Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

JP Mishra Cardiology, P.C.
Docket No. A-19-21
Decision No. 2967
August 27, 2019

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DISMISSAL

Petitioner JP Mishra Cardiology, P.C. (Petitioner) appeals an administrative law judge (ALJ) dismissal of its request for a hearing on the Centers for Medicare and Medicaid Services' (CMS) determination of the effective date for Petitioner's enrollment as a supplier in the Medicare program. *JP Mishra Cardiology PC*, Dismissal, Docket No. C-18-1192 (Sept. 13, 2018) (ALJ Dismissal). The ALJ dismissed Petitioner's hearing request pursuant to 42 C.F.R. § 498.70(c) after concluding it was not filed within the time limit specified in 42 C.F.R. § 498.40. We uphold the dismissal.

Summary of the Applicable Law

A provider or supplier[1] seeking to bill the Medicare program for Medicare-covered services or supplies provided to Medicare beneficiaries must comply with the enrollment requirements in 42 C.F.R. §§ 424.500-570 of the regulations and be approved for enrollment by CMS. To maintain enrollment and billing privileges, a supplier must periodically revalidate its enrollment. *Id.* § 424.515. To do so, it must submit an enrollment application and supporting documentation that meets the requirements for enrollment applications in section 424.510. *Id.* § 424.515(a). The effective date of a physician's or physician organization's billing privileges is the later of the date the supplier files a Medicare enrollment application that is subsequently approved by a Medicare contractor or the date an enrolled supplier begins practicing at a new location. *Id.* § 424.520(d).

[1] The regulations define a "supplier" as "a physician or other practitioner, or an entity other than a provider that furnishes health care services under Medicare." 42 C.F.R. § 400.202. Since Petitioner meets the definition of "supplier," we use that term throughout our decision.

CMS may deactivate a Medicare provider's or supplier's billing privileges for specified reasons that include failure to "furnish complete and accurate information . . . within 90 calendar days of receipt of notification from CMS to submit an enrollment application . . . ." 42 C.F.R. § 424.540(a)(3). As relevant here, a supplier seeking to reactivate its billing privileges must submit a new enrollment application or, if CMS deems it appropriate, recertify the correctness of enrollment information currently on file. *Id*. § 424.540(b)(1).

CMS's initial determination regarding the effective date of a supplier's approval is subject to appeal. 42 C.F.R. § 498.3(b)(15). The supplier must first seek reconsideration by the Medicare contractor and, if dissatisfied with the reconsidered determination, may seek an ALJ hearing. *Id*. § 498.5(*l*)(1), (2). A supplier seeking an ALJ hearing must file its hearing request within 60 days after receiving the reconsidered determination. *Id*. § 498.40. The date the reconsidered determination is "received" by the supplier is presumed to be five days after the date on the notice of the reconsidered determination unless the supplier shows that it received the notice earlier or later. *Id*. §§ 498.40(a)(2), 498.22(b)(3). An ALJ has discretion to extend the time to file a hearing request, but only for good cause shown. *Id*. § 498.40(c)(2).

Background[2]

A. Petitioner's revalidation application

In a letter dated March 1, 2018, Medicare contractor National Government Services (NGS) notified Petitioner that its application to revalidate its Medicare enrollment had been approved but with a gap in billing privileges from November 15, 2017 through February 12, 2018. ALJ Dismissal at 1; Petitioner Exhibit (P. Ex.) 13, at 1. The NGS letter explained that the gap in billing privileges was "for failing to respond to a development request related to a revalidation application[]" and that Petitioner "w[ould] not be reimbursed for services provided to Medicare beneficiaries during this time period

[2] We take these background facts from the ALJ Dismissal and exhibits of record. We make no new findings of fact, and the facts we state are undisputed unless we indicate otherwise.

since you were not in compliance with Medicare requirements." *Id.* The letter further stated that Petitioner had 60 days to seek reconsideration if it disagreed with the effective date determination.[3] ALJ Dismissal at 1; P. Ex. 13, at 5.

Petitioner timely filed a request for reconsideration with NGS. ALJ Dismissal at 2; P. Ex. 14. In a letter dated March 26, 2018 (which we also refer to as the "reconsideration determination" or "reconsidered determination"), NGS informed Petitioner that it had reviewed the documentation Petitioner submitted with its reconsideration request but that the documentation did not support an earlier effective date.[4] ALJ Dismissal at 2; P. Ex. 15, at 4. NGS's March 26, 2018 reconsideration determination further informed Petitioner that it had 60 days after receiving this letter to request a hearing before an ALJ. ALJ Dismissal at 2; P. Ex. 15, at 4-5. The letter provided the address to which Petitioner should send a hearing request and also gave instructions for alternative electronic filing of the hearing request. P. Ex. 15, at 5.

B. The ALJ proceeding

Petitioner filed its request for hearing on July 6, 2018. ALJ Dismissal at 2. On August 7, 2018, the ALJ ordered Petitioner to show cause why its hearing request should not be dismissed for untimeliness. *Id.* Prior to filing its hearing request, Petitioner had contacted the office of Chris Collins, a member of the United States House of Representatives, for assistance. *Id.* A staff member in Representative Collins's office sent an inquiry to NGS, and NGS responded in a letter dated May 15, 2018. *Id.*; P. Ex. 16. In its response to the ALJ's order to show cause, Petitioner argued that this May 15, 2018 letter constituted a revised determination under 42 C.F.R. §§ 498.30 and 498.32(a) and that Petitioner's hearing request, therefore, was timely since it was filed within 60 days of Petitioner's having received what it argued was a revised determination. ALJ

[3] The notice of the gap in billing privileges is preceded by a statement that Petitioner's "PTAN . . . [provider transaction access number] and effective date . . . remain . . . the same," and the "Effective Date" stated under "Medicare Enrollment Information" in the letter is "January 01, 2008." P. Ex. 13, at 1. Since Petitioner is appealing the effective date associated with the November 15, 2017 through February 12, 2018 gap in billing privileges, January 1, 2008 could not possibly be the effective date at issue in this proceeding. As we note later, NGS's reconsideration determination letter clarified that the effective date at issue is February 13, 2018, the day after the gap in billing privileges (which was caused by Petitioner's not completing its revalidation application) ended.

[4] NGS's March 26 2018 reconsideration determination letter upholding the initial determination does not specifically state that February 13, 2018, is the "effective date"; however, it is clear from the letter as a whole that the effective date upheld on reconsideration (and that is being appealed) is February 13, 2018. NGS explained in the March 26, 2018 letter that since Petitioner's billing privileges were deactivated for a period of time due to its failure to submit requested information needed for the revalidation application, NGS was required to use the date NGS received a new and complete application to "establish an effective date" for the reactivation of Petitioner's enrollment and billing privileges. *See* P. Ex. 15, at 2 (citing Medicare Program Integrity Manual § 15.29.4.3). The date NGS received the new and complete application was February 13, 2018. *Id.* at 4.

Dismissal at 3; Petitioner's Response to the Order to Show Cause That Its Hearing Request Was Timely Filed (P. Response) at 1-3. Petitioner also argued that even if the ALJ concluded the May 15, 2018 letter was not a revised determination, the ALJ should find "good cause" for providing a hearing on the ground that Petitioner had "relied on explicit instructions about the timing of its request which were issued from both NGS and [a staff member in Representative Collins's office] who was acting as CMS's agent[]" and "[t]hus, the circumstances under which [Petitioner's] appeal was filed support good cause for the late filing, as defined by 42 C.F.R. § 478.22." P. Response at 1-2.

The ALJ rejected these arguments. The ALJ applied the requirement in section 498.40 that a hearing request must be filed within 60 days from the date the affected party receives the notice of reconsidered determination. ALJ Dismissal at 2. The ALJ noted that Petitioner did not contend that it received NGS's reconsidered determination earlier or later than March 31, 2018, the presumed date of receipt under section 498.40(a)(2). *Id.* at 2-3. Thus, in order to be timely, Petitioner's hearing request needed to be filed by May 30, 2018. *Id.* at 5. Petitioner's hearing request, the ALJ found, was not filed until July 6, 2018, which was 97 days after the presumed date of receipt. *Id.* at 2-3, 5. The ALJ further found that NGS's May 15, 2018 letter to Representative Collins's office did not meet the criteria for reopening and did not constitute a revision of NGS's reconsidered determination under sections 498.30 and 498.32. *Id.* at 3. Nor, the ALJ found, did the circumstances asserted by Petitioner constitute good cause allowing the ALJ to extend the time for filing under section 498.40(c)(2). *Id.* at 3-4.

Standard of Review

The standard of review on a disputed factual issue is whether the ALJ decision is supported by substantial evidence in the record as a whole. The standard of review on a disputed issue 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 https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/enrollment/index.html. "The standard of review for an ALJ's exercise of discretion to dismiss a hearing request, where such dismissal is committed by regulation to the discretion of the ALJ, is whether the discretion has been abused." *St. George Health Care Ctr.*, DAB No. 2645, at 3 (2015) (quoting *High Tech Home Health, Inc.*, DAB No. 2105, at 7-8 (2007), *aff'd, High Tech Home Health, Inc. v. Leavitt*, Civ. No. 0780940 (S.D. Fla. Aug. 15, 2008)).

Discussion

A. There is no dispute that Petitioner did not file its hearing request until July 6, 2018, more than 90 days after receiving NGS's March 26, 2018 reconsidered determination.

As stated above, requests for hearing on reconsidered determinations of effective dates (or other Medicare enrollment reconsidered determinations) must be filed no later than 60 days after the provider or supplier received the contractor's reconsidered determination, and the receipt date is presumed to be five days after the date on the reconsidered determination letter, unless the provider or supplier shows earlier or later receipt. 42 C.F.R. §§ 498.40; 498.40(a)(2); 498.22(b)(3). Petitioner does not dispute that the date on NGS's reconsidered determination is March 26, 2018. Nor does Petitioner attempt to rebut the presumption that Petitioner received the reconsidered determination on March 31, 2018. Petitioner also does not dispute that it filed its hearing request on July 6, 2018, which is more than 97 days after it received the reconsideration determination. Nonetheless, Petitioner argues here, as it did before the ALJ, that its hearing request is not late because, according to Petitioner, NGS issued a revised determination dated May 15, 2018, under 42 C.F.R. § 498.32, which gave it new appeal rights under section 498.5(*l*)(2). The ALJ rejected this argument, as do we.

B. NGS's May 15, 2018 letter to Representative Collins's office did not reopen and revise the reconsidered determination.

Petitioner argues that NGS's May 15, 2018 letter to Representative Collins reopened and revised NGS's March 26, 2018 reconsidered determination and, thus, gave him a new 60-day appeal period. With an exception not relevant here, CMS has authority to reopen and revise an initial or reconsidered determination within 12 months of the date of the initial determination. 42 C.F.R. § 498.30. When CMS exercises that authority, it "gives the affected party notice of reopening and of any revision of the reopened determination." *Id.* § 498.32(a)(1). CMS's notice is required to "state[] the basis or reason for the revised determination." *Id.* § 498.32(a)(2). A revised determination is binding unless the affected party requests a hearing before an ALJ or CMS or the contractor further revises the revised determination. *Id.* § 498.32(b). We have reviewed NGS's May 15, 2018 letter and agree with the ALJ that this letter is not a revised determination under 42 C.F.R. §§ 498.30 and 498.32.

1. NGS did not send the May 15, 2018 letter to Petitioner – the "affected party" – or to someone authorized to act as Petitioner's agent.

The first reason NGS's May 15, 2018 letter did not constitute a reopening and revision of NGS's reconsidered determination is that although Petitioner is the "affected party," NGS did not address or send the May 15, 2018 letter to Petitioner as section 498.32(a) requires; instead, NGS addressed and sent the letter to Representative Collins's office. Petitioner does not dispute either of these facts. However, Petitioner argues that the fact that NGS addressed and sent the May 15, 2018 letter to Representative Collins's office, rather than to Petitioner, does not preclude finding that the letter reopened and revised the reconsidered determination because, Petitioner claims, Representative Collins's office was acting as Petitioner's "agent/representative" at the time. Petitioner's Brief in Support of Request for Review (RR) at 6.

The appeals procedures for determinations that affect participation in Medicare provide that an "affected party may appoint as its representative anyone not disqualified or suspended from acting as a representative in proceedings before the Secretary or otherwise prohibited by law." 42 C.F.R. § 498.10(a). "If the representative appointed is not an attorney," the regulations further provide, "the party must file written notice of the appointment with CMS, the ALJ, or the Departmental Appeals Board." *Id.* § 498.10(b). Here, Petitioner does not aver that it filed the written notice required by section 498.10(b) to appoint any non-attorney to represent it in this Medicare enrollment matter. Nor does the record contain evidence that Petitioner filed such a notice. We also find no factual support in the record for Petitioner's argument that Representative Collins's office was acting as an agent or representative of Petitioner with respect to CMS's revalidation of Petitioner's enrollment in Medicare or the effective date of Petitioner's Medicare billing privileges. Indeed, the record undercuts Petitioner's argument.

Petitioner submitted as an attachment to its response to the ALJ's show cause order an Affidavit of Dora J. Ewell (Ewell Aff.), its Director of Billing. The affidavit addresses Ms. Ewell's contacts with NGS and Representative Collins's office. Ms. Ewell states:

> When I learned that [Petitioner's] request for reconsideration of the billing gap was denied, I immediately reached out to my local Congressman, Chris Collins, for assistance in pursuing [Petitioner's] appeal. Patrick McKinney, Constituent Service Liaison for Congressman Chris Collins, agreed to respond to NGS on [Petitioner's] behalf.

Ewell Aff. ¶ 26. Notably, Ms. Ewell does not state in this paragraph or anywhere else in her affidavit that Petitioner authorized or appointed Representative Collins's office to be an agent or representative for Petitioner.[5] Moreover, it is clear from the language in this paragraph that the contacts Representative Collins's staff member had with NGS were in his capacity as Representative Collins's Constituent Service Liaison, not in the capacity of an authorized agent or representative of Petitioner in CMS's provider and supplier Medicare enrollment process. This is further confirmed by the staff member's email correspondence with Petitioner which clearly indicates that he contacted NGS in his capacity as a "Constituent Service Liaison" for Representative Collins in order to inquire about the appeal process, not to represent Petitioner in that process or any other CMS matter. *See* P. Exs. 17, 18. It is also underscored, as CMS points out, by Ms. Ewell's statement elsewhere in her affidavit that "[u]pon information and belief, [Representative Collins's staff member] submitted a letter with supporting documentation to NGS on or about May 7, 2018 . . . [but] did not share his submission with [Petitioner]." Ewell Aff. ¶ 27; CMS's Brief in Opposition to Petitioner's Request for Review (CMS Br.) at 6, n.3. Presumably, Representative Collins's office would have shared a copy of such a communication with Petitioner, had it viewed itself as acting as an agent or representative of Petitioner in this matter.

2. NGS's May 15, 2018 letter did not state that it was revising or reopening the reconsidered determination.

Another reason for rejecting Petitioner's argument that NGS's May 15, 2018 letter reopened and revised NGS's March 26, 2018 reconsidered determination is because that letter did not indicate that it was reopening or revising the reconsidered determination; it merely responded to the inquiry from Representative Collins's office about the reconsidered determination. Petitioner argues that the regulations do not require that a notice under section 498.32 identify itself as a reopening or revision, but only require that the notice state the basis or reasons for the revised determination. RR at 6-7. That is not correct. Section 498.32(a)(1) states that CMS "gives … notice of reopening and of any revision of the reopened determination." Thus, the regulation specifically provides that the notice must provide notice that CMS has taken the administrative action to reopen a determination or reconsidered determination, not just notice of any revisions.

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[5] Notable too is the fact that when discussing Ms. Ewell's affidavit, Petitioner does not assert that her outreach to Representative Collins's office was to authorize the Representative or his staff to act as Petitioner's agent or representative with respect to NGS or CMS. Petitioner merely asserts that her outreach was to request "assistance with properly pursuing a further appeal." RR at 2.

We also find unpersuasive Petitioner's assertion that "it would not be consistent with NGS's own practices to require a revised determination to be expressly identified as such . . . [since] the March 26, 2018 letter **also does not identify that it is a reconsidered determination**." RR at 7 (emphasis in original). Whether NGS's reconsideration determination letter expressly identified itself as a reconsidered determination is irrelevant, because the notice requirements of 498.32(a) that apply to revised determinations do not govern reconsideration determinations, and Petitioner cites no regulation applicable to reconsideration determinations that require such identification. In any event, both NGS's initial determination letter and NGS's reconsidered determination letter in this case explicitly identify an appeal of NGS's initial determination as a "reconsideration." *See* P. Ex. 13, at 2 (stating, *e.g.*, "If you disagree with the effective date determination in this letter, you may request a reconsideration before a contractor hearing officer."); P. Ex. 15, at 1 (stating, "This letter is in response to your reconsideration request . . . ."). Accordingly, NGS's reconsidered determination of such an appeal was implicitly identified as a "reconsideration determination," regardless of whether NGS's March 26, 2018 letter used that specific term.

3. NGS's May 15, 2018 letter did not make new or revise the existing findings in the reconsidered determination.

NGS's May 15, 2018 letter does not constitute a reopening or revision under sections 498.30 and 498.32 for the additional reason that it made no new findings and did not revise the existing findings in the reconsideration determination letter, a copy of which NGS attached to its May 15, 2018 letter. Instead, NGS's May 15, 2018 letter, "after review of [Petitioner's] file," merely summarized the facts surrounding NGS's initial and reconsidered determinations and explained that NGS had determined there was a gap in Petitioner's billing privileges because of Petitioner's delay in sending the information NGS needed to complete processing Petitioner's application. P. Ex. 16. In short, NGS's March 26, 2018 reconsidered determination, and assignment of a February 13, 2018 effective date for reactivation of Petitioner's billing privileges, remained unchanged. Contrary to what Petitioner asserts (RR at 7), the fact that the "summary of issue" and "summary of findings" in NGS's May 15, 2018 letter did not contain the complete content included in the March 26, 2018 reconsidered determination does not make the May 15 letter a revision. A "summary" by its very nature does not state the full content of the writing it is summarizing but states that content in abbreviated fashion. Here, the summary in NGS's May 15, 2018 letter stated in abbreviated fashion the issues and findings in NGS's March 26, 2018 reconsidered determination and nothing more. The March 26, 2018 reconsidered determination remained unrevised and fully operational.

Petitioner cites *Mark A. Kabat, D.O.*, DAB No. 2875 (2018) as alleged support for its position that the fact that the May 15, 2018 letter does not contain a new or revised basis for CMS's determination does not preclude its being found a revised determination under section 498.32(a)(2). P. Reply in Support of Request for Review (Reply) at 4. *Kabat* does not help Petitioner. *Kabat*, unlike this case, was an appeal from a reconsidered determination that CMS specifically identified as a reopened and revised determination under sections 498.30 and 498.32. DAB No. 2875, at 4. Dr. Kabat did not dispute that the letter in question was a reopened and revised determination under those regulations but made a due process claim that the reasons given for the reopening and revision were not sufficiently specific. It was in that context (not in the context of determining whether the letter at issue was a revised determination), that the Board, as Petitioner notes, rejected Dr. Kabat's suggestion that the regulations required CMS or its contractor to explain why it was reopening or revising the prior determination. *Id*. at 13. Contrary to what Petitioner suggests, the Board did not address whether a revised determination must state a new basis for the determination in order to be a revised determination within the meaning of sections 498.30 and 498.32. However, comparing the content of the original determination letter with that of the revised determination letter, the Board did find (although Petitioner does not note this) that "on reopening, [the CMS contractor] did, in fact, revise the determination." *Id*. As the ALJ and we have found, NGS's May 15, 2018 letter did not revise the reconsidered determination here.

4. NGS's May 15, 2018 letter did not give new appeal rights.

One of the reasons the ALJ stated for concluding that NGS's May 15, 2018 letter did not reopen or revise the March 26, 2018 reconsidered determination is that the May 15 letter did not meet the requirement in section 498.32(a)(3) that such a determination give new appeal rights. Petitioner argues that the May 15 letter did meet this regulatory requirement because it contained a statement regarding appeal rights. RR at 7-8. However, the ALJ concluded that the statement in the May 15 letter did not convey **new** appeal rights but merely "restate[d] the hearing rights provided in the reconsidered determination." ALJ Dismissal at 7. We note that Petitioner does not expressly challenge the ALJ finding that the letter did not convey **new** appeal rights but states only that the letter "explicitly [meets the requirement in section 493.32(a)(3)] by directing [Petitioner] to 'file his appeal within 60 calendar days after the date of receipt of **the decision.**'" RR at 7. We read "the decision" as a reference to the reconsideration decision summarized in the immediately preceding paragraph, especially since the letter does not state a different or revised decision. Petitioner makes no showing to the contrary.

For the multiple reasons we have discussed, the May 15, 2018 letter simply does not meet the substantive notice and content requirements of sections 498.30 and 498.32 for determinations that reopen and revise a prior initial or revised reconsidered determination. Accordingly, even if we were to disagree with the ALJ's finding (and we do not) that the May 15, 2018 letter did not convey appeal rights beyond those conveyed in NGS's letter advising Petitioner of its reconsidered determination, we would still conclude that NGS's May 15, 2018 letter did not reopen or revise NGS's March 26, 2018 reconsidered determination.

C. The ALJ applied the correct "good cause" standard and did not abuse her discretion when she dismissed the appeal for untimeliness.

Petitioner argues that the dismissal must be reversed "because the ALJ applied an erroneous standard to determine whether [Petitioner] established 'good cause' to request an extension of time [to] request a hearing." RR at 8. The ALJ, according to Petitioner, "declined to apply the standard set forth in 42 C.F.R. § 478.22(a) and instead erroneously considered whether [Petitioner] had sufficiently established equitable estoppel against the federal government." *Id.* We find no basis for this argument.

1. The good cause standard in 42 C.F.R. § 478.22 does not apply to appeals of Medicare enrollment determinations.

At the outset, we find Petitioner's statement about the ALJ's actions inaccurate because the word "**declined**" suggests the standard Petitioner urges is the applicable standard but the ALJ refused to apply it in this case. That is not correct. The ALJ did not apply the standard in section 478.22(a) because, as she correctly concluded, it does not apply here as a matter of law. The standard in section 478.22(a) applies to requests for reconsideration or hearings on certain coverage denials made by Quality Improvement Organizations operating in the Medicare program. 42 C.F.R. § 478.14; ALJ Dismissal at 4. Appeals of effective date determinations in provider and supplier reconsidered determinations are governed by the Part 498 regulations, not the Part 478 regulations.

The Part 498 regulations permit an ALJ to extend the time for filing an appeal for good cause shown but do not define "good cause." *Id.* § 498.40(c)(2). As the ALJ stated, the Board "has never attempted to provide an authoritative or complete definition of the term."[6] ALJ Dismissal at 3 (citing *Hillcrest Healthcare, L.L.C.*, DAB No. 1879, at 5

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[6] Petitioner argues that by not defining "good cause," the regulation "lacks constitutionally-appropriate definiteness[] [and] violates due process." RR at 11. The Board may not overturn or refuse to follow a regulation for constitutional reasons. *E.g. John A. Hartman, D.O*, DAB No. 2911, at 24 (2018). Accordingly, we do not address this argument further.

(2003)). Instead, the Board has indicated that ALJs should make that determination based on the relevant circumstances in particular cases. *Id.* (citing *NBM Healthcare, Inc.*, DAB No. 2477, at 3-4 (2012)). Applying this authority, the ALJ correctly evaluated whether Petitioner had shown that the particular circumstances of this case constituted good cause to extend the time for filing its hearing request and concluded they did not.[7] As discussed below, we find no error in that conclusion or abuse of discretion in the ALJ's consequent dismissal of Petitioner's hearing request under section 498.70(c).

2. *The ALJ did not err or abuse her discretion in rejecting Petitioner's claims that its interactions with Representative Collins's office prevented it from filing its hearing request on time.*

Petitioner largely reiterates here the arguments it made to the ALJ as to why, in Petitioner's view, the circumstances surrounding its late filing constituted good cause to extend the time for filing its hearing request. Petitioner avers that it was misled into thinking it had until mid-July 2018, to file its appeal because it "received express advice [to that effect] from the Congressman's office . . . ." RR at 9. Petitioner further claims that "the overall circumstances surrounding [its] interactions with NGS and Representative Collins' staff prevented Petitioner from timely filing its request for hearing." RR at 12 (quoting ALJ Dismissal at 3-4); *see generally id.* at 8-13. Petitioner, as noted above, suggests that the ALJ did not properly consider whether these circumstances showed good cause but, instead, "erroneously considered" whether equitable estoppel would lie against CMS based on those circumstances. *Id.* at 8. This suggestion misreads the ALJ Dismissal.

The ALJ did not discuss equitable estoppel **in lieu of** considering whether the circumstances constituted good cause but, rather, **in the context of** explaining why she concluded that those circumstances did not support a finding of good cause. The ALJ found Petitioner's claim that it "relied to its detriment on the advice from Representative Collins' staff member, who should be regarded as NGS' agent for this purpose[]" to be "in essence, a claim for equitable estoppel." ALJ Dismissal at 4. The ALJ explained why she found "no merit" in that claim:

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[7] We note the ALJ's statement that "even if [section 478.22(a)] set the standard for good cause before me, I would not find good cause under the circumstances of this case." ALJ Dismissal at 4. We do not separately discuss this ALJ finding since section 478.22(a) does not apply but conclude that good cause does not exist here "under any reasonable definition of that term." *See Maximum Hospice & Palliative Care*, DAB No. 2898, at 6-7 (2018).

> Representative Collins' staff member is not an employee of, agent of, or in any way associated with, CMS, its contractor, or the Medicare program. As such, the staff member had neither actual nor apparent authority to act on behalf of CMS. A member of a congressional representative's staff is an employee of the federal legislature. By contrast, CMS is a subagency of the Department of Health and Human Services, part of the executive branch.

Id.

The ALJ further stated that even assuming the staff member had the authority to act on behalf of CMS in this matter, "the staff member's inaccurate instructions would be insufficient to establish estoppel against the government because such errors do not rise to the level of affirmative misconduct." *Id*. (citing *US Ultrasound*, DAB No. 2302, at 8 (2010)). Instead, the ALJ concluded, "the communications between Petitioner, NGS, and Representative Collins' office suggest 'misunderstandings, miscommunications, or confusion' rather than affirmative misconduct." *Id*. (quoting *Richard Weinberger, M.D. & Barbara Vizy, M.D.*, DAB No. 2823, at 19 (2017)).

We find no error in the ALJ's viewing Petitioner's argument that it was misled by information it received from the Representative's office as one for equitable estoppel and rejecting that argument for the reasons the ALJ stated. We agree with the ALJ that the staff member in Representative Collins's office could not have been acting as an agent or representative of CMS since a Congressional office is in the legislative, not the executive, branch of government. Thus, an essential predicate for asserting estoppel against the federal government – that the federal employee giving allegedly erroneous or inaccurate advice be authorized to act on behalf of his or her employing entity – does not exist. Moreover, the ALJ correctly concluded, as the cases she cited indicate, that, in the absence of affirmative misconduct, which did not occur here, equitable estoppel would not lie even if that predicate existed. Petitioner, we note, cites no authority for its claim that the staff member in Representative Collins's office was CMS's agent or representative. Nor does it specifically dispute the ALJ's finding that "Petitioner could not reasonably believe that Representative Collins' staff spoke for CMS, particularly since Petitioner likely sought Representative Collins' aid precisely to bring pressure to bear on CMS and NGS from an outside source." ALJ Dismissal at 4.

3. The ALJ did not err in rejecting Petitioner's claim that NGS's May 15, 2018 letter to Representative Collins's office misled Petitioner as to the appeal deadline.

The ALJ found that NGS's March 26, 2018 "reconsidered determination clearly explained how to file an appeal and the deadline for doing so, informing Petitioner that it had the right to request an administrative law judge hearing within 60 calendar days after the date of receipt of 'this decision.'" ALJ Dismissal at 5 (citation omitted). The ALJ concluded, "No reasonable reader in Petitioner's position could have been confused by this language." *Id*.

Petitioner does not dispute the ALJ's conclusion that NGS's March 26, 2018 reconsidered determination clearly instructed Petitioner regarding its appeal rights and the time limits for asserting them. Petitioner, however, argues that it "was misled" by reiteration in NGS's subsequent May 15, 2018 letter to the Representative's office that Petitioner had to "file [its] appeal within 60 calendar days after the date of receipt of the decision." RR at 7, 9. Petitioner, also asserts that "[b]ecause the evidence in the record conclusively established that [Petitioner] had received both letters before the May 30, 2018 deadline, the ALJ should have considered the impact of the latter letter.[8] She did not and therefore ignored the substantial weight of the evidence when she evaluated the content of the March 26, 2018 letter in a vacuum." *Id.* at 13. We find no basis for this argument. In focusing on the March 26, 2018 letter, the ALJ did not ignore the "substantial weight of the evidence." The March 26 letter was the **dispositive** evidence with respect to the appeal period given the ALJ's conclusion, which we have affirmed, that the May 15, 2018 letter, as a matter of law, did not reopen or revise NGS's March 26, 2018 reconsidered determination and, therefore, could not convey new appeal rights or toll the existing appeal period. The ALJ correctly relied on NGS's March 26, 2018 letter and the undisputed clarity with which that letter notified Petitioner of its appeal rights and the deadline for exercising them.

We also do not find persuasive Petitioner's argument that it was misled by the statement of appeal rights in the May 15, 2018 letter into believing that it had another 60 days to appeal. Petitioner's argument rests on the words "the decision" in that letter's statement regarding appeal rights. Petitioner does not explain why it could reasonably have thought "the decision" referred to anything other than NGS's March 26, 2018, reconsidered determination. Petitioner points to no new determination or revision of the reconsidered

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[8] Petitioner does not identify what "conclusive" evidence supports its assertion that it received the May 15, 2018 letter before May 30, 2018, but Petitioner seems to be referring to Petitioner Exhibit 17, which is a May 16, 2018 email from Representative Collins's staff member forwarding that letter to Petitioner, and to paragraph 29 of Ms. Ewell's affidavit, which states that she received the letter on May 16, 2018, and cites Petitioner Exhibit 17. We will assume this fact is correct, but, for the reasons discussed above, it is irrelevant.

determination in the May 15, 2018 letter, and we have found that the May 15 letter contained none but, instead, merely summarized the March 26, 2018 reconsidered determination. Moreover, the summary occurred in the paragraph immediately preceding the statement of appeal rights for "the decision." *See* P. Ex. 16. Thus, reasonably read, "the decision" refers to the reconsideration decision.[9]

Even apart from the clarity of NGS's March 26, 2018 letter, Petitioner, as a supplier enrolled in the Medicare program knew, or should have known, that its time to appeal the effective date for the reactivation of its billing privileges was 60 days from the date it received that letter. Courts and the Board have recognized that Medicare suppliers, as participants in the program, have a duty to familiarize themselves with Medicare requirements. *Weinberger,* DAB No. 2823, at 21 (citing *Gulf South Med.*, DAB No. 2400, at 9 (2011) (quoting *Heckler v. Cmty. Health Servs. of Crawford Cnty., Inc.*, 467 U.S. 51, 63 (1984))); *Hartman,* DAB No. 2564, at 3. The Medicare regulations at 42 C.F.R. § 498.5(*l*)(2) clearly provide that the appeal rights for a provider or supplier dissatisfied with a reconsidered determination lie from that determination. The regulations explaining and governing that appeal process are in 42 C.F.R. Part 498, and section 498.40 provides that such an appeal must be filed within 60 days after receiving the reconsidered determination unless that determination is revised under section 498.30. Petitioner, we note, has not argued that at the time it decided not to follow the instructions in the March 26, 2018 letter for requesting a hearing but, instead, chose to contact Representative Collins's office, it had any reason to expect that the stated time limits for filing the appeal would not be binding. Nor would such an expectation have been reasonable, especially since Petitioner would have needed to pursue the possibility of CMS's reopening and revising the reconsideration through CMS, which Petitioner did not do, choosing instead to seek its Congressman's intervention.

Petitioner states that it was "dissuaded from seeking further clarification from NGS because it had been receiving conflicting information from CMS for several months." RR at 10. Petitioner, however, does not identify any specific "conflicting information" but only makes a general citation to paragraphs 2-22 of the Ewell Affidavit. In those paragraphs, Ms. Ewell did express general frustration with certain communications she had with NGS during the enrollment process, but she made no statement that any of these communications "dissuaded [Petitioner] from seeking further clarification" from NGS at any point. It is particularly notable that Ms. Ewell made no such statement in paragraph 26, where she discussed how she "immediately reached out to my local Congressman . . .

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[9] In its Reply, Petitioner also quoted the sentence in the May 15 letter immediately preceding the sentence referring to "the decision." The preceding sentence reads, "If [Petitioner] believes that **this determination** is not correct, he may request a final [ALJ] review." Reply at 5 (emphasis added by Petitioner). This does not change our conclusion. The terms "this determination" and "the decision" both follow the paragraph summarizing NGS's March 26, 2018 reconsidered decision, and the May 15, 2018 letter did not change that decision.

for assistance in pursuing [Petitioner's] appeal," rather than following the unambiguous appeal directions in NGS's March 26, 2018 reconsideration determination letter. We also note that in addition to clearly stating Petitioner's appeal rights and how to pursue them, NGS's March 26, 2018 letter explained the history of Petitioner's enrollment application and the communications between NGS and Petitioner in considerable detail. Thus, any confusion that Ms. Ewell or Petitioner might have experienced during the enrollment process itself should have been dispelled going forward, and Petitioner cannot reasonably rely on any such confusion as good cause for not timely filing its appeal.

In summary, we agree with the ALJ that the notice of hearing rights in NGS's March 26, 2018 reconsidered determination was unambiguous and that "Petitioner knew or had reason to know that it must file the request for hearing 60 days after it received [that] reconsidered determination." ALJ Dismissal at 5. We also agree with the ALJ that Petitioner's delay in filing its hearing request occurred not because of any ambiguity in NGS's March 26, 2018 letter but, rather, because Petitioner "attempted to resolve the matter through other channels, *i.e.* by contacting Representative Collins's office." *Id.* While Petitioner was certainly free to contact that office, doing so did not and could not eliminate or substitute for Petitioner's obligation to timely file its hearing request as instructed by the March 26, 2018 reconsidered determination letter if it chose to appeal that determination.

Petitioner tries to put the blame for the dismissal of its untimely hearing request on Representative Collins's office or staff, but this is unreasonable and legally untenable. As we have discussed, Representative Collins's office had no legal authority to act on behalf of CMS; nor did that office claim to be acting as CMS's agent. Thus, even if Petitioner actually thought contacting Representative Collins's office would toll or extend the time for Petitioner to exercise its appeal rights (and there is no evidence Petitioner thought this at the time), that thinking was not reasonable. We also note that Petitioner has not offered a persuasive challenge to the ALJ's observation that "Petitioner has not argued that its attempt to contact Representative Collins's office prevented Petitioner from simultaneously filing a timely request for hearing." *Id.* Petitioner objects that "this argument consistently has been asserted by [Petitioner] as a primary reason for which its hearing request should have been granted." RR at 12. However, the record excerpts Petitioner cites address only Petitioner's argument (which we have rejected) that its interactions with Representative Collins's office prevented it from filing its appeal timely, which is a different argument. The cited excerpts do not address why Petitioner could not have filed an appeal at the same time it was seeking assistance from the Congressman's office.

Based on the record before us, we find no reason to question the ALJ's finding that Petitioner was not somehow prevented from making a timely appeal but, rather, consciously chose not to, making a tactical choice to seek Representative Collins's assistance instead. As the ALJ noted, the Board has "consistently concluded that a conscious or tactical choice not to file a hearing request within the time allowed is not good cause to grant an extension of the deadline." ALJ Dismissal at 5 (citing *Nursing Inn of Menlo Park*, DAB No. 1812 (2002) and *Borger I Enterprises, LLC, d/b/a Caprock Nursing & Rehab*., DAB No. 2618, at 4 (2015)).

Conclusion

For the reasons stated above, we affirm the ALJ's dismissal of Petitioner's hearing request.

/s/
Christopher S. Randolph

/s/
Constance B. Tobias

/s/
Sheila Ann Hegy
Presiding Board Member