Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
Mikhail Paikin, DO (NPI: 1376587246),	)	Date: February 04, 2010
Petitioner,	)	Docket No. C-10-85
	)	Decision No. CR2064
v.	)	
Centers for Medicare & Medicaid Services.	)	

DECISION

Petitioner, Mikhail Paikin, DO, is not entitled to a hearing on the issues raised by his request for hearing and the request for hearing is dismissed pursuant to 42 C.F.R. § 498.70(b). A party may request that I vacate a dismissal for good cause but a request to vacate must be submitted within 60 days of receipt of the notice of dismissal. 42 C.F.R. § 498.72.

I. Background

The Medicare contractor, National Government Services (NGS), sent Petitioner[1] a letter dated November 18, 2008 advising Petitioner that his application for enrollment in Medicare was granted with an effective date of August 2, 1995. According to Petitioner, his enrollment was deactivated due to inactivity and a second application for enrollment was filed. NGS sent Petitioner a letter dated May 13, 2009, advising Petitioner that his application for enrollment was approved with an effective date of April 4, 2009. Petitioner requested reconsideration by letter dated August 25, 2009, specifically

[1] The request for hearing was actually filed by the practice group, A. Amerimed Physician, P.C. (Amerimed), with which Petitioner worked and to which he reassigned his right to bill Medicare for services he provided to Medicare eligible beneficiaries. However, it is the enrollment in Medicare of Mikhail Paikin, DO, that is in issue and not the enrollment of Amerimed.

requesting that the effective date for his participation in Medicare be changed to October 1, 2008. Petitioner asserted in his request for reconsideration that he was not aware that his prior enrollment would be deactivated if he failed to submit claims within 30 days of enrollment. On September 23, 2009, a contractor hearing officer issued a decision denying the reconsideration request for an earlier effective date of Medicare participation. On October 5, 2009, Petitioner requested a hearing challenging the reconsideration decision with the foregoing documents attached.

The case was assigned to me on November 2, 2009 for hearing and decision, and an Acknowledgement and Prehearing Order (Prehearing Order) was issued at my direction on that date. On December 2, 2009, the Centers for Medicare and Medicaid Services (CMS) filed a motion to dismiss Petitioner's request for hearing (CMS Motion) with CMS exhibits (CMS Ex.) 1 through 8. On January 5, 2010, Petitioner submitted a letter advising me that Petitioner elected not to file a response and requesting a decision on the record.

II. Discussion

A. Law

Section 1831 of the Social Security Act (the Act) (42 U.S.C. § 1395j) establishes the supplementary medical insurance benefits program for the aged and disabled known as Medicare Part B. Payment under the program for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of services and suppliers.[2] Act §§ 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395(u)(h)(1)). Administration of the Part B program is through contractors. Act § 1842(a) (42 U.S.C. § 1395u(a)).

[2] A "supplier" furnishes services under Medicare and includes physicians or other practitioners and facilities that are not included within the definition of the phrase "provider of services." Act § 1861(d) (42 U.S.C. § 1395x(d)). A "provider of services," commonly shortened to "provider," includes hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, hospice programs, and a fund as described in sections 1814(g) and 1835(e) of the Act. Act § 1861(u) (42 U.S.C. § 1395x(u)). The distinction between providers and suppliers is important because they are treated differently under the Act for some purposes.

The Act requires the Secretary to issue regulations that establish a process for the enrollment of providers and suppliers, including the right to a hearing and judicial review in the event of denial or non-renewal. Act § 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to 42 C.F.R. § 424.505, a provider or supplier must be enrolled in the Medicare program and be issued a billing number to have billing privileges and to be eligible to receive payment for services rendered to a Medicare-eligible beneficiary. If enrollment is approved, a supplier is issued a National Provider Identifier (NPI) to use for billing Medicare and a PTAN, an identifier for the supplier for inquiries. Medicare Program Integrity Manual (MPIM), CMS Pub. 100-08, Chapter 10, Healthcare Provider/Supplier Enrollment, § 6.1.1.

"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" the decision in accordance with 42 C.F.R. Part 498. 42 C.F.R. § 424.545(a). Pursuant to 42 C.F.R. § 498.5(a), (d), and (*l*)(1) and (2), a prospective provider or supplier dissatisfied with an initial decision to deny it enrollment may request reconsideration and, if dissatisfied with the reconsideration decision, is entitled to a hearing before an administrative law judge (ALJ). A provider or supplier dissatisfied with an initial decision to terminate its participation is entitled to a hearing before an ALJ. 42 C.F.R. § 498.5(b) and (e). Initial determinations are listed at 42 C.F.R. § 498.3(b) and include: whether a prospective provider qualifies as a provider; whether a prospective supplier meets the conditions for coverage specified by the regulations; whether services of a supplier continue to meet the conditions for coverage; the effective date of a Medicare provider agreement or supplier approval; and whether to deny or revoke a provider or supplier's Medicare enrollment pursuant to 42 C.F.R. §§ 424.530 and 424.535. 42 C.F.R. § 498.3(b)(1), (5), (6), (15), and (17).

B. Issue

Whether Petitioner has a right to a hearing on the facts of this case.

C. Findings of Fact, Conclusions of Law, and Analysis

My conclusions of law are set forth in bold followed by the pertinent facts and analysis.

1. Petitioner has no right to a hearing by an ALJ on the issue of whether his billing privileges were properly deactivated.

2. Petitioner has no right to a hearing by an ALJ on the issue of whether he may obtain reimbursement from Medicare for services provided to Medicare-eligible beneficiaries for more than 30 days prior to his effective date of participation in Medicare.

3. Petitioner, as a supplier not subject to survey and certification or accreditation, has no right to a hearing by an ALJ on the issue of whether or not his effective date of enrollment was correctly determined by CMS.

4. Petitioner has no right to a hearing by an ALJ and dismissal pursuant to 42 C.F.R. § 498.70(b) is appropriate.

The request for hearing in this case was filed by Amerimed. The request for hearing indicates that Petitioner began working as a member of Amerimed on or about October 1, 2008 and began providing services to Medicare beneficiaries. According to Petitioner, more than 320 Medicare claims for services he provided between October 1, 2008 and April 3, 2009 were denied for payment. Petitioner wants to have the claims paid and represents in the request for hearing that Amerimed was told the only way to accomplish that was to have Petitioner's date of participation pushed back to October 1, 2008. Petitioner also asserts that had Amerimed been told that it needed to submit claims within 30 days of the date of Petitioner's enrollment in November 2008, it would have done so and the issue would not have arisen. CMS Ex. 6. In the August 25, 2009 request for reconsideration, Petitioner indicates that the November 18, 2008 notice granting him an effective date of participation of August 2, 1995, was received on November 21, 2008, but that no claim was submitted for payment until March 2009, and at that time Petitioner was advised that his billing number was "deactivated for infrequent billing" because no claim was submitted for 30 days. Petitioner asserted in the request for reconsideration that Amerimed was unaware of the 30-day limit and believed it was 365 days as provided by regulation. CMS Ex. 3, at 1.

CMS does not deny Petitioner's assertion or rebut the evidence he presented with his request for hearing that on November 18, 2008 NGS notified him that his application for enrollment was approved with an effective date of August 2, 1995. CMS does not deny Petitioner's assertion in his request for hearing and request for reconsideration that his billing privileges, based upon his enrollment in November 2008, were deactivated because he failed to submit claims within 30 days of his enrollment. CMS Motion at 8-10. CMS also does not deny Petitioner's assertion in his request for reconsideration that he submitted a claim in March 2009, within five months of notice of his enrollment, but that he was nevertheless notified that his billing privileges were deactivated. CMS Ex. 3, 6.

Pursuant to 42 C.F.R. § 424.502, "[d]eactivate means that the provider or supplier's billing privileges were stopped, but can be restored upon submission of updated information." Pursuant to 42 C.F.R. § 424.540(a), CMS may deactivate a provider or supplier's billing privileges if a provider or supplier does not submit Medicare claims for 12 consecutive calendar months or fails to report certain changes of information within 90 calendar days of when the change occurred. If a provider or supplier is deactivated for

non-submission of a claim, the provider or supplier is required to recertify that enrollment information on file with Medicare is correct and furnish any missing information; must meet current Medicare requirements at the time of reactivation; and be prepared to submit a valid claim. 42 C.F.R. § 424.540(b)(2); MPIM, Chap. 10, ¶ 13.1. Reactivation after deactivation for failure to submit a claim does not require submission of a new enrollment application as is required when deactivation occurs for some other reason. 42 C.F.R. § 424.540(b)(1). The regulation provides that deactivation is an action to protect the provider or supplier from misuse of its billing number and to protect the Medicare Trust Fund, and that deactivation "does not have any effect upon a provider or supplier's participation agreement or any conditions of participation." 42 C.F.R. § 424.540(c).

The undisputed facts are that Petitioner was enrolled in Medicare on November 18, 2008 with an effective date of August 2, 1995; that he submitted a claim within five months but was advised that his billing privileges were deactivated for failure to submit a claim within 30 days; and that NGS and the hearing officer treated Petitioner's May 4, 2009 Medicare Enrollment Application (CMS 855R) as a new application rather than Petitioner's submission of updated information to reactive his billing privileges as required by 42 C.F.R. § 424.540(b)(1) and (2). Based on the undisputed facts, the regulations and the MPIM, NGS apparently failed to follow the regulations and CMS policy guidance by deactivating Petitioner's billing privileges after only 30 days with no claims being submitted rather than waiting 12 months as required by the regulations. NGS then committed a further error by treating Petitioner's May 4, 2009 application as a new enrollment rather than a request to reactivate his billing privileges. If it were in my power and absent further evidence, I would grant Petitioner relief on this basis. However, neither the Act nor the regulations grant Petitioner a right to a hearing before an ALJ based upon a deactivation of billing privileges pursuant to 42 C.F.R. § 424.540. Accordingly, I conclude that I have no jurisdiction or authority to grant Petitioner relief on this basis.

CMS argues that Petitioner has no right to a hearing and that I have no authority to review or grant relief in this case. I conclude that CMS is correct.

NGS, the hearing officer on reconsideration, and CMS treat Petitioner's Medicare Enrollment Application received by the NGS on May 4, 2009 as a new application for enrollment. CMS Ex. 1, at 1. Pursuant to 42 C.F.R. § 424.520(d),[3] the effective date for billing privileges for a physician is

[3] This provision was added by final rule at 73 Fed. Reg. 69,725; 69,773 (Nov. 19, 2008) and 73 Fed. Reg. 80,304 (Dec. 31, 2008) effective January 1, 2009, and is to be codified at 42 C.F.R. § 424.520(d).

> the later of the date of filing of a Medicare enrollment application that is subsequently approved by a Medicare contractor or the date an enrolled physician or nonphysician practitioner first began furnishing services at a new practice location.

The evidence shows that NGS received Petitioner's application on May 4, 2009, and this fact is not disputed by Petitioner. CMS Ex. 1, at 1. Petitioner does not assert that his effective date should be determined using the second approach of the regulation based upon when he first began furnishing services at a new practice location. The NGS letter to Petitioner advised Petitioner that his enrollment was actually effective April 4, 2009 rather than May 4, 2009 (CMS Ex. 2, at 1), which is inconsistent with 42 C.F.R. § 424.520(d), as the regulation establishes the effective date of enrollment as the date of filing of the application. *See also* 73 Fed. Reg. 69,725, 69,769 (Nov. 19, 2008) (date of filing is date Medicare contractor receives signed application that it can process to approval). CMS offers no explanation for Petitioner being granted an effective date of April 4, 2009 rather than May 4, 2009 as appears to be required by the regulation and legislative history. However, the effective date determination may have been based upon an incorrect application of 42 C.F.R. § 521(a)(1),[4] which permits an enrolled physician to bill "retrospectively" for services provided up to 30 days prior to their effective date if circumstances precluded enrollment in advance of providing services.[5] CMS Ex. 5, at 2. Petitioner does not specifically challenge the lawfulness of the new regulations at 42 C.F.R. §§ 424.520(d) and 521(a)(1). Even if Petitioner challenged the lawfulness of the regulations, I am bound to follow the Secretary's regulations, including 42 C.F.R. §§ 424.520(d) and 521(a)(1), and I have no authority to find the regulations invalid.

The CMS position, stated simply, is that Petitioner's enrollment as a supplier was not denied and no right to hearing is triggered in this case. CMS Motion at 6-8, 10-11. The Act only provides for a right to hearing and judicial review in the case of denial or non-renewal of enrollment. Act § 1866(j) (42 U.S.C. § 1395cc(j)). The Secretary has provided by regulation for a right to hearing and judicial review for both denial and revocation of enrollment. 42 C.F.R. §§ 424.545(a); 498.3(b)(1), (5), (6), (17); 498.5(a),

---

[4] This provision was also added by final rule at 73 Fed. Reg. 69,725; 69,768-69; 69,773; 69,939 (Nov. 19, 2008) and 73 Fed. Reg. 80,304 (Dec. 31, 2008) effective January 1, 2009, and is to be codified at 42 C.F.R. § 424.521(a)(1).

[5] Prior to the change in the regulations effective January 1, 2009, physicians were permitted to retroactively bill Medicare for services furnished up to 27 months prior to enrollment. CMS Motion at 5, n.1. Whether or not Petitioner can submit claims for services preformed 30 days prior to April 4, 2009 under authority of 42 C.F.R. § 521(a)(1) is not an issue raised by the request for hearing, nor is it within my jurisdiction for the reasons discussed hereafter.

(d), and (*l*)(1) and (2); 42 C.F.R. § 498.5(b) and (e). CMS acknowledges that the plain language of 42 C.F.R. § 498.3(15) indicates that the determination of the effective date of a Medicare provider agreement or supplier approval, is an initial determination that is subject to hearing and judicial review. However, CMS argues that 42 C.F.R. § 498.3(b)(15) is not a provision applicable in the case of a supplier such as Petitioner. CMS Motion at 12-13. Although the plain language of a regulation would normally control, review of legislative or regulatory history is appropriate when an issue of interpretation is raised as it is in this case. The regulatory history for 42 C.F.R. § 498.3(b)(15) at 62 Fed. Reg. 43,931, 43,933-34 (Aug. 18, 1997) supports the CMS position that the provision only permits a right to hearing related to an effective date determination for providers and suppliers subject to survey and certification or to accreditation by an accrediting organization. Petitioner was not subject to survey and certification or accreditation in order to enroll and qualify as a supplier participating in Medicare. Accordingly, I conclude that 42 C.F.R. § 498.3(b)(15), creates no right for Petitioner to request a hearing to challenge the effective date determination by CMS or its contractor.

Finally, I note that the request for hearing in this case was filed by the practice group with which Petitioner works and to which he reassigned his right to bill Medicare. CMS Ex. 6. The request for hearing states clearly that its purpose is to have approximately 320 claims related to services provided by Petitioner between October 1, 2008 and April 3, 2009 reconsidered for payment by Medicare. Petitioner acknowledges that I have no jurisdiction to provide individual claim review by stating that Petitioner understands that this can only be accomplished by changing the effective date of Petitioner's participation to a date on or before he began providing services to Medicare-eligible beneficiaries. Indeed, Petitioner is correct that I have no statutory or regulatory authority to provide any review of individual claims.

Accordingly, I conclude that Petitioner has not shown that he has a right to a hearing and I have found no basis upon which to exercise jurisdiction and grant Petitioner review.

III. Conclusion

I conclude, based on the foregoing, that Petitioner has no right to a hearing and dismissal of his request for hearing is appropriate pursuant to 42 C.F.R. § 498.70(b).

/s/
Keith W. Sickendick
Administrative Law Judge