Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Eugene Rubach, M.D.,
(NPI: 1881692200),

Petitioner

v.

Centers for Medicare & Medicaid Services.

Docket No. C-10-270

Decision No. CR2125

Date: May 7, 2010

DECISION

I deny the motion of the Centers for Medicare and Medicaid Services (CMS) to dismiss the hearing request of Petitioner, Eugene Rubach, M.D. I grant CMS's motion for summary judgment. Accordingly, the effective date of Petitioner's enrollment as a provider in the Medicare program remains May 15, 2009, and Petitioner's right to bill for Medicare services became effective on April 14, 2009.

I. Background

By letter dated May 29, 2009, Medicare contractor National Government Services, Inc. (NGS) notified Petitioner that his Medicare enrollment application 855I was approved, effective April 14, 2009.[1] CMS Exhibit (Ex.) 5. Petitioner filed a request for

[1] CMS points out in its brief that Petitioner's enrollment application was filed on May 14, 2009, which is therefore the actual effective date. CMS Br. at 9 n.2. Pursuant to 42 C.F.R. § 424.520(d), the date identified by NGS as the "effective" date (April 14, 2009) is actually the date from which Petitioner may retroactively bill for services. *Id.*

reconsideration by letter dated August 14, 2009, [2] stating an earlier enrollment application first submitted on January 11, 2009[3] was rejected only because Petitioner's office never received a fax from NGS requesting information necessary to complete the application. CMS Ex. 6, at 2 (Reconsideration Request). Petitioner argues that as a consequence, it submitted the additional information beyond the time frame given to respond to NGS's request and therefore the application was rejected. *Id.* Petitioner thereafter submitted another application with the necessary documentation, which was processed to approval with an effective date of April 14, 2009, which is thirty days before the date the second application was received. *Id.*; CMS Ex. 7. Petitioner seeks an earlier effective date based on the date when his first enrollment application was submitted to NGS. Hearing Request (HR) at 2; CMS Ex. 6, at 3.

On October 12, 2009, the NGS hearing officer denied Petitioner's request to change the effective date, citing 42 C.F.R. §§ 424.520(d) and 424.521(a)(1) as the basis of the decision. CMS Ex. 7, at 1-2. Petitioner requested a hearing by submitting the same letter, dated August 14, 2009, that he submitted to request reconsideration, together with the reconsideration decision letter dated October 12, 2009, and the enrollment approval letter dated May 29, 2009. *See* HR at 1-2; *see also* CMS Exs. 5, 7, and 8.

This case was assigned to Administrative Law Judge (ALJ) Alfonso J. Montaño for hearing and decision on January 8, 2010, and an initial Order was issued at his direction. On or about March 9, 2010, 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 8. This case was transferred to me for hearing and decision on April 7, 2010, pursuant to 42 C.F.R. § 498.44. Petitioner submitted to me a letter, dated April 6, 2010, addressed to CMS Chief Counsel, restating his arguments as to why the effective date should be changed to reflect the date the first enrollment application was submitted. Petitioner's representative indicated by telephone on April 14, 2010 that this letter and its attachments constitute Petitioner's response to CMS's motion. Petitioner submitted no exhibits, and he did not object to CMS's exhibits that are admitted as evidence.

II. Issues, Findings of Fact, Conclusions of Law

A. Issues

The issues in this case are:

---

[2] It is noted in the reconsideration decision letter that the request for reconsideration was untimely. Although CMS states this fact in its brief, CMS does not dispute jurisdiction on this ground.

[3] In its letter dated March 25, 2009, CMS states that it received Petitioner's enrollment application on January 12, 2009.

1. Whether Petitioner has a right to a hearing on the effective date of his Medicare participation; and
2. Whether Petitioner is entitled to retroactive billing privileges earlier than April 14, 2009.

B. Findings of fact and conclusions of law

1. The effective date of a Medicare provider agreement or supplier approval is an appealable initial determination; thus, Petitioner has a right to a hearing.

a. Standard of review

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."

b. Analysis

CMS argues that – –

> [t]he Medicare Act only permits providers and suppliers to appeal from "initial determination[s]," which are defined by regulation. While an initial determination may include the denial of an enrollment application, CMS's or its contractor's approval of a supplier's enrollment application and determination for the physician's effective date for billing Medicare is not an initial determination subject to appeal . . . .

CMS Br. at 10-11.

The regulations at 42 C.F.R. Part 498 that govern appeals procedures for determinations affecting participation in Medicare (and certain Medicaid determinations) set out a list of initial determinations by CMS that are subject to appeal and specify administrative actions that are not subject to appeal under part 498. One of the initial determinations listed as subject to appeal is as follows:

> The effective date of a Medicare provider agreement or supplier approval.

42 C.F.R. § 498.3(b)(15). None of the administrative actions identified as not subject to appeal under part 498 refers to the determination of an effective date for a provider or supplier to participate in Medicare.

CMS argues that a supplier has no right to appeal enrollment applications that are returned or rejected. CMS Br. at 5-6. However, that argument is irrelevant to this appeal, because the Petitioner has requested a hearing for purposes of reviewing the effective date of an approved enrollment application, not the return or rejection of an application.

CMS further argues that "[t]he Medicare Act and applicable regulations limit a provider's or supplier's appeal rights to denial of enrollment applications or revocations of billing privileges." CMS Br. at 12. 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.

Part 424 unquestionably does grant appeal rights from denials and revocations, but it does so by reference to the provisions of subpart A of part 498. 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. 46,362, 46,363 (Oct. 8, 1992). The same reasoning applies whether the denial of an earlier effective date results from a survey and certification process or an enrollment process.

CMS next asserts that section 498.3(b)(15) was only intended to apply to providers and suppliers subject to survey and certification requirements as a basis for determining their participation. CMS Br. at 14-18. CMS further contends that the effective date of a provider agreement or supplier approval is distinct from the effective date of billing privileges, and that the latter is not made appealable by section 498.3(b)(15). CMS Br. at 15. In other words, CMS argues that section 498.3(b)(15) is inapplicable here.

ALJs who have considered this jurisdictional question have been divided in their conclusions. In a number of recent cases, ALJs 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, that is, of a provider agreement or of supplier approval. *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). On the other hand, one ALJ recently accepted CMS's argument that the regulatory history of section 498.3(b)(15) should be understood to restrict appeals of effective dates to those suppliers and providers subject to survey and certification or accreditation. *Mikhail Paikin, DO*, DAB CR2064 (2010).

In a 2007 case, the Departmental Appeals Board (Board) concluded that an ALJ erred in holding that CMS had non-reviewable discretion on when to certify that a federally qualified health center (FQHC) met participation requirements, because the addition of

section 498.3(b)(15) was intended to make existing appeal procedures available for effective date determinations. *Family Health Servs. of Darke County*, DAB No. 2092, at 16-17 (2007) (citing 62 Fed. Reg. 43,931, at 43,934 (Aug. 18, 1997)). The Board also noted that nothing in section 489.13(a)(2)(i) governing effective dates for FQHCs "suggests an ALJ may not review CMS's determination of an effective date . . . ." DAB No. 2092, at 17 (emphasis in original). In that case, however, unlike the present one, CMS did not assert that an effective date determination could not be challenged. *See id.* The Board did not address the arguments CMS now makes and, since the case involved a FQHC, it is not directly on point. I note, however, that CMS's failure to make such a claim in that case casts further doubt on the claim that CMS has had any consistent interpretation of its regulations as precluding such challenges.

It is well-established, and not questioned by either party here, that both the Board and all ALJs are bound by statute and regulations. Where a regulation speaks clearly on its face and applies to the question before me, I am bound to follow it. ALJs who have found a right to appeal the effective dates assigned to all suppliers and providers who are accepted for enrollment in Medicare have relied on this principle. ALJ Kessel, for example, states:

> CMS would have me ignore the plain meaning of the regulation. It contends that this regulation predates the Part 424 regulations and was intended to confer hearing rights only in situations not covered under Part 424. That argument is unpersuasive. The regulation is plain and unambiguous.

Andrew J. Elliott, M.D., DAB CR2103, at 3 (2010).

I agree. The wording of section 498.3(b)(15) is straightforward in providing that the "effective date of a Medicare provider agreement or supplier approval" is an appealable initial determination and includes no qualifying or limiting language.

Regulatory history and other sources of guidance are relevant in interpreting language which is ambiguous or which is unclear in its application or which leaves gaps. 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.

Even reviewing the regulatory history on which CMS relies, however, I do not find any clear indicator that section 498.3(b)(15) was intended at the time of its issuance to mean anything other than what it states, or to restrict challenges to effective date determinations as CMS now argues.

The provision that became section 498.3(b)(15) was first proposed in 1992 in a notice of proposed rulemaking that aimed at doing two things: (1) establishing "uniform criteria

for determining the effective date of participation for all Medicare and Medicaid providers and Medicare 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. at 46,362. There is no question that the uniform criteria for establishing effective dates for provider agreements and supplier approvals proposed in 1992 (and finalized in 1997) apply to those providers and suppliers subject to survey and certification requirements (or accreditation by a CMS-approved accrediting organization). The regulatory language explicitly states that the effective date of agreement or approval criteria apply to "Medicare provider agreements with, and supplier approval of, entities that, as a basis for participation in Medicare" are subject to CMS or state agency survey and certification, or are deemed to meet requirements based on accreditation, with two exceptions which apply only to community mental health centers, FQHCs, or laboratories. 42 C.F.R. § 489.13.

This observation does not, however, necessarily mean that the appeal rights added to part 498 by the same rulemaking are limited to those 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.* (The provider or supplier may not, however, argue that the initial survey should have been scheduled sooner. 42 C.F.R. § 498.3(d)(15)). This discussion indicates that the drafters were thinking of the type of providers and suppliers that then had appeal rights, but does not indicate that they had an intention to restrict the scope of appeals by others who might be granted Medicare hearings.

The 1997 preamble states that the final rule "makes clear that the rules for determination of the effective date of a provider agreement or supplier approval apply to all providers and suppliers that are subject to survey and certification . . . or have deemed status on the basis of accreditation." 62 Fed. Reg. at 43,934 (emphasis added). The 1997 preamble further states that the final rule "[m]akes existing Medicare appeals procedures available, and requires Medicaid agencies to make their existing appeals procedures available, for effective date determinations." *Id.* Notably, the statement of the expansion of Medicare and Medicaid hearings to include effective date determinations contains no parallel limitation to those subject to survey and certification or accreditation.[4] Furthermore, the regulatory impact statement indicates that the drafters believed that court decisions had

[4] It is not possible to construe the limitation in the explanation of the scope of the uniform effective determination rules to apply to the entire summary of the final rule's effect, because other clauses are clearly discussing the effects on other subsets of providers (such as laboratories and community mental health centers).

already confirmed a right to appeal effective date determinations as analogous to denials of participation, even though that right had not previously been codified in the regulations. *Id.* In addition, the preamble states that effective date hearings would, "for the most part," focus on noncompliance issues similar to those that arise in denial appeals, but does not state that such appeals could only arise in that context. *Id.* I conclude that nothing in the regulatory history of the addition of section 498.3(b)(15) demonstrates an intent to restrict challenges to effective date determination to a subset of providers and suppliers, as opposed to all providers and suppliers that then had appeal rights.

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 14-15. 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. The question is not whether the drafters at the time contemplated granting such rights to suppliers and providers who were not then covered by the effective date determination criteria applicable to those requiring survey and certification or accreditation. The question is whether, despite the plain language, the drafters actually intended to affirmatively exclude other providers and suppliers who might later gain appeal rights from challenging their effective date determinations. As discussed above, the 1992 and 1997 preambles do not reflect any such intention.

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' decision 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).

To the extent that CMS is suggesting 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 15-16. 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, which were adopted as part of the 1997 rulemaking. 62 Fed. Reg. at 43,931. Section 489.13 is not 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."[5] 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.

I note, however, that a right to challenge the effective date is not a license to seek an effective date other than that prescribed by law. I turn next, therefore, to what the applicable law provides as to the proper effective date in Petitioner's circumstances.

2. The effective date of Petitioner's participation in Medicare was properly determined under 42 C.F.R. § 424.520(d); thus, Petitioner cannot be granted earlier retroactive billing privileges.

a. Standard of review

The Board stated the standard of review for summary judgment as follows:

[5] CMS suggests that I should disregard this definition of supplier approval, because the definitions in 42 C.F.R. § 424.502 are those "used in this subpart unless the context indicates otherwise . . . ." CMS Br. at 16, n.6. It is in the same subpart, however, that the regulations grant appeal rights under part 498 to providers and suppliers whose enrollment is denied. 42 C.F.R. § 424.545. Therefore, the definition of approval applicable to those appeals would be the one at 42 C.F.R. § 424.502.

> Summary judgment is appropriate when the record shows that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. *Kingsville Nursing and Rehabilitation Center*, DAB No. 2234, at 3 (2009), citing *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986). While the Federal Rules of Civil Procedure (FRCP) are not binding in this administrative appeal, we are guided by those rules and by judicial decisions on summary judgment in determining whether the ALJ properly granted summary judgment. *See Thelma Walley*, DAB No. 1367 (1992) . . . . The party moving for summary judgment bears the initial burden of showing that there are no genuine issues of material fact for trial and that it is entitled to judgment as a matter of law. *Kingsville* at 3, citing *Celotex*, 477 U.S. at 323. If the moving party carries its initial burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial.'" *Matsushita Elec. Industrial Co. v. Zenith Radio*, 475 U.S. 574, 587 (1986) (quoting FRCP 56(e)). To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact – a fact that, if proven, would affect the outcome of the case under governing law. *Id.* at 586, n.11; *Celotex*, 477 U.S. at 322. In determining whether there are genuine issues of material fact for trial, the reviewer must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. *U.S. v. Diebold, Inc.*, 369 U.S. 654, 655 (1962).

Senior Rehab. & Skilled Nursing Ctr., DAB No. 2300, at 3 (2010). The role of an ALJ in deciding a summary judgment motion differs from the ALJ's role in resolving a case after a hearing. The ALJ should not be assessing credibility or evaluating the weight of conflicting evidence. *Holy Cross Village at Notre Dame*, DAB No. 2291, at 4-5 (2009).

b. Analysis

The determination of the effective date of Medicare billing privileges here is governed by 42 C.F.R. § 424.520, which reads, in pertinent part:

> (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 does not dispute the fact that the application that was submitted on or about January 12, 2009 was not approvable as submitted or that additional information was in fact required. Because it is undisputed that that application could not be processed to approval as submitted, there is no legal basis to use the date of filing that application to determine the effective date.

Petitioner argues:

> . . . I was informed this application was rejected out because our office did not respond to a fax on February 23, 2009 requesting verification of an address change. Unfortunately, we never received the fax, therefore we were unaware of the information your office required to complete the application. Our office is extremely efficient and timely, especially when a request for information of extreme importance is involved. We have submitted numerous applications for many physicians and they have been completed promptly and efficiently.

CMS Ex. 8, at 1. That statement implies that if Petitioner had received the fax, he would have timely responded to the request just as his office has in the past. That argument is purely speculative. Essentially, Petitioner is arguing that the original application should not have been rejected.

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 has no appeal right from the rejection and was required to submit a new application.

In any case, I find no merit to Petitioner's argument that the contractor should have followed up by telephone when Petitioner did not respond to a faxed request for additional information. Section 5.3A of chapter 10 of the Medicare Program Integrity Manual (MPIM) reads, in pertinent part:

> **Commencement of Timeframe** – For information requests under 42 CFR §424.525(a)(1), the 30-day clock described above commences when the contractor mails, faxes, or e-mails the letter.

(Emphasis added). In regard to whether a fax alone is sufficient notification to the provider of the information request, section 3.1 of chapter 10 of the MPIM reads, in pertinent part:

> If the provider: (1) files an application with at least one missing required data element, or (2) fails to submit all required supporting documentation, the contractor shall send a letter to the provider – preferably via e-mail or fax – that contains, at a minimum, the elements listed below. . ..
>
> • A list of all missing data or documentation . . ..

(Emphasis added).

The contractor's letter rejecting Petitioner's January 12, 2009 application states that the additional information required was requested on February 23, 2009. CMS Ex. 3. CMS alleges and the Petitioner has not disproved that the information request was faxed on that date. Although Petitioner alleges that he never received the fax, he makes no claim that the first application was approved or was approvable. As noted, there is no right to appeal from the rejection of that first application. I must apply the regulations and guidelines as stated in determining the legally required effective date for the approved application. Because Petitioner's application submitted on January 12, 2009 was not

subsequently approved, the date that application was submitted cannot be used for purposes of determining the effective date. *See* 42 C.F.R. § 424.520(d).

It is undisputed that the application that was subsequently approved was received by NGS on May 15, 2009. Pursuant to 42 C.F.R. § 424.520(d), the May 15, 2009 application must be used for purposes of determining the effective date. Therefore, NGS was correct in so using it.

CMS regulations permit certain suppliers, including physicians, to bill retroactively for certain services provided before approval if they have met all program requirements. 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 "if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries" or 90 days in certain disaster situations. 42 C.F.R. § 424.521(a). This billing period is retroactive **from the effective date** of their 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. Thus, I have no authority to extend the retroactive billing period for Petitioner.

In conclusion, the earliest effective date was properly determined to be May 15, 2009. *See* 42 C.F.R. § 424.520(d). Thus, Petitioner's request for retroactive billing privileges earlier than April 14, 2009 must be denied. *See* 42 C.F.R. 424.521(a).

Because there is no genuine issue to any material fact, and for the foregoing reasons, CMS's motion for summary judgment is granted.

/s/
Leslie A. Sussan
Board Member