Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Pamela D. Cowell, M.D.,
(NPI: 1619934429),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-91

Decision No. CR2842

Date: June 25, 2013

DECISION

Petitioner, Pamela D. Cowell, M.D., is a physician who practices in Washington State and has participated in the Medicare program as a supplier of services. To maintain her Medicare billing privileges, she was required to resubmit and recertify the accuracy of her enrollment information. 42 C.F.R. § 424.515. Thereafter, the Centers for Medicare & Medicaid Services (CMS) approved her re-enrollment with an effective date of April 7, 2012. Petitioner now challenges that effective date.

CMS moves for summary judgment. For the reasons set forth below, I grant CMS's motion, and find that CMS appropriately granted Petitioner's re-enrollment effective April 7, 2012.[1]

[1] CMS has submitted a motion for summary judgment and supporting brief (CMS Br.) with nine exhibits (CMS Exs. 1-9). Petitioner declined to respond to CMS's motion, but submitted a letter, dated January 16, 2013, "questioning the legality of responding to documents" from this office, because, in error, my acknowledgment and pre-hearing order included the incorrect NPI (National Provider Identifier). In an order dated January 29, 2013, I directed Petitioner to submit her pre-hearing exchange, her response to CMS's

CMS properly determined the effective date for Petitioner's Medicare revalidation enrollment, because the evidence establishes that she filed her enrollment application on May 7, 2012, and her effective date can be no earlier than the date she filed her application.[2]

To receive Medicare payments for services furnished to program beneficiaries, a Medicare supplier must be enrolled in the Medicare program. 42 C.F.R. §§ 424.500; 424.505. "Enrollment" is the process used by CMS and its contractors to: 1) identify the prospective supplier; 2) validate the supplier's eligibility to provide items or services to Medicare beneficiaries; 3) identify and confirm a supplier's owners and practice location; and 4) grant the supplier Medicare billing privileges. 42 C.F.R. § 424.502. To enroll in Medicare, a physician must complete and submit an enrollment application. 42 C.F.R. §§ 424.510(d)(1); 424.515(a). To maintain her billing privileges, she must, every five years, resubmit and recertify the accuracy of her enrollment information by submitting a new application. 42 C.F.R. § 424.515.

An enrollment application is either a CMS-approved paper application or an electronic process approved by the Office of Management and Budget. 42 C.F.R. § 424.502. In this case, Petitioner was required to submit her revalidation information on form CMS-855I. *See* 71 Fed. Reg. 20,753, 20,756 (April 21, 2006); Medicare Program Integrity Manual, CMS Pub. 100-08, ch. 15 § 15.1.2.[3]

The application must include "complete, accurate, and truthful responses" to all questions. The supplier must submit

> all required documentation . . . to uniquely identify the . . . supplier. This documentation may include, but is not limited to, proof of the legal business name, practice location, social security number (SSN), tax identification number (TIN), National Provider Identifier (NPI), if issued, and owners of the business.

42 C.F.R. §§ 424.510(d)(2); 424.515(a). The applicant must also submit all documentation necessary to establish that she is eligible to provide Medicare-covered services to Medicare beneficiaries. 42 C.F.R. § 424.510(d)(2)(iii)(B).

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motion, and her correct NPI. She did not respond. I therefore closed the record and issue this decision based on the record before me.

[2] I make this one finding of fact/conclusion of law.

[3] CMS program manuals are found at http://www.cms.gov/Manuals/IOM/list.asp.

When CMS determines that a physician meets enrollment requirements, it grants her Medicare billing privileges, which means that she can submit claims and receive payments from Medicare for covered services provided to program beneficiaries. For physicians and some other practitioners, the effective date for billing privileges "is the *later* of the date of filing" a subsequently approved enrollment application or "the date an enrolled physician . . . first began furnishing services at a new practice location." 42 C.F.R. § 424.520(d) (emphasis added).

If a physician meets all program requirements, CMS allows her to bill retrospectively for up to "30 days prior to their effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries." 42 C.F.R. § 424.521(a)(1).

Here, Petitioner is a physician who owns and operates a practice in obstetrics and gynecology. In order to revalidate her Medicare enrollment, she submitted an application (CMS-855I) to the Medicare contractor, Noridian Administrative Services. CMS Ex. 2 at 28. The application was post-marked July 29, 2011, and the contractor received it on August 2, 2011. CMS Ex. 1 at 2 (Oien Decl. ¶ 4); CMS Ex. 2 at 1. Unfortunately, the application was lacking, and, after considerable effort on the contractor's part, Petitioner eventually submitted the requested additional documentation. CMS Ex. 1 at 2 (Oien Decl. ¶¶ 4-7); CMS Ex. 3 at 1, 2. However, the contractor found discrepancies with respect to Petitioner's Social Security information, so it could not approve her enrollment. CMS Ex. 1 at 2 (Oien Decl. ¶¶ 8, 9). After attempting, unsuccessfully, to resolve the problem, the contractor ultimately denied her application. CMS Ex. 1 at 2-(Oien Decl. ¶¶ 10-15); CMS Ex. 4.

By letter dated December 28, 2011, the contractor advised Petitioner that her application was denied, that all her Medicare payments were on hold until she furnished the missing information, and that her Medicare PTAN (Provider Transaction Access Number) was deactivated and would be reopened only if she submitted the missing information "within the proper timeframe." The letter directed her to submit a corrective action plan within 30 calendar days. The letter also advised her of her appeal rights. CMS Ex. 4. Petitioner did not submit a corrective action plan. She did not appeal, and the deadline for appeal has long since passed. CMS Ex. 1 at 3 (Oien Decl. ¶ 18). The contractor's determination is therefore final and binding. 42 C.F.R. §§ 424.545; 498.20 (b).

On February 7, 2012, Petitioner advised the contractor that she had obtained a new Social Security card, thus resolving the problems with her Social Security information. The contractor advised her to submit a new enrollment application. CMS Ex. 1 at 3 (Oien Decl. ¶ 19). Three months passed, and, on May 7, 2012, Petitioner filed a new enrollment application (CMS-855I), which, after obtaining additional documentation, CMS subsequently approved. CMS Ex. 5; CMS Ex. 1 at 4 (Oien Decl. ¶¶ 20-23). May 7, 2012 is therefore the date Petitioner filed her "subsequently approved enrollment application." Factoring in that she may bill retrospectively for up to 30 days prior to May

7, CMS properly determined that the earliest allowable effective date for her Medicare enrollment is April 7, 2012. 42 C.F.R. §§ 424.520(d); 424.521(a)(1).

That Petitioner may have provided otherwise-billable services to Medicare beneficiaries does not alter this result. *See* Request for Hearing. She is simply not entitled to Medicare payment for those services because she was not enrolled in the program when she provided them. *See US Ultrasound*, DAB No. 2302 at 8 (2010).

For these reasons, I grant CMS's motion for summary judgment and find that CMS appropriately granted Petitioner's Medicare re-enrollment effective April 7, 2012.

/s/
Carolyn Cozad Hughes
Administrative Law Judge