Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	Date: March 3, 2009
Vestibular Diagnostics, LLC,	)	
	)	Docket No. C-08-707
Petitioner,	)	Decision No. CR 1912
	)	
-v.-	)	
	)	
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

The request for hearing of Petitioner is dismissed pursuant to 42 C.F.R. § 498.70(b)[1] as Petitioner has no right to a hearing under statute or regulation, and I have no jurisdiction to hear and decide this case.

I. Background

Petitioner filed a request for hearing dated August 27, 2008, requesting a hearing before an administrative law judge (ALJ). Petitioner seeks review of a decision by the Medicare contractor, Palmetto GBA, denying Petitioner's enrollment in Medicare as an Independent Diagnostic Testing Facility (IDTF). The case was assigned to me for hearing and decision on September 4, 2008, and an Acknowledgment and Prehearing Order (Prehearing Order) was issued at my direction.

On September 24, 2008, the Centers for Medicare & Medicaid Services (CMS) filed a motion to dismiss or for summary judgment (CMS Motion), with CMS exhibits (CMS Ex.) 1 through 4 and 6 through 16. On October 13, 2008, Petitioner filed its response to the CMS motion to dismiss or for summary judgment and its cross-motion for summary

[1] The Code of Federal Regulations cited throughout is the 2008 version, available at http://www.gpoaccess.gov/cfr/index.html.

judgment (P. Response). CMS filed a reply brief on November 17, 2008 (CMS Reply). On October 31, 2008, Petitioner filed Petitioner's exhibits (P. Ex.) 1 through 12.[2] No objection has been made to my consideration of the exhibits and all are admitted.

II. Discussion

A. Issue

Whether Petitioner's request for hearing must be dismissed for lack of jurisdiction.

B. Applicable Law

Section 1831 of the Social Security Act (Act) (42 U.S.C. § 1395j) establishes the supplementary medical insurance benefits program for the aged and disabled known as Medicare Part B. Payment under the program for services rendered to Medicare eligible beneficiaries may only be made to eligible providers of services and suppliers.[3] Act §§ 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395u(h)(1)). Administration of the Part B program is through Medicare contractors. Act § 1842(a) (42 U.S.C. § 1395u(a)). The Act requires that the Secretary issue regulations that establish a process for the enrollment of providers and suppliers, including the right to a hearing and judicial review in the event of denial or non-renewal. Act 1866(j) (42 U.S.C. § 1395cc(j)). The Secretary promulgated regulations at 42 C.F.R. Part 424 governing the conditions for Medicare payment. The regulations at 42 C.F.R. Part 424, subpart P establish the requirements for enrollment as a provider or supplier. Pursuant to 42 C.F.R. § 424.505, a provider or supplier must be enrolled in the Medicare program and be issued a billing number to have billing privileges and to be eligible to receive payment for services

---

[2] Petitioner exhibits marked and submitted as part of its prehearing exchange are referenced rather than the exhibits listed on the attachment to Petitioner's cross-motion for summary judgment.

[3] A "supplier" furnishes services under Medicare and includes physicians or other practitioners and facilities that are not a "provider of services." Act § 1861(d) (42 U.S.C. § 1395x(d)). A "provider of services," commonly shortened to "provider," includes hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, hospice programs, or are subject to section 1814(g) and section 1835(e) of the Act. Act § 1861(u) (42 U.S.C. § 1395x(u)). The distinction between providers and suppliers is important because they are treated differently under the Act for some purposes.

rendered to a Medicare-eligible beneficiary.[4] An IDTF, such as Petitioner, is a type of supplier described at 42 C.F.R. § 410.33, which also sets forth the specific requirements an IDTF must meet to participate in Medicare.

The regulations distinguish between a rejection of an enrollment application and the denial of an enrollment application. 42 C.F.R. § 424.502. A denial of an enrollment application requires a determination that a prospective provider or supplier is ineligible to participate in Medicare. A rejection means that an enrollment application was not processed due to missing information or supporting documents. Pursuant to 42 C.F.R. § 424.525(a), CMS and its Medicare contractor may reject a provider or supplier's enrollment application because the application does not contain all required information or because not all required supporting documents are submitted. Rejection of an enrollment application does not trigger the right to appeal or request a hearing. 42 C.F.R. § 424.525(d). If an application is rejected, the prospective provider or supplier may submit the complete enrollment application without any waiting period. 42 C.F.R. § 424.525(c).

CMS may deny a supplier's enrollment application if a supplier is not in compliance with Medicare enrollment requirements. 42 C.F.R. § 424.530(a)(1). An incomplete application is not one of the grounds listed for denial. A supplier enrollment is considered denied when a supplier is determined to be "ineligible to receive Medicare billing privileges for Medicare covered items or services provided to Medicare beneficiaries" for one or more of the reasons listed in 42 C.F.R. § 424.530. 42 C.F.R. § 424.502. CMS's contractor notifies a supplier in writing when it denies enrollment and explains the reasons for the determination and information regarding the supplier's right to appeal. 42 C.F.R. § 498.20(a). The supplier may submit a written request for reconsideration to CMS. 42 C.F.R. § 498.22(a). CMS must give notice of its reconsidered determination to the supplier, giving the reasons for its determination and specifying the conditions or requirements the supplier failed to meet. 42 C.F.R. § 498.25. If the CMS decision on reconsideration is unfavorable to the supplier, the Act and regulations provide for a hearing by an ALJ and judicial review. Act § 1866(j); 42 C.F.R.

---

[4] Currently, if enrollment is approved, a supplier is issued a National Provider Identifier (NPI) to use for billing Medicare and a Provider Transaction Access Number (PTAN), an identifier for the supplier for inquiries. Medicare Program Integrity Manual (MPIM), Chapter 10 – Healthcare Provider/Supplier Enrollment, § 6.1.1. In this case it is sufficient to understand that Petitioner's billing number and related billing privileges were revoked.

§ 424.545, 498.5. A prospective provider or supplier that is denied enrollment may not submit a new application until its right to review or appeal has lapsed or expired or until it receives notice that the denial was upheld on appeal. 42 C.F.R. § 424.530(b).

C. Analysis

Petitioner alleges in its request for hearing that it was advised of the initial denial of its application to enroll in Medicare by letters from the Medicare contractor dated February 5, 2008 (P. Ex. 1, at 1) and March 12, 2008 (P. Exs. 1, at 3). Petitioner alleges that its request for reconsideration dated April 8, 2008 (P. Ex. 6), supplemented by a letter dated May 20, 2008 (P. Ex. 7), was denied by the Medicare contractor, although Petitioner agrees it never received a notice to that effect. Request for Hearing at 1-3; Petitioner's Prehearing Exchange at 1. CMS argues as grounds for dismissal of Petitioner's request for hearing that there was no initial determination to deny Petitioner's application; there was no reconsideration decision adverse to Petitioner; therefore, Petitioner has no right to a hearing; and I have no jurisdiction to review and decide this case.[5] CMS Motion at 1, 5-9; CMS Reply at 1. Because the CMS motion to dismiss is meritorious this case must be dismissed and it is not necessary to address the cross-motions for summary judgment.

Petitioner filed its first application to enroll in Medicare, a Form CMS-855B, on October 18, 2007. P. Ex. 2. The Medicare contractor notified Petitioner by letter dated November 6, 2007, that Petitioner's application was received but the application was returned because it did not reflect that Petitioner was functioning as an IDTF, that technicians were available at the site, and that equipment was calibrated and ready for use. The Medicare contractor listed specific information that must be included when the application was resubmitted after Petitioner officially opened for business. P. Ex. 3. Petitioner resubmitted its enrollment application on January 22, 2008. P. Response at 4-6. The Medicare contractor advised Petitioner by letter dated February 5, 2008, the letter Petitioner alleges constituted the initial denial, that Petitioner's application was received but it was "not processable at this time" because the application did not include information regarding an audiologist.[6] The contractor further advised Petitioner that it

---

[5] It is not disputed that on July 30, 2008, the contractor notified Petitioner that its enrollment in Medicare was effective May 22, 2008. CMS Ex. 1.

[6] The parties argue extensively in their briefs regarding whether or not an audiologist was actually required to perform testing Petitioner intended to perform. Whether or not dismissal of the request for hearing is required does not turn on resolution of the issue of whether or not the Medicare contractor was correct in its determination

(continued...)

could resubmit its application to a specific individual on the contractor's staff when the information regarding the audiologist was provided. P. Ex. 1, at 1. The Medicare contractor's March 12, 2008 letter to Petitioner, the second letter Petitioner alleges constituted an initial denial, contained a further discussion of the basis for the contractor's conclusion that a qualified audiologist was required for some of the testing Petitioner intended to perform. P. Ex. 1, at 3. Petitioner asserts in its letter to the Medicare contractor dated April 8, 2008, that it was requesting reconsideration of the initial denial of its enrollment reflected by the contractor's letters dated February 5 and March 12, 2008; that Petitioner did not consider either of the contractor's letters to state that Petitioner's enrollment application was rejected and, thus, Petitioner elected to treat the letters as an initial determinations denying enrollment; and that as initial determinations the letters did not meet the notice requirements of 42 C.F.R. § 498.20(a).

My review of the correspondence from the Medicare contractor to Petitioner reveals that no determination was made that Petitioner was not eligible to participate in Medicare and, thus, Petitioner's enrollment application was not denied. Rather, the Medicare contractor's letter clearly advised Petitioner that its application was not processed due to missing information and that the application could be resubmitted as soon as the missing information was provided. The letters show that the Medicare contractor rejected Petitioner's application within the meaning of 42 C.F.R. §§ 424.502 and 424.525. Accordingly, I conclude that Petitioner had no right to request reconsideration or to a hearing by an ALJ. 42 C.F.R. § 424.525(d).

III. Conclusion

For the foregoing reasons discussed, Petitioner's request for hearing is dismissed.

/s/
Keith W. Sickendick
Administrative Law Judge

[6](...continued)
that Petitioner needed an audiologist for some of its tests. I will not render an advisory opinion on an issue not properly before me for resolution due to a lack of jurisdiction.