Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Gayathri Tadepalli, M.D.,
(PTAN: 0892387),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-10-512

Decision No. CR2211

Date: August 12, 2010

DECISION

I deny the motion of the Centers for Medicare & Medicaid Services (CMS) to dismiss the hearing request of Petitioner, Gayathri Tadepalli, M.D. I grant CMS's motion for summary disposition and sustain its determination setting the effective date of Petitioner's enrollment in Medicare as September 17, 2009, with billing privileges retroactive for 30 days to August 17, 2009.

I. Background

Petitioner, a psychiatrist, joined the physician practice group, Butler Behavioral Health Services, Inc., and began treating Medicare patients on February 2, 2009. Hearing Request (HR). Petitioner completed applications (CMS Form 855I and CMS Form 855R) seeking to establish Petitioner's enrollment in the program and reassign benefits to the group practice at four locations. CMS Ex. 2. Palmetto, the Medicare contractor, received her applications on September 17, 2009. CMS Ex. 2. On September 24, 2009, the contractor notified Petitioner that it approved her enrollment and provided a 30-day

period of retroactive billing, authorizing her to bill for services beginning August 17, 2009.[1,2] CMS Ex. 3.

By letter dated December 10, 2009, Petitioner submitted a "Corrective Action Plan/Redetermination Request" form which the contractor interpreted as a reconsideration request. CMS Ex. 6. Palmetto then issued a reconsideration decision on January 11, 2010, upholding its initial determination. CMS Ex. 7. Palmetto's reconsideration stated that Petitioner's effective date was determined in accordance with 42 C.F.R. § 424.520(d), "the later of the date of filing or the date they first began furnishing services at a new practice location." CMS Ex. 7, citing 42 C.F.R. § 424.520(d).

Petitioner filed a timely request for a hearing and included copies of her November 13, 2009 initial determination and December 10, 2009 request for contractor review. HR. Petitioner also submitted a copy of her reconsideration decision by facsimile on March 12, 2010. All of these documents were also submitted by CMS as exhibits. This case was originally assigned to Administrative Law Judge (ALJ) Carolyn Cozad Hughes. On March 10, 2010, ALJ Hughes issued an Acknowledgment and Initial Pre-Hearing Order setting a briefing schedule. The case was subsequently transferred to me pursuant to 42 C.F.R. § 498.44, which permits a Member of the Departmental Appeals Board (Board) to hear appeals taken under Part 498. In a submission dated April 12, 2010, CMS filed a brief containing its Motion to Dismiss or, in the alternative, Motion for Summary Disposition and submitted its exhibits 1 through 7. CMS argues that the effective date of a physician's Medicare enrollment is not an initial determination subject to an appeal and, alternatively, that it properly determined Petitioner's effective date. On June 3, 2010,

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[1] The "effective date" listed in the approval letter is August 17, 2009, which the contractor describes as "30 days [prior to] the Receipt Date of the application" citing 42 C.F.R. § 424.521(a)(1). CMS Exs. 3, 5. In other words, that "effective date" is the date to which Petitioner may retroactively bill for services. It follows that the "effective date" of Petitioner's enrollment in the Medicare program, pursuant to 42 C.F.R. § 424.520(d), was determined to be September 17, 2009, the receipt date of Petitioner's enrollment application. CMS Ex. 2. I note, however, that 30 days prior to September 17, 2009, is August 18, 2009, rather than August 17, 2009 as set by the contractor and CMS. CMS has not sought review of this issue and, therefore, I will not address it further.

[2] Petitioner's enrollment and reassignment of benefits applications requested enrollment at four locations. The September 24, 2009 contractor letter approved only one of the locations. CMS Exs. 1, 3. Petitioner submitted a second application received by the contractor on October 29, 2009, for the approval of the remaining three group practice locations. CMS Ex. 4. On November 13, 2009, the contractor approved Petitioner's application authorizing the additional three practice locations, also with the "effective date" listed as August 17, 2009. CMS Ex. 5 n.1.

Petitioner's representative indicated that she would not submit a reply to CMS's Motion to Dismiss and/or for Summary Disposition. Accordingly, I ordered the record closed on June 7, 2010, and notified the parties that I would proceed to rule on CMS's motions based on the record. In the absence of any objection, I admit the CMS exhibits to the record.

II. Issues, Findings of Fact, Conclusions of Law

A. Issues

The issues in this case are whether:

1. I have authority to hear Petitioner's challenge to the effective date of her enrollment; and

2. CMS is entitled to summary disposition on the ground that undisputed facts demonstrate that CMS properly determined the effective date of Petitioner's enrollment in Medicare.

B. Findings of Fact and Conclusions of Law

My findings and conclusions are in the italicized headings supported by the subsequent discussions below.

1. I have authority to hear Petitioner's challenge to the determination of the effective date of her approved Medicare enrollment.

a. Applicable standard

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

b. Analysis

CMS argues that the Medicare regulations do not allow a physician supplier whose Medicare enrollment has been approved to appeal the effective date of billing privileges and that I must therefore dismiss the appeal. CMS Br. at 7. CMS acknowledges that other ALJs in a number of recent cases 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. CMS Br. at 7-8 (*citing cf., Jorge M. Ballesteros, CNRA*, DAB CR2067 (2010) and *Jason Wardell, P.A.*, DAB CR2095 (2010)). CMS, however, requests that I concur with the ALJ decisions adopting CMS's position, including *Mikhail Paikin, D.O.*,

DAB CR2064 (2010), *Peter Manis, M.D.*, DAB CR2036 (2009), and *Rachel Ruotolo, M.D.*, DAB CR2029 (2009). CMS Br. at 8.

The Board recently addressed this specific issue in *Victor Alvarez, M.D.*, DAB No. 2325 (2010). In *Alvarez*, the Board concluded that "a determination of a supplier's effective date of enrollment in Medicare is an initial determination subject to appeal rights under 42 C.F.R. Part 498." *Alvarez*, DAB No. 2325, at 1. The Board explained that this determination is consistent with the historical interpretation of hearing rights under section 1866(h)(1)(A) and as discussed in the rulemaking process. Further, "while section 498.3(b)(15) originally applied primarily to suppliers subject to survey and certification, the term 'supplier' as used in 42 C.F.R. Part 498 was amended to cover all Medicare suppliers, including physicians." *Id.* at 3.

In several prior decisions, I also came to the same conclusion. *See, e.g., Michael Majette, D.C.*, DAB CR2142 (2010); *Eugene Rubach, M.D.*, DAB CR2125 (2010); *Mobile Vision, Inc.*, DAB CR2124 (2010). I likewise concluded that the wording of section 498.3(b)(15) appears 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. A legislative rule generally binds the agency that issues it, and the agency is legally bound to follow its own regulations as long as they are in force. *Cal. Dep't of Soc. Servs.*, DAB No. 1959 (2005); *Hermina Traeye Mem'l Nursing Home*, DAB No. 1810 (2002), citing Kenneth Culp Davis and Richard J. Pierce, Jr., *Administrative Law Treatise* § 6.5 (3rd ed. 1994), *aff'd Sea Island Comprehensive Healthcare Corp. v. U.S. Dep't of Health & Human Servs.*, 79 F. App'x 563 (4th Cir. 2003); 2 AM. JUR. 2d *Administrative Law* § 236 (2010), *available at* WL AM. JUR. ADMINLAW § 236. Absent further rulemaking, I am bound to follow the plain meaning of the regulation and, as the Board mandated, permit an appeal by any provider or supplier dissatisfied with a determination as to the effective date of its provider agreement or supplier approval.

I therefore reject CMS's contention that Petitioner's challenge to the assigned effective date is not properly before me.

I turn next, therefore, to what the applicable law provides as to the proper effective date in Petitioner's circumstances.

2. I grant CMS summary disposition on the ground that it properly determined the effective date of Petitioner's participation in Medicare.

a. Applicable standard

CMS seeks summary disposition in the nature of summary judgment. The Board stated the standard for summary judgment as follows.

> 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. . . . 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. . . . 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. . . . 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.

Senior Rehab. & Skilled Nursing Ctr., DAB No. 2300, at 3 (2010) (citations omitted). 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 assess credibility or evaluate the weight of conflicting evidence. *Holy Cross Vill. at Notre Dame*, DAB No. 2291, at 4-5 (2009).

b. Applicable regulations

The determination of the effective date of Medicare billing privileges is governed by 42 C.F.R. §§ 424.520 and 424.521. Section 424.520(d) provides that 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 . . . 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).

Certain suppliers, including physicians, may be permitted to bill retrospectively for certain services provided before approval, if they have met all program requirements. Current regulations limit retrospective 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).

c. Analysis

These regulations establish the effective date of Petitioner's enrollment as a Medicare supplier as the date Palmetto received the application it subsequently approved (or, the date Petitioner began providing those services, had it been later, which was not the case). 42 C.F.R. §§ 424.520(d), 424.521(a). The undisputed evidence shows that Petitioner signed the enrollment and reassignment of benefits applications (CMS-855I and CMS

855R) and dated them September 8, 2009. CMS Ex. 2, at 22, 25. The applications were postmarked September 16, 2009, and stamped as received by the contractor on September 17, 2009. *Id.* at 27.

Petitioner acknowledges all of these facts in her own submissions. In fact, Petitioner declined the opportunity to respond to CMS's brief and motion and did not dispute CMS's description of the evidence. Order Closing Record. Petitioner does not argue that she submitted a prior enrollment application that was approved or approvable or contend that the date of receipt of her reenrollment application was in error. Petitioner in effect expresses frustration with the enrollment process and difficulty in obtaining the information she needed to complete her application whose timeliness became very important due to recent regulatory changes affecting retrospective billing. HR. Petitioner's only argument is that she had difficulty obtaining her supplier number which was needed to complete her enrollment applications because her former employer obtained the number for her. HR. It is, however, Petitioner's responsibility to obtain the proper information required to complete her enrollment applications. Whether or why Petitioner failed to maintain a record of her assigned number or other identifying information is not relevant to these proceedings.

Petitioner further contends that the requested enrollment date of February 2, 2009, is not "prior to the allowable date for billing for services (365 days) which have already been provided to Medicare patients by this physician." HR. This contention is not entirely clear; however, to the extent that Petitioner is arguing that, *if* she were properly enrolled in the Medicare program from February 2, 2009, she would be allowed to bill for such services, it must fail. Petitioner was *not* enrolled in the program during that period. To the extent that Petitioner is arguing that she should be permitted retrospective billing privileges of up to 365 days, such flexibility is no longer permissible under the governing regulations.

The regulations set the effective date as the date of receipt of Petitioner's approved application and limit retrospective billing privileges to the 30-day period that was granted here. (No indication exists that the provision authorizing a 90-day period in the case of certain disasters applies here). No regulations currently authorize me to consider challenges to the period for retroactive billing beyond hearing an appeal that the effective date of approval itself was wrongly determined. Furthermore, the regulation at section 424.521(a) binds 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.

I note that previous regulations did authorize CMS to grant physician suppliers up to 27 months of retroactive billing privileges; however, that provision and the authority it provided were eliminated when the current regulations became effective on January 1, 2009. 73 Fed. Reg. at 69,940. As physicians previously could be permitted to bill

Medicare up to 27 months prior to the effective date of Medicare enrollment, issues relating to the effective dates of their enrollments were unlikely to arise. With the shorter time frame for retrospective billing, the applicable effective date has obviously become more important. The law as to when approval is effective, however, now links the commencement of that shortened period of retrospective billing to the receipt of the approved application.

Given this record, I conclude that no dispute of any material fact exists and that CMS is entitled to summary judgment on the ground that the effective date of Medicare enrollment is September 17, 2009 as a matter of law. CMS also properly granted a 30-day period of retrospective billing as the regulations authorized.

Petitioner contends that the physician group is a "non-profit organization, and [Petitioner's] services have legitimately been provided to [the group's] patients, going back to 02/02/09." HR. Petitioner's arguments, including those regarding difficulty in completing the application, however, are essentially those of equity. Petitioner asks me, in effect, to estop the government from applying federal law and regulations based on Petitioner's good intentions or on the financial effect on her. Estoppel against the federal government, if available at all, is presumably unavailable absent "affirmative misconduct," such as fraud. *See, e.g.*, *Pacific Islander Council of Leaders*, DAB No. 2091, at 12 (2007); *Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414, 421 (1990). None of the circumstances described fit that standard or permit me to ignore the unmistakable requirements of the regulations governing Petitioner's enrollment in Medicare, by which I am bound.

III. Conclusion

Because no genuine issue to any material fact exists, and for the foregoing reasons, I grant CMS's motion for summary disposition and sustain its determination setting the effective date of Petitioner's Medicare enrollment as September 17, 2009, with a retrospective billing period beginning August 17, 2009.

/s/
Leslie A. Sussan
Board Member