Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Arkady B. Stern, M.D., Petitioner
Docket No. A-10-45
Decision No. 2329
September 16, 2010

REMAND OF ADMINISTRATIVE LAW JUDGE DECISION

Arkady B. Stern, M.D. (Dr. Stern) requests review of the February 26, 2010 decision of Administrative Law Judge (ALJ) Steven T. Kessel upholding an initial determination of the Centers for Medicare & Medicaid Services (CMS) as to the effective date for the reactivation of Dr. Stern's Medicare billing privileges. *Arkady B. Stern, M.D.*, DAB No. CR2078 (2010) (ALJ Decision). On the basis of a reactivation enrollment application Dr. Stern filed in June 2009, CMS authorized Dr. Stern to bill Medicare for services he provided as of May 19, 2009. Dr. Stern asserts that, based on an application that he allegedly filed in October 2008, he should be allowed to bill Medicare as of October 2008.

The record in this case raises an issue as to whether Dr. Stern filed an application to reactivate his Medicare billing privileges in October 2008, which was prior to CMS's amendment of regulations determining the effective date of enrollment that the ALJ applied here. Therefore, we remand this case to the ALJ to conduct further proceedings consistent with this decision or to further remand the case to CMS so that it can review information in its contractors' records to determine whether an earlier reactivation effective date should be approved on the basis of an October 2008 application and regulations and policies in effect at that time.

Standard of Review

The standard of review on factual issues is whether the ALJ decision is supported by substantial evidence in the whole record. The standard of review on issues of law is whether the ALJ decision is erroneous. *See* Guidelines -- Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program at http://www.hhs.gov/dab/divisions/appellate/guidelines/prosupenrolmen.html.

Applicable Regulations

Title XVIII of the Social Security Act (the Act) governs the healthcare program for the aged and disabled known as Medicare.[1] Section 1866(j) of the Act, as added by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law No. 108-173, required the Secretary to promulgate regulations for "a process for enrollment of . . . suppliers under [Medicare]." The implementing regulations at 42 C.F.R. Part 424, subpart P, set out the enrollment process Medicare uses to establish eligibility to submit claims for Medicare covered services and supplies.

To receive payment for covered Medicare items or services, a supplier must be enrolled in Medicare, which requires submission of an enrollment application. 42 C.F.R. §§ 424.505, 424.510(d)(1). A Medicare-enrolled supplier whose billing privileges have been deactivated, however, is not, in all circumstances, required to submit an enrollment application or a full enrollment application in order to reactivate those privileges. Section 424.502 defines "deactivated" to mean that "the . . . supplier's billing privileges were stopped, but can be restored upon the submission of updated information." Section 424.540 provides:

> (b) Reactivation of billing privileges. (1) When deactivated for any reason other than nonsubmission of a claim, the provider or supplier must complete and submit a new enrollment application to reactivate its Medicare billing privileges or, when deemed appropriate, at a minimum, recertify that the enrollment information currently on file with Medicare is correct.
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> (2) Providers and suppliers deactivated for nonsubmission of a claim are required to recertify that the enrollment information currently on file with Medicare is correct and furnish any missing information as appropriate. The provider or supplier must meet all current Medicare requirements in place at the time of reactivation, and be prepared to submit a valid Medicare claim.

(Emphasis added.)

Background

Below we set out representations made by Dr. Stern and facts established by CMS's exhibits that are relevant to our analysis of the ALJ Decision.

Dr. Stern's Medicare physician billing privileges were deactivated, according to Dr. Stern, in October 2008. CMS Ex. 2, at 1. Dr. Stern's assertion that his billing privileges

[1] The current version of the Act can be found at www.ssa.gov/OP_Home/ssact/comp-ssa.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section.

were deactivated is supported by the fact that CMS subsequently approved, in August 2009, his "reactivation" application filed in June 2009 and assigned him his prior Provider Transaction Access Number and National Provider Identifier.[2] CMS Exs. 1, at 1; 5, at 5 and 17.

Dr. Stern asserted before the CMS contractor, Palmetto GBA (Palmetto), that the deactivation was related to his relocating his office in October 2008. CMS Ex. 2, at 1. Before the ALJ, he and an employee from his billing service asserted in a sworn declarations that in October 2008 he moved his practice location and that he filed a Medicare application that month for the new location with a CMS contractor. P. Exs. 1, 2. They represented further that, upon inquiry, the CMS contractor informed them that the review process had been delayed by a transition to Palmetto as contractor but that "all [was] well" with the application and that it was "in the approval process." *Id.* Finally, they represented that the billing service was informed that the application had been lost and that Dr. Stern should submit a new application. *Id.*

Dr. Stern subsequently filed a reactivation application in May 2009 with Palmetto, but that application was returned because he mistakenly requested an effective date of October 2009 instead of October 2008. CMS Ex. 6 (copy of May application); CMS Ex. 5.[3] He reapplied in June 2009. CMS Ex. 4 (copy of June application). By letter dated August 10, 2009, Palmetto approved the June application with an effective date that, together with the 30-day retrospective billing period set forth in 42 C.F.R. § 424.521(a)(1), allowed Dr. Stern to bill Medicare for services provided as of May 19, 2009. CMS Ex. 1.

Allegedly relying on advice from Palmetto to an employee at Dr. Stern's billing service, Dr. Stern then filed a Corrective Action Plan (CAP), which Palmetto subsequently treated as a "request for reconsideration" of the effective date determination. P. Ex. 2, at 2; CMS Ex. 3, at 6-7. On October 2, 2009, Palmetto issued a reconsideration decision upholding the original effective date determination. CMS Ex. 3, at 6-7.

Dr. Stern appealed Palmetto's reconsideration decision pursuant to 42 C.F.R. Part 498, arguing that the effective date should be calculated on the basis of an application he alleged that he filed in October 2008. P. Br. dated January 15, 2010. In support of his

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[2] The CMS-855I, which is the enrollment application for physicians, instructs the applicant to identify the "reason for application" and gives, as one of six choices "You are reactivating your Medicare enrollment." CMS Ex. 4, at 5. Dr. Stern checked this option on the June application. *Id.*

[3] CMS asserts that the May application was returned in accordance with the Medicare Program Integrity Manual (PIM), which instructs contractors to return applications "received more than 30 days prior to the effective date listed on the application." CMS Br. at 1-2, citing PIM, Ch. 10.3.2A (at http:///www.cms.hhs.gov/Manuals/IOM/list.asp). Dr. Stern does not contest CMS's treatment of the May application.

arguments, Dr. Stern submitted two declarations (one from himself and one from an employee at his billing service) describing his filing of the alleged October 2008 application and his and the billing service's attempts to follow up on that application.[4] P. Exs. 1 and 2. Although entitled to file a reply brief and request an opportunity to cross-examine the declarants, CMS did not do so and, therefore, did not respond to or challenge Dr. Stern's assertions or evidence about the alleged October 2008 application.

The ALJ upheld Palmetto's determination of May 19, 2009 based on the June 2009 application. He rejected Dr. Stern's arguments that were based on the alleged October 2008 application because Dr. Stern had not supported his testimonial evidence with documents "showing that he filed an application that is dated earlier than May 19, 2009." ALJ Decision at 3.

Analysis

As of January 1, 2009, the effective date of a physician's enrollment and billing privileges in Medicare is governed by 42 C.F.R. § 424.520. 73 Fed. Reg. 69,940 (Nov. 12, 2008). This effective date rule also applies, as of that date, to reactivation applications.[5] Under section 424.520(d), the date must be the later of: the date when the physician files the application for enrollment that is subsequently approved by a Medicare contractor; or the date when the physician first begins providing services at the new practice location. 42 C.F.R. § 424.520(d). Here, CMS (and the ALJ) based the effective date determination on Dr. Stern's June 2009 application, which the ALJ found to have been received by Palmetto (and thus "filed") on June 18, 2009.[6] ALJ Decision at 3. Therefore, based on these facts, the earliest effective enrollment date possible for the

[4] The ALJ admitted this testimony into the record, and CMS did not object, before the ALJ or on appeal to the Board, to its admission. ALJ Decision at 2. Testimonial evidence that is submitted in written form in lieu of live in-person testimony is not "documentary evidence" within the meaning of 42 C.F.R. § 498.56(e), which requires good cause for submitting new documentary evidence to the ALJ. Thus, the ALJ properly considered the written testimony proffered by Dr. Stern in this case without finding that good cause existed despite statements in his Pre-Hearing Order that could be read as treating written direct testimony as "documentary evidence." Pre-Hearing Order at 2, 3-4 (¶¶ 3, 8).

[5] Effective January 1, 2009, CMS modified the Medicare Provider Integrity Manual (PIM) to state that, for purposes of 42 CFR §§ 424.520(d) and 424.521(a), a CMS-855 reactivation application is treated as an initial enrollment application. This means that a reactivated provider will have a new effective date (i.e., the later of the date of filling or the date it first began furnishing services at a new practice location) and, per section 425.521(a), limited ability to bill retrospectively. See PIM Rev. 289, issued April 15, 2009, effective January 1, 2009. Previous regulations authorized CMS to grant physician suppliers up to 27 months of retroactive billing privileges. That provision and the authority it provided were eliminated when the current regulations, i.e., sections 424.520(d) and 424.521(a), became effective on January 1, 2009. 73 Fed. Reg. at 69,940 (Nov. 19, 2008).

[6] The ALJ did not address Dr. Stern's assertions that Palmetto subsequently sent him conflicting letters – one saying that the effective date was May 17, 2009 and one setting the effective date as August 7, 2009. Dr. Stern represented that, as a result, he was "left with unpaid billings for the prior October 10, 2008 till August 7, 2009." P. Br. before ALJ at 2 (unnumbered).

June application under section 424.520(d) was June 18, 2009. Because section 424.521(a)(1) allows physicians, under certain circumstances, to retrospectively bill for 30 days prior to their effective enrollment date, Palmetto set Dr. Stern's retrospective billing date as May 19, 2009, 30 days prior to June 18. CMS Ex. 1 (citing section 424.521(a)(1) as the basis for May 19, 2009 date). As the ALJ correctly determined, this was the earliest possible date for which Dr. Stern could be reimbursed for Medicare services under the June 2009 application.[7] ALJ Decision at 3.

On appeal, Dr. Stern does not challenge the ALJ's analysis of the appropriate effective date under the June application. Rather, he objects to the ALJ's effective date determination on the ground that CMS did not deny that he filed an October 2008 application, and that, while the ALJ faulted Dr. Stern for not producing a copy of the October application, CMS and Palmetto were not asked "to produce their records which would clearly show I am right." Request for Review at 2.

For the following reasons, we conclude that the case should be remanded so that CMS can determine whether Palmetto or the prior contractor received an October 2008 application from Dr. Stern and have information in their files that would support an effective date for reactivation of Dr. Stern's billing privileges earlier than May 19, 2009.

- The ALJ faulted Dr. Stern for not filing "corroborating documents" such as a copy of the October application or copies of subsequent "correspondence" with the contractor. ALJ Decision at 3. It is not clear from the record whether Dr. Stern has no corroborating documents or simply did not appreciate that such documents would make his testimony more credible. However, Dr. Stern appeared pro se. There is no indication in the record that he was knowledgeable about legal processes and, therefore, understood that his or his billing service employee's uncontroverted testimony might be rejected absent supporting documentation. Also, while the ALJ's Pre-hearing Order allowed parties to file requests for "subpoenas," there is no indication that Dr. Stern would have understood this would include the option of subpoenaing documents in CMS's possession that could corroborate his assertions.

- There are no documents or objective evidence in the record that contradict the sworn statements of Dr. Stern and the billing service employee. Further, CMS (before the ALJ or the Board) has never challenged either the veracity or accuracy of the sworn testimony by Dr. Stern and the billing service employee. Finally, CMS did not provide any evidence, even though it is in the best position to do so, that Palmetto (or the prior contractor) has no records that would support Dr.

[7] Previous regulations authorized CMS to grant physician suppliers up to 27 months of retroactive billing privileges. That provision and the authority it provided were eliminated when the current regulations, i.e., sections 424.520(d) and 424.521(a), became effective on January 1, 2009. 73 Fed. Reg. at 69,940 (Nov. 19, 2008).

Stern's allegations that Palmetto or its predecessor received his October 2008 application and that he and the billing service made inquiries thereafter about that application.[8] *Compare Family Healing Healthcare Clinic, Patricia Williams, ARNP*, DAB CR2133 (2010) (in which the ALJ rejected the physician's unsupported allegations about filing an application after CMS submitted evidence in which the contractor indicated that it had "no record" of such an application).

- The record indicates that Palmetto's employees misadvised Dr. Stern in a way that could have prejudiced his attempts to effectively appeal Palmetto's August 10, 2009 decision. The August 10 decision letter informed him that he could file a CAP within 30 days and/or a request for reconsideration within 60 days. The billing service employee testified that, on receipt of the August 10 decision, they immediately called Palmetto and were told to file a CAP, which they did. P. Ex. 2, at 2; CMS Ex. 2, at 1, 5. On October 2, 2009, prior to the expiration of Dr. Stern's 60-day time for requesting a reconsideration of the decision, Palmetto issued what it characterized as a "decision letter . . . in response to your reconsideration request" for the decision of August 10, 2009. CMS Ex. 3, at 6-7. Therefore, Palmetto arguably prematurely cut off Dr. Stern's option of filing a request for reconsideration in which he could have explained about the October application. Additionally, there is nothing in the record to show that Palmetto informed Dr. Stern that he was entitled to submit "written evidence and statements that are relevant and material to the matters at issue" within a "reasonable time after the request for reconsideration" as provided for in 42 C.F.R. § 498.24(a). Had Dr. Stern filed a more complete initial reconsideration request with Palmetto, Palmetto would have been prompted to examine its files about the alleged October 2008 application and produce that information before the ALJ.

- The ALJ made an incorrect statement about the evidence. The ALJ wrote that "none of the documents submitted by [Dr. Stern] to Palmetto which are in evidence in the case make any reference to an alleged October 2008 application." ALJ Decision at 4. This factual finding is not supported by substantial evidence in the record. CMS submitted to the ALJ an October 9, 2009 letter from Dr. Stern to Palmetto discussing an October 2008 application. CMS Ex. 3, at 4-5.

Therefore, we remand this case to the ALJ for further proceedings consistent with this decision, including allowing Dr. Stern to produce any corroborating documents he may have. In addition, the ALJ should require CMS: (1) to address Dr. Stern's assertions

[8] The fact that CMS changed contractors while the alleged October 2008 application was being processed (which CMS does not deny) adds plausibility to Dr. Stern's assertions that he and the billing service were told first that all "was well" with the application but that the processing was delayed by the transition to Palmetto and then told that the October 2008 application had been lost. P. Exs. 1, 2.

about the alleged October 2008 application; (2) to produce information from Palmetto's or the prior contractor's file about Dr. Stern's alleged October 2008 application; and (3) to consider whether the regulations and policies governing the reactivation of billing privileges in effect as of October 2008 provide a basis for approving an effective date earlier than May 19, 2009. Alternatively, the ALJ may decide to further remand the case to CMS so that it can determine, consistent with this decision, whether a reactivation effective date earlier than May 19, 2009 should be approved.

Conclusion

We remand this case for proceedings consistent with this decision.

/s/
Judith A. Ballard

/s/
Constance B. Tobias

/s/
Stephen M. Godek
Presiding Board Member