Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Ezmina Lalani, D.O.,
(NPI: 1831407964 / PTAN: 437461YXPF),
Petitioner,

v.

Centers for Medicare & Medicaid Services.

Respondent

Docket No. C-16-353

Decision No. CR4696

Date: August 30, 2016

DECISION REMANDING AND DISMISSING CASE

This case is remanded to the Centers for Medicare & Medicaid Services (CMS) pursuant to 42 C.F.R. § 498.56(d).[1] This case is dismissed pursuant to 42 C.F.R. § 498.70(b) to permit action by CMS in accordance with current regulations. This dismissal is without prejudice to any right of Petitioner to request a hearing as to a determination by CMS on remand that triggers such a right. Either party may request in writing that I vacate, for good cause, the dismissal within 60 days of the date of this Decision. 42 C.F.R. § 498.72.

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[1] References are to the revision of the Code of Federal Regulations (C.F.R.) in effect at the time of the initial and reconsidered determinations, unless otherwise stated.

I. Procedural History and Findings of Fact

Novitas Solutions, Inc. (Novitas), a Medicare administrative contractor, notified Petitioner by letter dated October 13, 2015, that her "Reassignment of Benefits request" was approved. The letter does not mention approval of a Medicare enrollment application. The letter stated that Petitioner's effective date was July 19, 2015.[2] Centers for Medicare & Medicaid Services (CMS) Exhibit (Ex.) 12.[3] Because the letter only refers to approval of Petitioner's reassignment request, the letter could be read to state that July 19, 2015, was the effective date of the reassignment from Petitioner to EA Health Physicians Medical Group Texas PA (EA Health) rather than a Medicare enrollment date. CMS Ex. 12 at 2. At best the letter is unclear.

On October 21, 2015, Petitioner requested reconsideration of the initial determination. Petitioner requested that the "effective date" be changed to May 1, 2015, the date she first

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[2] Novitas lists Petitioner's "effective date" as July 19, 2015. CMS Ex. 12 at 2. Novitas' characterization is in error. The effective date of enrollment for Petitioner as a physician would be the date that Petitioner's applications that were processed to completion by Novitas were **filed**. 42 C.F.R. § 424.520(d)(1). Novitas actually received Petitioner's CMS-855I and CMS-855R applications on August 18, 2015, so the applications were filed by Petitioner on or before that date. Therefore, August 18, 2015 would be the effective date of enrollment. *Alexander C. Gatzimos, MD, JD, LLC* , DAB No. 2730 (2016). July 19, 2015, which is 30 days prior to the effective of enrollment, would be the earliest date for which Petitioner could retrospectively bill. 42 C.F.R. § 424.521(a). The effective date and retrospective billing dates were addressed in the reconsidered determination. CMS Ex. 4 at 2. This is a common error that has recurred for several years in contractor notices and appears to be based on the imprecise use of terms in some CMS policies. In its brief, counsel for CMS also incorrectly refers to the first day of the retrospective billing period as the "effective date" of Petitioner's enrollment. CMS Br. at 2, 7, 9. Counsel is encouraged to be cautious in the use of terms and not simply rely upon the terms used by the contractor.

[3] Counsel for CMS failed to follow the direction of the Acknowledgment and Prehearing Order dated March 7, 2016 (Prehearing Order), paragraph III.D.1, which required that the "first CMS exhibit will be a copy of the decision that is challenged with copies of the evidence considered by the hearing officer or official who made the reconsideration decision." Counsel's failure to follow directions makes it difficult to know exactly what evidence was considered on reconsideration. Counsel should ensure compliance with all orders to avoid the need for remedial action and unnecessarily complicating the task of the fact finder.

began providing services to Medicare beneficiaries at her new employer, EA Health. CMS Exs. 13, 15.

Novitas notified Petitioner by letter dated February 19, 2016, that her request for reconsideration was denied. CMS Ex. 4. The reconsidered determination states that Novitas received a CMS-855I (Medicare enrollment application) and a CMS-855R (reassignment of benefits application) from Petitioner on May 21, 2015. But, because Petitioner only partially responded to Novitas' request for additional information, the May 21 applications were rejected on July 8, 2015. The reconsidered determination states further that Novitas received a CMS-855I and two CMS-855R applications from Petitioner on August 18, 2015, and these applications were approved on October 13, 2015. The reconsidered determination explained that the effective date of Medicare billing privileges would be August 18, 2015, the date the applications were received, and that pursuant to 42 C.F.R. § 424.521(a), the first day authorized for retrospective billing would be July 19, 2015. CMS Ex. 4 at 2. It is clear from the reconsidered determination that the reconsideration hearing officer treated Petitioner as a new enrollee in Medicare. The reconsideration hearing officer did not take note of the fact that the initial determination dated October 13, 2015, approved a reassignment but did not specifically treat Petitioner as newly enrolling in Medicare. The reconsidered determination does not reflect that the hearing officer considered publically available evidence that Petitioner may have already been enrolled in Medicare. If Petitioner was already enrolled and merely requesting to reassign her benefits, the reconsidered determination was in error both as to the facts and CMS policy related to an enrolled provider reassigning benefits. Accordingly, remand is necessary to permit a new reconsidered determination.

On February 26, 2016, Petitioner's employer, acting as Petitioner's representative, requested a hearing (RFH) before an administrative law judge (ALJ). RFH. Petitioner alleges that her application was for the reassignment of benefits to her employer and that she requested an effective date of April 30, 2015 for the reassignment. Petitioner asks that the effective date of the reassignment be no later than May 21, 2015, the date Novitas received her initial CMS-855B. RFH. The case was assigned to me on March 7, 2016, for hearing and decision, and a Prehearing Order was issued at my direction.

CMS filed a motion for summary judgment, a brief in support of its motion, and CMS Exs. 1 through 15 on March 28, 2016. Petitioner filed her response to the CMS motion for summary judgment with no exhibits on May 4, 2016 (P. Br.). On May 20, 2016, CMS filed a reply. Petitioner has not objected to my consideration of CMS Exs. 1 through 15 and they are admitted as evidence.

Petitioner's National Provider Identifier (NPI) is 1831407964. CMS Ex. 12 at 2. The NPI, a single, unique, ten-digit identifier for each health care provider, is required by 45 C.F.R. §§ 162.406 - .410. Pursuant to 45 C.F.R. § 162.408(f), CMS disseminates National Provider System (NPS) information, including NPIs, upon approved requests.

CMS maintains the National Plan and Provider Enumeration System (NPPES) NPI Registry website (https://npiregistry.cms.hhs.gov/) to provide NPI information upon public request. The NPPES NPI Registry indicates that Petitioner may have been enrolled in Medicare as early as September 23, 2010, and that the entry in the registry was updated as of April 15, 2014. The registry indicates that the NPI continues in active status.

II. 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 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.[4] Administration of the Part B program is through contractors such as Noridian. 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. The effective date of 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

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[4] 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. Act §§ 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395(u)(h)(1)).

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.

The Medicare beneficiary, one who is entitled to benefits under Medicare part A or enrolled under part B, is the individual covered by Medicare and entitled to request payment for Medicare-covered health care items and services. Act § 1802. The assignment of the right to file a claim for Medicare coverage of health care charges from a Medicare beneficiary to a Medicare-enrolled provider or supplier is limited. The reassignment of the right to file a Medicare-claim from an enrolled provider or supplier to another is very limited. 42 C.F.R. pt. 424, subpt. F. Reassignment to an employer is permitted from a supplier, such as a physician, when reassignment is required as a condition of employment. 42 C.F.R. § 424.80(b)(1). The Secretary's regulations do not specify an effective date for an authorized reassignment. 42 C.F.R. pt. 424, subpt. F. However, CMS has issued a policy statement found in the Medicare Program Integrity Manual, CMS Pub. 100-08 (MPIM) that directs CMS and Medicare contractors regarding determinations related to reassignments. MPIM § 15.5.20A requires that a CMS-855R must be completed and filed by an individual that wants to reassign benefits to an eligible entity or to terminate a reassignment. Both the party seeking to reassign (reassignor) and the party to whom reassignment is intended (reassignee) must be enrolled in Medicare. A party seeking to reassign that is not enrolled may submit a CMS-855I concurrently with the CMS-855R to accomplish enrollment and reassignment. If the party receiving the reassignment is not enrolled, that party must file the appropriate version of CMS-855. MPIM §15.5.20A. The MPIM further provides that:

> **If the reassignor currently has an active Form CMS-855I on file and is only submitting a Form CMS-855R to establish a new reassignment, the effective date shall be the date the practitioner began or will begin rendering services with the reassignee.** If the Form CMS-855R is accompanied by a Form CMS-855I, the effective date of the enrollment and the reassignment shall be consistent with the 30-day rule (i.e., the later of the date of filing or the date the reassignor first began furnishing services at the new location) specified in section 15.17 of this chapter.

MPIM § 15.5.20E.5 (emphasis added).

MPIM 15.8.1A addresses when a contractor should return an application. Among other situations, the policy requires the return of an application when the application is not necessary for the transaction requested. The policy lists the example of an enrolled physician who wants to reassign benefits and submits both a CMS-855I and a CMS-855R, which appears to be the case before me. The policy specifies that because only the CMS-855R is required, the CMS-855I "shall be returned." MPIM 15.8.1A.

B. Analysis

Pursuant to 42 C.F.R. § 498.56(d), I may remand a case to CMS for consideration of a new issue and a new determination.

Publically available information from CMS through the NPPES NPI Registry indicates that Petitioner may have been enrolled in Medicare as early as September 23, 2010, and that the entry in the registry was updated as of April 15, 2014. The registry indicates that the NPI continues in active status. There is no evidence to suggest that Petitioner's enrollment was terminated at any time.

If Petitioner was enrolled at the time she submitted the CMS-855Is and CMS-855Rs involved in this case and, if as Petitioner indicates, she was merely requesting reassignment to a new employer, CMS policy requires that the CMS-855Is be returned to Petitioner and treated as if never filed. MPIM § 15.8.1.

If Petitioner was already enrolled and only attempting to reassign benefits to a new employer, the effective date of that reassignment should be determined according to MPIM § 15.5.20E.5, as there is no regulatory provision establishing an effective date for a reassignment by a physician to an employer.

The hearing officer does not indicate in the reconsidered determination that CMS records were checked to confirm Petitioner's enrollment status. The reconsidered determination does not address why the initial determination addressed only reassignment. If Petitioner was already enrolled and only reassigning her benefits to a new employer, the reconsidered determination incorrectly determined an effective date of enrollment and failed to establish an effective date of reassignment consistent with the published policy of CMS.

Accordingly, this case is remanded to CMS for a new reconsidered determination that addresses the issues specified herein; such additional issues as CMS and the hearing officer determine necessary and appropriate; and action consistent with the Act, regulations, and CMS policy. This case is dismissed to permit action by CMS. 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. If CMS completes its action on this case more than 60 days from the date of this Order and Petitioner desires my further review, Petitioner will file a request for hearing referring to this case with a copy of this Decision attached.

III. Conclusion

For the foregoing reasons, this case is remanded and dismissed.

/s/
Keith W. Sickendick
Administrative Law Judge