Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Family Healing Healthcare Clinic,
Patricia Williams, ARNP,

Petitioners

v.

Centers for Medicare & Medicaid Services.

Docket Nos. C-10-363 and C-10-364
Decision No. CR2133

Date: May 20, 2010

DECISION

I deny the motion of the Centers for Medicare and Medicaid Services (CMS) to dismiss this case. As to the merits of the case, I decide the case on the written record and find that the effective date of Petitioners' enrollment in the Medicare program is July 17, 2009. Thus, pursuant to 42 C.F.R. § 424.521(a), Petitioners may retrospectively bill for services rendered as of June 17, 2009.

I. Background

This case involves Petitioners, Family Healing Healthcare Clinic (FHHC) and Patricia Williams, who is an advanced registered nurse practitioner (ARNP). Petitioner FHHC is identified in the enrollment application (Form CMS 855I) as a professional corporation, which Ms. Williams formed and at which she began practicing on May 4, 2009. CMS Ex. 1, at 20.

By two identical letters, both received January 8, 2010, Ms. Williams sent in hearing requests to challenge the effective date of enrollment in the Medicare program for Ms. Williams and for FHHC. Hearing Requests (HR). With the hearing requests, Petitioners submitted the National Government Services' (NGS) reconsideration determination, dated November 24, 2009, which rejected the request of both Petitioners to change their assigned effective date to May 4, 2009, the date on which Ms. Williams began furnishing

services at FHHC.[1] At Ms. Williams' request and with CMS's agreement, I consolidated both appeals. I determined that the two cases relate to the same medical practice, and the issues appear to be the same in both. *See* Order Granting Consolidation.

On March 16, 2010, CMS moved to dismiss arguing that Petitioners have no right to a hearing, because the effective date of a non-physician practitioner's Medicare enrollment is not an initial determination subject to appeal. Along with its motion, CMS filed a brief in support of its decision arguing, in the alternative, that it properly determined Petitioners' effective date as June 17, 2009.[2] CMS also submitted CMS Exhibits (CMS Exs.) 1-9, with its motion and brief (CMS Br.).

By letter dated March 16, 2010, Ms. Williams stated that she was unable to attend a hearing. Attached to the letter was Petitioners' Exhibit (P. Ex.) 1 consisting of 15 pages composed of: a two-page letter signed by Ms. Williams dated March 16, 2010, containing Petitioners' arguments and assertions; a one-page letter signed by FHHC's practice manager Jacqueline Napier-Dunn, dated October 21, 2009; and an 11-page attachment to that letter described as FHHC's electronic funds transfer authorization agreement. Ms. Williams confirmed by telephone on April 26, 2010 that she wished me to proceed to decision based on the written record before me without further submissions or proceedings. CMS did not seek to present witnesses or request an evidentiary hearing.

I admit CMS Exs. 1-9 and P. Ex. 1 into evidence, and I will decide this case on the written record submitted by the parties.

II. Issues, Findings of Fact, Conclusions of Law

A. Issues

The issues in this case are:

1. Whether I should dismiss Petitioners' hearing request on the ground that Petitioners have no right to appeal; and

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[1] NGS is a Medicare contractor with the initial authority to approve or deny enrollment in Medicare.

[2] NGS's reconsideration decision letter, dated November 24, 2009, states that NGS received Medicare enrollment forms for Petitioners on July 17, 2009 and that the effective date of billing privileges is June 17, 2009. CMS makes clear in its brief (to which Petitioners did not respond) that the effective date of Petitioners' enrollment in the Medicare program is actually July 17, 2009 and that NGS, acting pursuant to 42 C.F.R. § 424.521(a), permitted Petitioners to retrospectively bill for services provided at the enrolled practice location for up to 30 days prior to the effective date of their enrollment, i.e., back to June 17, 2009.

2. Whether Petitioners can bill Medicare for all services that Ms. Williams rendered at FHHC, starting on May 4, 2009.

B. Findings of fact and conclusions of law

My findings of fact and conclusions of law are set forth in bold and italics below.

1. The effective date of a Medicare provider agreement or supplier approval is an initial determination reviewable in this forum; thus, Petitioners have a right to a hearing.

a. Applicable standard

Pursuant to 42 C.F.R. § 498.70(b), I may dismiss a hearing request in the circumstance where a party requesting a hearing "does not otherwise have a right to a hearing."

b. Analysis

According to CMS, statute and regulations limit a supplier's or provider's appeal rights to challenging denials of enrollment applications and revocations of billing privileges. CMS Br. 9-10 (citing 42 U.S.C. § 1395cc(j)(2) and 42 C.F.R. §§ 424.545(a), 405.874, 498.5(1), and 498.22(a)). CMS asserts that "[t]here is no regulatory authority permitting a provider or supplier to appeal an approval of an enrollment application, or to appeal the effective date of that provider's or supplier's billing privileges." CMS Br. 10, 13-14 (citing 42 C.F.R. Part 424, Subpart P; *see Mikhail Paikin, DO*, DAB CR2064 (2010); *Rachel Ruotolo, M.D.*, DAB CR2029 (2009); *Bradley D. Anawalt, M.D., et al.*, DAB CR2021 (2009); *but see Jorge M. Ballesteros, CRNA*, DAB CR2067, at 1 (2010) (stating that 42 C.F.R. § 498.3(b)(15) explicitly allows for review of "effective date of a Medicare provider agreement or supplier approval"), and *Victor Alvarez, M.D.*, DAB CR2070, at 3 (2010) (finding 42 C.F.R. § 498.3(b)(15) confers hearing rights to Petitioners challenging the effective date of its enrollment in the Medicare program)).

Part 424, subpart P, unquestionably does grant appeal rights from denials and revocations, but it does so by reference to the provisions of subpart A of part 498. The regulations at 42 C.F.R. Part 498 that govern appeals procedures for determinations affecting participation in Medicare (and certain Medicaid determinations) sets out a list of initial determinations by CMS that are subject to appeal and specifies administrative actions that are not subject to appeal under part 498. One of the initial determinations listed as subject to appeal is as follows:

> The effective date of a Medicare provider agreement or supplier approval.

42 C.F.R. § 498.3(b)(15). None of the administrative actions identified as not subject to appeal under part 498 refers to the determination of an effective date for a provider or supplier to participate in Medicare. In adopting section 498.3(b)(15), CMS recognized that approving participation at a date later than that sought amounts to a denial of

participation during the intervening time and generally involves the same kind of compliance issues that arise from initial denials. 62 Fed. Reg. 43,931, 43,933 (Aug. 18, 1997); 57 Fed. Reg. 46,361, 46,363 (Oct. 8, 1992). The same reasoning applies whether the denial of an earlier effective date results from a survey and certification process or an enrollment process. In short, given the express adoption subpart A of part 498 granting appeal rights for effective date determinations of supplier approvals, the regulation on which CMS relies, rather than precluding effective date challenges, adopts the provision granting them.

It is well-established, and not questioned by either party here, that both the Departmental Appeals Board Members (collectively the "Board") and all ALJs are bound by statute and regulations. Where a regulation speaks clearly on its face and applies to the question before me, I am bound to follow it. The wording of section 498.3(b)(15) appears straightforward in providing that the "effective date of a Medicare provider agreement or supplier approval" is an appealable initial determination and includes no qualifying or limiting language.

CMS argues, however, that 42 C.F.R. § 498.3(b)(15) is limited to suppliers who are subject to survey and certification, before they are permitted to participate in the Medicare program. CMS Br. at 14 (citing 62 Fed. Reg. 43,931). According to CMS, the fact that "'supplier approval' for purposes of survey and certification is a separate process from reviewing an application under the enrollment requirements of 42 C.F.R. [Part] 424 Subpart P" demonstrates that the effective date determination arising from approval of an enrollment application is not appealable. CMS Br. at 16.

The Board has not directly decided this jurisdictional question, and ALJs who have considered it have been divided in their conclusions. In a number of recent cases, ALJs have concluded that the plain language of section 498.3(b)(15) creates a right for any provider or supplier to challenge the effective date of enrollment of a provider agreement or of supplier approval. *Alvarez*, DAB CR2070; *Romeo Nillas, M.D.*, DAB CR2069 (2010); *Ballesteros*, DAB CR2067; *Vincent Pirri, M.D.*, DAB CR2065 (2010).

Those ALJs have relied on the following principle:

> CMS would have me ignore the plain meaning of the regulation. It contends that this regulation predates the Part 424 regulations and was intended to confer hearing rights only in situations not covered under Part 424. That argument is unpersuasive. The regulation is plain and unambiguous.

Andrew J. Elliott, M.D., DAB CR2103, at 3 (2010).

I agree. The wording of section 498.3(b)(15) is straightforward in providing that the "effective date of a Medicare provider agreement or supplier approval" is an appealable initial determination and includes no qualifying or limiting language.

In *Paikin*, DAB CR2064, a case on which CMS relies in its brief, one ALJ recently accepted CMS's argument that the regulatory history of section 498.3(b)(15) should be understood to restrict appeals of effective dates to those suppliers and providers subject to survey and certification or accreditation. CMS Br. at 13-14. Notably, the ALJ first acknowledged the rights conferred by the plain language of the statute, stating:

> CMS acknowledges that the plain language of 42 C.F.R. § 498.3[(b)](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. 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.

Paikin, DAB CR2064, at 7 (citation omitted) (emphasis added). The ALJ in *Paikin* did not explain further why, despite CMS's reported acknowledgement that the plain language indicates that the determination of the effective date of supplier approval is an initial determination, he nevertheless looked behind the face of a binding regulation to read in a restriction that nowhere appears in the regulation.

I disagree that review of regulatory history is appropriate when an issue of interpretation is merely raised, without more. Regulatory history and other sources of guidance are relevant in interpreting language, which is ambiguous, unclear in its application, or which leaves gaps. However, courts do not resort to such interpretive tools when the wording is clear on its face. *See, e.g., Connecticut Nat'l Bank v. Germain*, 503 U.S. 249, 253-54 (1992) ([T]he "cardinal canon" of construction is that a statute means what it says and, when unambiguous, "this first canon is also the last: judicial inquiry is complete."). CMS has not identified in what respect the wording of section 498.3(b)(15) may be said to be ambiguous or unclear or where the language leaves a gap requiring interpretation to give it meaning. I thus find little room for interpretation and therefore find review of legislative or regulatory history inappropriate.

Even reviewing the regulatory history on which CMS relies, however, I do not find any clear indicator that section 498.3(b)(15) was intended at the time of its issuance to mean anything other than what it states, or to restrict challenges to effective date determinations as CMS now argues.

The provision that became section 498.3(b)(15) was first proposed in 1992 in a notice of proposed rulemaking that aimed at doing two things: (1) establishing "uniform criteria for determining the effective date of participation for all Medicare and Medicaid providers and Medicare suppliers"; and (2) specifying that "those dissatisfied with a decision on their effective date of participation under Medicare are entitled to a Medicare hearing on the decision." 57 Fed. Reg. at 46,362. There is no question that the uniform criteria for establishing effective dates for provider agreements and supplier approvals proposed in 1992 (and finalized in 1997) apply to those providers and suppliers subject to

survey and certification requirements (or accreditation by a CMS-approved accrediting organization). The regulatory language explicitly states that the criteria set out for determining the correct effective date of agreement or approval apply to "Medicare provider agreements with, and supplier approval of, entities that, as a basis for participation in Medicare" are subject to CMS or state agency survey and certification, or are deemed to meet requirements based on accreditation, with two exceptions not applicable here. 42 C.F.R. § 489.13.

This observation does not, however, necessarily mean that the appeal rights added to part 498 by the same rulemaking are limited to those providers and suppliers. The 1992 preamble indicates that the prior practice had been inconsistent about whether the date on which a prospective provider or supplier was entitled to participate in Medicare was a "proper subject for Medicare hearings." 57 Fed. Reg. at 46,362-63. The rule was intended to ensure that, when a provider or supplier is found not to meet conditions of participation initially but later to meet requirements, the resulting effective date could be appealed (even though participation was ultimately approved). *Id.* (The provider or supplier may not, however, argue that the initial survey should have been scheduled sooner. 42 C.F.R. § 498.3(d)(15)). This discussion indicates that the drafters were thinking of the type of providers and suppliers that then had appeal rights but does not indicate that they had an intention to restrict the scope of appeals by others who might be granted Medicare hearings.

The 1997 preamble states that the final rule "makes clear that the rules for determination of the effective date of a provider agreement or supplier approval apply to all providers and suppliers that are subject to survey and certification . . . or have deemed status on the basis of accreditation." 62 Fed. Reg. at 43,934 (emphasis added). The 1997 preamble further states that the final rule "[m]akes existing Medicare appeals procedures available, and requires Medicaid agencies to make their existing appeals procedures available, for effective date determinations." *Id.* Notably, the statement of the expansion of Medicare and Medicaid hearings to include effective date determinations contains no parallel limitation to those subject to survey and certification or accreditation.[3] Furthermore, the regulatory impact statement indicates that the drafters believed that court decisions had already confirmed a right to appeal effective date determinations as analogous to denials of participation, even though that right had not previously been codified in the regulations. *Id.* In addition, the preamble states that effective date hearings would, "for the most part," focus on noncompliance issues similar to those that arise in denial appeals but does not state that such appeals could only arise in that context. *Id.* I conclude that nothing in the regulatory history of the addition of section 498.3(b)(15) demonstrates an intent to restrict challenges to effective date determination to a subset of providers and suppliers, as opposed to all providers and suppliers that then had appeal rights.

[3] It is not possible to construe the limitation in the explanation of the scope of the uniform effective determination rules to apply to the entire summary of the final rule's effect, because other clauses clearly discuss the effects on other subsets of providers (such as laboratories and community mental health centers).

CMS also contends that the fact that section 498.3(b)(15) was adopted long before section 936(a)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, codified at 42 U.S.C. § 1395cc(j), required the Secretary to establish an appeals process from the denial of applications for enrollment should suffice to demonstrate that it was not intended to affect those appeal rights. CMS Br. at 14-15. This argument is not persuasive. A later statute does not elucidate the intended meaning of a prior regulation. The regulation on its face grants appeal rights to challenge effective date determinations of provider agreements and supplier approvals generally. The question is not whether the drafters at the time contemplated granting such rights to suppliers and providers who were not then covered by the effective date determination criteria applicable to those requiring survey and certification or accreditation. The question is whether, despite the plain language, the drafters actually intended to affirmatively exclude other providers and suppliers who might later gain appeal rights from challenging their effective date determinations. As discussed above, the 1992 and 1997 preambles do not reflect any such intention.

In fact, the long lag between the addition of effective date determinations to the list of appealable initial determinations, and the creation of an appeals process for denials of enrollment applications, cuts the other way. By the time that CMS adopted 42 C.F.R. Part 424, Subpart P, setting out enrollment requirements as a condition for participation in Medicare, CMS was well aware of the longstanding provision granting "appeal rights and procedures for entities that are dissatisfied with effective date determinations." 62 Fed. Reg. at 43,931-32. Yet, CMS provided that a prospective provider or supplier whose enrollment is denied or revoked "may appeal CMS' decision in accordance with part 498, subpart A of this chapter." 42 C.F.R. § 424.545(a). Section 498(b)(15) is part of subpart A of part 498, yet CMS did not exclude section 498(b)(15) or otherwise indicate that the effective date determination would not be a proper subject for these Medicare hearings. Hence, the plain language of section 424.545(a) reinforces the plain language of section 498.3(b)(15).

To the extent that CMS is suggesting that an ambiguity arises from the term "supplier approval" referenced in section 498.3(b)(15), I am not persuaded that the language of section 498.3(b)(15) bears a reading that excludes approval after submission of an enrollment application rather than after a survey or deeming of an accredited supplier, or by CMS's assertion that it should be read to refer only to the language of section 489.13. CMS Br. at 15-16. Section 489.13 applies to the determination of the effective date of provider agreements, and the "supplier approval, of entities that, as a basis for participation in Medicare" are subject to survey and certification or accreditation. This argument is circular, since section 489.13 merely codifies the provisions for uniform effective date determinations for all providers and suppliers subject to survey and certification or accreditation, which were adopted as part of the 1997 rulemaking. 62 Fed. Reg. at 43,931. Section 489.13 is not the only provision for approval of suppliers to participate in Medicare. Approval is defined in section 424.502 as meaning the determination that the supplier is "eligible under Medicare rules and regulations to receive a Medicare billing number and be granted Medicare billing privileges." 42 C.F.R. § 424.520(c) and (d) govern the effective date of such approval for suppliers not

requiring survey and certification or accreditation. Importantly, section 498.3(b)(15) does not state that appealable initial determinations are limited to the effective dates of provider agreements and supplier approvals under section 489.13.

Illustrating inconsistent interpretation of the regulations, CMS next argues that, "while it is true that CMS issued guidance in May 2009, directing its contractors to permit appeals of effective date determinations for approved suppliers and providers, it later retracted such guidance after determining that it was issued in error." CMS Br. at 17 (citing Joint Signature Memoranda (JSM) issued by CMS on May 7, 2009 and Nov. 2, 2009). CMS argues that the policy guidance in the May 7, 2009 JSM "is not binding on this tribunal and cannot be applied so as to conflict with applicable statutory and regulatory law," and the subsequently retracted policy "is not sufficient to provide appeal rights that do not exist under the Medicare Act and regulations." *Id.* at 17-18. CMS further argues that "CMS reiterated in its November 2, 2009 JSM that physicians and NPPs [non-physician practitioners] can only appeal initial determinations that are the result of an initial determination of enrollment denial or revocation and that physicians and NPPs cannot appeal the effective date decisions made by the contractor." *Id.* at 17 (citing CMS Ex. 9 (JSM Nov. 2, 2009) (emphasis in original)).

CMS's discussion of its two policy issuances provides no basis to ignore the plain language of section 498.3(b)(15) granting the right to appeal "[t]he effective date of a Medicare provider agreement or supplier approval" and demonstrates no contrary regulatory intent. As CMS itself notes, its policy guidance "cannot be applied so as to conflict with applicable statutory and regulatory law." *Id.* at 17 (citing and quoting *Foxwood Springs Living Ctr.*, DAB CR1966, at 6 (2009) ("CMS policy issuances may only be construed and applied consistently and in harmony with 'controlling provisions of the law – the Act and the Secretary's regulations.'")).

The May 7, 2009 JSM nowhere suggested that it provided "new" appeal rights or that new regulations would be proposed, or needed, to implement them. Instead, the first JSM appears to have been issued as clarification based on the expectation that the substantial reduction of the period for retroactive billing would cause many affected suppliers to challenge effective date determinations. CMS's presumption of effective date appeal rights in that JSM undercuts CMS's claim that it has consistently interpreted subpart P of part 424 as precluding challenges to effective dates, or that it interpreted 498.3(b)(15) as excluding effective date appeals by providers and suppliers not subject to survey and certification or accreditation. On the contrary, as discussed earlier, CMS had interpreted approval letters with an effective date which the provider or supplier argued was later than that provided for by law as amounting to denials of approval for the earlier period and as appealable on that basis.

I note that the language at section 498.3(b)(15) has been in place since 1997, and section 424.545 has been in place since 2006. However, as late as May 7, 2009, CMS expressly read them as granting appeal rights for effective date determinations (which obviously exist only after an approval is granted but for a date subsequent to that sought by the provider or supplier). CMS's reversal of this position in the November 2, 2009 JSM thus

does not merit any controlling weight in light of the plain language of section 498.3(b)(15) and the absence of any demonstrated intent to prohibit effective date appeals by providers and suppliers.

Based on the foregoing, I deny CMS's motion to dismiss.

2. The effective date of Petitioners' participation in Medicare was properly determined under 42 C.F.R. § 424.520(d).

As explained above, I decide the merits of this case based on the written record.

The effective date of approved enrollment in the Medicare program for these Petitioners is governed by 42 C.F.R. § 424.520(d), which reads:

> (d) *Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations.* The effective date for billing privileges for physician, nonphysician practitioners, and physician and nonphysician practitioner organizations is the later of the date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor or the date an enrolled physician or nonphysician practitioner first began furnishing services at a new practice location.

(Emphasis added). The "date of filing" is the date that the Medicare contractor receives a signed provider enrollment application that the Medicare contractor is able to process to approval. 73 Fed. Reg. 69,725, 69,769 (Nov. 19, 2008) (emphasis added).

Petitioners assert that an enrollment application for Ms. Williams and FHHC was mailed on April 2, 2009 to the Medicare contractor's office. P. Ex. 1, at 1 (setting forth Petitioners' arguments and assertions). Petitioners report having submitted this application with the expectation that they would be able to bill for services, starting May 4, 2009, the start date of Ms. Williams' employment at FHHC. *Id.* Petitioners state that on July 6, 2009, the practice manager at FHHC called the Medicare contractor, because no payments were received for claims submitted for services that Ms. Williams rendered. *Id.* Petitioners assert that at that time, the practice manager was told that they had to file a new enrollment application, because the "original enrollment application completed in April had been lost, misplaced, or stolen." *Id.* It is undisputed that NGS received an enrollment application for Petitioners on July 17, 2009, with a cover letter from the practice manager, dated July 15, 2009, stating that the application was being resubmitted because the NGS system had no record of the April 2009 application and requesting that "it be back dated to May 4, 2009." CMS Ex. 1, at 1-3.

Petitioners were given an effective date of enrollment in the Medicare program of July 17, 2009, the date on which NGS received Petitioners' enrollment forms that were processed to approval. CMS Exs. 5 and 7.

Petitioners' request that they be able to bill for services rendered beginning on May 4, 2009, the date Ms. Williams first rendered services at FHHC, because an initial application was sent by regular mail service on April 2, 2009, and payment for services already rendered to an established provider should not be withheld due to misplaced forms. P. Ex. 1, at 1-2.

In accordance with the above regulations, for me to give Petitioners an effective date of May 4, 2009, the date Ms. Williams began furnishing services at FHHC, it is necessary to prove that an application was received prior to, or on, that date that was approvable as submitted. Here, NGS indicated that it has "no record of receiving an application in April 2009." CMS Ex. 7, at 2. Petitioners have not submitted proof beyond their bald assertions to that effect that an approvable enrollment application was actually submitted to NGS in April 2009.[4] P. Ex. 1, at 1.

Petitioners have submitted no proof at all that NGS ever received any application from them prior to May 4, 2009. Petitioners state that had they "known in April 2009" that NGS might lose forms and have problems receiving documents, "the original packet would have been sent overnight mail with signature required." P. Ex. 1, at 1. That statement amounts to recognition that Petitioners could have taken measures within their own control to establish the date of receipt of their enrollment applications and simply failed to do so. In addition, Petitioners complain that they received no rejection notice, but also state that they did not contact NGS to follow up on the applications allegedly submitted on April 2, 2009 until July 6, 2009, despite representing that they understood processing to take 4-8 weeks and despite beginning to provide services at the new location on May 4, 2009. Obviously, an application that was not received would not be rejected.

Without proof of an earlier date of filing, I do not have the authority to change the effective date of Petitioners' enrollment in the Medicare program. In this case, I must conclude that the effective date determination is correct pursuant to 42 C.F.R. § 424.520(d). Specifically, because May 4, 2009, the date Ms. Williams began furnishing services at FHHC, is earlier than the date the enrollment application that was processed to approval was submitted, it cannot be used as the effective date of Petitioners' enrollment in the Medicare program. *See* 42 C.F.R. § 424.520(d).

Because CMS has come forward with evidence establishing that Petitioners first filed their subsequently-approvable enrollment applications on July 17, 2009, and Petitioners have not responded with any evidence of specific facts establishing that a dispute exists, CMS is entitled to summary judgment. I therefore sustain CMS's determination as to the effective date of Petitioners' Medicare enrollment.

Despite the clarity of this rule, confusion has been introduced by a muddling of the effective date for which a supplier is approved as eligible to bill Medicare, governed by

[4] The application received by NGS in July 209 was not approvable as initially submitted but required additional information to complete processing. CMS Exs. 3 and 4.

42 C.F.R. § 424.520(d), with the earliest date for which an approved supplier may be permitted to bill retroactively for services provided prior to the effective date, if the contractor finds that certain prerequisites are met, governed by 42 C.F.R. § 424.521(a). The contractor in this matter contributed to this confusion by conflating the two date determinations and setting out as the "effective dates" the earliest dates for which it would permit Petitioners to bill retroactively for services provided. CMS Ex. 5, at 2 (letter granting Petitioners' approval to participate in the Medicare program); CMS Ex. 7, at 1 (reconsideration determination letter).

For many years, the question as to the proper effective date was unlikely to arise, because physicians and non-physician practitioners were permitted to bill for services provided up to 27 months retroactively. *See* 73 Fed. Reg. at 69,766. Effective January 1, 2009, however, CMS's regulations were changed to prohibit reimbursement to providers and suppliers for items or services that they provided prior to the dates of their enrollment with narrowly defined exceptions. 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. *Id.* To avoid this problem, CMS considered requiring that billing privileges begin only on the date when the contractor approved the supplier as eligible to receive reimbursement from Medicare and no retroactive billing be permitted. *Id*. Commenters pointed out that this policy would penalize suppliers who demonstrated their eligibility in their enrollment applications but who were not approved for some time thereafter as a result of processing time by their contractors. *Id.* at 69,767. CMS addressed the public concern about contractor processing timeliness by adopting the approach of setting the effective date for approval of eligibility to the date of filing of the enrollment application that was ultimately processed to approval (or the date that the applicant is open for business at the new location, if later). *Id.* CMS explained that "it is not possible to verify that a supplier has met all of Medicare's enrollment requirements prior to submitting an enrollment application." *Id.* Commenters also complained, however, that a prospective supplier might have to begin offering items and services prior to filing an enrollment application and that refusing to pay for those items or services was unfair to them. *Id.* at 69,768. CMS responded that suppliers, including physicians and NPPs are responsible for filing timely enrollment applications and, in most cases, can do so prior to providing Medicare services at a practice location. *Id.* For those situations where they can not, CMS explained that it was - -

> finalizing a provision that allows physicians, NPPs (including CRNAs), and physician or NPP organizations to retrospectively bill for services up to 30 days **prior to their effective date of billing** when the physician or nonphysician organization has met all program requirements, including State licensure requirements, where services were provided at the enrolled practice location prior to the date of filing and circumstances, such as, when a physician is called to work in a hospital emergency department which precluded enrollment in advance of providing services to Medicare beneficiaries in § 424.521(a)(1).

Id. (emphasis added).[5] A careful reading of the regulations and preamble discussions makes clear that the grant of a retroactive billing period of up to 30 days does not constitute a change in the effective date of the supplier's approval of eligibility to participate in Medicare and is based on a showing of circumstances precluding timely enrollment, not a determination of an earlier date of eligibility.

Petitioners do not identify any authority for a right to appeal the grant of, or length of, a retroactive billing period.[6] I do not find that section 498.3(b)(15) permits me to extend the retroactive billing period of the July 17, 2009 application to May 4, 2009. The billing period under section 424.521(a) is retroactive **from the effective date** of approval. It follows that section 498.3(b)(15) does not provide for challenges to the period for retroactive billing beyond an appeal that the effective date of approval itself was wrongly determined. Furthermore, the regulation at section 424.521(a) is binding on me. I can

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[5] The regulations also permit a retroactive billing period of up to 90 days prior to the effective date in certain disaster situations not relevant here. 42 C.F.R. § 424.521(a)(2).

[6] I note that two of the cases on which CMS relied in arguing against any right to appeal an effective date determination actually do not address that issue but rather involved challenges to the period of retroactive billing. First, in *Ruotolo,* DAB CR2029, the ALJ states:

> [W]hile Petitioner argues that I do have authority to hear an decide this matter pursuant to 42 C.F.R. § 498.3(b)(15); that particular authority is inapplicable here as Petitioner does not contend that she was entitled to an earlier effective date of enrollment; rather she argues about when she may begin billing for her services. *See* 42 C.F.R. § 498.3(b)(15).

Id. at 3. Similarly, in *Anawalt*, DAB CR2021, the ALJ states:

> . . . [T]hese cases appear[] to involve a challenge to regulations which govern the time frame for which Medicare will retrospectively reimburse items or services provided prior to the effective dates of enrollment by physicians who are newly enrolled in the Medicare program (or re-enrolled at a point in time after enrollment has lapsed). The regulations are 42 C.F.R. §§ 424.520(d) and 424.521(a).
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> Petitioners' challenge of the regulations and the policies that they embody is not something that I have the authority to hear and decide. As a delegate of the Secretary of this Department I must apply her policies as are stated in regulations. I have no authority to declare a regulation to be unlawful or ultra vires.

Id. at 3.

neither alter nor deviate from its explicit limitation on retroactive billing to the 30 days already granted to Petitioners. Thus, I have no authority to extend the retroactive billing period for Petitioners earlier than June 17, 2009.

In conclusion, the earliest effective date of Petitioners' enrollment in the Medicare program was properly determined to be July 17, 2009. *See* 42 C.F.R. § 424.520(d). Thus, Petitioners' request for billing privileges to start on May 4, 2009, the date on which Ms. Williams began rendering services at FHHC, must be denied.

/s/
Leslie A. Sussan
Board Member