Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Family Eyecare Associates OD, PC,
(NPI: 1700831633 / PTAN: J100317896)

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-17-87

Decision No. CR4849

Date: May 17, 2017

DECISION DISMISSING CASE

This case is dismissed for lack of jurisdiction. Petitioner, Family Eyecare Associates OD, PC, has no right under the Social Security Act (the Act) or the regulations to a hearing before an administrative law judge (ALJ) related to determinations of the Centers for Medicare & Medicaid Services (CMS) or its contractors to deactivate or reactivate its Medicare billing privileges, or related to the determination of the effective date of the reactivation of its Medicare billing privileges. Act § 1866(h) and (j)(8); 42 C.F.R. §§ 424.540, 424.545, 498.3(b)(15), and 498.5(*l*).[1] Accordingly, I have no jurisdiction and this case must be dismissed.

I. Appeal Rights

The parties may request that an order dismissing a case be vacated within 60 days for good cause shown pursuant to 42 C.F.R. § 498.72. Pursuant to 42 C.F.R. §§ 498.80 and 498.82(a), either party may request Departmental Appeals Board (Board) review of this

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[1] Citations are to the 2015 revision of the Code of Federal Regulations (C.F.R.), unless otherwise stated.

dismissal within 60 days of receiving this decision. Detailed appeal procedures are set out in the guidelines for appellate review of decisions of ALJs at http://www.hhs.gov/dab/divisions/appellate/guidelines/ index.html.

An appeal may be filed electronically at: https://dab.efile.hhs.gov and following the e-filing instructions for "Appeals to Appellate Division/Board." Pursuant to regulation, a request for review must specify the issues, the findings of fact or conclusions of law with which Petitioner disagrees, and the basis for contending that the findings and conclusions are incorrect. 42 C.F.R. § 498.82(b). If a request for appeal cannot be filed electronically, it may be filed by sending the required documents to the Board by mail or commercial delivery service to:

Carolyn Reines-Graubard
Director, Appellate Division, MS 6127
Department of Health & Human Services
Departmental Appeals Board
Cohen Building, Room G-644
330 Independence Ave., S.W.
Washington, DC 20201

Questions regarding filing an appeal should be directed to the Appellate Division Director, Carolyn Reines-Graubard, at carolyn.reines-graubard@hhs.gov or at (202) 565-0116.

II. Procedural History and Findings of Fact

On October 1, 2015, National Government Services (NGS), a Medicare administrative contractor (MAC), deactivated Petitioner's group billing privileges. CMS Exhibits (Exs.) 1 at 2; 5 at 4. Petitioner's Medicare enrollment was deactivated because Petitioner failed to timely file a revalidation application in response to a revalidation request from NGS dated January 2, 2015.[2] CMS Exs. 1 at 2; 4 at 1.

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[2] On February 12, 2015, NGS received Petitioner's Medicare enrollment application (CMS 855B) to revalidate Petitioner's enrollment. CMS Ex. 6. On March 25, 2015, NGS requested additional information from Petitioner in order to process and approve Petitioner's application. CMS Ex. 7. On April 2, 2015, Petitioner responded to NGS with additional information. CMS Exs. 8, 9. On May 5, 2015, NGS rejected Petitioner's application because NGS determined that Petitioner did not provide complete information, but NGS offered Petitioner another opportunity to provide the requested information so that Petitioner could be "reinstated." CMS Ex. 10. On May 7, 2015, Petitioner submitted additional information to NGS. CMS Ex. 11. On June 3, 2015, NGS requested additional information and warned Petitioner that NGS may reject its

Continued on next page.

On April 19, 2016, NGS received an enrollment application (CMS-855B) from Petitioner to reactivate Petitioner's Medicare billing privileges. CMS Exs. 1 at 2; 14. On May 25, 2016, NGS requested additional information regarding Petitioner's enrollment application. CMS Ex. 15. On May 31, 2016, NGS received Petitioner's response, but NGS found that Petitioner provided incomplete information. CMS Exs. 1 at 2; 16. On June 30, 2016, NGS rejected Petitioner's reactivation application and advised Petitioner that it must complete a new Medicare enrollment application. CMS Ex. 1 at 2, 10.

On July 11, 2016, NGS received another reactivation application from Petitioner. CMS Ex. 3. On July 18, 2016, NGS requested supporting documentation. CMS Ex. 17. On July 22, 2016, Petitioner submitted the additional documentation requested. CMS Ex. 18. On August 23, 2016, NGS approved Petitioner's application with an effective date of reactivation of Petitioner's billing privileges of June 11, 2016. CMS Ex. 1 at 2, 11-13. On September 2, 2016, Petitioner requested reconsideration of the June 11, 2016 effective date of the reactivation of its billing privileges. CMS Ex. 1 at 5-13. On September 8, 2016, NGS issued a reconsidered determination denying Petitioner's request for an earlier effective date. CMS Ex. 1 at 1-4.

Petitioner filed a request for hearing before an ALJ on October 26, 2016. On November 17, 2016, the case was assigned to me for hearing and decision, and an Acknowledgment and Prehearing Order (Prehearing Order) was issued at my direction.

CMS filed a motion for summary judgment (CMS Br.) and CMS Exs. 1 through 24 on December 21, 2016. On January 18, 2017, Petitioner filed its response brief (P. Br.) with no exhibits. Petitioner has not objected to my consideration of CMS Exs. 1 through 24 and they are admitted as evidence.

III. Discussion

A. Applicable Law

Section 1831 of the Social Security Act (the Act) (42 U.S.C. § 1395j) establishes the supplementary medical insurance benefits program for the aged and disabled known as

(*Footnote continued.)*

application if Petitioner did not provide complete information within 30 days. CMS Ex. 12. On July 29, 2015, NGS rejected Petitioner's application because Petitioner did not provide the information to complete its enrollment application within 30 days. CMS Ex. 13. On October 1, 2015, NGS deactivated Petitioner's billing privileges due its failure to timely respond to the January 2, 2015 revalidation request. CMS Exs. 1 at 2; 5 at 4.

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. § 1395(u)(h)(1)). Administration of the Part B program is through contractors such as NGS. Act § 1842(a) (42 U.S.C. § 1395u(a)).

The Act requires the Secretary of Health and Human Services (the Secretary) to issue regulations that establish a process for the enrollment of providers and suppliers, including the right to a hearing and judicial review of certain enrollment determinations. Act § 1866(j) (42 U.S.C. § 1395cc(j)).

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 rendered to a Medicare eligible beneficiary. Pursuant to 42 C.F.R. § 424.505, "once enrolled the provider or supplier receives billing privileges and is issued a valid billing number. . . ." The "effective date of billing privileges," that is, enrollment in Medicare of a physician, nonphysician practitioner, and physician and nonphysician practitioner organizations, is governed by 42 C.F.R. § 424.520(d). The effective date of enrollment for a physician or nonphysician practitioner may only be the later of two dates: the date when the physician filed an application for enrollment that was subsequently approved by a Medicare contractor charged with reviewing the application on behalf of CMS; or the date when the physician first began providing services at a new practice location. *Id.* An enrolled physician or nonphysician practitioner may retrospectively bill Medicare for services provided to Medicare-eligible beneficiaries up to 30 days prior to the effective date of enrollment, if circumstances precluded enrollment before the services were provided. Retrospective billing for up to 90 days prior to the effective date of enrollment is permitted only in case of a Presidentially-declared disaster pursuant to 42 U.S.C. §§ 5121-5206. 42 C.F.R. § 424.521.

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[3] Petitioner is a "supplier" under the Act and the regulations. A "supplier" furnishes services under Medicare and the term supplier applies to physicians or other practitioners and facilities that are not included within the definition of the phrase "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, and a fund as described in sections 1814(g) and 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.

Pursuant to 42 C.F.R. § 424.502, deactivate "means that the provider or supplier's billing privileges were stopped, but can be restored upon the submission of updated information." The Secretary has authorized CMS to deactivate a provider's or supplier's Medicare billing privileges if the provider or supplier does not submit any Medicare claims for 12 consecutive calendar months. 42 C.F.R. § 424.540(a)(1). CMS may also deactivate a provider's or supplier's billing privileges if the provider or supplier does not report certain changes of information, such as a change in practice location or change of any managing employee, within 90 calendar days of when the change occurred; does not report a change in ownership or control within 30 days; or does not provide complete and accurate information within 90 days of CMS's request for such information. 42 C.F.R. § 424.540(a)(2), (3). A provider or supplier "deactivated for any reason other than nonsubmission of a claim" is required to "complete and submit a new enrollment application to reactivate its Medicare billing privileges or, when deemed appropriate, at a minimum, recertify that the enrollment information currently on file with Medicare is correct." 42 C.F.R. § 424.540(b)(1). A provider or supplier who is "deactivated for nonsubmission of a claim" for 12 months is "required to recertify that the enrollment information currently on file with Medicare is correct and furnish any missing information as appropriate. The provider or supplier must meet all current Medicare requirements in place at the time of reactivation, and be prepared to submit a valid Medicare claim." 42 C.F.R. § 424.540(b)(2). Deactivation of Medicare billing privileges is to protect the provider or supplier from misuse of their billing privileges and the Medicare Trust Funds. The Secretary has provided by regulation that deactivation does not have any effect upon the provider's or supplier's participation in Medicare. 42 C.F.R. § 424.540(c).

B. Analysis

There is no dispute that Petitioner was enrolled in Medicare with billing privileges prior to deactivation. CMS Ex. 5. On October 1, 2015, NGS deactivated Petitioner's billing privileges as a Medicare supplier because Petitioner failed to timely revalidate its enrollment. CMS Exs. 1 at 2; 5. There is no evidence suggesting that NGS or CMS revoked Petitioner's enrollment and billing privileges at the time or subsequently. CMS Ex. 5.

The September 8, 2016 reconsidered determination shows that the NGS applied 42 C.F.R. § 424.520(d) to determine the June 11, 2016 effective date of reactivation of Petitioner's billing privileges pursuant to CMS policy articulated in Medicare Program Integrity Manual (MPIM) CMS Pub. 100-08 §§ 15.29.3.3 and 15.29.4.3. CMS Ex. 1 at 1-3.

In its request for hearing, Petitioner contends it was never told that its account was deactivated. P. Br. at 1. Petitioner argues it should have been told that it may not get reimbursed for the services provided while in the revalidation process. P. Br. at 2.

Additionally, Petitioner blames NGS for providing misinformation during the revalidation process. P. Br. at 2. However, Petitioner's arguments are ineffective because Petitioner has no right to ALJ review and I have no authority to grant any relief.

Section 1866(j)(8) of the Act provides,

> [a] provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) under this title is denied may have a hearing and judicial review of such denial under the procedures that apply under subsection (h)(1)(A) to a provider of services that is dissatisfied with a determination by the Secretary.

Pursuant to sections 1866(b)(2) and (h)(1) of the Act, "an institution or agency dissatisfied with a determination by the Secretary that it is not a provider of services" or whose enrollment in Medicare has been denied or terminated for failure to meet participation requirements, is entitled to a hearing and judicial review. The Secretary has, as required by sections 1866(j)(1) and 1871 (42 U.S.C. § 1395hh) of the Act, issued regulations providing for the enrollment of providers and suppliers and the administration of the Medicare program. The Secretary has provided by regulations that some actions by CMS or its contractors are subject to ALJ, Board, and judicial review, but not all.

The regulations applicable to establishing and maintaining Medicare billing privileges are at 42 C.F.R. pt. 424, subpt. P. The regulations define "enroll" or "enrollment" to mean the "process that Medicare uses to establish eligibility to submit claims for Medicare-covered items and services, and the process that Medicare uses to establish eligibility to order or certify Medicare-covered items and services." 42 C.F.R. § 424.502. Approval of an enrollment application means that the provider or supplier has been determined eligible "to receive a Medicare billing number and be granted Medicare billing privileges." *Id.* Denial of enrollment means that the provider or supplier has been determined ineligible for Medicare billing privileges and to seek payment from Medicare for services provided to Medicare-eligible beneficiaries. *Id*. Revoke or revocation means that a provider or supplier's billing privileges are terminated. *Id*. Deactivation of a provider's or supplier's billing privileges means that billing privileges were stopped, not revoked, and the billing privileges can be restored by the submission of updated information. *Id*.

The Secretary has provided that a provider or supplier denied enrollment or whose enrollment had been revoked may appeal the CMS decision in accordance with 42 C.F.R. pt. 498. 42 C.F.R. § 424.545(a). A provider or supplier whose billing privileges are deactivated, that is, stopped, may file a rebuttal under 42 C.F.R. § 405.374, but no right to appeal under 42 C.F.R. pt. 498 is accorded. 42 C.F.R. § 424.545(b). If a rebuttal is

submitted under 42 C.F.R. § 405.374, the rebuttal statement is considered by the Medicare contractor, which issues a determination, and that determination is not an initial determination or subject to appeal. 42 C.F.R. § 405.375(b) and (c).

Appeal rights are established by 42 C.F.R. § 498.5. An enrolled supplier, such as Petitioner, that is dissatisfied with an initial determination that its services no longer meet the conditions for coverage under Medicare is entitled to a hearing before an ALJ. 42 C.F.R. § 498.5(e). The right to Board review is accorded by 42 C.F.R. § 498.5(f). The evidence does not show such a determination was made in this case. Petitioner's billing privileges were deactivated; neither CMS nor NGS determined that Petitioner's services were not subject to coverage.

A practitioner, provider, or supplier who has been suspended or whose services are excluded from coverage or who has been sanctioned under 42 C.F.R. § 498.3(c)(2) or (3) is entitled to a hearing before an ALJ and Board review. The imposition of sanctions and exclusions covered by 42 C.F.R. § 498.3(c) are initial determinations by the Inspector General and there is no evidence of such an action in this case.

Appeal rights related to provider and supplier enrollment are established by 42 C.F.R. § 498.5(*l*). Initial determinations of CMS and its contractors that are subject to review are listed in 42 C.F.R. § 498.3(a)(2) and (b). Whether to deny or revoke enrollment and the effective date of enrollment are specifically listed as initial determinations subject to review. 42 C.F.R. § 498.3(b)(15), (17). Determinations by CMS or its contractor to deactivate and reactivate or ***the effective date of reactivation*** are not listed in 42 C.F.R. § 498.3 as determinations subject to review. Under 42 C.F.R. § 498.5(*l*), prospective or existing providers or suppliers dissatisfied with an initial or revised initial determination related to the denial or revocation of Medicare billing privileges may request reconsideration. CMS or its contractor or a prospective or existing provider or supplier is granted the right to request ALJ review of an unfavorable reconsidered or revised reconsidered determination. Board and judicial review are also granted. 42 C.F.R. § 498.5(*l*). There is no specific language granting a right to ALJ, Board, or judicial review related to deactivation or reactivation of billing privileges or the effective date of reactivation in 42 C.F.R. § 498.5(*l*). In *Victor Alvarez, M.D.*, DAB No. 2325 (2010) the Board construed 42 C.F.R. § 498.3(b)(15) as according a right to ALJ, Board, and judicial review to a supplier dissatisfied with a reconsidered determination related to the effective date of enrollment and billing privileges of the supplier in Medicare. The situation in *Alvarez* is distinguishable because in that case there was clear authority to review the enrollment determination. The Board reasoned that the determination of effective date was actually a determination to not enroll Alvarez in Medicare on an earlier date as he requested. *Alvarez*, DAB No. 2325 at 3. Unlike *Alvarez*, the reconsidered determination before me is related to a deactivation and reactivation of Medicare billing privileges for which the Secretary has specifically determined not to accord a right to ALJ, Board, and judicial review. In this case, there was no initial determination by CMS

or NGS that is subject to further review under 42 C.F.R. §§ 498.3(b) and 498.5(*l*). Because there was no initial determination subject to review, Petitioner had no right to reconsideration or ALJ review of the reconsidered determination. I conclude that I have no authority to grant Petitioner review under § 1866(j)(8) of the Act or 42 C.F.R. §§ 424.545 and 498.5, or by extension as in *Alvarez*, under 42 C.F.R. § 498.3(b)(15). Accordingly, Petitioner's request for hearing must be dismissed.

Previously I issued decisions remanding and dismissing cases involving deactivation, reactivation, and the determination of the effective date of reactivation. *See e.g.*, *East Cooper Surgical Assoc.*, DAB CR3235 (2014), *Kamran Hamidi, M.D.*, DAB CR4577 (2016); *Jean-Claude Henry, M.D.*, DAB CR4627 (2016). The cases were remanded to permit CMS to ensure action on reconsideration by its contractors was consistent with the regulations and CMS policies related to deactivation, reactivation, and the effective date of reactivation. CMS has reissued its policy during the period spanned by the decisions and an additional remand based on these issues appears pointless. Accordingly, I will not remand this case but simply dismiss for lack of jurisdiction for the reasons discussed.

I have no authority or jurisdiction to review or invalidate CMS policy in this case or to grant Petitioner any form of equitable relief. However, CMS may wish to resolve apparent inconsistencies between its policies related to deactivation, reactivation, and the determination of the reactivation effective date consistent with the Secretary's regulations. CMS policy with respect to reactivations is set forth in MPIM § 15.27. Previous CMS policy was that if the MAC approved a provider or supplier's reactivation application or reactivation certification package, the reactivation effective date was the provider or supplier's date of deactivation. MPIM § 15.27.1.2 (rev. 474, iss'd July 5, 2013, eff. October 8, 2013). The policy appeared consistent with the Secretary's regulation that provided that deactivation had no effect on a provider or supplier's participation agreement or conditions of participation. 42 C.F.R. § 424.540(c). But CMS subsequently changed its policy in December 2014. The policy as changed provided that if a CMS contractor approves a supplier's reactivation application, "the reactivation effective date shall be the date the contractor received the application . . . that was processed to completion." MPIM § 15.27.1.2 (rev. 561, iss'd Dec. 12, 2014, eff. Mar. 18, 2015). When Petitioner's July 11, 2016 application for revalidation was submitted, the CMS policy for reactivation instructed contractors that if a revalidation was received more than 120 days after deactivation, a new effective date would be issued to the supplier consistent with the effective date requirements of MPIM § 15.17, which applies 42 C.F.R. § 424.520(d), which regulates the effective date of a new enrollment by a physician, nonphysician practitioner, or organizations of either. MPIM § 15.29.4.3 (rev. 578, iss'd Feb. 25, 2015, eff. May 15, 2015). CMS has again revised its policy and re-issued MPIM § 15.29.4.3 (rev. 685, iss'd Nov. 3, 2016, eff. Sep. 6, 2016), and the current version states, in relevant part:

> MACs shall require the provider/supplier to submit a new full application to reactivate their enrollment record after they have been deactivated. The MAC shall process the application as a reactivation and establish an effective date based on the receipt date of the application. The provider/supplier shall maintain their original PTAN but the MAC shall reflect a gap in coverage (between the deactivation and reactivation of billing privileges) on the existing PTAN using Action Reason (A/R) codes in the Multi-Carrier Claims System (MCS) based on the receipt date of the application. The provider will not be reimbursed for dates of service in which they were not in compliance with Medicare requirements (deactivated for non-response to revalidation). This requirement also applies to group members whose reassignment association was terminated when the group was deactivated.

The CMS policy regarding reactivation and the reactivation effective date appears to be inconsistent with the Secretary's regulation, which provides that deactivation of Medicare billing privileges is to protect the provider or supplier from misuse of their billing privileges and the Medicare Trust Funds and does not have any effect upon the provider's or supplier's participation in Medicare. 42 C.F.R. § 424.540(c). If current CMS policy in the MPIM is given effect, it prevents the filing of claims for covered services rendered to Medicare-eligible beneficiaries during the period of the deactivation and before the contractor receives the Medicare application (a CMS-855 or PECOS application) filed for purposes of reactivation. This effect is clearly contrary to the Secretary's regulation that provides deactivation **"does not have any effect upon the provider's or supplier's participation agreement or conditions of participation."** 42 C.F.R. § 424.540(c) (emphasis added).[4] I note that 42 C.F.R. § 424.555(b) states that "[n]o payment may be made for otherwise Medicare covered items or services furnished to a Medicare beneficiary by a provider or supplier if the billing privileges of the provider or supplier

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[4] The current CMS policy also creates a conflict among 42 C.F.R. § 424.545(b), 42 C.F.R. § 498.5(*l*), and 42 C.F.R. § 498.3(b)(15). Under 42 C.F.R. §§ 424.545(b), 498.5(*l*), a supplier has no right to review of the decision to deactivate billing privileges or the reactivation of those privileges. However, as the Board has previously concluded, 42 C.F.R. § 498.3(b)(15) recognizes a right to review of a determination by CMS or its contractors as to the effective date of a Medicare provider agreement or the approval of a supplier's participation in Medicare. If the CMS policy related to deactivation and reactivation is enforced as currently published, a provider or supplier is effectively deprived of a period of billing privileges without the due process provided by the Act and Secretary for a denial or revocation of billing privileges.

are deactivated, denied, or revoked." The regulation clearly distinguishes between a deactivation of billing privileges and a denial or revocation of billing privileges. The regulation states that payment may not be made, but it does not state that a provider or supplier whose billing privileges are deactivated is in the same status as one whose billing privileges are revoked or denied, that is, unable to deliver Medicare-covered care and services and to bill for such services. Indeed, 42 C.F.R. § 424.545(a)(2) recognizes that even a revoked or denied provider or supplier is not prohibited from providing Medicare-covered services to a Medicare-eligible beneficiary during the pendency of an action to deny or revoke enrollment, including the period of appeal. The regulation specifies that payment for claims is not made during the appeal of the denial or revocation and payment will only be made if the claims are resubmitted after the provider or supplier successfully overturns the denial or revocation. The CMS policy related to providing services and billing during a period of deactivation appears to treat a supplier more harshly than a supplier subject to a proceeding to deny or revoke billing privileges without providing a right to ALJ, Board, or judicial review.

CMS policies as set forth in MPIM § 15.27.1.2 and 15.29.4.3 are arguably not enforceable to the extent the policies are inconsistent with the Secretary's regulation. CMS policy statements such as those set forth in the MPIM do not have the force and effect of law, *i.e.*, the statutes or regulations. Act § 1871; *Perez v. Mortgage Bankers Ass'n*, 575 U.S. ___, 135 S. Ct. 1199 at 1204 (2015) (Convenience of issuing an interpretive rule or policy rather than a legislative rule using the Administrative Procedure Act (APA) notice and comment procedure "comes at a price: **Interpretive rules** 'do not have the force and **effect** of **law** and are not accorded that weight in the adjudicatory process.'" (citation omitted) (emphasis in original)); *Ind. Dep't. of Pub. Welfare v. Sullivan*, 934 F.2d 853 (7th Cir. 1991) (substantive rules promulgated under the APA notice and comment rulemaking procedures as regulations are enforceable as law; agency interpretative rules or policy statements are not subject to notice and comment rulemaking requirements but are not enforceable as law); *Nw. Tissue Ctr. v. Shalala*, 1 F.3d 522 (7th Cir. 1993). Furthermore, as an ALJ, I am bound to follow the Constitution, the Act, and the Secretary's regulations, and I am to give effect to the policies of the Secretary and CMS to the extent they are not inconsistent with the law, when I have jurisdiction to do so. *1866ICPayday.com, L.L.C.*, DAB No. 2289 at 14 (2009) ("[a]n ALJ is bound by applicable laws and regulations and may not invalidate either a law or regulation on any ground.").

IV. Conclusion

For the foregoing reasons, this case is dismissed for lack of jurisdiction.

/s/
Keith W. Sickendick
Administrative Law Judge