DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-13-07

In the case of	**Claim for**
Delphi Hospitalist Services, LLC (Appellant)	Supplementary Medical Insurance Benefits (Part B)
**** (Beneficiary)	**** (HIC Number)
National Government Services (Contractor)	**** (ALJ Appeal Number)

The Medicare Appeals Council has decided, on its own motion, to review the Administrative Law Judge's (ALJ's) decision dated August 3, 2012, because there is an error of law material to the outcome of the claims. *See* 42 C.F.R. § 405.1110. The decision concerned physician services furnished to thirty-three beneficiaries from September 22, 2010, to December 7, 2010. The services were denied through the reconsideration level because the physician (who had re-assigned benefits to the appellant group practice) was not enrolled in Medicare until December 12, 2010.[1]

On appeal, the ALJ concluded that the effective date of the appellant's enrollment in the Medicare program was September 23, 2010. Because the ALJ found that the effective date of the appellant's enrollment was prior to nearly all the physician services at issue, he further addressed whether the services were reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act (Act).[2] He concluded that most of the

[1] To maintain privacy, the Council will refer to the beneficiaries by their initials throughout this action. Their initials and redacted HICNs, as well as the ALJ appeal number and the specific dates of service at issue are listed in the attachment (Attachment A) to this action.

[2] The ALJ found that one date of service at issue, for beneficiary M.A., was prior to the September 23, 2010, and thus, would remain denied.

physician services were reasonable and necessary, and thus covered by Medicare. For the physician services that the ALJ found were not covered by Medicare, the ALJ found that the appellant was liable for the non-covered services under section 1879 of the Act.

In a memorandum dated September 28, 2012, the Centers for Medicare & Medicaid Services (CMS) requested that the Council take own motion review of the ALJ's decision. The CMS memorandum is herby entered into the record in this case as Exhibit (Exh.) MAC-1. The appellant did not file a response to the CMS memorandum.

The Council has considered the record and CMS's contentions. As set forth below, the Council reverses the ALJ's decision, in part. We find that the ALJ lacked delegated authority under section 1869 of the Act to review the effective date of enrollment.

BACKGROUND AND PROCEDURAL HISTORY

The appellant, Delphi Hospitalist Services, LLC (the provider), a medical practice, sought Medicare coverage for physician services furnished by Dr. ****, the affiliated physician, to thirty-three beneficiaries on dates of services from September 22, 2010, to December 7, 2010. The physician provided primarily evaluation and management (E&M) services and interpretations of electrocardiograms (EKGs). The Medicare contractor, National Government Services, denied the claims initially. Each claim denial had a "B7" claim adjustment reason code, which indicates that the provider was not certified/eligible to be paid for the identified procedure/service on the respective date of service. *See* Exh. 31, at 1-26.

A letter in the administrative record sheds light on the issues in this case. The letter from the appellant to the contractor dated November 10, 2010, states:

> [Dr. ****] transferred to our group to cover an urgent need in a physician scarcity area. He began seeing patients on 9/23/10.
>
> We are submitting the enclosed Medicare Enrollment Application, CMS-855R, and ask that you backdate the credentialing to his start date, due to the urgent situation of his transfer and joining our group.

Exh. 32, at 12.

The contractor denied the claims on redetermination, finding that the appellant did not have both a Medicare provider number and National Provider Identifier (NPI) number to file claims for payment. Exh. 32, at 2. The appellant requested reconsideration by a Qualified Independent Contractor (QIC). On reconsideration, the QIC issued an unfavorable decision in which it stated:

> The documentation indicated [Dr. ****] had moved to upstate New York in August of 2010 to work in a physician scarcity area with Delphi Hospitalists Services. The Reconsideration Request noted that [Dr. ****] had a National Provider Identification (NPI) number since 2006. Also noted was [Dr. ****'s] certification with both Medicare and National Government Services prior to relocating. However, a provider must have an NPI number *and* a Medicare provider number tied to each practice to be certified/eligible to bill for Medicare services. According to the documentation, three CMS 855R enrollment applications were submitted beginning in August of 2010. The first two applications were returned due to missing data/clerical error. While [Dr. ****] did have an NPI number, research noted the effective date of enrollment in the Medicare program with Delphi Hospitalist Services was December 12, 2010. All services at issue in this appeal were rendered prior to the above noted enrollment effective date. As noted in the above regulations, no provider or supplier shall receive payment for services furnished to a Medicare beneficiary unless the provider or supplier is enrolled in the Medicare program.
>
> Based on the information in the case file, [Dr. ****] was not certified/eligible to bill for Medicare services for the dates of service at issue for this appeal.

Exh. 35, at 8. The QIC also found the appellant financially responsible for the non-covered services.

The appellant requested a hearing before an ALJ. The ALJ held a hearing on May 30, 2012, by telephone. Hearing CD. The appellant's director of billing and coding appeared and testified. Dec. at 2; *see also* Hearing CD. On appeal, the appellant argued that the effective date of the provider's enrollment was actually September 23, 2010, and that the services provided met Medicare coverage criteria. Thereafter, the ALJ issued his hearing decision in which he found that the contractor did not process the appellant's Medicare enrollment application with "timeliness and accuracy" and that due to the delay, the contractor erred by approving the effective date of enrollment as December 12, 2010. Dec. at 15. The ALJ determined that the effective date for the approval of the enrollment application should have been September 23, 2010, and the provider and physician were "certified and eligible" to submit claims for physician services furnished to beneficiaries on that date forward. *Id.* Due to the ALJ's favorable finding on the enrollment issue, he then addressed the medical necessity of the actual physician services. The ALJ concluded that Medicare would cover:

- all of the services provided to 24 of the beneficiaries
- some of the services provided to 7 of the beneficiaries, and
- none of the services provided to 2 of the beneficiaries.

See Dec. at Addendum A. The ALJ also found that the QIC properly dismissed two claims because it had previously adjudicated the claims in another appeal. Dec. at 15. Finally, the ALJ determined that the appellant was liable for the non-covered services pursuant to section 1879 of the Act. Dec. at 16.

CMS referred this case for the Council's own-motion review, contending that the ALJ's decision is erroneous as a matter of law. Exh. MAC-1, at 2. CMS argues that the ALJ erred as a matter of law in adjudicating the effective date of enrollment of the provider of the physician services and ultimately allowing Medicare coverage for the physician services billed. CMS asserts that the determination of the effective date of enrollment is not an initial determination that is appealable under section 1869 of the Act and 42 C.F.R. Part 405 Subpart I, rather it is subject to the appeals process established under section 1866(j)(2) of the Act and codified at 42 C.F.R. Part 498 as an initial determination that is "related to the denial or revocation of Medicare billing privileges." Exh. MAC-1, at 2

quoting 42 C.F.R. § 498.5(l)(1). Thus, the ALJ was without authority to review the effective date of enrollment, in the course of issuing a decision on a claim appeal under section 1869.

DISCUSSION

Medicare coverage was initially denied on the basis that, at the time the provider furnished the physician services from September 22, 2010, to December 7, 2010, the provider was not enrolled in Medicare for purposes of billing for the services. The contractor on redetermination and the QIC found that Medicare would not cover the services, because the provider's effective date of enrollment was subsequent to all the dates of service at issue. The ALJ disagreed and found that the appellant and the affiliated physician group were certified and eligible to submit claims to Medicare on or after September 23, 2010. In the ALJ's decision, he stated that pursuant to section 1869(b)(1)(A) "a party appealing the reconsideration decision as to an initial determination is entitled to a hearing before [the Secretary]." Dec. at 6. Later in the decision, the ALJ stated that the primary issue of the appeal was "the propriety of the NGS processing of the Enrollment Application the Provider submitted for the change of its organization information due to the reassignment of benefits to the organization by [Dr. ****]." Dec. at 9. As noted above, the ALJ found that "September 23, 2010, should have been deemed to be the effective date" of enrollment. Dec. at 14. The ALJ's adjudication of the appellant's effective date of enrollment, and his resulting determination that the appellant could submit claims for payment of the physician services at issue, are erroneous as a matter of law.

Section 1866(j)(2) of the Act establishes the enrollment process for providers and suppliers. In turn, a provider or supplier that is denied enrollment on a certain date has appeal rights under 42 C.F.R. Part 498. The implementing regulations state "[a]ny prospective provider dissatisfied with an initial determination or revised initial determination that it does not qualify as a provider may request reconsideration in accordance with § 498.22(a)." 42 C.F.R. § 498.5(a)(1). 42 C.F.R. section 405.803(a) states "[a] provider or supplier may appeal the initial determination to deny a provider or supplier's enrollment application, or if applicable, to revoke current billing privileges by following the procedures specified in part 498 of this chapter." 42 C.F.R. section 424.545 states "[a]

prospective provider or supplier that is denied enrollment in the Medicare program, or a provider or supplier whose Medicare enrollment has been revoked may appeal CMS' decision in accordance with part 498, subpart A of this chapter." Finally, 42 C.F.R. section 498.5(l)(1) extends appeal rights under 42 C.F.R. Part 498 to "[a]ny prospective provider, an existing provider, prospective supplier or existing supplier dissatisfied with an initial determination or revised initial determination related to the denial or revocation of billing privileges."

We agree with CMS that the appellant's appeal of the effective date of enrollment was not an initial determination that is appealable under section 1869 of the Act. And an ALJ within the Office of Medicare Hearings and Appeals only has delegated authority from the Secretary to issue a decision on an initial determination arising under section 1869. Pursuant to 42 C.F.R. § 498.3(b)(15), the implementing regulations specify that the determination of the effective date of enrollment in Medicare is an initial determination subject to the appeals procedures set forth in 42 C.F.R. Part 498. We further agree with CMS that the "appeals procedures of provider enrollment issues are wholly distinct from appeals procedures regarding denials of claims for payment of Part A and Part B services." Exh. MAC-1, at 5. A provider or supplier whose Medicare enrollment is denied may appeal to a Medicare Administrative Contractor hearing officer and then it has an opportunity to appeal to an ALJ at the Departmental Appeals Board (DAB); whereas, a supplier or provider that contests denials of claims for payment may appeal to a Medicare contractor and a QIC, and then to an ALJ at the Office of Medicare Hearings and Appeals (OMHA). Thus, the ALJ had no authority as a matter of law to review the effective date of enrollment.

As set forth above, the Council finds that the denial of the appellant's enrollment application is not appealable under section 1869 of the Act. The Council, and the ALJ, must accept the effective date of enrollment determined under the appropriate process as a binding adjudicative fact, unless and until that date is revised as a result of an appeal under the cognizant provisions. We find that Medicare will not cover the physician services at issue, because the enrollment was not effective until December 12, 2010, which was after the period at issue.

The appellant has not filed any exceptions to the redetermination or reconsideration which found that it could not bill the beneficiaries for the denied services.

DECISION

The ALJ was without authority to review the effective date of the appellant's enrollment in the Medicare Program. It is the decision of the Medicare Appeals Council that Medicare will not cover the physician services furnished from September 22, to December 7, 2010, furnished to the beneficiaries listed in Attachment A of this decision. The ALJ's decision is reversed, in part.

MEDICARE APPEALS COUNCIL

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

/s/ Constance B. Tobias, Chair
Departmental Appeals Board

Date: December 19, 2012