Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Ankle & Foot Specialty Clinics, LLC,
(PTAN: MI4296),
(NPI: 1043509433),

Petitioner,

v.

Centers for Medicare & Medicaid Services

Docket No. C-17-402

Decision No. CR4871

Date: June 16, 2017

DECISION

I sustain the determination by a Medicare contractor, as subsequently confirmed on initial determination and reconsideration, to reactivate the billing privileges of Petitioner, Ankle & Foot Specialty Clinics, LLC effective October 12, 2016.

I. Background

The Centers for Medicare & Medicaid Services (CMS) moved for summary judgment. With its motion it filed 18 proposed exhibits that it identified as CMS Ex. 1-CMS Ex. 18. Petitioner filed a brief in opposition and filed no proposed exhibits.

It is unnecessary that I decide whether the criteria for summary judgment are met although, as I discuss below, the material facts are undisputed. Neither side proposed witness testimony and, consequently, this case is ripe for decision based on the parties' written exchanges. I receive CMS Ex. 1- CMS Ex. 18 into the record.

II. Issue, Findings of Fact, and Conclusions of Law

A. Issue

The issue is whether a Medicare contractor properly reactivated Petitioner's Medicare billing privileges effective October 12, 2016.

B. Findings of Fact and Conclusions of Law

The parties agree as to the material facts. Petitioner's sole argument is equitable: it asserts that any delays in reactivating its Medicare participation requirement resulted from problems it encountered filing its application and associated information online and it contends that those delays should not cause it to be penalized for untimely filing. As I discuss below, I am without authority to consider this argument.

These are the material facts. On April 7, 2016, a Medicare contractor sent a request to Petitioner, asking it to revalidate its Medicare enrollment. CMS Ex. 2.[1] In that letter the contractor advised Petitioner of a June 30, 2016 deadline for submitting its revalidation request.

Petitioner failed to meet the June 30 deadline. On July 6, 2016, the contractor notified Petitioner that it had not received its revalidation request. CMS Ex. 3. On July 11, 2016, the contractor told Petitioner that it was withholding payments for claimed services because of Petitioner's failure to revalidate its Medicare enrollment. CMS Ex. 4.

Petitioner filed a revalidation application on July 14, 2016. CMS Ex. 5 at 1-2. However, the application was incomplete. *Id*. On August 30, 2016, the contractor advised Petitioner by email that the application was incomplete and told Petitioner that there were items that required either correction or additional information. *Id.*

Petitioner did not reply immediately to the contractor's August 30 notification. On September 29, 2016, the contractor stopped Petitioner's billing privileges due to its failure to reply to the August 30 email. CMS Ex. 9. On that same date the contractor notified Petitioner that its revalidation request was incomplete because it failed to supply several mandatory items. CMS Ex. 10.

Petitioner submitted a revalidation application on October 12, 2016. CMS Ex. 11. However, that application also lacked certain mandatory information. On October 13, 2016, by email, the contractor told Petitioner that its application was incomplete and

[1] On that same date the contractor sent an identical request to Steven L. Sheridan, D.P.M., Petitioner's owner and proprietor, asking that he revalidate his individual participation in Medicare. CMS Ex. 1. Dr. Sheridan's revalidation is not at issue here.

specified what additional information was necessary. CMS Ex. 12. The contractor telephoned Petitioner on October 13 and 14 in order to discuss the issues pertaining to Petitioner's revalidation application. CMS Ex. 15 at 4. The contractor confirmed that Petitioner's application remained incomplete in a letter dated October 17, 2016. CMS Ex. 13.

Petitioner finally complied with the contractor's requests, after receiving the contractor's October 17 letter. Consequently, on October 25, 2016, the contractor approved Petitioner's revalidation effective October 12, 2016. CMS Ex. 14. The contractor also notified Petitioner on that date that there would be a billing gap for the period from September 28 to October 12, due to Petitioner's failure to supply the contractor timely with requested information.

The law governing revalidations of Medicare billing privileges is set forth in regulations and it is unequivocal. An enrolled Medicare physician supplier (or participating entity that is owned and operated by the physician supplier) is subject to a five-year revalidation cycle. Once notified of the need to revalidate the participating supplier has 60 calendar days within which to recertify the accuracy of its enrollment application. 42 C.F.R. § 424.515(a)(2). CMS may deactivate an enrolled supplier's Medicare billing privileges if it fails timely to revalidate its enrollment. 42 C.F.R. § 424.540(a)(3). The purpose of deactivation is to protect the supplier from misuse of its billing privileges and also to protect Medicare from making unnecessary overpayments. 42 C.F.R. § 424.540(c). If CMS or one of its contractors deactivates a Medicare supplier's billing privileges it may not reimburse the deactivated supplier for items or services that it provides during the deactivation period. 42 C.F.R. § 424.555(b).

A supplier that is deactivated for any reason other than non-submission of claims must submit a new Medicare enrollment application in order to be reactivated. 42 C.F.R. § 424.540(b)(1).[2] The same requirements that govern a new enrollment application govern an application for reactivation. 42 C.F.R. § 424.515(a); *see* 42 C.F.R. 424.510.

The terms of 42 C.F.R. § 424.520(d) establish the effective date of reactivation of billing privileges for any supplier that files a new enrollment application. As is applicable to this case, the effective date is the date of filing of an enrollment application that a contractor subsequently approves.

The contractor deactivated Petitioner's billing privileges effective September 29, 2016, because Petitioner – notwithstanding numerous requests by the contractor – had not filed complete recertification information with the contractor by that date. The determination

[2] In some circumstances, CMS or one of its contractors has discretion to accept a recertification from a supplier that the enrollment application currently on file is correct, in lieu of a new application. The contractor did not elect to do so here.

to deactivate is in accord with the requirements of 42 C.F.R. § 424.540(a)(3). The inexorable consequence of deactivation was that Petitioner could not receive reimbursement for Medicare items or services that it provided during the deactivation period. 42 C.F.R. § 424.555(b). Petitioner did not submit an application for reactivation of its billing privileges that the contractor subsequently approved until October 12, 2016. The earliest date that the contractor could reinstate Petitioner's billing privileges was October 12. 42 C.F.R. § 424.520(d). The result was that the contractor could not reimburse Petitioner for Medicare items or services that Petitioner provided from September 29 through October 11, 2016.

As I have stated, Petitioner does not dispute any of the facts of this case. Indeed, in its request for reconsideration Petitioner explicitly admitted that these facts are accurate. Nor does it assert that the regulations allow it to receive reimbursement for items or services during the September 29-October 11 deactivation period. Rather, Petitioner makes an equitable argument. According to Petitioner, it was led astray by Medicare's relatively new process that directs suppliers to file revalidation applications online. Petitioner contends that it found this process to be confusing and cumbersome and that it either had problems uploading requisite items or that some of them were simply lost in filing. Petitioner asserts, essentially, that it is blameless for its late filing and that it should not be penalized. I don't have authority to rule on these arguments. Equitable arguments are generally not reviewable in appeals of administrative determinations. *Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414 (1990). They clearly are not reviewable in cases involving challenges to determinations made by and on behalf of CMS. *Amber Mullins, N.P.*, DAB No. 2729 (2016); *US Ultrasound*, DAB No. 2302 (2010).

That said, I do not agree with Petitioner's assertion that it is blameless for its failure to file timely its Medicare revalidation request. The record of this case is replete with efforts by the contractor to explain to Petitioner the shortcomings of its documentation. Petitioner has not offered any cogent explanation for its failures, either to respond immediately to the contractor, or to work out the issues and problems it contends that it faced. For example, it hasn't explained why, if it was encountering technical difficulties with online filing, it didn't endeavor to correct those difficulties immediately through communications with the contractor.

_____/s/_____
Steven T. Kessel
Administrative Law Judge