DEPARTMENTAL APPEALS BOARD
Appellate Division

Deann Worthington, NP
Docket No. A-15-72
Decision No. 2661
October 8, 2015

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Deann Worthington (Petitioner) appeals the April 1, 2015 decision of an Administrative Law Judge (ALJ). *Deanna Worthington, NP*, DAB CR3750 (2015) (ALJ Decision).[1] The ALJ upheld a determination by the Centers for Medicare & Medicaid Services (CMS) to deny Petitioner's application for enrollment (or re-enrollment) as a nurse practitioner (NP) in Part B of the Medicare program, which she submitted following a period of deactivation of her billing privileges. The ALJ determined that the application was properly denied because Petitioner did not meet the qualifications for a NP in 42 C.F.R. § 410.75(b).

Petitioner requests review of the ALJ Decision by the Board. For the reasons stated below, the Board upholds the ALJ Decision.

Legal Background

The Medicare program is administered by CMS, which in turn delegates certain program functions to private contractors. Social Security Act (Act) §§ 1816, 1842, 1874A[2]; 42 C.F.R. § 421.5(b).

The requirements for establishing and maintaining Medicare billing privileges are contained in 42 C.F.R. Part 424, subpart P. In order to receive payment for services furnished to Medicare beneficiaries, a provider or supplier – "supplier" includes a NP –

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[1] The caption to the ALJ Decision identifies Petitioner as "Deanna Worthington, NP." The caption to the Board's decision reflects "Deann Worthington, NP" consistent with Petitioner's request for review and other submittals reflecting "Deann" as Petitioner's first name. As discussed later in this decision, Petitioner participated in the Medicare program as a NP and is licensed as an Advanced Registered Nurse Practitioner (ARNP) in Florida.

[2] The current version of the Social Security Act can be found at http://www.socialsecurity.gov/OP_Home/ssact/ssact-toc.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross-reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp. Table.

must be "enrolled" in Medicare and maintain active enrollment status.[3] 42 C.F.R. §§ 424.500, 424.505, 424.510, 424.516. "Enroll/Enrollment" is defined as "the process that Medicare uses to establish eligibility to submit claims for Medicare covered services and supplies." *Id.* § 424.502. The process includes "[v]alidation of the provider's or supplier's eligibility to provide items or services to Medicare beneficiaries" and "[g]ranting the provider or supplier Medicare billing privileges." *Id.*

CMS may deny a provider's or supplier's enrollment in the Medicare program for the reasons set out in 42 C.F.R. § 424.530(a), one of which is when a "provider or supplier at any time is found not to be in compliance with the Medicare enrollment requirements described in [section 424.530] or on the applicable enrollment application to the type of provider or supplier enrolling, and has not submitted a plan of corrective action as outlined in part 488 of this chapter." 42 C.F.R. § 424.530(a)(1). "Deny/Denial" means "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." *Id.* § 424.502.

The reconsidered determination to deny the enrollment of a provider or supplier under 42 C.F.R. § 424.530, made by CMS or its contractor, is an "initial determination" that may be appealed through the administrative process, to the ALJ and then to the Board. 42 C.F.R. § 498.3(b)(17). *See* Act § 1866(j)(8) (providing that a "provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) . . . is denied may have a hearing and judicial review of such denial . . . ."). A provider or supplier that was denied enrollment but did not appeal the denial may reapply after its appeal rights have lapsed. 42 C.F.R. § 424.530(b)(1). A provider or supplier that appealed the denial of enrollment may reapply after the provider or supplier has received notification that the determination was upheld. *Id.* § 424.530(b)(2). The denial becomes effective within 30 days of the initial denial notification. *Id.* § 424.530(e).

Deactivation of a provider's or supplier's billing privileges is to be distinguished from denial of enrollment of a provider or supplier. "Deactivate" is defined to mean that "the provider or supplier's billing privileges were stopped, but can be restored upon the submission of updated information." *Id.* § 424.502. Medicare may deactivate an enrolled provider's or supplier's billing privileges for the reasons cited in 42 C.F.R. § 424.540(a), one of which is that the provider or supplier has not submitted any Medicare claims for 12 consecutive months, from "the 1st day of the 1st month without a

[3] "Suppliers" also include physicians and other non-physician health care practitioners. 42 C.F.R. § 400.202 (stating that, unless the context indicates otherwise, "[s]upplier means a physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare"). "Providers" include, *inter alia*, hospitals, nursing facilities, and comprehensive outpatient rehabilitation facilities. *Id.*

claims submission through the last day of the 12th month without a submitted claim." *Id.* § 424.540(a)(1). "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 unnecessary overpayments." *Id.* § 424.540(c); *see also* Final Rule, 77 Fed. Reg. 29,002, 29,010 (May 16, 2012) (explaining that the purpose of deactivating a provider's or supplier's billing privileges for non-submission of claims for 12 consecutive months in accordance with section 424.540(a)(1) is "to prevent situations in which unused, idle Medicare billing numbers could be accessed by individuals and entities to submit false claims").

The regulations also permit CMS to ask a provider or supplier (other than a supplier of durable medical equipment, prosthetics, orthotics and supplies) to periodically "resubmit and recertify the accuracy of its enrollment information" in order to maintain billing privileges. 42 C.F.R. § 424.515. A provider or supplier whose billing privileges were deactivated for non-submission of a claim for 12 consecutive months is "required to recertify that the enrollment information currently on file with Medicare is correct and furnish any missing information as appropriate . . . [and] must meet all current Medicare requirements in place at the time of reactivation, and be prepared to submit a valid Medicare claim." *Id.* § 424.540(b)(2). *See also* 77 Fed. Reg. at 29,010 (stating that, in general, the recertification process entails "the submission of a completed CMS-855 enrollment application").

The Act defines "nurse practitioner" and authorizes the Secretary of Health and Human Services to prescribe regulations on the qualification requirements for nurse practitioners. Section 1861(aa)(5)(A) defines "nurse practitioner" as a "nurse practitioner who performs such services as the individual is legally authorized to perform (in the State in which the individual performs such services) in accordance with State law . . . *and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations*." Emphasis added. The implementing regulations in section 410.75 set out the requirements NPs must meet to qualify to participate in the Medicare program and obtain coverage for the services they furnish to Medicare beneficiaries, as follows:

> (b) *Qualifications*. For Medicare Part B coverage of his or her services, a nurse practitioner must be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with State law, and must meet one of the following:
>
> (1) Obtained Medicare billing privileges as a nurse practitioner for the first time on or after January 1, 2003, and meets the following requirements:
>
> > (i) Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners.

> (ii) Possess a master's degree in nursing or a Doctor of Nursing Practice (DNP) doctoral degree.
>
> (2) Obtained Medicare billing privileges as a nurse practitioner for the first time before January 1, 2003, and meets the standards in paragraph (b)(1)(i) of this section.
>
> (3) Obtained Medicare billing privileges as a nurse practitioner for the first time before January 1, 2001.

42 C.F.R. § 410.75(b).[4]

Case Background[5]

It is undisputed that Petitioner is licensed as a ARNP in Florida. Petitioner's Exhibit (P. Ex.) 1, at 5 (internal numbering).[6] It is also undisputed that Petitioner first enrolled in Medicare as a NP years before the denial of her enrollment (or re-enrollment) application from which this appeal arises. Moreover, neither Petitioner nor CMS disputes that CMS deactivated Petitioner's billing privileges some time ago for non-submission of claims for a period of 12 consecutive months. *See* Request for hearing (RFH) at 1; CMS's brief to the ALJ at 1; Petitioner's response to CMS's brief to the ALJ at 1.

However, the parties do not appear to be in complete agreement on certain aspects of the factual background of this case, concerning when exactly Petitioner first enrolled as a NP participating in Medicare, when her Medicare billing privileges were deactivated, and the circumstances surrounding deactivation. We will address below the parties' positions on these factual issues, including that part of the ALJ Decision that discussed these issues. The ALJ expressly noted that the parties were not in full agreement as to these issues, but

[4] Section 410.75(b), as quoted here, has been in effect since January 1, 2009. *See* 73 Fed. Reg. 69,726, 69,933-34 (Nov. 19, 2008). CMS has issued related guidance in its manuals, listing seven national certifying bodies for NPs: American Academy of Nurse Practitioners; American Nurses Credentialing Center; National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties; Pediatric Nursing Certification Board (previously named the National Certification Board of Pediatric Nurse Practitioners and Nurses); Oncology Nurses Certification Corporation; AACN Certification Corporation; and National Board on Certification of Hospice and Palliative Nurses. Medicare Benefit Policy Manual (MBPM), CMS Pub. 100-02, Ch. 15, § 200; Medicare Program Integrity Manual (PIM), CMS Pub. 100-08, Ch. 15, § 15.4.4.8. The MBPM and PIM are available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html.

[5] The factual information in this section, unless otherwise indicated, in drawn from the ALJ Decision and the facts in the record and is presented to provide a context for the discussion of the issues raised on appeal.

[6] Petitioner submitted below one supporting document, not marked as an exhibit or paginated, which the ALJ admitted into the record as Petitioner's Exhibit 1. ALJ Decision at 1-2. Petitioner's Exhibit 1 is comprised of Form CMS-855I (Medicare Enrollment Application, Physicians and Non-Physician Practitioners) and Form CMS-460 (Medicare Participating Physician or Supplier Agreement).

nevertheless found and concluded that CMS properly denied Petitioner's enrollment application on the ground that Petitioner did not meet the NP qualification requirements in section 410.75(b).

This appeal arises from an enrollment (or re-enrollment) application that the CMS contractor, FCSO, Inc. (contractor or FCSO), stated it received from Petitioner in July 2014. CMS Exhibit (CMS Ex.) 1, at 1. By letter dated July 31, 2014, the contractor informed Petitioner that her application was incomplete and that Petitioner must submit additional information as specified in the contractor's letter within 30 days (i.e., by August 30, 2014) to avoid "closure" of her application "as well as revocation of [her] existing billing number (if applicable)." CMS Ex. 2, at 1, 3. Petitioner evidently submitted a response within the 30-day period. *See* CMS Ex. 3 (the response is not dated, but the last page of the response bears Petitioner's signature dated August 4, 2014, and the response apparently was sent to the contractor on August 5, 2014 by facsimile). In her response, Petitioner stated that she is licensed in Florida, has participated in Medicare "for many years" and "didn't need to get a certification because she was grandfathered in back in the 1990's." *Id.* at 3.[7]

By letter dated August 7, 2014, the contractor informed Petitioner that her enrollment application was being denied because she did not meet "all of the qualifications to enroll in the Medicare Program." CMS Ex. 4, at 1 (quoting a substantial part of 42 C.F.R. § 410.75(b)). The contractor stated that, because Petitioner first obtained billing privileges before January 1, 2003, she must meet the requirements in 42 C.F.R. § 410.75(b)(1)(i), i.e., be certified as a NP by a recognized national certifying body that has established standards for NPs. *Id.* at 2. The contractor also informed Petitioner that if she disagrees with the denial she may either submit a corrective action plan within 30 days or request reconsideration, i.e., an independent review, within 60 days. *Id.*

Petitioner requested reconsideration, stating only that she "did have billing privileges before Jan[uary] 1[,] 2003." CMS Ex. 5, at 2. By reconsidered determination dated September 10, 2014, the contractor informed Petitioner that her application was denied for lack of certification as a NP by a recognized national certifying body that has established standards for NPs. CMS Ex. 6, at 2. Petitioner then filed an appeal to the ALJ.

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[7] We do not construe Petitioner's statement that she was "grandfathered in back in the 1990's" (CMS Ex. 3, at 3) as an assertion that she was first enrolled in Medicare in the 1990s. Petitioner informs the Board that she "became an RN [registered nurse] in 1974" and that she "became a nurse practitioner in 1991," thereby distinguishing her status as an RN from her status as a NP, and then writes that "[n]o certification tests were mandatory at that time [referring to 1991]." RR at 1. A reasonable reading of these statements to the Board, considered within the context of the remainder of the record, is that Petitioner is asserting that she became a NP in 1991 when the national certification requirements were not in place, not that she was first enrolled in Medicare as a NP in 1991 (or in the 1990s).

ALJ Decision

The ALJ upheld the denial of Petitioner's application for enrollment (or re-enrollment), making one "finding of fact/conclusion of law": "CMS properly denied [Petitioner's] Medicare enrollment application because she did not meet the Medicare requirements in place at the time of her reactivation." ALJ Decision at 2.[8]

The ALJ first noted that, while the parties agreed that "at one time" Petitioner was enrolled in Medicare and that CMS deactivated Petitioner's enrollment, they did not agree about "the timing or circumstances of her original enrollment or the deactivation." *Id.* The ALJ wrote:

> CMS claims that it deactivated her enrollment on October 17, 2006, because she had not billed the Medicare program for 12 consecutive months. CMS Br. at 1.
>
> Petitioner claims otherwise. She says that she participated in the Medicare program until August 2013, when she was "asked to revalidate." P. Br. at 1. She thought that she had complied with the agency's requests, but CMS deactivated her enrollment in September 2013. P. Br. at 1; Hrg. Req. She complains that she did not learn about the deactivation until July 2014, following which she submitted a new enrollment application. P. Br. at 1.
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> Neither party submits documentation in support of its position. CMS relies solely on the reconsideration determination, which is not evidence. CMS Ex. 6 at 1. Petitioner submits only a Medicare enrollment application (CMS-855I), signed and dated on July 31, 2013, which does not exactly support the claim that CMS asked her to revalidate in August 2013. P. Ex. 1.
>
> On the other hand, Petitioner does not dispute CMS's assertion that her billing privileges were deactivated because she had not billed the Medicare program for 12 consecutive months. CMS may deactivate a supplier's Medicare billing privileges if the supplier does not submit any Medicare claims for 12 consecutive months. 42 C.F.R. § 424.540(a)(1).

[8] CMS moved for summary judgment, asserting that "[t]he undisputed material facts establish that CMS properly denied [Petitioner's] application to enroll in Medicare because she did not meet the qualifications for enrolling as a nurse practitioner, as set forth in 42 CFR [§] 410.75(b)." CMS's brief to the ALJ, at 1. The ALJ noted that neither party proposed to call any witnesses or submitted any written declarations of witnesses and stated, "Because a hearing would therefore serve no purpose, I issue this decision without considering CMS's motion for summary judgment." ALJ Decision at 2. Neither party disputes the ALJ's issuance of a decision on the written record. CMS does not dispute the ALJ's issuance of a decision without considering its motion.

Id. (footnote omitted).[9]

The ALJ further explained that, to have billing privileges reactivated, a supplier must recertify that the enrollment information on file with Medicare is correct, furnish any additional information necessary, meet all current Medicare requirements in place at the time of reactivation, and be prepared to submit a valid Medicare claim. *Id.* at 3, *citing* 42 C.F.R. § 424.540(b)(2). The ALJ also stated that a NP must meet certain qualification requirements, including the section 410.75(b) certification requirements, depending on when the NP first obtained billing privileges as a NP. *Id.*

Petitioner, the ALJ determined, has not shown that she has the certification required for NPs who first enrolled on or after January 1, 2003, or, on or after January 1, 2001 but before January 1, 2003. *See id.* at 1, 3; 42 C.F.R. § 410.75(b)(1)(i), (b)(2). The ALJ noted, too, that section 410.75(b) does not require certification if the NP first obtained Medicare billing privileges before January 1, 2001. *See* ALJ Decision at 3 ("Unless [a NP] first obtained her first billing privileges before January 1, 2001, she must meet other criteria, depending on when she first obtained those billing privileges as a nurse practitioner . . . ."); 42 C.F.R. § 410.75(b)(3). The ALJ noted, however, that "Petitioner does not claim to have obtained Medicare billing privileges before January 1, 2001." ALJ Decision at 3. Therefore, the ALJ determined, CMS properly required Petitioner to show that she has certification and denied her enrollment application for failure to show that she is certified. *Id.* Moreover, the ALJ noted, Petitioner has not shown that she has a master's degree or a doctorate in nursing. *Id.* In other words, the ALJ considered the section 410.75(b) NP qualification requirements in full in light of the apparently unsettled questions about the specific dates of Petitioner's enrollment (and the date of deactivation and circumstances surrounding deactivation), and determined that regardless of whether Petitioner enrolled on or after January 1, 2003 or sometime between January 1, 2001 and January 1, 2003, Petitioner does not fully meet the NP qualification requirements in the absence of certification as a NP by a recognized national certifying body. *See id.*

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[9] It is true that CMS's brief to the ALJ, page 1, cited CMS Exhibit 6, page 1 as support for CMS's position that Petitioner's billing privileges were deactivated on October 17, 2006. CMS Exhibit 6, page 1 is the first page of the contractor's September 10, 2014 reconsidered determination, which states, in part, "Your prior Medicare Identification number . . . with an effective date of July 24, 2002 was deactivated on October 17, 2006 for not billing for the previous 12 months." We note, however, that CMS submitted to the ALJ another document that is not a determination from which this appeal stems, but is the contractor's August 22, 2014 letter to Petitioner, apparently intended to respond to Petitioner's request for written confirmation about her enrollment status. CMS Ex. 5, at 5. It provides the same enrollment and deactivation dates given in the reconsidered determination: "Provider: [Petitioner], NP, [PTAN], with an effective date of 07-24-2002, End date (Deactivated) 10-17-2006." *Id.*

Also, we, like the ALJ, observe that the sole evidence of application, Form CMS-855I (P. Ex. 1), was signed on July 31, 2013. Likewise, the "Medicare Participating Physician or Supplier Agreement" (*id.*) was signed the same day. It is not clear why, as the ALJ noted, the application Petitioner offered to the ALJ was prepared no later than July 31, 2013 if, as Petitioner says, CMS asked her to revalidate in August 2013 (as opposed to revalidate by or no later than August 2013). Nor does the record explain why there is a one-year gap in time between the July 31, 2013 application and the contractor's acknowledgement of receipt of Petitioner's application in July 2014.

Standard of Review

The Board's standard of review on a disputed factual issue is whether the ALJ's decision is supported by substantial evidence in the record as a whole. The Board's standard of review on a disputed issue of law is whether the ALJ's decision is erroneous. *See Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program* (*Guidelines*), section entitled "Completion Of The Review Process," ¶ (c). The *Guidelines* are available at http://www.hhs.gov/dab/divisions/appellate/guidelines/prosupenrolmen.html.

Substantial evidence is "'more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.'" *Richardson v. Perales*, 402 U.S. 389, 401 (1971), *quoting Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938).

Analysis

For the reasons set out below, the Board concludes that the ALJ Decision is supported by substantial evidence in the record and is free of legal error and, accordingly, upholds the ALJ Decision. We further conclude that none of the documents Petitioner submitted to the Board are admissible. Moreover, even had they been offered to the ALJ and made a part of the record of the ALJ proceedings, they would not provide a basis for changing the outcome in Petitioner's favor.

1. *The ALJ did not err in concluding that CMS properly denied Petitioner's Medicare enrollment application for failure to meet the NP qualification requirements on certification in section 410.75(b).*

Petitioner does not raise any specific allegation of ALJ error of fact or law. Rather, she explains that she became a NP in 1991, long before she was "given a Medicare provider number in 2002" and was "'grandfathered in' without a certification." Request for review (RR) at 1. She states that she became a self-employed NP in 2005 and has "worked full time since then and received Medicare payments every month." *Id.* She writes:

> Around July 2014, a DME [durable medical equipment] vendor informed me that I did not have PECOS [Provider Enrollment, Chain and Ownership System] number [apparently referring to her billing number]. When I called Medicare, I was told that my number had been deactivated September 16, 2013, after not receiving a piece of information back from me related to my revalidation notice. I had filled out all of the revalidation

> notices, and had sent them back to Medicare in a timely manner. I was never notified that I needed to send in more information. (Medicare did a US wide revalidation of all of its providers in 2013.)
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> After finding out that my number was deactivated, I then had to resubmit a new application for a provider number, and have been denied a number because I do not have a certification . . . .
>
> After the last appeal was denied, I stopped seeing Medicare patients. I have not been paid for the visits that I made September 16, 2013 through March 31, 2015. I have made numerous appeals, all denied . . . .
>
> I would like to have my Medicare provider number reactivated and hopefully be paid for the visits that I made September 16, 2013 to March 31, 2015.

Id.[10] Other than the assertion concerning non-payment for NP services provided to Medicare beneficiaries from September 16, 2013 through March 31, 2015, Petitioner's statements in her request for review essentially reiterate the statements she made below.

Petitioner's statement that she was "given a Medicare provider number in 2002" (RR at 1) reasonably may be understood to mean that Petitioner does not in fact dispute that she first enrolled in Medicare in 2002. CMS consistently asserted that Petitioner first enrolled effective July 24, 2002. *See* CMS Ex. 6, at 1; CMS Ex. 5, at 5; CMS's brief to the ALJ at 1. While Petitioner has raised questions about the events surrounding her deactivation, she does not dispute that she was requested to submit an enrollment application or that it was denied for lack of certification as a NP by a recognized national certifying body. *See* RFH at 1; Petitioner's response to CMS's brief to the ALJ at 1; RR at 1.

Assuming that Petitioner was first enrolled in 2002, she may be held to the certification requirement because a NP who first obtained Medicare billing privileges between January 1, 2001 and January 1, 2003 must be certified. The certification would be required even assuming Petitioner was initially enrolled on or after January 1, 2003. Only NPs who first obtained billing privileges as a NP for the first time *before January 1, 2001* – which, as the ALJ noted, Petitioner does *not* assert applies to her, *see* ALJ Decision at 3 – are exempted from the requirement. 42 C.F.R. § 410.75(b)(3). The NP

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[10] Petitioner's statement to the effect that she has "received Medicare payments every month" since she became a self-employed NP in 2005 until September 16, 2013 seems inconsistent with CMS's position that Petitioner's billing privileges were deactivated on October 17, 2006 for non-submission of claims. *See, e.g.*, CMS Ex. 5, at 5. Neither party has addressed this question.

qualification requirements in section 410.75(b) as quoted above have been in effect since January 1, 2009 – long before Petitioner submitted the application that the contractor stated was received in July 2014 – and therefore may be applied, and were appropriately applied. *See* 73 Fed. Reg. 69,726, 69,933-34 (Nov. 19, 2008).

In fact, the regulatory history of section 410.75(b) indicates that the requirement of certification as a NP by a recognized national certifying body was in place a decade earlier, though the specific regulatory language on certification has evolved with revisions over time since then. Section 410.75(b), published on November 2, 1998, read as follows:

> (b) *Qualifications*. For Medicare Part B coverage of his or her services, a nurse practitioner must –
> (1) Possess a master's degree in nursing;
> (2) Be a registered professional nurse who is authorized by the State in which the services are furnished, to practice as a nurse practitioner in accordance with State law; and,
> (3) Be certified as a nurse practitioner by the American Nurses Credentialing Center or other recognized national certifying bodies that have established standards for nurse practitioners as defined in paragraphs (b)(1) and (2) of this section.

63 Fed. Reg. 58,814, 58,908 (Nov. 2, 1998). By "Correction of final rule with comment period" published on May 12, 1999, with an effective date of January 1, 1999, CMS clarified that in the regulation published in 63 Fed. Reg. at 58,908 for section 410.75(b), the clause "After December 31, 1999" should be inserted at the beginning of the first sentence. 64 Fed. Reg. 25,456, 25,457 (May 12, 1999). As a result, after December 31, 1999, NPs were required to have certification as a NP by the American Nurses Credentialing Center or other recognized national certifying body.

Section 410.75(b) was revised effective January 1, 2000, to read as follows:

> (b) *Qualifications*. For Medicare Part B coverage of his or her services, a nurse practitioner must-
> (1)(i) Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with State law; *and*
> (ii) Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners; *or*
> (2) Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with State law and have been granted a Medicare billing number as a nurse practitioner by December 31, 2000; or

> (3) Be a nurse practitioner who on or after January 1, 2001, applies for a Medicare billing number for the first time and meets the standards for nurse practitioners in paragraphs (b)(1)(i) and (b)(1)(ii) of this section; or
> (4) Be a nurse practitioner who on or after January 1, 2003, applies for a Medicare billing number for the first time and possesses a master's degree in nursing and meets the standards for nursing practitioners in paragraphs (b)(1)(i) and (b)(1)(ii) of this section.

64 Fed. Reg. 59,380, 59,440 (Nov. 2, 1999) (emphasis in original). In effect, under this version of the regulation, a NP who has a state license but not a master's degree or certification by a recognized national certifying body would qualify for enrollment if he or she obtained a Medicare billing number as a NP on or before December 31, 2000. Otherwise, the NP must meet additional requirements as stated in the regulation. With subsequent revision, section 410.75(b), as quoted above under the "Legal Background" section of this decision, went into effect on January 1, 2009. 73 Fed. Reg. 69,726, 69,933-34.

The regulatory history of section 410.75(b) reveals that the certification requirement for NPs went into effect years before 2002, the year Petitioner says she was first enrolled (RR at 1), and Petitioner therefore was (and still is) subject to the requirement. CMS does not address why Petitioner was nevertheless enrolled initially. But, Petitioner herself has never asserted, much less shown, that she met the certification requirement at any time. Petitioner's own statements to the Board that "[t]he certification board for 'Women's Health'"[11] denied her request to take the "certification test" in the area of "Women's Health" and that two other "certification boards" denied her request to sit for the "adult/geriatric certification test" (RR at 1) strongly suggest that Petitioner is not now certified and was not certified in July 2014. And, to the extent Petitioner's statement that she was "grandfathered in" long ago may be considered to be an assertion that CMS should therefore consider allowing her to continue to remain enrolled and bill Medicare, even though she does not fully meet the NP qualification requirements, Petitioner cites no authority for such "grandfathering."

[11] Petitioner cited and submitted to the Board, *inter alia*, a May 7, 2015 letter from The National Certification Corporation (NCC), the admissibility of which we will discuss later. NCC, in Chicago, Illinois appears to be one of the seven national certifying bodies identified in the MBPM and PIM. The MBPM, Ch. 15, § 200 and PIM, Ch. 15, § 15.4.4.8 identify "National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties" as one recognized body. NCC's website (www.nccwebsite.org) identifies Inpatient Obstetric Nursing, Maternal Newborn Nursing, Low Risk Neonatal Nursing and Neonatal Intensive Care Nursing as NCC's core certification examination subjects and indicates that NCC offers Neonatal Nurse Practitioner and Women's Health Care Nurse Practitioner certification programs as well as programs in the subspecialty areas of Electronic Fetal Monitoring and Neonatal Pediatric Transport.

Furthermore, Petitioner does not contest CMS's identification of recognized national certifying bodies published in the MBPM and PIM. Nor does she claim that she held, or holds, certification by any other "recognized" body. *See* MBPM, Ch. 15, § 200 (Revision 75, issued August 17, 2007, effective and implemented on November 19, 2007); PIM, Ch. 15, § 15.4.4.8 (Revision 519, issued May 30, 2014, effective and implemented on July 31, 2014).

We note Petitioner's request that she be allowed to claim payment for all services she states she provided from September 16, 2013 through March 31, 2015, but we have no authority to grant such relief. The only matter decided by the contractor, and properly before the ALJ and now before the Board, is the contractor's denial of the enrollment (or re-enrollment) application the contractor stated was received in July 2014. *See* 42 C.F.R. § 498.3(b) (identifying initial determinations that are appealable in accordance with the Part 498 regulations), 498.3(b)(17) (the denial of enrollment is an initial, and appealable, determination). Petitioner is not entitled to payment for any services provided when she was not enrolled in Medicare. Since we uphold the denial of enrollment, our decision does not affect her entitlement to payment.

2. *The documents Petitioner submitted with her request for review are not admissible.*

Petitioner submitted with her request for review five one-page documents, marked Exhibit 1 through Exhibit 5. The documents (which we will describe below) are not admissible because, by regulation, the Board is required to decide supplier enrollment appeals based on the evidentiary record before the ALJ. The regulation expressly excepts "provider and supplier enrollment appeals" – which would include this appeal, which involves the denial of enrollment (or re-enrollment) – from those appeals in which the Board may admit evidence in addition to the evidence introduced at the ALJ hearing or considered by the ALJ if the hearing was waived. 42 C.F.R. § 498.86(a); *see also Guidelines*, section entitled "Development Of The Record On Appeal," ¶ (f) ("The Board may not admit evidence into the record in addition to the evidence introduced at the ALJ hearing or in addition to the documents considered by the ALJ if the hearing was waived. See 42 C.F.R. § 498.86(a)."). And, even in appeals other than provider and supplier enrollment appeals for which 42 C.F.R. Part 498 procedural regulations apply, the Board has discretionary authority to admit (or exclude) evidence, because the regulation states that the Board "may" admit additional evidence that the Board "considers" "relevant and material to an issue before it." 42 C.F.R. § 498.86(a).

Even had all five documents Petitioner submitted to the Board been submitted earlier and made a part of the record of the ALJ proceedings, they would not alter our conclusion that Petitioner did not have the requisite certification when she submitted the July 2014 application. First, the documents marked Exhibits 1 and 3 together are evidence of Petitioner's active licensing status as a ARNP in Florida, which has not been in dispute.

The basis for CMS's denial of enrollment (or re-enrollment) and the ALJ Decision upholding that denial had nothing to do with Petitioner's state licensing status.

The document marked Exhibit 2 is a copy of CMS Exhibit 5, page 5 (the contractor's August 22, 2014 letter to Petitioner indicating that her enrollment, effective July 24, 2002, was deactivated effective October 17, 2006). Admitting duplicate evidence at this level of appeal would do nothing to further Petitioner's cause.

The document marked Exhibit 4 appears to be the first page of a four-page bank statement for the period from August 30, 2014 through September 30, 2014 that includes among the list of deposits and credits FCSO's payments to Petitioner during this period, with payment dates ranging from September 2, 2014 to September 22, 2014. A part of a bank statement indicating that FCSO paid Petitioner in September 2014 raises questions about why the contractor apparently paid Petitioner as recently as in September 2014 when CMS reportedly deactivated her billing privileges in September 2013 (RR at 1) and when the July 2014 application had been denied. The document does nothing to establish that Petitioner met the certification requirement or any other NP qualification requirement in section 410.75(b) when the application was filed in July 2014.

Lastly, the document marked Exhibit 5 is a copy of NCC's May 7, 2015 letter to Petitioner informing her that NCC's Policy Review Committee decided to "uphold the stated policy that candidates for [the Women's Health Care Practitioner Certification Examination] must meet eligibility criteria which require[] a graduate degree as a Women's Health Care Nurse Practitioner within the last 8 years." Evidently NCC denied Petitioner's request to sit for the examination, as NCC also stated, "At this time your only option is to demonstrate eligibility to take this examination. We regret that we cannot honor your request." NCC's letter, if admitted, arguably would weaken Petitioner's case because it reinforces that Petitioner does not have certification as a NP from NCC, which appears to be one of the seven national certifying bodies identified in the MBPM and PIM.

In sum, none of the proffered exhibits, even if admissible, would offer any material support to Petitioner's position.

Conclusion

Based on the foregoing reasons, we uphold the ALJ Decision.

/s/
Constance B. Tobias

/s/
Leslie A. Sussan

/s/
Susan S. Yim
Presiding Board Member