Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Kimberly Bergeron NP, et al.,

Petitioners,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-642[1]

Decision No. CR3438

Date: October 29, 2014

DECISION

Petitioners here are employees of Tri-City Express Care, PLLC, d/b/a FastMed Urgent Care (FastMed), a physician-owned urgent care company that participates in the Medicare program. The company describes itself as "rapidly growing," and, from September 2011 through October 2012, it hired 28 healthcare professionals who began providing services to Medicare beneficiaries. In error, a FastMed employee delayed filing Medicare enrollment applications for these new employees. As a result, the employees were not enrolled until months after they started providing services. Medicare will not pay for services provided by individuals who are not yet enrolled in the Medicare program (in this case, services provided to approximately 1,161 program beneficiaries).

Petitioners asked the Medicare contractor, Noridian Healthcare Solutions, to issue earlier effective dates. In a series of 38 reconsidered determinations, dated December 4, 2013 (12 determinations) and December 11, 2013 (26 determinations), a Medicare hearing officer denied their requests; in every case except one, the hearing officer found no

[1] The individual petitioners are listed in the attached appendix by the docket number they were assigned prior to consolidation of the cases. The provider transaction access numbers (PTANs) of each Petitioner are also listed.

evidence to support an earlier effective date.[2] The individual employees separately appealed those determinations, and, because their resolution turns on the same issue, I have consolidated their appeals.

The Centers for Medicare & Medicaid Services (CMS) has submitted a pre-hearing brief (CMS Br.) and motion for summary judgment, along with 38 exhibits (CMS Exs. 1- 38). In the absence of any objection, I admit into evidence CMS Exs. 1-38. Petitioners submitted a pre-hearing brief asking that I decide this case based on its initial filing. Because neither party proposes calling any witnesses, an in-person hearing would serve no purpose, and the cases may be decided based on the written record.

For the reasons set forth below, I affirm the reconsidered determinations.

Discussion

CMS properly determined the effective dates for the FastMed employees' Medicare enrollment because their effective dates can be no earlier than the dates they filed their enrollment applications.[3]

To receive Medicare payments for services furnished to program beneficiaries, a Medicare supplier must be enrolled in the Medicare program. 42 C.F.R. § 424.505. "Enrollment" is the process used by CMS and its contractors to: 1) identify the prospective supplier; 2) validate the supplier's eligibility to provide items or services to Medicare beneficiaries; 3) identify and confirm a supplier's owners and practice location; and 4) grant the supplier Medicare billing privileges. 42 C.F.R. § 424.502. To enroll in Medicare, a prospective supplier must complete and submit an enrollment application. 42 C.F.R. §§ 424.510(d)(1); 424.515(a). An enrollment application is either a CMS-approved paper application or an electronic process approved by the Office of Management and Budget. 42 C.F.R. § 424.502. When CMS determines that a physician or nonphysician practitioner meets the applicable enrollment requirements, it grants Medicare billing privileges, which means that the practitioner can submit claims and receive payments from Medicare for covered services provided to program beneficiaries.

For physicians and nonphysician practitioners, the effective date for billing privileges "is the *later* of the date of filing" a subsequently approved enrollment application or "the date an enrolled physician or nonphysician practitioner first began furnishing services at a new practice location." 42 C.F.R. § 424.520(d) (emphasis added).

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[2] In error, one reconsidered determination omits any actual decision section. *Kimberly Bergeron NP*, Docket No. C-14-642. I discuss below my authority to correct this error and decide the case.

[3] I make this one finding of fact/conclusion of law.

If a physician or nonphysician practitioner meets all program requirements, CMS allows him/her to bill retrospectively for up to "30 days prior to their effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries . . . ." 42 C.F.R. § 424.521(a)(1).[4]

Here, the parties agree that certain FastMed employees – physicians, nurse practitioners, and physician assistants – began providing services to Medicare beneficiaries before submitting their Medicare enrollment applications. Eventually, their applications were filed, and the Medicare contractor approved each of them, effective the date of filing, with billing privileges beginning 30 days prior to the effective date. Specifically:

- C-14-642 – Kimberly Bergeron NP. Application filed June 6, 2012. CMS Ex. 1 at 1.[5] Enrollment effective June 6, 2012. Retrospective billing date: May 6, 2012. Petitioner Bergeron asks for an effective date of January 21, 2012.[6]

- C-14-643 – Kimberly Bergeron NP. Application filed June 6, 2012. CMS Ex. 2 at 1. Enrollment effective June 6, 2012. Retrospective billing date: May 6, 2012. Petitioner Bergeron asks for an effective date of January 21, 2012.

- C-14-644 – Kimberly Bergeron NP. Application filed June 6, 2012. CMS Ex. 3 at 1. Enrollment effective June 6, 2012. Retrospective billing date: May 6, 2012. Petitioner Bergeron asks for an effective date of January 21, 2012.

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[4] As authorized by the regulation, the Medicare contractor approved billing 30 days prior to the effective date of enrollment for each of the petitioners. The contractor refers to those earlier billing dates as the "effective dates." But "the effective date for billing privileges" in each of these cases is the date of filing, not the retrospective billing date. 42 C.F.R. § 424.520(d).

[5] The parties agree to all of these filing dates. In addition, CMS submits the applications themselves, each of which is stamped with a "Julian date stamp." On Petitioner Bergeron's June 6 application, for example, the number "121581633.0425" appears stamped on the lower left side of its cover. The first five digits signify the date of filing. "12" indicates the year, 2012. "158" refers to the date – the 158th day of 2012 – which is June 6.

[6] The reconsidered determinations in these cases do not mention the petitioners' proposed effective dates. CMS provides those dates, citing sections of the petitioners' enrollment applications and a "Summary by Provider" spreadsheet, which the petitioners attached to their hearing requests. CMS Br. at 3-16. Petitioners have not disputed the dates proffered by CMS.

- C-14-645 – Mary Bieber NP. Application filed May 30, 2012. CMS Ex. 4 at 1. Enrollment effective May 30, 2012. Retrospective billing date: April 30, 2012. Petitioner Bieber asks for an effective date of January 10, 2012.

- C-14-646 – Ryan Brower PA. Application filed June 6, 2012. CMS Ex. 5 at 1. Enrollment effective June 6, 2012. Retrospective billing date: May 6, 2012. Petitioner Brower asks for an effective date of October 10, 2011.

- C-14-647 – Patricia Daly NP. Application filed May 30, 2012. CMS Ex. 6 at 1. Enrollment effective May 30, 2012. Retrospective billing date: April 30, 2012. Petitioner Daly asks for an effective date of March 12, 2012.

- C-14-648 – Lisa Daniels PA. Application filed July 16, 2012. CMS Ex. 7 at 1. Enrollment effective July 16, 2012. Retrospective billing date: June 16, 2012. Petitioner Daniels asks for an effective date of November 30, 2011.

- C-14-649 – Lisa Daniels PA. Application filed May 30, 2012. CMS Ex. 8 at 1. Enrollment effective May 30, 2012. Retrospective billing date: April 30, 2012. Petitioner Daniels asks for an effective date of November 30, 2011.

- C-14-650 – Kelli Favata MD. Application filed June 6, 2012. CMS Ex. 9 at 1. Enrollment effective June 6, 2012. Retrospective billing date: May 6, 2012. Petitioner Favata asks for an effective date of November 3, 2011.

- C-14-651 – Kelli Favata MD. Application filed July 16, 2012. CMS Ex. 10 at 1. Enrollment effective July 16, 2012. Retrospective billing date: June 16, 2012. Petitioner Favata asks for an effective date of November 3, 2011.

- C-14-652 – Erin Ford PA. Application filed February 6, 2012. CMS Ex. 11 at 1. Enrollment effective February 6, 2012. Retrospective billing date: January 6, 2012. Petitioner Ford asks for an effective date of December 6, 2011.

- C-14-653 – Georgette George NP. Application filed July 16, 2012. CMS Ex. 12 at 1. Enrollment effective July 16, 2012. Retrospective billing date: June 16, 2012. Petitioner George asks for an effective date of March 7, 2012.

- C-14-654 – Georgette George NP. Application filed May 30, 2012. CMS Ex. 13 at 1. Enrollment effective May 30, 2012. Retrospective billing date: April 30, 2012. Petitioner George asks for an effective date of March 7, 2012.

- C-14-655 – Jennifer Francyk PA. Application filed July 16, 2012. CMS Ex. 14 at 1. Enrollment effective July 16, 2012. Retrospective billing date: June 16, 2012. Petitioner Francyk asks for an effective date of January 24, 2011.

- C-14-665 – Lynn Helseth MD. Application filed June 14, 2012. CMS Ex. 15 at 1. Enrollment effective June 14, 2012. Retrospective billing date May 14, 2012. Petitioner Helseth asks for an effective date of March 5, 2012.

- C-14-666 – Kyle Hoffman PA. Application filed May 30, 2012. CMS Ex. 16 at 1. Enrollment effective May 30, 2012. Retrospective billing date April 30, 2012. Petitioner Hoffman asks for an effective date of September 9, 2011.

- C-14-667 – Kyle Hoffman PA. Application filed July 16, 2012. CMS Ex. 17 at 1. Enrollment effective July 16, 2012. Retrospective billing date: June 16, 2012. Petitioner Hoffman asks for an effective date of September 9, 2011.[7]

- C-14-668 – Stephanie Hulme NP. Application filed May 30, 2012. CMS Ex. 18 at 1. Enrollment effective May 30, 2012. Retrospective billing date: April 30, 2012. Petitioner Hulme asks for an effective date of February 28, 2012.

- C-14-669 – Abigail Kraemer PA. Application filed May 30, 2012. CMS Ex. 19 at 1. Enrollment effective May 30, 2012. Retrospective billing date: April 30, 2012. Petitioner Kraemer asks for an effective date of October 26, 2011.

- C-14-670 – Abigail Kraemer PA. Application filed July 16, 2012. CMS Ex. 20 at 1. Enrollment effective July 16, 2012. Retrospective billing date: June 16, 2012. Petitioner Kraemer asks for an effective date of October 26, 2011.

- C-14-671 – Jane Lykins MD. Application filed July 16, 2012. CMS Ex. 21 at 1. Enrollment effective July 16, 2012. Retrospective billing date: June 16, 2012. Petitioner Lykins asks for an effective date of January 14, 2012.

- C-14-672 – Jane MacDonald PA. Application filed July 16, 2012. CMS Ex. 22 at 1. Enrollment effective July 16, 2012. Retrospective billing date: June 16, 2012. Petitioner MacDonald asks for an effective date of December 1, 2011.

[7] In error, the December 11, 2013 reconsidered determination lists August 23, 2012 as the filing/effective date and July 23, 2012 as the retrospective billing date. CMS concedes that these dates are not correct. CMS Br. at 9-10; CMS Ex. 17 at 1, 7.

- C-14-673 – Jane MacDonald/Stevenson PA. Application filed May 30, 2012. CMS Ex. 23 at 1. Enrollment effective May 30, 2012. Retrospective billing date: April 30, 2012. Petitioner MacDonald/Stevenson asks for an effective date of December 1, 2011.

- C-14-674 – Thomas Morris NP. Application filed August 17, 2012. CMS Ex. 24 at 1. Enrollment effective August 17, 2012. Retrospective billing date: July 17, 2012. Petitioner Morris asks for an effective date of February 1, 2012.

- C-14-675 – Diane Musante PA. Application filed February 27, 2012. CMS Ex. 25 at 1. Enrollment effective February 27, 2012. Retrospective billing date: January 28, 2012. Petitioner Musante asks for an effective date of December 1, 2011.[8]

- C-14-676 – Diane Musante PA. Application filed July 16, 2012. CMS Ex. 26 at 1. Enrollment effective July 16, 2012. Retrospective billing date: June 16, 2012. Petitioner Musante asks for an effective date of November 29, 2011.

- C-14-677 – Ian Myers PA. Application filed May 30, 2012. CMS Ex. 27 at 1. Enrollment effective May 30, 2012. Retrospective billing date: April 30, 2012. Petitioner Myers asks for an effective date of December 19, 2011.

- C-14-678 – Ian Myers PA. Application filed July 16, 2012. CMS Ex. 28 at 1. Enrollment effective July 16, 2012. Retrospective billing date: June 16, 2012. Petitioner Myers asks for an effective date of December 19, 2011.

- C-14-679 – Rudy Noriega PA. Application received July 16, 2012. CMS Ex. 29 at 1. Enrollment effective July 16, 2012. Retrospective billing date: June 16, 2012. Petitioner Noriega asks for an effective date of February 13, 2012.

- C-14-680 – Guy O'Connor MD. Application received June 14, 2012. CMS Ex. 30 at 1. Enrollment effective June 14, 2012. Retrospective billing date: May 14, 2012. Petitioner O'Connor asks for an effective date of February 1, 2012.

- C-14-681 – Deepali Rastogi MD. Application received June 14, 2012. CMS Ex. 31 at 1. Enrollment effective June 14, 2012. Retrospective billing date: May 14, 2012. Petitioner Rastogi asks for an effective date of February 20, 2012.

[8] Again, the December 11, 2013 reconsidered determination lists wrong filing/effective and retrospective billing dates (April 2, 2012 and March 2, 2012). CMS concedes these dates are not correct. CMS Br. at 12; CMS Ex. 25 at 1, 7.

- C-14-682 – Dana Robinson NP. Application received May 30, 2012. CMS Ex. 32 at 1. Enrollment effective May 30, 2012. Retrospective billing date: April 30, 2012. Petitioner Robinson asks for an effective date of March 15, 2012.

- C-14-683 – Stephanie Schmit PA. Application received January 21, 2013. CMS Ex. 33 at 1. Enrollment effective January 21, 2013. Retrospective billing date: December 22, 2012. Petitioner Schmit asks for an effective date of May 6, 2012.

- C-14-684 – Janet Scott NP. Application received June 14, 2012. CMS Ex. 34 at 1. Enrollment effective June 14, 2012. Retrospective billing date: May 14, 2012. Petitioner Scott asks for an effective date of February 19, 2012.

- C-14-685 – Kimberly Thuillez[9] PA. Application received July 16, 2012. CMS Ex. 35 at 1. Enrollment effective July 16, 2012. Retrospective billing date: June 16, 2012. Petitioner Thuillez asks for an effective date of February 10, 2012.

- C-14-686 – Benjamin Tyau PA. Application received July 16, 2012. CMS Ex. 36 at 1. Enrollment effective date July 16, 2012. Retrospective billing date: June 16, 2012. Petitioner Tyau asks for an effective date of January 21, 2012.

- C-14-687 – Craig Wells NP. Application received July 16, 2012. CMS Ex. 37 at 1. Enrollment effective July 16, 2012. Retrospective billing date: June 16, 2012. Petitioner Wells asks for an effective date of January 17, 2012.

- C-14-688 – Myles Whitfield PA. Application received July 16, 2012. CMS Ex. 38 at 1. Enrollment effective date July 16, 2012. Retrospective billing date: June 16, 2012. Petitioner Whitfield asks for an effective date of March 30, 2012.

Thus, pursuant to 42 C.F.R. § 424.520(d), CMS correctly determined the effective dates of enrollment for all of the petitioners.

Petitioners complain that they provided substantial services to Medicare beneficiaries, for which the Medicare program will not reimburse FastMed. This is unfortunate but does not entitle them to earlier effective dates. Under the regulations, suppliers must be enrolled before the Medicare program can pay them for the services they provide. *US Ultrasound*, DAB No. 2302 at 8 (2010).

Flawed Reconsidered Determination. Unfortunately, one of the reconsidered determinations contains a significant error. In *Kimberly Bergeron NP*, C-14-642, the

[9] The reconsidered determination cites Petitioner's last name as Thuille. Her last name is actually Thuillez. CMS Ex. 35.

decision section of the December 4 reconsidered determination has not been completed. It says:

> *[Provider/Supplier Name] SELECT ONE* Choose an item. *Therefore, we SELECT ONE you access to the Medicare Trust Fund (by way or issuance) of a SELECT ONE.*
>
> This decision is SELECT ONE DECISION. Please see below for additional appeal rights.

Reconsideration at 2; *see* CMS Ex. 1 at 7. In an attached exchange of emails, dated December 12, 2013, the FastMed representative points out the error, and a contractor representative (presumably the hearing officer) apologizes: "Oops, should be unfavorable sorry about that." Reconsideration at 5.

Neither party suggests that this December 4 issuance is not a reconsidered determination. It identifies the prospective supplier (Petitioner Bergeron) and refers to the initial determination (although, based on the record before me, I cannot verify that the determination accurately indicates the date of its issuance). A follow-up email clarifies that the determination is unfavorable to the Petitioner, although neither it nor the reconsidered determination itself explains why.

Until May of this year, this would not have presented a significant problem.[10] Notwithstanding the quality or content of a reconsidered determination, administrative law judges (ALJs) could consider bases other than those relied on by the hearing officer, so long as the parties were given adequate notice.[11] The Departmental Appeals Board summarized the scope of the ALJ's review authority in *Fady Fayad, M.D.*, DAB No. 2266 (2009), *aff'd*, 803 F. Supp.2d 699 (E.D. Mich. 2011). There, a physician (supplier), whose Medicare billing privileges had been revoked, argued that, during the administrative review process, CMS changed the bases for its actions. He claimed that the revocation notice did not cite the applicable statutes and regulations and contained no "detailed factual rationale" for the determination, deficiencies that, he maintained, were not corrected by the hearing officer at reconsideration. The Board rejected this position:

> To the extent that Petitioner is claiming that the revocation should be overturned because he lacked sufficient notice of the basis of CMS's revocation determination *at the*

[10] Indeed, CMS, which filed its brief in March, did not even mention the flawed reconsidered determination.

[11] I recognize that ALJs may be limited with respect to admitting new evidence. *See* 42 C.F.R. § 498.56(e).

> *reconsideration stage* . . . we stress that Petitioner subsequently received a de novo hearing before the ALJ concerning the validity of the revocation determination. In general, *the ALJ proceeding is not an appellate or quasi-appellate review of the adequacy of the federal agency's decision-making or review process. Rather, the ALJ hearing under 42 C.F.R. Part 498 is a de novo proceeding* in which the ALJ determines the legality of the challenged determination based on the evidence presented in that proceeding.

DAB No. 2266 at 11 (first emphasis in the original; second emphasis added). The *Fayad* decision reflected the Board's long-standing position on the scope of ALJ review under Part 498. Indeed, hearings held pursuant to section 205(b) of the Social Security Act (Act), as provider and supplier enrollment cases are (Act § 1866(j)(8)), have long been considered de novo. *Heckler v. Campbell*, 461 U.S. 458, 463 n.6 (1983); *see also Matthews v. Eldridge*, 424 U.S. 319, 339 n.21 (1976). This position is consistent with general principals of administrative law, allowing the ALJ to correct administratively any errors made below. It achieves the laudable goals of administrative efficiency and ensuring that cases are decided on their merits, without being side-tracked because the contractor hearing officer omitted a reference or committed some procedural error.

The regulations have not changed since the Board issued *Fayad*. However, without mentioning that decision or any of the myriad decisions that consistently describe Part 498 hearings as de novo, the Board recently issued several decisions that dramatically change the scope of ALJ review to something even more limited than standard appellate review. The Board now says that 42 C.F.R. § 498.5(*l*) "limits ALJs to considering the basis or bases for denial or revocation of enrollment and billing privileges set forth in the CMS contractor's reconsidered determination." *Precision Prosthetic, Inc.*, DAB No. 2597 at 11 (2014); *see Benson Ejindu, d/b/a Joy Medical Supply*, DAB No. 2572 (2014); *Neb Group of Arizona* LLC, DAB No. 2573 (2014).[12]

[12] Most recently the Board said that it has "repeatedly" articulated this view and chided an ALJ for his apparent disregard of its position. *Precision Prosthetic, Inc.*, DAB No. 2597 at 11. The Board cited *Ortho Rehab Designs Prosthetics and Orthotics, Inc.*, DAB No. 2591 (2014), and *Better Health Ambulance*, DAB No. 2475 (2012) as the "repeated" instances in which it held that section 498.5(*l*) restricts an ALJ's review authority. But *Better Health Ambulance* did not say that. It said that ALJ jurisdiction is triggered by the reconsidered determination; it said nothing about the scope of the ALJ's review. *See Better Health Ambulance*, DAB No. 2475 at 4. Moreover, *Ortho Rehab* and the decisions limiting an ALJ's review authority were issued on or after May 2014. *See Ortho Rehab*, DAB No. 2591 at 9. The harshness of the Board's admonishment in *Precision Prosthetic* is puzzling inasmuch as the ALJ decision in that case predated *Joy Medical* and its

In *Joy Medical Supply*, the Board mentioned, for the first time, that ALJs are limited to the four corners of the reconsidered determination. The Board there cited with approval the ALJ's limiting the scope of his review:

> The ALJ properly refrained from going beyond that issue to address other possible grounds for revocation because the reconsidered determination which Petitioner appealed (*in contrast to the initial determination*) did not rely on any additional legal ground for revocation. . . . 42 C.F.R. § 498.5(*l*)(2) (with respect to denial or revocation of billing privileges, the provider or supplier's appeal rights lie from the reconsidered or revised reconsidered determination, not the initial determinations.).

DAB No. 2572 at 5 (emphasis added).

The impact of the *Joy Medical Supply* decision might not have been great, since the Board was not resolving an issue raised in the case before it. The language quoted is dicta. However, immediately thereafter the Board issued *Neb Group of Arizona*. Citing *Joy Medical Supply*, the Board faulted the ALJ for considering whether the facility was operational and therefore subject to revocation under 42 C.F.R .§ 424.535(a)(5)(ii). The Board acknowledged that CMS's initial determination made that finding, but ruled that, because the contractor's reconsidered determination did not, the ALJ improperly considered the issue. In the Board's view the "only issue properly before the ALJ" was that addressed in the reconsidered determination. DAB No. 2573 at 7 (2014). Several months later, in *Ortho Rehab*, the Board relied on *Joy Medical Supply* and *Neb Group* to reach the same conclusion, faulting the ALJ for considering an issue raised in CMS's initial determination but not mentioned in the reconsideration.

The Board's newfound position creates some serious problems:

First, I am not aware of any reviewing authority that is so limited – and with good reason. Issues raised in the initial determination as well as issues raised by the parties during the reconsideration process are necessarily before the hearing officer. But the issues raised do not always find their way into the final reconsidered determination. Indeed, a hearing officer could preclude further review of a thorny issue by simply omitting it from his/her written determination. Under the *Neb* reasoning, the issue is lost forever. A petitioner

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progeny, having been issued on April 2, 2014, more than a month before the first of those Board decisions, when the prevailing – indeed the *only* – view was that ALJs provided de novo review.

would have no definitive way of preserving an issue for appeal, which seems a fairly obvious denial of due process.

Second, as this case illustrates, hearing officers, like everyone else, make mistakes. They cite the wrong regulation, they leave things out – even the entire "Decision" portion of a determination. Sometimes they cite regulations unrelated to the case before them. Pre-*Neb*, ALJs were empowered to correct such errors. Post-*Neb*, they are hamstrung by them.

In *Rey R. Palop, M.D.*, DAB CR3273, for example, the reconsidered determination was seriously flawed. Nevertheless, the proper outcome of the case was certain: the supplier's Medicare number had to be revoked retroactively because, in his application for it, he misled the Medicare contractor about an earlier felony conviction. The parties to the ALJ proceedings were fully apprised of the issues. Basing my decision there on the weaknesses of the reconsidered determination would, at best, have caused the parties needless expenses of time and money, and, at worst, would have perverted the administrative review process:

> I recognize that the quality of the reconsidered determination here leaves something to be desired. Nevertheless, the purpose of administrative review is to correct agency errors and reach the correct decision, based on the evidence presented. Here, Petitioner has been fully apprised of the bases for CMS's actions and has not complained about the adequacy of the notice provided. The matter has been fully briefed, and the law and undisputed facts lead to one conclusion. Petitioner is absolutely not entitled to prevail, no matter what the shortcomings of the reconsidered determination. My remanding the case – to allow CMS to present a more thorough determination – would unnecessarily prolong these proceedings, requiring all parties to expend additional time and resources to achieve the same result.

DAB CR3273 at 5 n.4 (2014).

This case presents a similar dilemma. The parties are fully aware of and agree to the issues presented; the regulations dictate that Petitioner cannot prevail, so the outcome, on the merits, is certain. Yet, I cannot review the findings included in the reconsidered determination, because the hearing officer mistakenly omitted any findings. My undesirable alternatives include: 1) to decide that there has been no reconsideration and dismiss, thus denying Petitioner Bergeron any review because the reconsidered determination is inadequate; 2) to rule in favor of Petitioner based on the inadequate reconsidered determination, contrary to the regulations that I am required to follow; or 3)

to remand the case with instructions to issue a new reconsidered determination. As in *Palop*, a remand would unnecessarily prolong these proceedings and require the parties to expend additional time and resources to achieve an inevitable result.

Moreover, the Board recently cast doubt on the ALJ's authority to remand these cases. In *Precision Prosthetic*, the reconsidered determination discussed revocation under 42 C.F.R. § 424.535(a)(3) only. The Board held that the ALJ could not properly remand the matter to CMS to consider denial under 42 C.F.R. § 424.530 (a provision that, substantively, is nearly identical to section 424.535(a)(3)).[13] If ALJs can neither correct reconsideration errors nor remand cases so that CMS can correct them, they are left with very little recourse.

Third, the Board's underlying support for limiting the scope of ALJ review is particularly weak. The Board cited its own decisions and its (apparently new) interpretation of 42 C.F.R. § 498.5(*l*)(2). That regulation provides that any supplier "dissatisfied with a reconsidered determination . . . or a revised reconsidered determination is entitled to a hearing before an ALJ." I see nothing in this language to preclude de novo review of the reconsidered determination. Moreover, the language of section 498.5(*l*)(2) is *identical* in all key respects to the language of 42 C.F.R. § 498.5(*l*)(3): any supplier "dissatisfied with a hearing decision may request Board review." To my knowledge, the Board has *never* interpreted this language to limit its own review of ALJ decisions. *See, e.g.*, *Complete Home Care, Inc*., DAB No. 2525 (2013) ("[W]e conclude that CMS had authority to revoke Complete Home Care's enrollment based on the same facts . . . but on a different legal basis."); *Main Street Pharmacy, LLC*, DAB No. 2349 (2010) ("[W]e uphold the revocation of MSP's billing privileges but modify the rationale."); *Robert F. Tzeng, M.D.*, DAB No. 2169 (2008) ("Although our analysis . . . differs . . . we . . . affirm [the ALJ's] ultimate conclusion.")

Fortunately, I am not required to follow the Board's dictates in this instance. I recognize that ALJ reliance on prior Board decisions makes obvious practical sense, given the Board's review authority. Of course, this is much more difficult where, as here, the

[13] The Board was particularly harsh in this regard, suggesting that the ALJ effectively coerced CMS. *Precision Prosthetic*, DAB No. 2597 at 13 (stating that the ALJ's remand order "clearly influenced CMS" to make a different determination). I find baffling the suggestion that either CMS or a petitioner would act improperly rather than appeal a purportedly objectionable ruling. In any event, remanding the case to CMS for a more careful analysis seems preferable to issuing a plainly incorrect decision – *e.g.* on the one hand, allowing an obvious bad actor to remain in the program, or, on the other, wrongfully barring a perfectly blameless supplier from program participation for up to three years. In this case, those options would be dismissing the case entirely (based on the absence of a reconsidered determination) versus deciding the matter against CMS, an outcome contrary to the regulations.

Board decisions are in conflict. *Compare Fayad*, DAB No. 2266 (reaffirming the ALJ's review under Part 498 as de novo) with *Neb Group*, DAB No. 2573 (limiting the ALJ's review to the four corners of the reconsidered determination). In any event, with only one exception, I am aware of no authority, inherent or express, establishing that a Board decision binds the ALJs beyond the immediate case in which it is rendered. The Secretary has been explicit in defining what she considers binding authorities. She has expressly provided that Board decisions in cases reviewing local coverage determinations (LCDs) have a degree of precedential effect. 42 C.F.R. § 426.431(a)(4) ("Treat as precedent any previous Board decision under § 426.482 that involves the same LCD provision(s), same specific issue and facts in question, and the same clinical conditions."). Outside this narrow standard, the ALJ is directed to follow "all applicable laws, regulations, rulings, and [national coverage determinations]." 42 C.F.R. § 426.431(c).

Likewise, the Secretary made CMS rulings, which are published under the authority of the CMS Administrator, binding "on all HHS components that adjudicate matters under the jurisdiction of CMS . . . ." 42 C.F.R. § 401.108(c); *see also* 42 C.F.R. § 405.1063(b); 70 Fed. Reg. 11,420, 11,457 (Mar. 8, 2005) (expanding the scope of CMS rulings to all matters in CMS jurisdiction was done to "help ensure consistency among appeals decisions."); 42 C.F.R. § 401.108(a) (providing that "a precedent final opinion or order or a statement of policy or interpretation . . . may be published in the Federal Register as a CMS Ruling and will be made available in the publication entitled *CMS Rulings*.").[14]

I note also that, if the Board decisions were binding precedent, such departure from its prior norms without any explanation would be contrary to generally accepted administrative procedures. As the Supreme Court has noted, we presume that an agency will follow its existing policies, procedures, and decisions in order to uphold congressional mandates. From this presumption "flows the agency's duty to explain its departure from prior norms." *Atchison, T. & S. Fe Ry. Co. v. Wichita Bd. of Trade*, 412 U.S. 800, 808 (1973). The Board made no attempt to do so in *Joy Medical Supply*, *Neb Group*, or *Ortho Rehab*. Moreover, the Court of Appeals for the D.C. Circuit has determined that "agencies act arbitrarily and capriciously when they 'ignore [their] own relevant precedent,'" and that "agencies may depart from precedent, but 'an agency changing its course must supply a reasoned analysis indicating that prior policies and standards are being deliberately changed, not casually ignored.'" *Nat'l Fed'n of Fed. Emps. v. FLRA*, 412 F.3d 119, 121 (2005) (*quoting B B & L, Inc. v. NLRB*, 52 F.3d 366, 369 (D.C. Cir. 1995) and *Greater Boston Television Corp. v. FCC*, 444 F.2d 841, 852 (D.C. Cir. 1970).

[14] In contrast, Board and ALJ decisions are merely posted on the DAB website, as required by the Freedom of Information Act, 5 U.S.C. § 552(a)(2)(A).

For all of these reasons, I follow the Board's well-reasoned decision in *Fayad* and its predecessors and consider whether the Medicare contractor properly determined the effective date for Petitioner Bergeron's program enrollment. As with the effective enrollment dates for FastMed's other employees, I affirm the contractor's determination. 42 C.F.R. § 424.520(d).

Conclusion

For the reasons set forth above, I affirm CMS's determinations as to the effective dates for Petitioners' participation in the Medicare program.

/s/
Carolyn Cozad Hughes
Administrative Law Judge

APPENDIX

C-14-642 Kimberly Bergeron NP (PTAN Z153964)

C-14-643 Kimberly Bergeron NP (PTAN Z153963)

C-14-644 Kimberly Bergeron NP (PTAN Z153962)

C-14-645 Mary Bieber NP (PTAN Z153657; PTAN Z153656; PTAN Z153655)

C-14-646 Ryan Brower PA (PTAN Z154926; PTAN Z154927; PTAN Z154928)

C-14-647 Patricia Daly NP (PTAN Z155027; PTAN Z155028; PTAN Z155029)

C-14-648 Lisa Daniels PA (PTAN Z155012; PTAN Z155013)

C-14-649 Lisa Daniels PA (PTAN Z154051)

C-14-650 Kelli Favata MD (PTAN Z153632)

C-14-651 Kelli Favata MD (PTAN Z154636; PTAN Z154637)

C-14-652 Erin Ford PA (PTAN Z151102; PTAN Z151103)

C-14-653 Georgette George NP (PTAN Z154635)

C-14-654 Georgette George NP (PTAN Z153482; PTAN Z153481)

C-14-655 Jennifer Francyk PA (PTAN Z154989; PTAN Z154990; PTAN Z154991)

C-14-665 Lynn Helseth MD (PTAN Z153877; PTAN Z153878; PTAN Z153879)

C-14-666 Kyle Hoffman PA (PTAN Z154050)

C-14-667 Kyle Hoffman PA (PTAN Z154608; PTAN Z154609)

C-14-668 Stephanie Hulme NP (PTAN Z153658; PTAN Z153659; PTAN Z153514)

C-14-669 Abigail Kraemer PA (PTAN Z153684)

C-14-670 Abigail Kraemer PA (PTAN Z154584; PTAN Z154585)

C-14-671 Jane Lykins MD (PTAN Z154804; PTAN Z154805; PTAN Z154640)

C-14-672 Jane MacDonald PA (PTAN Z154596; PTAN Z154597)

C-14-673 Jane MacDonald/Stevenson PA (PTAN Z154049)

C-14-674 Thomas Morris NP (PTAN Z90178; PTAN Z90179; PTAN Z90180)

C-14-675 Diane Musante PA

C-14-676 Diane Musante PA (PTAN Z154590; PTAN Z154591)

C-14-677 Ian Myers PA (PTAN Z153687)

C-14-678 Ian Myers PA (PTAN Z154587; PTAN Z154588)

C-14-679 Rudy Noriega PA (PTAN Z155033; Z155034)

C-14-680 Guy O'Connor MD (PTAN Z153885; Z153886; Z153887)

C-14-681 Deepali Rastogi MD (PTAN Z153882; PTAN Z155883; Z153884)

C-14-682 Dana Robinson NP (PTAN Z153538; PTAN Z153539; PTAN Z153540)

C-14-683 Stephanie Schmit PA (PTAN Z93438; PTAN Z93439; PTAN Z93440)

C-14-684 Janet Scott NP (PTAN Z153855; PTAN Z153856; PTAN Z153857)

C-14-685 Kimberly Thuillez PA (PTAN Z155018; PTAN Z155019; PTAN Z155020)

C-14-686 Benjamin Tyau PA (PTAN Z154543; PTAN Z154544; PTAN Z154545)

C-14-687 Craig Wells NP (PTAN Z155119; PTAN Z155120; PTAN Z155121)

C-14-688 Myles Whitfield PA (PTAN Z155022; PTAN Z155023; PTAN Z155024)