Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Victor Alvarez, M.D., Petitioner
Docket No. A-10-53
Decision No. 2325
July 23, 2010

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

The Centers for Medicare & Medicaid Services (CMS) requests review of the February 22, 2010, decision by Administrative Law Judge (ALJ) Steven T. Kessel denying CMS's motion to dismiss and remanding for reconsideration a determination by a CMS contractor regarding the effective date of Medicare billing privileges for Victor Alvarez, M.D. Victor Alvarez, M.D., DAB CR2070 (2010) (ALJ Decision). The ALJ determined that there was no basis to dismiss the hearing request, concluding in pertinent part that the regulation at 42 C.F.R. § 498.3(b)(15) confers appeal rights on all providers and suppliers who challenge the effective dates of their enrollment in Medicare. The ALJ also elected to treat Dr. Alvarez's hearing request as a request for reconsideration.

Under the procedures at 42 C.F.R. Part 498, an ALJ may dismiss a hearing request if, among other things, the "party requesting a hearing is not a proper party or otherwise does not have a right to a hearing." 42 C.F.R. § 498.70. On appeal, CMS does not challenge the ALJ's factual findings, but challenges the ALJ's legal conclusions that Dr. Alvarez has a right to a hearing and that remand is appropriate. Our standard of review on a disputed issue of law is whether the ALJ decision is erroneous. We conclude the decision is not erroneous and uphold the ALJ decision. We find 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.

Background

Title XVIII of the Social Security Act (the Act) governs the healthcare program for the aged and disabled known as Medicare.[1] Section 1866(j) of the Act, as added by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law No. 108-173, required the Secretary to promulgate regulations governing enrollment of providers of services and suppliers under Medicare. The implementing

[1] The current version of the Act can be found at www.ssa.gov/OP_Home/ssact/comp-ssa.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section.

regulations at 42 C.F.R. Part 424, subpart P, set out the enrollment process Medicare uses to establish eligibility to submit claims for Medicare covered services and supplies. To participate in Medicare, all providers and suppliers must submit an enrollment application. Under that process, if the provider or supplier is determined to be ineligible to receive Medicare billing privileges, billing privileges will be denied. If the provider or supplier is determined to be eligible, billing privileges will be approved.

Section 1866(j)(2) of the Act, as enacted by MMA, provides that a provider or supplier who is denied Medicare enrollment has a right to a hearing under the procedures that apply under subsection 1866(h)(1)(a) of the Act.[2] Those procedures are codified at 42 C.F.R. Part 498. They provide for an ALJ hearing and Board review.

Dr. Alvarez, a physician, filed an application to enroll in Medicare as a supplier in November 2008. CMS Ex. 2. After Dr. Alvarez had submitted several additional applications, Palmetto GBA, a CMS contractor, approved an enrollment application submitted on August 10, 2009 and granted Dr. Alvarez billing privileges effective July 8, 2009. CMS Ex. 5. Dr. Alvarez filed a request for hearing in November 2009, contending that his first enrollment application was incorrectly rejected and that his billing privileges should be effective on April 2, 2008. CMS Ex. 6 at 3. Before the ALJ, CMS argued that Dr. Alvarez was not entitled to hearing rights for the effective date of his enrollment because he was not a supplier subject to survey and certification requirements. CMS December 2009 Response Brief at 15-21. As previously indicated, the ALJ concluded that section 498.3(b)(15) "on its face, explicitly confers appeals right on all providers [and suppliers] who challenge the effective dates of their enrollment in Medicare." ALJ Decision at 3. Section 498.3(b)(15) provides that a determination by CMS of the "effective date of a Medicare provider agreement or supplier approval" is an "initial determination" to which the Part 498 procedures apply.

CMS filed a notice of appeal with the Board, arguing that the Act and regulations "clearly provide for appeals related to provider or supplier enrollment if enrollment has been denied or revoked" but that "there are no statutory and regulatory provisions that specifically provide for appeal rights related to the approval of an enrollment application or the effective date of billing privileges." CMS Br. at 8. CMS also contends that section 498.3(b)(15) provides the right to appeal a CMS determination of the effective date of a provider agreement or supplier approval only to certified, surveyed, and accredited providers and suppliers and that this same right is not afforded to non-certified and non-surveyed suppliers, such as physicians. CMS Br. at 7, 13. In making its argument, CMS relies primarily on the preamble to the rulemaking in 1997 by which section 498.3(b)(15) was added. 62 Fed. Reg. 43,931 (Aug. 18, 1997).

[2] Section 1866(j)(2) of the Act was redesignated section 1866(j)(7) by section 6401of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (Dec. 24, 2009).

Analysis

As more fully explained below, we find that an approval of enrollment with a particular effective date is in essence a denial of enrollment for an earlier period. Thus, the provision at 498.5(l) regarding appeal rights "related to" denial of enrollment reasonably encompasses a right to appeal an effective date determination (including a right to reconsideration). This conclusion is consistent with the historical interpretation of hearing rights for prospective providers under section 1866(h)(1)(A). We also find that 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. Moreover, the term "supplier approval" in section 498.3(b)(15) cannot reasonably be read as applying only to certain suppliers and as not encompassing the action by CMS or its contractor on an enrollment application. The term "approval" is used in the related regulations to mean the opposite of "denial" of billing privileges with respect to all prospective suppliers that submit an enrollment application. Accordingly, we conclude that a determination of a supplier's effective date of enrollment in Medicare is an initial determination subject to appeal.

The history of enrollment requirements and appeal rights

As indicated above, section 1866(j)(1) of the Act requires the Secretary to "establish by regulation a process for the enrollment of providers of services and suppliers" under Medicare. Section 1866(j)(2) of the Act provides:

> A provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) under this title is denied may have a hearing and judicial review of such denial under the procedures that apply under subsection (h)(1)(A) to a provider of services that is dissatisfied with a determination by the Secretary.

Section 1866(j)(1) was first implemented by the rulemaking in 2006 that established the enrollment process set forth in Part 424, subpart P. That rulemaking discussed enrollment as the process of obtaining Medicare billing privileges, thus equating denial of enrollment with denial of billing privileges. 77 Fed. Reg. 20,754, 20,766 (Apr. 21, 2006); see also 42 C.F.R. 424.502 (definition of "enroll/enrollment"). The 2006 rulemaking also partially implemented section 1866(j)(2). Among other things, the 2006 rulemaking added a new provision to the list of CMS determinations that are considered initial determinations for purposes of Part 498. That provision, section 498.3(b)(17), was revised in a later technical amendment, to read "whether to deny or revoke a provider's or supplier's Medicare enrollment in accordance with § 424.530 or § 424.535." 71 Fed. Reg. 37,505 (June 30, 2006). The 2008 rulemaking subsequently added section 498.5(l) to "clarify" administrative appeal rights related to enrollment. 73 Fed. Reg. 36,448, 36,457 (June 27, 2008). Among other things, section 498.5(l) sets out appeal rights for any "prospective supplier. . . dissatisfied with an initial determination or revised initial

determination related to the denial . . . of Medicare billing privileges . . . ." (Emphasis added.)

CMS argues that the Act and regulations "clearly provide for appeals related to provider or supplier enrollment if enrollment has been denied or revoked" but that "there are no statutory and regulatory provisions that specifically provide for appeal rights related to the approval of an enrollment application or the effective date of billing privileges." CMS Br. at 8. CMS relies on the fact that section 498.3(b)(17) mentions only a determination concerning "whether to deny or revoke a provider or supplier's Medicare enrollment."

CMS is correct that the provision in subsection (l) that was added to section 498.5 in 2008 refers only to initial determinations "related to" denial and does not specifically mention "effective date" determinations. That does not mean, however, that the only determination "related to" denial is whether to deny enrollment. The pre-existing provision in subsection (d)(1) of section 498.5 (addressing appeal rights for prospective suppliers who had appeal rights before section 1866(j) was added to the Act) similarly does not specifically mention effective date determinations. Yet, the 1997 rulemaking clearly identified the effective date of supplier approval as an appealable initial determination, without finding it necessary to specify this in section 498.5(d)(1).[3] Similarly, the pre-existing provision in subsection 498.5(a)(1) on appeal rights for prospective providers was not revised in 1997 to specify that an effective date determination is considered an initial determination that a prospective provider does not qualify as a provider.

The reason why no amendment to section 498.5 was considered necessary in 1997 is simple. Even before the 1997 rulemaking, it was well established that, by setting an effective date for a provider agreement later than the date sought by the prospective provider, CMS (then HCFA) was in essence refusing to enter into an agreement at an earlier date on the basis that the prospective provider did not qualify as a provider before that date. See, e.g., Central Suffolk Hospital v. Shalala, 841 F.Supp. 492, 497 (E.D.N.Y. 1994)(addressing 1987 effective date determination); Arbor Hospital of Greater Indianapolis, DAB No. 1591 (1996)(addressing 1990 effective date determination); National Hospital for Kids in Crisis, DAB No. 1600 (1996)(addressing 1993 effective date determination).

[3] CMS points out that section 498.5(d) provides hearing rights for suppliers that are determined not to meet the "conditions for coverage" and that CMS did not determine that Dr. Alvarez did not meet the conditions for coverage. CMS Br. at 11. "Conditions for coverage" is a term of art used in Part 488 with respect to the term "suppliers" as used in that part, and relates to the hearing rights those suppliers have had since at least 1994. 42 C.F.R. §§ 488.1, 488.24; 59 Fed. Reg. 56,237 (Nov. 10, 1994). The issue here, however, is not whether the effective date determination is appealable under section 498.5(d), but whether it is appealable under section 1866(j)(2) of the Act and the related regulations, including section 498.5(l), which expanded hearing rights for all suppliers.

Thus, the preamble to the 1997 rulemaking stated:

> Although this rule makes only minimal changes in the way effective dates are determined, it does add an appeals mechanism. We do not anticipate a significant increase in the number of requests for hearings for two reasons:
>
> First, the current Federal regulations provide appeal rights for a prospective provider or supplier who is denied participation in the Medicare program. . . . A determination to deny a prospective provider's or prospective supplier's request for participation in Medicare is usually based on the entity's lack of compliance with our requirements for participation. Effective date hearings would, for the most part, focus on the same noncompliance issues. Appeals from effective date determinations will probably arise when an entity disagrees with the date that HCFA or the State determines that noncompliance was corrected. . . . .
>
> Second, the right to appeal an effective date determination, while not previously codified, had already been confirmed by court decisions.

62 Fed. Reg. at 43,932.

Similarly, a determination about the effective date of supplier approval after the 2008 rulemaking can reasonably be considered an initial determination within the scope of section 498.5(l), as added by that rulemaking. An effective date determination resulting from the enrollment process is in essence a denial of billing privileges for a period prior to that date. Thus, such a determination is "related to" denial of billing privileges and within the scope of the appeal rights addressed in section 498.5(l), even if not specifically mentioned in that section.

For this reason, it does not matter that section 498.3(b)(17) refers to the denial of billing privileges pursuant to section 424.530, but does not specifically refer to effective date determinations. Section 498.3(b)(15) lists a determination by CMS of the effective date of supplier approval as an initial determination, and that determination is within the scope of initial determinations described in section 498.5(l).

Moreover, the 2008 rulemaking recognized how integrally related the determination of an effective date is to the issue of whether to deny or approve enrollment, and therefore billing privileges. For example, the 2008 rulemaking added a provision to Part 405, subpart H, stating: "If the denial of a supplier's billing privileges is reversed upon appeal and becomes binding, then the appeal decision establishes the date that the supplier's billing privileges become effective." 73 Fed. Reg. 36,460, § 405.874(d)(4). Given this relationship, the history of section 498.3(b)(15), and the logical effect on section 498.3(b)(15) of broadening the definition of "supplier" as used in Part 498 (as discussed below), we conclude that an effective date determination is "related to" a denial of enrollment.

The term "supplier" in section 498.3(b)(15)

Section 498.3(b)(15) identifies the "effective date of a Medicare provider agreement or supplier approval" as an appealable initial determination under Part 498. We conclude that the applicable definition of the term "supplier" as used in section 498.3(b)(15) includes physicians.

As previously noted, CMS argues that section 498.3(b)(15) provides the right to appeal a CMS determination of the effective date of a provider agreement or supplier approval only to certified, surveyed, and accredited providers and suppliers and that this same right is not afforded to non-certified and non-surveyed suppliers, such as physicians. CMS Br. at 7, 13. In support of this reading of section 498.3(b)(15), CMS relies on preamble language to the 1997 final rule that added section 498.3(b)(15) (then designated as section 498.3(b)(14)) to Part 498 and amended the effective date provisions in section 489.13. 62 Fed. Reg. 43,931. CMS argues that the preamble "makes clear that this regulation was intended to apply to CMS actions 'determining the effective dates . . . of the approval of Medicare suppliers when the . . . supplier is subject to survey and certification as a basis for determining participation in [the Medicare program].'" CMS Br. at 13, citing to 62 Fed. Reg. 43,931. CMS concludes that "the regulation was not intended to apply to suppliers, such as physicians, that are not subject to survey and certification requirements." Id. CMS points out that section 498.3(b)(15) was adopted "long before" section 1866(j)(2) of the Act "required the Secretary to establish an appeals process for providers and suppliers whose applications for enrollment . . . have been denied, and long before the enrollment regulations . . . were promulgated." Id.

When section 498.3(b)(15) was originally added to the regulation, it was not intended to apply to certain suppliers, such as physicians. This was clear not only from the preamble, but also from the definition of the term "supplier" in section 498.2 in effect at that time. In 1997, section 498.2 provided that, for purposes of Part 498, as relevant here —

> *Supplier* means an independent laboratory, supplier of portable x-ray services, rural health clinic (RHC), Federally qualified health center (FQHC), ambulatory surgical center (ASC), organ procurement organization (OPO), or end-stage renal disease (ESRD) treatment facility that is approved by [CMS] as meeting the conditions for coverage of its services, and *prospective provider* means any of the listed entities that seeks to be approved for coverage of its services under Medicare.

42 C.F.R. § 498.2 (1997). Like the effective date provision in 489.13, this list primarily refers to suppliers that are subject to survey and certification. Both sections, however, also refer to suppliers or providers, such as FQHCs, that are not subject to survey and certification. See 42 C.F.R. § 488.1 (identifying suppliers subject to survey and certification); § 489.13 (providing effective dates for some providers or suppliers not

subject to survey and certification, such as FQHCs); see also § 498.5(g) (according certain practitioners the same appeal rights as "suppliers" had prior to enactment of section 1866(j)(2) of the Act).

More important, CMS's argument fails to address the 2008 rulemaking clarifying hearing rights under section 1866(j)(2) of the Act. The 2008 rulemaking amended the definitions of the terms "supplier" and "prospective supplier" for purposes of Part 498, effective August 26, 2008. 73 Fed. Reg. 36,448. As amended, section 498.2 provides, in relevant part, that—

> *Prospective supplier* means any of the listed entities specified in the definition of supplier specified in this section that seeks to be approved for coverage of its services under Medicare.
>
> * * *
>
> *Supplier* means any of the following entities:
>
> (1) An independent laboratory.
> (2) Supplier of durable medical equipment, prosthetics, orthotics, or supplies (DMEPOS).
> (3) Ambulance service provider.
> (4) Independent diagnostic testing facility.
> (5) Physician or other practitioner such as physician assistant.
> (6) Physical therapist in independent practice.
> (7) Clinical laboratories.
> (8) Supplier of portable X-ray services.
> (9) Rural health clinic (RHC).
> (10) Federally qualified health center (FQHC).
> (11) Ambulatory surgical center (ASC).
> (12) An entity approved by CMS to furnish outpatient diabetes self-management training.
> (13) End-stage renal disease (ESRD) treatment facility that is approved by CMS as meeting the conditions for coverage of its services.

73 Fed. Reg. at 36,460 (emphasis added). Since this list now defines the term "supplier" as used in Part 498, it is the applicable definition for purposes of 498.3(b)(15) and clearly includes physicians, as well as other suppliers who are not subject to survey and certification or accreditation. The fact that section 498.3(b)(15) as originally promulgated used a more narrow definition of "supplier" that did not include physicians is no longer relevant, given the definitional change. The question before us in this case is whether the term "supplier" as used in section 498.3(b)(15) at the time the determination was appealed included physicians, which it clearly did.

The term "supplier approval" in section 498.3(b)(15)

CMS also argues that section 498.3(b)(15) refers simply to a determination of the effective date of "supplier approval," not to approval of the effective date of billing privileges as specified at 42 C.F.R. § 424.520. According to CMS, the reference to supplier approval "clearly tracks and references the language" of section 489.13. CMS Br. at 14. In support of this argument, CMS states that section 489.13 specifies that it —

> [a]pplies to Medicare provider agreements with, and supplier approval of, entities that, as a basis for participation in Medicare —
>
> > (i) are subject to survey and certification by CMS or the State survey agency; or
> > (ii) are deemed to meet Federal requirements on the basis of accreditation by an accrediting organization whose program has CMS approval at the time of [the] accreditation survey and accreditation decision.

Id., referencing CMS Br. at 7.

We note that section 489.13 also provides for effective dates for FQHCs. FQHCs are not subject to survey, certification, or accreditation but were included in the definition of "supplier" applicable in 1997 to appeals under Part 498. Nothing in the 1997 rulemaking indicated that FQHCs could not appeal effective date determinations.

In any event, even if CMS had shown that the term "approval" was originally used only for CMS actions related to suppliers subject to survey and certification or accreditation (which it did not), interpreting the term "approval" in section 498.3(b)(15) as narrowly as CMS suggests is not reasonable in light of the overall wording and history of Part 424, subpart P, and the 2008 rulemaking. As CMS acknowledges, the term "approve/approval" is used in Part 424, subpart P, to mean that "the enrolling provider or supplier has been determined to be eligible under Medicare rules and regulations to . . . be granted billing privileges." 42 C.F.R. § 424.502; CMS Br. at 15 n. 4. Subpart P applies to all suppliers (with an exception not relevant here), not just those subject to survey and certification or accreditation. 42 C.F.R. § 424.500; see also 42 C.F.R. § 400.202. CMS attempts to dismiss this use of the term "approval" on the ground that "this definition applies only to 42 C.F.R. [Part] 424, Subpart P." CMS Br. at 15 n. 4. However, the 2008 rulemaking as a whole indicates that the term "approval" was intended to have the same meaning for purposes of Part 498 and subpart P of Part 424.

In addition, section 498.5, as amended in the 2008 rulemaking, refers to the hearing rights accorded to "[a]ny . . . prospective supplier . . . dissatisfied with an initial determination . . . related to the denial . . . of Medicare billing privileges." As indicated above, the amended definition of "prospective supplier" as used in Part 498 refers to any of the

listed entities that "seeks to be approved for coverage." (Emphasis added.) The 2008 rulemaking that amended Part 498 to include this definition of "prospective supplier" also amended 42 C.F.R. Part 405, subpart H, § 405.802 to include the same definition of "prospective supplier." 73 Fed. Reg. at 36,460. Subpart H was also amended to add provisions addressing appeals of a determination by a CMS contractor that "a supplier fails to meet the requirements for Medicare billing privileges." 42 C.F.R. § 405.874 (lead-in language). The subsection governing deadlines for processing enrollment applications states: "Contractors approve or deny complete provider or supplier enrollment applications to approval or denial within the [specified] timeframes: . . ." 42 C.F.R. § 405.874(h)(emphasis added). The provisions governing whether to approve or deny an enrollment application are those in Part 424, subpart P.

Moreover, section 424.502 defines "deny/denial" to mean "the enrolling provider or supplier has been determined to be ineligible to receive Medicare billing privileges for Medicare covered items or services provided to Medicare beneficiaries." This is essentially the converse of the definition of "approve/approval." In other words, the relevant regulations, as amended, effectively use the term "approval" to mean the opposite of "denial" of billing privileges, with respect to all prospective suppliers.

Section 405.874(d)(2), as amended by the 2008 rulemaking, also states that a supplier might be "determined not to have qualified for billing privileges in one period but qualified in another." A similar provision was in section 405.874(e) prior to the 2008 amendment. Indeed, prior to the 2008 amendments, section 405.874 required any supplier whose request for a billing number was disallowed to first appeal to a Medicare contractor and, if a contractor "fair hearing officer" then issued a decision for which the provider had a further right to appeal, the decision was to inform the supplier of this right. Presumably, this would include any right to appeal a determination that a supplier was qualified in one period, but not in another (that is, an effective date determination), since some suppliers specifically had a right to appeal such a determination before the 2008 rulemaking.[4]

CMS also argues that "supplier approval" for the "purposes of survey and certification is

[4] The term "qualified" is used in Part 498 to describe an initial determination to deny Medicare program participation to a prospective provider. To interpret that term to be limited only to the issue of whether the provider meets the conditions or requirements that are subject to survey, however, would be inconsistent with the statute. Section 1866(h)(1) of the Act accords hearing rights to any provider dissatisfied with a determination that it is not a "provider of services" (a term defined in section 1861 of the Act) or with a determination described in section 1866(b)(2). That section, in turn, permits the Secretary to refuse to enter into a provider agreement after the Secretary "has determined that the provider fails to comply substantially with . . . the provisions of this title and regulations thereunder" or "fails substantially to meet the applicable provisions of section 1861" (which define the entities that are providers of services), or for other specified reasons.

a separate process from reviewing an application under the enrollment requirements of 42 C.F.R. [Part] 424, Subpart P." CMS Br. at 15 (emphasis added). CMS states that, under its Medicare Provider Integrity Manual (MPIM), "first the enrollment application must be approved by a CMS contractor and then the application is forwarded to the state agency to determine if the entity meets survey and certification requirements." CMS Br. at 14, citing MPIM, Chapter 10, Section 6.1.2. The issue, however, is not whether all suppliers follow the same process to be approved for billing privileges, but whether the term "supplier approval" in section 498.3(b)(15) refers only to the result of a survey and certification process, as CMS contends. The fact that the MPIM refers to contractor "approval" of an enrollment application undercuts, rather than supports, CMS's contention.

Effective dates for physicians under section 424.520(d)

CMS also relies on the provision governing effective dates for physicians at 42 C.F.R. § 424.520(d) that was effective on January 1, 2009. 73 Fed. Reg. 69,726, 69,940 (Nov. 19, 2008). That provision states:

> The effective date for billing privileges for physicians . . . 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 . . . first began furnishing services at a new practice location.

CMS argues that section 424.520 —

> also includes provisions for determining the effective date of billing privileges for surveyed, certified or accredited providers and suppliers, independent diagnostic testing facilities [IDTFs] and DMEPOS [durable medical equipment prosthetics and orthotics supplies] suppliers[;] however, unlike the subsection pertaining to physicians . . . , each provision refers to another regulation for determining the effective date for each of these entities.

CMS Br. at 8. According to CMS, because the effective date of billing privileges for physicians is "governed solely" by section 424.520(d), we should conclude that "CMS clearly intended to distinguish the process for determining the effective date for each of these different types of entities by establishing the effective date for these different providers and suppliers in separate subsections of the regulation." Id. (emphasis added). CMS also argues that "the regulation that determines Petitioner's effective date does not include the terms 'provider agreement' or 'supplier approval'" and therefore is distinguishable from the effective date provision in section 489.13. CMS Br. at 14.

We note that CMS is relying on the version of section 424.520 that was promulgated in a final rule effective January 1, 2009, establishing a new effective date rule for physicians

and non-physician practitioners. 73 Fed. Reg. at 69,766-69,774. We conclude that the fact that the new section 424.520 incorporated some pre-existing effective date provisions for providers and for some types of suppliers, but did not do so for physicians and non-physician practitioners, merely reflects the fact that the effective date rule for physicians and non-physician practitioners was a new rule, not a pre-existing one that could be incorporated by reference. Nothing in revised section 424.520 indicates any distinction among suppliers for the purpose of appeal rights, much less a distinction based on whether the applicable effective date provision is set out in section 424.520 or merely incorporated by reference.

Even assuming the distinction in section 424.520 somehow reflects CMS intent to establish a process for physicians and other practitioners whose effective date is governed by subsection (d) that is separate from the processes for other suppliers and providers, it does not necessarily follow that the result of the process for physicians – an effective date determination – is not appealable. Indeed, the reference in subsection (d) to a physician's application being "subsequently approved" supports our conclusion that the term "supplier approval" applies to physicians.

Contrary to what CMS suggests, determination of effective dates under section 489.13 for providers and suppliers subject to survey and certification may involve issues other than the health and safety issues examined during the survey process. CMS has argued in past Board cases (and the Board has concluded) that the federal "requirements" that govern effective dates under section 489.13 include requirements such as the disclosure of ownership requirements that are now examined as part of the enrollment process. See, e.g., Golden State Manor, DAB No. 1597 (1996); see also, Central Suffolk Hospital v. Shalala, supra; 45 Fed. Reg. 22,933, 22,934 (1980). Yet, the 1997 rule adding section 498.3(b)(15) did not limit the scope of review of effective date determinations governed by section 489.13 to only the health and safety requirements examined as part of the survey process. We see no reason why only providers and suppliers subject to the survey process should have a right to challenge findings by CMS or its contractor regarding when they met enrollment requirements that are unrelated to that process.

Finally, while CMS issued a memorandum in November 2009 stating that physicians and non-physician practitioners "cannot" appeal effective date determinations, CMS had in a May 2009 memorandum stated that such suppliers "may" appeal an effective date determination. Compare CMS Ex. 9 with CMS Ex. 7. Nothing in the November 2009 memorandum explains the reason for this change or why it would apply only to physicians and non-physician practitioners, and not to the other types of suppliers who may appeal denial of enrollment but are not subject to the survey process. All of those suppliers are now covered by the definition of "prospective supplier" in Part 498, and all are subject to approval or denial of billing privileges through the enrollment process. In sum, while some providers and suppliers may be subject to different processes or effective date rules than physicians, we conclude that CMS has not established that this

distinction has any relevance to the issue of whether an effective date determination, once made, is appealable.

The ALJ appropriately remanded the case to CMS for reconsideration of the effective date determination

CMS also argues on appeal that Dr. Alvarez is not entitled to a reconsidered determination of his effective date. CMS Br. at 17. Thus, CMS argues, the ALJ erred in remanding the case to Palmetto GBA in order that the determination may be reconsidered. See ALJ Decision at 5.

Section 498.22(a), as amended, states, in pertinent part:

> *Right to reconsideration.* CMS or one of its contractors reconsiders an initial determination that affects a prospective provider or supplier . . . if the affected party files a written request in accordance with paragraphs (b) and (c) of this section. For denial . . . of enrollment, prospective providers and suppliers . . . have a right to reconsideration.

(Emphasis added.) CMS acknowledges that the matters with respect to which CMS makes an initial determination include the effective date of a provider agreement or supplier approval, but argues that "the clear language and legislative history of 42 C.F.R. § 498.3(b)(15) reveal that the regulation only applies to suppliers subject to survey and certification." CMS Br. at 17. Since Dr. Alvarez did not have his enrollment in the Medicare program denied or revoked, CMS argues, "CMS' approval of [his] application and the determination of his effective date of billing privileges is not an initial determination" and he is not entitled to reconsideration under section 498.22(a).

For the reasons explained above, we conclude that CMS's reliance on the legislative history of section 498.3(b)(15) is misplaced. Moreover, Palmetto GBA's approval of the enrollment application with an effective date of billing privileges of July 8, 2009, was in essence a denial of enrollment (and therefore of billing privileges) prior to that date. While the last sentence of section 498.22(a) makes clear that there is a right to reconsideration for a denial of enrollment, nothing in the amended section indicates that an initial determination regarding effective date will be reconsidered only if the affected prospective provider or supplier is subject to survey and certification.

Finally, the purpose of the reconsideration process is to "provide an additional opportunity for the matter to be resolved prior to the filing of an appeal to an ALJ." 73 Fed. Reg. at 36,451. Since Palmetto GBA did not notify Dr. Alvarez of a right to reconsideration, this opportunity was not provided. Yet, reconsideration by an independent hearing officer might resolve the issue and avoid the need for a more formal ALJ hearing.

Accordingly, we conclude that the ALJ appropriately remanded the case for reconsideration.

Conclusion

For the reasons stated above, we uphold the ALJ Decision denying CMS's motion to dismiss and remanding this case for reconsideration.

_____/s/_____
Stephen M. Godek

_____/s/_____
Judith A. Ballard

_____/s/_____
Constance B. Tobias
Presiding Board Member