Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Gloria D. Johnson, NP
(PTAN: VVJ823D260),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-16-672

Decision No. CR4803

Date: March 3, 2017

DECISION

This case involves a Medicare supplier, Gloria D. Johnson, NP (Petitioner) whose billing privileges were deactivated as a result of her failure to timely respond to a revalidation request. Petitioner's billing privileges were subsequently reactivated effective December 14, 2015, the date Palmetto GBA (Palmetto), a Medicare administrative contractor, received Petitioner's enrollment application to reactivate her billing privileges, with retrospective billing privileges beginning 30 days earlier, on November 14, 2015. Petitioner has appealed the effective date assigned for her reactivated billing privileges. For the reasons discussed below, I conclude that the effective date of Petitioner's reactivated billing privileges remains December 14, 2015, with retrospective billing allowed beginning November 14, 2015.

I. Background

The Centers for Medicare & Medicaid Services (CMS) asserts that it sent Petitioner a letter requesting that she revalidate her Medicare enrollment on February 12, 2015.[1]

[1] The exhibit that CMS relied on in its brief as evidence that it requested that Petitioner revalidate her enrollment does not support that Palmetto made such a request of

CMS Brief (Br.) at 2; CMS Exhibit (Ex.) 1. After Petitioner did not respond to the revalidation request, Palmetto notified Petitioner, in a letter dated July 27, 2015, that it had deactivated her Medicare enrollment and billing privileges. CMS Ex. 2. Petitioner submitted an enrollment application in order to reactivate her Medicare enrollment and billing privileges on December 14, 2015. CMS Ex. 3. On February 2, 2016, Palmetto informed Petitioner that it had approved her application, and it assigned a new Provider Transaction Access Number (PTAN), with an effective date of billing privileges of November 14, 2015.[2] CMS Ex. 8 at 1.

Petitioner. CMS Ex. 1. This document appears to be a computer-generated report that does not demonstrate that a revalidation letter was issued to Petitioner on February 12, 2015. CMS Ex. 1. Following a December 28, 2016 pre-hearing conference, CMS provided, via email, a copy of a February 12, 2015 letter requesting that Petitioner revalidate her Medicare enrollment. Petitioner has objected to the submission of that document, based on the fact that CMS did not timely submit it with its pre-hearing exchange and submitted it via email, rather than as a marked exhibit. I agree with Petitioner's objections and I have not admitted that document as an exhibit. CMS thereafter did not attempt to submit that document as an exhibit, but rather, asked that the same document be admitted as CMS Ex. 8 *only* if "the Board determines that the actions taken by CMS and Palmetto to request revalidation and to deactivate Petitioner are subject to review." CMS Supplemental Brief (Supp. Br.) at 9-10. CMS explained that the document "was not previously submitted because, [at] the time of briefing, counsel for CMS was informed that Palmetto could not locate an actual copy of the revalidation letter." CMS Supp. Br. at 10. CMS continued that "[i]n response to the ALJ's order of December 15, 2016, counsel attempted to confirm with CMS that a copy of the letter did not exist, and was told that, *contrary to prior representations*, a copy of the letter could be located if needed." CMS Supp. Br. at 10 (emphasis added). If CMS was unable to obtain a copy of the revalidation letter in advance of filing its brief because Palmetto misrepresented the availability of the document, CMS could have submitted written direct testimony interpreting the report submitted as CMS Ex. 1. Such testimony would have subjected the declarant to cross-examination, if requested by Petitioner.

[2] Palmetto favorably assigned a November 14, 2015 effective date of billing privileges based on its apparent interpretation that 42 C.F.R. § 424.521(a) allowed for an earlier effective date of billing privileges based on the 30-day retrospective billing provision contained in that regulation. *See* CMS Br. at 5; CMS Exs. 4 at 1, 6 at 1; *see* 42 C.F.R. § 424.521(a). The effective date of Petitioner's reactivated Medicare enrollment and billing privileges is December 14, 2015, and retrospective billing privileges were permitted 30 days earlier, effective November 14, 2015. *See* CMS Br. at 5; 42 C.F.R. § 424.521(a); CMS Ex. 6 at 1.

Petitioner requested reconsideration of the effective date of her reactivated Medicare billing privileges, at which time she contended that she did not receive the revalidation request. CMS Ex. 5 at 2. In a reconsidered determination dated April 26, 2016, Palmetto denied Petitioner's request for an earlier effective date of her reactivated Medicare billing privileges. CMS Ex. 6. Palmetto explained that it mailed the revalidation letter on February 12, 2015, and that after it received no response, it notified Petitioner of her deactivation on July 27, 2015. CMS Ex. 6 at 1. Palmetto explained that "[t]he revalidation application must have been received within 120 days of the date of deactivation in order to secure the previous PTAN and effective date. Based on the regulations cited above, Palmetto has properly awarded Gloria Johnson the correct effective date of November 14, 2015." CMS Ex. 6 at 1.

Petitioner submitted a request for an administrative law judge (ALJ) hearing that was dated June 24, 2016, and received at the Civil Remedies Division on June 27, 2016. CMS filed a pre-hearing brief and motion for summary disposition (CMS Br.), along with seven exhibits (CMS Exs. 1 to 7). Petitioner filed a response (P. Br.), along with three exhibits (P. Exs. 1 to 3). I convened a pre-hearing conference on December 28, 2016, and I ordered supplemental briefing following the conference (CMS Supp. Br; P. Supp. Br.). In the absence of any objections, I admit CMS Exs. 1 to 7 and P. Exs. 1 to 3 into the record.

Neither party has offered the testimony of any witnesses, and therefore, a hearing for the purpose of cross-examination of witnesses is not necessary. *See* Acknowledgment and Prehearing Order §§ 8, 9, and 10. I consider the record in this case to be closed, and the matter is ready for a decision on the merits.[3]

II. Issue

Whether CMS had a legitimate basis for establishing December 14, 2015, as the effective date of the reactivated billing privileges for Petitioner, with retrospective billing privileges beginning November 14, 2015.

III. Jurisdiction

I have jurisdiction to decide this case. 42 C.F.R. §§ 498.3(b)(15), 498.5(*l*)(2).

[3] CMS has argued that summary disposition is appropriate. It is unnecessary in this instance to address the issue of summary disposition, as neither party has requested an in-person hearing.

IV. Findings of Fact, Conclusions of Law, and Analysis[4]

1. ***Palmetto did not receive a completed enrollment application for purposes of revalidation within 120 days of the date CMS states it requested that Petitioner revalidate her enrollment information, February 12, 2015, and it subsequently deactivated Petitioner's billing privileges on July 27, 2015.***

2. ***Palmetto received Petitioner's enrollment application seeking reactivation of her billing privileges on December 14, 2015.***

3. ***An effective date earlier than December 14, 2015, with retrospective billing beginning November 14, 2015, is not warranted for the reactivation of Petitioner's billing privileges.***

Petitioner is considered to be a "supplier" for purposes of the Social Security Act (Act) and the regulations. *See* 42 U.S.C. §§ 1395x(d), 1395x(u); *see also* 42 C.F.R. § 498.2. A "supplier" furnishes services under Medicare and the term applies to physicians or other practitioners that are not included within the definition of the phrase "provider of services." 42 U.S.C. § 1395x(d). A supplier must enroll in the Medicare program to receive payment for covered Medicare items or services. 42 C.F.R. § 424.505. The regulations at 42 C.F.R. Part 424, subpart P, establish the requirements for a supplier to enroll in the Medicare program. 42 C.F.R. §§ 424.510 - 424.516; *see also* Act § 1866(j)(1)(A) (authorizing the Secretary of the U.S. Department of Health and Human Services (Secretary) to establish regulations addressing the enrollment of providers and suppliers in the Medicare program). A supplier that seeks billing privileges under Medicare must "submit enrollment information on the applicable enrollment application." 42 C.F.R. § 424.510(a). "Once the provider or supplier successfully completes the enrollment process . . . CMS enrolls the provider or supplier into the Medicare program." 42 C.F.R. § 424.510(a), (d).

To maintain Medicare billing privileges, a supplier must revalidate its enrollment information at least every five years. 42 C.F.R. § 424.515. CMS (or its contractor) reserves the right to perform off-cycle revalidations in addition to the regular five-year revalidations and may request that a provider or supplier recertify the accuracy of the enrollment information when warranted to assess and confirm the validity of the enrollment information maintained by CMS. 42 C.F.R. § 424.515. Off-cycle revalidations may be triggered as a result of random checks, information indicating local health care fraud problems, national initiatives, complaints, or other reasons that cause CMS to question the compliance of the provider or supplier with Medicare enrollment

[4] My findings of fact and conclusions of law are set forth in italics and bold font.

requirements. 42 C.F.R. § 424.515(d). When CMS notifies a supplier that it is time to revalidate, the supplier must provide the requested information and documentation within 60 calendar days of CMS's notification. 42 C.F.R. § 424.515(a)(2).

CMS is authorized to deactivate an enrolled supplier's Medicare billing privileges if the enrollee fails to comply with revalidation requirements within 90 days of CMS's notice to revalidate. 42 C.F.R. § 424.540(a)(3). If CMS deactivates a supplier's Medicare billing privileges, "[n]o payment may be made for otherwise Medicare covered items or services furnished to a Medicare beneficiary." 42 C.F.R. § 424.555(b). The regulation authorizing deactivation explains that "[d]eactivation of Medicare billing privileges is considered an action to protect the provider or supplier from misuse of its billing number and to protect the Medicare Trust Funds from unnecessary overpayments." 42 C.F.R. § 424.540(c).

The reactivation of an enrolled provider or supplier's billing privileges is governed by 42 C.F.R. § 424.540(b), and the process for reactivation is contingent on the reason for deactivation. If CMS deactivates a provider or supplier's billing privileges due to an untimely response to a revalidation request, as CMS contends occurred in this case, the enrolled provider or supplier may apply for CMS to reactivate its Medicare billing privileges by completing the appropriate enrollment application or recertifying its enrollment information, if deemed appropriate. 42 C.F.R. § 424.540(a)(3), (b)(1).

Palmetto explained that it deactivated Petitioner's billing privileges after it did not receive a response more than five months after it requested Petitioner revalidate her enrollment information. CMS Ex. 2. Petitioner eventually submitted an enrollment application for purposes of revalidation that Palmetto received on December 14, 2015. CMS Exs. 3, 4, 6. Palmetto accepted Petitioner's application, reactivated her billing privileges, and assigned a new PTAN, effective December 14, 2015, with retrospective billing privileges permitted effective November 14, 2015. CMS Exs. 4, 6.

The pertinent regulation with respect to the effective date of reactivation, as cited by Palmetto in its reconsidered decision, is 42 C.F.R. § 424.520(d). CMS Ex. 6 at 1; *Arkady B. Stern, M.D.*, DAB No. 2329 at 4 (2010). Section 424.520(d) states that "[t]he effective date for billing privileges . . . is the later of – (1) [t]he date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor; or (2) [t]he date that the supplier first began furnishing services at a new practice location." [5]

[5] Policy guidance previously contained in the MPIM instructed that "[t]he PTAN and effective date shall remain the same if the revalidation application was received prior to 120 days after the date of deactivation" and "[i]f the revalidation is received more than 120 days after deactivation, a new PTAN and effective date shall be issued to the provider or supplier . . . ." MPIM, ch. 15 § 15.29.4.3 (rev. 578, issued February 25, 2015, effective May 15, 2015). The Secretary recently revised portions of section 15.29.4.3 and

The Departmental Appeals Board (Board) has explained that the "date of filing" is the date "that an application, however sent to a contractor, is actually received." *Alexander C. Gatzimos, MD, JD, LLC*, DAB No. 2730 at 5 (2016) (emphasis omitted). Accordingly, based on the date of filing of Petitioner's enrollment application for purposes of revalidation, which was more than 120 days after deactivation, Palmetto reactivated Petitioner's billing privileges effective December 14, 2015, with retrospective billing privileges beginning November 14, 2015. 42 C.F.R. § 424.520(d).

Petitioner is seeking an effective date of billing privileges dating back to January 1, 2014, which pre-dates the deactivation on July 27, 2015. However, Petitioner does not identify any authority supporting this retrospective effective date for the reactivation of billing privileges. As Petitioner was enrolled as a Medicare supplier until her deactivation on July 27, 2015, I construe that she is requesting an effective date dating back to her deactivation date.

Palmetto deactivated Petitioner's billing privileges based on its determination that Petitioner failed to provide a complete response to the revalidation request, and the deactivation resulted in an approximately three and a half month lapse in billing privileges. As I discuss below, I am not empowered to disturb CMS's deactivation of billing privileges; therefore, I may only consider whether the effective date assigned for reactivated billing privileges is correct.

A failure to respond to a revalidation request, as alleged by CMS, previously could have resulted in a revocation of billing privileges and an enrollment bar for a minimum of one year. 42 C.F.R. § 424.535(b), (c) (2010) (stating that "[w]hen a provider's or supplier's billing privilege is revoked any provider agreement in effect at the time of revocation is terminated effective with the date of revocation" and "[a]fter a . . . supplier . . . has had their billing privileges revoked, they are barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar," which is a minimum of one year and no more than three years.). The Secretary's former authority to revoke billing privileges and establish a re-enrollment bar was implemented through a final rule published on June 27, 2008, and the regulatory amendment had a stated purpose "to prevent providers and suppliers from being able to immediately re-enroll in Medicare after their billing privileges were revoked." 76 Fed. Reg. 65,909, 65,912 (October 24, 2011), citing 73 Fed. Reg. 36,448. When the Secretary later determined, in subsequent rulemaking, that this basis for revocation and a re-enrollment bar should be eliminated through removing the pertinent language in 42 C.F.R. § 424.535(c), the Secretary's final rule explained:

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related sections of the MPIM, but those revisions do not substantively impact the discussion herein. (Revision 666, issued August 5, 2016, and effective September 6, 2016).

> In our October 24, 2011, proposed rule, we proposed to revise § 424.535(c) to eliminate the re-enrollment bar in instances where providers and suppliers have had their billing privileges revoked under § 424.535(a) solely for failing to respond timely to a CMS revalidation request or other request for information. As we explained in the proposed rule, we believe that this change is appropriate because the re-enrollment bar in such circumstances often results in unnecessarily harsh consequences for the provider or supplier and causes beneficiary access issues in some cases . . . . Moreover, *there is another, less restrictive regulatory remedy available* for addressing a failure to respond timely to a revalidation request. This remedy was identified in proposed § 424.540(a)(3).

77 Fed. Reg. 29,002, 29,009 (May 16, 2012) (emphasis added). The final rule further stated:

> We do not believe that the finalization of our proposed revision to § 424.535(c) will impact our ability to prevent or combat fraudulent activity in our programs. Providers and suppliers that fail to respond once or repeatedly to a revalidation or other informational request *will still be subject to adverse consequences*, including—as explained below—the deactivation of their Medicare billing privileges.

77 Fed. Reg. at 29,010 (emphasis added). Finally, in amending section 424.540(a)(3), as referenced above, the final rule stated:

> We proposed to add a new § 424.540(a)(3) that would allow us to deactivate, rather than revoke, the Medicare billing privileges of a provider or supplier that fails to furnish complete and accurate information and all supporting documentation within 90 calendar days of receiving notification to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information. While the deactivated provider or supplier would still need to submit a complete enrollment application to reactivate its billing privileges, *it would not be subject to other, ancillary consequences that a revocation entails*; for instance, a prior revocation must be reported in section 3 of the Form CMS-855I application, whereas a prior deactivation need not.

77 Fed. Reg. at 29,013 (emphasis added). Thus, while the rulemaking explained that the regulatory amendment was intended to mitigate the "unnecessarily harsh consequences" of revocation and a mandatory enrollment bar for a supplier's failure to respond to a revalidation request, the final rule recognized that there was a "less restrictive regulatory remedy available for addressing a failure to respond timely to a revalidation request" and

that a supplier "will still be subject to adverse consequences" that included "the deactivation of their Medicare billing privileges." The final rule implemented section 424.540(a)(3), which specified that deactivation of billing privileges, rather than revocation, was appropriate, and stated that deactivation "does not have any effect on a provider or supplier's participation agreement or any conditions of participation." [6] 42 C.F.R. § 424.540(a)(3), (c).

Although section 424.540(a)(3) indicates that the deactivation does not have any effect on the supplier's participation agreement or conditions of participation, deactivation nonetheless may cause "adverse consequences," most significantly, the loss of billing privileges. The effective date of reactivation of billing privileges is governed by 42 C.F.R. § 424.520, "Effective date of Medicare billing privileges," which states, in pertinent part, that the effective date for billing privileges, as applicable to this case, is "[t]he date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor." 42 C.F.R. § 424.520(d)(1). The April 26, 2016 reconsidered determination explicitly relied on 42 C.F.R. § 424.520(d) in determining the effective date of Petitioner's reactivated billing privileges. CMS Ex. 6 at 1. Palmetto, while it incorrectly stated that the effective date of Petitioner's billing privileges was November 14, 2015, correctly applied section 424.520(d) such that it granted retrospective billing privileges beginning November 14, 2015. Palmetto favorably assigned a November 14, 2015 effective date of billing privileges based on its apparent interpretation that 42 C.F.R. § 424.521(a) allowed for an earlier effective date of billing privileges based on the 30-day retrospective billing provision contained in that regulation. *See* CMS Br. at 5; CMS Ex. 6 at 1; 42 C.F.R. § 424.521(a).

Petitioner has argued that she was unaware of the revalidation request (P. Br. at 1-2), and CMS argues that the revalidation letter was mailed to a correct address. CMS Br. at 6-7. CMS further asserts that "[t]he Administrative Law Judge (ALJ) is only authorized to adjudicate disputes involving 'initial determinations,'" and that "[d]eactivation is not, however, an 'initial determination' under the regulations." CMS Br. at 7, citing 42 C.F.R. § 498.3. CMS contends that "Petitioner's arguments revolve solely around whether CMS acted properly in requesting revalidation and subsequently deactivating her billing privileges when she failed to respond; issues that are not subject to review by the ALJ." CMS Supp. Br. at 5. CMS further contends that "[e]ven if the ALJ had jurisdiction over these issues, which it does not, the internal policy guidance set forth in

[6] A physician or supplier participation agreement can be made through a Form CMS-460. When a physician or supplier enters into such an agreement, it "enters into an agreement with the Medicare program to accept assignment of the Medicare Part B payment for all services for which the participant is eligible to accept assignment under the Medicare law and regulations." Form CMS-460. A supplier such as Petitioner is not subject to conditions of participation. *See* 42 C.F.R. Parts 482 and 485.

the Medicare Program Integrity Manual (MPIM) is not binding and does not form a legal obligation on the part of Palmetto or CMS." CMS Supp. Br. at 2. CMS explains that "Petitioner's allegations that the contractor failed to follow to the letter every procedure listed in the MPIM is irrelevant, as the MPIM is not binding on CMS." CMS Supp. Br. at 6.

CMS makes the following statement in its supplemental briefing: "While Petitioner asserts that CMS did not provide proper or sufficient notice of revalidation or deactivation, Petitioner does not cite to any legal authority which imposes such obligations on CMS." CMS Supp. Br. at 7. In essence, CMS contends in its briefing that if it fails to provide "proper or sufficient notice" of a revalidation request or of a deactivation based on a failure to comply with a revalidation request, then a provider or supplier cannot appeal such an error, even if it resulted in the deactivation of billing privileges.[7] CMS Supp. Br. at 6. By making such a statement, CMS has asserted that it is not bound by its own policies and is not accountable if it fails to adhere to its policies.

CMS is correct that a deactivation action is not an initial determination that is subject to appeal to an ALJ, pursuant to 42 C.F.R. § 498.3. CMS contends it was not required to provide notice of the revalidation request to more than one address, even though its own policy directed that it furnish notice to more than one address and the May 12, 2015 letter, itself, indicated that it would be mailed to the various addresses that were on file. CMS Supp. Br. at 13; *see* CMS Supp. Br. at 12 (stating that "[t]he regulations do not provide any specific requirements when it comes to providing notice to providers or suppliers" and that "the Board has upheld cases where CMS and its contractors have literally failed to provide any notice of the deactivation . . . "). Congress has given the Secretary the broad authority to "make and publish such rules and regulations . . . as may be necessary to the efficient administration of the functions with which [he] is charged under the Act." 42 U.S.C. § 1302(a). In turn, CMS's regulations at 42 C.F.R. part 498 afford it considerable discretion, and CMS has not applied its discretion in this instance.

CMS correctly argues that Petitioner cannot challenge the deactivation of her billing privileges and that she can only challenge the effective date assigned for her reactivated billing privileges. 42 C.F.R. § 498.3. As I explained above, based on the facts of this case, the effective date of Petitioner's reactivated billing privileges is the date she submitted a new enrollment application for purposes of revalidation, and Palmetto afforded her retrospective billing privileges 30 days earlier, effective November 14, 2015. CMS has asserted that no administrative or judicial body can review a deactivation

[7] CMS acknowledges that a provider or supplier may submit a rebuttal pursuant to 42 C.F.R. §§ 405.374, 424.545(b), but states that CMS is not required to notify a provider or supplier of the right to submit rebuttal.

action, and therefore, any error in the adjudication of such an action is final and unappealable. CMS Supp. Br. at 9 (stating "CMS contends that it is well established that there is no judicial review available for CMS's revalidation and deactivation decisions.").

As previously discussed, CMS submitted, via email, a February 12, 2015 letter in which Palmetto requested that Petitioner revalidate her enrollment. CMS contends that it sent this letter to an address at 100 Witmer Road in Horsham, PA.[8] CMS Br. at 6-7. Although the letter explained that Petitioner should expect to "RECEIVE MULTIPLE COPIES OF THIS REQUEST AS WE WILL ATTEMPT TO CONTACT YOU AT THE VARIOUS ADDRESSES WE HAVE ON FILE," CMS sent the letter to only a *single* address. This is noteworthy because it appears that Petitioner had multiple addresses on file at the time of the revalidation request, and it is clear that she was not physically located even in the same state as the address to which Palmetto sent the letter. *See* P. Br.; CMS Ex. 7 (listing numerous other addresses for Petitioner's employer, to include a separate address for special payments and two other physical practice locations in Virginia, along with yet another address in the "Contact Person Information" section). It is additionally concerning that an MPIM provision that was issued the same month as the revalidation request required that the "contractor shall send the letter to the provider or supplier's special payment address and correspondence address.[9] MPIM, Section 15.29.2

[8] I make no finding whether Petitioner actually received the letter that CMS contends was sent to the address at 100 Witmer Road in Horsham, PA. I observe that while Petitioner's enrollment application lists the address in Horsham, PA, it is clear that Petitioner resides and works in Virginia. CMS Ex. 3. Thus, it appears that Petitioner did not personally receive the single revalidation request that was mailed to Horsham, PA, but rather, a billing company and/or corporate entity received that letter. Had the correspondence been sent to more than one address, as the February 12, 2015 letter explained would happen and is required by previous and current versions of the MPIM, it is presumably more likely that Petitioner, herself, would have received notice that she needed to revalidate her Medicare enrollment.

[9] CMS contends that the February 25, 2015 version of the MPIM did not become effective until May 15, 2015, and is "irrelevant to revalidation and deactivation actions taken before that date." CMS Supp. Br. at 7. However, CMS explained in the summary of changes contained in Transmittal 578, that "[t]he purpose of this change request (CR) *is to incorporate various existing revalidation policies* into Pub. 100-08, Program Integrity Manual (PIM), chapter 15." MPIM, Transmittal 578, February 25, 2015 (emphasis added). CMS clearly stated that it was incorporating *existing* policies, meaning that CMS did not indicate it was creating new policies, but rather, had incorporated policies that were already in existence at the time of its issuance on February 25, 2015. The February 12, 2015 letter was issued less than two weeks prior to the issuance date of Transmittal 578, meaning that the same existing policies that were addressed in the transmittal would have assuredly already been in effect. Further, the

(Transmittal 575, February 25, 2015); *see* MPIM, Section 15.29.2 (Transmittal 676, September 16, 2016) (more recent version of the MPIM that continues to direct the contractor to send a revalidation notice to more than one address, instructing that the contractor "shall mail two revalidation notices to the provider/supplier's correspondence and special payment address and/or practice location").

CMS, and its contractors, have a significant amount of authority and discretion under the regulations, particularly pursuant to 42 C.F.R. part 498. Yet, part 498 does not afford the same amount of discretion to an administrative law judge. While CMS and its contractors may deactivate billing privileges for failure to comply with an enrollment requirement, and CMS and its contractors have the discretion to postpone or waive a deactivation of billing privileges, an administrative law judge cannot exercise such discretion over a determination deactivating a supplier's or provider's billing privileges. *See, e.g.,* 42 C.F.R. § 498.3.

In addressing the due process available to a provider or supplier who feels that there was error in the deactivation, "CMS asserts that the ALJ does not have jurisdiction to review deactivation decisions . . . " and that "while the ALJ has limited jurisdiction, providers and suppliers can file statements in rebuttal to deactivation determinations as set forth in CMS regulations." CMS Supp. Br. at 1-2; *see* 42 C.F.R. §§ 404.374, 424.545(b). CMS did not notify Petitioner that she had a right to submit a rebuttal statement, and CMS contends there is no regulation that requires it to provide notice that a provider or supplier can file a rebuttal statement. CMS Supp. Br. at 9. CMS states "[t]here is no requirement for CMS to affirmatively notify Petitioner of this right to rebuttal," yet nonetheless CMS apparently faults Petitioner because she "opted not to follow the procedures for rebuttal . . . ." that had not been provided to Petitioner. CMS Supp. Br. at 9.

There is limited recourse available to suppliers and providers seeking an earlier effective date of reactivated billing privileges after their billing privileges have been deactivated for failure to respond to a revalidation notice, and CMS and its contractors are not required to exercise discretion, even when invited by an ALJ to exercise such discretion. Even if CMS and its contractors do not adhere to sub-regulatory policy, such as providing compliant notice of a revalidation request, there is not necessarily any recourse for a provider or supplier. I am unable to reverse a deactivation of billing privileges that results from a provider's or supplier's failure to strictly comply with revalidation requirements.[10]

February 12, 2015, letter clearly indicates that it would be sent to "the various addresses we have on file," which is consistent with the existing policies addressed in the February 2015 MPIM provisions.

[10] That does not mean that I lack authority to remand under certain circumstances. 42 C.F.R. § 498.78.

To the extent that Petitioner is requesting equitable relief in the form of an earlier effective date of reactivated billing privileges, I am unable to grant equitable relief. *US Ultrasound*, DAB No. 2302 at 8 (2010) ("[n]either the ALJ nor the Board is authorized to provide equitable relief by reimbursing or enrolling a supplier who does not meet statutory or regulatory requirements"). In the absence of any basis to grant an earlier date for the reactivation of billing privileges, the effective date of December 14, 2015, with retrospective billing privileges beginning November 14, 2015, for the reactivation of Petitioner's billing privileges must stand.

V. Conclusion

I uphold the December 14, 2015 effective date of the reactivation of Medicare billing privileges for Petitioner, with retrospective billing privileges beginning November 14, 2015.

/s/
Leslie C. Rogall
Administrative Law Judge