Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Auburn Hills Sleep Center, LLC,
(PTAN: 0N74970),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-16-895

ALJ Ruling No. 2017-17

Date: May 9, 2017

DISMISSAL

For the reasons explained below, I conclude that the issue in this case is not one over which I may exercise jurisdiction. I therefore dismiss Petitioner's hearing request. For the same reasons, I deny the parties' cross-motions for summary judgment as moot.

I. Background

Petitioner, Auburn Hills Sleep Center, LLC, is an Independent Diagnostic Testing Facility (IDTF). Petitioner has been enrolled as a Medicare supplier since June 4, 2003. *See* Centers for Medicare & Medicaid Services (CMS) Exhibit (Ex.) 9 at 1. In a letter dated March 10, 2016, Wisconsin Physicians Service (WPS), a CMS Medicare Administrative Contractor, approved a number of change requests to add new HCPCS/CPT codes[1] to Petitioner's Medicare enrollment information. CMS Ex. 9. In the

[1] Current Procedural Terminology (CPT) is an American Medical Association publication listing billing codes for medical services. CMS created the Healthcare Common Procedure Coding System (HCPCS) to develop uniform national definitions of physician services, codes for those services and payment modifiers, in order to process, screen, identify, and pay Medicare claims. *See* 42 C.F.R. §§ 414.2 and 414.40. HCPCS incorporates the CPT coding system and includes additional coding references.

case of each added code or procedure, WPS indicated the effective date the change was approved. CMS Ex. 9 at 1. In addition to approving new codes, WPS also informed Petitioner that previously approved codes associated with home anticoagulation therapy monitoring using Coaguchek equipment would be deleted, effective December 18, 2014. *Id.* The March 10, 2016 letter went on to state: "If you disagree with the effective date determination in this letter, you may request a reconsideration before a contractor hearing officer." CMS Ex. 9 at 3.

Petitioner requested reconsideration and a WPS hearing officer issued an unfavorable reconsidered determination by letter dated July 19, 2016. CMS Exs. 10, 11. The reconsideration explained:

> According to our records WPS Provider Enrollment (PE) received a CMS-855B change of information application on November 23, 2015 . . . . A review of the Auburn Hills Sleep Center LLC enrollment file was conducted and it was identified at that time that WPS PE added the Coaguchek . . . equipment in error because Auburn Hills Sleep Center LLC does not have qualified technicians that are licensed as a RN, [LPN] or Medical Technologist (MT) with a certification acquired [from] an accredited MT program. Therefore the appropriate actions were taken to delete this equipment effective December 18, 2014.

CMS Ex. 11 at 2. The reconsidered determination further stated: "If you believe that this determination is not correct, you may request a final ALJ [administrative law judge] review." *Id.*

Petitioner timely submitted a hearing request and the case was assigned to me for a hearing and decision. I issued an Acknowledgment and Pre-Hearing Order, dated September 21, 2016. Pursuant to my order, the parties submitted cross-motions for summary judgment and proposed exhibits. Thereafter, in an order issued March 8, 2017, I directed the parties to file supplemental briefs addressing the jurisdictional issue that is the subject of this ruling. The parties filed briefs as directed (CMS Supp. Br.; P. Supp. Br.). Having considered the parties' briefs, I now conclude that WPS erred in informing Petitioner that Petitioner had a right to request review by an administrative law judge after WPS disapproved Petitioner's enrollment change requests.

II. Discussion

Pursuant to 42 C.F.R. § 424.545, providers and suppliers have the following appeal rights with respect to their enrollment in Medicare:

> A prospective provider or supplier that is denied enrollment in the Medicare program, or a provider or supplier whose Medicare enrollment

> has been revoked may appeal CMS' decision in accordance with part 498, subpart A of this chapter.

42 C.F.R. § 424.545(a). The hearing provisions in 42 C.F.R. part 498 include similar language:

> *(l) Appeal rights related to provider enrollment.* (1) Any prospective provider, an existing provider, prospective supplier or existing supplier dissatisfied with an initial determination or revised initial determination related to the denial or revocation of Medicare billing privileges may request reconsideration in accordance with § 498.22(a).

42 C.F.R. § 498.5(*l*)(1). Significantly, the regulation makes clear that appeal rights attach to an "initial determination" by CMS or its contractor. Pursuant to 42 C.F.R. § 498.3, CMS makes an initial determination on "[w]hether to deny or revoke a provider or supplier's Medicare enrollment in accordance with § 424.530 or § 424.535 of this chapter." 42 C.F.R. § 498.3(b)(17). CMS also makes an initial determination regarding "[t]he effective date of a Medicare provider agreement or supplier approval." 42 C.F.R. § 498.3(b)(15).

The regulation specific to the participation of IDTFs in Medicare provides: "the effective date of billing privileges for a *newly enrolled* IDTF" is the later of (1) the filing date of its enrollment application that was subsequently approved or (2) the date it started furnishing services at its new practice location. 42 C.F.R. § 410.33(i) (emphasis added).

In its supplemental brief CMS argues that, under the cited regulations, there is no right to administrative law judge review in this case. CMS Supp. Br. at 2. CMS's position is that the right to appeal an effective date determination applies only to newly-enrolling IDTFs. *Id.* CMS states, "The regulation does not contemplate that a new enrollment effective date will be calculated every time that an IDTF changes information with CMS or its contractor." *Id.* By contrast, in its supplemental brief, Petitioner states that "this case is not about an Effective Date." P. Supp. Br. at 2 (capitalization original). Petitioner goes on to explain why, in its view, WPS erred by concluding that Petitioner's employees were not properly credentialed to provide and bill for home anticoagulation monitoring. Petitioner's argument misses the point. If this case is *not* about an effective date, as Petitioner seems to concede,[2] then there is no basis for my exercise of jurisdiction in this case.

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[2] I am mindful that Petitioner is not represented by counsel before me. For this reason, Petitioner may not fully realize the significance of conceding that the effective date of enrollment is not at issue here. Nevertheless, for the reasons explained in this ruling, I believe Petitioner is correct in stating that the effective date of Petitioner's enrollment is not at issue in this case.

I agree with CMS that the actions of WPS in this case do not represent an initial determination regarding the effective date of Petitioner's enrollment. WPS did not alter the effective date of Petitioner's enrollment in Medicare. It is undisputed that Petitioner enrolled in the Medicare program with an effective date of June 4, 2003. *See, e.g.*, CMS Ex. 9 at 1. No action taken in WPS's March 10, 2016 letter had any effect on that date. Nor did WPS deny or revoke Petitioner's Medicare billing privileges pursuant to 42 C.F.R. § 424.530 or § 424.535. Instead, WPS's March 2016 letter notified Petitioner that WPS rescinded its previous approval of Petitioner's requests to change certain aspects of its enrollment information. *See* CMS Ex. 9 at1. These actions do not provide a basis under the regulations for review by an administrative law judge.

I do not doubt that I would have jurisdiction to hear and decide this case if WPS had, for example, determined to revoke Petitioner's Medicare enrollment due to Petitioner's alleged failure to employ non-physician personnel who meet the requirements of 42 C.F.R. § 410.33(g)(12). But that is not the case here. Petitioner remains an enrolled supplier authorized to submit claims to Medicare for services it renders to Medicare beneficiaries.

I understand that Petitioner is not presently authorized to submit claims to Medicare for HCPCS/CPT codes associated with anticoagulation therapy home monitoring using Coaguchek equipment. Petitioner has fully explained its reasons for disagreeing with WPS's decision that it may not add the codes for anticoagulation therapy home monitoring to its enrollment. I am aware that WPS informed Petitioner that Petitioner had the right to request reconsideration on the issue; that Petitioner did so; and that WPS issued an unfavorable reconsidered determination. Nevertheless, neither the contractor nor an administrative law judge may create a hearing right where none is authorized by statute or regulation. *See Conchita Jackson, M.D.*, DAB No. 2495 at 9 (2013); *see also Integrated Diagnostic of South Florida, Inc.*, DAB CR2508 at 2-3 (2012). Nor can the parties confer jurisdiction by stipulation or waiver. *See Cerebral Palsy Center of the Bay Area*, DAB CR295 at 6, 14 (1993).

For the reasons stated, I conclude that a contractor's approving or denying a change request to a provider or supplier's enrollment information is not an initial determination within the meaning of 42 C.F.R.§ 498.3(b).

III. Conclusion

Petitioner does not have a right to a hearing before an administrative law judge in this matter. The contractor's disapproval of Petitioner's request to change its enrollment information is not an initial determination as defined in 42 C.F.R. § 498.3(b). Accordingly, I order that Petitioner's hearing request be dismissed pursuant to 42 C.F.R. § 498.70(b). The parties' cross-motions for summary judgment are therefore moot.

/s/

Leslie A. Weyn
Administrative Law Judge