Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Bellingham Medical Clinic, Inc.,
(PTAN: G8900457)
(NPI: 1457532004)

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-17-441

Decision No. CR4973

Date: November 22, 2017

DECISION

Noridian Healthcare Solutions (Noridian), a Medicare administrative contractor (MAC) for the Centers of Medicare and Medicaid Services (CMS), deactivated the Medicare enrollment and billing privileges of Bellingham Medical Clinic (Bellingham) as of July 31, 2016. Noridian revalidated Bellingham's Medicare enrollment and billing privileges effective August 30, 2016. Noridian concluded that Bellingham was not permitted to bill Medicare from July 31 through August 29, 2016. Gittle Goodman, M.D. (Dr. Goodman), the sole owner of Bellingham, requested that the effective date of Bellingham's enrollment be changed to eliminate the lapse in Bellingham's billing privileges. For the reasons discussed below, I find that Noridian did not apply the CMS guidance in effect at the time Dr. Goodman requested revalidation. The applicable guidance provides that Bellingham's effective date of enrollment prior to deactivation remains unchanged. I therefore reverse the reconsidered determination setting Bellingham's revalidation effective date as August 30, 2016.

I. Background and Procedural History

By letter dated May 12, 2016, Noridian requested that Dr. Goodman revalidate her Medicare enrollment information. CMS Exhibit (Ex.) 6. The letter notified Dr. Goodman that she was required to revalidate her Medicare enrollment record by July 31, 2016. *Id.* The letter instructed her to update or confirm all the information in her records, including her practice locations and reassignments.[1] *Id.* Finally, the letter stated that if Dr. Goodman failed to respond to the notice, her billing privileges might be deactivated, which would result in a gap in reimbursement. *Id*. Dr. Goodman did not respond to the revalidation request and Noridian deactivated Petitioner's billing privileges effective July 31, 2016. CMS Ex. 3 at 2.

On August 30, 2016, Dr. Goodman submitted a web application (#883628184) to Noridian via the Provider Enrollment, Chain and Ownership System (PECOS). CMS Ex. 7. In a September 14, 2016 email, Noridian asked for revisions to the August 30, 2016 web application. CMS Ex. 5. On September 15, 2016, Noridian sent a follow-up email stating that some, but not all of the requested information had been received. CMS Ex. 4.

By letter dated September 23, 2016, Noridian notified Dr. Goodman that it had approved Bellingham's revalidation. CMS Ex. 3 at 1. The letter also stated that a lapse in Medicare coverage had occurred from July 31, 2016, to August 29, 2016. *Id*. at 2.

In a letter dated October 1, 2016, Dr. Goodman requested that Noridian reconsider its determination that Bellingham's effective date of reactivation was August 30, 2016. CMS Ex. 2. Dr. Goodman argued that the effective date should be August 1, 2016. *Id.* She explained that "[she] is a single provider practice that is nearly 80% Medicare… we did everything we were instructed to do and were told that there would not be any breaks in payments." *Id.*

Noridian issued an unfavorable reconsidered determination dated January 6, 2017. CMS Ex. 1 at 2. The reconsidered determination stated, "According to 42 C.F.R. § 424.520(d), the effective date once a PTAN [provider transaction access number] is deactivated is the date the contractor receives the application that is processed and is not eligible for retrospective billing . . . [Since Bellingham] had not provided evidence to definitely support an earlier effective date . . . Noridian Healthcare Solutions is not granting you . . . a new effective date." *Id*.

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[1] The revalidation letter is addressed solely to Dr. Goodman. There is no evidence that Noridian ever requested revalidation of Bellingham itself. Yet, Noridian deactivated Bellingham, and not Dr. Goodman. CMS Ex. 7. Because Dr. Goodman is the sole owner of Bellingham, it appears that the deactivation of either Dr. Goodman or Bellingham would prevent the other from billing Medicare. Nevertheless, it would be better practice for CMS contractors to be precise in making requests for revalidation.

In a letter dated February 1, 2017, Dr. Goodman requested an administrative law judge hearing.[2] The case was assigned to me and I issued an Acknowledgment and Prehearing Order (Prehearing Order), dated March 20, 2017. Pursuant to the Prehearing Order, CMS filed a motion for summary judgment (CMS Br.) and seven proposed exhibits (CMS Exs. 1-7). Dr. Goodman filed a letter, dated May 20, 2017[3] (Petitioner's (P.) Br.) and two proposed exhibits (P. Exs. 1-2). Neither party objected to the exhibits proposed by the opposing party. Therefore, in the absence of objection, I admit CMS Exs. 1-7 and P. Exs. 1-2 into the record.

Neither party proposed to call any witnesses. As I informed the parties in my Prehearing Order, a hearing is only necessary if a party offers the written direct testimony of a witness and the opposing party requests to cross-examine the witness. Prehearing Order ¶ 10. Although CMS moved for summary judgment, because an in-person hearing to cross-examine witnesses is not necessary, I decide this case based on the written record, without considering whether the standards for summary judgment are satisfied.

II. Issue

The issue in this case is whether Noridian, acting on behalf of CMS, properly determined that the effective date for reactivation of Bellingham's Medicare billing privileges was August 30, 2016, the date Noridian received the revalidation application.

III. Jurisdiction

I have jurisdiction to hear and decide this case. 42 C.F.R. §§ 424.545(a), 498.3(b)(15), (17), 498.5(*l*)(2); *see also* Social Security Act (Act) § 1866(j)(8) (codified at 42 U.S.C. § 1395cc(j)(8)).

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[2] The letter is postmarked March 8, 2017. My office received it March 13, 2017. A hearing request must be filed within 60 days after the affected party receives the reconsidered determination. 42 C.F.R. § 498.40(a)(2). I presume that Dr. Goodman received Noridian's reconsidered determination five days after the date of the notice, or January 11, 2017. 42 C.F.R. § 498.22(b)(3), *incorporated by reference in* 42 C.F.R. § 498.40(a)(2). Therefore, her hearing request was timely, as it was filed on or before March 13, 2017.

[3] Dr. Goodman's letter was filed in the DAB E-File system on May 30, 2017 under the title "medicare_file.pdf."

IV. Discussion

A. Statutory and Regulatory Background

The Social Security Act authorizes the Secretary of Health and Human Services to promulgate regulations governing Medicare enrollment for providers and suppliers. Act § 1866 (j) (42 U.S.C. §§ 1302, 1395cc(j)). Providers and suppliers must enroll in the Medicare program to receive payment for covered Medicare items or services. 42 C.F.R. § 424.505. The regulations define enrollment: "*Enroll/Enrollment* means the process that Medicare uses to establish eligibility to submit claims for Medicare covered services and supplies." 42 C.F.R. § 424.502. A "provider or supplier must submit a complete enrollment application and supporting documentation to the designated Medicare fee-for-service contractor," and the application must include "complete, accurate, and truthful responses to all information requested within each section as applicable to the provider or supplier type." 42 C.F.R. § 424.510(d)(1)-(2). "Once the provider or supplier successfully completes the enrollment process . . . CMS enrolls the provider or supplier into the Medicare program." 42 C.F.R. § 424.510(a).

Once enrolled, "[t]he provider or supplier must meet the submission, content, signature, verification, operational, inspection, and other requirements outlined in § 424.510." 42 C.F.R. § 424.515(a). CMS contacts the "provider or supplier directly when it is time to revalidate their enrollment information." 42 C.F.R. § 424.515(a)(1). Once contacted, the "provider or supplier must submit to CMS the applicable enrollment application with complete and accurate information and applicable supporting documentation within 60 calendar days of our notification to resubmit and certify to the accuracy of its enrollment information." 42 C.F.R. § 424.515(a)(2). "Medicare providers and suppliers…may be required to revalidate their enrollment outside the routine 5-year revalidation cycle." 42 C.F.R. § 424.515(e). CMS will contact providers or suppliers to revalidate their enrollment for off-cycle revalidation. 42 C.F.R. § 424.515(e)(1).

If a provider or supplier does not properly revalidate its enrollment information, billing privileges may be stopped ("deactivated"). 42 C.F.R. § 424.540(a)(3). The decision of CMS or its contractor to deactivate a provider or supplier is not an initial determination subject to administrative review. *See* 42 C.F.R. §§ 498.3(b), 424.545(b).

B. Findings of Fact, Conclusions of Law, and Analysis[4]

1. I may not review whether Noridian properly deactivated Bellingham's Medicare billing privileges.

Dr. Goodman's principal argument is that Bellingham's enrollment effective date should be August 1, 2016, rather than August 30, 2016, so that Bellingham would not be subject to a lapse in its Medicare billing privileges. P. Br. at 1. This could be read as an argument that Bellingham should not have been deactivated. As I explain in this section, it appears to me that Noridian acted prematurely in deactivating Bellingham's Medicare billing privileges. Nevertheless, I am unable to set aside the deactivation, even though I believe the deactivation was not imposed consistent with CMS guidance in effect at the time. This is because the regulations do not authorize administrative law judge review of CMS's or its contractor's determination to deactivate a supplier's Medicare billing privileges. Rather, the only avenue of review for a supplier whose billing privileges are deactivated is to file a rebuttal statement with CMS or its contractor. *See* 42 C.F.R. § 424.545(b). In this case, the prohibition on administrative review prevents me from remedying what appears to be an incorrect deactivation by CMS's contractor.[5]

By letter dated May 12, 2016, Noridian sent Dr. Goodman a request to revalidate her Medicare enrollment information. CMS Ex. 6. The letter stated that Dr. Goodman must revalidate by July 31, 2016, or risk a lapse in billing privileges. *Id.* It is undisputed that Dr. Goodman did not respond to the revalidation request until August 30, 2016. Guidance published by CMS in Chapter 15 of the Medicare Program Integrity Manual (MPIM), CMS Pub. 100-08, (Rev. 578, Effective May 15, 2015), provided that if a supplier did not respond to a revalidation request, the contractor was to apply a "pend

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[4] My findings of fact/conclusions of law appear as numbered headings in bold italic type.

[5] My observation that Noridian may have incorrectly deactivated Bellingham is based on my reading of CMS interpretive guidance. Because the language of 42 C.F.R. § 424.540(a)(3) is permissive (CMS "may" deactivate), CMS is free to issue interpretive guidance explaining the circumstances under which it will exercise its discretion. As discussed herein, CMS did so in the Medicare Program Integrity Manual. I am not bound by CMS's manual provisions; they are not entitled to the same force and effect as the regulations themselves. In general, however, where a regulation is susceptible to more than one interpretation, administrative law judges and appellate panels of the Departmental Appeals Board (DAB) defer to CMS's interpretation so long as it is a reasonable reading and not inconsistent with the regulation and the affected party had notice. *See, e.g.*, *Marcia M. Snodgrass, APRN*, DAB No. 2646 at 9 n.10 (2015) (*citing Ark. Dep't of Health & Human Res.*, DAB No. 2201, at 12 (2008) & *Missouri Dep't of Soc. Servs.*, DAB No. 2184 (2008)). Therefore, in this decision, I defer to CMS's interpretation of its deactivation/revalidation authority as expressed in the MPIM.

status." MPIM (Rev. 578) § 15.29.3.2. The pend status imposes a temporary hold on Medicare payments to the supplier. *Id.* CMS instructed its contractors to impose the pend status if they did not receive a response to the revalidation notice within 71 to 75 days after the date of the notice. *Id.* I take administrative notice that July 26, 2016 is 75 days after May 12, 2016, the date of Noridian's revalidation request to Dr. Goodman.

The MPIM further instructed, "If a revalidation application has not been received by days 120 – 125 of sending the revalidation notice, the contractor shall end-date the pend status and deactivate the provider's or supplier's enrollment record (including all associated PTANs) in PECOS." MPIM (Rev. 578) § 15.29.3.3. In the present case, Noridian received Dr. Goodman's revalidation application on August 30, 2016. I take administrative notice of the fact that August 30, 2016, is 110 days after May 12, 2016.[6]

According to the MPIM, if a supplier submits a revalidation application while in pend status, the contractor will remove the pend status, "even though the application has not been processed to completion." MPIM (Rev. 578) § 15.29.4.2. By contrast, if the contractor receives a revalidation application after it has deactivated the supplier, the supplier "must submit a full application to revalidate." MPIM (Rev. 578) § 15.29.4.3.

As I read the MPIM instructions, because Dr. Goodman had not revalidated her enrollment information by July 26, 2016 (the 75th day after the revalidation notice), Noridian was authorized to apply a temporary hold to Dr. Goodman's (and Bellingham's) Medicare billing privileges by placing their privileges in a pend status. However, because Dr. Goodman submitted her revalidation application before 120 days had elapsed from the date of the notice, Noridian should have removed the pend status and not deactivated Dr. Goodman or Bellingham. As I have stated, I may not review or set aside Noridian's deactivation of Bellingham's Medicare enrollment and billing privileges even though it appears to have been imposed incorrectly. Nevertheless, for the reasons explained in the following section, I conclude that Noridian similarly did not apply CMS guidance correctly in determining the effective date of Bellingham's revalidation.

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[6] By its terms, 42 C.F.R. § 424.540(a)(3) *permits* (but does not require) CMS to deactivate a supplier's billing privileges 90 days after a revalidation request if the supplier has not responded. Yet, even by this measure, Bellingham should not have been subject to deactivation before August 10, 2016 (90 days after May 12, 2016).

2. CMS guidance in effect on August 30, 2016 provided that Bellingham's effective date of Medicare enrollment and billing privileges remained October 12, 2010; therefore, a lapse in billing privileges did not occur.

As discussed in the previous section of this decision, Revision 578 of the MPIM was in effect on August 30, 2016, the date Dr. Goodman submitted the revalidation application at issue. By September 23, 2016, the date of Noridian's initial determination regarding the effective date of revalidation (CMS Ex. 3), CMS had published Revision 685 to the MPIM, which was effective September 6, 2016. This is significant because, in Revision 685, CMS changed its instructions to contractors regarding how they were to process the revalidation applications of deactivated providers and suppliers.

In the version of the MPIM in effect on August 30, 2016, CMS instructed contractors that suppliers would only be subject to a new enrollment date (and, thereby, a lapse in billing privileges), if the contractor received the revalidation application more than 120 days after the date of *deactivation* (*not* 120 days after the revalidation request):

> The contractor shall reactivate the deactivated PTAN(s) within 15-20 days of receiving the revalidation application or missing information, even though the revalidation has not been processed to completion. <u>The PTAN and effective date shall remain the same if the revalidation application was received prior to 120 days after the date of deactivation.</u> If the revalidation is received more than 120 days after deactivation, a new PTAN and effective date shall be issued to the provider or supplier, consistent with the effective date requirements in section 15.17 of this chapter.

MPIM (Rev. 578) § 15.29.4.3 (underscore added). In the present case, Dr. Goodman submitted a revalidation application within 30 days after the date of deactivation (which, as noted above, was premature under applicable guidance). Accordingly, if the instructions in Revision 578 apply, Bellingham would not be subject to a new effective date.

By contrast, in Revision 685, effective September 6, 2016, CMS explained that, once a supplier had been deactivated, it would have to submit a new application and be subject to a new enrollment effective date, without regard to when the revalidation application was received:

> MACs shall require the provider/supplier to submit a new full application to reactivate their enrollment record after they have been deactivated. The MAC shall process the application as a reactivation and establish an effective date based on the receipt date of the application. The provider/supplier shall maintain their original PTAN but the MAC shall

> reflect a gap in coverage (between the deactivation and reactivation of billing privileges) on the existing PTAN . . . .

MPIM (Rev. 685) § 15.29.4.3.

It is apparent that Noridian applied the instructions in Revision 685 to the revalidation application submitted by Dr. Goodman on August 30, 2016. Noridian's September 23, 2016 letter stated that Bellingham's "lapse in coverage dates are July 31, 2016 thru August 29, 2016." CMS Ex. 3 at 2. Although CMS's change in policy had become effective by September 23, 2016 (the date Noridian issued its initial determination), the change occurred after the date Dr. Goodman submitted the revalidation application.

I conclude that applying the policy change reflected in Revision 685 to Dr. Goodman's revalidation application would represent an improper retroactive application of the policy. In the present case, had Noridian applied the MPIM instructions in effect on August 30, 2016, Bellingham would not have been subject to a gap in its Medicare billing privileges. But, because Noridian applied the MPIM instructions that were effective as of September 6, 2016, Bellingham was prevented from billing Medicare for items and services furnished between July 31, 2016 and August 29, 2016. Thus, Bellingham was subject to adverse consequences based on a rule that became effective after the conduct at issue had occurred. *Cf Robert F. Tzeng, M.D.*, DAB No. 2169 at 13 (2008) (challenged regulation was not retroactive because it did not invalidate actions or impose additional requirements on circumstances existing before its effective date). For this reason, I conclude that the effective date of Dr. Goodman's revalidation application on behalf of Bellingham must be calculated consistent with the interpretation of the regulations CMS had announced in Revision 578 of the MPIM. Accordingly, the effective date of Bellingham's Medicare enrollment and billing privileges remained October 12, 2010, and Bellingham is not subject to a lapse in its billing privileges.

V. Conclusion

I reverse CMS's determination that the effective date of Bellingham's Medicare billing privileges is August 30, 2016. The October 12, 2010 effective date of Bellingham's Medicare enrollment and billing privileges was unchanged by revalidation.

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Leslie A. Weyn
Administrative Law Judge