Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Maria Anna Go, APRN, et al.,

Petitioners

v.

Centers for Medicare & Medicaid Services.

Docket Nos. C-10-230 through C-10-257

Decision No. CR2136

Date: May 21, 2010

DECISION

I deny the motion of the Centers for Medicare and Medicaid Services (CMS) to dismiss the hearing requests of Petitioners, 28 nurse practitioners (NPs), who are, or were, at the relevant times employed by Park Avenue Medical Associates, LLC, (PAMA) (NPI: 1063653467). I grant CMS's motion for summary judgment as to all Petitioners. Although the effective date of PAMA's enrollment as a supplier in the Medicare program is March 2, 2009, I conclude that the effective date for the NPs is either July 6, 2009 (for 22 NPs) or July 13, 2009 (for 6 NPs), according to the date on which each NP's application was received. I conclude that, as a matter of law, the NPs are not entitled to bill for services provided more than 30 days prior to the respective effective dates of the enrollment.

I. Background

This case arises from the October 8, 2009 decision by Medicare contractor National Government Services, Inc. (NGS) denying PAMA's request for reconsideration of the effective dates assigned to its NP group members. CMS Exhibits (CMS Exs.) 34, 38. On December 2, 2009, PAMA submitted a timely request for an Administrative Law Judge (ALJ) hearing on behalf of the 28 NPs. I append to this decision a list of the individual

NPs, the docket number assigned to each NP, the date that NGS received the individual's application, and the number of the exhibit containing that application.[1]

On February 19, 2010, CMS filed a motion to dismiss (CMS MD) and an alternative motion for summary judgment (MSJ). On April 2, 2010, Petitioners filed an opposition to both motions (Opposition). CMS submitted a reply dated April 15, 2010 (Reply). CMS filed exhibits 1-42 with its motions. Respondent submitted one exhibit and two affidavits. I admit all the exhibits for purposes of resolving the outstanding motions.

CMS does not dispute Petitioners' representations that PAMA is a limited liability company, based in Connecticut, which provides nurse practitioner services to nursing homes and other facilities for which it bills Medicare directly. Opposition at 5. PAMA acquired a predecessor agency for which the NPs (with one exception who came directly to PAMA) previously worked. *Id.* at 5-6. PAMA sought to enroll both the new group and the individual NPs in the Medicare program. *Id.*

It is further undisputed that NGS approved PAMA's group enrollment application (CMS Form 855-I) on June 24, 2009, and the application took effect on March 2, 2009. CMS Exs. 32, 33. PAMA then submitted individual enrollment applications for the NPs (CMS Form 855-R) to reassign their billing rights to PAMA. CMS Exs. 2-29. These applications were sent in two batches a week apart and were all approved. Each NP was assigned an effective date of enrollment 30 days before the date on which NGS received the corresponding application.[2]

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[1] CMS's briefing injects some confusion about the number and identity of the Petitioners. First, CMS refers to PAMA as a Petitioner. PAMA, however, does not challenge the effective date of its approval as an eligible supplier. Its involvement in these appeals arises solely from its role as employer of the NPs to which they seek to reassign their rights to payment. CMS Reply at 1. Second, both CMS and counsel for Petitioners describe Petitioners as "consisting of 29 nurse practitioners." CMS MD at 1; *see* Petitioners' Hearing Request. However, the only Petitioners identified in the hearing requests, and whose appeals are before me, are the 28 identified by name and case number in the Appendix. Earlier in the case, the attorneys for Petitioners raised questions about whether they were authorized to represent all of the Petitioners, but, ultimately, they confirmed their authority to do so in a letter dated April 9, 2009. CMS advised that it had no objection to that representation in an email dated April 15, 2009. I therefore accept that all 28 Petitioners are properly represented.

[2] CMS asserts that the approval letters "advised Park Avenue that it may retrospectively bill Medicare for services rendered, beginning on the thirty day period" prior to the dates the applications were received, i.e., from June 6, 2009 for applications received July 6, 2009, and from June 13, 2009 for applications received July 13, 2009. CMS MD at 9 (citing CMS Exs. 30, 31). While, as I discuss below, this explanation reflects the

(continued…)

Petitioners contend that they should all have been assigned an effective date of March 2, 2009, the effective date of enrollment assigned to PAMA. Opposition at 12. According to Petitioners, they would have filed their applications on the same date as PAMA, as the applications were already prepared, but for erroneous advice received from the contractor to wait until the group application was approved before submitting applications for the individual practitioners. Opposition at 12-13, 16-21. Petitioners contend that they can demonstrate the elements of estoppel and that, under the "unique" circumstances here, CMS has so mismanaged the enrollment process as to justify estoppel against the government. *Id*. at 16-21.

II. Issues, Findings of Fact, Conclusions of Law

A. Issues

The issues in this case are:

1. Whether Petitioners may challenge the effective dates for their approved Medicare enrollments;

2. If so, what are the legally correct dates on which Petitioners' approval is effective and for which Petitioners may bill Medicare for services provided; and

3. Whether Petitioners are entitled to earlier dates than those provided by law based on equitable estoppel.

B. Findings of fact and conclusions of law

1. I have authority to hear Petitioners' challenge to the determination of the effective dates of their approved Medicare enrollments.

a. 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."

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[2] (…continued)

regulatory standards for determining the effective date for approval of the supplier's enrollment and the retroactive billing privileges granted to certain suppliers, the approval letters do not actually provide this information. In each case, the letters simply list the earlier date (i.e., either June 6 or 13, 2009) as the "group member effective date." CMS Exs. 30, 31.

b. Analysis

CMS argues that I should dismiss these appeals, because my jurisdiction is limited to hearing appeals from denials of enrollment applications or revocations of billing privileges, whereas Petitioners' applications were approved. CMS MD at 12. Specifically, CMS argues that part 424, subpart P, grants appeal rights only from denials and revocations of enrollment. *Id.* at 12-13 (citing 42 C.F.R. § 424.545 (provider and supplier appeal rights); 42 C.F.R. §§ 405.874 (which deals only with contractor decisions that supplier standards are not met); 498.5(l) (appeal rights related to provider enrollment)). 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 further asserts that "there is not a single statutory or regulatory provision that permits a provider or supplier to appeal the effective date of billing privileges once its enrollment application has been approved, or that defines the effective date as an 'initial determination' under the circumstances of this case." CMS MD at 14.

This blanket assertion fails to acknowledge section 498.3(b)(15), which lists as an initial determination subject to appeal the following:

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

While part 424, subpart P, unquestionably does grant appeal rights from denials and revocations, as CMS notes, it does so by reference to the provisions of subpart A of part 498. The regulations at part 498 govern appeals procedures for determinations affecting participation in Medicare (and certain Medicaid determinations) and list those initial determinations by CMS that are subject to appeal and those administrative actions that are not subject to appeal under Part 498. It thus appears that the regulation on which CMS relies, rather than precluding effective date challenges, adopts the provision granting them. Furthermore, none of the administrative actions identified as <u>not</u> subject to appeal under part 498 refers to the determination of an effective date for a provider or supplier to participate in Medicare or identifies circumstances in which section 498.3(b)(15) is not applicable according to its terms.

CMS argues nevertheless that its regulations "specifically state" that a supplier has no right to appeal enrollment applications that are rejected, as opposed to denied, or to any review beyond an opportunity to submit a rebuttal when its billing privileges are deactivated. CMS MD at 13 (citing 42 C.F.R. §§ 405.374, 424.525(b)). According to CMS, I should conclude that these limitations demonstrate that only denials and revocations are subject to appeal. None of the cited regulations, however, contains any specific statement restricting suppliers from challenging adverse effective date determinations. Those provisions are thus not relevant to this appeal, because the Petitioner has requested a hearing for purposes of reviewing the effective date determined after its enrollment was approved, not the rejection of an application or deactivation of billing privileges. I note, moreover, that these provisions amply illustrate that, when CMS wishes to restrict or preclude appeal rights, it is capable of doing so expressly.

CMS does not identify any analogous provision limiting challenges to adverse effective date determinations.

CMS suggests that I should rely on a Supreme Court decision to conclude that the affirmative provision of some appeal rights in its regulations should be read as precluding appeal rights in circumstances not so specified. CMS MD at 14 (citing *Your Home Visiting Nurse Servs. v. Shalala*, 525 U.S. 449 (1999)). That case involved the options available to a provider dissatisfied with the decision of a fiscal intermediary acting as an agent of the Secretary in setting the amount of reimbursement to which the provider is entitled, based on the analysis of the provider's cost report. *Your Home*, 525 U.S. at 451. The statute provided for appeals to the Provider Reimbursement Review Board (PRRB) within 180 days of an adverse determination, but Your Home Visiting Nursing Services (VNS) did not seek such review. The regulations also permitted a provider to request reopening by the intermediary within three years. *Id*. Your Home VNS sought reopening, and the intermediary denied the request. Accordingly, Your Home VNS sought to appeal the denial of reopening, and the PRRB dismissed for lack of jurisdiction. *Your Home*, 525 U.S. at 451-52. The Court found that the regulations stated a reopened and revised reimbursement determination would be appealable as a separate determination but said "nothing about the appeal of a refusal to reopen." *Id.* at 453. The Court upheld as within the bounds of reasonable interpretation the Secretary's position that the statutory right to appeal a "final determination" as to the amount of total reimbursement due did not extend to a right to appeal the refusal to make a new determination on request. *Id*.

Your Home is inapposite here. Contrary to the situation in *Your Home*, the regulations at section 498.3(b)(15) expressly grant appeal rights from adverse effective date determinations in supplier approvals. *Your Home* does not provide any support for CMS's claim here that the later extension of appeal rights to suppliers and providers from adverse denials and revocations somehow precludes sub silentio the applicability of existing regulatory language providing that the determination of an effective date for supplier approval is an appealable initial determination.

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. 57 Fed. Reg. 46,362, 46,363 (Oct. 8, 1992); 62 Fed. Reg. 43,931, 43,933 (Aug. 18, 1997). The same reasoning applies whether the denial of an earlier effective date results from a survey and certification process or an enrollment process.

CMS now 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 MD at 22-25. 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). *Id.* at 23. In other words, CMS argues that section 498.3(b)(15) is inapplicable here.

Administrative Law Judges (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 of a provider agreement or of supplier approval. *Rushita Patel, M.D.*, DAB CR2129 (2010); *Michael Nillas*, M.D., DAB CR2077 (2010); *Blue Plastic Surgery Ctr., LLC*, DAB CR 2075 (2010); *Kate Suskin, LICSW*, DAB CR2072 (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).

CMS, on the other hand, quotes one ALJ's analysis in *Mikhail Paikin*, DAB CR2064 (2010) as follows:

> 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. The regulatory history for 42 C.F.R. § 498.3(b)(15) at 62 Fed. Reg. 43,931, 43,933-34 (Aug. 18, 1997) supports the CMS position that the provision only permits a right to hearing related to an effective date determination for providers and suppliers subject to survey and certification or to accreditation by an accrediting organization. Petitioner was not subject to survey and certification or accreditation in order to enroll and qualify as a supplier participating in Medicare. Accordingly, I conclude that 42 C.F.R. § 498.3(b)(15), creates no right for Petitioner to request a hearing to challenge the effective date determination by CMS or its contractor.

CMS MD at 25 (quoting *Paikin*, DAB CR2064, at 7; citing inter alia *Rachel Ruotolo, M.D.*, DAB No. CR2029 (2009); *Bradley D. Anawalt, M.D., et al.*, DAB No. CR2021 (2009)). The ALJ in *Paikin* did not explain further why, despite CMS acknowledging to him that the plain language of section 498.3(b)(15) makes the determination of the effective date of a Medicare supplier approval reviewable, he nevertheless looked behind the face of a binding regulation to read in a restriction that nowhere appears in the regulation.

It is well-established, and not questioned by either party here, that statute and regulations bind both the Departmental Appeals Board (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. 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. The ALJ in *Andrew J. Elliott, M.D.*, DAB CR2103 (2010), 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, 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 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.

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. No question exists 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 criteria set out for determining the correct effective date of agreement or approval 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 not applicable here. 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.[3] Furthermore, the regulatory impact statement indicates that the drafters believed that court decisions had 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.

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 498.3(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).

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[3] 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).

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 MD at 22-24. 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.[4] 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.

CMS acknowledges that it "issued guidance in May 2009, directing its contractors to permit appeals of effective date determinations for approved suppliers and providers," but argues that its "policy guidance is not binding on this tribunal" and that the May 2009 guidance was retracted in November 2009. CMS MD at 15; CMS Exs. 35-37. CMS argues that, since it never amended 42 C.F.R. Part 424 to add appeal rights for effective date determinations, its "retracted policy is not sufficient to provide appeal rights that do not exist under the Medicare Act and regulations." CMS MD at 16.

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[4] As one ALJ recently pointed out, in making this argument CMS commits the "syllogistic fallacy of the illicit major term: all A=B; no C=A; therefore, no C=B . . . or, as here: all § 489.13(a)(1) effective date determinations are reviewable; supplier enrollment effective date determinations are not § 489.13(a)(1) effective date determinations; therefore, supplier enrollment effective date determinations are not reviewable." DAB CR 2129, at 3 n.3.

[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 MD at 24 n.12. 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.

This argument misconceives the relevance of the two policy documents. I agree that the May 2009 document does not provide any independent basis to find appeal rights not provided for in binding law. As discussed above, section 498.3(b)(15) provides the appeal rights. CMS's discussion of its two policy issuances provides no basis to ignore the plain language of section 498.3(b)(15) granting the right to appeal "[t]he effective date of a Medicare provider agreement or supplier approval" and demonstrates no contrary regulatory intent. The May 2009 document nowhere suggested that it provided "new" appeal rights or that new regulations would be proposed or needed to implement the right to appeal adverse effective determinations. CMS Ex. 35. Instead, the document indicates that it was issued as clarification based on the expectation that the substantial reduction of the period for retroactive billing would cause many affected suppliers to challenge effective date determinations. The document also reminded contractors performing reconsiderations of such a challenge to include the applicable regulatory citations in their decisions. CMS Ex. 35, at 1. CMS also provided model approval letters for contractors to use that expressly provided for reconsideration requests to contractor hearing officers (the prerequisite step for ALJ review) when a provider disagreed with any part of the "initial determination" in the approval. CMS Ex. 36, at 6-7. The relevance of the May 2009 policy is thus that it undercuts CMS's claim that it has consistently interpreted subpart P of part 424 as limited to denials and revocations and precluding challenges to effective dates, or that it interpreted 498.3(b)(15) as excluding effective date appeals by providers and suppliers not subject to survey and certification or accreditation.

On the contrary, CMS originally interpreted approval letters with an effective date that the provider/supplier argued was later than that provided for by law as amounting to denials of approval for the earlier period and as appealable on that basis. I note that the language at section 498.3(b)(15) has been in place since 1997 and section 424.545 has been in place since 2006; however, as late as May 2, 2009, CMS expressly read them together as granting appeal rights for effective date determinations (which obviously exist only after an approval is granted but for a date subsequent to that sought by the provider/supplier). The fact that, in May 2009, CMS did not believe that any amendment to its regulations was needed for it to require its contractors to provide express notice to providers that they could appeal effective date determinations with which they disagreed in the context of supplier approval letters is strong evidence that the existing regulations sufficiently support such appeal rights.

CMS is correct that its policy guidance does not bind me and "cannot be applied so as to conflict with applicable statutory and regulatory law." CMS MD at 15 (citing inter alia *Beverly Health & Rehab. Servs., et al. v. Thompson*, 223 F. Supp. 73, 98-103 (D.D.C. 2002); *Vencor Nursing Ctrs., L.P. v. Shalala*, 63 F. Supp. 1, 11-12 (D.D.C. 1999)). In its November 2009 guidance, CMS ordered that contractors revise their approval letters to remove appeal rights stating that "[p]hysicians and non-physician practitioners cannot appeal the effective date decision made by the contractor" and noting that a "Change Request is forthcoming." CMS Ex. 37, at 1. This late change in CMS's policy is not binding and would conflict with the regulations if I applied it here. I therefore conclude

that CMS's reversal of its prior position in the November 2009 policy document does not merit any controlling weight, in light of the plain language of section 498.3(b)(15) and the absence of any demonstrated intent to prohibit effective date appeals by providers and suppliers at the time of the adoption of part 424, subpart P.

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 Petitioners' circumstances.

2. I grant CMS summary judgment on the grounds that the effective dates of Petitioners' approval to participate in Medicare are governed by 42 C.F.R. § 424.520(d).

a. Applicable Standard

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. *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 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).

Approval of an enrollment application establishes eligibility to submit claims for providing Medicare-covered services and supplies. 42 C.F.R. § 424.502. Under section 424.520, contractors must assign the effective date based on the date the approvable application was filed with them. The dates of filing of Petitioners' applications are not in dispute. PAMA's application was filed on May 20, 2009. CMS Exs. 32, 33. As previously noted, the individual NPs' applications were filed on July 6 and July 13, 2009. *See* Petitioners' Hearing Request. None of the Petitioners is alleged to have begun furnishing services at their new practice location on a date later than the date of filing.

I conclude that, as a matter of law based on these undisputed facts, the effective dates for which the individual Petitioners' billing privileges were approved must be July 6 or July 13, 2009, as the case may be.

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 Petitioners to bill retroactively for services provided. CMS Exs. 30, 31.

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. Effective 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.* at 69,766. CMS considered requiring that, to avoid this problem, 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 processing time by their contractors. *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 non-physician practitioners (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 cannot, CMS explained that it was --

> finalizing a provision that allows physicians, NPPs (including CRNAs), and physician or NPP organizations 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).[6] 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 eligibility.

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[6] 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).

Petitioners do not identify any authority for a right to appeal the grant of or length of a retroactive billing period.[7] I need not resolve whether any such right exists, because Petitioners here do not claim to be appealing the grant of a 30-day retroactive billing period but, rather, assert that they should be assigned an earlier effective date. Opposition at 14.

Petitioners contend that they "can readily demonstrate that they are entitled to an effective date of March 2, 2009, not June 6 & 13, 2009." *Id.* at 12. Their demonstration, however, consists of only two points. First, they argue that they would have submitted the individual applications along with the group application but for contrary, incorrect advice from the contractor. *Id.* at 13. I address and reject this estoppel claim below. Second, they assert that the contractor itself, perhaps "confused by the new 30-Day Rule," failed to correctly apply section 424.520(d), which called for effective dates of July 6 and 13. *Id*. They reason that this error establishes a "genuine issue of material fact . . . with regard to NGS's calculation of the effective dates" and precludes summary

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[7] I note that two of the cases on which CMS relied in arguing against any right to appeal an effective date determination actually do not address that issue but rather involved challenges to the period of retroactive billing. First, in *Ruotolo,* the ALJ states:

> [W]hile Petitioner argues that I do have authority to hear and decide this matter pursuant to 42 C.F.R. § 498.3(b)(15); that particular authority is inapplicable here as Petitioner does not contend that she was entitled to an earlier effective date of enrollment; rather she argues about when she may begin billing for her services. *See* 42 C.F.R. § 498.3(b)(15).

Ruotolo, DAB No. CR2029, at 3. Similarly, in *Anawalt*, the ALJ states:

> . . . [T]hese cases appear[] to involve a challenge to regulations which govern the time frame for which Medicare will retrospectively reimburse items or services provided prior to the effective dates of enrollment by physicians who are newly enrolled in the Medicare program (or re-enrolled at a point in time after enrollment has lapsed). The regulations are 42 C.F.R. §§ 424.520(d) and 424.521(a).
>
> * * *
>
> Petitioners' challenge of the regulations and the policies that they embody is not something that I have the authority to hear and decide. As a delegate of the Secretary of this Department I must apply her policies as are stated in regulations. I have no authority to declare a regulation to be unlawful or ultra vires.

Anawalt, DAB No. CR2021, at 3.

judgment. *Id.* CMS does not dispute that July 6 and 13 are the correct effective dates for approval of the Petitioners' enrollment applications and that June 6 and 13 are the dates from which they may begin retroactive billing under the applicable regulations. This is a matter of law, not a factual dispute, in any case. Petitioners note that claims for services rendered within 30 days prior to the June 6 and 13 dates have been denied and suggest that NGS should have given them the "benefit" of the retroactive billing rule, even if assigning the effective dates in June was erroneous. *Id.* at 14. Petitioners did get the benefit of the retroactive billing opportunity permitted under section 424.521(a). I am not persuaded that the confusion created by the contractor calling the first date of the retroactive billing period the effective date (which Petitioners themselves recognize was an error) entitles Petitioners to an additional 30 days of retroactive billing. In any case, I fail to see in these arguments any demonstration that Petitioners are "entitled to an effective date of March 2, 2009, as well as the benefit of the retroactive billing privileges of the 30-Day Rule," as they claim. Opposition at 14.

Petitioners next contend that NGS's decision not to permit them to bill for services prior to June 6 or 13 amounts to an effective revocation or denial of PAMA's enrollment and billing privilege during the "gap in time" between those dates and March 2, 2009 during which any claims submitted for services provided by its NPs are denied. *Id.* at 14. According to Petitioners, the effect is "exactly the same" as a revocation, but PAMA did not "commit any of the offenses warranting revocation" and should have had an opportunity to appeal this revocation under section 424.545(a) providing for appeals of denials and revocations. *Id.* at 14-15 (emphasis in original). Plainly, the effect of the later effective date applicable to the Petitioners, as opposed to the earlier date obtained by PAMA, is not the same as a revocation, since PAMA was enrolled and had billing privileges from March 2, 2009, whereas a revocation would not only have removed PAMA's billing privilege but would have barred PAMA from even reapplying for enrollment for at least one year. 42 C.F.R. § 424.535(c). As explained above, I agree that an adverse effective date determination as to Petitioners' approval to enroll as Medicare suppliers does amount to a denial of their applications for the period during which they are improperly not approved and, therefore, gives rise to appeal rights under section 498.3(b)(15). To prevail, however, the Petitioners had to show that they were entitled to an earlier effective date under the applicable regulations. This they have failed to do.[8]

[8] In their hearing requests, Petitioner also argued that CMS could and should as a matter of discretion extend their billing privileges back to March 2, 2009, based on section 424.525(b), and that I do so in this proceeding. Hearing Request of each Petitioner, at 3-4. CMS correctly pointed out that section 424.525(b) only permits CMS to extend the 30-day period within which an applicant is otherwise required to furnish missing information requested to process their pending application if the applicant is "actively working with CMS to resolve any outstanding issues." CMS MSJ at 9-10. If CMS exercises its discretion, the application that would otherwise be rejected for failure to submit information timely would continue to be processed. This provision thus

(continued…)

For the reasons explained above, I grant summary judgment to CMS on the grounds that Petitioners were not entitled under the applicable law to approval as Medicare suppliers prior to July 6 or 13, 2009 or to bill retroactively for services provided any earlier than June 6 or 13, 2009.

3. Petitioners' contention that the government is estopped from applying the effective date and retroactive billing determinations for equitable reasons is without merit.

Much of Petitioners' argument focuses not on any claims of legal entitlement to an earlier effective date for their supplier approval or to a longer period of retroactive billing (claims which, in any case, are unsupportable as explained above) but rather on the equitable contention that their good faith reliance on bad advice from a government contractor should estop CMS from denying them "Medicare payments to which they are otherwise entitled." Opposition at 1. In this regard, Petitioners submit an affidavit from Dorothy Watson, PAMA provider enrollment coordinator (Watson Affidavit), and an affirmation from Steven J. Chananie, Esq., an attorney with the firm representing Petitioners (Chananie Affirmation). For purposes of resolving the summary judgment motion, I accept all of the assertions in these two submissions as true and view the facts set out in them in the light most favorable to Petitioners. I conclude that I can nevertheless not grant the equitable relief which Petitioners seek.

The events as set out in the Watson Affidavit and Chananie Affirmation may be summarized as follows. Ms. Watson, who has almost six years of experience, was responsible for assisting the NPs with completing and submitting enrollment applications to arrange for Medicare to pay PAMA directly for services the NPs would provide at nursing homes and other facilities, after PAMA acquired the assets of the NPs' former employer (NP Care, LLC). Watson Affidavit at 2. She knew that, after its purchase of NP Care, LLC, PAMA would need to file a CMS 855I for the group and individual CMS 855Rs for the individual NPs but was not sure in what order to file these applications, especially in light of the new restriction of retroactive billing to 30 days. *Id.* at 3.

Consequently, she contacted NGS for guidance and was told that "filing both sets of applications simultaneously would cause confusion within NGS because, until such time as the group application had been approved, the two sets of applications would not be 'linked' together at NGS with an identifiable provider number." *Id.* at 4. The (unidentified) NGS representative advised her to submit the group application first and

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[8] (…continued)

has no relevance to this proceeding, which does not involve any rejection. Furthermore, Petitioners nowhere explain how I would have authority to exercise or review CMS's discretion to extend the submission time. I do not discuss this argument further, because Petitioners did not pursue it in their Opposition.

hold the individual applications until PAMA had received its group number. *Id.* She then called again "out of an abundance of caution" and spoke to a different NGS representative who gave the same advice. *Id.* She then followed that advice in good faith, whereas she would otherwise have "filed both sets of applications at the same time." *Id.*

Mr. Chananie agrees with Ms. Watson that the change restricting retroactive billing resulted in widespread "confusion in the healthcare industry." Chananie Affirmation at 2; Watson Affidavit at 3. He asserts that the confusion was caused by CMS's "mismanagement of this change in billing rules," pointing to NGS's failure to post timely written guidance and eventual issuance of conflicting information. Chananie Affirmation at 3 (citing CMS Exs. 35, 37).[9] He states that one of his associates was given the same advice about submitting a group application first and holding individual CMS 855Rs until after the group number was issued when the associate called NGS on behalf of a different client. *Id.* The associate however was "suspicious of these faulty instructions" and called another NGS representative (this time identified as Mary Cook) who correctly instructed the associate to file the applications simultaneously. *Id.*

I can only regret that Ms. Watson did not have the luck to speak to Ms. Cook, instead of the two representatives who gave her mistaken advice. And I can certainly sympathize with Ms. Watson's frustration at the consequences that flowed from following the advice she reports receiving. The issue before me, however, is whether these events suffice to support Petitioners' assertion that CMS "is estopped from denying [them] an effective date of March 2, 2009" due to NGS's "egregiously faulty advice" and CMS's "systemwide mismanagement in implementing and enforcing Medicare rules and regulations." Opposition at 16.

Petitioners acknowledge that CMS is correct in citing numerous decisions establishing that I lack authority to grant an equitable estoppel claim but seek to preserve this claim in the event of future court appeals. *Id.* at 16 n.3; *see Oklahoma Heart Hosp.*, DAB No. 2183, at 15 (2008). In any case, Supreme Court decisions in *Office of Personnel Management v. Richmond*, 496 U.S. 414 (1990) and *Heckler v. Community Health Services of Crawford County, Inc.*, 467 U.S. 51 (1984), make clear that equitable estoppel will not lie against the federal government at least absent a showing of affirmative misconduct, and especially not in cases involving ordering money to be paid from the federal fisc. *Wade Pediatrics*, DAB No. 2153, at 21 n.9 (2008). Recognizing this, Petitioners assert that affirmative misconduct should be found in its allegations that the government's adoption and implementation of the "30-Day Rule" without providing more guidance to providers was "highly irresponsible" and well beyond merely isolated

[9] CMS Exhibits 35 and 37 are the policy guidance documents issued by CMS first recognizing and then retracting a right to challenge determinations of the effective date for which suppliers are approved. Nothing in either document deals with how a supplier group should proceed in filing group and individual applications.

instances of misinformation. Opposition at 19. The regulatory changes to which Petitioners object were adopted by formal notice and comment rulemaking. While clear administrative guidance is naturally a good thing and misinformation is unfortunate, the regulations on their face were explicit in advising providers that their effective date would depend on the date on which an approvable application was received by their contractor and that retroactive billing would only be permitted up to 30 days prior to that effective date. 42 C.F.R. §§ 424.520(d) and 424.521(a). Petitioners do not even allege that Ms. Watson inquired about whether submitting the individual applications after approval of the group application would result in different effective dates, only that the two NGS representatives with whom she spoke agreed that sending them in simultaneously would "cause confusion within NGS." Watson Affidavit at 4.

I reject Petitioners' arguments that CMS is estopped from applying the regulations in setting the effective date of their supplier approvals and the resultant period of retroactive billing.

III. Conclusion

For the reasons explained above, I deny CMS's motion to dismiss and grant CMS's motion for summary judgment.

/s/
Leslie A. Sussan
Board Member

APPENDIX

Petitioner Name	Docket No.	Date NGS received application	Exhibit No.	NPI
Maria Anna Go, APRN	C-10-230	July 6, 2009	CMS Ex. 2	1790769107
Melinda R. Wellington, APRN	C-10-231	July 6, 2009	CMS Ex. 3	1720231020
Linda S. Kowalczuk, APRN	C-10-232	July 13, 2009	CMS Ex. 24	1124171103
Virginia E. Napiello, APRN	C-10-233	July 13, 2009	CMS Ex. 25	1487750782
Deloretta T. Lawrence, APRN	C-10-234	July 13, 2009	CMS Ex. 26	1083663058
Nadine D. Seltzer, APRN	C-10-235	July 13, 2009	CMS Ex. 27	1538208368
Stephanie L. Wilborne, APRN	C-10-236	July 13, 2009	CMS Ex. 28	1366419251
Pamela D. Yukna, APRN	C-10-237	July 13, 2009	CMS Ex. 29	1619995099
Kristin Sutcliffe, APRN	C-10-238	July 6, 2009	CMS Ex. 4	1548269608
Jennifer Remigio-Mandac, APRN	C-10-239	July 6, 2009	CMS Ex. 5	1285809319
Yvonne L. Joy, APRN	C-10-240	July 6, 2009	CMS Ex. 6	1316198534
Catherine G. Micinilio, APRN	C-10-241	July 6, 2009	CMS Ex. 7	1932295656
Ma Ellen D. Novicio, APRN	C-10-242	July 6, 2009	CMS Ex. 8	1578503231
Carol L. Jin, APRN	C-10-243	July 6, 2009	CMS Ex. 9	1366476293
Meredith B. Messing, APRN	C-10-244	July 6, 2009	CMS Ex. 10	1639172265
Theresa P. Averion, APRN	C-10-245	July 6, 2009	CMS Ex. 11	1356344097
Ellen M. Williams, APRN	C-10-246	July 6, 2009	CMS Ex. 12	1831222629
Nina Marie LaMagna, ANP	C-10-247	July 6, 2009	CMS Ex. 13	1053588426
Shannon S. Desimone, APRN	C-10-248	July 6, 2009	CMS Ex. 14	1669456976
Sarah F. Bryan, APRN	C-10-249	July 6, 2009	CMS Ex. 15	1922253483
April Y. McConner, APRN	C-10-250	July 6, 2009	CMS Ex. 16	1861673519
Ankita Patel, APRN	C-10-251	July 6, 2009	CMS Ex. 17	1912940636
Elizabeth T. Kamlani, APRN	C-10-252	July 6, 2009	CMS Ex. 18	1093718876
Sarah E.C. Kellogg, APRN	C-10-253	July 6, 2009	CMS Ex. 19	1093846644
Elizabeth C. Cozza, APRN	C-10-254	July 6, 2009	CMS Ex. 20	1801031604
Karlene A. Hylton, APRN	C-10-255	July 6, 2009	CMS Ex. 21	1376546168
Yongmei Jin, APRN	C-10-256	July 6, 2009	CMS Ex. 22	1598918773
Sunimole Joseph, APRN	C-10-257	July 6, 2009	CMS Ex. 23	1194709402