Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Roland J. Pua, M.D.,
(NPI: 1215009782),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-10-457

Decision No. CR2163

Date: June 22, 2010

DECISION

I deny the motion of the Centers for Medicare and Medicaid Services (CMS) to dismiss the hearing request of Petitioner, Roland J. Pua, M.D. I grant CMS's motion for summary disposition. Accordingly, the effective date of Petitioner's enrollment as a provider in the Medicare program is June 24, 2009, the filing date of the enrollment application. Pursuant to 42 C.F.R. § 424.521(a) and as the Medicare contractor granted, Petitioner may retrospectively bill for services rendered as of May 24, 2009.

I. Background

Petitioner Roland J. Pua, M.D., first started seeing patients at The Medical Group in North Las Vegas, Nevada, on January 1, 2009. Hearing Request Letter, dated January 15, 2010 (HR). On June 6, 2009, Petitioner submitted an enrollment application, form CMS-855I, to participate in the Medicare program and requested an effective date of enrollment of January 1, 2009 in several sections of the enrollment application. HR.

By letter dated September 17, 2009, Palmetto GBA, a Medicare contractor, approved Petitioner's enrollment in the Medicare program. The effective date of Petitioner's enrollment in the Medicare program was based on the filing date of June 24, 2009, and Petitioner was provided the benefit of a 30-day period of retroactive billing back to May 24, 2009.[1] CMS Exs. 2, 9.

Petitioner filed a reconsideration request, asking Palmetto GBA to change the effective date to January 1, 2009, the date on which Petitioner began caring for Medicare patients at The Medical Group. Reconsideration Request Form.

Palmetto denied Petitioner's request, and stated, in pertinent part:

> All of the documentation in the file for this case has been reviewed and the decision has been made in accordance with Medicare guidelines as outlined in Federal Register 42 CFR § 424.520 and 424.521.

Reconsideration Decision Letter, dated January 4, 2010. Petitioner then timely submitted a request for hearing to the Civil Remedies Division (CRD) of the Departmental Appeals Board (DAB), again requesting an effective date of January 1, 2009. HR.

This case was initially assigned to Administrative Law Judge (ALJ) Richard J. Smith who issued an initial order on March 10, 2010. On April 12, 2010, CRD received CMS's Motion to Dismiss and/or Motion for Summary Disposition, dated April 8, 2010. This case was transferred to me on April 13, 2010.

On May 4, 2010, Petitioner's representative telephoned inquiring about the status of this case and was advised to submit any arguments that it wished to make to the DAB and to counsel for CMS. No submission was received from Petitioner. On May 24, 2010, I ordered the record in the case closed. I indicated in that Order Closing Record that I will proceed to rule on CMS's motions based on the record.

On May 28, 2010, I received a second Motion to Dismiss and/or Motion for Summary Disposition from CMS, dated May 25, 2010. In that motion, CMS argued that, as stated in the initial order issued by ALJ Smith, "[a]ny [potentially-dispositive] motions not opposed . . . will be treated as conceded and will be granted without further notice."

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[1] The "effective date" listed in the approval letter is May 24, 2009, which is described as "30 days [prior to] the receipt date of the application, per Title 42 CFR § 424.521(a)(1)." In other words, that "effective date" is the date to which Petitioner may retroactively bill for services. It follows that the "effective date" of Petitioner's enrollment in the Medicare program, pursuant to 42 C.F.R. § 424.520(d), was determined to be June 24, 2009, the receipt date of Petitioner's enrollment application.

CMS argues that because Petitioner did not submit a motion by the April 8, 2010 deadline and did not respond to CMS's motion within the required twenty days after the date of mailing, its motion dated April 8, 2010 "should be treated as conceded by Petitioner and granted without further notice." I deny the May 25, 2010 motion to dismiss the case on these grounds and will proceed to rule on CMS's April 8, 2010 motion based on the record, as I indicated in my May 24, 2010 Order Closing Record.

CMS accompanied its April 8, 2010 motion and supporting memorandum with CMS Exs. 1-9, which I admit into evidence.

Petitioner accompanied its hearing request letter dated January 15, 2009 with: (1) part of its Medicare Enrollment Application CMS-855I; (2) Palmetto GBA's letter to Petitioner dated September 17, 2009, approving Petitioner's participation in the Medicare program; (3) the Reconsideration Request form that Petitioner filed; and (4) Palmetto GBA's reconsideration decision letter dated January 4, 2010. I mark these documents as Petitioner's Exhibits (P. Exs.) 1-4, respectively, and admit them into evidence for purposes of this decision.

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, whether the effective date should be January 1, 2009, the date on which Petitioner first rendered services at The Medical Group.

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 when a party requesting a hearing "does not otherwise have a right to a hearing."

b. Analysis

CMS argues that the Medicare regulations "do not permit the Petitioner to appeal the effective date of . . . enrollment in the Medicare program" and that I must therefore dismiss the appeal. CMS Motion at 13. 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 13-14, citing *Rachel Ruotolo, M.D.*, DAB CR2029 (2009) and *Bradley D. Anawalt, M.D., et al.*, DAB CR2021 (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."

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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 14 (*citing cf., Victor Alvarez, M.D.*, DAB CR2070 (2010) and *Jorge M. Ballesteros, CNRA*, DAB CR2067 (2010)).

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 involve the same kind of compliance issues that arise from initial denials; and (3) the right to appeal an effective date determination, while not previously codified, had already been confirmed by court decisions. 62 Fed. Reg. at 43,933-34 (final rule); 57 Fed. Reg. 46,362, 46,363 (Oct. 8, 1992) (proposed rule). While criteria for determining effective dates adopted at the same time as section 498.3(b)(15) expressly applied only to providers and suppliers subject to certification or accreditation, the part of the rulemaking addressing section 498.3(b)(15) contains no language parallel to that addressing the criteria for setting effective dates to limit 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 initial and final rulemakings do not indicate any intent to restrict the scope of appeals by others who might later be granted the right to Medicare hearings.

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. *Cal. 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 & 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.

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; *compare* Joint Signature Memorandum (JSM) issued by CMS on May 7, 2009 *with* JSM issued by CMS on November 2, 2009. CMS maintains that its "earlier policy guidance is not binding on this tribunal and cannot be applied so as to conflict with applicable statutory and regulatory law." CMS Br. at 17.

In several prior decisions, I have explained why CMS's discussion of its two policy issuances provides no basis to ignore the plain language of section 498.3(b)(15) that grants the right to appeal "[t]he effective date of a Medicare provider agreement or supplier approval" and demonstrates no contrary regulatory intent. *See Michael Majette, D.C.*, DAB CR2142, at 10-11; *Family Healing Healthcare Clinic*, DAB CR2133, at 8-9 (2010). I adopt the reasoning explained in my prior decisions and briefly summarize my conclusion here.

As CMS itself notes, its policy guidance "cannot be applied so as to conflict with applicable statutory and regulatory law." CMS Br. 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.'"). Moreover, CMS's reversal of its position in the November 2, 2009 JSM 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.

c. Conclusion

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

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 Vill. at Notre Dame*, DAB No. 2291, at 4-5 (2009).

b. Analysis

In his letter requesting a hearing, dated January 15, 2010, Petitioner argues for an effective date of January 1, 2009, stating:

> Our application indicated that our practice started seeing Medicare patients on January 1, 2009 and indicated so on page 18 section 4E effective date of add 1/1/09, page 20 Section 6A effective date of add 1/1/09, page 21 section 8 effective date of add 1/1/09, and Medicare Participation agreement OMB No 0938-0373 section 2 effective date of the agreement 01/01/2009.
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> ***
>
> We are clear on our initial original CMS-855I of the effective date we requested and on the Participation agreement that was submitted. Under Title 42 Code of Federal Regulations 424.520 "the date an enrolled physician or non-physician practitioner first began furnishing services at a new practice location."
>
> The CMS-855I was submitted with the effective date that the physician began furnishing services at a new practice location and I am requesting an Appeal regarding the determination of the effective date of participation for CCN: 09173102500026-003.

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 physicians 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).

Here, the date of filing of a Medicare enrollment application that the Medicare contractor subsequently approved is June 24, 2009. CMS Ex. 9; *see* P. Ex. 2. The date Petitioner first began furnishing services at a new practice location, at The Medical Group, is June 1, 2009. HR. Because the date of filing of Petitioner's enrollment application is later than the date Petitioner first provided services at a new location, in accordance with section 424.520(d), the date of filing, June 24, 2009, must be used as the effective date of Petitioner's enrollment in the Medicare program.

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).

As indicated in Palmetto GBA's letter dated September 17, 2009, Petitioner was granted that 30-day period of retrospective billing to May 24, 2009. P. Ex. 2; CMS Ex. 2. Thus, the date from which Petitioner may retrospectively bill for services rendered is May 24, 2009, thirty days prior to the date of filing of Petitioner's enrollment application. I do not have the authority to grant a longer retrospective billing period than that allowed by statute.

III. Conclusion

The effective date of Petitioner's enrollment in the Medicare program was properly determined based on the June 24, 2009 filing date of Petitioner's enrollment application. *See* 42 C.F.R. §424.520(d). Thus, Petitioner's request for billing privileges to start on January 1, 2009, the date on which Petitioner began rendering services at The Medical Group, must be denied.

/s/
Leslie A. Sussan
Board Member