Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Krish Venoo, M.D.,
(NPI: 1487829834),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-12-223

Decision No. CR2553

Date: June 15, 2012

DECISION AND REMAND

Petitioner, Krish Venoo, M.D., is an Illinois physician. The Centers for Medicare & Medicaid Services (CMS) granted his Medicare enrollment application effective August 1, 2011. Petitioner here challenges that effective date, and CMS has moved for summary judgment. However, Petitioner has come forward with evidence which, drawing all reasonable inferences in Petitioner's favor, suggests that material facts are in dispute and raises additional issues, which CMS has not previously addressed.

For the reasons discussed below, I deny CMS's motion for summary judgment. Pursuant to 42 C.F.R. § 498.56(d), I remand this matter to CMS to consider new issues and issue a new determination.

Discussion

> ***CMS is not entitled to summary judgment because Petitioner has come forward with evidence of specific facts showing that a dispute exists.[1]***

[1] I make this one finding of fact/conclusion of law.

Initially, this case appeared to be a straight-forward challenge to CMS's determination as to the effective date for Petitioner's participation in the Medicare program. CMS submitted a copy of Petitioner's paper application, along with evidence that the Medicare contractor, Wisconsin Physician Services (WPS) received it on August 1, 2011. CMS Exs. 1, 2. Based on this, a contractor hearing officer determined, on reconsideration, that, under 42 C.F.R. § 424.520(d), the effective date of Petitioner's Medicare enrollment must be August 1, 2011, the date Petitioner filed a subsequently-approved enrollment application. The hearing officer also concluded, without further explanation, that "[t]he contractor correctly deactivated the . . . supplier's Medicare billing privileges due to 12 consecutive months of non-billing. . . ." CMS Ex. 6 at 1. CMS explained that Petitioner Venoo earlier participated in the Medicare program, but that his program participation was deactivated effective January 6, 2007 because of "12 consecutive months of non-billing." CMS Ex. 4 at 1.

At the outset of this case, Petitioner was not represented by counsel. He did not timely respond to CMS's motion for summary judgment nor submit an acceptable prehearing exchange (due March 7, 2012). *See* Acknowledgment and Initial Pre-hearing Order (December 29, 2011). On March 2, 2012, he asked for a one-week extension of time in which to file his exchange. I granted the request but warned that no further extensions would be granted. On March 13, 2012, Petitioner submitted an unsigned and undated letter along with a stack of un-marked documents. By letter dated March 14, 2012, we returned the submission and directed Petitioner to file within ten days an amended exchange that complied with Civil Remedies procedures and my December 29, 2011 order. Petitioner did not comply, but apparently retained an attorney.

In a letter dated March 26, 2012, received March 28, 2012, Petitioner's newly-retained counsel sought an additional extension of time. I would not formally grant additional time, but suggested that Counsel could submit Petitioner's response, accompanied by a motion to file out-of-time, which I would consider if received before I issued my decision.[2] Finally, in a letter dated June 6, 2012, we directed Petitioner to submit, prior

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[2] In cases involving denial of an enrollment application, an Administrative Law Judge (ALJ) must issue a decision no later than the end of the 180-day period beginning from the date the appeal was filed. 42 C.F.R. § 498.79. Whether this regulatory deadline applies here is an open question. On the one hand, Petitioner's enrollment application was granted, not denied. Further, if the time limit's purpose is to assure that providers/suppliers timely learn whether they can expect to be paid for future Medicare-covered services, that purpose is not served here; Petitioner is enrolled and knows that, going forward, he will be paid for providing covered services. On the other hand, the Board has ruled, albeit in a different context, that "approval of enrollment with a particular effective date is in essence a denial of enrollment for an earlier period." *Alvarez*, DAB No. 2325 at 3 (2010). So it seems wise to err on the side of caution and assume the regulation applies. Unfortunately, the regulation allows for no exceptions,

to the close of business June 7, any documentation or argument that he wished me to consider.

In response, Petitioner's counsel filed an appearance, and submitted five exhibits, including a statement from Petitioner Venoo. In his statement, Petitioner Venoo said that his Medicare enrollment application was processed in 2009 and, thereafter, he was not advised that his enrollment had been revoked. P. Ex. 5. He included a November 9, 2009 letter from WPS approving his October 26, 2009 enrollment application with an effective billing date of July 8, 2009. P. Ex. 1.

CMS was unavailable to participate in a timely conference to discuss the new evidence, but claimed, via e-mail and without supporting evidence, that Petitioner's 2009 Medicare enrollment is "entirely unrelated to the provider enrollment under [Petitioner's] own name." CMS counsel also suggested that I could meet the regulatory deadline (if applicable) by entering "judgment in CMS's favor, under the facts presented here." CMS asserted that "[t]here is no basis here for challenging either the correctness of the [2007] deactivation at the time that it was made or the determination of the effective date. . . ." I cannot grant CMS summary judgment based on unsupported representations included in an e-mail. Further, in considering CMS's motion for summary judgment, I must draw all reasonable inferences in Petitioner's favor. *Livingston Care Center v. Dep't. of Health & Human Services*, 388 F.3d 168, 172 (6th Cir. 2004); *I866ICPayday, L.L.C.*, DAB No. 2289 at 3 (2009). Petitioner comes forward with a November 2009 letter approving his Medicare enrollment. On its face, the letter does not establish that it is "entirely unrelated to the provider enrollment under [Petitioner's] own name." It refers to Petitioner personally, without mentioning any group practice. It describes a "CMS 855 Medicare enrollment application," generally, without specifying a category of application, e.g., basic physician enrollment (855I), group practice (855B), reassignment of benefits (855R).

Thus, Petitioner's submissions raise additional issues regarding his earlier Medicare enrollments and the circumstances under which one or more enrollment was deactivated:

- When and why did the contractor deactivate Petitioner's program participation? What is the effect of Petitioner's 2009 enrollment and what happened thereafter to cause him to submit an application in August 2011?

- In light of 42 C.F.R. § 424.540(c), which says that deactivation of Medicare billing privileges "does not have any effect on a supplier's participation agreement or any conditions of participation," why is Petitioner not able to bill for services he provided while his enrollment was deactivated?

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even where, as here, parties miss deadlines, request multiple extensions of time, raise new issues as the deadline looms, and are unavailable for conferences.

- If Petitioner's program participation was deactivated for nonsubmission of a claim, why was Petitioner required to submit a new enrollment application? 42 C.F.R. § 424.540(b) explicitly exempts from filing a new enrollment application providers/suppliers deactivated for nonsubmission of a claim. *See* 71 Fed. Reg. 20,762; 20,769. Is Petitioner entitled to an opportunity to rebut his deactivation? If so, has he been given that opportunity? 42 C.F.R. §§ 424.545(b), 405.374.

- Finally, CMS suggests that, due to the passage of time since his deactivation, section 424.540 does not apply here. What is the rationale for this claim and how much time must pass before the regulation no longer applies? If, in fact, Petitioner was not required to submit a new enrollment application, what was he required to do in order to preserve his billing privileges?

Conclusion

Drawing all reasonable inferences in the light most favorable to the non-moving party, I find that material facts are in dispute here and deny CMS's motion for summary judgment. I also find that Petitioner raises issues not previously addressed by the contractor or CMS regarding his deactivation and his 2009 Medicare enrollment. Pursuant to 42 C.F.R. § 498.56(d), I remand this case to CMS to consider these issues and address them in a new determination. If dissatisfied with CMS's new determination, Petitioner may request review as provided for in 42 C.F.R. § 424.545 and 42 C.F.R. Part 498.

/s/

Carolyn Cozad Hughes
Administrative Law Judge