Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Rosemary Sachs, ARNP
Docket No. A-19-133
Decision No. 2978
December 2, 2019

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Petitioner Rosemary Sachs, ARNP, appeals an Administrative Law Judge (ALJ) decision affirming the determination by the Centers for Medicare & Medicaid Services (CMS) that the effective date for reactivation of Petitioner's Medicare billing privileges is May 12, 2017. *Rosemary Sachs, ARNP*, DAB CR5383 (2019) (ALJ Decision). We affirm the ALJ Decision.

Legal Background

A "supplier" of Medicare services must enroll (and maintain enrollment) in the Medicare program to receive payment for Medicare-covered items and services furnished to Medicare beneficiaries. 42 C.F.R. §§ 400.202 (defining "Supplier"), 424.500, 424.502, 424.505, 424.510, 424.516.[1] The Medicare enrollment process includes: (1) identifying a supplier; (2) validating the supplier's eligibility to provide items or services to Medicare beneficiaries; (3) identifying and confirming the supplier's practice locations and owners; and (4) granting the supplier Medicare billing privileges. *Id*. § 424.502 (defining "Enroll/Enrollment").

In administering the Medicare program, CMS delegates certain program activities to private contractors that function as CMS's agents. *See* Social Security Act (Act) §§ 1816, 1842, 1866, 1874, 1874A; 42 C.F.R. Part 421.[2]

[1] We cite and apply the enrollment regulations in effect when CMS's contractor issued the initial determination. *Cf. John P. McDonough III, Ph.D., et al.*, DAB No. 2728, at 2 n.1 (2016) (applying regulations in effect on date of initial determination to revoke supplier enrollment).

[2] The current version of the Act can be found at https://www.ssa.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. Also, a cross-reference table for the Act and the United States Code can be found at https://www.ssa.gov/OP_Home/comp2/G-APP-H.html.

To maintain Medicare billing privileges, an enrolled supplier must "revalidate" enrollment every five years by resubmitting and recertifying the enrollment information. 42 C.F.R. § 424.515. CMS "contacts [the] . . . supplier directly when it is time to revalidate their enrollment information," and the supplier "must submit to CMS the applicable enrollment application with complete and accurate information and applicable supporting documentation within 60 calendar days." *Id*. § 424.515(a).

CMS may "deactivate" the Medicare billing privileges of a supplier who "does not furnish complete and accurate information and all supporting documentation within 90 calendar days of receipt of notification from CMS to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information." *Id*. § 424.540(a)(3). "*Deactivate* means that the . . . supplier's billing privileges were stopped, but can be restored upon the submission of updated information." *Id*. § 424.502. A supplier whose billing privileges are deactivated (for reasons other than the failure to submit any Medicare claims for one year) "must complete and submit a new enrollment application to reactivate its Medicare billing privileges" unless CMS permits the supplier to recertify that the enrollment information currently on file with Medicare is correct. *Id*. § 424.540(b)(1).

CMS may reject a supplier's enrollment application if the "supplier fails to furnish complete information on the . . . enrollment application within 30 calendar days from the date of the contractor request for the missing information." *Id*. § 424.525(a)(1). After CMS rejects an enrollment application, the supplier "must complete and submit a new enrollment application and submit all supporting documentation for CMS review and approval." *Id*. § 424.525(c). If CMS approves an enrollment application, the effective date of a supplier's billing privileges is the later of either: "(1) The date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor; or (2) The date that the supplier first began furnishing services at a new practice location." *Id*. § 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).

The determination of the effective date of a supplier's billing privileges is an "initial determination" subject to review under 42 C.F.R. Part 498. 42 C.F.R. § 498.3(a)(1), (b)(15). A supplier may request contractor reconsideration of the effective date, and may thereafter request a hearing before an ALJ on the reconsidered determination, and may request review of the ALJ decision by the Departmental Appeals Board (Board). 42 C.F.R. § 498.5(*l*), (f); *see Victor Alvarez, M.D.*, DAB No. 2325, at 3 (2010) (approval of enrollment with a specific effective date is in essence a denial of enrollment with an earlier effective date and the supplier has a right to reconsideration review of the effective date of enrollment under section 498.5(*l*)).

Neither the rejection of an enrollment application nor the deactivation of billing privileges, however, is an "initial determination" subject to review under 42 C.F.R. Part 498. *See id*. § 498.3(b). Thus, "[e]nrollment applications that are rejected are not afforded appeal rights," and a supplier "whose billing privileges are deactivated may file a rebuttal in accordance with [42 C.F.R.] § 405.374," by filing a written statement with the contractor, but has no right to appeal the contractor's determination on deactivation to an ALJ or the Board. *Id*. §§ 424.525(d), 424.545(b).

Case Background

This background information is taken from the ALJ Decision and the record on which the ALJ issued his decision. We make no new findings of fact.

Petitioner is a nurse practitioner.[3] In 2011, she enrolled in Medicare as a supplier. CMS Ex. 1. By notice dated June 15, 2016, First Coast Service Options, Inc., a CMS Medicare Administrative Contractor, informed Petitioner that she needed to revalidate her enrollment by August 31, 2016, and that the failure to respond to the notice "will result in a hold on [Medicare] payments and possible deactivation" of her enrollment. CMS Ex. 2, at 1. First Coast later informed Petitioner by letter dated February 24, 2017 that her billing privileges were "**stopped**" "on February 24, 2017," and that Medicare "will not pay any claims after this date" because Petitioner did not revalidate her enrollment record or respond to the revalidation notice. CMS Ex. 3, at 1.

On May 8, 2017, Petitioner[4] sent First Coast a Form CMS-855I to revalidate her enrollment and reactivate her billing privileges. CMS Ex. 6. By letter dated September 21, 2017, First Coast informed Petitioner that her enrollment was revalidated effective December 21, 2015. CMS Ex. 7, at 1. Petitioner sought reconsideration. CMS Ex. 4. In her reconsideration request, Petitioner referred to the "[r]eassignment process for [Petitioner] to Scott R English MD PA"[5] and stated that she "never" received the revalidation notice because it was sent to her "previous employers." *Id*. at 3. Petitioner

[3] The ALJ Decision and some parts of the record refer to Petitioner using "ARNP" (Advanced Registered Nurse Practitioner), while other parts of the record refer to her using "NP" (Nurse Practitioner). In the first page of our decision we refer to Petitioner using "ARNP" for consistency with the ALJ Decision. The variations in the record references to "ARNP" and "NP" have no material bearing on our analysis.

[4] A billing or credentialing agent communicated with First Coast on Petitioner's behalf. CMS Ex. 6, at 1. Petitioner appointed that individual to act as her non-attorney representative during the ALJ proceedings. Request for hearing; December 2017 appointment of non-attorney representative. That individual also represents Petitioner before the Board. Request for review.

[5] The regulations prohibit reassignment of claims by suppliers, with certain exceptions. For instance, Medicare may pay a supplier's employer if the supplier is required, as a condition of employment, to turn over to the employer the fees for the supplier's services. 42 C.F.R. § 424.80(a), (b)(1).

also stated that her claims "from February 24 to May 21st, 2017" were "denied" and that "[t]here is nothing on the approval letter [dated September 21, 2017] to state that she has a lapse of coverage" during that period. *Id.* at 4. According to Petitioner, First Coast received her revalidation application on May 12, 2017. *Id.*

In its October 26, 2017 reconsidered determination, First Coast stated that the "gap" in billing privileges from February 24, 2017 through May 11, 2017 was "correctly" determined because Petitioner did not respond to the revalidation notice "within the allotted timeframe." CMS Ex. 5, at 2.

Petitioner then filed a timely request for hearing, again recounting her efforts to have her Medicare payments reassigned to a group medical practice and asserting that First Coast did not inform her during the course of communication about reassignment that she needed to revalidate her enrollment. Request for hearing. Petitioner again stated that First Coast received her revalidation application on May 12, 2017. *Id*. at 2.

Noting that neither party offered written direct testimony of any witness who could be cross-examined at a hearing, the ALJ decided the appeal based on the written record. ALJ Decision at 3. The ALJ concluded that the "contractor correctly determined that the effective date for the reactivation of billing privileges was May 12, 2017." *Id*. at 1. The ALJ made the following findings of fact and conclusion of law:

1. Petitioner mailed a revalidation enrollment application (CMS-855I) via priority mail on May 8, 2017, which the CMS contractor received on May 12, 2017. The CMS contractor approved that application on September 21, 2017.
2. The effective date for Petitioner's Medicare billing privileges is May 12, 2017.

Id. at 5 (italics and bolding removed). The effective date of billing privileges for a non-physician practitioner, the ALJ stated, is the later of the date of filing (the date on which the contractor receives a signed enrollment application the contractor is able to process to approval) or the date on which the practitioner first began furnishing services at a new practice location. *Id.* (citing 42 C.F.R. § 424.520(d); 73 Fed. Reg. at 69,769; *Donald Dolce, M.D.*, DAB No. 2685, at 8 (2016); Medicare Program Integrity Manual (MPIM), CMS Pub. 100-08, Ch. 15, § 15.27.1.2)). The ALJ stated that May 12, 2017 "appears to be the correct effective date for reactivation" since that is the undisputed date on which the contractor received the application (sent on May 8, 2017 (CMS Ex. 6, at 35)) that it later approved.[6] ALJ Decision at 5.

[6] The ALJ noted that there is no evidence of the date of the contractor's receipt of the May 2017 application, but that the parties did not dispute that May 12, 2017 was the date of receipt. *See* ALJ Decision at 5-6; CMS Ex. 5, at 2 (reconsidered determination, acknowledging receipt on May 12, 2017); reconsideration request (CMS Ex. 4, at 4) and Request for hearing at 2 (asserting that May 12, 2017 is the date of receipt).

Also, noting the contractor's earlier determination that the effective date of reactivation was December 21, 2015 (CMS Ex. 7, at 1), the ALJ stated that "such a date was obviously incorrect given that the CMS contractor had deactivated Petitioner on February 24, 2017." ALJ Decision at 5 (citing CMS Ex. 3, at 1). The ALJ then stated that "[a]pparently the CMS contractor actually considered May 12, 2017, to be the effective date for reactivation, even though this was not stated in the initial determination," but, "[w]hen the CMS contractor issued the reconsidered determination, it confirmed that May 12, 2017, was the reactivation effective date." *Id.* (citing CMS Exs. 4, at 4; 5, at 2).

With respect to Petitioner's complaints about the contractor sending the revalidation notice to an incorrect address and failing to inform Petitioner about the need to revalidate during the course of communication about the reassignment of benefits, the ALJ stated that he had no authority to consider those matters or review the contractor's actions related to deactivation. *Id.* at 6 (citing 42 C.F.R. §§ 424.545(b), 498.3(b); *Willie Goffney, Jr., M.D.*, DAB No. 2763, at 4-5 (2017)), *aff'd, Goffney v. Azar*, 2:17-cv-8032 (C.D. Cal. Sept. 25, 2019), *appeal docketed*, No. 19-56368 (9th Cir. Nov. 25, 2019). Finally, the ALJ stated that, to the extent Petitioner's complaints may be understood as a request for equitable relief, he had no authority to provide relief based on principles of fairness or equitable estoppel. *Id.* (citing *US Ultrasound*, DAB No. 2302, at 8 (2010)).

Standard of Review

The Board's standard of review on a disputed factual issue is whether the ALJ decision is supported by substantial evidence in the record as a whole. The Board's standard of review on a disputed conclusion of law is whether the ALJ 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.

Discussion

1. The issue on appeal is the effective date of reactivation of billing privileges; Petitioner's arguments are unavailing on this issue or are not cognizable.

Medicare suppliers have the right to appeal certain categories of CMS "initial determinations" to an ALJ and, if dissatisfied with the ALJ decision, to the Board. 42 C.F.R. §§ 498.3(b), 498.5. The appealable determinations include unfavorable reconsidered determinations of the effective date of a Medicare provider agreement or supplier approval. *Goffney* at 3-5. "The regulations do not grant suppliers the right to appeal deactivations," however. *Urology Group of NJ, LLC*, DAB No. 2860, at 6 (2018)

(citing *Goffney* at 5). While CMS and its contractors are authorized to reject a supplier's revalidation application and deactivate the supplier's billing privileges, ALJs and the Board are not authorized to assess whether the deactivation of billing privileges was correct. *Urology Group* at 6; *Goffney* at 3-5.

Thus, the only action in the reconsidered determination that is appealable is the determination that the effective date of reactivation of billing privileges is May 12, 2017. *See* CMS Ex. 5, at 2 (stating that the "gap" in billing privileges from February 24, 2017 through May 11, 2017 is "correct[]"). Accordingly, Petitioner's arguments about the "unjust" "lapse" in or "hold" on billing privileges resulting from deactivation on February 24, 2017 (reactivated on May 12, 2017[7]) are not cognizable. *See Urology Group* at 7 ("Petitioner may not now challenge the effectuation of the deactivation through an appeal that solely concerns the effective date of reactivation.").

Petitioner complains that First Coast took over 300 days to approve "the original application" and then later deactivated her billing privileges. Request for review. Petitioner made similar statements earlier, setting out a timeline of communications with the contractor beginning in early 2016. *E.g.*, CMS Ex. 4, at 3-4. Petitioner's complaint appears to be based on her belief that First Coast should have processed the revalidation and reassignment of benefits application simultaneously and that the reassignment process took an unusually long time. *See* Request for hearing at 1; February 7, 2018 "Pre-Hearing Exchange by Petitioner," page 2. Reassignment of benefits and revalidation of enrollment are two different matters. In any case, the argument is not cognizable to the extent it goes to the validity of deactivation that followed upon the failure to revalidate (by August 2016, which appears consistent with the 5-year revalidation cycle since the record indicates that Petitioner enrolled in the Medicare program in 2011) and the resulting interruption in billing privileges until reactivation. And, to the extent the argument may be construed as a request for equitable relief, the Board, like the ALJ, lacks authority to provide equitable relief. *US Ultrasound*, DAB No. 2302, at 8.

2. The ALJ correctly determined that the effective date for reactivation of Petitioner's billing privileges is May 12, 2017.

Section 424.520(d) states that the effective date for billing privileges for a non-physician practitioner is the later of: "(1) The date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor; or (2) The date that the

[7] Petitioner reports the denial of claims from February 24, 2017 through May **21**, 2017. *E.g.*, CMS Ex. 4, at 4; Request for hearing at 2. The Board has no jurisdiction over payment of Medicare claims. *See Urology Group* at 7. Based on First Coast's determinations in the record, there remains a gap in billing privileges from February 24, 2017 (deactivation) through May **11**, 2017 (reactivation on May 12, 2017), not through May 21, 2017.

supplier first began furnishing services at a new practice location."[8] The date of filing is the date of receipt of a signed application that is processed to approval. *See* 73 Fed. Reg. at 69,769; *see also* MPIM, Ch. 15, § 15.27.1.2.

The record shows that: (1) on May 8, 2017, Petitioner sent First Coast an application to revalidate enrollment and reactivate her billing privileges; (2) CMS and Petitioner do not dispute that First Coast received that application on May 12, 2017; and (3) First Coast determined that May 12, 2017, the date of receipt of the application it processed to approval, is the effective date for billing privileges. ALJ Decision at 5 (record citations omitted). Applying section 424.520(d) to the facts established by the evidence (or undisputed, as to the date of receipt of the only application processed to approval), May 12, 2017 is the effective date. *Id.* at 5-6. The ALJ's decision was correct.

Conclusion

We affirm the ALJ Decision.

/s/
Christopher S. Randolph

/s/
Constance B. Tobias

/s/
Susan S. Yim
Presiding Board Member

[8] The Board previously stated that CMS modified the MPIM effective January 1, 2009, to provide that, "for purposes of 42 CFR §§ 424.520(d) and 424.521(a), a CMS-855 reactivation application is treated as an initial enrollment application." *Arkady B. Stern*, DAB No. 2329, at 4 n.5 (2010) (citing MPIM Rev. 289, issued April 15, 2009). This means that, on reactivation, the provider will have a new effective date that is the later of the date of filing or the date it first began furnishing services at a new practice location (if the latter applies) and, per section 424.521(a), limited ability to bill retrospectively. *Id.*