Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Brooke Joseph-Banks,
(NPI: 1275593733),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-10-143

Decision No. CR2082

Date: March 4, 2010

DECISION

Petitioner, Brooke Joseph-Banks,[1] CRNA (Certified Registered Nurse Anesthetist), is not entitled to a hearing on the issues raised by her request for hearing and the request for hearing is dismissed pursuant to 42 C.F.R. § 498.70(b). A party may request that I vacate a dismissal for good cause but a request to vacate must be submitted within 60 days of receipt of the notice of dismissal. 42 C.F.R. § 498.72.

I. Background

The Medicare contractor, National Government Services (NGS), notified Petitioner by letter dated August 21, 2009 that her application for enrollment in Medicare was approved with a group member effective date of June 13, 2009. Centers for Medicare and Medicaid Services (CMS) Exhibit (CMS Ex.) 5. Petitioner requested reconsideration

[1] The request for hearing was actually filed by the practice administrator for Woodland Anesthesiology Associates, P.C. (Woodland), Petitioner's employer to which, I infer, she reassigned her right to bill Medicare for services she provided to Medicare eligible beneficiaries. However, it is the enrollment in Medicare of Brooke Joseph-Banks that is in issue and not that of Woodland Anesthesiology Associates, P.C.

by letter dated September 1, 2009, specifically requesting that the effective date for her participation in Medicare be changed to April 1, 2009, the date she started with Woodland. Petitioner argued that her start date preceded the date of the CMS policy to limit retrospective effective dates for billing Medicare claims to 30 days from the date an approvable application was filed; that Petitioner's initial application of March 5, 2009 and a later application submitted on May 28, 2009 were rejected; and a complete an approvable application was submitted on July 10, 2009. CMS Ex. 6. On September 29, 2009, a contractor hearing officer denied Petitioner's request for reconsideration of the effective date of her participation in Medicare. CMS Ex. 8. On November 6, 2009, Petitioner requested a hearing challenging the reconsideration decision.

The case was assigned to me for hearing and decision on November 20, 2009, and an Acknowledgement and Prehearing Order (Prehearing Order) was issued at my direction. On December 10, 2009, CMS filed a motion to dismiss Petitioner's request for hearing, or, in the alternative, a motion for summary judgment, with CMS exhibits 1 through 9. Petitioner failed to respond to the CMS motions and was ordered to show cause why the motions should not be granted. On January 28, 2010, Petitioner submitted a letter objecting to CMS's motion to dismiss.[2] Petitioner submitted no further response to CMS's motion to dismiss and motion for summary judgment. Petitioner submitted no exhibits, and she did not object to CMS's exhibits which are admitted as evidence.

II. Discussion

A. Law

Section 1831 of the Social Security Act (the Act) (42 U.S.C. § 1395j) establishes the supplementary medical insurance benefits program for the aged and disabled known as Medicare Part B. Payment under the program for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of services and suppliers.[3] Act

[2] Petitioner did not address why she failed to timely file her response. However, Petitioner's hearing request is not dismissed for failure to show good cause for why she did not file a timely response or as a sanction.

[3] A "supplier" furnishes services under Medicare and includes physicians or other practitioners and facilities that are not included within the definition of the phrase "provider of services." Act § 1861(d) (42 U.S.C. § 1395x(d)). A "provider of services," commonly shortened to "provider," includes hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, hospice programs, and a fund as described in sections 1814(g) and 1835(e) of the Act. Act § 1861(u) (42 U.S.C. § 1395x(u)). The distinction between providers and suppliers is important because they are treated differently under the Act for some purposes.

§§ 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395(u)(h)(1)). Administration of the Part B program is through contractors. Act § 1842(a) (42 U.S.C. § 1395u(a)).

The Act requires the Secretary to issue regulations that establish a process for the enrollment of providers and suppliers, including the right to a hearing and judicial review in the event of denial or non-renewal. Act § 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to 42 C.F.R. § 424.505, a provider or supplier must be enrolled in the Medicare program and be issued a billing number to have billing privileges and to be eligible to receive payment for services rendered to a Medicare eligible beneficiary. If enrollment is approved, a supplier is issued a National Provider Identifier (NPI) to use for billing Medicare and a Medicare Provider Transaction Access Number (PTAN), an identifier for the supplier for inquiries. Medicare Program Integrity Manual (MPIM), CMS Pub. 100-08, Chapter 10, Healthcare Provider/Supplier Enrollment, § 6.1.1.

"A prospective provider or supplier that is denied enrollment in the Medicare program, or a provider or supplier whose Medicare enrollment has been revoked may appeal" the decision in accordance with 42 C.F.R. Part 498. 42 C.F.R. § 424.545(a). Pursuant to 42 C.F.R. § 498.5(a), (d), and (l)(1) & (2), a prospective provider or supplier dissatisfied with an initial decision to deny it enrollment may request reconsideration and, if dissatisfied with the reconsideration decision, is entitled to a hearing before an administrative law judge (ALJ). A provider or supplier dissatisfied with an initial decision to terminate its participation is entitled to a hearing before an ALJ. 42 C.F.R. § 498.5(b) and (e). Initial determinations are listed at 42 C.F.R. § 498.3(b) and include: whether a prospective provider qualifies as a provider; whether a prospective supplier meets the conditions for coverage specified by the regulations; whether services of a supplier continue to meet the conditions for coverage; the effective date of a Medicare provider agreement or supplier approval; and whether to deny or revoke a provider or supplier's Medicare enrollment pursuant to 42 C.F.R. §§ 424.530 and 424.535. 42 C.F.R. § 498.3(1), (5), (6), (15), and (17).

B. Issue

Whether Petitioner has a right to a hearing on the facts of this case.

C. Findings of Fact, Conclusions of Law, and Analysis

My conclusions of law are set forth in bold followed by the pertinent facts and analysis.

1. Petitioner has no right to a hearing by an ALJ on the issue of whether she may obtain reimbursement from Medicare for services provided to Medicare eligible beneficiaries for more than 30 days prior to her effective date of participation in Medicare.

2. Petitioner, as a supplier not subject to survey and certification or accreditation, has no right to a hearing by an ALJ on the issue of whether or not her effective date of enrollment was correctly determined by CMS.

3. Petitioner has no right to a hearing by an ALJ and dismissal pursuant to 42 C.F.R. § 498.70(b) is appropriate.

Petitioner's applications for enrollment in Medicare and the request for hearing in this case were filed by Petitioner's employer, Woodland. CMS does not dispute the assertions in the request for reconsideration and the request for hearing that Petitioner began working for Woodland on April 1, 2009; that enrollment applications were filed on March 5, 2009 and May 28, 2009 and that both were rejected by NGS; or that Petitioner submitted a correct and complete application on July 10, 2009. CMS Exs. 6 and 9. Petitioner does not allege that the rejection of the applications filed in March and May was improper. Petitioner does not dispute that the application submitted on July 10, 2009, was received by NGS on July 13, 2009. CMS Ex. 8. On August 21, 2009, NGS notified Petitioner that her application was approved with an effective date of participation of June 13, 2009. CMS Ex. 5. The decision on reconsideration approved the effective date of Petitioner's participation as June 13, 2009. CMS Ex. 8. Pursuant to 42 C.F.R. § 424.520(d),[4]

> 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 is subsequently approved by a Medicare contractor or the date an enrolled physician or nonphysician practitioner first began furnishing services at a new practice location.

The date of filing is the date the Medicare contractor receives a signed application that it can process to approval. *See* 73 Fed. Reg. 69,725, 69,769 (Nov. 19, 2008). In this case,

[4] This provision was added by final rule at 73 Fed. Reg. 69,725; 69,773 (Nov. 19, 2008) and 73 Fed. Reg. 80,304 (Dec. 31, 2008) effective January 1, 2009, and will be codified at 42 C.F.R. § 424.520(d).

there is no dispute that the date of filing was July 13, 2009. Petitioner does not assert that the second prong of 42 C.F.R. § 424.520(d) is applicable in this case. Because Petitioner does not dispute that she did not file a complete and approvable application with NGS prior to the application received by NGS on July 13, 2009, it is clear that her disagreement is with the operation of the new regulation which limits to 30 days the period for which she may obtain retrospective reimbursement. Petitioner cites no authority for the proposition that her eligibility to claim retrospective reimbursement is an initial determination that is subject to my review and I find no such authority. Petitioner does not specifically challenge the lawfulness of the new regulations at 42 C.F.R. §§ 424.520(d) and 424.521(a)(1). Even if Petitioner challenged the lawfulness of the regulations, I am bound to follow the Secretary's regulations, including 42 C.F.R. §§ 424.520(d) and 424.521(a)(1), and I have no authority to find the regulations invalid.

I note that in this case NGS granted Petitioner an effective date of June 13, 2009 (CMS Ex. 3) rather than July 13, 2009, which is inconsistent with 42 C.F.R. § 520(d), as the regulation establishes the effective date of enrollment as the date of filing of the application. The effective date determination may have been based upon an incorrect application of 42 C.F.R. § 521(a)(1),[5] which permits enrolled physicians, nonphysician practitioners and physician and nonphysician practitioner organizations to bill "retrospectively" for services provided up to 30 days prior to their effective date if circumstances precluded enrollment in advance of providing services.[6] However, I will not disturb the June 13, 2009 effective date determined by the contractor.

CMS correctly argues as grounds for dismissal that Petitioner has no right to a hearing because the determination of the effective date of her enrollment in Medicare is not an initial determination that triggers a right to a hearing. The CMS position, stated simply, is that Petitioner's enrollment as a supplier was not denied and no right to a hearing is triggered in this case. CMS Motion at 1, 6-9, 11-14. The Act only provides for a right to hearing and judicial review in the case of denial or non-renewal of enrollment. Act § 1866(j) (42 U.S.C. § 1395cc(j)). The Secretary has provided by regulation for a right to hearing and judicial review for both denial and revocation of enrollment. 42 C.F.R. §§ 424.545(a); 498.3(1), (5), (6), (17); 498.5(a), (d), and (l)(1) & (2); 42 C.F.R. § 498.5(b) and (e). CMS acknowledges that the plain language of 42 C.F.R. § 498.3(15) indicates

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[5] This provision was also added by final rule at 73 Fed. Reg. 69,725; 69,768-69; 69,773; 69,939 (Nov. 19, 2008) and 73 Fed. Reg. 80,304 (Dec. 31, 2008) effective January 1, 2009, and is to be codified at 42 C.F.R. § 424.521(a)(1).

[6] Prior to the change in the regulations effective January 1, 2009, physicians were permitted to retroactively bill Medicare for services furnished up to 27 months prior to enrollment. CMS Motion at 5, note 1. Whether or not Petitioner can submit claims for services preformed 30 days prior to May 30, 2009 under authority of 42 C.F.R. § 521(a)(1) is also not an issue within my jurisdiction.

that the determination of the effective date of a Medicare provider agreement or supplier approval, is an initial determination that is subject to hearing and judicial review. However, CMS argues that 42 C.F.R. § 498.3(15) is not a provision applicable in the case of a supplier such as Petitioner. CMS Motion at 14-17. Although the plain language of a regulation would normally control, review of legislative or regulatory history is appropriate when an issue of interpretation is raised as it is in this case. The regulatory history for 42 C.F.R. § 498.3(15) at 62 Fed. Reg. 43,931, 43,933-34 (Aug. 18, 1997) supports the CMS position that the provision only permits a right to hearing related to an effective date determination for providers and suppliers subject to survey and certification or to accreditation by an accrediting organization. Petitioner was not subject to survey and certification or accreditation in order to enroll and qualify as a supplier participating in Medicare. I conclude that 42 C.F.R. § 498.3(15), creates no right for Petitioner to request a hearing to challenge the effective date determination by CMS or its contractor.

Accordingly, I conclude that Petitioner has not shown that she has a right to a hearing and I have found no basis upon which to exercise jurisdiction and grant Petitioner review.

III. Conclusion

I conclude, based on the foregoing, that Petitioner has no right to a hearing and dismissal of her request for hearing is appropriate pursuant to 42 C.F.R. § 498.70(b).

/s/
Keith W. Sickendick
Administrative Law Judge