Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Amber Mullins, N.P.
Docket No. A-16-47
Decision No. 2729
August 18, 2016

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Amber Mullins, N.P. (Petitioner) appeals the February 9, 2016 decision of Administrative Law Judge (ALJ) Steven T. Kessel sustaining the determination of a Medicare contractor of an effective date of Petitioner's Medicare enrollment. *Amber Mullins, N.P.,* DAB CR4528 (2016) (ALJ Decision). The ALJ rejected Petitioner's request for an earlier effective date. We affirm the ALJ Decision.

Regulatory Authority and Board Guidance

In order to receive payment by Medicare for services furnished to a Medicare beneficiary, a "supplier," such as Petitioner, a nurse practitioner, must be approved by the Centers for Medicare and Medicaid Services (CMS) for "enrollment" in the program. *See* 42 C.F.R. §§ 424.500, 424.505. The regulations governing Medicare enrollment, 42 C.F.R. Part 424, subpart P (sections 424.500-.555), define enrollment as the process that CMS and its contractors (here, Trailblazer/Novitas) use to identify the prospective supplier, validate the supplier's eligibility to provide items or services to Medicare beneficiaries, identify and confirm a supplier's owners and practice location, and grant the supplier Medicare billing privileges. See 42 C.F.R. § 424.502.

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

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

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

Like the regulations, the Board's guidelines require petitioners to specify in their request for review each finding of fact and conclusion of law with which they disagree, and their basis for contending that each such finding or conclusion is unsupported or incorrect. The Board expects that the basis for each challenge to a finding or conclusion in the ALJ decision or dismissal will be set forth in a separate paragraph or section, and that the accompanying arguments will be concisely stated. In addition, where appropriate, each argument should be supported by precise citations to the record and/or by precise citations to statutes, regulations or other relevant authorities upon which petitioners are relying. *See* Departmental Appeals Board, *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program* (*"Guidelines"*),[1] "Starting the Review Process," ¶ (d).

Procedural and Factual Background[2]

Petitioner submitted three applications to enroll in Medicare, dated, respectively, September 1, 2014, December 1, 2014, and March 31, 2015. ALJ Decision at 2. The contractor received the first two applications on January 7, 2015. *Id.* The contractor rejected the first two applications because each was incomplete and Petitioner failed to provide additional information the contractor requested. *Id.* The contractor accepted the third application, eventually approved it, and established March 31, 2015 as the effective date for Petitioner's enrollment in Medicare. *Id.*

Petitioner has not challenged these facts at any stage of review. In the reconsideration request filed on her behalf by her billing agent, rather than challenge the contractor's determination of the effective date of enrollment, Petitioner wrote:

> We submitted (CMS application form) 855R'[s] in January 2015 and they were denied due to not having a 855I. The delay in following up was due to change of our credentialing employee. We take full responsibility, but are hoping for sympathetic outcome. **This has put a real financial hardship on our company.**

CMS Ex. 13 (emphasis in the original).

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[1] The *Guidelines* are available at http://www.hhs.gov/dab/divisions/appellate/guidelines/prosupenrolmen.html.

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

In her request for hearing before an ALJ (RFH) (also filed by her billing agent), Petitioner did not argue that the contractor failed to comply with the regulation at 42 C.F.R. § 424.520(d)[3] in determining the effective date of her Medicare enrollment as March 31, 2015. Instead, she urged the ALJ to base the effective date on the date she first furnished services to Medicare beneficiaries because: 1) unforeseen staff errors and turnover caused the rejection of the earlier applications; 2) Petitioner had anticipated a January 2015 effective date based on her submission of the two rejected applications; and 3) the March 2015 effective date caused financial hardship for her employer. *See* November 30, 2015 RFH.

The ALJ reviewed the contractor's determination of Petitioner's effective date of enrollment and found that it was correct. ALJ Decision at 2. In his decision, the ALJ wrote,

> The *earliest* effective participation date that the contractor could have assigned to petitioner was March 31, 2015, based on the contractor's acceptance of the application it received on that date.

Id. (italics in original). In his analysis, the ALJ considered Petitioner's arguments, observing:

> Petitioner essentially makes equitable arguments in support of her contention that she should be assigned an earlier effective participation date than March 31, 2015. She argues that: she provided appropriate medical care to patients, including beneficiaries prior to March 1, 2015; that her employer has a history of complying with CMS requirements and that it did not receive a "timely notice" of a missing form; and that Petitioner had intended all along to be "credentialed" for participation in Medicare as of September 2014. Essentially, Petitioner asserts that she acted in good faith,

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[3] On the date of CMS's effective-date determination, the regulation stated:

> § 424.520 Effective date of Medicare billing privileges.
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> *   *   *
>
> (d) *Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations.* The effective date for billing privileges for physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations 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 or nonphysician practitioner first began furnishing services at a new practice location.

42 C.F.R. § 424.520(d) (Oct. 1, 2014).

> that any errors that were made in filing the applications were unintentional, and that it would be inequitable to deny her reimbursement for legitimate services that she provided to beneficiaries.

Id. at 2-3.

Having determined that Petitioner's request for hearing was based solely upon equitable grounds, the ALJ concluded that Petitioner had presented no basis for him to overturn the contractor's decision, stating, in pertinent part:

> As a general rule, I do not have the authority to consider equitable arguments. More important, however, is that Petitioner has provided me with no evidence or argument that suggests that the contractor incorrectly applied the requirements of 42 C.F.R. § 424.520(d) to the facts.

Id. at 3.

On appeal to the Board, Petitioner reiterates the bases she advanced before the ALJ and on reconsideration. The body of Petitioner's request for review (also submitted by her billing agent), consists entirely of the following:

> I am requesting a review of the decision CR4528 (C-16-77, Amber Mullins, NP) because of unfortunate circumstances that occurred during the crucial credentialing period of Amber Mullins.
>
> I had a trusted employee of 2 and a half years, who was in charge of the credentialing of Amber Mullins, that due to unforeseen circumstances I had to terminate without notice because of misconduct on March 9th, 2015. Previous to this date I was completely unaware that there was any issues with the 855-R process and it was at this time that I became aware of the failure to complete the CMS 855-I application. I was completely blindsided by the betrayal of this employee and had I known of the corrections needed and the deadline thereof would be no issue. I have been credentialing with Trailblazer/Novitas for many years and have never had a problem. As this is my first infraction, I am pleading with you to make an exception on Amber Mullins' Medicare Effective date. Please do not punish my client for the oversight and confusion of my former staff member. I am seeking your utmost compassion on this matter.

Request for Review (RR). The request for review is Petitioner's only submission to the Board.[4]

Standard of Review

We review a disputed factual issue as to whether the ALJ's decision is supported by substantial evidence in the record as a whole. We review a disputed issue of law as to whether the ALJ's decision is erroneous. *See Guidelines*.

Analysis

Petitioner takes no issue before the Board with the ALJ's conclusion that the regulations mandate an effective enrollment date of March 31, 2015. She does not claim that the ALJ erred on the merits, and she does not argue that the ALJ erred in not considering her claimed equitable bases for relief. Rather, Petitioner "plead[s]" for the Board's "utmost compassion," and asks that Petitioner not be punished "for the oversight and confusion" of the billing agent's former staff member, and that after many years of "credentialing with Trailblazer/Novitas" "this is her first infraction." RR.[5] The applicable regulations, however, do not provide for consideration of such equitable arguments in ALJ or Board appeals of CMS enrollment determinations. Furthermore, the regulations are clear that a request for review of an ALJ decision or dismissal must ***specify*** the issues, the findings of fact or conclusions of law with which the party ***disagrees*** and the basis for contending that the findings and conclusions are incorrect. 42 C.F.R. § 498.82(b) (emphasis added); *see also Guidelines.* Failure to articulate at least some disagreement with the bases for the ALJ decision permits the Board to summarily affirm the ALJ's findings of fact and conclusions of law. *See Wisteria Care Center*, DAB No. 1892 (2003). An appeal to sympathy, without more, does not constitute such a disagreement.

All of Petitioner's contentions revolve around administrative error within her billing agent's office, committed by her billing agent's staff. Her sole request of the Board is for "compassion." Petitioner thus makes less specific a request than she made in asking the ALJ to set her date of enrollment in January 2015 rather than March, on the grounds that she provided "appropriate medical care to patients, including beneficiaries" prior to March 1, 2015; that her employer has a history of complying with CMS requirements and had not received a "timely notice" of a form missing from her application; and that she had intended all along to be "credentialed" for participation in Medicare as of September 2014. ALJ Decision at 3. We nevertheless construe Petitioner's request for

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[4] When presented with the opportunity to submit a reply to CMS's brief in response to the request for review, Petitioner waived the opportunity.

[5] We note that no punishment for any "infraction" is involved. Petitioner has been granted billing privileges based on the earliest effective date of enrollment available to her by law.

compassionate treatment by the Board as referencing these arguments that she made to the ALJ. Yet this still leaves Petitioner's request for review without a proper basis for this Board to review the ALJ's decision, and therefore presents no basis for overturning the ALJ's decision. *See St. George Health Care Center,* DAB No. 2645, at 4 (2015) (no issue for the Board to review and no basis for disturbing the ALJ Decision where Petitioner does not even "articulate" disagreement with the ALJ).
The Board has consistently held that neither it nor an ALJ may provide equitable relief. *See, e.g. US Ultrasound*, DAB No. 2302, at 8 (2010) ("Neither the ALJ nor the Board is authorized to provide equitable relief by reimbursing or enrolling a supplier who does not meet statutory or regulatory requirements."); *Pepper Hill Nursing & Rehab. Ctr., LLC,* DAB No. 2395, at 11 (2011) (holding that the ALJ and Board were not authorized to provide equitable relief by reimbursing or enrolling a supplier who does not meet statutory or regulatory requirements); *UpturnCare Co.*, DAB No. 2632, at 19 (2015) (Board may not overturn denial of provider enrollment in Medicare on equitable grounds).

In her request for review, Petitioner neither disagrees with the ALJ's conclusion that he could not take equitable concerns into consideration, nor argues that the Board can consider such concerns. Absent an exception to the ALJ's findings of fact or conclusions of law, absent any argument that the ALJ erred in not considering equitable bases for relief, and absent any authority supporting her request for the Board to do so, we must deny the relief Petitioner seeks.

Conclusion

For the foregoing reasons, we affirm the ALJ's decision upholding the CMS contractor's determination that March 31, 2015 is the effective date of Petitioner's enrollment in Medicare.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Christopher S. Randolph
Presiding Board Member