Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Allen Peters, M.D. (Nourishing Wellness Medical Center),
(NPI: 1881608909)

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-10-511

Decision No. CR2148

Date: June 9, 2010

DECISION

I deny the motion of the Centers for Medicare and Medicaid Services (CMS) to dismiss the hearing request of Petitioner, Allen Peters, M.D., and his practice, Nourishing Wellness Medical Center. I grant CMS's motion for summary disposition. Accordingly, the effective date of Petitioner's enrollment remains July 8, 2009, with billing privileges retroactive for 30 days to June 9, 2009, as CMS granted consistent with applicable regulations.

I. Background

Petitioner appeals the October 1, 2009 determination of Palmetto GBA, a CMS contractor, granting Medicare enrollment to Petitioner and his practice and permitting billing effective June 11, 2009, which, during this proceeding, CMS revised to June 9, 2009.[1] Petitioner Hearing Request (PHR); CMS Ex. 6, at 4. Petitioner seeks

[1] CMS reports that Palmetto received the enrollment application on July 8, 2009, and that "Palmetto will correct its records to indicate a June 9, 2009 effective date" for Petitioner, 30 days prior to the receipt of the application, as 42 C.F.R. § 424.521(a)

(continued…)

reimbursement for services rendered back to December 20, 2005, which represents the undisputed effective date of the initial Medicare enrollment of both Petitioner and his practice. PHR at 2; CMS Exs. 13, 14. Palmetto affirmed its determination in a reconsideration decision on January 4, 2010, on the grounds that no right exists to appeal an effective date determination and that Palmetto had determined the effective date in accordance with applicable regulations. CMS Ex. 9.

Petitioner asserts that Medicare has paid none of the claims he submitted since his enrollment, which he attributes to a variety of reasons, including:

- Medicare would not process his claims, because he submitted them on paper instead of electronically, despite his having requested permission to do so;
- His provider number was wrongly deactivated for inactivity, because Medicare would not process the paper claims or because the claims used the provider number of his practice, rather than his individual provider number;
- Medicare misplaced his paperwork seeking reactivation or new enrollment during CMS's change of Medicare contractors, from NHIC, Inc. to Palmetto GBA, Inc. in October 2008; and
- The contractors were confused, because his practice location moved twice since the initial enrollment.

PHR at 1-3; P. Request for Reconsideration (Oct. 6, 2009) at 1-2 (P. Ex. 1; CMS Ex. 7). Petitioner recounts communications in 2009 with a Palmetto employee who agreed that his case had not been handled correctly; however, she left Palmetto's employ before she could expedite the processing of his application, as she had assured would occur. PHR at 2-3. He alleges a "tsunami of carrier/contractor deficiencies involving multiple occasions where the personal or group provider numbers were deactivated and the reactivated and then deactivated, etc." P. Response to CMS Motion at 2.

CMS does not address all of Petitioner's allegations in detail. CMS agrees that NHIC originally enrolled Dr. Peters and Nourishing Wellness in Medicare on November 13, 2006, effective December 20, 2005. CMS Motion at 2; CMS Exs. 13 and 14. CMS also notes that Petitioner wrote to NHIC on April 15, 2008 that, although the group practice number was active, Dr. Peters' individual number had "for some reason" been "rendered inactive" and requested that the number be made active retroactive to the business start

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[1] (…continued)
authorizes. CMS Motion to Dismiss Petitioner's Request for Hearing and/or for Summary Disposition (CMS Motion) at 3 n.4, 4 (citing CMS Exhibit (Ex.) 11, at 1; CMS Ex. 6, at 1).

date. CMS Ex. 15; CMS Motion at 2. NHIC enrolled Petitioner again on July 25, 2008 with the same number effective to December 20, 2005. CMS Ex. 16. On October 14, 2008, Petitioner was notified that Palmetto had replaced NHIC as Medicare contractor. CMS Ex. 17.

Neither party has submitted evidence of direct notice to Petitioner of deactivation of his individual enrollment. However, CMS points to a letter sent by Palmetto on January 27, 2009 to Congresswoman Jane Harmon in response to her inquiry on behalf of Dr. Peters who had complained that he was not receiving payment from Medicare. CMS Motion at 3 (citing CMS Ex. 18). Palmetto explained that it had "terminated" Dr. Peters' Medicare eligibility "due to infrequent billing," because it found "no claims on file under his individual PTAN" notwithstanding his having been "enrolled into the Medicare program since December 20, 2005." CMS Ex. 18, at 1. The letter also stated that to "reenroll as becoming a Medicare provider," Dr. Peters would need to submit an application to the Medicare contractor. CMS Ex. 18, at 2.

Dr. Peters did submit the new application, which Palmetto received on July 8, 2009. CMS Ex. 1. The contractor required additional information, which Dr. Peters submitted timely, and ultimately approved the application and assigned a new individual number permitting retroactive billing for 30 days prior to the date of submission of the application. CMS Exs. 2-6. Petitioner sought reconsideration of the effective date on the grounds that: (1) Palmetto "inadvertently inactivated" his individual billing number, in one of a series of errors, despite diligent and good faith efforts to work with the prior contractor; (2) a pending application "mysteriously disappeared" during the transition to Palmetto; and (3) failing to provide an effective date that allowed billing for services provided for at least the prior two or more years was "unfair." CMS Ex. 7, at 1-2. The hearing officer issued an unfavorable decision on reconsideration. CMS Ex. 9.

Petitioner timely requested a hearing on Palmetto's reconsideration decision. PHR. This case was assigned for hearing and decision to Administrative Law Judge (ALJ) Richard J. Smith. The case was transferred to me for hearing and decision on March 23, 2010, pursuant to 42 C.F.R. § 498.44, which permits a Member of the Departmental Appeals Board (Board) to be designated to hear appeals taken under Part 498.

In a submission dated April 12, 2010, CMS filed its motion to dismiss Petitioner's request for hearing and/or for summary disposition. CMS argues that the effective date of a non-physician practitioner's Medicare enrollment is not an initial determination subject to an appeal and, alternatively, that it properly determined Petitioner's effective date. Petitioner submitted a response to CMS's motion dated April 30, 2010.

CMS submitted with its motion its exhibits 1 through 18. Petitioner submitted, with its request for a hearing and its response to CMS's motion, copies of correspondence with the CMS contractors and other materials, some of which Petitioner reports were submitted to Palmetto with the request for reconsideration. In the absence of any

objection to the admission of CMS's exhibits or Petitioner's materials, or any representation from CMS that Petitioner's submissions constitute new documentary evidence, the admission of which is limited by 42 C.F.R. § 498.56(e), I admit both parties' submissions as evidence. Petitioner's exhibits were not numbered or designated as exhibits, and I have marked them as Petitioner's exhibits 1 – 33.

II. Issues, Findings of Fact, Conclusions of Law

A. Issues

The issues in this case are:

1. Whether Petitioner has a right to a hearing on the effective date of his Medicare participation, and

2. If so, what is the legally correct date on which Petitioners' approval is effective.

B. Findings of fact and conclusions of law

1. I have authority to hear Petitioner's challenge to the determination of the effective date of his approved Medicare enrollment.

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

CMS argues that the Medicare regulations "do not allow a physician supplier whose Medicare enrollment has been approved to appeal the effective date of billing privileges" and that I must therefore dismiss the appeal. CMS Motion at 1-2. As support, CMS cites ALJ decisions adopting CMS's position, principally *Mikhail Paikin, DO*, DAB CR2064 (2010). The ALJ there agreed with CMS that the regulation at 42 C.F.R. § 498.3(b)(15), which permits appeals of "[t]he effective date of a Medicare provider agreement or supplier approval," applies only to providers and suppliers that are enrolled in Medicare on the basis of survey and certification, or accreditation by a CMS-approved accrediting organization (under 42 C.F.R. Part 489), and not to suppliers such as physicians enrolled on the basis of applications submitted under 42 C.F.R. Part 424. CMS Motion at 6-10 (citing *Peter Manis, M.D.*, DAB CR2036 (2009) and *Rachel Ruotolo, M.D.*, DAB

CR2029 (2009)).[2] *Paikin* also held that 42 C.F.R. § 424.545 provides for appeals only of denials of enrollment applications or revocations of billing privileges and thus does not, CMS argues, permit an appeal by Petitioner whose application was approved.

In several prior decisions, I have explained why I do not agree with CMS and the decisions it cites. *See Michael Majette, D.C.*, DAB CR 2142 (2010); *see also Eugene Rubach, M.D.*, DAB CR2125 (2010); *Mobile Vision, Inc.*, DAB CR2124 (2010). I adopt the reasoning explained in my prior decisions, which I summarize briefly here.

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. None of the administrative actions identified in section 498.3 as *not* subject to appeal under Part 498 include the determination of an effective date for a provider or supplier to participate in Medicare.

While subpart P of part 424 unquestionably does grant appeal rights from denials and revocations, as CMS notes, it does so by reference to the provisions of subpart A of Part 498, stating 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). Subpart A of Part 498 includes section 498.3(b)(15), yet CMS did not exclude section 498.3(b)(15) or otherwise indicate that effective date determinations would not be proper subjects for these Medicare hearings. When CMS published subpart P of Part 424 in 2006 (71 Fed. Reg. 20,753, 20,776 (Apr. 21, 2006)), it was well-aware of the longstanding provision in section 498.3(b)(15), which it had described in 1997 as granting "appeal rights and procedures for entities that are dissatisfied with effective date determinations." 62 Fed. Reg. at 43,931-32 (Aug. 18, 1997). Yet, section 424.545(a) incorporated section 498.3 without limitation. Hence, the plain language of section 424.545(a) reinforces the plain language of section 498.3(b)(15).

The history of section 498.13(b)(15) shows CMS's recognition that: (1) approving participation at a date later than that sought amounts to a denial of participation during the intervening time, (2) effective date appeals generally involves the same kind of compliance issues that arise from initial denials, and (3) the right to appeal an effective

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[2] I note that, in *Ruotolo*, the petitioner did not argue that she was entitled to an earlier effective date but challenged the lawfulness of the regulation, thus seeking relief that I agree I am not authorized to grant. *Ruotolo*, DAB CR2029, at 3. Additionally, as CMS acknowledges, other ALJs in a number of recent cases 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, that is, of a provider agreement or of supplier approval. CMS Motion at 9 n.9 (*citing cf., Jason Wardell, P.A.*, DAB No. CR2095 (2010) and *Jorge M. Ballesteros, CNRA*, DAB CR2067 (2010)).

date determination, while not previously codified, had already been confirmed by court decisions. 62 Fed. Reg. 43,931, 43,933-34 (1997) (final rule); 57 Fed. Reg. 46,362, 46,363 (Oct. 8, 1992) (proposed rule). While rules for determining effective dates adopted at the same time as section 498.3(b)(15) applied only to providers and suppliers subject to certification or accreditation, the rulemaking addressing section 498.3(b)(15) contains no language parallel to that addressing determining effective dates, limiting its application to only providers and suppliers that are subject to survey and certification or accreditation. 62 Fed. Reg. at 43,934; 57 Fed. Reg. at 46,363. The rulemakings do not indicate any intent to restrict the scope of appeals by others who might later be granted the right to Medicare hearings.

That the regulations do not provide for appeals of deactivations[3] is not relevant here. If anything, this limitation, as with the bar on appealing rejections as opposed to denials of enrollment at section 424.525, illustrates that when CMS wishes to restrict or preclude appeal rights, it is capable of doing so expressly. CMS does not identify any analogous provision limiting challenges to adverse effective date determinations.

The ALJ in *Paikin*, despite accepting CMS's contention that the plain language of section 498.3(b)(15) could be interpreted to preclude effective date appeals in the case of approval of enrollment, reached the underlying facts and determined that the effective date and retrospective billing date had been established consistent with 42 C.F.R. §§ 424.520(d) and 424.521(a). *Paikin*, DAB CR2064, at 6. I find no room for such an interpretation where the regulatory language is plain on its face. A legislative rule is generally binding on the agency that issues it, and the agency is legally bound to follow its own regulations as long as they are in force. *California Dep't of Soc. Servs.*, DAB No. 1959 (2005); *Hermina Traeye Mem'l Nursing Home*, DAB No. 1810 (2002) (citing Kenneth Culp Davis and Richard J. Pierce, Jr., *Administrative Law Treatise* § 6.5 (3rd ed. 1994)), *aff'd Sea Island Comprehensive Healthcare Corp. v. U.S. Dep't of Health and Human Servs*, 79 F. App'x 563 (4th Cir. 2003); 2 Am. Jur. 2d Administrative Law § 236. Absent further rulemaking, CMS and I are bound to follow the plain meaning of the regulation permitting an appeal by any provider or supplier dissatisfied with a determination as to the effective date of its provider agreement or supplier approval.

c. Conclusion

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

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[3] CMS points out that the ALJs in *Paikin* and *Bradley D. Anawalt, M.D., et al.*, DAB CR2021 (2009), held that no right exists to a hearing on a deactivation. CMS Motion at 9-10. Indeed, section 424.545(b) permits only the opportunity to submit "a rebuttal." I agree that deactivation is not identified as an appealable initial determination, and no process beyond submission of rebuttal is identified in the regulations in the case of a deactivation.

I note, however, that a right to challenge the effective date is not a license to seek an effective date other than that prescribed by law. I turn next, therefore, to what the applicable law provides as to the proper effective date in Petitioner's circumstances.

2. I grant CMS summary disposition on the ground that it properly determined the effective date of Petitioner's participation in Medicare.

a. Applicable standard

The Board stated the standard for summary judgment as follows.

> Summary judgment is appropriate when the record shows that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law . . . . The party moving for summary judgment bears the initial burden of showing that there are no genuine issues of material fact for trial and that it is entitled to judgment as a matter of law . . . . To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact – a fact that, if proven, would affect the outcome of the case under governing law . . . . In determining whether there are genuine issues of material fact for trial, the reviewer must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor.

Senior Rehab. & Skilled Nursing Ctr., DAB No. 2300, at 3 (2010) (citations omitted). The role of an ALJ in deciding a summary judgment motion differs from the ALJ's role in resolving a case after a hearing. The ALJ should not assess credibility or evaluate the weight of conflicting evidence. *Holy Cross Village at Notre Dame*, DAB No. 2291, at 4-5 (2009).

b. Applicable regulations

The determination of the effective date of Medicare billing privileges is governed by 42 C.F.R. §§ 424.520 and 424.521. Section 424.520(d) provides that 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. 69,769 (Nov. 19, 2008) (emphasis added). Certain suppliers, including physicians, may be permitted to bill

retrospectively for certain services provided before approval, if they have met all program requirements. Current regulations limit retrospective billing to 30 days prior to the effective date, "if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries," or 90 days in certain disaster situations. 42 C.F.R. § 424.521(a).

c. Analysis

Petitioner asserts that he is "not contesting the 'effective date'" for his practice but seeking to appeal claims he says were wrongly denied or not paid since his initial enrollment in Medicare in December 2005. P. Response at 2. This request is beyond the scope of my review authority. I do not find, and Petitioner does not identify, any authority for me to review denials of claims for payment. Medicare beneficiaries, and in some cases providers and suppliers, may appeal denials of individual claims for Medicare coverage or benefits through the Medicare carrier or fiscal intermediary and then through the Office of Medicare Hearings and Appeals and the Medicare Appeals Council. *See* 42 C.F.R. Part 405, Subparts G, H, I; 74 Fed. Reg. 65,295 (Dec. 9, 2009). Denials of claims are not among the initial determinations in Part 498 that I may review in this forum. Additionally, Petitioner has provided no documentation of any individual Medicare claims that he submitted for reimbursement.

Furthermore, the relief Petitioner seeks would necessarily entail reversal of CMS's effective date determination, since Petitioner cannot receive payment for services provided during a period for which he was not enrolled in Medicare and not eligible for any retroactive billing privileges. Petitioner's appeal rights in this forum are limited to the "initial determinations" specified at 42 C.F.R. § 498.3. Of those initial determinations, the only one relevant here is CMS's determination of "[t]he effective date of a Medicare provider agreement or supplier approval," that is, CMS's decision granting Petitioner's application for enrollment and setting the effective date for billing Medicare. 42 C.F.R. § 498.3(b)(15). Petitioner essentially seeks the ability to receive Medicare reimbursement for periods prior to that date.

The date of receipt of an application, which the contractor could process to approval, is not in dispute. The record indicates no legal error by CMS in applying the regulation to the undisputed facts. CMS's determination that Petitioner may bill Medicare effective June 9, 2010, 30 days prior to the date on which Palmetto received Petitioner's enrollment application, is consistent with the applicable regulations quoted above. 42 C.F.R. §§ 424.520(d), 424.521(a). Petitioner does not, in fact, dispute that CMS correctly applied the regulation here.

The facts that Petitioner does allege relate to matters apart from that effective date determination and the approved application that I have no authority to review. Petitioner's reports that the two successive contractors were negligent in handling his case and that an individual formerly employed by Palmetto made commitments that were

not honored, provide no basis for me to set an effective date earlier than specified in the regulations or authorize payment for individual claims. Such arguments seek estoppel against the federal government, which, if available at all, is presumably unavailable absent "affirmative misconduct," such as fraud. *See, e.g.*, *Pacific Islander Council of Leaders*, DAB No. 2091 (2007); *Office of Personnel Management v. Richmond*, 496 U.S. 414, 421 (1990). Petitioner's frustration over the events he describes is understandable, and there appears to have been no shortage of confusion over the enrollment status of Petitioner and his practice. However, this does not permit me to ignore the unmistakable requirements of the regulations governing his enrollment in Medicare, by which I am bound.[4]

It appears that one source of confusion is the fact that Medicare regulations changed effective January 1, 2009 to eliminate the prior practice of granting physician suppliers up to 27 months of retroactive billing privileges and substitute the current rule that retroactive billing privileges may be granted only for 30 days from the effective date of approval of enrollment (or 90 days in certain disasters). 73 Fed. Reg. at 69, 726, 69,940. Contractor employees may thus have correctly indicated at some point in the communications with Petitioner that his "retroactivity date would go back, at minimum, 2+ years." However, by the time that the contractor received the approvable application, that option was no longer legally available. PHR at 2.

I accept as true for purposes of summary judgment Petitioner's contentions that: (1) on several occasions his personal and group billing privileges were deactivated improperly; (2) he submitted at various times claims which were denied or not processed; and (3) he acted in good faith and followed instructions in his efforts to establish billing privileges, to provide care, and to seek payment. It is also not clear to me that the Medicare contractor correctly advised Petitioner to reapply for enrollment. Petitioner has not, however, identified, and I do not find, any authority for me to alter the effect of the governing regulations on the effective date resulting from the application that Petitioner filed on July 9, 2009. As far as Petitioner's concerns about the deactivations, as noted above, the regulations provide only for a deactivated supplier to submit a rebuttal to the contractor under 42 CFR § 424.545(b), in accordance with 42 CFR § 405.374.[5] A denial of reactivation after rebuttal is not appealable to an ALJ. Palmetto's reconsideration

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[4] CMS characterizes Petitioner's arguments as "implicit challenges to the lawfulness of the regulations" at 42 C.F.R.§§ 424.520(d) and 424.521(a). CMS Motion at 8-9. While Petitioner has not directly argued that these regulations are unlawful, I agree with CMS that I have no authority to find them invalid. *Id.*

[5] CMS may deactivate a supplier's Medicare billing privileges if the supplier "does not submit any Medicare claims for 12 consecutive calendar months." 42 C.F.R. § 424.540(a)(1). The regulations do not provide for notifying suppliers regarding the deactivation under those circumstances.

decision also discloses no indication that Petitioner's submission of paper, instead of electronic claims, was the basis for the adverse determination, as Petitioner suggests, and Petitioner in any event states that he does not have documentation of communications concerning his desire to submit paper claims. P. Response at 1.

Petitioner has thus alleged no dispute of fact material to this appeal, and summary disposition is appropriate here.

d. Conclusion

The earliest effective date for the approval of Petitioner's enrollment in Medicare was July 8, 2009, the date of the filing of his enrollment application, with retrospective billing privileges permitted back 30 days to June 9, 2009. Thus, Petitioner's request for an earlier effective date or for earlier billing privileges must be denied.

Because there is no genuine issue to any material fact, and for the foregoing reasons, I grant CMS's motion for summary disposition.

/s/
Leslie A. Sussan
Board Member