Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Karthik Ramaswamy, M.D.
Docket No. A-13-87
Decision No. 2563
March 24, 2014

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Karthik Ramaswamy, M.D. (Petitioner) appeals the May 1, 2013 decision of an Administrative Law Judge (ALJ) affirming the determination of a Medicare contractor setting the effective date of Petitioner's enrollment in the Medicare program as May 21, 2012 with an effective billing date of April 21, 2012. *Karthik Ramaswamy, M.D.*, DAB CR2771 (2013) (ALJ Decision).

This case was heard by a panel of all five Board members, which upholds the ALJ Decision by a four-member majority. The decision of the majority is below, and the dissenting opinion by the original Presiding Board Member follows.

Legal background

A physician or other "supplier" of Medicare services must be enrolled in the Medicare program in order to receive payment for items and services covered by Medicare.[1] 42 C.F.R. § 424.505. "Enrollment" is the process that the Center for Medicaid & Medicare Services (CMS) and its contractors use 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, suppliers must submit enrollment information on the applicable enrollment application. "Once the provider or supplier successfully completes the enrollment process . . . CMS enrolls the provider or supplier into the Medicare program." 42 C.F.R. § 424.510(a). A prospective supplier "must submit a complete enrollment application and supporting documentation to the designated Medicare … contractor." 42 C.F.R. § 424.510(d)(1). An "enrollment application" is the CMS-approved paper enrollment application or an electronic Medicare enrollment process approved by the Office of

[1] A physician is among several types of health care practitioners considered "suppliers" who, along with "providers," participate in the Medicare program. Social Security Act § 1861(d).

Management and Budget. 42 C.F.R. § 424.502. The approved form for physicians is the CMS-855I. 71 Fed. Reg. 20,754, 20,756 (Apr. 21, 2006). CMS "may reject" an application if a supplier "fails to furnish complete information" or supplemental materials within 30 days "from the date of the contractor request." 42 C.F.R. § 424.525(a). CMS may "at its discretion, choose to extend the 30 day period if CMS determines that the [supplier] is actively working with CMS to resolve any outstanding issues." 42 C.F.R. § 424.525 (b).

The preamble at 71 Fed. Reg. 20,759 (emphasis added) provides:

> In new § 424.525, we proposed that if a provider or supplier enrolling in the Medicare program for the first time fails to furnish complete information on the CMS 855, or fails to furnish missing information or any necessary supporting documentation as required by CMS under this or other statutory or regulatory authority within 60 calendar days of our request to furnish the information, we would reject the provider or supplier's CMS 855 application. Rejection would not occur if the provider or supplier is actively communicating with us to resolve any issues regardless of any timeframes.
>
> **Upon notification of a rejected CMS 855, the provider or supplier must again begin the enrollment process by completing and submitting a new CMS 855 and all applicable documentation.** We proposed to specify in § 424.525(b) that the new form must also update any information that is different from that originally submitted. This would ensure that we have the most recent information about the provider or supplier. **The enrollment process would culminate in the granting of billing privileges or denial or rejection of the application.**

Denial of an enrollment application is an initial determination as to which a supplier may seek reconsideration within 60 days of receipt of notice of denial, which is presumed to occur 5 days after the date on the notice, absent a showing to the contrary. *See* 42 C.F.R. §§ 498.3(b)(17); 498.22; *see also* 498.5(l)(a supplier may "request reconsideration in accordance with § 498.22(a)" if dissatisfied with such an initial determination and is entitled to an ALJ hearing if dissatisfied "with a reconsidered determination" issued under 498.5(l)(1)). A properly filed request for reconsideration results in a "reconsidered determination, affirming or modifying the initial determination and the findings on which it was based." 42 C.F.R. § 498.24(c). A prospective "supplier, or existing supplier dissatisfied with a reconsidered determination under paragraph (1)(l) of this section, or a revised reconsidered determination under § 498.30, is entitled to a hearing before an ALJ." 42 C.F.R. § 498.5(l)(2). An initial determination is final and binding unless it is reconsidered in accordance with section 498.24, reopened and revised, or remanded after an ALJ hearing. 42 C.F.R. § 498.20(b).

When an enrollment application is approved, the contractor sets the effective date of the approval for billing privileges. The effective date of a physician's enrollment in Medicare is "the later of the date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor or the date an enrolled physician ... first began furnishing services at a new practice location." 42 C.F.R. § 424.520(d). The preamble for the effective date regulation states that the "date of filing" is the date that a Medicare contractor receives a signed application that the contractor is "able to process to approval." 73 Fed. Reg. 69,726, 69,769 (Nov. 19, 2008). In general, an enrolled physician who meets all program requirements and has been providing services at the enrolled practice location may bill for services for "up to– . . . 30 days prior" to the effective date of enrollment "if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries." 42 C.F.R. § 424.521(a)(1).[2]

The determination of the effective date of a supplier's enrollment in the Medicare program is also an "initial determination" that is subject to the hearing and review procedures set forth in 42 C.F.R. Part 498. 42 C.F.R. §§ 498.3(a)(1), (b)(15); s*ee Victor Alvarez, M.D.*, DAB No. 2325, at 3 (2010) (finding that a supplier enrolled in Medicare has a right to a hearing under section 498.5(l) on the determination of the supplier's date of enrollment).

Case Background[3]

In May 2012, Petitioner submitted Medicare enrollment and reassignment applications to the CMS Medicare contractor, Wisconsin Physicians Service (WPS). CMS Exs. 1, 2; P. Ex. 2. On July 9, 2012, WPS approved Petitioner's Medicare enrollment with an effective date of May 21, 2012, the date WPS received the applications, and notified Petitioner that he could bill as of April 21, 2012. CMS Ex. 3. Petitioner timely requested reconsideration of this initial determination, seeking an earlier effective date based on an earlier application submitted and denied in 2011. CMS Ex. 4. On October 20, 2012, WPS confirmed the May 21, 2012 enrollment date and the April 21, 2012 billing date, again based on the receipt date of May 21, 2012. CMS Ex. 5, at 2. WPS stated that "based on the guidelines stated" in 42 C.F.R. § 424.520(d), "[t]he effective date is determined by the receipt date of a valid application that is approved." *Id*. Petitioner timely appealed WPS's reconsideration determination, resulting in the ALJ Decision that he now appeals.

[2] CMS, in its Program Integrity Manual (PIM) available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html, requires the Medicare contractor to "interpret the phase 'circumstances precluded enrollment'" in section 424.521(a)(1) "to mean that the physician … meets all program requirements (including State licensure) during the 30-day period before an application was submitted and no final adverse action, as identified in 42 CFR §424.502, precluded enrollment." PIM, Pub. 100-08, § 15.17.B.

[3] The background information is drawn from the ALJ Decision and the record before him.

Petitioner argued before the ALJ that his effective date instead should have been determined based on WPS's date of receipt of an earlier application which Petitioner submitted in May 2011. That application was denied by letter dated June 29, 2011 on the grounds that it was incomplete (specifically lacking license information) and WPS determined that Petitioner had failed to submit the required information to complete the application within 30 days. Petitioner contended, however, that he had in fact submitted the requested information to WPS by fax on May 24, 2011, the date on the notice from WPS that the application was incomplete. Further, Petitioner asserted that he did not receive WPS's denial letter until April 3, 2012. He also stated that his office contacted WPS on October 17, 2011, December 14, 2011, January 17, 2012 and March 19, 2012 but was given inconsistent information about the status of his application and the supplemental materials he submitted and not told of the denial until March 28, 2012. CMS Ex. 4, at 4.

On May 1, 2012, Petitioner sought reconsideration of the denial of his May 2011 application, setting out his contentions that he did not actually receive the denial letter until April 2012 and that he had made timely efforts to complete his application and to communicate with WPS. CMS Ex. 11. On May 18, 2011, WPS dismissed the reconsideration request finding that it was untimely and that Petitioner had failed to show good cause for late filing. CMS Ex. 10.

The ALJ Decision

The ALJ made the following findings of fact and conclusions of law:

1. WPS received Petitioner's completed applications (Forms CMS-855I and CMS-855R) on May 21, 2012.

2. WPS properly concluded that Petitioner's enrollment and reassignment of Medicare benefits was effective on May 21, 2012, with a retrospective billing period commencing on April 21, 2012.

3. The initial determination surrounding Petitioner's May 4, 2011 applications (Form CMS-855I and Form CMS-855R) is administratively final and does not provide a basis for altering Petitioner's effective date of enrollment.

ALJ Decision at 3-4.

The ALJ noted Petitioner's argument that he was entitled to earlier enrollment and billing dates based on the May 2011 application, but concluded that the ALJ's review authority was "limited to the [second] applications filed in May 2012, and [that] Petitioner's earlier applications are not relevant to the decision in this case." *Id*. at 5. The ALJ found that

WPS's denial of Petitioner's enrollment had become "administratively final" because "WPS never issued a reconsidered determination concerning [Petitioner's] May 4, 2011 applications" but had instead "dismissed Petitioner's [May 1, 2012] request for reconsideration as untimely." *Id.*, citing 42 C.F.R. § 498.5(1)(2) (granting ALJ appeal rights to a supplier "dissatisfied with a reconsidered determination") and 498.20(b). The ALJ also cited Board decisions that he described as holding that "[o]nly reconsidered determinations related to the denial or revocation of billing privileges are eligible for ALJ review and [an ALJ does] not have authority to inquire into a Medicare contractor's determination whether there is good cause for the late filing of a request for reconsideration." *Id*.

The ALJ based his decision on the written record after cross-motions for summary judgment. The parties' exhibits and the written direct testimony of the credentialing coordinator of Petitioner's medical group were admitted without objection. ALJ Decision at 2. The ALJ determined that an in-person hearing was not required because CMS did not affirmatively request an opportunity to cross-examine Petitioner's witness, and the pre-hearing order stated that the ALJ would convene an in-person hearing only if one party sought to cross-examine a witness. *Id*.

Standard of Review

The standard of review on a disputed factual issue is whether the ALJ decision is supported by substantial evidence in the record as a whole. The standard of review on a disputed issue of law is whether the ALJ 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* at http://www.hhs.gov/dab/divisions/appellate/guidelines/prosupenrolmen.html.

Analysis

1. The ALJ correctly applied the regulations in determining the effective date of Petitioner's enrollment.

The regulations provide that the effective date of enrollment is the date on which a contractor received an application which it was subsequently able to process to approval. Thus, while the contractor may require and request additional information to complete the application, the effective date will relate back to the date of filing so long as that application continues to be processed to a decision on whether to approve it. The process ends, however, once the application is rejected or denied. 71 Fed. Reg. at 20,759 (enrollment process culminates in "the granting of billing privileges or denial or rejection of the application"). A later submitted application, therefore, even if then processed to completion, will be approved with the effective date of **its** filing date, not that of any earlier application which the contractor was not able to process to approval.

Petitioner's position essentially is that the ALJ should have looked to the date of filing of his 2011 application because Petitioner was not aware that the processing of that application had culminated in a denial for which he could, within the regulatory time frame, seek reconsideration, and that he provided information that should have made it possible for the contractor to continue processing that application to approval. Request for Review (RR) at 3-4. Petitioner provided testimony to establish that he did respond to the May 24, 2011 notice from WPS that his application was incomplete and might be denied. P. Ex. 5. He offered a fax transmission notice of the same date to show that he sent the missing information to WPS. P. Ex. 6.

CMS disputed before the ALJ that Petitioner's evidence sufficed to show its fax was actually received by WPS or that it contained all the necessary information, given that WPS had no record of its receipt, that Petitioner did not claim to have any acknowledgment of receipt from WPS, and that Petitioner did not follow up with WPS to verify the receipt or adequacy of this submission for about 5 months. CMS Motion for Summary Judgment Brief (MSJ Br.) at 5. CMS's position in its MSJ, however, was not so much that the ALJ should resolve these factual issues in its favor but that they could not form a basis for altering the applicable effective date which had been set as a matter of law and could not be altered on equitable grounds however unfortunate Petitioner's experience may have been. CMS MSJ at 6-7. Hence, CMS did not treat Petitioner's allegations as material disputes of fact, nor did the ALJ.

We agree with the ALJ that Petitioner's factual allegations are not material. As noted, 42 C.F.R. § 424.520(d) provides that the effective date of a physician's enrollment in Medicare is "the later of the date of filing of **a Medicare enrollment application that was subsequently approved** by a Medicare contractor or the date an enrolled physician . . . first began furnishing services at a new practice location." (Emphasis added.) Thus, under the plain language of the regulation, neither an ALJ nor the Board may change an effective date to the date of receipt of an earlier application that was denied, because such an application was **not** processed to approval. To the extent that Petitioner contends that the denial of the earlier application was wrong because he did provide the missing information, the regulations provide a separate channel for review through a timely reconsideration on the denial of that application.

Petitioner argues that, in this case, he could not avail himself of reconsideration because he was not informed of the denial of his original application until almost a year later, despite inquiries, and that his request for reconsideration was not acted on even though it was filed within 60 days of when he actually received the denial. RR at 12-14. He presented this argument in requesting reconsideration of the denial of his May 2011 application, as noted above, but WPS nevertheless concluded that his request was untimely and that good cause was not shown. CMS Exs. 10, 11. Petitioner contends that

WPS improperly dismissed his reconsideration request merely because the contractor "arbitrarily and capriciously decided not to evaluate" the request rather than because it actually determined that the request was untimely. RR at 7. (In making this argument, Petitioner mistakenly points to the document indicating the contractor's return of the new application which Petitioner sought to file as part of his corrective action plan – at Petitioner's Exhibit 10 – rather than the dismissal of his reconsideration request – at CMS Exhibit 10.)

Even if we accept as true for purposes of this decision that events occurred as Petitioner alleges and even if we were to agree with Petitioner that the decision to dismiss his reconsideration request was ill-founded or improper, we would not conclude that the ALJ erred in applying the effective date regulation.

The regulations set out which contractor actions and determinations are reviewable. They do not provide for further review from a contractor dismissal of a reconsideration request as untimely. For us to entertain arguments that WPS applied erroneous standards, made erroneous findings, or reached erroneous conclusions in dismissing this reconsideration request would amount to reviewing the dismissal, which we, like the ALJ, have no authority to do. If we could credit such arguments in order to grant the same effective date that would have been available had the Petitioner been determined to have timely sought reconsideration and prevailed on the merits in showing that his first application was complete and approvable, we would effectively have made a nullity of the regulations making final and binding an initial determination that has not been the subject of a reconsidered determination. 42 C.F.R. § 498.20(b).

This conclusion is consistent with the settled case law. In *Better Health Ambulance*, DAB No. 2475 (2012), the supplier (BHA) argued that the contractor should not have dismissed his reconsideration request as untimely because it was addressed to a different company and, hence, had not been received on time. The ALJ found that BHA failed to prove good cause for its late filing. The Board concluded that the ALJ erred in reaching the question of whether there was good cause because a dismissal for untimeliness does not result in a reconsidered determination and is not subject to further review. The Board explained that, if "a supplier does not request and receive reconsideration of an initial determination, then the initial determination is 'binding.'" DAB No. 2475, at 1 (emphasis added). *See also Haissam Elzaim, M.D.*, DAB No. 2501 (2013) (petitioner has no right to ALJ review of a revocation where he argues that his reconsideration request was improperly dismissed as untimely because the notice went to an old address.); *Denise A. Hardy, D.P.M.*, DAB No. 2464, at 4 (2012); *Hiva Vakil, M.D.*, DAB No. 2460, at 5 (2012) (noting that "the regulations plainly require that CMS or one of its contractors issue a 'reconsidered determination' before the affected party is entitled to request a hearing before an ALJ").

Because the propriety of WPS's dismissal for untimeliness is not subject to review (and therefore the merits of the underlying denial are no longer subject to review), the factual allegations proffered by Petitioner regarding his interactions and communications with WPS in regard to each are not material facts as to any issue properly subject to our review in this matter.

2. Prior Board decisions do not mandate an earlier effective date under the circumstances here.

Petitioner further argues that a prior Board decision established that the filing date of an earlier application that the contractor returned or rejected, an action from which there are no appeal rights, could be considered in setting an effective date of participation after approval of a subsequent application. RR at 21, citing *Tri-Valley Family Medicine, Inc*., DAB No. 2358, at 7 (2010). First, we note that *Tri-Valley* did not involve the issue presented here of whether the Board may consider, in determining the proper effective date after approval of an application, the filing date of an earlier application which was denied, and where the request for reconsideration of that denial was dismissed as untimely. Indeed, the Board explained that its decision in *Tri-Valley* addressed only "a narrow issue regarding how to apply a revised effective date regulation to an enrollment application that had been submitted before that regulation was in effect." DAB No. 2358, at 3. By contrast, in the present case, the effective date regulation was in effect long before even the first application at issue was submitted by Petitioner. We also note that neither *Tri-Valley* nor the prior decision in *Andrew J. Elliott, M.D.*, DAB No. 2334 (2010) discussed the effect of the limitation on appeal rights to reconsidered determinations in 42 C.F.R. § 498.5(l)(2), a limitation critical to our decision here, as it was to the Board decisions in *Better Health Ambulance, Hardy*, *Elzaim* and *Vakil*, discussed above.

In any case, we find that the factual and procedural underpinnings in *Tri-Valley* and *Elliott* are clearly distinguishable from the present matter. In *Tri-Valley*, the contractor returned an application without processing because it was not certified. The decision pointed to regulations which provide the contractor with only two options in processing an incomplete application -- to permit the applicant time to correct by submitting a signed certification, or to deny the application -- and that, the applicant would have an opportunity to correct and a right to appeal in the event of a denial. *Id*. at 5-6. Having found that the contractor employed a mechanism not contemplated by the regulation which deprived the supplier of a regulatory review right, the Board determined that it should look to the prior application and determine whether it could have been processed to approval had the contractor provided an opportunity to correct. *Id*. at 8-10. In *Elliott*, the Board remanded on the basis that the ALJ had granted summary judgment in part on an issue not put forward by CMS and had not viewed the evidence in the light most

favorable to the non-movant party. DAB No. 2334, at 1, 5-8. Only in dicta did the Board comment that "while the regulations provide that '[e]nrollment applications that are rejected are not afforded appeal rights,' 42 C.F.R. § 424.525, the regulations do not bar an ALJ, on a properly filed appeal of an effective date of enrollment determination, from considering an earlier enrollment application in that process in order to determine the correct effective date for the provider or supplier." *Id.* at 7 n.7.

We limit these cases to their unique factual circumstances and do not read them to permit a provider or supplier to dispute the merits of the contractor's handling of a prior reconsideration request from a denial of an enrollment application, administrative actions for which the Secretary has not provided appeal rights, in the context of an effective date review relating to a later approved application. We will not determine de novo that an application could have been processed to approval in the face of the contractor's actual determination to deny the application because it was not approvable. To do so would improperly use scope of review to revisit a legally binding and administratively final determination.

In addition, we conclude that Petitioner's contentions that the contractor should have found his request for reconsideration timely and should have then reversed the denial amount to collateral attacks on a prior administrative decision that is also already final. These contentions too are not subject to review here in the context of an effective date appeal from a later approval.

Conclusion

For the reasons explained above, we affirm the ALJ Decision.

/s/
Stephen M. Godek

/s/
Sheila Ann Hegy

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

DISSENT TO DAB NO. 2563

Summary of my rationale

I respectfully dissent. Below, I provide a more detailed discussion of why I dissent, but here I briefly summarize my reasons. In my view, Petitioner showed that he did not receive the WPS letter denying his May 2011 enrollment application until April 3, 2012, and, therefore, the contractor Hearing Officer should have accepted his May 1, 2012 request for reconsideration of the denial as timely. The preponderance of the evidence in the record (which was fully developed at the ALJ level) also shows that Petitioner did timely fax the information WPS requested and that WPS could have approved the May 2010 application. Had the other four Board Members simply disagreed with me about how to evaluate the evidence or determined that the proper recourse is to remand the case rather than to decide it in Petitioner's favor, I would likely have deferred to their judgment. Instead, they have determined that the Board has no authority to provide any relief to Petitioner (even if he did timely request reconsideration of the denial of his May 2010 application and did timely complete that application), based on an analysis of the regulations and case law with which I cannot concur.

The majority opinion fails to even mention several factors that I consider relevant to any proper analysis of the issues here. First, in dismissing Petitioner's request for reconsideration, the contractor Hearing Officer did not apply the regulatory standard for timeliness. The regulations measure the 60 days from receipt of the initial determination. The WPS Hearing Officer said that the 60 days started with the postmark date. Then, remarkably, he made no findings regarding either the postmark date or the date of receipt, even though Petitioner's request for reconsideration quoted the correct regulatory standard and addressed it and the contractor was required to send the denial letter by certified mail.

Second, nothing in the regulations explicitly provides for CMS or its contractor to dismiss a request for reconsideration. The regulations may reasonably be read as implying that such authority exists, given that the regulations specify what CMS will do if a reconsideration request is filed in accordance with the regulatory requirements. Nothing in the regulations can reasonably be read as authorizing a contractor hearing officer to apply a standard for timeliness that conflicts with the regulation or to dismiss a request that was properly filed, however.

Similarly, nothing in the regulations specifically precludes an ALJ or the Board from reviewing whether a reconsideration request was timely, and the regulations as a whole make that determination a prerequisite for determining whether an initial determination has become final. The regulations do, moreover, specifically provide for ALJ dismissal of a hearing request in specified circumstances and for either the ALJ or the Board to

vacate such a dismissal. In light of this, it is illogical to interpret the regulations as permitting a contractor hearing officer to dismiss an appeal, but nonetheless to read those regulations as precluding higher level review of whether the hearing officer had a proper basis for doing so.

The majority decision here may be "consistent with" the line of cases on which CMS and the ALJ relied (*Vakil, Hardy,* and *Better Health Ambulance*), as the majority asserts, but those cases certainly do not govern here. In each of those cases, it was undisputed that the petitioner had failed to timely exercise appeal rights of which it had timely and adequate notice and therefore the determination the petitioner sought to overturn had become final. As the Board said in *Hardy,* an initial determination becomes final **if** an affected party does not request reconsideration of that determination in accordance with the regulations.[4] Treating a determination on the merits as final when it is **not** timely appealed does not necessarily lead to the conclusion that neither the ALJ nor the Board may even inquire whether the determination was, in fact, timely appealed under the correct timeliness standard. None of those decisions contains a complete analysis of the relevant regulatory provisions because the issue here was not raised in those cases. In any event, that line of cases addressed whether the ALJ had properly dismissed a request for an ALJ hearing. Here, Petitioner clearly had a right to an ALJ hearing on the reconsidered determination about the effective date of enrollment. It is undisputed that Petitioner properly appealed that reconsidered determination.

Based on the preamble to the final regulation amending the effective date provisions, past Board decisions established that an ALJ and the Board may, in determining the effective date of billing privileges, consider an enrollment application other than the one a contractor approved and may set an effective date based on an earlier application that the contractor "could have" processed through to approval. Instead of applying this precedent, the majority decision treats the fact that WPS did not in fact approve the May 2011 application as determinative of the effective date. Yet, the majority does not even acknowledge that it is departing from prior case law on how to determine effective date, asserting instead that it is merely limiting the Board's prior holdings to the facts of those cases. In my view, those cases applied the correct standard for determining effective date and correctly held that nothing in the regulations bars the Board from considering whether an earlier enrollment application could have been processed to approval. In overturning those cases, the majority renders the right to appeal an effective date determination by CMS essentially meaningless.

[4] The majority also cites *Elzaim,* which purports to be based on the earlier decisions, but which states a conclusion not found anywhere in those decisions and which I find unclear, in any event, for reasons explained below.

My position on scope of review in an effective date case does not mean that I would not, on different facts, conclude that an earlier application could not have been processed to approval because the contractor denied the application and the petitioner did **not** properly request reconsideration of the denial. In such a case, the application could not have been processed through to approval at a higher level because the petitioner failed to follow the correct procedures. But the majority would preclude an ALJ and the Board from even inquiring into whether a contractor hearing officer's dismissal was inconsistent with the regulations and improperly prevented the petitioner from the reconsideration to which the petitioner was entitled and which might have led to approval of the earlier application. This result is in my view inconsistent with the regulations read as a whole, is not compelled by anything in past Board decisions, and is also flawed because it is—

- inconsistent with Congressional intent that the enrollment process be governed by regulation and that independent review of CMS/contractor determinations be available;
- inconsistent with the Secretary's intent that physicians and other practitioners have the ability to preserve an effective date of enrollment in situations where a contractor determines that not all the required information was timely received;
- inconsistent with longstanding Board precedent establishing that any ambiguity will be resolved in favor of finding that hearing rights exist;
- not necessary in order to meet the goal of the enrollment process to preserve the integrity of the Medicare program, and
- not in the best interests of the program beneficiaries.

Detailed Analysis

In this section of my dissent, I provide relevant statutory and regulatory background and explain more fully the basis for my opinion. Although the key issue in this case is what is the scope of review in an appeal properly before us, and is not whether an ALJ properly dismissed a hearing request -- the issue addressed in the Board decisions on which the majority relies, I nonetheless address those decisions to explain why I do not find the majority's reasoning to be persuasive.

1. **Section 1866(j) of the Social Security Act (Act) requires the Medicare enrollment process to be governed by regulation.**

Title XVIII of the Act governs the healthcare program for the aged and disabled known as Medicare. In 2003, Congress enacted section 1866(j) of the Act, which specifically directed the Secretary to "establish **by regulation** a process for the enrollment of providers of services and suppliers" in Medicare. Section 936(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L. No. 108-173 (emphasis added). Congress noted that CMS had previously established provider and supplier enrollment processes in instructions to the contractors. *See* H.R.

Rep. No. 108-391, at 786 (2003) (Conf. Rep.). The instructions to the contractors provided a physician the right to appeal to a fair hearing officer under 42 C.F.R. § 405.874, as then in effect. However, unlike providers and some other suppliers, physicians were not entitled to further appeal a denied Medicare enrollment application or revoked Medicare billing privileges to an ALJ or the Board under 42 C.F.R. Part 498. MMA, however, provided that a provider or supplier whose enrollment was denied would have a right to a hearing under the procedures that apply under section 1866(h)(1)(A) of the Act, that is, the Part 498 procedures. Act § 1866(j)(2) (later redesignated as (j)(8)).

2. The Secretary promulgated regulations establishing a Medicare enrollment process in 2006.

In 2003, prior to the enactment of MMA, the Secretary had proposed that all providers and suppliers be required to complete an enrollment form and submit specified information. 68 Fed. Reg. 22,064 (Apr. 25, 2003). If the information submitted on an initial application was determined to be incomplete, invalid, or insufficient to meet Medicare requirements, billing privileges could be rejected or denied. *Id*. The Secretary proposed that rejection of an enrollment application would not occur if the provider or supplier was actively communicating with CMS to resolve any issues. *Id*. at 22,070. Denial of the enrollment application was proposed if the provider or supplier was found not to be in compliance with Medicare enrollment requirements. *Id*.

In 2006, the Secretary issued implementing regulations at 42 C.F.R. Part 424, subpart P, setting out the enrollment process Medicare uses to establish eligibility to submit claims for Medicare covered items and services.[5] 71 Fed. Reg. 20,776 (Apr. 21, 2006). To receive payment for items and services covered by Medicare, "a provider or supplier must be enrolled in the Medicare program." 42 C.F.R. § 424.505. "Once enrolled, the provider or supplier receives billing privileges . . . ." *Id.* To enroll, "[p]roviders and suppliers must submit enrollment information on the applicable enrollment application. Once the provider or supplier successfully completes the enrollment process . . . CMS enrolls the provider or supplier into the Medicare program." 42 C.F.R. § 424.510(a).

The 2006 rulemaking also partially implemented section 1866(j)(2). Among other things, the 2006 rulemaking added a new provision to the list of CMS determinations that are considered initial determinations for purposes of Part 498. That provision, section 498.3(b)(17), was revised in a later correcting amendment to read "[w]hether to deny or revoke a provider's or supplier's Medicare enrollment in accordance with § 424.530 or § 424.535." 71 Fed. Reg. 37,504, 37,505 (June 30, 2006).

[5] Unless as noted here, the regulations cited in this section of my dissent were in effect as of November 2008.

Recognizing that the application process was complex, the regulations established criteria for CMS, or its contractor, to reject or deny an enrollment application, in two places – section 424.525 and section 424.530. Section 424.525 requires a Medicare contractor that receives an enrollment application with missing information or supporting documentation to request the information or documentation from the provider or supplier and to give the provider or supplier at least 30 calendar days to respond with the missing information in order to cure any deficiencies in the application. 42 C.F.R. § 424.525.[6] CMS "may reject" an application if a supplier "fails to furnish complete information" within the 30-day period, but CMS "at its discretion, may choose to extend the 30 day period if CMS determines that the prospective . . . supplier is actively working with CMS to resolve any outstanding issues." *Id.* "Enrollment applications that are **rejected** are not afforded appeal rights," and to obtain billing privileges after rejection, the supplier must complete and submit a new enrollment application and supporting documents. *Id.* (emphasis added). Under section 424.530(a)(1), enrollment may be **denied** if the provider or supplier is found not to be in compliance with the enrollment requirements, including when an application is incomplete. 73 Fed. Reg. at 69,773. Under that section, however, the supplier is given an opportunity to submit a corrective action plan and appeal rights apply.

Prior to January 1, 2009, "depending on their effective date of enrollment, [physicians were permitted to] retroactively bill the Medicare program for services that were furnished up to 27 months prior to being enrolled to participate in the Medicare program." 73 Fed. Reg. 69,726, 69,766 (Nov. 19, 2008); 42 C.F.R. §§ 424.44, 424.510. Thus, a physician could retroactively bill Medicare for up to 27 months during the application process so long as he or she remained licensed and submitted claims in a timely manner. Under these rules, the adverse effect on a physician if a contractor rejected an enrollment application was minimal – the physician could still be paid retroactively for services provided during the period the physician was licensed once a new application was submitted and approved.

3. The Secretary promulgated amended regulations governing the Medicare enrollment process, effective January 1, 2009.

Effective January 1, 2009, the Secretary re-designated 42 C.F.R. § 424.520 as 42 C.F.R. § 424.516 and added a new section 424.520 entitled "Effective date of Medicare billing privileges." Under the new section 424.520(d), the effective date for billing privileges for physicians is "the later of the date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor or the date an enrolled physician

[6] The 2006 regulation provided for at least a 60-day period to correct deficiencies before an application could be rejected, which was subsequently reduced to 30 days in 2008. *See* 73 Fed. Reg. 36,448, 36,455 (June 27, 2008); *see also* 73 Fed. Reg. at 69,769 ("During the application review process, contractors notify applicants about missing information and documentation and afford the applicant at least 30 days to correct deficiencies.").

. . . first began furnishing services at a new practice location." 42 C.F.R. § 424.520(d) (2009). The preamble for the new section 424.520(d) stated that the "date of filing" is the date that a Medicare contractor receives a signed application that the contractor is "able to process to approval." 73 Fed. Reg. at 69,769. Under the new provisions, moreover, a physician could bill retroactively only 30 days from the effective date of billing privileges, rather than 27 months as previously had been the case.

As the Board said in *Elliott*, nothing in the regulations or in the preamble indicates that the effective date was to be determined by the submission of a **complete** application. Instead, the regulation refers to an application that is "subsequently approved." It does not require that the application be "approvable" as initially submitted. The regulatory process, which was unchanged, included provision for the contractor to request information or supporting documentation if an application was not complete. Thus, if the information or documentation was timely submitted and all other requirements were met, that application could be approved, and a provider or supplier was not required to submit an additional application. As noted above, the preamble language recognizes this by referring to an application that a contractor is "able to process to approval." 73 Fed. Reg. at 69,769. Indeed, the preamble indicated agreement with the comment that the filing date should **not** be the date when the application is "deemed complete and ready for approval." 73 Fed. Reg. at 69,769. Thus, as discussed below, the issue in *Tri-Valley* was stated as whether the CMS contractor was able to process an earlier application to approval, or whether there continued to be "'missing information or supporting documentation' within the scope of section 424.525 or the type of noncompliance that should have resulted in the denial of application under section 424.530." DAB No. 2358, at 8.

As noted above, before these 2009 changes, the rejection of a physician's application had no adverse effect other than the need to submit a new application. After the amendments, however, a rejection could result in loss of payments for covered services provided between the filing of the initial application and the filing of a new application. Thus, in response to a comment suggesting an approach that "would address the situations where denial errors and clarifications can be corrected without delaying the effective date," the preamble to the final rule noted the 30-day opportunity to cure any deficiencies/ technicalities and stated:

> With the implementation of this final rule, we would require [the] contractor to deny, rather than reject paper or Web applications when a physician . . . fails to cure any deficiencies/technicalities.

73 Fed. Reg. at 69,769; *see also* 73 Fed. Reg. at 69,770 (response to concern that contractors might return an application based on a technicality). In summarizing the changes, the preamble stated that the reasons for the changes to the retroactive billing provisions were to ensure that a Medicare contractor would be able to verify that a

physician met all program requirements at the time of filing, including licensure, and to afford Medicare beneficiaries the appropriate protections. 73 Fed. Reg. at 69,773. The preamble went on to say:

> To ensure that eligible physicians . . . receive reimbursement for services furnished, we will require that Medicare contractors deny Medicare billing privileges when a Medicare contractor is not able to process an incomplete enrollment application . . . . This is a change from our earlier final rule . . . . In this earlier rulemaking effort, we stated that we would reject an incomplete enrollment application. In order to provide physician . . . organizations and individual practitioners with the opportunity to preserve an initial application filing date, we will deny incomplete applications for these supplier types. . . . By denying billing privileges . . . , rather than rejecting an enrollment application, physicians . . . will be afforded appeal rights which will preserve the original date of filing the application. Reimbursement for services furnished back to the effective date of billing will be permitted as long as the applicant submits a corrective action plan or appeal in accordance with § 405.874 and submits the necessary information to cure any application deficiencies. However, if the applicant does not submit a corrective action plan or appeal within the timeframe established in § 405.874, then the applicant would not preserve the right to bill the Medicare program for services furnished from the date of the initial filing of the application . . . .

Id. Thus, the Secretary recognized the need to allow a physician to seek review of contractor actions in order to preserve an earlier effective date because of the new potential for a significant adverse effect on the physician if an initial application is not approved and the contractor requires the physician to file a new application. That recognition is consistent with the grant of appeal rights under Part 498 for other CMS actions in recognition of the significant adverse effect of the initial determination. *See, e.g.*, 64 Fed. Reg. 39,934 (July 23, 1999).

4. The Secretary promulgated regulations amending Part 498 in 2008, providing for reconsideration as an additional opportunity for a provider/supplier to be heard.

As noted above, the regulations implementing section 1866(h)(1)(A) of the Act are in 42 C.F.R. Part 498. Under those regulations, most appeals of an initial determination by CMS are directly to an ALJ, but some initial determinations must first be reconsidered by CMS or its contractor. The regulations implementing the hearing rights granted by section 1866(j) of the Act provided that, once CMS or one of its contractors makes an initial determination related to the denial or revocation of a provider's or supplier's billing privileges and corresponding provider or supplier agreement, an affected party

"may request reconsideration in accordance with [section] 498.22(a)." 42 C.F.R. § 498.5(l)(1); 73 Fed. Reg. 36,462 (June 27, 2008). Several commenters on the proposal to add the reconsideration step stated that a reconsideration is an unnecessary delay in the appeals process, and that applicants should be able to appeal directly to an ALJ; in response, the preamble said: "We believe that the reconsideration level provides an additional opportunity for the matter to be resolved prior to the filing of an appeal to an ALJ." 73 Fed. Reg. at 36,451.

The reconsideration process is set out in subpart B of Part 498. Section 498.22(a) provides:

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

Paragraph (b) of section 498.22 provides, in relevant part, that the request for reconsideration must be filed "[w]ithin 60 days from **receipt** of the notice of initial determination, unless the time is extended in accordance with paragraph (d) of this section." (Emphasis added.)[7] Paragraph (d), in turn, provides that the affected party must request an extension to the filing deadline in writing, and that "CMS will extend the time for filing a request for reconsideration if the affected party shows good cause for missing the deadline."

Section 498.24 provides that "[w]hen a request for reconsideration has been properly filed in accordance with § 498.22," CMS or its contractor takes certain steps and "[m]akes a reconsidered determination affirming or modifying the initial determination and the findings on which it was based." Thus, the regulations contemplate that, if there is a properly filed request for reconsideration, there will be a reconsidered decision. Similarly, the preamble statement quoted above indicates that a physician may preserve any right to an earlier effective date for billing privileges by timely appealing a denial of an application in accordance with the procedures in 42 C.F.R. Part 405 (which in turn refer to the Part 498 procedures).

[7] Under section 498.22(b)(3), the "date of receipt will be presumed to be 5 days after the date on the notice unless there is a showing that it was, in fact, received earlier or later." As I discuss below, the contractor Hearing Officer did not address this issue, and I would find that Petitioner did make such a showing.

Section 498.20(b) states:

> *Effect of initial determination.* An initial determination is binding unless it is—
> (1) Reconsidered in accordance with § 498.24;
> (2) Reversed or modified by a hearing decision in accordance with § 498.78; or
> (3) Revised in accordance with § 498.32 or § 498.100.

The majority relies on paragraph (b)(1) of this section, and on section 498.5(l)(b) which provides that an aggrieved party is entitled to an ALJ hearing on a "reconsidered determination" related to denial of billing privileges. As discussed below, however, in analyzing the effect of these sections, the majority failed to consider not only the provisions requiring reconsideration of a timely filed reconsideration request, but also the larger context.

5. Nothing in the regulations precludes ALJ or Board review of a dismissal of a reconsideration request, and the regulations as a whole clearly imply that the ALJ and the Board have the authority to provide for such review.

The majority decision rests on the premise that, because the contractor Hearing Officer dismissed Petitioner's request for reconsideration of the denial of his May 2010 enrollment application, the ALJ correctly determined that the contractor's initial determination became final and that the ALJ had no authority to review the dismissal. The majority infers that, since there is nothing specifically providing for ALJ review of a dismissal, neither the ALJ nor the Board has authority even to examine whether the dismissal was consistent with the applicable procedures. Drawing such an inference is, in my view, inconsistent with the regulations as a whole and with past Board decisions and Congressional and Secretarial intent.

The majority fails to mention that the Part 498 regulations do not explicitly provide for dismissal of a reconsideration request. Any authority to dismiss a reconsideration request for untimeliness is only implicit. The regulations specify that CMS or its contractor **will** reconsider an initial determination if the affected party files a written request in accordance with paragraphs (b) and (c) of section 498.22 and direct CMS or its contractor to take certain steps as part of a reconsideration when a request has been properly filed. Thus, I do not think the regulations can reasonably be read as permitting dismissal of a properly filed reconsideration request. In other words, any dismissal of a reconsideration request is invalid unless it is based on a factually and legally sound determination that the affected party did not file a written request in accordance with section 498.22.

The dismissal here had no valid basis. The WPS Hearing Officer, in dismissing Petitioner's request for reconsideration as untimely, applied an incorrect standard for determining timeliness, stating that a supplier must file its request "within 60 days after

the postmark of the notice to be considered timely filed." CMS Ex. 10, at 1. Section 498.22(b)(3), however, begins the 60-day filing period with "receipt of the notice of initial determination" by the supplier. The Hearing Officer made no finding as to the date Petitioner received the letter, despite the fact that Petitioner's request for reconsideration of the denial quoted section 498.22(b)(3) and stated that the denial was not received until

April 3, 2012, less than 60 days before the filing of the reconsideration request. P. Ex. 9.[8] Section 498.20(b) on when an initial determination becomes binding also has to be read in context. Since the regulations provide for a reconsidered determination if an affected party requests reconsideration pursuant to the regulations, section 498.20(b)(1) assumes that, if there is no reconsidered determination, the reason is that the affected party did not properly request reconsideration. Thus, this provision should not be read as applying if an affected party did, in fact, do so. My interpretation on this is consistent with the following statement in *Hardy*, interpreting section 498.20(b): "If an affected party does not request reconsideration of an initial determination in accordance with section 498.22(a), then the initial determination is 'binding.'" DAB No. 2464, at 2.

Moreover, reading section 498.20(b) as intended to make an initial determination binding only if there was no timely request for reconsideration is needed in order to reconcile that section with other sections of Part 498. Section 498.70(a) provides that an ALJ "may dismiss a hearing request either entirely or as to any stated issue" if "[t]here has been a previous determination or decision with respect to the rights of the same affected party on the **same facts and law pertinent to the same issue** or issues which **has become final . . . because the affected party did not timely request reconsideration** . . . with respect to that determination or decision." (Emphasis added.) Section 498.83(b) on Board review states that the "Board will grant the affected party's request for review unless it dismisses the request for one of the following reasons." The fourth reason is:

> A previous determination or decision, based **on the same facts and law, and regarding the same issue**, **has become final** through judicial affirmance or **because the affected party failed to timely request reconsideration**, hearing, Board review, or judicial review, as appropriate.

(Emphasis added.) Indeed, these sections not only support a reading of section 498.20(b) as applying only if the affected party failed to timely request reconsideration, but also clearly indicate that an ALJ and the Board have authority to review whether an affected party did fail to timely request reconsideration, since that is necessary in order to

[8] The Hearing Officer also made no finding regarding the postmark date, despite citing that as the relevant date. CMS Ex. 10, at 1. The Hearing Officer did state that the denial was sent in June 2011, but did not say to whom it was sent, how it was sent, or on what evidence he was relying. *Id.*

determine whether to dismiss or to grant review.[9] Neither these provisions nor any other provision of Part 498 makes a CMS or contractor hearing officer determination about timeliness binding on the ALJ – for good reason, given that CMS is a party in the case and the contractor is CMS's agent.

Interpreting the regulations to permit review of a contractor hearing officer's dismissal is also consistent with the fact that, although an ALJ has explicit authority to dismiss a request for hearing in specified circumstances, Part 498 also explicitly provides that either the ALJ or the Board may vacate a dismissal. 42 C.F.R. §§ 498.68-72. To me, this indicates that the Secretary intended to ensure that an affected party would not lose hearing rights based on an improper dismissal. Given that ALJs have a greater degree of independence than contractor hearing officers, it does not appear to me to be consistent with the regulations as a whole to permit a contractor hearing officer to dismiss a reconsideration request, even if that authority is only implicit, but to preclude any review of that dismissal merely because the authority to review that dismissal is not explicitly stated in the reconsideration provisions.

I recognize that section 498.5(l)(2), on which the majority relies, does describe the appeal rights related to enrollment as follows:

> CMS, a CMS contractor, any prospective provider, prospective supplier, or existing supplier dissatisfied with a reconsidered determination under paragraph (l)(1) of this section, or a revised reconsidered determination under § 498.30, is entitled to a hearing before an ALJ.

Reading this provision as precluding inquiry into whether a dismissal of a prospective supplier's reconsideration request was proper, however, ignores the fact that paragraph (l)(1) of section 498.5 accords to any prospective supplier dissatisfied with an initial determination or revised initial determination the right to request reconsideration in accordance with section 498.22(a). The regulations as a whole anticipate that, if a prospective supplier exercises that right in accordance with section 498.22(a), the initial determination will be reconsidered and the prospective supplier will receive a reconsidered determination in accordance with the regulations. Improper dismissal by CMS or its contractor unfairly deprives the prospective supplier of the right to reconsideration and to a reconsidered determination and therefore to the right to an ALJ hearing.

[9] Section 498.20 itself conditions the binding effect of an initial determination not only on it not being reconsidered, but also on it not being reversed or modified by a hearing decision. If an ALJ declines to dismiss an issue about an earlier application from a case or the Board grants review, having found that reconsideration was timely requested, and the ALJ or the Board then reverses the initial determination, it would not be binding.

Also, while an ALJ "may" dismiss a case pursuant to section 498.70(d) if there is no right to a hearing, the ALJ is not required to dismiss but is given discretion about whether to do so. I see no reason why, in considering whether to exercise that discretion or to take a different action, an ALJ may not inquire into whether that right would have accrued but for a failure by CMS or its contractor to apply the regulatory reconsideration procedures and standards and to issue a reconsidered determination. Section 498.70(a) certainly suggests that, in determining whether to dismiss, an ALJ may inquire whether a reconsideration request was timely filed. At the very least, an ALJ should be able to remand the case to CMS or its contractor to correct any procedural errors, to make findings consistent with the applicable standards, and to provide for reconsideration if a proper request was timely filed.

As Petitioner argues, under the interpretation in the ALJ Decision (which the majority now affirms), "WPS would be able, were it so inclined, to avoid appellate review of, or ultimate responsibility for, any of its own administrative errors in processing Medicare enrollment applications by simply failing to provide *any* reconsiderations at all." RR at 21 (italics in original). As noted above, however, the stated purpose of applying the reconsideration procedures to provider/supplier enrollment cases is to provide an additional opportunity to have the matter resolved prior to an appeal to an ALJ. To interpret the regulations to permit a contractor hearing officer to deprive an affected party of that opportunity, without any further review of whether the contractor properly dismissed the request is, in my view, inconsistent with that intent. It is also inconsistent with Congressional intent in MMA to have the enrollment process governed by regulation and to provide for independent review when CMS or its contractor denies enrollment.

6. The ALJ erred in relying on Board decisions that addressed ALJ dismissals and that are distinguishable.

The ALJ Decision here did not even discuss *Elliott* or what the scope of review is in an effective date case, even though Petitioner clearly had a right to a hearing on the reconsidered determination on the effective date of his enrollment. Instead, the ALJ Decision relied on Board decisions that addressed whether an ALJ properly dismissed a hearing request where the reason there was no reconsidered determination was that a supplier had **not** timely appealed an initial determination. The majority decision also focuses on these past Board decisions, concluding that they are "consistent with" the majority view, but without saying how they govern here.

In *Vakil*, the Board upheld an ALJ's dismissal of a hearing request where it was undisputed that the petitioner failed to timely request reconsideration of the contractor's determination of his effective date of enrollment. The Board said: "Dr. Vakil's right to a reconsidered determination by [the contractor] Noridian, established by section 498.22(a), no longer applied once he failed to file a request for reconsideration within 60

days of receiving Noridian's initial determination and failed to show good cause for Noridian to extend the filing deadline for the request." DAB No. 2460, at 4. While the Board and ALJ thus found that the initial determination had become final, both treated the factual issue of whether the request for reconsideration was timely filed as material to their decisionmaking and addressed it.

In *Hardy*, the Board upheld an ALJ dismissal because—

> Petitioner never filed a request for reconsideration by WPS. Nevertheless, Petitioner filed a request for a hearing before an ALJ. By filing a request for a hearing without having first obtained a reconsidered determination, Petitioner did not comply with the procedures set forth in the applicable regulations, which were stated in WPS's revocation notice, and is therefore not entitled to a hearing before an ALJ.

DAB No. 2464, at 5. In doing so, the Board modified the rationale for the dismissal, citing section 498.70(b) (no right to a hearing), rather than section 498.70(c) (hearing request not timely filed). In other words, the Board concluded that the ALJ did not need to address either timeliness or good cause shown because petitioner had not filed **any** reconsideration request with the contractor. While the decision in *Hardy* stated that, under the regulations "only reconsidered determinations related to the denial or revocation of billing privileges are eligible for ALJ review," that statement is clearly overbroad since the regulations also provide appeal rights in other situations. But, in any event, there is a reconsidered determination in this case. Moreover, as noted above, the Board in *Hardy* described the regulations as providing: "If an affected party does not request reconsideration of an initial determination in accordance with section 498.22(a), then the initial determination is 'binding.'" *Id.* at 2. The clear implication of this is that an initial determination does **not** become final and binding if an affected party **does** request reconsideration in accordance with section 498.22(a). Nothing in the decision suggests that an ALJ is precluded from addressing the timeliness of a reconsideration request that was otherwise properly filed with the contractor. Indeed, addressing timeliness in that circumstance is a necessary prerequisite to determining whether the initial determination has become final and binding, for the reasons I have explained above.

In *Better Health Ambulance*, the petitioner "conceded it did not timely request reconsideration of the initial revocation determination." DAB No. 2475, at 3. The ALJ decision in that case had gone on to address the issue of whether the contractor, First Coast, correctly determined that the petitioner had not shown good cause for its untimely filing, but the Board concluded that the regulations "do not authorize this inquiry by an ALJ," citing sections 498.5(l)(2) and 498.20(b) and *Hardy* and *Vakil*. *Id.* at 4. Neither of the cited decisions actually held that such an inquiry was unauthorized. But, in any event, even accepting *Better Health Ambulance* as determinative on whether an ALJ may

second guess a contractor hearing officer's good cause determination, nothing requires us to extend that holding to preclude ALJ review of a hearing officer's determination of timeliness of a reconsideration request. Indeed, in *Better Health Ambulance*, although the contractor hearing officer applied the wrong timeliness standard, the Board noted in footnote 2 that the petitioner "does not cite the discrepancy between the regulations and the text of the letter, and the discrepancy is not relevant to our decision." Here, however, Petitioner did raise the discrepancy and did not concede that the request for reconsideration was untimely.

The majority decision also cites *Elzaim*, but I would not rely on that decision as precedent, for the following reasons. In that case, the ALJ dismissed the hearing request because he found that the contractor's initial determination upholding revocation of petitioner's billing privileges "became administratively final after Petitioner failed to timely request reconsideration of that determination" and the contractor never issued a reconsideration determination. DAB CR2650 (2012). The Board decision in *Elziam* recites "background information" suggesting that the contractor did not timely appeal and says that this recitation of the background facts is not intended to substitute for the ALJ's findings. DAB No. 2501, at 2 n.2. The decision then recites various arguments petitioner made on appeal, including arguments related to whether the contractor's notices were sent to the correct address (issues that it does not appear that the petitioner raised to the ALJ). *Id.* at 4. Finally, the decision gives the following analysis (which I quote here in its entirety):

> Neither the Board nor the ALJ are authorized to address the issues raised by Petitioner because under the regulations, TrailBlazer's November 10, 2011 initial determination was binding and Petitioner was not entitled to an ALJ hearing. As described above, the regulations governing appeals of enrollment determinations specify that a supplier "dissatisfied with a *reconsidered* determination … is entitled to a hearing before an ALJ." 42 C.F.R. § 498.5(l)(2) (emphasis added). Recent Board decisions explain that by regulation, "only reconsidered determinations related to the denial or revocation of billing privileges are eligible for ALJ review." *Denise A. Hardy, D.P.M.*, DAB No. 2464, at 4 (2012), *quoted in Better Health Ambulance*, DAB No. 2475, at 4 (2012); *cf. Hiva Vakil, M.D.*, DAB No. 2460, at 5 (2012) (noting that "the regulations plainly require that CMS or one of its contractors issue a 'reconsidered determination' before the affected party is entitled to request a hearing before an ALJ."). In this case, TrailBlazer never issued a reconsideration determination. Without a reconsidered determination to provide a basis for further review, the initial determination to revoke Petitioner's billing privileges became "binding." Section 498.20(b); *see also Better Health Ambulance* (holding that the initial determination became binding where the contractor never issued a reconsideration determination but instead dismissed the

> reconsideration request as untimely). Consequently, we conclude that the ALJ did not err in dismissing Petitioner's hearing request under section 498.70(b) because Petitioner had no right to an ALJ hearing.

Id. at 4-5.

This analysis relies on language in the cited decisions that was taken out of context, ignores the findings in *Vakil* and *Better Health Ambulance* regarding timeliness (which indicates that the panels in those decisions did consider timeliness as within the scope of ALJ and Board review), and ignores the statement in *Hardy* that an initial determination becomes final if a petitioner does not request reconsideration in accordance with the regulations. Moreover, there is no indication in the decision in *Elzaim* that the petitioner there raised the issues that Petitioner raised here regarding whether the finality provision applies when a petitioner did timely request reconsideration of the initial determination. Nor was there any issue in *Elzaim* (as there is here) about the standard that the contractor applied for determining timeliness.

Finally, I note that *Elzaim* appears to me to be inconsistent with longstanding Board precedent, first established in *Alden-Princeton Rehabilitation & Health Care Ctr., Inc.*, DAB No. 1709 (1999). In *Alden-Princeton*, the Board recognized that, since an ALJ's dismissal under section 498.70(c) is discretionary, the ALJ must consider not only whether there is a basis to dismiss but also whether, based on the particular circumstances presented in the case, he or she should exercise discretion **not** to dismiss the case. Certainly it is relevant to that consideration to inquire whether a reconsideration request was timely.

For these reasons, I do not consider *Elzaim* to be applicable or meaningful precedent regarding these issues.

In sum, none of these decisions stands for the proposition that an initial determination becomes final and binding even if it is timely appealed in accordance with the regulations. Nor do they stand for the proposition that the Board is bound by a contractor hearing officer's determination on timeliness, even if the hearing officer applied the wrong legal standard and made no finding under the correct standard. They simply did not address those issues. In each case, moreover, a finding was made at either the ALJ level or both the ALJ and Board level that the petitioner **did not** timely request reconsideration. Thus, the issue was whether the ALJ properly dismissed the hearing request, not whether the ALJ could have exercised discretion not to dismiss the request had the ALJ determined that the petitioner had timely requested reconsideration.

Here, it is undisputed that Petitioner **did** timely request reconsideration of the effective date determination and did timely request an ALJ hearing on the effective date. Thus, the issue before us now is properly framed as what is the scope of review on appeal.

7. Board decisions on effective date establish the standard for determining effective date and the scope of review of an effective date determination.

The standard for determining effective date

The majority decision here states that, "under the plain language of [section 424.520(d)], neither an ALJ nor the Board may change an effective date to the date of receipt of an earlier application that was denied, because such an application was **not** processed to approval." Majority Decision (MD) at 6 (emphasis in original).

This statement ignores both what the preamble to the effective date regulation said about determining effective date and previous Board decisions, based on that preamble language. The preamble explains that the "date of filing" is the date that the Medicare contractor receives a signed provider enrollment application that the Medicare contractor is "able to process to approval." 73 Fed. Reg. 69,725, 69,769 (Nov. 19, 2008). Moreover, in the proposed rule, the preamble also explained the proposal, as follows:

> The date of filing the enrollment application is the date that the Medicare [fee-for-service, or FFS] contractor receives a signed Medicare enrollment application that the Medicare FFS contractor is able to process to approval. This option would allow a supplier that is already seeing non-Medicare patients to start billing for Medicare patients beginning on the day they submit an enrollment application that can be fully processed.

73 Fed. Reg. 38,502, 38,535 (July 7, 2008). There is no indication in the preamble to the final rule that the regulatory wording chosen to implement this option was intended to have a different meaning than proposed. Indeed, if that were the case, arguably a new comment period would have been required.

Thus, in *Tri-Valley*, one of the first Board decisions addressing effective date, the Board concluded that "Tri-Valley is entitled to an effective enrollment date of November 20, 2008, which is the date Palmetto received Tri-Valley's enrollment application that **could have been processed to approval** had Palmetto properly requested from Tri-Valley any information that was missing." DAB No. 2358, at 1 (emphasis added). The Board reversed the decision below, which had set the effective date as "July 8, 2009 because Tri-Valley had not submitted a signed, fully complete Medicare enrollment application prior to that date." *Id.* According to the Board, "the regulations in effect at the time of the November 2008 application created a process in which a contractor was able to subsequently approve an application even if it was not *signed and fully complete* when it was first submitted." *Id.* at 8 (italics in original).

The Board clearly viewed the relevant, overarching issue in that case as whether the contractor "was able to process the November 2008 application to approval." *Id.*. The July 2009 application had been subsequently approved by the contractor, but the November 2008 application had not. Indeed, even the decision below noted that the emphasis in the preamble "thus appears to be on when the contractor first received an approvable application." DAB CR 2179, at 10. Moreover, that decision notes that CMS did **not** in that case take the position that the regulation should "be interpreted to mean that the effective date must be the date on which the contractor received the actual application which it approved." *Id.* Other Board decisions on effective date also looked not only to the application that had, in fact, been approved by a contractor, but to earlier applications. *See, e.g., Arkady B. Stern*, DAB No. 2329 (2010).

In my view, treating the fact that a **contractor** did not process an earlier application through to approval as conclusive on the effective date of billing privileges (as the majority does here) is a result that is not required by the plain language of section 424.520(d) and that is inconsistent with the regulations read as a whole, as well as the preamble. Read literally, section 424.520(d) would mean that only if an application is "subsequently approved by the Medicare contractor" could the filing date of that application be used as the effective date. Under the regulations, however, if a contractor denies, rather than approves, an application, the affected party may appeal the denial, which may be reversed by a higher level on appeal. If the reversal becomes final, billing privileges are approved and the appeal decision establishes the date that the billing privileges become effective. 42 C.F.R. § 405.806(d). Indeed, as discussed above, the Secretary determined that a contractor should deny, rather than reject, a physician's application that the contractor decided was incomplete, precisely because this would enable a physician to appeal in order to preserve an effective date earlier than what the physician would be given based on a later-filed application that the contractor did approve.

Since the overall context introduces an ambiguity into what is meant by section 424.520(d), reference to and reliance on the preamble in the earlier Board decisions was appropriate. I also note that, although the enrollment regulations have been amended since the *Tri-Valley* decision was issued in 2010, no change was made that would override the Board's interpretation and application of section 424.520(d).

Board scope of review

The logical statement of the issue on appeal of a determination of the effective date of billing privileges is whether that determination was correct, under the relevant law and facts. This is consistent with how the Board addressed scope of review of an effective date determination in *Elliott.* Specifically, the Board said in *Elliott*:

> The question of whether a provider or supplier may appeal a contractor's rejection or "return" of an enrollment application is separate from the issue of the scope of review on appeal of a determination regarding the effective date of a provider's or supplier's Medicare enrollment. While the regulations provide that "[e]nrollment applications that are rejected are not afforded appeal rights," 42 C.F.R. § 424.525, **the regulations do not bar an ALJ, on a properly filed appeal of an effective date of enrollment determination, from considering an earlier enrollment application in that process in order to determine the correct effective date for the provider or supplier**. Thus, the ALJ in this case did not err in considering Dr. Elliott's August and October 2008 applications to be within the scope of review.

DAB No. 2334, at 7 n. 7 (emphasis added).[10] In other words, the Board has already decided that the Board may consider earlier enrollment applications as part of determining effective date of billing privileges even though the regulations provide that rejection of an application is not an appealable initial determination and even though the regulations do not explicitly provide for appeal of a return of an application. If the provision explicitly stating that a rejection is not appealable would not bar inquiry into whether a contractor properly rejected an application submitted earlier than the one the contractor in fact approved, I fail to see why we would conclude that we are barred from even inquiring into whether a contractor hearing officer properly dismissed a request for reconsideration of a denial of an earlier application.

In my view, in determining the effective date of enrollment, the Board should not be bound by the Hearing Officer's dismissal of Petitioner's request for reconsideration of the denial of the earlier application, given that the dismissal—

- applies the wrong legal standard for when an appeal must be filed (60 days after the postmark date, rather than 60 days after receipt); and
- cites to no evidence and makes no finding regarding date of receipt.

In other effective date cases, the Board has addressed and corrected for contractor failures to follow the correct procedures, as have ALJs.

The majority says they are "limit[ing] these cases" to "their unique factual circumstances" and that they "will not determine de novo that an application could have been processed to approval in the face of a contractor's actual determination to deny the application because it was not approvable." MD at 9 (emphasis in original).

[10] The majority characterizes this statement as "dicta." MD at 8. Had the Board determined, however, that lack of appeal rights for the return of an earlier application precluded ALJ review of that application, the Board would have reached a different result. I note, moreover, that the majority gives no rationale for disagreeing with what the Board stated in *Elliott.*

The key problem with this analysis is that it treats the contractor's denial as final and determinative of approvability, even if the denial was timely appealed. As part of resolving whether an application is approvable, however, one of the regulatory steps the contractor must follow is to provide a reconsideration by a hearing officer of a denial if the affected party requests reconsideration in accordance with the regulations. Failure by a contractor to follow the procedures for reconsideration of a denial can be as prejudicial to a petitioner as failure to follow any other applicable procedure. Also, the Board is the final decision-maker under Part 498 appeals procedures, so the reasons for Board review of whether a contractor's dismissal correctly applied the Part 498 rules seem, if anything, even stronger to me than the reasons why we would review whether a contractor followed other procedures for enrollment, as we have in the past. In addition, the majority's statement assumes that the reason for the denial was that the application was not approvable, whereas the evidence here suggests otherwise.

The majority also says that "Petitioner's contentions that the contractor should have found his request for reconsideration timely and should have then reversed the denial amount to collateral attacks on a prior administrative decision that is also already final." MD at 9. This reasoning is again premised on the mistaken interpretation of the regulations as providing for finality of an initial determination regardless of whether a petitioner did request reconsideration in accordance with the regulations.[11] Indeed, sections 498.70(a) and 498.83 provide for dismissal of a case or an issue in a case based on an earlier initial determination only if the facts, law, and issues are the same **and** the determination became final because the petitioner did not timely request reconsideration. The contractor Hearing Officer here misstated the issue regarding timeliness and made no finding of fact regarding when Petitioner first received the denial letter, so giving conclusive effect to the dismissal, as the majority does, is inconsistent with these provisions. In other words, Petitioner's arguments about the timeliness of his request for reconsideration do not amount to an impermissible collateral attack on a determination involving the same facts, law, and issues. Yet, the majority treats the dismissal here as binding and beyond ALJ and Board review, and treats the denial as final, without addressing whether Petitioner did timely request reconsideration.

Finally, distinguishing this case from other effective date determination cases on the basis that the contractor denied the initial application rather than taking some other action is particularly unwarranted, given the Secretary's statements in the preamble to the effective date change (quoted above) assuring physicians that they could preserve an earlier effective date by appealing a denial. That appeal right, intended to protect physicians

[11] To the extent the majority implies that the failure of Petitioner to directly attack the contractor Hearing Officer's dismissal should preclude him from raising the issue here, I disagree. The Hearing Officer's dismissal did not inform Petitioner of any means by which he could seek to vacate the dismissal. This Board has always treated a failure by an agency to give notice of appeal rights as a good cause for an extension of the time to appeal. Here, when informed of his appeal rights regarding the effective date of enrollment, Petitioner consistently exercised those rights in a timely manner and consistently asserted that he did timely request reconsideration of the denial.

from improper contractor actions, is meaningless if the contractor hearing officer can dismiss an appeal as untimely based on the wrong standard and that dismissal is considered unreviewable, even in a proceeding to determine effective date.

8. Petitioner showed that he did not receive the denial letter until April 3, 2012 and, therefore, that he timely requested reconsideration of the denial.

The majority decision suggests that, because CMS moved for summary judgment and because the majority thinks summary judgment appropriate, the record here was not complete. To the contrary, the ALJ specifically closed the record in this case, after explaining how he had developed the record and why he concluded that CMS had waived any right to cross-examine Petitioner's witness. ALJ Decision at 2. Thus, as the original Presiding Board Member in the case, I proposed that we resolve this case in Petitioner's favor, for the following reasons.

The threshold factual issue is whether Petitioner did timely appeal WPS's initial determination to deny the May 2011 enrollment application.

In her written direct testimony, the credentialing coordinator for Petitioner's medical practice testified that on October 17, 2011, she called WPS to inquire about the status of Petitioner's May 2011 application. P. Ex. 5, at ¶ 3. She stated that she spoke to a WPS customer service representative and was told "that all necessary materials had been received and that the application was in process" but not that the application had been denied. *Id.* She stated that she did not consider the delay surprising or unreasonable because at the time of that phone call, she was aware, from her experience as a credentialing coordinator, that applications to WPS were taking longer than normal. *Id.* at ¶ 4. The credentialing coordinator testified that on December 14, 2011, she again called WPS to inquire about the status of Petitioner's application and was again told it was "in process" with WPS, and that WPS did not respond to messages she left on January 17, 2012 and March 19, 2012. *Id.* at ¶¶ 5, 6.[12]

The credentialing coordinator further testified that on March 28, 2012, she called WPS and was told that Petitioner's application had been denied effective June 29, 2011; neither she nor anyone in her organization, including Petitioner, she testified, had received written notice of the denial. *Id.* at ¶ 7. The denial notice was received by fax on April 3, 2012, she stated, after she "repeatedly" requested it be sent. *Id*. at ¶ 8. She then submitted a corrective action plan and an appeal of the denial (i.e., a request for reconsideration) to WPS on May 1, 2011. *Id*. at ¶ 10.

[12] The majority describes this as testimony that she received inconsistent responses to her inquiries. But the only inconsistent response to which she testifies was in March 2012. Her testimony about the inquiries and WPS's responses over the period from October 2011 until the end of March 2012 surely suggests that WPS had not in fact denied the application in June 2011, despite its much later inconsistent statement that it had.

As noted above, the ALJ determined that CMS had waived its right to cross-examine the credentialing coordinator.[13] CMS proffered no evidence to rebut the credentialing coordinator's testimony that Petitioner's medical group did not receive any letter denying Petitioner's enrollment application until WPS faxed the denial letter to her on April 3, 2012. CMS asserted only that the letter was "issued" on June 29, 2011, not that it was mailed or otherwise sent to the Petitioner, and proffered no evidence, such as mailing records or the testimony of WPS employees, that would establish that WPS sent the denial letter to Petitioner on a date earlier than April 3, 2012 or even that would establish WPS's usual practices with respect to denial letters. CMS Br. at 6; CMS Resp. at 5, 6. The regulations specify that "[i]f CMS or a CMS contractor denies a . . . supplier's enrollment application, CMS or the CMS contractor must notify the . . . supplier by certified mail." 42 C.F.R. § 405.874(a) (2010); 42 C.F.R. § 405.800(a) (2012). Thus, if WPS had mailed the denial letter in June 2011, WPS should have had evidence of mailing, such as a certified mail number that could be traced. Yet, the only evidence CMS produced about the denial letter is a WPS record with mostly handwritten entries by the WPS analyst assigned to process the initial application. An entry dated June 29, 2011, states "denial letter sent no response" without indicating how it was sent or to whom. CMS Ex. 7, at 6. The previous page of this document merely states an "Imaging: Date Sent" of June 29, 2011. *Id*. at 5. Thus, this document does not evidence even that the denial letter was sent **to Petitioner** on that date, much less that it was sent to Petitioner by certified mail, as required.

In any event, I consider the WPS document noting that the denial letter was "sent" in June to be unreliable. The analyst who signed the document and apparently filled it out did not testify, nor did anyone from WPS testify about the document. The document notes the WPS analyst's e-mail of May 24, 2011 requesting more information but does not note an e-mail that the credentialing coordinator sent in response on that day. *Id*. at 6. WPS must have received that e-mail because CMS submitted it to the ALJ. CMS Ex. 8, at 5. Also, the analyst entered the date of receipt of the initial application as May 9, 2011, whereas the return receipt shows that it was received two days earlier on May 7. CMS Ex. 7, at 1; P. Ex. 1, at 1. The receipt date is important and should have been accurately recorded because a contractor is required to process an application in no more than 180 days from the date of receipt. 42 C.F.R. § 405.874(h)(1) (2010); 42 C.F.R. § 405.818 (2012).

Also, CMS proffered no evidence to contradict the credentialing coordinator's testimony that she was told by WPS on October 17 and December 14, 2011 that the application was still being processed, and that, when she again called WPS on March 28, 2012 and was verbally informed of the denial, it took WPS almost a week to fax her a copy of the

[13] As the Board has stated, "[w]hen parties have chosen not to cross-examine a witness, [the] credibility of that particular witness has not been in question." *Pacific Regency Arvin*, DAB No. 1823, at 7-8 (2002), quoting *Kuntz v. Sea Eagle*, 199 F.R.D. 665, 666 (D. Haw. 2001).

written denial notice it allegedly had sent on June 29, 2011. CMS produced no logs of telephone calls or other evidence to contradict Petitioner's account of the telephone calls. *See* PIM § 15.7.3.A (contractor to "[d]ocument any and all actual or attempted telephonic or face-to-face contacts with the provider, any representative thereof, or any other person regarding a provider" including "Phone calls from the provider"); *see also Daniel H. Kinzie, IV, M.D.*, DAB No. 2341, at 9 (2010) (noting, in context of revocation of Medicare billing privileges for failure to report the revocation of a state medical license, that "CMS did not proffer any evidence in support of its motion" for summary judgment "such as a declaration from a CMS or [contractor] official stating that [the contractor's] telephone or mail logs had been reviewed and there was no record of Dr. Kinzie reporting his license revocation").

Indeed, CMS appears to accept at least in part the credentialing coordinator's account of the telephone contacts with WPS, as CMS faults Petitioner for "not inquir[ing] as to the status of his application until October 17, 2011," the date of the credentialing coordinator's first phone call to WPS. CMS Br. at 6. The credentialing coordinator explained, however, that "at the time of her October 17, 2011, phone call . . . applications to WPS were taking longer than normal . . . , so [she] did not consider the delay surprising or unreasonable." P. Ex. 5, at ¶ 4. I find this testimony credible in light of the longstanding concerns about contractor delays that led Congress to mandate deadlines for processing applications and that continues to lead to comments on the enrollment regulations. *See, e.g.*, Act § 1866(j)(1)(B); 76 Fed. Reg. 5862, 5911 (Feb. 2, 2011). Also, in my view, her testimony that she waited to inquire about the status of the application is more consistent with her testimony that she had timely submitted the requested information (and had not been notified that the application was denied) than it is with CMS's position that she did not submit the information and that the application had been denied in June. If CMS were right, it would have been in the credentialing coordinator's interest to file a new application immediately in order to minimize the loss of payment for services Petitioner had provided, rather than to wait until months later and then call WPS to inquire about the status of the May 2011 application.

CMS does not explain, moreover, why WPS would have told the credentialing coordinator in October and December 2011 that the application was still being processed if, in fact, it had been denied in June. Nor does CMS explain why, if the denial letter had in fact been sent to imaging in June 2011, it would take until April 3, 2012 for WPS to fax a copy of the letter to Petitioner after the March 28 call in which the credentialing coordinator was informed that the application was denied.

I would therefore find that the denial letter was not received by Petitioner until April 3, 2012.[14] It is undisputed that Petitioner's request for reconsideration of the denial was filed on May 1, 2012. Accordingly, I would find that Petitioner did timely appeal the denial of his March 2011 application and therefore the denial did not become binding.

9. Petitioner timely responded to WPS's May 24, 2011 request for information needed to process Petitioner's enrollment application.

The credentialing coordinator testified that she responded to WPS's May 24, 2011 letter requesting information to process Petitioner's enrollment application by faxing the requested information to WPS on May 24, 2011, and that the fax transmission receipt "demonstrates that the faxed response was successfully received in full – six pages in total – by WPS on May 24, 2011." P. Ex. 5, at ¶ 2; P. Ex. 6. Petitioner submitted the materials that the credentialing coordinator testified that she faxed. P. Ex. 6. These materials consist of three updated pages from Petitioner's enrollment application, WPS's May 24, 2011 two-page letter, and a fax cover sheet with a fax transmission report showing, as the ALJ noted, that on May 24, 2011 a six-page fax was sent to and was received by WPS at the fax number the WPS analyst identified in her information request. P. Ex. 6, at 1-2; ALJ Decision at 4.

Before the ALJ, CMS asserted that WPS "has no record of receiving any documents from Petitioner on May 24, 2011 or at any time prior to June 29, 2011," but CMS cited to no evidence at all in support of this assertion, much less to any evidence showing that WPS had conducted a thorough search of its records. CMS Br. at 5. CMS argued instead that Petitioner "has not provided evidence sufficient to prove that WPS received the requested information" because a "fax transmission page which does not show what documents were transmitted does not establish that Petitioner submitted all or even any of the documents requested by WPS." *Id.* However, CMS identified no reason not to credit the credentialing coordinator's sworn testimony. As noted above, CMS waived the opportunity to cross-examine the credentialing coordinator and proffered no testimony of its own that would contradict or call into question her account of the events and circumstances surrounding the enrollment application Petitioner submitted in May 2011.

Moreover, the May 24, 2011 fax transmission page is not silent as to the contents of the fax as CMS contends. The transmission page states that the fax contained "Mcare updated pages," which is consistent with both the contents of Petitioner's exhibit and

[14] The WPS Hearing Officer did not have the credentialing coordinator's affidavit before him. He did, however, have a written statement signed by the head of Petitioner's medical practice averring that the denial letter was not received until April 2012. P. Ex. 9. A reconsideration is less formal and is to include consideration of statements made by a party. 42 C.F.R. § 498.24(a). Also, since the contractor Hearing Officer applied the wrong timeliness standard, he made no findings regarding when Petitioner received the denial, so the case is in a different posture than if he had made such findings.

WPS's May 24, 2011 letter that instructed Petitioner to provide the requested information "on new application pages." P. Ex. 6. The record additionally contains e-mails showing that the WPS analyst e-mailed to the credentialing coordinator a copy of the request for information on May 24, 2011 and that the coordinator responded by e-mail almost immediately and asked about submitting, along with the information WPS requested, an updated application page relating to Petitioner's specialty. CMS Ex. 8. The promptness of the credentialing coordinator's e-mail response, and the fact that the materials she says she faxed to WPS include an updated application page identifying the specialty, along with the updated pages WPS had requested, buttresses the credentialing coordinator's testimony that she timely faxed the information requested to WPS on May 24, 2011. P. Ex. 6.

The only evidence CMS submitted to support its assertion that WPS did not receive the requested information is the document discussed above, apparently filled out by the WPS analyst who requested the additional information. CMS Ex. 7. CMS proffered no testimony from the analyst. Nor did CMS submit any records from the fax machine at the number on the fax transmission form submitted by Petitioner. As discussed above, moreover, there are reasons to question the completeness and accuracy of the WPS document regarding the events related to the May 2011 application.

Accordingly, I would find that Petitioner timely responded to WPS's May 24, 2011 request for information needed to process Petitioner's enrollment application. Petitioner asserted that the materials identified as the updated pages faxed to WPS on that date in response to WPS's request were sufficient to correct any deficiencies in the initial enrollment application. CMS does not dispute this assertion and on their face the documents are responsive to the request. Nor does CMS identify any basis for denying billing privileges based on the application as supplemented.

In other words, the application was approvable, and WPS should have approved it. Petitioner is entitled to an earlier effective date based on the date that application was filed.

10. Review by an ALJ or the Board of a contractor hearing officer dismissal does not contravene the purposes of providing for an enrollment process, but precluding such review could have adverse effects on beneficiaries.

In considering whether to dissent in this case, I have also considered, in light of the purposes of the enrollment provisions and the larger purposes of the Medicare program, what the potential effects would be of ALJ and Board review of a contractor hearing officer's dismissal of a reconsideration request. The purpose of the enrollment provisions generally is to protect the Medicare program from providers or suppliers who lack integrity or are not qualified to provide the services for which they seek Medicare reimbursement.

Congress clearly did not think it would contravene the purposes of the enrollment process to permit ALJ and Board review of denials of enrollment, however, since Congress specifically provided for it. Review of a contractor dismissal of a reconsideration request at most would lead to a remand to CMS and/or to ALJ and Board review of a denial of enrollment – a result that Congress intended. In this case, Board review would, I think, ultimately lead to approval of Petitioner's earlier application, even if we remanded the case rather than deciding it. I do not see how that would contravene the purposes of the process. Throughout the various proceedings, neither CMS nor WPS identified any reason why Petitioner would not be considered trustworthy and qualified to provide Medicare services as of the filing of the May 2011 application. Yet, the consequence of the majority decision will be that Petitioner will receive no reimbursement for covered services he provided in the good faith belief that he had satisfied program requirements for enrollment, that his application was being processed, and that he would be given an effective date for billing privileges of May 7, 2011.

Thus, the majority decision could discourage qualified and trustworthy physicians (and other practitioners) from enrolling in the Medicare program if they feel they will not receive a fair process, under the governing regulations, even if they timely take the steps they are required to take to preserve their rights. This, in turn, could affect access of Medicare beneficiaries to physician services.

As the Board said in *Alden Nursing Ctr. – Morrow*, DAB No. 1825, at 12 (2002), "While these proceedings are unquestionably adversarial processes, the government's interest ultimately lies in the factual and legal accuracy of its determinations . . . , not merely in victory in litigation by any means permissible."

If the regulations clearly precluded Board review of a contractor hearing officer's dismissal, I would defer to the Secretary's policy judgment on this issue. Absent such a clear preclusion, I see no reason to ignore program purposes and the potential negative consequences of the majority's narrow and legally unsound interpretation of the regulations.

/s/
Judith A. Ballard