009, and then to grant a 30-day period of retroactive billing as that regulation permitted.

Given CMS's failure to document any undisputed date of receipt in this case and its failure to explain the calculation of the August 17, 2009 purported effective date, however, I am unwilling to presume and correct the error on summary judgment. On summary judgment, I must view the factual evidence in the light most favorable to the non-movant, here Petitioner. I therefore accept for purposes of the motion and, in the absence of any contrary evidence, that Petitioner was continuously enrolled, that the disconnection of Petitioner's number from the group was an administrative error rather than an adverse action, and that the CMS 855 forms were merely intended to assist the correction of that error rather than as re-enrollment applications.

Given that the effective date that the contractor set is erroneous, that the record does not establish the exact effective date that would be applicable treating Petitioner's submissions to the contractor as enrollment applications, and that Petitioner has raised disputes of fact as to whether the submissions were actually intended as, or properly treated as, enrollment applications, I conclude that CMS has not established that it is entitled to summary judgment by law.

### *C. Dismissal without prejudice and remand is appropriate action based on the record before me.*

As I have noted, neither the reconsideration decision nor CMS in its motions and supporting memoranda provides any argument or explanation at all in response to Petitioner's account of events. This silence leaves me without the benefit of CMS's reasoning as to the legal significance of Petitioner's account. If the "unlinking" was mere administrative error, rather than the result of any substantive change or adverse action in relation to Petitioner or her group, it is not clear why reestablishing the link in Palmetto's records constituted an action resulting in a new effective date of Medicare enrollment for Petitioner at all.

Given the cryptic and sparse record and pleadings, I do not find the written record adequate to support a final decision on the merits. In light of CMS's inadequate response to my repeated orders to provide all relevant materials for my consideration, I do not believe that further proceedings before me will generate a clearer record.

Pursuant to 42 C.F.R. § 498.78(b), I may remand "at any time before notice of hearing decision is mailed." I therefore dismiss without prejudice and remand this matter to CMS to more fully develop the basis for action and issue a new determination. Petitioner may file a new request for hearing before me if the decision on remand is unfavorable.

/s/

Leslie A. Sussan
Board Member