Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Dr. Elinor Schottstaedt, M.D.
Docket No. A-10-75
Decision No. 2337
September 30, 2010

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Dr. Elinor Schottstaedt, M.D. (Petitioner) appeals a decision by Administrative Law Judge (ALJ) Keith W. Sickendick dated May 14, 2010. *Elinor Schottstaedt, M.D.*, DAB CR2131 (2010) (ALJ Decision). The ALJ granted a Motion to Dismiss filed by the Centers for Medicare & Medicaid Services (CMS). The ALJ concluded that Petitioner's hearing request was untimely under 42 C.F.R. § 498.40(a)(2) and that Petitioner had not stated good cause to extend the time for filing.

As explained below, we uphold the ALJ Decision.

Standard of Review

The standard of review on factual issues is whether the ALJ decision is supported by substantial evidence in the whole record. The standard of review on issues of law is whether the ALJ decision is erroneous. *See* Guidelines -- Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program at http://www.hhs.gov/dab/divisions/appellate/guidelines/prosupenrolmen.html. Our standard of review on an ALJ's exercise of discretion in determining whether there is "good cause" to extend the filing time is whether the ALJ abused his or her discretion. *Hillcrest Healthcare, L.L.C.*, DAB No. 1879, at 5 (2003).

Relevant Legal Authority

Title XVIII of the Social Security Act (the Act) governs the healthcare program for the aged and disabled known as Medicare.[1] To receive payment for covered Medicare items or services, a supplier must be enrolled in Medicare, which requires submission of an

[1] The current version of the Act can be found at www.ssa.gov/OP_Home/ssact/comp-ssa.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section.

enrollment application. 42 C.F.R. §§ 424.505, 424.510(d)(1). Currently enrolled suppliers must thereafter report changes in their enrollment data. 42 C.F.R. §§ 424.515; 424.520(b); 410.33(g)(2) (reporting requirements specific to Independent Diagnostic Testing Facilities (IDTFs)). CMS may deny a supplier's enrollment application if the supplier is not in compliance with Medicare enrollment requirements. 42 C.F.R. § 424.530(a)(1).

A supplier whose enrollment application has been denied (as Petitioner's was) may ask for reconsideration of that denial by a contractor hearing officer, i.e., a reconsideration determination. 42 C.F.R. §§ 498.22(a); 405.874(c). If the supplier is dissatisfied with the reconsideration determination, the supplier may request a hearing before an ALJ of the Civil Remedies Division of the Departmental Appeals Board. Act § 1866(j), (h)(1); 42 C.F.R. § 498.3(b)(5), (6). A request for an ALJ hearing must be filed within 60 days of the supplier's receipt of the reconsideration determination. Act, §§ 1866(h)(1), 205(b); 42 C.F.R. § 498.40(a)(2). The ALJ may extend the time for filing a hearing request for good cause. 42 C.F.R. § 498.40(c). An ALJ may dismiss a hearing request where the request was not timely filed and the time for filing was not extended. 42 C.F.R. § 498.70(c).

Background

The following facts from the ALJ Decision and the record are undisputed.

In December 2008, Petitioner, a physician, filed an enrollment application reporting changes in enrollment data for the IDTF she owned and operated. CMS Ex. 5, at 5-6; *see also* CMS Ex. 2 (Medicare contractor letter stating it had reviewed "application to make changes to your Medicare record as an [IDTF].") On January 6, 2009, the Medicare contractor denied the application. CMS Ex. 2. The basis for the denial was the contractor's finding that the IDTF's technical staff did not have the credentials required by 42 C.F.R. § 410.33(g)(12). The notice informed Petitioner that, if she believed the determination was "not correct," she could file a request for reconsideration before a contractor hearing officer. The "reference number" on the notice was 102356771.

On March 2, 2009, Petitioner filed a request for reconsideration with the contractor that referred to "102356771." CMS Ex. 3. In that request, she did not dispute that her technical staff did not have the credentials required by 42 C.F.R. § 410.33(g). *Id.* Instead, Petitioner said she was "requesting a reconsideration of the initial decision to revoke payment of several (old) claims . . . ." CMS Ex. 3, at 1. She attached to her

reconsideration request a list of services allegedly provided prior to October 1, 2007.[2] *Id.* at 3.

On April 24, 2009, a contractor hearing officer issued a reconsideration determination upholding the denial of the IDTF enrollment application because Petitioner had not shown that the IDTF's technician met the licensing and certification requirements of section 410.33. CMS Ex. 1. The reconsideration determination did not mention the 2007 billing issue that Petitioner raised in her March 2 hearing request. The reconsideration determination informed Petitioner that she could seek further review of the reconsideration determination but that she "must act quickly" by "fil[ing] [her] appeal within 60 calendar days after the date of receipt of this decision" with the Civil Remedies Division of the Departmental Appeals Board at the stated address. *Id.* at 3.

On December 15, 2009, Petitioner, under the signature of her Office/Billing Manager (Manager), filed a hearing request with the Departmental Appeals Board, Civil Remedies Division, titled "Appeal for Good Cause for Late Filing for ALJ Hearing." However, the substance of her hearing request made it clear that she was not challenging the contractor's finding that her technician did not meet the section 410.33(g)(12) requirements, which was the basis for the contractor's reconsideration determination denying enrollment. Rather, she was trying to appeal the nonpayment of her claims for 2007 services.

CMS moved to dismiss the hearing request for untimely filing under 42 C.F.R. § 498.40(a)(2). CMS alleged that Petitioner had not stated good cause for the late filing.

Petitioner did not timely respond to CMS's motion, and the ALJ issued an order to show cause why the hearing request should not be dismissed. Petitioner, through the Manager, then responded, asserting that the good cause for the late filing was "stated" in the initial request, apparently meaning that the hearing officer's failure to address the 2007 claims constituted good cause. Letter of March 2, 2010. She also stated that "[d]uring the time this 'event' was taking place," she was suffering "deep depression" which "hindered [her] job performance greatly" and that Petitioner had had "no control over this." *Id.*

The ALJ granted CMS's Motion to Dismiss. He concluded that the hearing request was

[2] According to Petitioner, after the contractor discovered that Petitioner's technical staff did not meet the requirements of section 410.33(g)(12), it revoked and denied payments for services provided while Petitioner was not in compliance with that section, including services provided in 2007. CMS Ex. 3. It is apparent that Petitioner believes section 410.33(g)(12) became effective on October 1, 2007, that she was compliant with Medicare requirements prior to that date, and, therefore, CMS should reimburse her for services she provided prior to October 1, 2007. CMS Ex. 3. As discussed later, consideration of the alleged claims denials is not within our jurisdiction. However, to provide clarification to Petitioner, we note that the effective date of section 410.33(g)(12) was January 1, 2007, not October 1, 2007. 71 Fed. Reg. 69,624 (Dec. 1, 2006). We also note that CMS amended the Medicare Program Integrity Manual to include the January 1, 2007 regulatory change in a transmittal dated July 13, 2007 that identified October 1, 2007 as the "implementation date" but January 1, 2007 as the "effective date." *See* https://www.cms.gov/transmittals/downloads/R216PI.pdf. Perhaps the manual provision was a source of this misunderstanding.

over 5 months late under 42 C.F.R. § 498.40(a)(2); that Petitioner had failed to show good cause for extending the time for filing a hearing request under section 498.40(c); and that the request should be dismissed under section 498.70(c). He also ruled that, to the extent Petitioner was seeking review of "some denied old claims," he would not have jurisdiction and "dismissal would be required on that basis." ALJ Decision at 4.

Petitioner appeals the ALJ's dismissal. She does not dispute the ALJ's conclusion that her hearing request was untimely or his conclusion that she failed to show good cause for its untimeliness. She argues that dismissal was not appropriate because her 2007 claims were not properly denied.

Analysis

As explained below, we conclude that the ALJ did not err in dismissing this hearing request.

Section 498.70(c) authorizes an ALJ to dismiss a hearing request where the "affected party did not file a hearing request timely and the time for filing has not been extended." An ALJ may extend the time for filing "for good cause shown" by the affected party. 42 C.F.R. § 498.40(c)(2). Petitioner agrees that she did not meet the filing deadline, and the dates on the relevant documents establish this fact. Accordingly, the ALJ's finding that the request was untimely was correct. The only issue remaining is whether the ALJ abused his discretion in finding Petitioner had not established good cause for extending the deadline.

The ALJ based his determination that Petitioner had failed to show good cause on the following considerations:

> Petitioner . . . argues, apparently with the thought that this explanation excuses the late filing, that her office manager was having personal problems when the appeal should have been filed. However, Petitioner, not her office manager, is responsible to ensure she complies with the program participation requirements, and the office manager's personal problems are no excuse for Petitioner's failure to ensure she complied with the law. Petitioner also argues that Medicare is complicated, which I accept as an understatement. However, the reconsideration decision clearly stated: Petitioner's right to request a hearing by an ALJ; the requirement that she do so in writing to the address provided; and that the request must be filed within 60 calendar days of receipt of the decision. Petitioner only needed to read the decision to be aware of her rights. Petitioner offers no argument or evidence that she was unable to read and understand the reconsideration decision. Thus, I am left to infer that Petitioner's failure to timely request review was the result of carelessness, which is never good cause to extend the time for filing a request for hearing.

ALJ Decision at 4. On appeal, Petitioner does not challenge the ALJ's conclusion or make any argument that could be construed as allegations of good cause. Instead, she continues to argue that her 2007 claims were improperly denied, a matter that is not within the scope of an appeal under 42 C.F.R. Part 498. Moreover, we conclude that the ALJ's determination that the Petitioner did not establish good cause is not an abuse of his discretion. The ALJ was correct in stating that Petitioner, not her office manager, was responsible for assuring compliance with program participation standards, including those of part 498. *See Cary Frounfelter*, DAB No. 2211, at 22 (2008).

Petitioner's argument that her 2007 claims were improperly denied is irrelevant to the issue before the ALJ and the Board. The appeal process at issue here is for the contractor's denial of her enrollment application, the denial that started this process. Enrollment denial appeals are heard under the procedures at 42 C.F.R. Part 498, and all appeals under part 498 must involve an "initial determination" as that term is defined at section 498.3. Initial determinations, as defined in section 498.3, do not include CMS's decision to deny payment of a supplier's specific claims.[3] Therefore, the ALJ correctly stated that, if Petitioner was "requesting review of some denied old claims . . . this case would not be within my jurisdiction, and dismissal would be required on that basis." ALJ Decision at 4.

For the preceding reasons, we uphold the ALJ's dismissal of the hearing request.

Conclusion

We affirm the ALJ's decision in full.

/s/
Judith A. Ballard

/s/
Constance B. Tobias

/s/
Sheila Ann Hegy
Presiding Board Member

[3] A supplier may appeal claim denials to a CMS contractor in accordance with procedures set out in 42 C.F.R. Part 405, subpart I. Claim denials may be further appealed, in appropriate circumstances, to the ALJs in the Office of Medicare Hearings and Appeals (OMHA) and then to the Medicare Appeals Council. *See generally* 42 C.F.R. § 405.1000-1140. When a claim is denied, a contractor must give notice and information about the process by which the denial may be appealed. 42 C.F.R. § 405.921. Petitioner has not indicated whether she did or did not receive such notice, but even if she did not, the appeals process for supplier enrollment in Part 498 (which applies to the matter we are deciding) would not apply to the review of the claim denials.