Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Michael Majette, D.C. (Integrated Health Solutions)
(NPI: 1922244482),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-10-365

Decision No. CR2142

Date: June 4, 2010

DECISION

I deny the motion of the Centers for Medicare and Medicaid Services (CMS) to dismiss the hearing request of Petitioner, Michael Majette, D.C., regarding his practice, Integrated Health Solutions. I grant CMS's motion for summary disposition. Accordingly, the effective date of Petitioner's enrollment remains May 22, 2009, with billing privileges retroactive for 30 days to April 22, 2009, as CMS granted consistent with applicable regulations.

I. Background

The following facts are not disputed. By letter dated December 12, 2008, Petitioner submitted to CMS contractor, First Coast Service Options (First Coast), a form, CMS-855R (Medicare Enrollment Application - Reassignment of Medicare Benefits), requesting the reassignment of his Medicare benefits to Integrated Health Solutions d/b/a Advanced Spinal Care, a practice that Petitioner was opening in February 2009. CMS Exhibit (Ex.) 1; P. Request for Hearing (RH). In his letter, Petitioner requested that CMS reassign his benefits with an effective date of February 1, 2009. CMS Ex. 1. First Coast acknowledged receipt of the application in a letter to Petitioner dated December 17, 2008. CMS Ex. 2. First Coast returned the application by letter dated January 7, 2009 stating that it was unable to process the application, because Petitioner had not submitted a form

CMS 855B (Application for Health Care Suppliers that will Bill Medicare Carriers) for Integrated Health Solutions, and that Petitioner could reapply. CMS Ex. 2.

Petitioner submitted, by letter dated May 19, 2009, a second application, consisting of forms CMS-855R and CMS-855I (Medicare Enrollment Application - Physicians and Non-Physician Practitioners). First Coast received the application on May 22, 2009 and acknowledged receipt in a letter dated May 26, 2009. CMS Exs. 3, 4, 9. In two letters dated June 18, 2009, First Coast: (1) informed Petitioner that it could not process his application, unless he submitted within 30 days a "Completed Form 588, Authorization Agreement for Electronic Funds Transfer;" and (2) returned the form CMS-855R, because it "is not needed for the transaction in question."[1] CMS Ex. 4. Petitioner submitted a form 588 dated June 19, 2009, and First Coast, by letter dated July 30, 2009, approved Petitioner's practice Integrated Health Solutions and assigned it a Provider Transaction Access Number (PTAN) effective May 24, 2009, on the ground that this was "[t]he date requested on the application." CMS Exs. 5, 6.

Petitioner requested reconsideration of the effective date, stating that he had been treating Medicare patients since February 16, 2009 and had been "in network" prior to starting his practice. CMS Ex. 7. In a decision dated November 3, 2009, First Coast granted Petitioner an "eligibility date" of April 22, 2009, as this was "30 days retroactive to the receipt date of the application" on May 22, 2009. CMS Ex. 9, at 3. The reconsideration decision informed Petitioner that he could appeal the determination to an Administrative Law Judge (ALJ) within 60 days, and Petitioner submitted the hearing request by letter dated January 6, 2010. CMS Ex. 9.

This case was assigned for hearing and decision to ALJ Carolyn Cozad Hughes, who issued an initial pre-hearing order that included instructions on briefing and the submission of exhibits on February 3, 2010. This case was transferred to me for hearing and decision on March 23, 2010, pursuant to 42 C.F.R. § 498.44, which permits a Board Member of the Departmental Appeals Board (Board) to be designated to hear appeals taken under Part 498.

In a submission dated March 5, 2010, CMS filed a motion to dismiss Petitioner's request for hearing and/or for summary disposition, along with CMS exhibits 1 through 16. 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 declined to submit a response to CMS's motion and

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[1] CMS states that "in most instances solely-owned practitioner organizations are required to file only an 855I, not an 855B or 855R." CMS Motion to Dismiss for Summary Disposition (Motion) at 3 n.4 (citing Medicare Program Integrity Manual, Ch. 10, § 4.4.3). CMS reports, presumably by way of explanation for the contractor's initial request for an 855B, that at the time Petitioner originally filed the CMS 855R in December 2008, he "had not indicated to CMS that Integrated Health Solutions was Petitioner's own practice." CMS Motion at 21 n.11.

indicated that all of Petitioner's argument had been presented with the requests for reconsideration and for a hearing. Petitioner made no objections to CMS's exhibits, which I admit as evidence.

With his request for a hearing, Petitioner enclosed seven pages of "Medicare Remittance Notices" from First Coast reflecting the denial of claims. The regulations governing this appeal bar Petitioner from offering "new documentary evidence . . . for the first time at the ALJ level," absent a showing of good cause. 42 C.F.R. § 498.56(e). The reconsideration decision does not list these notices among the documentation that Petitioner provided with his request for reconsideration, but the record does not indicate whether they were part of the case file that the hearing officer reviewed on reconsideration since they are documents that the contractor issued. In resolving this case in favor of CMS by summary judgment, I view all evidence in the light most favorable to the non-movant and draw all reasonable inferences in Petitioner's favor. I therefore infer that the documents were before the hearing officer and consider them as part of the record for decision for purposes of resolving this dispositive motion.[2]

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 are the legally correct dates on which Petitioners' approval is effective and for which Petitioners may bill Medicare for services provided.

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."

[2] If this case were to proceed to hearing, I would have to determine as questions of fact whether the documents were "new" in the sense that the regulation intends and, if so, whether Petitioner had good cause for producing them only at this level, before I could admit as documentary evidence. As I discuss in the section of this decision addressing CMS's motion for summary disposition, however, the notices are not material to the appeal, so the issue has little practical significance in this case.

b. Analysis

CMS argues in its motion to dismiss that Petitioner has no right to a hearing to challenge the effective date of his enrollment. CMS argues that the Medicare Act and applicable regulations in Part 424 "limit a provider's or supplier's appeal rights to denials of enrollment applications or revocations of billing privileges" and that "there is no authority granted to providers or suppliers like the Petitioner to appeal an approval of an enrollment application so as to alter the effective date of its billing privileges." CMS Motion at 13-14 (citing U.S.C. § 1395cc(h)(1)(A)); 42 C.F.R. §§ 424.545, 405.874, 498.5(1), 498.22. CMS argues that First Coast permitted Petitioner to challenge the effective date determination pursuant to a prior CMS policy that CMS has since retracted, because CMS determined that the policy was erroneous.

I disagree with CMS's arguments for the following reasons.

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. 42 C.F.R. § 424.545(a). Subpart A of Part 498 governs appeals procedures for determinations affecting participation in Medicare (and certain Medicaid determinations) and includes lists of CMS initial determinations that are subject to appeal and administrative actions, which are not subject to appeal under Part 498. One of the initial determinations listed as subject to appeal is:

> 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. 46,362, 46,363 (Oct. 8, 1992). Since the subpart of Part 498 containing the grant of appeal rights for effective date determinations of supplier approvals is expressly adopted by section 424.545(a), it follows that Part 424, 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 the Board and its 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 nonetheless that the plain language of section 498.3(b)(15) is inapplicable here. CMS argues that this provision is meant to apply only to those suppliers or providers subject to survey and certification (or accreditation by a CMS-approved accrediting organization) as a basis for determining their participation in Medicare and whose effective dates are governed by 42 C.F.R. § 489.13, but not to suppliers, such as Petitioner, whose Medicare enrollment is approved under Part 424, subpart P. CMS points out that section 498.3(b)(15) was adopted "long before" the Medicare statute was amended (by section 936(a)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (codified at 42 U.S.C. § 1395cc(j))) to permit suppliers not subject to survey and certification or accreditation to appeal denials of applications for enrollment (CMS Motion at 17) and that the regulations in Part 424 implementing the 2003 amendment permit such suppliers to appeal only denials and revocations of enrollment.

CMS's argument is not persuasive. A later statute does not elucidate the intended meaning of a prior regulation. The wording of section 498.3(b)(15) is straightforward and unambiguous 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 restricting its application to suppliers or providers subject to survey and certification or accreditation. The question is not whether the drafters of that regulation 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.

While regulatory history and other sources of guidance are relevant in interpreting language which is ambiguous, unclear in its application, or which leaves gaps, 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) is ambiguous or unclear, or where the language leaves a gap requiring interpretation to give it meaning. I thus find little room for the interpretation CMS advances.

Moreover, the history on which CMS relies provides no clear indication 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 aimed at: (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 46,363. While it is true that the rules for determination of the effective

dates in that rulemaking, which became final in 1997, apply "to all providers and suppliers . . . subject to survey and certification . . . or . . . accreditation," this does not necessarily mean that the appeal rights added to Part 498 by the same rulemaking are limited to those providers and suppliers. 62 Fed. Reg. at 43,934. The rulemaking that granted the right to appeal an effective date determination contains no parallel language limiting its application to only providers and suppliers that are subject to survey and certification or accreditation.[3] The preamble to the final rule published in 1997 simply states that it "[m]akes existing Medicare appeals procedures available, and requires Medicaid agencies to make their existing appeals procedures available, for effective date determinations." *Id.*.

Other discussions of appeal rights in the preambles to the 1992 proposed rule and the 1997 final rule evince no intent to restrict appeal rights in the way that CMS argues. The 1992 preamble indicates that 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. Section 498.3(b)(15) was intended to ensure that, when a provider or supplier is found not to meet conditions of participation initially but is later found to meet Medicare requirements, the resulting effective date could be appealed (even though participation was ultimately approved). *Id.* While this discussion indicates that the drafters were thinking of the type of providers and suppliers that then had appeal rights, it does not indicate any intent to restrict the scope of appeals by others who might be granted the right to Medicare hearings. Furthermore, the regulatory impact statement to the final rule published in 1997 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. 62 Fed. Reg. at 43,934. In addition, the 1997 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.

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 in 2006 that CMS adopted subpart P of Part 424 setting out enrollment requirements as a condition for participation in Medicare (71 Fed. Reg. 20,753, 20,776 (Apr. 21, 2006)), CMS was well-aware of the longstanding provision in section 498.13(b)(15), which it had described in 1997 as granting "appeal rights and procedures for entities that are dissatisfied with effective date

[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 are clearly discussing the effects on other subsets of providers (such as laboratories and community mental health centers).

determinations." 62 Fed. Reg. at 43,931-32. While 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. 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). Subpart A of Part 498 includes section 498.3(b)(15), 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).

CMS further argues that the "effective date of a . . . supplier approval," defined as an appealable initial determination in section 498.3(b)(15), is "not . . . the effective date of billing privileges as specified at 42 C.F.R. § 424.520" and contends that the term "supplier approval" in section 498.3(b)(15) "tracks and references" the language of section 489.13, which establishes the effective date of "supplier approval" for those suppliers subject to survey and certification, or accreditation. CMS Motion at 17.

To the extent that CMS suggests 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 and certification or after accreditation, or by CMS's assertion that it should be read to refer only to section 489.13. 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. That effective date determinations under section 489.13(a)(1) are reviewable does not logically support a conclusion that effective date determinations under other provisions are not reviewable.[4] Section 489.13 is not the only provision for approval of suppliers to participate in Medicare. Section 424.502 defines "approval" to mean the determination that the supplier is "eligible under Medicare rules and regulations to receive a Medicare billing number and be granted Medicare billing privileges."[5] The effective date of such approval for suppliers not requiring survey and certification or accreditation is governed by sections 42 C.F.R. § 424.520(c), (d). 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.

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[4] As one ALJ recently pointed out, in making this argument, CMS commits the "syllogistic fallacy of the illicit major term: all A=B; no C=A; therefore, no C=B." *Rushita Patel, M.D.*, DAB CR2129, at 3 n.3 (2010).

[5] CMS suggests that I should disregard this definition of supplier approval, because the definitions in 42 C.F.R. § 424.502 are those "used in this subpart unless the context indicates otherwise . . . ." CMS Motion at 18 n.8. It is in the same subpart, however, that the regulations grant appeal rights under Part 498 to providers and suppliers whose enrollment is denied. 42 C.F.R. § 424.545. Therefore, the definition of approval applicable to those appeals would be the one at 42 C.F.R. § 424.502.

Given this definition of "approval" for suppliers, such as Petitioner, who are not subject to survey and certification or accreditation, I am also not persuaded that use of "effective date for billing privileges" in section 424.520 means that the effective date established thereunder is something other than the effective date for which section 498.3(b)(15) provides appeal rights. For such suppliers, the relevant approval by CMS and its contractors is the determination that the supplier is eligible to participate in Medicare and receive payment for Medicare services. The effective date of such approval is prescribed by section 424.520(d) and is tied to the submission of an approvable enrollment application. I note that the preamble to the notice of final rulemaking that implemented section 424.520 describes the effective date provided in section 424.520(d) as "the initial enrollment date" for those suppliers. 73 Fed. Reg. 69,726, 69,766 (Nov. 19, 2008). Section 424.521 permits only a limited opportunity to bill for services provided prior to the effective date of enrollment, which represented a significant change from prior regulations that permitted physicians and non-physician practitioners to bill for services provided "up to 27 months prior to being enrolled to participate in the Medicare program." *Id.* at 69,766. That the elimination of the ability to bill retrospectively for 27 months meant that the effective date of a supplier's approval to participate in Medicare would in most cases also be the first date the supplier could provide services eligible for Medicare payment (and would thus have much greater significance to suppliers than under the prior practice) does not mean that the effective date of a "supplier approval" in section 498.3(b)(15) is something other than the effective date established in section 424.520(d).

CMS cites ALJ decisions that have accepted some of its arguments above. CMS Motion at 15. CMS cites: *Mikhail Paikin, DO*, DAB CR2064 (2010), holding that "the regulatory history for 42 C.F.R. § 498.3(b)(15) . . . supports the CMS position that the provision only permits a right to hearing related to an effective date determination for providers and suppliers subject to survey and certification or to accreditation by an accrediting organization;" and *Rachel Ruotolo, M.D.*, DAB CR2029 (2009), holding that section 498.3(b)(15) was "inapplicable . . . 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." I do not view those cases as supporting CMS's arguments here, however.

The ALJ in *Paikin* did not explain why he looked behind the face of the regulation to read in a restriction that nowhere appears in its text, despite noting that "CMS acknowledges that the plain language of 42 C.F.R. § 498.3(15) indicates that the determination of the effective date of a Medicare provider agreement or supplier approval, is an initial determination that is subject to hearing and judicial review." (DAB CR2064, at 7). I note, moreover, that the ALJ still examined 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). *Id.* at 6. In *Ruotolo*, the petitioner did not argue that she was entitled to an earlier effective date of enrollment but, rather, disputed the brevity of the permitted period for retroactive billing by challenging the lawfulness of the relatively newly enacted regulation mandated that result. *Ruotolo,*

DAB CR2029, at 3. Because the petitioner there was not arguing that she was entitled to an earlier effective date, the ALJ found that 42 C.F.R. § 498.3(b)(15) was inapplicable to that case. *Id*. As in *Paikin,* the ALJ in *Ruotolo* also observed that CMS had correctly applied the regulations governing the establishment of effective dates and retroactive billing. The ALJ decisions CMS cites demonstrate no error in my conclusions that the language is plain in granting appeal rights and that, in any case, the regulatory history does not demonstrate any intent to exclude suppliers approved under Part 424 from the purview of section 498.3(b)(15).

Additionally, in a number of recent cases, ALJs have concluded, as I do here, 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. *See, e.g., Rushita Patel, M.D.*, DAB CR2129 (2010); *Michael Nillas, M.D.*, DAB CR2077 (2010); *Blue Plastic Surgery Ctr., LLC*, DAB CR2075 (2010); *Kate Suskin, LICSW*, DAB CR2072 (2010); *Victor Alvarez, M.D.*, DAB CR2070 (2010); *Romeo Nillas, M.D.*, DAB CR2069 (2010); *Jorge M. Ballesteros*, CNRA, DAB CR2067 (2010); *Vincent Pirri, M.D.*, DAB CR2065 (2010). In so holding, the ALJs have relied on the principle that where a regulation speaks clearly on its face and applies to the question presented, they are bound to follow it. *Andrew J. Elliott, M.D.*, DAB CR2103 (2010), for example, states:

> 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.

I agree, and conclude that I am bound to follow the plain language of section 498.3(b)(15).

CMS also argues that its regulations "specifically state" that a provider or supplier has no right to appeal from a rejection [as opposed to a denial] of its enrollment application. CMS Motion at 14 (citing 42 C.F.R. § 424.525). CMS also points to section 434.545(b), which affords a provider or supplier only the opportunity to submit "a rebuttal" when its billing privileges are deactivated. CMS Motion at 11. Apparently, CMS would have me conclude that these limitations demonstrate that only denials and revocations are subject to appeal. None of the regulations CMS cites in its arguments contains any specific statement, however, restricting suppliers from challenging adverse effective date determinations. The explicit bar on appealing rejections and the limitation on review of deactivations are thus not relevant to this appeal, because Petitioner has requested a hearing for purposes of reviewing the effective date determined after its enrollment was approved, not for the rejection of an application or deactivation of billing privileges. I note, however, that these provisions amply illustrate 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.

Finally, I reject CMS's argument that First Coast's approval letter, affording Petitioner the opportunity to contest the determination of the effective date, was based on an erroneous interpretation of the regulations. CMS Ex. 6. CMS argues that, "[w]hile 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 Motion at 15 (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 that the subsequently retracted policy "is not sufficient to provide appeal rights that do not exist under the Medicare Act and regulations." *Id.* at 16. 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 NPP practitioners cannot appeal the effective date decisions made by the contractor." *Id.* (citing CMS Ex. 14 (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 16 (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 argument that subpart P of Part 424 precludes challenges to effective dates, or that section 498.3(b)(15) excludes effective date appeals by providers and suppliers not subject to survey and certification or accreditation.

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 involving providers and suppliers not subject to survey or accreditation (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.

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.

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 judgment on the ground that the effective date of Petitioner's participation in Medicare was properly determined under 42 C.F.R. § 424.520(d).

a. Applicable standard

The Board stated the standard of review 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. *Kingsville Nursing and Rehabilitation Center*, DAB No. 2234, at 3 (2009), citing *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986). While the Federal Rules of Civil Procedure (FRCP) are not binding in this administrative appeal, we are guided by those rules and by judicial decisions on summary judgment in determining whether the ALJ properly granted summary judgment. *See Thelma Walley*, DAB No. 1367 (1992) . . . . 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. *Kingsville* at 3, citing *Celotex*, 477 U.S. at 323. If the moving party carries its initial burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial.'" *Matsushita Elec. Industrial Co. v. Zenith Radio*, 475 U.S. 574, 587 (1986) (quoting FRCP 56(e)). 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. *Id.* at 586, n.11; *Celotex*, 477 U.S. at 322. 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. *U.S. v. Diebold, Inc.*, 369 U.S. 654, 655 (1962).

Senior Rehab. & Skilled Nursing Ctr., DAB No. 2300, at 3 (2010). 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 be assessing credibility or evaluating the weight of conflicting evidence. *Holy Cross Village at Notre Dame*, DAB No. 2291, at 4-5 (2009).

b. Analysis

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 (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).

In this case, although the application for Petitioner and his practice that First Coast approved was received on May 22, 2009, First Coast assigned an effective date of May 24, 2009, on the ground that this was "[t]he date requested on the application." CMS Exs. 6, at 2-3. However, upon reconsideration, First Coast acknowledged that it had received the application on May 22, 2009 and granted Petitioner a 30-day retrospective billing period correctly determined to be effective April 22, 2009, pursuant to 42 C.F.R. § 424.521(a). CMS Ex. 9, at 3.

Petitioner does not dispute these facts, or that First Coast's reconsideration determination was consistent with the applicable regulations. He also does not dispute that the first application he submitted on or about December 12, 2008 was not approvable as submitted but states he has no record of Medicare having returned the application. He does not, however, dispute that First Coast returned the application to the address listed on it (from which he had moved). CMS Motion at 20-21 (citing CMS Exs. 1, 2). Petitioner also states that he had thought that the reason he was not being reimbursed for services "had something to do with our billing software" and points to notices of denials

of claims for services he provided during the period February 24 through April 24, 2009 that were sent to his old practice.[6] P. RH. He states that "I realize proper steps weren't taken to ensure my participation" and cites the "tumultuous journey" of opening a new practice, hiring staff, and treating patients. P. RH.

The regulation is clear in providing that the earliest date of Medicare eligibility is the date that the contractor received a subsequently-approved application. Petitioner has not established or even argued that the application he submitted in December 2008 was approvable or should have been approved, or that an approvable application was submitted at any time prior to the application that First Coast received on May 22, 2009. Thus, as a matter of law, the earliest effective date of the approval of his application was May 22, 2009, and the earliest date for the beginning the period of retrospective billing was April 22, 2009. Although Petitioner states that he heard nothing from First Coast subsequent to First Coast's letter acknowledging receipt of Petitioner's application, he also made no efforts to inquire about the status of the application for enrollment, despite being aware that his claims were being denied. The circumstances Petitioner describes provide no basis to ignore the clear requirements of the regulations, by which I am bound.

c. Conclusion

The earliest effective date for the approval of Petitioner's enrollment in Medicare was May 22, 2009, with retrospective billing privileges permitted back to April 22, 2009. *See* 42 C.F.R. § 424.521(a). Thus Petitioner's request for an earlier effective date 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

[6] In support of his argument that he was not aware that First Coast had not approved his application, as I noted above, Petitioner submitted, with his request for hearing, seven pages of "Medicare Remittance Notices" from First Coast reflecting the denial of claims for service during February through April 2009, addressed to what Petitioner identifies as his old practice. These notices provide no support for concluding that the initial application was complete and approvable and hence are not material to the issue of the appropriate effective date.