Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Decatur Health Imaging, LLC
Docket No. A-17-37
Decision No. 2805
July 24, 2017

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Decatur Health Imaging, LLC (DHI, Petitioner), an "independent diagnostic testing facility" (IDTF), appeals an Administrative Law Judge's decision sustaining the effective date of DHI's reactivated Medicare billing privileges that the Centers for Medicare & Medicaid Services (CMS) assigned (March 7, 2016), instead of the earlier date (January 25, 2016) DHI sought. *Decatur Health Imaging, LLC*, DAB CR4759 (2016) (ALJ Decision).

We affirm the ALJ Decision. The applicable regulations compel the effective date the ALJ affirmed, based on the date DHI filed the Medicare enrollment application to reactivate its billing privileges that CMS approved, and do not permit the ALJ or the Board to set an earlier date based on DHI's arguments.

Legal Background

The Medicare program is administered by CMS, which delegates certain program functions to private contractors. Social Security Act (Act) §§ 1816, 1842, 1874A; 42 C.F.R. § 421.5(b).[1]

To receive payment for services furnished to Medicare beneficiaries, a Medicare provider or supplier – an IDTF is a "supplier"– must be "enrolled" in Medicare and maintain active enrollment status.[2] 42 C.F.R. § 424.505. "Enrollment" is the process that CMS

[1] The current version of the Social Security Act can be found at http://www.socialsecurity.gov/OP_Home/ssact/ssact-toc.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross-reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp. Table.

[2] "Suppliers" also include physicians and other non-physician health care practitioners. 42 C.F.R. § 400.202 (stating that, unless the context indicates otherwise, "*[s]upplier* means a physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare"). "Providers" include, inter alia, hospitals, nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities. *Id*.

uses to (1) identify the prospective supplier; (2) validate the supplier's eligibility to provide items or services to Medicare beneficiaries; (3) identify and confirm a supplier's owners and "practice location(s)"; and (4) grant the supplier "Medicare billing privileges." *Id.* § 424.502.

Regulations set the effective date of Medicare billing privileges for different types of Medicare suppliers and providers. For IDTFs, the regulations at 42 C.F.R. § 410.33(i) set the effective date as follows:

> (i) *Effective date of billing privileges.* The filing date of the Medicare enrollment application is the date that the Medicare contractor receives a signed provider enrollment application that it is able to process to approval. The effective date of billing privileges for a newly enrolled IDTF is the later of the following:
>
> (1) The filing date of the Medicare enrollment application that was subsequently approved by a Medicare fee-for-service contractor; or
>
> (2) The date the IDTF first started furnishing services at its new practice location.

See also 42 C.F.R. § 424.520(b), "Effective date of Medicare billing privileges" ("[t]he effective date for billing privileges for IDTFs is specified in § 410.33(i) of this chapter").

Medicare suppliers and providers must report changes in enrollment information, including changes in their ownership or control, within time periods specified in regulations applicable to the type of supplier or provider (generally 30-90 days). *See* 42 C.F.R. § 424.516(a)-(e). For IDTFs, "[c]hanges in ownership, changes of location, changes in general supervision, and adverse legal actions must be reported to the Medicare fee-for-service contractor on the Medicare enrollment application within 30 calendar days of the change" and "[a]ll other changes to the enrollment application must be reported within 90 days." *Id.* § 410.33(g)(2); *see also id.* § 424.516(b) ("IDTF reporting requirements are specified in § 410.33(g)(2) of this chapter").

CMS may revoke the enrollment and billing privileges of a supplier that does not comply with applicable requirements in the regulations, including reporting requirements. 42 C.F.R. §§ 424.535(a)(1), (9), 410.33(h). As a lesser remedy, CMS may "deactivate" the Medicare billing privileges of a supplier that does not timely report changes in its enrollment information. *Id.* § 424.540(a)(2). The deactivation of Medicare billing privileges "does not have any effect on a provider or supplier's participation agreement or any conditions of participation." *Id.* § 424.540(c). (By contrast, a supplier or provider whose Medicare enrollment or participation agreement is *revoked* is generally barred

from re-enrolling for a period of one to three years, *id*. § 424.535(c)(1).) A supplier or provider whose billing privileges are deactivated (for reasons other than non-submission of Medicare claims) must complete and submit a new enrollment application to reactivate its billing privileges. *Id*. § 424.540(b)(1).

The determination of the "effective date of a Medicare provider agreement or supplier approval" is an "initial determination" subject to administrative review under 42 C.F.R. Part 498. 42 C.F.R §§ 498.3(a)(l), (b)(15); *Victor Alvarez, M.D.,* DAB No. 2325, at 3, 6 (2010). This means that a supplier may request that CMS reconsider the effective date determination and may appeal the reconsidered determination before an ALJ. Either CMS or the supplier may appeal the ALJ's decision to the Board. 42 C.F.R. § 498.80.

Background

On July 9, 2015, one of DHI's owners, a physician who held a 6.7% ownership stake in DHI, died. ALJ Decision at 1, citing CMS Exs. 1; 8, at 133; and Petitioner (P.) Ex. 1. DHI does not dispute the ALJ's finding that the physician owner's death was a change in DHI's ownership that it was required to timely report to CMS. *See id*. at 5 ("Petitioner was obligated to timely notify CMS" of "the death of one of its owners"); 42 C.F.R. § 410.33(g)(2) (IDTFs must timely report "[c]hanges in ownership . . . on the Medicare enrollment application"). The CMS contractor, by letter dated October 23, 2015, stated that it had received and verified that the physician "associated with your organization is deceased," and accordingly instructed DHI to report the change in ownership by submitting "an 855 change request to delete the individual from [DHI's] Medicare record" within 90 days or face the deactivation of its Medicare billing privileges. ALJ Decision at 1-2, quoting CMS Ex. 3.

On December 22, 2015, or 60 days after the CMS contractor's notice to DHI, DHI filed form CMS-855R (855R), "Medicare Enrollment Application — Reassignment of Medicare Benefits," indicating DHI was seeking to terminate the reassignment of Medicare benefits from the deceased physician owner to DHI. *Id*. at 2; CMS Ex. 4. On December 31, 2015, the CMS contractor notified DHI that it had received the enrollment application but was closing the request to terminate the reassignment of the late physician's benefits because "[t]he CMS-855R application is not necessary" to terminate the reassignment, as the physician's enrollment had already been deactivated due to his death. ALJ Decision at 2, citing CMS Exs. 6, 18.

On January 25, 2016, 94 days after the CMS contractor's notice to DHI, the CMS contractor deactivated DHI's Medicare billing privileges because DHI was not in compliance with Medicare requirements. *Id*., citing CMS Ex. 7. DHI does not dispute that the contractor found DHI out of compliance with the requirement to timely report the change in DHI's ownership that occurred upon the death of the physician owner.

On March 7, 2016, DHI filed form CMS-855B (855B), "Medicare Enrollment Application — Clinic/Group Practices and Certain Other Suppliers," to reactivate its Medicare billing privileges and to update its ownership information, including the removal of the late physician as an owner. *Id*., citing CMS Ex. 8, at 106, 110, 112, 133; and CMS Ex. 9; CMS Ex. 8, at 9. The CMS contractor approved DHI's enrollment application by letter dated April 18, 2016 and set March 7, 2016 as the effective date of DHI's reactivated billing privileges. ALJ Decision at 2, citing CMS Ex. 15, at 1. DHI requested reconsideration and sought an effective date of January 25, 2016, the date its billing privileges had been deactivated. *Id*., citing CMS Ex. 16. On June 20, 2016, a contractor hearing officer upheld the March 7, 2016 effective date, and DHI timely requested an ALJ hearing. *Id*., citing CMS Ex. 17.

Before the ALJ, CMS filed a motion for summary judgment and supporting brief, along with 18 exhibits. DHI filed a brief in response (P. Br.) and five exhibits. ALJ Decision at 2. The ALJ decided the case on the written record without a hearing, as neither party offered written direct testimony, which the ALJ in his pre-hearing order instructed the parties to do if they wished to present witness testimony. *Id*. at 3.

The ALJ found that "[t]he CMS administrative contractor received an enrollment application (CMS-855B) from Petitioner on March 7, 2016, which the CMS administrative contractor ultimately approved" and concluded that "[t]he effective date for the reactivation of Petitioner's Medicare billing privileges is March 7, 2016." *Id*. at 4 (bold italics omitted); *see also id.* at 1 ("Because the CMS administrative contractor received an enrollment application to reactivate Decatur's billing privileges on March 7, 2016, and the CMS administrative contractor approved that application, March 7, 2016, is the correct effective reactivation date for Decatur's billing privileges."). The ALJ thus "affirm[ed] CMS's determination that Petitioner's effective date for the reactivation of its Medicare billing privileges is March 7, 2016." *Id*. at 6.

The ALJ rejected DHI's argument "that the CMS administrative contractor provided Petitioner with incorrect information resulting in Petitioner's failure to file the correct CMS-855 form and deactivation" called into question the legitimacy of the deactivation. The ALJ held that he "cannot entertain" DHI's argument because he had no jurisdiction to review the deactivation. *Id*. at 5. The ALJ noted that the CMS contractor "reminded Petitioner of its duty to provide CMS with updated information" following the death of the physician owner even though the "contractor did not need to provide this notice because Petitioner was obligated to timely notify CMS of this on its own" and that the CMS contractor "provided Petitioner with 90 days to update its information with CMS when the regulations only provide for 30 days." *Id*., citing 42 C.F.R. § 410.33(g)(2). "[B]y the time Petitioner was deactivated," the ALJ found, "there had [thus] been a prolonged failure to properly report the death of one of its owners." *Id*. We address the ALJ's analysis more fully below.

Standard of Review

We review a disputed finding of fact to determine whether the finding is supported by substantial evidence in the record as a whole and a disputed conclusion of law to determine whether it is erroneous. *See* Departmental Appeals Board, *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program (Guidelines)*. The *Guidelines* are available at http://www.hhs.gov/dab/divisions/appellate/guidelines/prosupenrolmen.html.

Analysis

I. The ALJ's determination that March 7, 2016 was the correct effective date for DHI's billing privileges is supported by substantial evidence and is legally correct.

The ALJ sustained CMS's determination setting March 7, 2016 as the effective date for DHI's reactivated billing privileges because that was the date the CMS contractor received an enrollment application from DHI that the contractor approved (on behalf of CMS). ALJ Decision at 1, 4. As the ALJ correctly concluded, that effective date was required by the applicable regulation, which states that the effective date of IDTF billing privileges is "the later of . . . ***[t]he filing date of the Medicare enrollment application that was subsequently approved***" by the contractor (or "[t]he date the IDTF first started furnishing services at its new practice location," which neither party contends is applicable here); and the "filing date" of the enrollment application "is the date that the Medicare contractor receives a signed provider enrollment application that it is able to process to approval." 42 C.F.R. § 410.33(i) (emphasis added); ALJ Decision at 4-5.

As the ALJ also noted, CMS's Medicare Program Integrity Manual (MPIM) applies this effective date provision to applications for reactivation of billing privileges, providing "that the effective date for the reactivation of Medicare billing privileges is the date when the contractor receives the completed enrollment application that the contractor ultimately processes to approval." ALJ Decision at 5, citing MPIM § 15.27.1.2 ("the reactivation effective date shall be the date the contractor received the application or RCP [reactivation certification package] that was processed to completion");[3] *see Arkady B. Stern, M.D.*, DAB No. 2329, at 4 (2010) ("effective date rule also applies . . . to reactivation applications").

[3] Provisions of chapter 15 of the MPIM, CMS Publication 100-08, are primarily intended as guidance or instructions for CMS fee-for-service contractors. *Viora Home Health, Inc.*, DAB No. 2690, at 8 (2016) (quoting introduction to MPIM Chapter 15). CMS internet-only manuals including the MPIM are available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html.

Here, there is no dispute that the CMS contractor received the 855B enrollment application that it approved on March 7, 2016, which was thus the "filing date" of the application that provided the required information about the change in DHI's ownership. ALJ Decision at 2, 4, citing CMS Exs. 8 (855B received March 7, 2016); 9 (March 8, 2016 contractor letter confirming receipt of the 855B on March 7, 2016); *see* DHI's Request for Review of ALJ Decision (RR) at 1 (unnumbered) (ALJ's finding that contractor approved the CMS-855 it received March 7, 2016 is "technically correct"). Under the regulation, the effective date of DHI's billing privileges that CMS reactivated pursuant to DHI's 855B was the filing date of that application, March 7, 2016. *See*, *e.g.*, *Donald Dolce, M.D.*, DAB No. 2685, at 8 (2016) (effective date regulation "is based on the contractor's actual receipt of an actual application it processes to approval"); *Shalbhadra Bafna, M.D.*, DAB No. 2449, at 4 (2012) ("[t]he effective date determination hinges on two facts . . . the filing date of a Medicare enrollment application, and the date that [the supplier] first starts furnishing services at a new practice location"); *Arkady B. Stern, M.D.* at 4 (effective date "must be the later of: the date when the [supplier] files the application for enrollment that is subsequently approved by a Medicare contractor; or the date when the [supplier] first begins providing services at the new practice location").[4]

Thus, the ALJ correctly determined that March 7, 2016 was the correct effective reactivation date for DHI's billing privileges because that was the date that the CMS contractor received from DHI the enrollment application that the contractor approved.

II. DHI has shown no error of law or fact in the ALJ's determination that March 7, 2016 was the correct effective date for DHI's billing privileges.

DHI makes several arguments in support of reversing the ALJ Decision and assigning an earlier effective date for DHI's billing privileges. DHI argues that the ALJ erred in upholding the effective date based on the 855B that DHI filed on March 7, 2016 instead of on the 855R it filed in December 2015, and that its delay in reporting the change in its ownership was due to incorrect information provided by the CMS contractor. DHI also raises what are essentially equitable considerations in favor of an earlier effective date. We conclude that these arguments show no error in the ALJ Decision, are unsupported in the record, and seek relief that the ALJ and the Board are not authorized to provide.

[4] These decisions address the rule for determining the "[e]ffective date of Medicare billing privileges" for "physicians, non-physician practitioners, physician and nonphysician practitioner organizations" at 42 C.F.R. § 424.520(d) which, as of February 3, 2015, also applies to "ambulance suppliers." 79 Fed. Reg. 72,500, 72,531 (Dec. 5, 2014). These decisions are applicable here because section 424.520(d) is substantively identical to, and was intended to be consistent with, section 410.33(i). Each regulation sets the effective date of billing privileges, as applicable here, as the "filing date" or "date of filing" of a "Medicare enrollment application that was subsequently approved" by a Medicare contractor. The preamble to the effective date rule at section 424.520(d) states that its "approach" is "consistent with our requirements found at § 410.33(i) that limit the retrospective billing for IDTFs[.]" 73 Fed. Reg. 69,726, 69,767 (Nov. 19, 2008).

A. DHI has not shown that it was entitled to an effective date earlier than March 7, 2016 based on its filing of the 855B.

DHI argues that the ALJ's finding, that the 855B enrollment filed March 7, 2016 was the approved application for the purpose of setting the effective date, while "technically correct . . . omits additional facts" and that the ALJ "erred regarding the date the initial enrollment application was filed." RR at 1, 2; ALJ Decision at 4. DHI argues that the 855R it filed in December 2015 "notified the CMS administrative contractor of the ownership change in the entity (as required upon the death of one of its owners) in the same manner [DHI] did when ultimately filing the CMS-855B on March 7, 2016." RR at 1. DHI asserts that CMS should have known that the 855R "was an endeavor to notify CMS of the ownership change, not to terminate reassignment" of the late physician's benefits to DHI. DHI points out that the deceased physician owner "was not a reading radiologist at [DHI], merely a non-radiologist owner," meaning, presumably, that his Medicare benefits would not have been reassigned to DHI and there was thus no need for DHI to have terminated any such reassignment. RR at 3.

DHI also argues that the 855B enrollment application filed March 7, 2016, which the contractor approved, "was actually a continuation filing relating to the CMS-855R filed on December 22, 2015" and "should relate back" to that "prior filing." RR at 2, 3. DHI asserts that "[w]ith communication from the CMS administrative contractor, the form [855R] could have been processed to approval via the new filing[,]" the 855B that the contractor approved. RR at 3.

None of these arguments shows any error in the ALJ Decision. The 855R that DHI filed in December 2015 cannot serve as the basis for assigning an earlier effective date because it is not the application that was "subsequently approved" as required by the effective date regulation. The Board has held that "the plain language" of the effective date regulation (at section 424.520(d), which mirrors and is based on the effective date regulation for IDTFs at section 410.33(i)), requires that the effective date be based on an application that was "processed to approval" by the Medicare contractor. *Karthik Ramaswamy, M.D.*, DAB No. 2563, at 6 (2014), *aff'd*, *Ramaswamy v. Burwell*, 83 F. Supp. 3d 846 (E.D. Mo. 2015). The Board thus held that "neither an ALJ nor the Board may change an effective date to the date of receipt of an earlier application" that "was not processed to approval," such as, in *Ramaswamy*, one that was denied. *Id*. That analysis applies here, where the prior application, the 855R that DHI filed in December 2015, was not processed to approval. The ALJ thus correctly held that the effective date for DHI's reactivated Medicare billing privileges was March 7, 2016 "because that is the date on which Petitioner filed the enrollment application that the CMS administrative contractor approved." ALJ Decision at 5.

Moreover, even if the ALJ or the Board were authorized to change an effective date based on an earlier application that was not approved, there is no basis to do so here. DHI does not identify any portion of the 855R filed in December 2015 that could reasonably be read as reporting the change of DHI's ownership that occurred upon the passing of the physician owner. CMS Ex. 4. Indeed, that 855R does not identify the deceased physician as one of DHI's owners. As CMS points out, the 855R form does not seek information that the 855B form requires regarding a group practice's ownership interests and managing control information. CMS Resp. at 6 n.6, citing CMS Exs. 4; 8, at 31-72. DHI admits, moreover, that the 855R it filed in December 2015 is the "wrong form" to report a change in ownership and that DHI "mistakenly" checked "the 'termination' box" on the form indicating that it was filed to terminate the reassignment of the late physician owner's Medicare benefits to DHI. RR at 2-3. Because the 855R requested only termination of the reassignment of billing privileges and was "closed" by the contractor as unnecessary, and did not purport to contain any information related to DHI's ownership, the 855B that DHI filed in March 7, 2016 that the contractor approved could not "relate back" to the earlier form and did not convert it into an enrollment application that was subsequently approved, as required to set the effective date for billing privileges.[5]

DHI also argues that CMS could have exercised its "discretion to continue working with a provider or supplier regarding its enrollment application if such entity is working to resolve outstanding issues." RR at 3. DHI cites 42 C.F.R. § 424.525(b), which permits "CMS, at its discretion" to "choose to extend the 30 day period" that a prospective provider or supplier has following CMS's request to furnish complete information needed to process its enrollment application "if CMS determines that the prospective provider or supplier is actively working with CMS to resolve any outstanding issues."

That CMS *could* have sought more information after DHI filed what was admittedly the wrong application does not mean that the Board may reverse the effective date determination where CMS did not seek additional information. The regulation vests discretion to seek information in CMS, not in the reviewing authority such as an ALJ or the Board. The Board has held that it does not review CMS's exercise of discretion to take other actions the regulations authorize relating to the enrollment of suppliers and providers. *See generally Brian K. Ellefsen, DO*, DAB No. 2626, at 7 (2015) ("The ALJ and CMS are correct that where CMS is legally authorized to deny an enrollment

[5] CMS argues that the Board's *Guidelines* bar DHI from arguing that the 855B it filed on March 7, 2016 "should relate back" to the 855R it filed earlier because "Petitioner did not present the 'relation back' argument to [the] ALJ." CMS Resp. at 5, citing *Guidelines* ("the Board will not consider issues which could have been presented to the ALJ but were not"). Before the ALJ, DHI argued that "it did certify the change of ownership via the CMS-855R," which is similar to its appellate arguments that the 855B that CMS approved should "relate back" to the earlier 855R that DHI contends could have been processed to approval. P. Br. at 3 (unnumbered). In any event, we need not address whether the *Guidelines* prohibit DHI from making this argument because it is unavailing for the other reasons we discuss here.

application, an ALJ cannot substitute his or her discretion for that of CMS (or CMS's contractor) in determining whether, under the circumstances, denial is appropriate. Nor can the Board."); *Douglas Bradley, M.D.*, DAB No. 2663, at 13 n.13 (2015) (citations omitted) ("the reasonableness of CMS's exercise of discretion is not a reviewable issue under any standard of review"). Additionally, this argument essentially challenges the deactivation of DHI's billing privileges, which, as we have stated, is not properly before us in this appeal.

B. DHI's argument that it delayed reporting the change in ownership due to incorrect information provided by the CMS contractor is neither relevant nor supported by the record.

DHS also argues for an earlier effective date on the ground that it delayed filing the 855B reporting its ownership change due to incorrect information provided by the CMS contractor. DHI cites the ALJ's observation that "the hearing officer admitted [in the reconsidered determination] that in two separate phone calls, representatives of the CMS administrative contractor told Decatur that it needed to file a CMS-855B and CMS-855R, respectively." ALJ Decision at 2, cited at RR at 2 (CMS contractor "told DHI that it needed to file *both the CMS-855B and CMS-855R*, respectively") (DHI's emphasis). DHI argues that "[b]ased on communications from the Medicare contractor, when DHI filed its initial CMS-855 form, it assumed it was notifying CMS of all appropriate information to continue its enrollment status following a change of ownership." RR at 2.

DHI's reliance on the ALJ's observation misapprehends its context. The ALJ cited the hearing officer's findings about the two phone calls and the contractor's advice to file an 855R after noting that the hearing officer "denied that the CMS administrative contractor provided incorrect instructions to [DHI]." ALJ Decision at 2, citing CMS Ex. 17 (reconsidered determination). The ALJ did not resolve that seeming inconsistency and did not need to do so, as he concluded that DHI's argument, that the CMS contractor "provided Petitioner with incorrect information resulting in Petitioner's failure to file the correct CMS-855 form and deactivation[,] essentially questions the legitimacy of the deactivation" of DHI's billing privileges on January 25, 2016 and thus sought relief beyond the ALJ's jurisdiction. ALJ Decision at 5 ("I cannot entertain this argument because I have no jurisdiction to review the CMS administrative contractor's decision to deactivate Petitioner.").[6]

[6] The reconsidered determination describes the two phone calls by DHI staff to the contractor that the ALJ referenced. On November 3, 2015, DHI "wanted to know how to change the ownership of the business [because] one of the owners is now deceased" and was "advised . . . to complete an 855-B." CMS Ex. 17, at 2 (italics, underline omitted). On December 17, 2015, DHI asked how to "term[inate] a provider" and was told to file a 855R because "[s]ubmission of a CMS-855R is required to terminate a provider reassigned to an enrolled entity" – presumably meaning to discontinue the deceased physician's billing privileges or their assignment to DHI. *Id*. (italics omitted). As the ALJ made no findings regarding these details of the reconsidered determination's description of the phone calls, we do not rely on it here.

The ALJ did not err in declining to review the circumstances that DHI claims led to the deactivation of its billing privileges. As the ALJ noted, ALJs (and the Board) "only have jurisdiction to review the Secretary's 'initial determinations,' and CMS's decision to deactivate billing privileges is not an initial determination." *Id.*, citing 42 C.F.R. § 498.3; *see Willie Goffney, Jr., M.D.*, DAB No. 2763, at 3 (2017) ("[d]eactivation is not appealable and is not reviewable in this proceeding" under section 498.3(b) (italics removed)). The Board in *Goffney* also pointed out that deactivation is not appealable under 42 C.F.R. § 424.545(a)-(b), which permits the denial or revocation of enrollment to be appealed under section 498.3 but states that a "supplier whose billing privileges are deactivated may file a rebuttal," which the Board held "is not itself an appeal." *Id*. at 3, 5. For these reasons, the Board in *Goffney* held that it has "no authority" to address "a number of factual issues that appear to be designed to have the Board opine on the state of Petitioner's Medicare billing privileges" and could only "review[] the effective date set in the appealable determination" by the contractor on reconsideration. *Id*. at 6. That reasoning applies here – the circumstances that led to the deactivation of DHI's billing privileges are not relevant to the narrow issue before us. The only CMS determination in this matter that is subject to ALJ (and Board) review is CMS's April 18, 2016 determination setting March 7, 2016, as the effective date for DHI's reactivated billing privileges.

DHI also asserts that when it filed the 855R on December 22, 2015, the CMS contractor "confirmed the filing stating that if it needed anything further it would so advise DHI." RR at 1-2, citing P. Br. at 3 (stating, "and nothing more was received" from the contractor); *see* P. Ex. 5 (contractor's December 28, 2015 letter stating that DHI "will receive a letter within 30 calendar days if we need any additional information"). However, the contractor did contact DHI within 30 days. By letter dated January 25, 2016, the contractor deactivated DHI's billing privileges effective January 25, 2016. CMS Ex. 7. Given that the contractor informed DHI by letter dated October 23, 2015 of the requirement to report the change in ownership, and that the 855R that DHI filed in December 2015 did not report the late physician's ownership interest, the general statement in the contractor's December 28, 2015 letter cannot be viewed as a determination that DHI had met the requirement to timely report the change in ownership.

Finally, we note that DHI's request for reconsideration, which attributes the failure to timely report the change in ownership to "a series of miscommunications" between the contractor and DHI or its billing agent, describes the contents of multiple telephone calls between named staff of DHI (and its billing agent) and the contractor about the deactivation and what information DHI needed to provide. As we indicate above, inasmuch as the telephone conversations relate to why DHI failed to timely report its change of ownership, they are relevant only to the CMS contractor's deactivation decision and are not relevant to the effective date of reactivation, the only issue addressed in the ALJ's decision.

C. Equitable considerations DHI raises provide no basis to reverse the ALJ Decision or assign an earlier effective date.

DHI also raises what are essentially equitable considerations in favor of an earlier effective date. DHI notes that it has "served Medicare beneficiaries for many years" and "certainly met the spirit [of the reporting requirement] in its original filing" of the 855R in December 2015, and that it "mistakenly checked" the termination box on the 855R it filed in December 2015 with the intent of notifying CMS of the ownership change. RR at 3. DHI argues that its prior service as a Medicare supplier assures that CMS's "concern[] that Medicare not pay for services when it could not be certain that eligibility standards had been met," which led CMS in 2009 to curtail the ability of some practitioners to bill retroactively for services provided prior to enrollment, do not apply here. RR at 3, citing *Adrian Adrian, M.D.*, DAB CR2154 (2010) (citing 73 Fed. Reg. at 69,766 and discussing, at 9, how that rulemaking eliminated the former ability of physicians and non-physician practitioners to bill for services provided up to 27 months retroactively because "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").

The Board has no authority to reverse CMS's determination of the effective date based on these factors. "The applicable regulations . . . do not provide for consideration of such equitable arguments in ALJ or Board appeals of CMS enrollment determinations." *Amber Mullins, N.P.*, DAB No. 2729, at 5 (2016) (sustaining CMS's determination of supplier's effective date based on date the contractor received the enrollment application that it approved). The Board "has consistently held that neither it nor an ALJ may provide equitable relief." *Id*. at 6, citing *US Ultrasound*, DAB No. 2302, at 8 (2010) ("Neither 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."); *Pepper Hill Nursing & Rehab. Ctr., LLC,* DAB No. 2395, at 11 (2011) (holding that the ALJ and Board were not authorized to provide equitable relief by reimbursing or enrolling a supplier who does not meet statutory or regulatory requirements); *UpturnCare Co., d/b/a Accessible Home Health Care*, DAB No. 2632, at 19 (2015) (Board may not overturn denial of provider enrollment in Medicare on equitable grounds).[7]

[7] Even if we could consider them, the equitable circumstances do not all weigh in DHI's favor. As the ALJ pointed out, the CMS contractor "informed Petitioner of the death of one of its owners and reminded Petitioner of its duty to provide CMS with updated information" even through the contractor "did not need to provide this notice because Petitioner," by regulation, "was obligated to timely notify CMS of this on its own." ALJ Decision at 5, citing CMS Exs. 2, 3; and 42 C.F.R. § 410.33(g)(2). The CMS contractor "also provided Petitioner with 90 days to update its information with CMS when the regulations only provide for 30 days," meaning that "by the time Petitioner was deactivated, there had been a prolonged failure to properly report the death of one of its owners." *Id*. citing 42 C.F.R. § 410.33(g)(2).

Conclusion

For the reasons stated above, we affirm the ALJ's decision upholding CMS's determination that the effective date of DHI's reactivated billing privileges was March 7, 2016.

/s/
Constance B. Tobias

/s/
Susan S. Yim

/s/
Christopher S. Randolph
Presiding Board Member