Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Malini Narayanan, M.D.,
(PTAN: 4227652),

Petitioner

v.

Centers for Medicare & Medicaid Services.

Docket No. C-10-513

Decision No. CR2198

Date: July 29, 2010

DECISION

I grant the motion of the Centers for Medicare & Medicaid Services (CMS) for summary judgment and sustain its determination setting the effective date of Petitioner's, Malini Narayanan, M.D., enrollment in Medicare as June 22, 2009, with billing privileges retroactive for 30 days to May 22, 2009.

I. Background

Petitioner seeks billing privileges effective November 1, 2008, which is the date that she inadvertently terminated her enrollment as a provider in the Medicare program. Hearing Request (HR). Petitioner is a member of a physician practice group, Neurosurgical Network, Inc., and was initially enrolled as a Medicare provider on December 3, 2007. Petitioner states that, in an effort to add Petitioner to a second group practice location, the clerical assistant preparing the form mistakenly checked the box indicating that Petitioner wished to terminate the reassignment of benefits as a Medicare provider for the practice group effective November 1, 2008. HR. The Petitioner signed and submitted the form,

and the contractor accepted the form and sent an acknowledgment letter of the voluntary termination on February 23, 2009. CMS Exs. 1, 8.

Petitioner completed new applications (CMS Form 855I and CMS Form 855R) seeking to reestablish Petitioner's enrollment in the program and reassign benefits to the group practice. CMS Exs. 2-3. Palmetto received her applications on June 22, 2009. CMS Exs. 2-3. On July 20, 2009, the contractor notified Petitioner that it approved her enrollment and provided a 30-day period of retroactive billing, authorizing her to bill for services beginning May 22, 2009.[1] CMS Ex. 5.

Petitioner requested contractor reconsideration, explaining that the group "inadvertently disenrolled" Petitioner and requested billing privileges be reinstated back to November 1, 2008. CMS Ex. 6. Palmetto issued a reconsideration decision on January 7, 2010, upholding its initial determination. CMS Ex. 7. Palmetto's reconsideration stated that Petitioner's effective date was determined in accordance with 42 C.F.R. § 424.520(d), "the later of the date of filing or the date they first began furnishing services at a new practice location." CMS Ex. 7, citing 42 C.F.R. § 424.520(d).

Petitioner filed a timely request for a hearing, again asserting that, because Petitioner's voluntary termination was inadvertent, she should be provided the ability to bill for services provided beginning November 1, 2008. HR. Petitioner asserts that she continued to provide services to Medicare patients during "the unfortunate disenrollment period" and requests that I "reconsider paying her for the work she provided to . . . Medicare patients in good faith." HR.

This case was originally assigned to Administrative Law Judge (ALJ) Steven T. Kessel. On March 10, 2010, ALJ Kessel issued an Acknowledgment and Initial Pre-Hearing Order (Pre-Hearing Order), setting a briefing schedule. The case was subsequently transferred to me pursuant to 42 C.F.R. § 498.44, which permits a Member of the Departmental Appeals Board (Board) to be designated to hear appeals taken under Part 498. In a submission dated April 12, 2010, CMS filed a brief containing its motion for summary judgment and submitted its exhibits 1 through 8. On May 17, 2010,

[1] The "effective date" listed in the approval letter is May 22, 2009, which the contractor describes as "30 days [prior to] the Receipt Date of the application" citing 42 C.F.R. § 424.521(a)(1). CMS Exs. 5, 7. In other words, that "effective date" is the date to which Petitioner may retroactively bill for services. It follows that the "effective date" of Petitioner's enrollment in the Medicare program, pursuant to 42 C.F.R. § 424.520(d), was determined to be June 22, 2009, the receipt date of Petitioner's enrollment application. CMS Exs. 2-3. I note that this receipt date falls on a Sunday. I also note that the contractor extended 30 days retroactive billing privileges from Saturday, June 21, 2009. Given the parties' silence on the matter, I presume the actual date of receipt was Saturday, and I do not disturb the retroactive billing period that the contractor assigned.

Petitioner's representative indicated that she would not submit additional information or argument and reiterated the arguments asserted in the hearing request. Petitioner did not submit any exhibits with the hearing request or thereafter. Given the absence of any objection, I admit the CMS exhibits to the record.

II. Issues, Findings of Fact, Conclusions of Law

A. Issues

The issues in this case are whether:

1. I have authority to hear Petitioner's challenge to the effective date of her enrollment; and

2. CMS is entitled to summary disposition on the ground that undisputed facts demonstrate that CMS properly determined the effective date of Petitioner's enrollment in Medicare.

B. Findings of Fact and Conclusions of Law

1. I have authority to hear Petitioner's challenge to the determination of the effective date of her approved Medicare enrollment.

a. Applicable standard

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

b. Analysis

CMS does not file a motion to dismiss in this case but contends, to preserve the argument for appeal, that the Medicare regulations do not permit the Petitioner to appeal the effective date of enrollment in the Medicare program. CMS Br. at 7-8. As support, CMS cites ALJ decisions adopting CMS's position, including *Mikhail Paikin, D.O.*, DAB CR2064 (2010), *Peter Manis, M.D.*, DAB CR2036 (2009), and *Rachel Ruotolo, M.D.*, DAB CR2029 (2009).[2]

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[2] CMS acknowledged that other ALJs in a number of recent cases have concluded that the plain language of section 498.3(b)(15) creates a right for any provider or supplier to challenge the effective date of enrollment. CMS Br. at 8 (*citing cf., Jorge M. Ballesteros, CNRA*, DAB CR2067 (2010), *Jason Wardell, P.A.*, DAB CR2095 (2010), and *Kate Suskin*, LCSW, DAB CR2072 (2010)).

The Board recently addressed this specific issue in *Victor Alvarez*, M.D., DAB No. 2325 (2010). In *Alvarez*, the Board concluded that "a determination of a supplier's effective date of enrollment in Medicare is an initial determination subject to appeal rights under 42 C.F.R. Part 498." *Alvarez,* DAB No. 2325, at 1. The Board explained that this determination is consistent with the historical interpretation of hearing rights under section 1866(h)(1)(A) and as discussed in the rulemaking process. Further, "while section 498.3(b)(15) originally applied primarily to suppliers subject to survey and certification, the term 'supplier' as used in 42 C.F.R. Part 498 was amended to cover all Medicare suppliers, including physicians." *Id.* at 3.

In several prior decisions, I also came to the same conclusion. *See, e.g., Michael Majette, D.C.*, DAB CR 2142 (2010); *Eugene Rubach, M.D.,* DAB CR2125 (2010); *Mobile Vision, Inc.*, DAB CR2124 (2010). I likewise concluded that 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. A legislative rule is generally binding on the agency that issues it, and the agency is legally bound to follow its own regulations as long as they are in force. *Cal. Dep't of Soc. Servs.*, DAB No. 1959 (2005); *Hermina Traeye Mem'l Nursing Home*, DAB No. 1810 (2002), citing Kenneth Culp Davis and Richard J. Pierce, Jr., *Administrative Law Treatise* § 6.5 (3rd ed. 1994), *aff'd Sea Island Comprehensive Healthcare Corp. v. U.S. Dep't of Health & Human Servs.,* 79 F. App'x 563 (4th Cir. 2003); 2 AM. JUR. 2d *Administrative Law* § 236 (2010), *available at* WL AM. JUR. ADMINLAW § 236. Absent further rulemaking, CMS and I are bound to follow the plain meaning of the regulation and, as the Board addressed, permit an appeal by any provider or supplier dissatisfied with a determination as to the effective date of its provider agreement or supplier approval.

I therefore reject CMS's contention that Petitioner's challenge to the assigned effective date is not properly before me.

2. I grant CMS summary disposition on the ground that it properly determined the effective date of Petitioner's participation in Medicare.

a. Applicable standard

The Board stated the standard 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. . . . 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. . . . 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. . . . 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.

Senior Rehab. & Skilled Nursing Ctr., DAB No. 2300, at 3 (2010) (citations omitted). The role of an ALJ in deciding a summary judgment motion differs from the ALJ's role in resolving a case after a hearing. The ALJ should not assess credibility or evaluate the weight of conflicting evidence. *Holy Cross Vill. at Notre Dame*, DAB No. 2291, at 4-5 (2009).

b. Applicable regulations

The determination of the effective date of Medicare billing privileges is governed by 42 C.F.R. §§ 424.520 and 424.521. Section 424.520(d) provides that the effective date for billing privileges for physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations is "the *later of the date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor* 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. 69,726, 69,769 (Nov. 19, 2008).

Certain suppliers, including physicians, may be permitted to bill retrospectively for certain services provided before approval, if they have met all program requirements. Current regulations limit retrospective billing to 30 days prior to the effective date, "if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries," or 90 days in certain disaster situations. 42 C.F.R. § 424.521(a).

c. Analysis

Regulation fixes the date of Petitioner's reenrollment as a Medicare service provider as the date Palmetto received the application it subsequently approved (or, the date Petitioner began providing those services, had it been later, which was not the case). 42 C.F.R. §§ 424.520(d), 424.521(a). The undisputed evidence shows that Petitioner voluntarily terminated her enrollment effective November 1, 2008. CMS Ex. 1. CMS acknowledged that voluntary termination on February 23, 2009. CMS Ex. 8. Petitioner submitted a reenrollment form that Palmetto received on June 22, 2009, which the contractor processed to approval. CMS Exs. 2-3.

Petitioner acknowledges all of these facts in her own submissions. In fact, Petitioner declined the opportunity to respond to CMS's brief and motion and did not dispute

CMS's description of the evidence. E-mail from Petitioner (May 17, 2010, 2:45pm EST). Petitioner does not argue that she submitted a prior enrollment application that was processed to approval or contend that the date of receipt of her reenrollment application was in error. Petitioner's only argument is that she should not be penalized, because she was "inadvertently disenrolled" because of a clerical oversight on the part of her physician group practice. HR. Petitioner, however, is responsible for the voluntary termination, which she requested as evidenced by her signature on the form requesting the termination certifying that she examined the information and that it was true, accurate, and complete. CMS Ex. 1, at 3.

The regulations set the effective date as the date of receipt of Petitioner's approved application and limit retrospective billing privileges to the 30-day period that was granted here. (No indication exists that the provision authorizing a 90-day period in the case of certain Presidentially-declared disasters applies here). No regulations currently authorize me to consider challenges to the period for retroactive billing beyond hearing an appeal that the effective date of approval itself was wrongly determined. Furthermore, the regulation at section 424.521(a) binds me. I can neither alter nor deviate from its explicit limitation on retroactive billing to the 30 days already granted to Petitioner. Thus, I have no authority to extend the retroactive billing period for Petitioner.

I note that previous regulations did authorize CMS to grant physician suppliers up to 27 months of retroactive billing privileges; however, that provision and the authority it provided were eliminated when the current regulations became effective on January 1, 2009. 73 Fed. Reg. at 69,940. As physicians previously could be permitted to bill Medicare up to 27 months prior to the effective date of Medicare enrollment, issues relating to the effective dates of their enrollments were unlikely to arise. With the shorter time frame for retrospective billing, the applicable effective date has obviously become more important. The law as to when approval is effective, however, links the commencement of that shortened period of retrospective billing to the receipt of the approved application.

Given this record, I conclude that no dispute of any material fact exists and that CMS is entitled to summary judgment on the ground that the effective date of Medicare enrollment is June 22, 2009 as a matter of law. CMS also properly granted a 30-day period of retrospective billing as the regulations authorized.

Petitioner's representative contends that it would be unfair to not provide Petitioner with an earlier effective date so she could receive payment for "work that she performed in good faith to Medicare patients during this period of Medicare disenrollment of which she had no knowledge, direct involvement or control." E-mail from Petitioner (May 17, 2010, 2:45pm EST). Petitioner's arguments, however, are essentially those of equity, asking me in effect to estop the government from applying federal law and regulations based on Petitioner's good intentions or on the financial effect on her.

Estoppel against the federal government, if available at all, is presumably unavailable absent "affirmative misconduct," such as fraud. *See, e.g.*, *Pacific Islander Council of Leaders*, DAB No. 2091, at 12 (2007); *Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414, 421 (1990). None of the circumstances described fit that standard or permit me to ignore the unmistakable requirements of the regulations governing Petitioner's enrollment in Medicare, by which I am bound.

III. Conclusion

Because no genuine issue to any material fact exists, and for the foregoing reasons, I grant CMS's motion for summary disposition and sustain its determination setting the effective date of Petitioner's Medicare enrollment as June 22, 2009, with a retrospective billing period beginning May 22, 2009.

/s/

Leslie A. Sussan
Board Member