

**Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division**

Frederick Brodeur, M.D.
Docket No. A-17-15
Decision No. 2857
March 12, 2018

**FINAL DECISION ON REVIEW OF
ADMINISTRATIVE LAW JUDGE DECISION**

Frederick Brodeur, M.D., (Petitioner) appeals the Administrative Law Judge's (ALJ) decision sustaining the determination by a Medicare contractor of an effective date of Medicare reactivation. *Frederick Brodeur, M.D.*, DAB CR4703 (2016) (ALJ Decision). The ALJ rejected Petitioner's request for an earlier effective date. We affirm the ALJ Decision.

Relevant Authority

A provider or supplier seeking billing privileges in the Medicare program must submit enrollment information to the appropriate contractor on the applicable enrollment application for review. When that process is successfully completed, the Centers for Medicare & Medicaid Services (CMS) enrolls the provider or supplier into the Medicare program. 42 C.F.R. § 424.510(a). In order to receive payment by Medicare for services furnished to Medicare beneficiaries, suppliers, such as Petitioner (a physician), must meet certain conditions to be approved by CMS for "enrollment" in the program. *See* 42 C.F.R. §§ 424.500, 424.505. The regulations governing Medicare enrollment, 42 C.F.R. Part 424, subpart P (sections 424.500-.555), define enrollment as the process that CMS and its contractors (here, WPS Administrators, LLC., or "WPS") use to identify the prospective supplier, validate the supplier's eligibility to provide items or services to Medicare beneficiaries, identify and confirm a supplier's owners and practice location, and grant the supplier Medicare billing privileges. *See* 42 C.F.R. § 424.502.

The effective date of enrollment in Medicare is the later of the following: the date when the supplier submits a Medicare enrollment application that is subsequently approved by a Medicare contractor, or the date when the supplier first begins practicing at a new practice location. 42 C.F.R. § 424.520(d).

CMS may deactivate the Medicare billing privileges of a provider or supplier if the provider or supplier 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. 42 C.F.R. § 424.540(a)(3).

If deactivated, a provider or supplier may reactivate billing privileges by meeting certain regulatory and CMS policy benchmarks. In order to reactivate billing privileges, the provider or supplier must complete and submit a new enrollment application; or when deemed appropriate, the provider or supplier must, at a minimum, recertify that the enrollment information currently on file with Medicare is correct. 42 C.F.R. § 424.540(b).

Deactivation of Medicare billing privileges is considered an action to protect the provider or supplier from misuse of its billing number and to protect the Medicare Trust Funds from overpayments. The deactivation of Medicare billing privileges does not have any effect on a provider or supplier's participation agreement or conditions of participation. 42 C.F.R. § 424.540(c).

At the time that Petitioner's Medicare enrollment was deactivated, CMS policy provided that if a provider or supplier who was deactivated for failing to respond timely to a revalidation request from the CMS contractor submitted a revalidation application within 120 days of the notice of deactivation (sometimes referred to as a "grace period"), which CMS subsequently approved, the provider's or supplier's effective date of enrollment in Medicare would remain unchanged. Medicare Program Integrity Manual (MPIM)¹ Ch. 15, § 15.29.4.3 (Rev. 578, effective May 15, 2015, to September 5, 2016).

If the CMS contractor received the provider's or supplier's revalidation application more than 120 days following the notice of deactivation (i.e., beyond the grace period), the contractor would determine a new effective date of enrollment based on the date the CMS contractor received the revalidation request that the contractor was able to process to completion. *Id.*

¹ Provisions of Chapter 15 of the MPIM, CMS Publication 100-08, are primarily intended as guidance or instructions for CMS fee-for-service contractors. *Viora Home Health, Inc.*, DAB No. 2690, at 8 (2016) (quoting introduction to MPIM Ch. 15). CMS internet-only manuals including the MPIM are available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>.

The determination of a supplier's effective date of enrollment in Medicare is an initial determination subject to appeal. 42 C.F.R. § 498.3(b)(15); *Victor Alvarez, M.D.*, DAB No. 2325 (2010). A supplier dissatisfied with a hearing decision issued by an ALJ may request Departmental Appeals Board review of the ALJ's decision. *See* 42 C.F.R. § 498.5(f).

A physician whose enrollment application has been approved may be permitted to bill Medicare for services provided up to 30 days prior to the effective date called for under section 424.520(d). 42 C.F.R. § 424.521(a)(1); *see also* MPIM Ch. 15, § 15.17 (Rev. 582, effective May 28, 2015). We refer to those 30 days as the "retrospective billing" or "look back" period.

A supplier requesting review by the Departmental Appeals Board of an ALJ decision must specify the issues, the findings of fact or conclusions of law with which the party disagrees, and the basis for contending that the findings and conclusions are incorrect. 42 C.F.R. § 498.82(b).

Procedural and Factual Background²

A. WPS notified Petitioner to revalidate Medicare enrollment.

On January 13, 2015, WPS sent letters to Petitioner notifying him to revalidate his Medicare enrollment information.³ CMS Ex. 1; CMS Ex. 2. The notice indicated that Petitioner could submit the required enrollment application either via the internet-based Provider Enrollment, Chain and Ownership System (PECOS)⁴ or by submitting a paper version of form CMS-855B or 855I, as applicable. *Id.* By regulation, and as the notice advised, Petitioner was afforded 90 days from the date of the notice (or, until April 13, 2015) to submit the required enrollment application and supporting documentation. *See* 42 C.F.R. § 424.540(a)(3).

² The background information is drawn from the ALJ Decision and the record before him and is not intended to substitute for his findings.

³ WPS sent the notice to two addresses in its records for Petitioner and Petitioner's medical group practice: one in Traverse City, Michigan (CMS Ex. 1), and the other in Louisville, Kentucky (CMS Ex. 2).

⁴ PECOS is a web-based electronic enrollment process established under OMB System of Records Number (SORN) 09-70-0532. 66 Fed. Reg. 51,961-66 (Oct. 11, 2001); *see also* 71 Fed. Reg. 60,536-40 (Oct. 13, 2006); Privacy Act Issuances, Office of the Federal Register, 09-70-0532, available at <https://www.federalregister.gov/documents/2006/10/13/E6-16954/privacy-act-of-1974-report-of-a-modified-or-altered-system> (last visited February 1, 2018). A provider or supplier may use PECOS to apply to enroll in Medicare or make changes to its enrollment information. 42 C.F.R. § 424.502 (definition of "enrollment application").

Petitioner's billing specialist, E.K., stated that on January 20, 2015, she submitted a Revalidation Application for the group practice via PECOS. Affidavit of E.K., at 1, ¶ 1. E.K. stated further that on January 29, 2015, she submitted "an Individual Revalidation application" for Petitioner through PECOS. *Id.* at 1, ¶ 6. On February 5, 2015, CMS acknowledged receipt of a Medicare enrollment application for the group practice (but not for Petitioner as an individual physician supplier). CMS Ex. 14. On March 30, 2015, having received no response from Petitioner, WPS telephoned Petitioner to ask him to submit a revalidation application. CMS Ex. 6; Affidavit of E.K. at 2, ¶¶ 13-14.

B. WPS notified petitioner of deactivation.

The 90-day deadline for Petitioner to revalidate his Medicare enrollment elapsed on April 13, 2015. By letter dated May 21, 2015, WPS notified the Petitioner that it had deactivated his individual Medicare billing privileges. CMS Ex. 7. The deactivation notice explained that the Petitioner's Provider Transaction Access Number (PTAN)⁵ "ha[d] been deactivated effective [the date of the letter] due to the failure to respond to a revalidation request mailed on January 13, 2015." *Id.* The notice also contained the following instruction:

IN ORDER TO RESUME BILLING, IMMEDIATELY REVIEW, UPDATE, AND CERTIFY YOUR INFORMATION VIA THE INTERNET-BASED SYSTEM; OR SUBMIT AN UPDATED PROVIDER ENROLLMENT PAPER APPLICATION CMS-855 ENROLLMENT FORM.

Id. (Bold, capitalization and underlining in original.)

Once Petitioner was deactivated, CMS policy permitted him to regain his Medicare billing privileges with no change to his effective date of enrollment if he revalidated his enrollment within 120 days. *See* MPIM Ch. 15, § 15.29.4.3. Therefore, if Dr. Brodeur successfully revalidated his Medicare enrollment with an application submitted by September 15, 2015, his effective date of Medicare enrollment would remain unchanged. If he missed the 120-day deadline, CMS would establish a new effective date of enrollment for him based on the date his application, which was later processed to completion, was submitted. *See id.* §§ 15.17, 15.29.4.3.

⁵ A PTAN is used by Medicare's claims processing system to identify the physician as an enrolled supplier and ensure that proper payments are made. 42 C.F.R. § 424.505 (stating that the granting of billing privileges entails the issuance of a "valid billing number effective for the date a claim was submitted" for an item or service).

C. Petitioner applied to revalidate Medicare enrollment.

On November 19, 2015, Petitioner certified and submitted an individual Medicare revalidation application through PECOS, which WPS accepted.⁶ CMS Ex. 8. On December 11, 2015, WPS notified Petitioner that it had approved Petitioner's November 19, 2015 revalidation application and granted a retrospective billing period to October 20, 2015.⁷ CMS Ex. 10.

D. Petitioner requested reconsideration of the contractor's initial determination.

On January 29, 2016, Petitioner requested reconsideration of WPS's effective date of enrollment determination, contending that his revalidation "was in fact completed in PECOS in March/April 2015" but that "something was mishandled." Request for Reconsideration; Pet. Ex. F. Petitioner also stated that he continued to supply radiological services after his enrollment was deactivated, resulting in a "gap in his reimbursements." *Id.* Finally, Petitioner stated that he "immediately submitted an application to reinstate his billing privileges" once "notified in November" 2015. *Id.* Therefore, Petitioner asked that WPS establish May 21, 2015 as Petitioner's effective date of enrollment. *Id.* On April 11, 2016, WPS denied Petitioner's request for reconsideration, citing lack of "evidence to definitely support an earlier effective date." Pet. Ex. H at 2. WPS stated that its records show that Petitioner had submitted a reassignment of benefits application in January 2015 but that there was no record of a revalidation application submitted on Petitioner's behalf in March or April 2015.⁸ *Id.* at 1-2. Petitioner requested ALJ review.

⁶ On that same date the contractor also received from Petitioner an application for reassignment of his Medicare benefits. CMS Ex. 9.

⁷ WPS determined October 20, 2015 as Petitioner's effective date of enrollment and CMS has not, in its arguments to the ALJ or to the Board, objected to that date. We note, however, that this determination appears to be a misnomer. According to the regulations and sub-regulatory guidance, Petitioner's effective date of enrollment should have been determined as November 19, 2015 (the date Petitioner's subsequently approved application was submitted), with a retrospective billing date of October 20, 2015. *See* ALJ Decision at 1 n.1; *see also* 42 C.F.R. § 424.520(d); *Arkady B. Stern, M.D.*, DAB No. 2329, at 4 n.5 (2010) (discussing MPIM Rev. 289, issued April 15, 2009, effective January 1, 2009). Because CMS takes no issue with this result, we will not address it further in this decision.

⁸ WPS also noted that it had reviewed a copy of an e-mail from E.K. to a representative from WPS dated March 30, 2015, stating E.K. had completed Dr. Brodeur's revalidation online in January and had a copy of the approval letter. *Id.* at 1. The administrative record does not contain a copy of an e-mail from E.K. to WPS on March 30, 2015. The administrative record does, however, contain a copy of an e-mail from E.K. to a representative from WPS dated February 24, 2015 (as well as a fax on that date from Dr. Brodeur to WPS), seeking a replacement for a "revalidation approval letter" allegedly damaged by the postal service. Pet. Exs. B and C. CMS also submitted copies of telephone logs from March 30, 2015 reflecting two telephone calls from WPS to Petitioner's representative, approximately seven minutes apart, which went unanswered, ultimately resulting in WPS leaving a voice mail message informing Petitioner that he needed to revalidate his Medicare billing privileges. *See* CMS Ex. 6.

E. Petitioner requested ALJ review.

In his request for ALJ review, Petitioner made two arguments in support of reversal of the unfavorable contractor's determination and establishment of an earlier effective date of enrollment. *See* Petitioner's request for hearing. First, Petitioner argued that WPS erred in processing his revalidation enrollment application, contending that WPS employees misinformed Dr. Brodeur's representative E.K. regarding the status of his individual revalidation enrollment application. Second, Petitioner argued that WPS misled the group practice (Grand Traverse Radiologists) and Dr. Brodeur by providing no notification of Dr. Brodeur's termination from the Medicare program, and by continuing to reimburse claims submitted by Dr. Brodeur even after WPS had terminated his enrollment.

CMS filed a Pre-Hearing Brief and Brief in Support of Summary Judgment (CMS Brief). In sum, CMS argued that summary judgment was appropriate because Petitioner could not dispute the "key material fact" – the date (November 19, 2015) on which WPS received Petitioner's revalidation enrollment application. CMS Brief at 5. CMS further contended that WPS correctly calculated the Petitioner's effective date of enrollment by applying the regulation at 42 C.F.R. § 424.520(d) and that the Medicare policy on enrollment reactivation that WPS followed, as expressed in the MPIM, is consistent with the regulations. *See id.* at 5-8 (citing MPIM Ch. 15, §§ 15.17 and 15.29.4.3).⁹ CMS also contended that Petitioner's other arguments amount to a claim for equitable estoppel, which does not apply in this case. *Id.* at 9, citing *Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414, 426 (1990) and *US Ultrasound*, DAB No. 2102, at 8 (2010).

Petitioner filed a Brief in Response to CMS's Pre-Hearing Brief, in which Petitioner contended that WPS had acknowledged timely receipt (ostensibly, in January 2015) of Petitioner's individual revalidation application and still deactivated his Medicare enrollment. *See* Petitioner's Brief in Response to CMS's Pre-Hearing Brief at 1-3. Moreover, Petitioner contended, WPS withheld its call logs, thereby denying Petitioner the evidence necessary to demonstrate that Petitioner timely submitted his revalidation application. *Id.* at 2. In addition, Petitioner contended that the "Notice of Deactivation did not state that Dr. Brodeur's enrollment in Medicare would be revoked if Dr. Brodeur failed to timely submit the requested information." *Id.* at 6. Petitioner further contended that WPS failed to notify Petitioner at the correct Illinois and Michigan addresses that his Medicare billing privileges had been deactivated, and that the contractor's reconsidered determination was based on an error of law. *Id.* at 3-4.

⁹ CMS also cites the ALJ's decisions in *Barbara Vizy, M.D., and Richard Weinberger, M.D.*, DAB CR4643 and CR4644 (2016), which we subsequently upheld in *Richard Weinberger, M.D., and Barbara Vizy, M.D.*, DAB No. 2823 (2017).

CMS filed an additional “Limited Reply” brief in response to Petitioner’s response brief, in which CMS contended that WPS had sent notice of deactivation to Petitioner at the correct address in Kentucky and that WPS was not obligated to mail such notice to two addresses, particularly in view of Petitioner’s failure to correctly notify WPS of a change of address via submission of a form CMS-855.¹⁰ *See* CMS’s Motion for Leave to File a Limited Reply at 1-2.

F. The ALJ’s Decision

The ALJ did not grant summary judgment, and instead issued his decision based upon the written record, noting that CMS did not request to cross-examine Petitioner’s only witness, E.K., so an in-person hearing was unnecessary. ALJ Decision at 2. The sole issue the ALJ considered was whether the contractor appropriately assigned an effective date of October 20, 2015 to Petitioner for reactivation of his Medicare billing privileges. *Id.* The ALJ found that Petitioner failed to respond to WPS’s January 13, 2015 letter notifying Petitioner to revalidate his individual Medicare enrollment, and did not submit a revalidation application even after a representative from WPS telephoned Petitioner’s office on March 30, 2015 to notify Petitioner that it had not received a revalidation application from him. *Id.* at 3, citing CMS Exs. 1, 2, 6. Consequently, the ALJ found, WPS deactivated Petitioner’s Medicare billing privileges on May 21, 2015. *Id.*, citing CMS Ex. 7. The ALJ found that WPS received on November 19, 2015 an application for reactivation of Petitioner’s billing privileges, and that this was more than 120 days from the date WPS had deactivated Petitioner’s billing privileges. *Id.*, citing CMS Ex. 8. The ALJ also found that WPS processed the application submitted on November 19, 2015 and determined that October 20, 2015 was the effective date for the reactivation of Petitioner’s billing privileges. *Id.*, citing CMS Ex. 10.

The ALJ rejected Petitioner’s contentions that WPS erred when it determined the effective date of Petitioner’s reactivation. *Id.* at 4, citing Affidavit of E.K. at 1-3, ¶¶ 6-21. He did not find credible the testimony of Petitioner’s representative, E.K., noting the lack of evidence in the record to corroborate E.K.’s account of communications with WPS.¹¹ *Id.* The ALJ further noted that evidence in the

¹⁰ CMS rejects Petitioner’s argument that WPS sent its notice of deactivation to the incorrect address. CMS argues that Petitioner submitted an application form for the reassignment of Medicare benefits on January 29, 2015, and not an enrollment application form CMS-855, which is the correct form for a supplier or provider to give notice to CMS (or to its contractor) of a change of address.

¹¹ According to E.K., a representative from WPS stated that “Dr. Brodeur’s Individual Revalidation Application had been listed in PECOS as a change of information instead of an Individual Revalidation Application.” *Id.* at 2, ¶16.

administrative record shows that WPS received a revalidation application for Petitioner's *group practice* on January 29, 2015, which, the ALJ pointed out, is neither the same as Petitioner's individual revalidation application nor a substitute for it. *Id.*, citing CMS Ex. 13. In addition, the ALJ reasoned that Petitioner could have requested the ALJ subpoena the WPS call logs but made no such request. *Id.* The ALJ similarly found no merit in Petitioner's contention that WPS erred by sending its revalidation notice to Petitioner's address in Kentucky instead of to Petitioner's address in Wisconsin, reasoning that WPS was obligated only to send notices to the address Petitioner provided in his 2013 form CMS-855I application (the source of the information on file with WPS on May 21, 2015, the date of deactivation). *Id.* at 5. Further, the ALJ concluded, the regulations require providers and suppliers to notify CMS of their addresses and any change of address, and do not provide for CMS or its contractors to infer a provider's or supplier's address from other correspondence (such as here, where Petitioner submitted a reassignment of benefits form in January 2015 from what Petitioner argued was his current address). *Id.* The ALJ also rejected as an impermissible (as well as factually unsupported) equitable estoppel claim Petitioner's contention that he was misled by WPS's employees into believing he need not submit an application to revalidate his Medicare enrollment. *Id.* at 5-6, citing *Office of Pers. Mgmt. v. Richmond* and *US Ultrasound*.

Finally, the ALJ rejected Petitioner's request that he remand the determination for re-evaluation by WPS because, Petitioner had argued, a conflict exists between 42 C.F.R § 424.540(c) and CMS policy. *Id.* at 6. According to the ALJ, Petitioner argued that section 424.540(c) "effectively nullifies any policy determination by CMS or a contractor that allows for non-payment of claims for services delivered during a period of deactivation." *Id.* The ALJ rejected this argument, finding no such conflict. In rejecting Petitioner's argument, the ALJ distinguished deactivation from revocation of Medicare billing privileges this way in his decision:

This language (in section 424.540(c)) does not mean that a provider or supplier whose billing privileges are deactivated will nonetheless be able to claim reimbursement from Medicare for items or services provided during the deactivation period. Rather, it means exactly what it plainly says: deactivation of billing privileges is not tantamount to revocation of participation. A deactivated provider or supplier may reactivate his or her billing privileges by supplying CMS or its contractor via a new enrollment application with the information needed to update his or her enrollment information. [Citation omitted.] By contrast, a provider or supplier whose participation is revoked must reapply for participation and must satisfy all of the criteria for participation.

Id., citing 42 C.F.R. § 424.540(b)(1). The ALJ found that Petitioner ignored section 424.555(b) of the regulation, which prohibits payment for otherwise Medicare-covered items or services furnished to a Medicare beneficiary by a provider or supplier if the billing privileges of the provider or supplier are deactivated. *Id.* The ALJ concluded that it is the language of section 424.555(b) “that controls this case and it explicitly directs nonpayment to Petitioner for Medicare items or services during the period when his Medicare billing privileges were deactivated,” and that “[n]othing in [section] 424.540(c) conflicts with either this language or CMS policy.” *Id.* at 7.

G. Petitioner’s request for Board review

Petitioner contends on appeal that the ALJ erred in determining October 20, 2015 as the effective date of Petitioner’s reactivation as a Medicare supplier instead of May 21, 2015. Request for Review (RR) at 1, 5. In addition, Petitioner contends that the ALJ erred in finding the assertions of E.K. not credible. *Id.* at 8. Therefore, Petitioner requested:

- (1) that the ALJ Decision to uphold summary judgment be reversed;¹² (2) that the DAB conduct a *de novo* review of the record and supporting documents; and (3) that the DAB issue a ruling finding that the effective date of the revalidation at issue should be May 21, 2015, and not October 20, 2015.

Id. at 1. Petitioner also asked, in the alternative, that the Board “reverse the summary judgment dismissal and remand the case for an ALJ hearing.” *Id.* Petitioner also submitted a Response to CMS’s Brief in Opposition, which reiterates argument set forth in his Request for Review.

Standard of Review

We review a disputed factual issue as to whether the ALJ’s decision is supported by substantial evidence in the record as a whole. We review a disputed issue of law as to whether the ALJ’s decision is erroneous. *See Departmental Appeals Board, Guidelines -- Appellate Review of Decisions of Administrative Law Judges Affecting a Provider’s or Supplier’s Enrollment in the Medicare Program*, at <http://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/enrollment/index.html>.

¹² As noted above, the ALJ did not decide Petitioner’s request for hearing on summary judgment. Rather, the ALJ decided the case on the merits, based on the written record. ALJ Decision at 2.

Analysis

Petitioner makes two major arguments on appeal to the Board: (1) that the ALJ erred in finding the testimony of E.K. not credible regarding whether WPS acknowledged receipt in January 2015 of Petitioner's individual revalidation application; and (2) that the ALJ erred as a matter of law by disregarding a conflict between federal regulations and CMS policy. We resolve each issue in favor of CMS. Substantial evidence supports the ALJ Decision and it is free from legal error. Below we discuss each issue in detail.

1. The ALJ did not err when he found certain assertions made by witness E.K. not credible.

In order to reactivate billing privileges, the provider or supplier whose billing privileges were deactivated must complete and submit a new enrollment application; or when deemed appropriate, the provider or supplier must, at a minimum, recertify that the enrollment information currently on file with Medicare is correct. *See* 42 C.F.R. § 424.540(b). A supplier's application for Medicare enrollment pursuant to 42 C.F.R. § 424.520(d) is filed on the date a contractor *receives* it. *Alexander C. Gatzimos, MD, JD, LLC*, DAB No. 2730 (2016). Petitioner contends that the ALJ "did not appropriately consider and weigh the assertions set forth in the affidavit of" E.K. concerning Petitioner's efforts to submit timely a revalidation application to WPS. RR at 5.

We disagree. The ALJ considered Petitioner's evidence and argument, including the affidavit of E.K. ALJ Decision at 4-6. However, the ALJ did not find credible E.K.'s assertions that the contractor's representatives had assured E.K. that the contractor had received Petitioner's individual revalidation application in January 2015, because Petitioner offered no corroboration for this assertion. Further, the ALJ reasoned that Petitioner could have but did not request a subpoena for the telephone call logs Petitioner asserts would corroborate E.K.'s testimony. *See id.* at 4. The ALJ also considered but rejected Petitioner's assertion that, without the call logs, it was "impossible" for Petitioner to corroborate E.K.'s assertions, reasoning that the call logs were not the only way to demonstrate that WPS had received Petitioner's individual revalidation application, and that "Petitioner has not offered a copy of the individual enrollment application that he contends was filed on his behalf on January 29, 2015." *Id.* We also note that in its revalidation notice WPS "strongly recommend[ed] [Petitioner] mail [his] documents using a method that allows for proof of receipt." CMS Ex. 1, at 3. There is no evidence in the administrative record that Petitioner used such a mail service to submit an individual revalidation application for Dr. Brodeur in January 2015.

Petitioner also contends that the ALJ erred “in dismissing the case without an ALJ hearing and an opportunity to present witness testimony[.]” RR at 5. This, too, is incorrect. First, the ALJ did not “dismiss the case” or enter summary judgment in favor of CMS. Petitioner was not denied a hearing; rather, the ALJ concluded, since CMS did not list any witnesses and did not request to cross-examine E.K., that the taking of live testimony was not necessary. *See* ALJ Decision at 2 (“I decide the case based on the parties’ written exchanges including their exhibits.”). The ALJ’s Pre-Hearing Order directed the parties to exchange as a proposed exhibit the complete, written direct testimony of any proposed witness. Dkt. No. C-16-623, Ack. & Pre-Hr. Order at 5. The Order also stated that the ALJ would convene an in-person hearing only if a party asked to cross-examine an opposing party’s witness. *Id.* at 6. Petitioner did not object to the procedures established in the ALJ’s Pre-Hearing Order.

The Board has previously determined in proceedings conducted under the regulations at 42 C.F.R. Part 498 that an ALJ has discretion to require direct testimony in written form, so long as the right to effective cross-examination is protected and no prejudice is shown. *HeartFlow, Inc.*, DAB No. 2781, at 17-18 (2017). As the Board has also previously stated, the federal courts “have allowed, and even strongly encouraged, written direct testimony in a variety of proceedings. Since it is offered under oath, [written direct testimony] is generally no less credible in most instances than oral testimony in the hearing room, as long as the witness is subject to cross-examination.” *Pacific Regency Arvin*, DAB No. 1823, at 7- 8 (2002), citing *Kuntz v. Sea Eagle*, 199 F.R.D. 665 (D. Haw. 2001). Moreover, Petitioner concedes that “the ALJ has the broad discretion to determine whether an affidavit is credible or not.” RR at 8. However, Petitioner also argues that in the affidavit, E.K. referenced specific facts, such as the names of WPS employees, which should have established E.K.’s credibility. *Id.* Nonetheless, Petitioner fails to show why E.K.’s accurate recitation of the names of WPS employees also established E.K.’s veracity as to the substance of WPS employees’ representations during their telephone conversations.

Even if WPS employees made all of the representations E.K. contends, and assuming those representations were incorrect (both assumptions that the ALJ reasonably chose not to credit), Petitioner could not reasonably have relied on the statements of WPS employees alone to establish that WPS received Petitioner’s revalidation application. As courts and the Board have recognized, Medicare providers and suppliers, as participants in the program, have a duty to familiarize themselves with Medicare requirements. *Gulf South Med.*, DAB No. 2400, at 9 (2011), quoting *Heckler v. Cmty. Health Servs. of Crawford Cnty., Inc.*, 467 U.S. 51, 63 (1984); *John Hartman, D.O.*, DAB No. 2564, at 3 (2014). Medicare regulations at 42 C.F.R. § 424.510 set forth the requirements for

enrolling in the Medicare program. The MPIM provides generally for the form and content of letters which contractors may opt to send to Medicare providers and suppliers, acknowledging receipt of their revalidation applications. *See* MPIM Ch. 15, § 15.24.1 (Rev.578, effective May 15, 2015) – Model Acknowledgement Letter. WPS’s revalidation letter strongly recommended Petitioner use a method of mailing the revalidation application which provides proof of receipt. The MPIM also provides guidance for revalidation of suppliers after they have been deactivated. In view of such readily available written authority and guidance, Petitioner should have expected written notification of his individual application just as the contractor provided for the group’s revalidation application. Under these circumstances, we cannot conclude that it was reasonable for Petitioner to rely solely on the verbal representations of WPS staff about the status of Petitioner’s revalidation application without also obtaining corroborating documentation.

The ALJ provided Petitioner a full and fair opportunity to present his case, including the opportunity to submit witness E.K.’s testimony. Petitioner does not argue that the requirement that he submit written direct testimony prejudiced his ability to raise any issue or prove any fact bearing on his enrollment status. Accordingly, in the absence of corroborating evidence, the ALJ did not err by finding not credible E.K.’s assertion that WPS employees acknowledged via telephone conversations their receipt in January 2015 of Dr. Brodeur’s individual revalidation application; even if they had, it would have been unreasonable for Petitioner to rely on those assertions instead of using a verifiable method of delivery. E.K.’s testimony simply did not persuade the ALJ. Like the ALJ, we too find no support for Petitioner’s contention that he submitted a revalidation application in January 2015.

Ultimately, Petitioner’s claim that he submitted an individual enrollment application in January 2015 is irrelevant here because Petitioner was deactivated on May 21, 2015 after failing to provide the necessary revalidation information to WPS in response to the January 13, 2015 revalidation letter and the March 30, 2015 telephone call from WPS. A contractor’s deactivation decision is not an initial determination subject to ALJ or Board review. *See* 42 C.F.R. § 498.3(b) (“*Initial determinations by CMS.*”). Accordingly, even if Petitioner could prove that he submitted an individual Medicare revalidation application to WPS in January 2015, unless he could prove that the application had been processed to completion, it would have no bearing on the outcome of this appeal, because Petitioner nonetheless was deactivated in May 2015. Therefore, we conclude that the ALJ considered the evidence in the administrative record as a whole and reasonably judged certain testimony in the record not credible.

2. The ALJ did not err when he concluded that CMS’s policy on deactivation and revalidation of Medicare billing privileges does not conflict with Medicare regulations.

Petitioner argues that CMS guidance in MPIM Chapter 15, § 15.27.1.2 conflicts with the regulation at 42 C.F.R. § 424.540(c), and that, therefore, the ALJ erred when he upheld the contractor’s initial determination of his effective date of enrollment upon revalidation, and did not rely on the “previous DAB determinations on this direct issue as explained in *Kamran Hamidi, MD*, DAB No. CR4577 (April 8, 2016) and *Jean-Claude Henry, MD*, DAB No. CR4627 (June 8, 2016).” RR at 5, 6. Petitioner’s argument focuses on the portion of section 424.540(c) that states:

The deactivation of Medicare billing privileges does not have any effect on a provider or supplier’s participation agreement or any conditions of participation.

42 C.F.R. § 424.540(c); *see* RR at 6. Petitioner argues, in sum, that when a Medicare contractor determines an effective date by following MPIM Chapter 15, § 15.27.1.2, where (as here) the revalidation application is submitted more than 120 days after deactivation, it creates a period of time during which the supplier furnishes covered services to Medicare-eligible beneficiaries for which the supplier cannot submit claims for payment. Consequently, Petitioner argues, this gap between deactivation and reactivation, during which Petitioner may not claim payment from Medicare, conflicts with the mandate in section 424.540(c) that deactivation “does not have any effect upon the . . . supplier’s participation in Medicare.” RR at 6, citing *Hamidi* and *Henry*. As we discuss more fully below, we find no merit in Petitioner’s arguments.

The ALJ was not bound by the decisions of other ALJs which were not appealed to the Board. As we have stated,

[a]n unappealed ALJ decision does not set a precedent binding on ALJs or the Board. When the *Board* has not reviewed the ALJ decision, the *Board* has not issued a decision in that case. Regardless of whether an ALJ decision was appealed to the Board, an ALJ decision is not precedential and does not bind the Board, and is relevant in later cases only to the extent its reasoning is on point and persuasive.

Avalon Place Trinity, DAB No. 2819, at 13 (2017) (italics in original), citing *John M. Shimko, D.P.M.*, DAB No. 2689, at 5 (2016). We do not find the reasoning applied by the ALJ in *Hamidi* and *Henry* persuasive.

Petitioner's argument ignores the distinction between "deactivation" and "revocation" and misstates the regulatory consequences of deactivation. The subpart P regulations set forth the requirements for establishing and maintaining Medicare billing privileges, and provide definitions for relevant terms. "Enrollment" means "the process that Medicare uses to establish eligibility to submit claims for Medicare-covered items and services, and the process that Medicare uses to establish eligibility to order or certify Medicare-covered items and services." 42 C.F.R. § 424.502. Enrollment includes, among other steps, "validation of the provider or supplier's eligibility to provide items or services to Medicare beneficiaries," and "granting the Medicare provider or supplier Medicare billing privileges." *Id.* "Deactivate[d]" means that the provider or supplier's billing privileges were stopped, but can be restored upon the submission of updated information. *Id.* "Revoke/Revocation" means that the provider or supplier's billing privileges are terminated. *Id.*

Once enrolled (in Medicare), the provider or supplier receives billing privileges and is issued a valid billing number effective for the date a claim was submitted for an item that was furnished or a service that was rendered. 42 C.F.R. § 424.505. A physician, such as Dr. Brodeur, may be enrolled and not have billing privileges, but a physician may not have billing privileges without being enrolled. CMS may revoke an enrolled supplier's billing privileges, along with any corresponding provider agreement, for any of the reasons enumerated in section 424.535(a) of the regulations, such as being convicted of a felony, abuse of billing privileges, and improper prescribing practices. *See* 42 C.F.R. § 424.535(a)(3), (8) and (14). When a supplier's billing privileges are revoked, any agreement in effect at the time of revocation is terminated and the supplier's enrollment is terminated. *See id.* § 424.535(b). By contrast, CMS may merely deactivate a supplier's billing privileges if the provider does not submit a claim for 12 consecutive calendar months, if the supplier does not report within 90 calendar days a change to the supplier's enrollment information, or if the supplier does not within 90 calendar days of notice from CMS submit an enrollment application containing complete and accurate information, along with supporting documentation, or resubmit and certify the accuracy of its enrollment information. 42 C.F.R. § 424.540(a). Except under certain circumstances not relevant to this discussion, reactivation of Medicare billing privileges does not require a new certification of the provider or supplier by the state survey agency or the establishment of a new provider agreement. *See id.* § 424.540(b)(2).

The ALJ correctly found no conflict between the MPIM “grace period” provision and section 424.540(c) of the regulations. The regulatory history makes clear CMS’s intention to distinguish between revocation, which has a significant effect on a supplier’s participation, and deactivation, which does not. The final rule codifies CMS’s policy that failure to timely furnish CMS with updated enrollment information when notified to do so may result in temporary suspension of the privilege to bill Medicare for covered services but will not, without more, result in termination of the supplier’s enrollment or agreement to participate in the Medicare program. In the Federal Register notice announcing the final rule establishing the requirements for providers and suppliers to establish and maintain Medicare enrollment, CMS explained:

Deactivation of Medicare billing privileges is considered a temporary action to protect the provider or supplier from misuse of their billing number and to also protect the Medicare Trust Funds from unnecessary overpayments. The temporary deactivation of a billing number *would not* have any effect on a provider or supplier’s participation agreement or conditions of participation.

77 Fed. Reg. 20,754, 20,762 (Apr. 21, 2006) (*italics added*).¹³ The language here clarifies for CMS contractors, as well as suppliers, that the supplier’s enrollment in the Medicare program will not be jeopardized by deactivation the way it would be by revocation. It is not a mandate, contrary to what Petitioner and the ALJ in *Hamidi* and *Henry* posit, to CMS contractors to ensure that deactivation will not *affect* any aspect of the supplier’s relationship with the Medicare program. In fact, Petitioner’s reading of the provision would cause sections 424.540(a) and (b) to conflict with section 424.555(b) because if a contractor deactivated a supplier, Medicare would still be required to pay the supplier retroactively for services furnished during the “gap” prior to revalidation. This is expressly prohibited by section 424.555(b).

Petitioner’s argument posits that the contractor’s implementation of deactivation in fact does change the supplier’s conditions of participation, contrary to the regulation at section 424.540(c). In this case, following the guidance found in MPIM Chapter 15, § 15.27.1.2, WPS reset Petitioner’s effective date of Medicare enrollment to November 19, 2015 (although Petitioner’s prior effective date was apparently October 1, 1998. *See*

¹³ By contrast, revocation represents CMS’s wish to sever its relationship with the supplier:

We do not believe it would be prudent for us to maintain an active provider agreement for a provider or supplier whose business relationship with Medicare was adverse enough as to cause revocation of its billing privileges.

Id. at 20,761, citing section 1866(b)(2)(A) of the Social Security Act, 42 U.S.C. 1395cc(6)(2)(A), (“the Secretary may terminate a provider agreement after the Secretary has determined that the provider fails to comply substantially with the provisions of title XVIII.”).

CMS Ex. 8, at 2). The new effective date of Medicare enrollment deprived Petitioner of the privilege of billing Medicare for covered services furnished to eligible beneficiaries from May 21, 2015, the date of deactivation, through October 20, 2015, the first date of service for which Petitioner could bill Medicare under section 424.521(a) of the regulations. Absent the guidance to contractors contained in MPIM Chapter 15, § 15.27.1.2, deactivated suppliers would retain the same effective date of enrollment, thus allowing them to submit claims for payment for services furnished on any subsequent date – including on dates during the period of deactivation. Thus, Petitioner’s novel interpretation of the regulation as protecting suppliers from *any* consequence of deactivation would permit deactivated suppliers to seek and obtain reimbursement for covered services furnished during the “gap” period.

However, as the ALJ in this case pointed out, Petitioner’s proposed interpretation of section 424.540(c) ignores the regulation at 42 C.F.R. § 424.555(b), which prohibits payment for otherwise Medicare-covered services furnished to a Medicare beneficiary by a provider or “supplier if the billing privileges of the provider or supplier are deactivated.” When read together, CMS’s intention is clear in the regulations, and its subregulatory guidance is consistent with both of the regulations. Here, Petitioner’s failure to timely provide information in response to notice from CMS to do so resulted in deactivation, or the temporary suspension, of his Medicare billing privileges, but did not terminate his status as an enrolled supplier of services to Medicare beneficiaries, under section 424.540(c). Had Petitioner committed serious misconduct, CMS could have revoked his participation in Medicare under section 424.535(a) and barred his re-enrollment for at least one year. However, Petitioner remained enrolled in Medicare, but his deactivated status made ineligible for payment for any covered services he furnished to otherwise eligible Medicare beneficiaries, pursuant to section 424.555(b), until he provided the information necessary to reactivate his billing privileges.

To read section 424.540(c) to mean that Petitioner could experience no temporary change in his billing privileges for non-compliance with the regulatory requirement to timely provide requested revalidation information is to render sections 424.540(a) and (b) meaningless. We generally do not read one provision of a regulation in a manner that makes others superfluous where that reading can be avoided. *See, e.g., Ridgeview Hosp., DAB No. 2593, at 7 (2014), and authorities cited therein.* Thus, the provision of the MPIM establishing a new effective date of enrollment after the supplier was revalidated based on an application submitted more than 120 days after being deactivated is consistent with, and does not conflict with, section 424.540(c), but rather supports section 424.540(a) and (b). Any effective date of enrollment prior to deactivation would provide the basis for a deactivated supplier to bill for services furnished during the “gap” period, between the dates of deactivation and reactivation. Allowing a deactivated supplier to bill for services furnished during a period of deactivation would conflict with section 424.555(b) of the regulations; CMS policy as set forth in the MPIM is consistent with federal regulations.

Conclusion

For the foregoing reasons, we affirm the ALJ Decision upholding the CMS contractor's determination that October 20, 2015 is the effective date of Petitioner's enrollment in Medicare.

_____/s/
Leslie A. Sussan

_____/s/
Constance B. Tobias

_____/s/
Christopher S. Randolph
Presiding Board Member