**Department of Health and Human Services**
**DEPARTMENTAL APPEALS BOARD**
**Appellate Division**

Haissam Elzaim, M.D.
Southern Texas Physician Network
HSE Orthopaedic Surgery Clinic
Docket No. A-13-22
Decision No. 2501
March 11, 2013

# FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Haissam Elzaim, M.D. (Petitioner) appeals the October 17, 2012 decision of Administrative Law Judge (ALJ) Richard J. Smith dismissing Petitioner's request for an ALJ hearing pursuant to 42 C.F.R. § 498.70(b). *Haissam Elzaim, M.D.*, DAB CR2650 (2012) (ALJ Decision). The ALJ determined that Petitioner did not have a right to a hearing because there was no reconsidered determination by the Centers for Medicare and Medicaid Services (CMS) subject to review.

For the reasons explained below, we affirm the ALJ's dismissal of Petitioner's hearing request.

## Regulatory Background

CMS or its agent may revoke a supplier's Medicare billing privileges and corresponding supplier agreement if the supplier "is determined not to be in compliance with the enrollment requirements described in [42 C.F.R. Part 424]."[1] 42 C.F.R. § 424.535(a)(1). To maintain active enrollment status in the Medicare program, a physician must report a change of ownership, adverse legal action, or change in practice location within 30 days, and all other changes in enrollment within 90 days. 42 C.F.R. § 424.516(d).

The decision to revoke a supplier's Medicare enrollment is an "initial determination" that is subject to the review procedures at 42 C.F.R. Part 498. 42 C.F.R. § 498.3(a)(1), (b)(17). Section 498.5(l) delineates the procedures for appealing provider and supplier enrollment determinations. Under section 498.5(l)(1), a supplier "dissatisfied with an initial determination or revised initial determination related to the denial or revocation of Medicare billing privileges may request reconsideration in accordance with § 498.22(a)."

[1] Under 42 C.F.R. § 400.202, "[s]upplier means a physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare."

42 C.F.R. § 498.5(l)(1). The reconsideration request must be filed "[w]ithin 60 days from receipt of the notice of initial determination, unless the time is extended [by CMS for 'good cause']." 42 C.F.R. § 498.22(b), (d). When a request for reconsideration has been properly filed, CMS "[m]akes a reconsidered determination, affirming or modifying the initial determination…." 42 C.F.R. § 498.24(c). Under section 498.5(l)(2), a supplier "dissatisfied with a reconsidered determination under paragraph (l) … is entitled to a hearing before an ALJ." An initial determination to revoke billing privileges is "binding" unless it is reconsidered pursuant to section 498.24, reversed or modified by a hearing decision under section 498.78 (remand by an ALJ), or revised under sections 498.32 or 498.100 (reopening and revision). 42 C.F.R. §§ 498.20(b), 498.24.

An ALJ may dismiss a hearing request "for cause" when the requesting party "is not a proper party or does not otherwise have a right to a hearing." 42 C.F.R. § 498.70(b).

## Case Background[2]

In August 2010, Petitioner closed his sole ownership practice (HSE Orthopaedic Surgery Clinic) and his bank account associated with that practice. April 23, 2012 Request for ALJ Hearing at 1. Petitioner did not submit a CMS-855I form to officially terminate that practice under Medicare. *Id.* Petitioner subsequently began employment at Southern Texas Physician Network (STPN), and he reassigned his Medicare payments to STPN effective September 1, 2010. *Id.*

On March 31, 2011, CMS contractor, TrailBlazer Health Enterprises, LLC (TrailBlazer), issued a notice to Petitioner stating that TrailBlazer had received a return summary from Petitioner's financial institution showing that Petitioner's Electronic Funds Transfer (EFT) account had been closed. P. Ex. 1. TrailBlazer stated that a new EFT agreement with updated account information was required within 90 days. *Id.*

On August 25, 2011, Trailblazer issued a notice to Petitioner that his Medicare Provider Transaction Access Numbers (PTANs) and associated National Provider Identifiers (NPIs) were "currently in the revocation process." P. Ex. 2. The notice stated that TrailBlazer had not received the requested EFT documentation and that to prevent the revocation, Petitioner must submit a new EFT agreement within 30 days. *Id.* The letter explained that under 42 C.F.R. § 424.535(b), when a provider or supplier's billing privileges are revoked, any provider agreement in effect at the time of revocation is terminated effective with the date of revocation. *Id.*

On November 10, 2011, TrailBlazer issued to Petitioner a notice of revocation of his billing privileges and termination of any related supplier agreement. P. Ex. 3. The notice

[2] The background information is drawn from the ALJ Decision and the record before him and is not intended to substitute for his findings.

stated that the actions were being taken because Petitioner had not submitted the previously requested EFT documents and thereby failed to comply with the requirements for enrolling and maintaining active enrollment in the Medicare program in 42 C.F.R. §§ 424.516(d)(2) and 424.516(e)(2) that a supplier must "furnish complete and accurate information and all supporting documentation within 90 calendar days" of notification. *Id.* at 1. The notice also stated that CMS was imposing a one-year re-enrollment bar on Petitioner's participation in Medicare pursuant to section 424.535(c). *Id.* The notice stated that Petitioner had a right to request reconsideration of the determination by filing a request within 60 days from the postmark date of the letter. *Id.* at 3.

On February 14, 2012, HCA Physician Services, acting on behalf of Petitioner, sent TrailBlazer a request for reconsideration of Petitioner's revocation and re-enrollment bar. P. Ex. 5A. By notice dated March 7, 2012, TrailBlazer notified Petitioner that it was denying his request for reconsideration because it "was received past the time limit" and that "[f]ailure to timely request reconsideration is deemed a waiver of all rights to further administrative review." P. Ex. 7.

On April 23, 2012, Petitioner requested an ALJ hearing to contest the revocation of his Medicare billing privileges and one-year re-enrollment bar. Petitioner asserted that he was unaware of TrailBlazer's revocation notices "until all payments stopped for his current reassignment to [STPN]." Request for ALJ Hearing at 2. At that time, Petitioner stated, he contacted TrailBlazer, and a TrailBlazer employee faxed copies of the notices to him. *Id.* Petitioner stated that he had not previously received the notices because they had been mailed to addresses associated with his former, sole-ownership practice, which he closed in August 2010. P. Request for Summary Judgment, Docket No. C-12-643, at 2-4. However, Petitioner acknowledged that he did not submit the requisite CMS form to terminate the PTAN associated with his sole practice. *Id.* at 2. Petitioner stated that in August 2010 he submitted Medicare forms to update his information and "to reassign his benefits" to STPN but that TrailBlazer failed to use his updated mailing address. *Id.* at 7-9. Petitioner further argued that when he contacted TrailBlazer, a TrailBlazer employee instructed him how to file corrective documentation. *Id.* at 4-6. TrailBlazer's March 7, 2012 denial of his February 14, 2012 reconsideration request, Petitioner alleged, was inconsistent with those instructions. *Id.* at 5-6.

The ALJ, on his own motion, dismissed Petitioner's hearing request pursuant to 42 C.F.R. § 498.70(b). The ALJ determined that Petitioner did not have a right to a hearing because there was no reconsidered determination by CMS or TrailBlazer subject to ALJ review.

**Standard of Review**

We review a disputed factual issue as to whether the ALJ's decision is supported by substantial evidence in the record as a whole. We review a disputed issue of law as to

whether the ALJ's decision is erroneous. *See Departmental Appeals Board, Guidelines -- Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program*, at http://www.hhs.gov/dab/divisions/appellate/guidelines/prosupenrolmen.html.

**Analysis**

On appeal to the Board, Petitioner argues that the ALJ erred in concluding that he did not have a right to an ALJ hearing. Petitioner asserts that his request for reconsideration was timely under section 498.22(b)(3), under which a request for reconsideration must be filed within 60 days from receipt of the notice. "Specifically," Petitioner contends, "the rebuttable presumption that notice was received 5 days after the date on the notice may be overcome by 'a showing that the notice was, in fact, received earlier or later.'" P. Br. at 2, *citing* 42 C.F.R. § 498.22(b)(3). Petitioner alleges that on August 4, 2010, he submitted to TrailBlazer forms to update his address information and to reassign all of his Medicare reimbursements to STPN. *Id.* Due to TrailBlazer's administrative error, Petitioner contends, the updated address was not processed. Consequently, Petitioner argues, the revocation notice was not sent to the correct address, and Petitioner did not receive the notice until it was faxed to him on January 25, 2012. In an "addendum" to his appeal file, Petitioner further argues that the one-year enrollment bar placed on him was inconsistent with section 424.535(c), which states that the "re-enrollment bar does not apply in the event a revocation of Medicare billing privileges is imposed under paragraph (a)(1) of this section based upon a provider or supplier's failure to respond timely to a revalidation request or other request for information."[3]

Neither the Board nor the ALJ are authorized to address the issues raised by Petitioner because under the regulations, TrailBlazer's November 10, 2011 initial determination was binding and Petitioner was not entitled to an ALJ hearing. As described above, the regulations governing appeals of enrollment determinations specify that a supplier "dissatisfied with a *reconsidered* determination … is entitled to a hearing before an ALJ." 42 C.F.R. § 498.5(l)(2) (emphasis added). Recent Board decisions explain that by regulation, "only reconsidered determinations related to the denial or revocation of billing privileges are eligible for ALJ review." *Denise A. Hardy, D.P.M.*, DAB No. 2464, at 4 (2012), *quoted in Better Health Ambulance*, DAB No. 2475, at 4 (2012); *cf. Hiva Vakil, M.D.*, DAB No. 2460, at 5 (2012) (noting that "the regulations plainly require that CMS or one of its contractors issue a 'reconsidered determination' before the affected party is entitled to request a hearing before an ALJ."). In this case, TrailBlazer never issued a reconsideration determination. Without a reconsidered determination to provide a basis for further review, the initial determination to revoke Petitioner's billing privileges

[3] We note that at the time of the initial determination to revoke Petitioner's billing rights, section 424.535(c) did not include this exception to the one-year minimum re-enrollment bar. The revised regulation cited by Petitioner was effective July 16, 2012. 77 Fed. Reg. 29,002, 29,009 (May 16, 2012).

became "binding." Section 498.20(b); *see also Better Health Ambulance* (holding that the initial determination became binding where the contractor never issued a reconsideration determination but instead dismissed the reconsideration request as untimely). Consequently, we conclude that the ALJ did not err in dismissing Petitioner's hearing request under section 498.70(b) because Petitioner had no right to an ALJ hearing.

**Conclusion**

For the foregoing reasons, we affirm the ALJ's dismissal of Petitioner's hearing request on the ground that Petitioner had no right to an ALJ hearing.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Sheila Ann Hegy
Presiding Board Member