Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Adrian Adrian, M.D.,
(PTAN: CC606 and CC607),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-10-426

Decision No. CR2154

Date: June 11, 2010

DECISION

I deny the motion of the Centers for Medicare and Medicaid Services (CMS) to dismiss the hearing request of Petitioner, Adrian Adrian, M.D. I decide the merits of the case on the written record and find that the effective date of Petitioner's enrollment in the Medicare program is July 13, 2009. Thus, pursuant to 42 C.F.R. § 424.521(a), Petitioner may retrospectively bill for services rendered as of June 13, 2009.

I. Background

Petitioner filed a hearing request on January 28, 2010. Several documents accompanied the hearing request: a letter dated January 12, 2010 to Petitioner from his Medicare contractor, Palmetto GBA, containing an unfavorable reconsideration decision; Petitioner's corrective action plan request to the contractor dated September 25, 2009; Palmetto's September 21, 2009, enrollment approval letter to Petitioner, and a letter from Palmetto to Petitioner dated May 9, 2009. I have marked Petitioner's entire submission as Exhibit A and numbered the pages consecutively for reference in this decision.

Petitioner challenges the effective date of his enrollment in the Medicare program that Palmetto assigned, which was the date his application was received (July 13, 2009) with approval to bill 30 days retroactively, i.e., from June 13, 2009. Petitioner alleges he should have been enrolled in the Medicare program with a retroactive effective dated July 22, 2008, almost a year earlier than the date when CMS's contractor determined that Petitioner was eligible for enrollment. *See* Ex. A at 1.

This case was assigned to Judge Steven T. Kessel for hearing and decision on February 23, 2010, and an Acknowledgement and Initial Pre-Hearing Order (Prehearing Order) was issued at his direction. The case was then transferred to me for hearing and decision on March 19, 2010, pursuant to 42 C.F.R. § 498.44.

CMS moved to dismiss Petitioner's hearing request arguing that Petitioner has no right to appeal the effective date of his enrollment in the Medicare program. However, CMS failed to file a list of exhibits, list of proposed witnesses, pre-hearing brief, or any of the materials that the Prehearing Order, dated February 23, 2010, required. CMS did not file a motion for summary disposition or otherwise indicate what result it sought if its dismissal motion failed. CMS did not request any additional opportunity to make further submissions.

Petitioner too failed to file a pre-hearing exchange as the Prehearing Order required. Subsequently, Petitioner advised the Departmental Appeal Board (Board) that he had no further submissions to make and requested that I decide his appeal based on the current record.

I have reviewed the materials Petitioner submitted with his January 28, 2010 request for a hearing, as well CMS's motion, and proceed to decide this case on the written record that the parties submitted.

II. Issues, findings of fact and conclusions of law

1. Issues

The issues in this case are as follows:

1. Whether I should dismiss Petitioner's hearing request on the ground that he has no right to appeal; and

2. Whether CMS's contractor and CMS properly determined Petitioner's effective date of enrollment to be July 13, 2009.[1]

2. Findings of fact and conclusions of law

My findings of fact and conclusions of law are set forth in bold and italics below.

A. The effective date of a Medicare provider agreement or supplier approval is an initial determination reviewable in this forum; thus, Petitioner has a right to a hearing.

i. Applicable standard

Pursuant to 42 C.F.R. § 498.70(b), I may dismiss a hearing request in the circumstance where a party requesting a hearing "does not otherwise have a right to a hearing."

ii. Analysis

CMS argues that the Medicare Act and CMS regulations do not permit a supplier to appeal the effective date of a supplier's billing privileges and that Petitioner has no right to challenge the effective date of his participation in the Medicare program. CMS Br. at 2-5. CMS asserts that a supplier's appeal rights are limited solely to denials of enrollment applications or revocations of billing privileges. CMS Br. at 2. Specifically, CMS argues that part 424, subpart P, grants appeal rights only from denials and revocations of enrollment. 42 C.F.R. § 424.545(a). Since an effective date appeal arises after an approval, rather than a denial or revocation, CMS reasons that the regulations do not permit appeals of effective date determinations.

CMS admits that it is "aware that 42 C.F.R. § 498.3(b)(15) indicates that '[t]he effective date of a Medicare provider agreement or supplier approval' is a reviewable 'initial determination.'" CMS Br. at 3. CMS contends, however, that the regulation was not "intended to apply to physician practitioner organizations, that are not subject to survey and certification requirements." *Id*.

[1] Although Palmetto GBA stated in its January 12, 2010 reconsideration decision that Petitioner's effective date was established as June 13, 2009, Petitioner's enrollment application was filed on July 13, 2009, which is therefore the actual effective date. Pursuant to 42 C.F.R. § 424.520(d), the date that by Palmetto GBA identified as the "effective" date (June 13, 2009) is actually the date from which Petitioner may retroactively bill for services.

CMS's argument about the "intent" of the regulation flies in the face of its very plain and unambiguous terms. The wording of section 498.3(b)(15) appears entirely straightforward and includes no qualifying or limiting language. It is well established, and not questioned by either party here, that applicable statue and regulations bind the Board and all ALJs. Where a regulation speaks clearly on its face and applies to the question before me, I am bound to follow it.

CMS points to one ALJ decision that did consider the regulatory history of section 498.3(b)(15) and interpreted the section in light of that history in the manner CMS now advocates.[2] CMS Br. at 3. Notably, the ALJ first acknowledged the rights conferred by the plain language of the statute, stating:

> CMS acknowledges that the plain language of 42 C.F.R. § 498.3[(b)](15) indicates 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(b)(15) is not a provision applicable in the case of a supplier such as Petitioner. 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.

Mikhail Paikin. D.O., DAB CR2064, at 7 (2010) (citation omitted) (emphasis added). The ALJ in *Paikin* did not offer any further explanation of why he felt he could look behind the plain language of a binding regulation to read in a limitation that nowhere appears in the regulation.

I disagree that review of regulatory history is appropriate when an issue of interpretation is merely raised, without more. Regulatory history and other sources of guidance are relevant in interpreting language that is ambiguous, unclear in its application, or which leaves gaps; however, courts do not resort to such interpretive tools when the wording is clear on its face. *See, e.g., Connecticut Nat'l Bank v. Germain*, 503 U.S. 249, 253-54 (1992) ([T]he "cardinal canon" of construction is that a statute means what it says and, when unambiguous, "this first canon is also the last: judicial inquiry is complete."). CMS has not identified in what respect the wording of section 498.3(b)(15) may be said to be ambiguous or unclear or where the language leaves a gap requiring interpretation to give it meaning. I thus find little room for interpretation and therefore find review of legislative or regulatory history inappropriate.

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[2] CMS fails to acknowledge the many recent ALJ decisions that have concluded that the plain language of section 498.3(b)(15) creates a right for any provider or supplier to challenge the effective date of enrollment of a provider agreement or of supplier approval. *See, e.g., Andrew J. Elliot, M.D.*, DAB CR2103, at 3 (2010); *Victor Alvarez, M.D.*, DAB CR2070 (2010); *Romeo Nillas, M.D.*, DAB CR2069 (2010); *Jorge M. Ballesteros, CNRA*, DAB CR2067 (2010); *Vincent Pirri, M.D.*, DAB CR2065 (2010).

I also disagree that the regulatory history, even were I to rely on it, supports CMS's current position. The provision that became section 498.3(b)(15) was first proposed in 1992 in a notice of proposed rulemaking, which aimed at doing two things: (1) establishing "uniform criteria for determining the effective date of participation for all Medicare and Medicaid providers and suppliers" and (2) specifying that "those dissatisfied with a decision on their effective date of participation under Medicare are entitled to a Medicare hearing on the decision." 57 Fed. Reg. 46,362 (Oct. 8, 1992). The regulation proposed in 1992 (and finalized in 1997) did set out uniform criteria for establishing effective dates for provider agreements and supplier approvals for those providers and suppliers subject to survey and certification requirements (or accreditation by a CMS-approved accrediting organization). That fact does not necessarily mean that the expansion of Medicare hearings to include effective date challenges, which was proposed and finalized in the same rulemakings, was limited to such providers and suppliers. The 1992 preamble indicates that the prior practice had been inconsistent about whether the date on which a prospective provider or supplier was entitled to participate in Medicare was a "proper subject for Medicare hearings." 57 Fed. Reg. at 46,362-63. The rule was intended to ensure that, when a provider or supplier is found not to meet conditions of participation initially but later to meet requirements, the resulting effective date could be appealed (even though participation was ultimately approved). *Id*.

In adopting section 498.3(b)(15), CMS recognized that approving participation at a date later than that sought amounts to a denial of participation during the intervening time and generally involves the same kind of compliance issues that arise from initial denials. 62 Fed. Reg. 43,931, 43,933 (Aug. 18, 1997); 57 Fed. Reg. at 46,363. CMS's argument that suppliers like Petitioner cannot challenge an effective determination because their applications have been "approved" rather than denied or revoked is contrary to the expressed intent of the regulation.

CMS also contends that the fact that section 498.3(b)(15) was adopted long before section 936(a)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, codified at 42 U.S.C. § 1395cc(j), required the Secretary to establish an appeals process from the denial of applications for enrollment should suffice to demonstrate that it was not intended to affect those appeal rights. CMS Br. at 3. This argument is not persuasive. A later statute does not elucidate the intended meaning of a prior regulation. The regulation on its face grants appeal rights to challenge effective date determinations of provider agreements and supplier approvals generally. While it is certainly true that the drafters of section 498.3(b)(15) would not likely have known in advance that other suppliers would later acquire appeal rights, I cannot conclude that they therefore intended that the appeal rights of such suppliers should be more limited than those they were articulating for the suppliers who were able to request hearings at the time section 498.3(b)(15) was drafted.

In fact, the long lag between the addition of effective date determinations to the list of appealable initial determinations and the creation of an appeals process for denials of enrollment applications cuts the other way. By the time that CMS adopted 42 C.F.R. Part 424, Subpart P, setting out enrollment requirements as a condition for participation in Medicare, CMS was well aware of the longstanding provision granting "appeal rights and procedures for entities dissatisfied with effective date determinations." 62 Fed. Reg. at 43,931-32. Yet, CMS provided that a prospective provider or supplier whose enrollment is denied or revoked "may appeal CMS' determination in accordance with part 498, subpart A of this chapter." 42 C.F.R. § 424.545(a). Section 498(b)(15) is part of subpart A of part 498, yet CMS did not exclude section 498(b)(15) or otherwise indicate that the effective date determination would not be a proper subject for these Medicare hearings. Hence, the plain language of section 424.545(a) reinforces the plain language of section 498.3(b)(15).

CMS further contends that the effective date of a provider agreement or supplier approval is distinct from the effective date of billing privileges. CMS Br. at 4. To the extent that CMS suggests that an ambiguity arises from the term "supplier approval" referenced in section 498.3(b)(15), I am not persuaded that the language of section 498.3(b)(15) bears a reading that excludes approval after submission of an enrollment application rather than after a survey or deeming of an accredited supplier, or by CMS's assertion that it should be read to refer only to the language of section 489.13. CMS Br. at 4. Section 489.13 applies to the determination of the effective date of provider agreements and the "supplier approval of entities that, as a basis for participation in Medicare," are subject to survey and certification or accreditation. This argument is circular, since section 489.13 merely codifies the provisions for uniform effective date determinations for all providers and suppliers subject to survey and certification or accreditation that were adopted as part of the 1997 rulemaking. 62 Fed. Reg. at 43,931. Section 489.13 is not, however, the only provision for approval of suppliers to participate in Medicare. Approval is defined in section 424.502 as meaning the determination that the supplier is "eligible under Medicare rules and regulations to receive a Medicare billing number and be granted Medicare billing privileges." The effective date of such approval for suppliers not requiring survey and certification or accreditation is governed by sections 42 C.F.R. § 424.520(c) and (d). Importantly, section 498.3(b)(15) does not state that appealable initial determinations are limited to the effective dates of provider agreements and supplier approvals under section 489.13.

I am thus bound to follow the regulations in permitting an appeal by any provider or supplier dissatisfied with a determination as to the effective date of its provider agreement or supplier approval.

Based on the foregoing, I deny CMS's motion to dismiss.

B. The effective date of Petitioner's participation in Medicare was properly determined under 42 C.F.R. § 424.520(d).

As explained above, I decide the merits of this case based on the written record.

The undisputed facts of this case are as follows. Petitioner originally submitted an enrollment application to Palmetto GBA, a CMS contractor, in August of 2008. Ex. A at 1. Petitioner admits that the application submitted was not the correct application for the provider type. *Id*. Petitioner submitted another application to the CMS contractor in April of 2009, and admits that "the date was not on the signature page so the application was rejected." *Id*. Petitioner states that he "tried to reopen the CCN…with the date on the signature page. Due to CMS regulations, we were unable to reopen this CCN." *Id*.

Petitioner agrees that Palmetto GBA "finally received" a "complete clean application" on July 13, 2009. *Id*. By letter dated September 21, 2009, Palmetto GBA informed Petitioner that his application was approved, and he had been assigned a Provider Transaction Access Number to bill Medicare. *Id.* at 6. The letter indicated that an "effective date of 6/13/2009" was assigned based on this being "30 days from the receipt date of the application" pursuant to 42 C.F.R. § 424.521(a)(1). *Id.* at 7. The letter also instructed Petitioner that, if he disagreed with this determination, he could submit a corrective action plan (CAP) within 30 days or request reconsideration within 60 days. *Id.*

Petitioner then submitted a CAP on September 25, 2009. *Id.* at 4-5. In his CAP, he requested that his effective date be made retroactive to July 22, 2008. *Id*. at 5. He argued that he had been trying to get Medicare approval even under a prior contractor but "encountered several issues during this process" that included the fact that guidelines changed effective April 1, 2009 meant that billing privileges "will only go back 30 days from receipt of application." *Id.* Despite recognizing this rule, Petitioner asked Palmetto GBA to "retro his effective date to 7/22/08." *Id.*

Palmetto GBA evidently treated this CAP as a reconsideration request. On January 12, 2010, the Palmetto GBA hearing officer denied Petitioner's request to change the effective date, citing 42 C.F.R. §§ 424.520(d) and 424.521(a)(1). *Id*. at 2-3.

The present appeal followed. Petitioner now seeks an earlier effective date based on the date when Petitioner's first enrollment application was submitted to Palmetto GBA, plus a 30-day retroactive billing period. *Id*. at 1.

The effective date of approved enrollment in the Medicare program for Petitioner is governed by 42 C.F.R. § 424.520(d), which reads:

> (d) *Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations.* The effective date for billing privileges for physician, 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.

(Emphasis added). 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) (emphasis added).

Petitioner admits that CMS did not receive "a complete clean application" that was subsequently approved until July 13, 2009. Ex. A. at 1. Because it is undisputed that prior applications from Petitioner could not be processed to approval as submitted, no legal basis exists to use the date of filing of prior applications to determine the effective date of enrollment.

Petitioner did not, and could not, appeal the contractor's rejections of his earlier applications. The rejection of an enrollment application is governed by 42 C.F.R. § 424.525, which reads:

> **§ 424.525 Rejection of a provider or supplier's enrollment application for Medicare enrollment.**
>
> (a) *Reasons for rejection.* CMS may reject a provider or supplier's enrollment application for the following reasons:
> (1) The prospective provider or supplier fails to furnish complete information on the provider/supplier enrollment application within 30 calendar days from the date of the contractor request for the missing information.
> (2) The prospective provider or supplier fails to furnish all required supporting documentation within 30 calendar days of submitting the enrollment application.
> (b) *Extension of 30-day period.* CMS, at its discretion, may choose to extend the 30 day period if CMS determines that the prospective provider or supplier is actively working with CMS to resolve any outstanding issues.
> (c) *Resubmission after rejection.* To enroll in Medicare and obtain Medicare billing privileges after notification of a rejected enrollment application, the provider or supplier must complete and submit a new enrollment application and submit all supporting documentation for CMS review and approval.

> (d) *Additional review*. Enrollment applications that are rejected are not afforded appeal rights.

(Emphasis added). Petitioner thus had no appeal right from the rejection and was required to submit a new application.

It is undisputed that Palmetto GBA received the application that was subsequently approved on July 13, 2009. Pursuant to 42 C.F.R. section 424.520(d), the date of the contractor's receipt of that application must be used as the effective date.

Despite the clarity of this rule, confusion has been introduced by a muddling of the effective date for which a supplier is approved as eligible to bill Medicare, governed by 42 C.F.R. § 424.520(d), with the earliest date for which an approved supplier may be permitted to bill retroactively for services provided prior to the effective date, if the contractor finds that certain prerequisites are met, governed by 42 C.F.R. § 424.521(a). The contractor in this matter contributed to this confusion by conflating the two date determinations and setting out as the "effective dates" the earliest dates for which it would permit Petitioner to bill retroactively for services provided. Ex. A. at 6-10 (letter granting Petitioner's approval to participate in the Medicare program); *id.*, at 2-3 (reconsideration determination letter).

For many years, the question as to the proper effective date was unlikely to arise, because physicians and non-physician practitioners were permitted to bill for services provided up to 27 months retroactively. *See* 73 Fed. Reg. at 69,766. On January 1, 2009, however, CMS's regulations were changed to prohibit reimbursement to providers and suppliers for items or services that they provided prior to the dates of their enrollment with narrowly defined exceptions. CMS was concerned that Medicare not pay for items or services when it could not be certain that the supplier met Medicare eligibility standards at the time those items or services were provided. *Id.* To avoid this problem, CMS considered requiring that billing privileges begin only on the date when the contractor approved the supplier as eligible to receive reimbursement from Medicare and no retroactive billing be permitted. *Id*. Commenters pointed out that this policy would penalize suppliers who demonstrated their eligibility in their enrollment applications but who were not approved for some time thereafter as a result of their contractors' processing time. *Id.* at 69,767. CMS addressed the public concern about contractor processing timeliness by adopting the approach of setting the effective date for approval of eligibility to the date of filing of the enrollment application that was ultimately processed to approval (or the date that the applicant is open for business at the new location, if later). *Id.* CMS explained that "it is not possible to verify that a supplier has met all of Medicare's enrollment requirements prior to submitting an enrollment application." *Id.* Commenters also complained, however, that a prospective supplier might have to begin offering items and services prior to filing an enrollment application and that refusing to pay for those items or services was unfair to them. *Id.* at 69,768. CMS responded that suppliers, including physicians and NPPs, are responsible for filing

timely enrollment applications and, in most cases, can do so prior to providing Medicare services at a practice location. *Id.* For those situations where they can not, CMS explained that it was:

> finalizing a provision that allows physicians…to retrospectively bill for services up to 30 days **prior to their effective date of billing** when the physician or nonphysician organization has met all program requirements, including State licensure requirements, where services were provided at the enrolled practice location prior to the date of filing and circumstances, such as, when a physician is called to work in a hospital emergency department which precluded enrollment in advance of providing services to Medicare beneficiaries in § 424.521(a)(1).

Id. (emphasis added).[3] A careful reading of the regulations and preamble discussions makes clear that the grant of a retroactive billing period of up to 30 days does not constitute a change in the effective date of the supplier's approval of eligibility to participate in Medicare and is based on a showing of circumstances precluding timely enrollment, not a determination of an earlier date of approval.

Petitioner does not identify any authority for a right to appeal the grant of, or length of, a retroactive billing period. Current regulations, which were in effect at the time of Petitioner's approval for participation in Medicare, limit retroactive billing to 30 days prior to the effective date. 42 C.F.R. § 424.521(a). The billing period under section 424.521(a) is retroactive **from the effective date** of approval. It follows that section 498.3(b)(15) does not provide for challenges to the period for retroactive billing beyond an appeal that the effective date of approval itself was wrongly determined. Furthermore, the regulation at section 424.521(a) is binding on me. I can neither alter nor deviate from its explicit limitation on retroactive billing to the 30 days already granted to Petitioner. Thus, I have no authority to extend the retroactive billing period for Petitioner.

[3] The regulations also permit a retroactive billing period of up to 90 days prior to the effective date in certain disaster situations not relevant here. 42 C.F.R. § 424.521(a)(2).

III. Conclusion

In conclusion, the earliest effective date for enrollment in the Medicare program was properly determined to be July 13, 2009. *See* 42 C.F.R. § 424.520(d). Thus, I must deny Petitioner's request for an effective date earlier than July 13, 2009 or retroactive billing privileges earlier than June 13, 2009.

/s/
Leslie A. Sussan
Board Member