Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Jean-Claude Henry, M.D.,
(NPI: 1215022561/PTAN: CB 234986),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Respondent

Docket No. C-16-276

Decision No. CR4627

Date: June 8, 2016

DECISION REMANDING AND DISMISSING CASE

This case is remanded to the Centers for Medicare & Medicaid Services (CMS) pursuant to 42 C.F.R. § 498.56(d).[1] This case is dismissed pursuant to 42 C.F.R. § 498.70(b) to permit action by CMS in accordance with current regulations. This dismissal is without prejudice to any right of Petitioner to request a hearing as to a determination by CMS on remand that triggers such a right. Either party may request in writing that I vacate, for good cause, the dismissal within 60 days of the date of this Order. 42 C.F.R. § 498.72. Any other objection to this Order must be filed within ten days of the date of this Order.

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[1] References are to the revision of the Code of Federal Regulations (C.F.R.) in effect at the time of the initial and reconsideration determinations, unless otherwise stated.

I. Procedural History and Findings of Fact

Noridian Healthcare Solutions (Noridian) is a Medicare Administrative Contractor. Petitioner is Jean-Claude Henry, M.D. Noridian sent Petitioner a letter dated October 10, 2014, advising Petitioner that his Medicare billing privileges related to PTANs WA36648E, CV274A, CB203296, and WA36648G were deactivated. Nordian stated that the basis for the deactivation was Petitioner's failure to respond to a revalidation request mailed April 21, 2014. The letter advised Petitioner that to reactivate his billing privileges he needed to submit a paper CMS-855 or to file an electronic application through PECOS (Provider Enrollment, Chain, and Ownership System). Petitioner Exhibit (P. Ex.) 8.

Petitioner filed an enrollment application by PECOS on October 29, 2014. CMS Exhibit (CMS Ex.). 1 at 11. Corrections to the application were requested by email on May 15, 2015 and June 17, 2015. CMS Ex. 1 at 16-17, 19-20, 27-28. Noridian notified Petitioner by letter dated June 25, 2015, that Petitioner's "initial enrollment application" was approved effective January 1, 2015, with the new PTAN CB234986. CMS Ex. 1 at 6-7, 9-10. Petitioner timely requested reconsideration on June 25, 2015. CMS Ex. 1 at 3-5, 8. Noridian notified Petitioner by letter dated September 5, 2015, that Petitioner's effective date was changed to February 25, 2015. CMS Ex. 1 at 1-2.

On October 14, 2015, an unsigned reconsidered determination was issued by an unidentified contractor hearing officer. The reconsidered determination stated that Petitioner's request for an earlier effective date was denied. The reconsidered determination cited Medicare Program Integrity Manual (MPIM), CMS pub. 100-08, § 15.27.1.2 and 42 C.F.R. § 424.520(d) as the basis for its decision and stated that Petitioner's effective date of Medicare enrollment could be no earlier than Noridian's receipt of the signed application for reactivation. CMS Ex. 2. The reconsidered determination reflects that the unidentified contractor hearing officer recognized that Petitioner submitted the CMS-855I application to reactivate its billing privileges not for the purpose of enrollment as Petitioner was already enrolled in Medicare and his enrollment was never revoked. As explained hereafter, the reconsidered determination, which is the subject of my review, is based on an error of law and cannot be upheld or enforced.

Petitioner requested a hearing before an administrative law judge (ALJ) on November 20, 2015 accompanied by 14 supporting documents which were not subsequently marked and offered as evidence by Petitioner. The case was assigned to me on February 5, 2016 for hearing and decision and an Acknowledgment and Prehearing Order (Prehearing Order) was issued at my direction.

On March 7, 2016, CMS filed a motion for summary judgment with CMS Exs. 1 and 2. On April 4, 2016, Petitioner filed a response in opposition to the CMS motion for

summary judgment with P. Exs. 3 through 8. On April 21, 2016, CMS filed a reply brief (CMS Reply). CMS objects to my consideration of P. Ex. 3 on grounds that there is not good cause for receiving new evidence not considered on reconsideration. CMS Reply at 2-3. CMS Exs. 1 and 2 and P. Exs. 4 through 8 are admitted. P. Ex. 3 is not admitted because it is not relevant to the issue before me.

II. Discussion

A. Applicable 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.[2] Administration of the Part B program is through contractors such as Noridian. Act § 1842(a) (42 U.S.C. § 1395u(a)).

The Act requires the Secretary of Health and Human Services (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 of certain enrollment determinations. 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. The effective date of enrollment in Medicare of a physician, nonphysician practitioner, and physician and nonphysician practitioner organizations is governed by 42 C.F.R. § 424.520(d). The effective date of enrollment for a physician or nonphysician practitioner may only be the

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[2] Petitioner is a "supplier" under the Act and the regulations. A "supplier" furnishes services under Medicare and the term supplier applies to 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. Act §§ 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395(u)(h)(1)).

later of two dates: the date when the physician filed an application for enrollment that was subsequently approved by a Medicare contractor charged with reviewing the application on behalf of CMS; or the date when the physician first began providing services at a new practice location. *Id.* An enrolled physician or nonphysician practitioner may retrospectively bill Medicare for services provided to Medicare-eligible beneficiaries up to 30 days prior to the effective date of enrollment, if circumstances precluded enrollment before the services were provided. Retrospective billing for up to 90 days prior to the effective date of enrollment is permitted only in case of a Presidentially-declared disaster pursuant to 42 U.S.C. §§ 5121-5206. 42 C.F.R. § 424.521.

The Secretary has authorized CMS to deactivate a provider's or supplier's Medicare billing privileges if the provider or supplier does not submit any Medicare claims for 12 consecutive calendar months. 42 C.F.R. § 424.540(a)(1). CMS may also deactivate a provider's or supplier's billing privileges if the provider or supplier does not report certain changes of information, such as a change in practice location or change of any managing employee, within 90 calendar days of when the change occurred, or does not provide complete and accurate information within 90 days of CMS's request for such information. 42 C.F.R. § 424.540(a)(2), (3). A provider or supplier "deactivated for any reason other than nonsubmission of a claim" is required to "complete and submit a new enrollment application to reactivate its Medicare billing privileges or, when deemed appropriate, at a minimum, recertify that the enrollment information currently on file with Medicare is correct." 42 C.F.R. § 424.540(b)(1). A provider or supplier who is "deactivated for nonsubmission of a claim" for 12 months is "required to recertify that the enrollment information currently on file with Medicare is correct and furnish any missing information as appropriate. The provider or supplier must meet all current Medicare requirements in place at the time of reactivation, and be prepared to submit a valid Medicare claim." 42 C.F.R. § 424.540(b)(2). Deactivation of Medicare billing privileges is to protect the provider or supplier from misuse of their billing privileges and the Medicare Trust Funds. Deactivation does not have any effect upon the provider's or supplier's participation in Medicare. 42 C.F.R. § 424.540(c).

B. Analysis

CMS's evidence shows that on or about April 21, 2014, Noridian requested that Petitioner revalidate his Medicare enrollment. Noridian then notified Petitioner by letter dated October 10, 2014, that his billing privileges were deactivated on that date because Petitioner had not submitted the requested revalidation information. P. Ex. 8. There is no evidence that Noridian advised Petitioner that his enrollment in Medicare would be revoked if he failed to timely submit the requested information.

On October 29, 2014, Noridian electronically received an unsigned enrollment application, CMS-855I, from Petitioner. Petitioner electronically signed the application

on February 25, 2015. I infer from the fact that Noridian requested Petitioner to revalidate his Medicare enrollment information in April 2014, that Petitioner was enrolled at that time and I find no evidence to support a contrary inference. There is no evidence that CMS ever revoked Petitioner's Medicare enrollment or was authorized to do so under 42 C.F.R. § 424.535 or any other provision of the Act or regulations. Petitioner's billing privileges were deactivated under 42 C.F.R. § 424.540. Petitioner's Medicare enrollment was not revoked under 42 C.F.R. § 424.535. Therefore, the issue is not the effective date of Petitioner's enrollment in Medicare, as he has apparently remained continuously enrolled since prior to April 2014. The issue is the effective date of the reactivation of Petitioner's billing privileges. As discussed hereafter, the effective date of the reactivation of Petitioner's billing privileges must be determined in accordance with the Secretary's regulation, 42 C.F.R. § 424.540(c), not the CMS policy cited on reconsideration that is contrary to the regulation.

Petitioner submitted his application by PECOS on October 29, 2014. Petitioner electronically signed the application on February 25, 2015. CMS policy in effect at the time Petitioner filed and signed the application provided that if the contractor approves a provider's or supplier's reactivation application, the reactivation effective date will be the provider's or supplier's date of deactivation. MPIM, ch. 15, § 15.27.1 (C) (rev. 462, iss'd May 16, 2013, eff. Mar. 18, 2013); MPIM, ch. 15, § 15.27.1.2(D) (rev. 474, iss'd Jul. 5, 2013, eff. Oct. 8, 2013).

CMS subsequently changed its policy effective March 18, 2015. The new CMS policy in effect at the time of the initial and reconsidered determinations provides that, if a CMS contractor such as Noridian approves a supplier's reactivation application, "the reactivation effective date shall be the date the contractor received the application . . . that was processed to completion." MPIM, ch. 15, § 15.27.1.2 (rev. 561, iss'd Dec. 12, 2014, eff. Mar. 18, 2015). MPIM, ch. 15, § 15.29.4.3 (rev. 578, iss'd Feb. 25, 2015, eff. May 15, 2015) instructs contractors that if a revalidation is received more than 120 days after deactivation, a new effective date will be issued to the supplier consistent with the effective date requirements of section 15.17 of chapter 15, which applies 42 C.F.R. § 424.520(d), which pertains to establishing the effective date of a new enrollment by a physician, nonphysician practitioner, or organizations of either. The unknown hearing officer applied the new CMS policies on reconsideration. The new CMS policy is inconsistent with and violates the Secretary's regulation, which provides that deactivation of Medicare billing privileges is to protect the provider or supplier from misuse of their billing privileges and the Medicare Trust Funds and does not have any effect upon the provider's or supplier's participation in Medicare. 42 C.F.R. § 424.540(c) If the current version of MPIM, ch. 15, § 15.27.1.2 is given effect, it potentially prevents the filing of claims for covered services rendered to Medicare-eligible beneficiaries during the period

of the deactivation and before the contractor receives the CMS-855I filed for purposes of reactivation. This effect is clearly contrary to the Secretary's regulation that provides deactivation "**does not have any effect upon the provider's or supplier's participation agreement or conditions of participation**." 42 C.F.R. § 424.540(c) (emphasis added).[3]

The current version of MPIM, ch. 15, § 15.27.1.2 may not be enforced to the extent the policy is inconsistent with the Secretary's regulation. CMS policy statements such as those set forth in the MPIM do not have the force and effect of law, *i.e.*, the statutes or regulations. *Perex v. Mortgage Bankers Ass'n*, __ U.S. ___, 135 S.Ct. 1199 at 1204 (2015) (Convenience of issuing an interpretive rule or policy rather than a legislative rule using the Administrative Procedure Act (APA) notice and comment procedure "comes at a price: **Interpretive rules** 'do not have the force and **effect** of **law** and are not accorded that weight in the adjudicatory process.'" (citation omitted) (emphasis in original)); *Ind. Dep't. of Pub. Welfare v. Sullivan*, 934 F.2d 853 (7th Cir. 1991) (substantive rules promulgated under the APA notice and comment rulemaking procedures as regulations are enforceable as law; agency interpretative rules or policy statements are not subject to notice and comment rulemaking requirements but are not enforceable as law); *Nw. Tissue Ctr. v. Shalala*, 1 F.3d 522 (7th Cir. 1993). Furthermore, as an ALJ I am bound to follow the Constitution, the Act, and the Secretary's regulations, and I give effect to the policies of the Secretary and CMS to the extent they are not inconsistent with the law. 1*866ICPayday.com, L.L.C*., DAB No. 2289 at 14 (2009) ("[a]n ALJ is bound by applicable laws and regulations and may not invalidate either a law or regulation on any ground.").

Pursuant to 42 C.F.R. § 498.56(d), I may remand a case to CMS for consideration of a new issue and a new determination. In this case, the new CMS policy for determining the effective date of a reactivation of Medicare billing privileges set forth in MPIM, ch. 15, § 15.27.1.2 is inconsistent with 42 C.F.R. § 424.540(c). The application of that policy by the contractor hearing officer was legal error. This case is remanded to permit a new reconsidered determination that determines the effective date of the reactivation of Petitioner's Medicare billing privileges consistent with the Act and the Secretary's regulations.

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[3] The current CMS policy also creates a conflict among 42 C.F.R. § 424.545(b), 42 C.F.R. § 498.5(*l*), and 42 C.F.R. § 498.3(b)(15). Under 42 C.F.R. §§ 424.545(b), 498.5(*l*), a supplier has no right to review of the decision to deactivate billing privileges or the reactivation of those privileges. However, 42 C.F.R. § 498.3(b)(15) recognizes a right to review of a determination by CMS or its contractors as to the effective date of a Medicare provider agreement or the approval of a supplier's participation in Medicare.

Accordingly, this case is remanded to CMS and dismissed. The parties may request that an order dismissing a case be vacated within 60 days for good cause shown pursuant to 42 C.F.R. § 498.72. If CMS completes its action on this case more than 60 days from the date of this Order and Petitioner desires my further review, Petitioner will file a request for hearing referring to this case with a copy of this Order attached.

III. Conclusion

For the foregoing reasons, this case is remanded and dismissed.

/s/

Keith W. Sickendick
Administrative Law Judge