Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Mason Round Rock OP LLC, d/b/a
San Gabriel Rehabilitation and Care Center,

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-12-1041

Decision No. CR2688

Date: January 14, 2013

DECISION

Petitioner, Mason Round Rock OP LLC, d/b/a San Gabriel Rehabilitation and Care Center, appeals the Centers for Medicare and Medicaid Services (CMS) contractor reconsideration decision issued on June 28, 2012. For the reasons stated below, I affirm CMS's determination and find CMS had a legitimate basis to enroll Petitioner in the Medicare program effective February 8, 2012, the date it determined Petitioner met all federal requirements.

I. Background and Procedural History

On December 21, 2011, Petitioner, a long-term care facility, filed a Medicare enrollment application, CMS Form 855A, with TrailBlazer Health Enterprises, LLC (TrailBlazer), the administrative contractor acting on behalf of CMS. CMS Ex. 1; P. Ex. 2. Petitioner sought certification as a skilled nursing facility for Medicare reimbursement purposes and recognized in its cover letter that additional supporting documents might be needed to complete the application. *Id.* On December 30, 2011, TrailBlazer faxed a letter to Petitioner acknowledging its receipt of the application and requested clarifications and

further documentation. CMS Ex. 2. On January 30, 2012, Petitioner faxed a letter to TrailBlazer and attached responses to TrailBlazer's requests from its December 30, 2011 letter. CMS Ex. 3. On January 31, 2012, TrailBlazer sent an e-mail acknowledging its receipt of the January 30, 2012 fax submission and Trailblazer requested additional information about the identity of an owner listed on the application as "M. Craig Kelly." CMS Ex. 4. On February 2, 2012, TrailBlazer sent a follow-up e-mail to Petitioner, asking if Petitioner had submitted the requested documentation for Mr. Kelly. CMS Ex. 4, at 1. The next day, February 3, 2012, Petitioner faxed the requested information to Trailblazer. CMS Ex. 5. On February 8, 2012, TrailBlazer sent a letter to the Texas Department of Health, Health Facility Compliance Division, recommending approval of Petitioner's application and requesting an on-site visit or survey. CMS Ex. 6.

On May 7, 2012, CMS notified Petitioner that its Medicare enrollment application had been approved and determined that February 8, 2012 would be the effective date of its provider agreement. CMS Exs. 7, 8. On May 17, 2012, Petitioner requested reconsideration of this determination and asked that its effective date be changed to January 13, 2012, the date of Petitioner's state licensure and Medicaid certification, which is 26 days earlier. CMS Ex. 9; P. Br. at 1. On June 28, 2012, CMS issued an unfavorable reconsideration determination that confirmed February 8, 2012, as the effective date of Petitioner's Medicare provider agreement because that was the date TrailBlazer determined Petitioner met all enrollment requirements. CMS Ex. 10.

On July 6, 2012, Petitioner filed a hearing request with the Civil Remedies Division of the Departmental Appeals Board before receiving any reconsideration determination. After actually receiving CMS's June 28, 2012 reconsideration determination, Petitioner filed a second hearing request on July 17, 2012. Both appeals were docketed as C-12-1041, and the case was assigned to me for hearing and decision.

In accordance with my Acknowledgment and Pre-hearing Order (Order) issued on August 1, 2012, CMS timely filed its pre-hearing exchange, incorporating a motion for summary judgment and brief (CMS Br.), with ten exhibits (CMS Exs. 1-10), on September 5, 2012. Petitioner filed a pre-hearing brief/response to CMS's motion for summary judgment, as well as a cross-motion for summary judgment (P. Br.), on September 20, 2012. Petitioner timely filed its pre-hearing exchange, including 13 exhibits (P. Exs. 1-13) on October 4, 2012. CMS filed a reply (CMS Reply). In the absence of any objection, I admit CMS Exs. 1 through 10 and P. Exs. 1 through 13 into the record.

My Order stated that the parties must submit as a proposed exhibit the written direct testimony of each proposed witness and that an in-person hearing would only be necessary if the opposing party requested an opportunity to cross-examine a witness. Order ¶¶ 8-11. CMS did not provide a list of proposed witnesses or written direct testimony. Petitioner submitted the Declaration of Eva Digman. P. Ex. 1. CMS has not

requested an opportunity to cross-examine Ms. Digman. Consequently, I will not hold an in-person hearing in this case. The record is closed, and I decide this matter, including complete factual findings, based on the written record. Order ¶ 12.

II. Issue

The issue in this case is whether CMS's contractor and CMS had a legitimate basis to determine February 8, 2012 as the effective date of Petitioner's Medicare provider agreement.

III. Findings of Fact and Conclusions of Law

A. *Petitioner's effective date may not be earlier than the date that CMS determined Petitioner satisfied its enrollment requirements.*

Section 1866(j) of the Social Security Act provides that the Secretary of the U.S. Department of Health and Human Services "shall establish by regulation a process for the enrollment of providers of services and suppliers under this title." Title 42 C.F.R. Part 424, subpart P, governs the process for enrollment of all providers and suppliers in the Medicare program. Subpart P describes completion of the enrollment process as a prerequisite for a provider or supplier "to bill" and "to receive payment" for Medicare covered services. 42 C.F.R. §§ 424.500, 424.505.

The effective date for Medicare participation for a skilled nursing facility is regulated such that:

> The agreement is effective on the date the State agency, CMS, or the CMS contractor survey (including Life Safety Code survey, if applicable) is completed, . . . if on that date the provider or supplier meets all applicable Federal requirements . . . However, the effective date of the agreement or approval may not be earlier than the latest of the dates on which CMS determines that each applicable Federal requirement is met. Federal requirements include, but are not limited to—
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>> (1) Enrollment requirements established in part 424, subpart P, of this chapter. CMS determines, based upon its review and verification of the prospective provider's or supplier's enrollment application, the date on which enrollment requirements have been met;

42 C.F.R. § 489.13(b)(1) (emphasis added).

CMS explained the following in the Federal Register:

> We believe that the intent of [42 C.F.R. § 489.13] is to require that all applicable Federal requirements, including a determination of whether the enrollment requirements have been satisfied, must be met before a provider agreement or supplier approval may be effective. Any other reading of the regulations could result in a provider or supplier being permitted to bill the Medicare program for services provided at a time when its compliance with Medicare's requirements is unknown and possibly deficient. . . . It would not be consistent with our duty to protect the Medicare Trust Funds from unsupported claims against it to permit payment for services furnished by a health care facility after it has passed a State survey or been accredited, but before it has satisfied all other Medicare participation requirements, including enrollment requirements.

75 Fed. Reg. 23,852, at 24,048 (May 4, 2010).

Thus, a CMS contractor must verify that a prospective provider has met all enrollment requirements before a provider agreement will take effect. To permit a provider to bill the Medicare program before it has satisfied all Medicare participation requirements, including enrollment requirements, would put the Medicare Trust Funds at risk.

To be enrolled in the Medicare program, a provider or supplier must meet the "enrollment requirements" relating to applications, including:

> (a) Providers and suppliers must submit enrollment information on the applicable enrollment application. Once the provider or supplier successfully completes the enrollment process, including, if applicable, a State survey and certification or accreditation process, CMS enrolls the provider or supplier into the Medicare program. To be enrolled, a provider or supplier must meet enrollment requirements specified in paragraph (d) of this section.
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> * * * * * * *
>
> (d) Providers and suppliers must meet the following enrollment requirements:
>
> > (1) *Submittal of the enrollment application*. A provider or supplier must submit a complete enrollment application and supporting documentation to the designated Medicare fee-for-service contractor.

> (2) *Content of the enrollment application*. Each submitted enrollment application must include the following:
>
> > (i) Complete, accurate, and truthful responses to all information requested within each section as applicable to the provider or supplier type.

42 C.F.R. § 424.510(a), (d)(1) and (d)(2)(i).

B. *CMS did not determine that Petitioner provided complete and accurate responses to the questions on its enrollment application until February 8, 2012.*

TrailBlazer informed Petitioner, by letter dated December 30, 2011, that it had received Petitioner's application for enrollment in the Medicare program. TrailBlazer stated, "[a] required data element is omitted from the CMS-855A application, and/or supporting documentation is incomplete or missing. See the enclosed document to identify the information that must be submitted." CMS Ex. 2. TrailBlazer included a separate document with its December 30, 2011 letter showing "Additional Information Needed to Complete Processing" and listed the following items:

> Section 2A4 (page 10) – Please check a box.
>
> Section 4A (page 20) – For initial enrollment the ADD box need [sic] to be checked with effective date, unless there is a medicare number in place and you are requesting a change. Please confirm and submit corrections.
>
> Section 5A (page 29) – For organizations: Mason Health, LLC; Mason Capital Asset 1, LP; AJJ Health, LLC; DLP Health Strategies, LLC; 2009RCWDALLAS, LLC, Please check the ADD box and effective date.
>
> Section 6A (page 34) – For individuals: L. Gage; M. Kelly; D. Prince; M. Minor and R. Cramer, Please check the ADD box and provide effective date.
>
> Section 4B (page 21) – Please check the ADD box and effective date, on initial enrollment, unless there is an [sic] medicare number in place. Please confirm and submit corrections.
>
> Section 15B (page 38)[1] – A new signed and dated certification page must be submitted with the corrected pages.

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[1] The reference to page 38 of Petitioner's application appears to be incorrect. The apparent correct page reference is page 49.

Section 15C (page 49) – Please check the ADD box and provide effective date.

CMS Ex. 2, at 5.

I have examined these sections of Petitioner's application that TrailBlazer found to be incomplete or inaccurate. Specifically, Section 2A4 on the application asked the question "Is the provider a physician-owned hospital (as defined in the Special Enrollment Notes on page 9)?" P. Ex. 2, at 8. Petitioner had not originally provided an answer to this question on the application.

Section 4A ("Practice Location Information") requests the applicant to report all practice locations where services will be furnished and contains the statement, "[i]f you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section." In this Section, Petitioner had checked the "CHANGE" box and stated an effective date of "12/20/2011." P. Ex. 2, at 15.

Section 4B asks "Where do you Want Remittance Notices or Special Payments Sent?" Again, the applicant is prompted to indicate whether the applicant is "changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section." Under this Section, Petitioner had checked the "CHANGE" box and stated an effective date of "12/20/2011." P. Ex. 2, at 16.

Section 5A requests information about corporate entities that have ownership interest or managing control of the applying entity, and Section 6A requires the names of individuals who have ownership interest or managing control of the applying entity. Both Section 5A and Section 6A contain the statement, "[i]f you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section." On its application, Petitioner listed five corporate entities in Section 5A and five individuals in Section 6A, and, in connection with each of these responses, Petitioner indicated this was a "CHANGE" of information with an effective date of "12/20/2011." P. Ex. 2, at 21-65.

Section 15 is the "Certification Statement" page and requires the signatures of authorized officials. In this Section, two authorized officials of Petitioner had signed the certification and indicated there was a "CHANGE" of information effective "12/20/2011." P. Ex. 2, at 71.

On January 30, 2012, Petitioner responded to Trailblazer's December 30, 2011 requests for clarifications by sending a facsimile along with a copy of its facility license showing a license effective date of January 13, 2012. CMS Ex. 3; P. Ex. 5.

After further review of Petitioner's application, TrailBlazer requested additional information regarding the identity of M. Craig Kelly. Specifically, in an e-mail dated January 31, 2012 to Petitioner, a representative from TrailBlazer stated, in relevant part:

> Section 6a (page 34) M. Craig Kelly is listed on the 855a application, but Michael Kelly is listed in our system. Can you please provide documentation of individuals [sic] correct name along with the corrected Section 6a (page 34).
>
> Section 15 (page 49) new "signature page" needs to be sent as well to validate corrections.

CMS Ex. 4; P. Ex. 6.

That same day, January 31, 2012, Petitioner's representative responded via e-mail, stating that she believed "Mr. Kelly's proper name is Michael Craig Kelly" and that she would "ask him for official documentation to confirm this and submit it as soon as possible."

On February 2, 2012, the TrailBlazer representative sent a follow-up e-mail to her request for documentation on Mr. Kelly's name. CMS Ex. 4; P. Ex. 6. On February 3, 2012, Petitioner responded by faxing the following documents to TrailBlazer: a revised Section 6A, spelling out Michael Craig Kelly's name; a new Section 15 certification statement; Mr. Kelly's driver's license; and Petitioner's license certificate. CMS Ex. 5; P. Ex. 7.

After receiving and reviewing the requested information, TrailBlazer sent a letter to the Texas Department of Health, Health Facility Compliance Division, on February 8, 2012, recommending approval of Petitioner's application and requesting a site visit or survey to ensure compliance with the conditions of participation for the provider type. CMS Ex. 6; P. Ex. 8. Nonetheless, CMS did not base Petitioner's Medicare enrollment effective date on any further compliance action occurring after its February 8, 2012 determination.

Petitioner argues that its enrollment application, as originally submitted, was complete, accurate, and truthful. P. Br. at 13. Petitioner contends that the corrections TrailBlazer requested in its December 30, 2011 letter did not constitute substantive changes to the application information and contradicted what TrailBlazer required in the past. With respect to the clarification of Mr. Kelly's name, Petitioner asserts that TrailBlazer made this request "not less than 41 days after it received the application packet" and that "[s]pelling out [Mr. Kelly's] name was yet another clerical correction . . . in order to delay processing of the application." P. Br. at 14, 15.

Regardless of how Petitioner characterizes the corrections, I find Trailblazer was acting in good faith to obtain clarifications to incomplete or inaccurate information.

Petitioner first failed to answer a question – "Is the provider a physician-owned hospital . . . ?" – and also responded inaccurately in several sections by checking the "CHANGE" box instead of the "ADD" box. Although Petitioner characterizes the request to respond to the hospital question as "nonsensical" because it had already identified itself as a non-hospital provider in the previous section, it nevertheless does not dispute that it omitted this information.

Moreover, while checking a "CHANGE" box versus an "ADD" box may appear to be merely clerical and administrative to Petitioner, I find it reasonable for Trailblazer to want to clarify whether this was a new application or a modification of existing information, especially because Petitioner appears to have created the confusion by consistently indicating that Petitioner was changing information rather than adding it.

Petitioner's witness provided vague, and unchallenged, testimony that in the past Trailblazer approved an initial provider application she prepared, after October 2010, where she was not required to check any boxes regarding hospital-affiliated facility status, and the boxes for "CHANGE" were checked instead of boxes for "ADD." P. Ex. 1. Based on the scant information the witness provided, I am not able to reasonably explain any possible discrepancy, nor am I required to do so considering I must consider the application appealed before me now. Further, the clarification that ultimately affected the February 8, 2012 effective date centered on Trailblazer's request for more information regarding one of Petitioner's owners, not those other application sections that Trailblazer appears to have reconciled a bit earlier in the process.

With respect to this discrepancy concerning Mr. Kelly's name, Petitioner does not dispute that it originally only provided an initial instead of Mr. Kelly's first name as requested, but Petitioner minimizes its significance because TrailBlazer's system contained personal identifying information for a "Michael Kelly," with the same birth date and Social Security Number, which Petitioner claims should have clearly indicated to Trailblazer that this was the same individual, "regardless of the abbreviation." P. Br. at 14-15. However, I find it was reasonable for Trailblazer to clarify Petitioner's incomplete original application response. I accept CMS's justification that it uses the full name to check applicable exclusion databases and that it should not have to take extra steps because the applicant is not careful. *See* CMS Reply at 4.

C. Trailblazer did not unreasonably delay the approval of Petitioner's enrollment application.

Petitioner contends that TrailBlazer and CMS delayed processing its application. Petitioner specifically argues that TrailBlazer requested clarification of Mr. Kelly's name on January 31, 2012, which was 41 days after it received Petitioner's application packet and 33 days after TrailBlazer sent its December 2011 fax requesting corrections. However, I find that the timeline of events surrounding Petitioner's application does not

show any undue delay in processing, and, in fact, shows that Petitioner contributed to a longer processing time due to its own inaction.

After receiving Petitioner's application packet on December 22, 2011, TrailBlazer reviewed it and faxed a letter to Petitioner on December 30, 2011, requesting corrections. Considering that December 26, 2011 was a holiday, it took TrailBlazer only five business days to review and respond to Petitioner's application. Petitioner then waited 30 days, until January 30, 2012, to fax its corrections to TrailBlazer. The next day, via e-mail dated January 31, 2012, TrailBlazer sought clarification from Petitioner regarding Mr. Kelly's name. TrailBlazer followed up this request in another e-mail on February 2, 2012, and the next day, on February 3, 2012, Petitioner submitted the information. TrailBlazer reviewed the documents and three business days later, on February 8, 2012, verified the enrollment application and sent a letter to the state agency recommending approval of Petitioner's application and requesting an on-site visit or survey.

To further support its contention that Petitioner's application was processed without any delay, CMS cites a provision of the Medicare Program Integrity Manual (MPIM)[2]:

> The contractor shall process 80 percent of all Form CMS-855A initial applications within 60 calendar days of receipt, process 90 percent of all Form CMS-855A initial applications within 120 calendar days of receipt, and process 99 percent of all Form CMS 855A initial applications within 180 calendar days of receipt.

MPIM, CMS Pub. 100-08, Chap. 15, Section 15.6.1.1.1. Given that CMS notified Petitioner on May 7, 2012, that its Medicare enrollment application had been approved as of February 8, 2012, I find that TrailBlazer processed and approved Petitioner's application in accordance with the timeframe the MPIM anticipated.

IV. Conclusion

CMS's contractor did not determine that Petitioner met all federal requirements until after Petitioner submitted clarifications to its CMS 855A enrollment application. Thus, in

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[2] The MPIM is CMS's guidance for its affiliated contractors. It does not have the force and effect of binding law.

accordance with the effective date provisions of 42 C.F.R. § 489.13(b), CMS had a legitimate reason to grant Petitioner's provider agreement an effective date of February 8, 2012, and I affirm that decision.

/s/

Joseph Grow
Administrative Law Judge