Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Middlesex Rheumatology
(NPI: 1346583788; PTAN: 1346583788),
and
Crispin Abarientos, M.D.
(NPI: 1124292966; PTAN: D400148153),[1]

Petitioners,

v.

Centers for Medicare & Medicaid Services

Docket No. C-14-1711

Decision No. CR3660

Date: February 20, 2015

DECISION

The effective date of Medicare enrollment and billing privileges of Petitioner, Middlesex Rheumatology, is November 20, 2013, with retrospective billing privileges beginning October 21, 2013. The effective date of reassignment of Medicare claims from Petitioner, Crispin Abarientos, M.D., to Petitioner Middlesex Rheumatology is October 21, 2013.

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[1] This case was originally docketed listing only Middlesex Rheumatology. Only after reviewing the file and the pleadings of the parties did it become clear that both Middlesex Rheumatology and its owner and sole supplier, Dr. Crispin Abarientos, M.D., are affected parties within the meaning of 42 C.F.R. § 498.2.

I. Background

National Government Services (NGS), a Medicare contractor, notified Petitioner Middlesex by letter dated March 12, 2014, that its Medicare enrollment application had been approved with an "effective date" of October 22, 2013.[2] Centers for Medicare & Medicaid Services (CMS) Exhibit (Ex.) 1 at 5, 8-10.

Petitioner Abarientos submitted a request for reconsideration on behalf of Petitioner Middlesex that was received by NGS on March 17, 2014. Petitioner Abarientos requested that the "effective date" for Petitioner Middlesex be changed to July 1, 2013; the date treatment of patients began at that location. CMS Ex. 1 at 4.

On July 10, 2014, NGS notified Petitioner Abarientos (NPI 1124292966), that his application to reassign Medicare benefits to Petitioner Middlesex was approved effective October 22, 2013. The NGS notice advised Petitioner Abarientos that he could request reconsideration. CMS Ex. 1 at 12-14. Petitioner Abarientos requested reconsideration by letter dated July 10, 2014. Specifically he requested that his "group member effective date" be changed to July 1, 2013, because he was the sole physician at Petitioner Middlesex and he started seeing patients at Petitioner on July 9, 2013. CMS Ex. 1 at 11.

NGS notified Petitioner Middlesex and Petitioner Abarientos by letter dated August 13, 2014, that the request for an earlier effective date was denied on reconsideration. The reconsideration determination refers to a request for reconsideration on behalf of both Petitioner Middlesex and Petitioner Abarientos. CMS Ex. 1 at 1-3. On August 15, 2014, Petitioner Abarientos filed a request for hearing (RFH) before an administrative law judge (ALJ) in his capacity as co-owner of Petitioner Middlesex. According to the request for hearing, Petitioner Abarientos' wife, Antonieta Abarientos, MD, is the only other co-owner. This case was assigned to me for hearing and decision, and I issued an Acknowledgment and Prehearing Order (Prehearing Order) on August 25, 2014.

On September 9, 2014, CMS filed a combined motion for summary judgment and prehearing brief (CMS Br.) with CMS Exs. 1 and 2. On October 20, 2014, Petitioner Abarientos filed a prehearing exchange including a cross-motion for summary judgment and brief (P. Br.). Although Petitioner Abarientos did not submit supporting exhibits with its brief, he filed a document titled "Evidence" on August 28, 2014, which I treat as

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[2] NGS refers to October 22, 2013 as the "effective date." The terminology is confusing because the record shows that the date is actually the beginning of the 30-day period for retrospective billing rather than the effective date of enrollment and billing privileges.

P. Ex. 1 (Departmental Appeals Board Electronic Filing System (DAB E-File) Item 6). CMS filed a reply (CMS Reply) on October 22, 2014. The parties did not object to my consideration of the offered exhibits and CMS Exs. 1 and 2 and P. Ex. 1 are admitted.

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.[3] Act §§ 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395(u)(h)(1)). Administration of the Part B program is through contractors such as NGS. 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 Secretary has issued regulations that establish the right to a hearing and judicial review of certain enrollment determinations. Act § 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to section 1866(h)(1) and (j)(8), a provider or supplier whose enrollment application or renewal application is denied is entitled to an administrative hearing and judicial review. Pursuant to 42 C.F.R. § 424.545(a), a provider or supplier denied enrollment in Medicare or whose Medicare enrollment and billing privileges are revoked has the right to administrative and judicial review in accordance with 42 C.F.R. pt. 498. Appeal and review rights are specified by 42 C.F.R. § 498.5. Initial determinations of

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[3] 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. Petitioner is a supplier.

CMS or its contractors that are treated as being subject to administrative and judicial review are listed in 42 C.F.R. § 498.3(b). The effective date of a Medicare provider agreement or supplier approval and whether to deny or revoke a provider's or supplier's enrollment are listed as reviewable initial determinations. 42 C.F.R. § 498.3(b)(15), (17). Denial of reassignment or the effective date of a reassignment is not specifically listed but the language of 42 C.F.R. § 498.3(b)(15) and (17) is broad enough to permit review of the effective date of a reassignment to the extent that determination has the same impact upon an affected party as the determination of the effective date of enrollment and billing privileges. *Hiva Vakil, M.D.*, DAB No. 2460 (2012).

B. Issues

The issues in this case are:

> Whether summary judgment is appropriate;
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> Whether CMS and NGS correctly determined the effective date of Medicare enrollment and billing privileges for Petitioner Middlesex; and
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> Whether the effective date of Petitioner Abarientos' reassignment to Petitioner Middlesex was correctly determined.

C. Findings of Fact, Conclusions of Law, and Analysis

1. Summary judgment is appropriate

The parties have filed cross-motions for summary judgment. Summary judgment is not automatic upon request but is limited to certain specific conditions. The Secretary's regulations that establish the procedure to be followed in adjudicating Petitioners' case are at 42 C.F.R. pt. 498. 42 C.F.R. § 424.545(a)(1). The regulations do not establish a summary judgment procedure or recognize such a procedure. However, the Departmental Appeals Board (the Board) has long accepted that summary judgment is an acceptable procedural device in cases adjudicated pursuant to 42 C.F.R. pt. 498. *See, e.g., Illinois Knights Templar Home*, DAB No. 2274 at 3-4 (2009); *Garden City Med. Clinic*, DAB No. 1763 (2001); *Everett Rehab. & Med. Ctr.*, DAB No. 1628 at 3 (1997). The Board also has recognized that the Federal Rules of Civil Procedure do not apply in administrative adjudications such as this, but the Board has accepted that Federal Rule of Civil Procedure 56 and related cases provide useful guidance for determining whether summary judgment is appropriate. Furthermore, a summary judgment procedure was adopted as a matter of judicial economy within my authority to regulate the course of proceedings and made available to the parties in the litigation of this case by my Prehearing Order dated August 25, 2014, paragraph II.G. The parties were given notice by the Prehearing Order that summary judgment is an available procedural device and

that the law as it has developed related to Federal Rule of Civil Procedure 56 will be applied. The parties were advised that a fact alleged and not specifically denied, may be accepted as true for purposes of ruling upon a motion for summary judgment. The parties were also advised that on summary judgment evidence is considered admissible and true unless a specific objection is made. Prehearing Order ¶ II.G.

Summary judgment is appropriate when there is no genuine dispute as to any issue of material fact for adjudication and/or the moving party is entitled to judgment as a matter of law. In determining whether there are genuine issues of material fact for trial, the reviewer must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. The party requesting summary judgment bears the burden of showing that there are no genuine issues of material fact for trial and/or that it is entitled to judgment as a matter of law. Generally, the non-movant may not defeat an adequately supported summary judgment motion by relying upon the denials in its pleadings or briefs but must furnish evidence of a dispute concerning a material fact, i.e., a fact that would affect the outcome of the case if proven. *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 at 3 (2010) (and cases cited therein); *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986).

The standard for deciding a case on summary judgment and an ALJ's decision-making in deciding a summary judgment motion differs from resolving a case after a hearing. On summary judgment, the ALJ does not make credibility determinations, weigh the evidence, or decide which inferences to draw from the evidence, as would be done when finding facts after a hearing on the record. Rather, on summary judgment the ALJ construes the evidence in a light most favorable to the non-movant and avoids deciding which version of the facts is more likely true. *Holy Cross Vill. at Notre Dame, Inc.*, DAB No. 2291 at 5 (2009). The Board also has recognized that on summary judgment it is appropriate for the ALJ to consider whether a rational trier of fact could find that the party's evidence would be sufficient to meet that party's evidentiary burden. *Dumas Nursing & Rehab., L.P.*, DAB No. 2347 at 5 (2010). The Secretary has not provided for the allocation of the burden of persuasion or the quantum of evidence in 42 C.F.R. pt. 498. However, the Board has provided some persuasive analysis regarding the allocation of the burden of persuasion in cases subject to 42 C.F.R. pt. 498. *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 Fed. App'x 181 (6th Cir. 2005).

The material facts in this case are not disputed and there is no genuine dispute as to any material fact that requires a trial. Because the facts are undisputed, there is no need for me attempt to draw favorable inferences for either party. The issues in this case that require resolution are issues of law related to the interpretation and application of the regulations that govern enrollment and billing privileges in the Medicare program to the undisputed facts of this case. Accordingly, summary judgment is appropriate.

2. Pursuant to 42 C.F.R. § 424.520(d), Petitioner Middlesex's effective date of Medicare enrollment was November 20, 2013, the date on which NGS received a Medicare enrollment application from Petitioner Middlesex that it was able to process to approval.

3. Pursuant to 42 C.F.R. § 424.521(a)(1), Petitioner Middlesex was authorized to bill Medicare for services provided to Medicare-eligible beneficiaries by its enrolled supplier for which it had a valid reassignment, up to 30 days prior to it effective date of enrollment, that is, beginning on October 21, 2013.

4. The earliest effective date for reassignment by Petitioner Abarientos to Petitioner Middlesex was October 21, 2013.

a. Facts

The material facts are not disputed. Dr. Crispin Abarientos was enrolled in Medicare with billing privileges as a physician-supplier with his Medicare claims reassigned to Middlesex Hospital in Middletown, Connecticut. Middlesex Hospital was unrelated to Petitioner Abarientos new solo-practice, Petitioner Middlesex. Petitioner Abarientos and his wife, Dr. Antonieta Abarientos, created Petitioner Middlesex, a physician practice located at 80 E. Main Street, Middletown, Connecticut on April 25, 2013. CMS Ex. 1 at 6; RFH. As discussed in more detail hereafter, Petitioner Abarientos needed to enroll Petitioner Middlesex in Medicare to obtain billing privileges for Petitioner Middlesex so that he could reassign his Medicare claims to Petitioner Middlesex for billing.

Petitioners filed multiple enrollment applications in this case. NGS received applications from Petitioners on the following dates: June 20, 2013, August 9, 2013, August 30, 2013, and November 20, 2013. The parties do not dispute the applications were handled as follows:

June 20, 2013 application: Petitioners submitted the first application using an incorrect form. The contractor properly attempted to develop this application on July 19, 2013 by requesting additional information. However, the contractor received incorrect information and rejected Petitioners' first application on August 19, 2013. CMS Ex 2; RFH.

August 19, 2013 application: Petitioners' second and third applications were submitted only eleven days apart (August 19, 2013 and August 30, 2013) and were identical. NGS administratively began processing Petitioners' August 30 application before it began processing Petitioners' August 19 application. Because Petitioners' August 30 application was already in progress, the contractor rejected the August 19 application as a duplicate. RFH; P. Ex. 1 at 2; CMS Ex. 2.

August 30, 2013 application: Petitioners submitted the third application on August 30, 2013. On October 14, 2013, NGS requested additional information to process the application. CMS Ex. 1 at 26; CMS Ex. 2 at 2 ¶¶ 4-6; P. Ex. 1 at 2; RFH. Petitioners were unable to complete that information on-line, so on October 22, 2013, Petitioners contacted NGS and were instructed to submit the information by facsimile. Unfortunately, Petitioners misplaced the fax number and never submitted the information. P. Br at 2 ¶ 3; CMS Ex. 2 at 2 ¶ 5. Accordingly, on November 18, 2013 the contractor rejected the application because it did not receive the requested information. CMS Ex. 1 at 26-27; CMS Ex. 2 at 2 ¶¶ 5-6.

November 20, 2013 applications: The November 20, 2013 applications for enrollment of Petitioner Middlesex and the reassignment from Petitioner Abarientos to Petitioner Middlesex were processed to approval by NGS.

b. Analysis

1. Petitioner Middlesex's Effective Date and Retrospective Billing Date

Petitioner Abarientos argues that the effective date of the enrollment and billing privileges of Petitioner Middlesex and his reassignment should be based on the June 20, 2013 application, which was the first application submitted. RFH; P. Br. However, the June 20, 2013, August 9, 2013, and August 30, 2013 applications were all properly rejected by NGS. Rejection of an application is governed by 42 C.F.R. § 424.525. CMS may reject a Medicare enrollment application if the applicant fails to furnish complete information and supporting information within 30 days from the date the contractor requests it. 42 C.F.R. § 424.525(a)(1). Consistent with that regulation, the MPIM instructs Medicare contractors to reject an application that is on the wrong form if the applicant does not submit a new or corrected complete application within 30 days of the contractor's request. MPIM § 15.8.2A. The regulation also provides that there is no right to administrative or judicial review when an application is rejected. 42 C.F.R. § 424.525(d). Therefore, Petitioner's June 20, 2013, August 9, 2013, and August 30, 2013 applications are not subject to my review. Petitioner Abarientos urges me to at least consider that he filed the first application on June 20, 2013. However, it is clear that once an application is rejected it may not be considered for purposes of establishing an effective date of billing privileges. When a subsequent application is processed to completion, it is the filing date of that subsequent application that controls and not that of the earlier application the contractor was unable to process. *Karthik Ramaswamy, M.D.*, DAB No. 2563 at 6 (2014); 71 Fed. Reg. 20,754, 20,759 (April 21, 2006).

The November 20, 2013 applications for enrollment of Petitioner Middlesex and the reassignment by Petitioner Abarientos were processed to approval and those applications are properly before me.

Qualified physician services, subject to some limitations, are covered by Medicare Part B for those physicians enrolled in Medicare. Act §§ 1832(a) (42 U.S.C. § 1395k(a)); 1861(s)(1) (42 U.S.C. § 1395x(s)(1)); 42 C.F.R. § 410.20 (2013). "Physician's services" are professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls with certain exceptions. Physician services are only reimbursable by Medicare when those services are delivered by one of the professionals listed in the Act and regulations, who is legally authorized to practice in the state where the service is delivered and acting within the scope of his or her license. Act § 1861(q), (r), (s) (42 U.S.C. § 1395x(q), (r), (s)); 42 C.F.R. § 410.20. In this case, Petitioner Middlesex cannot deliver "physician services" because it is not a licensed professional in the state where the services are delivered. Petitioner Abarientos, however, could deliver physician services. In fact, he was previously enrolled in Medicare as a physician supplier with a reassignment to Middlesex Hospital.

Petitioner Middlesex is a "physician or nonphysician practitioner organization" under the regulations. A physician or nonphysician practitioner organization is a "physician or nonphysician practitioner entity that enrolls in the Medicare program as a sole proprietorship or organizational entity." 42 C.F.R. § 424.502. Although Petitioner Middlesex could not deliver physician services, the regulations allow physician organizations to file claims for services delivered to Medicare-eligible beneficiaries by the organizations' physicians when there is a valid reassignment of Medicare claims.

The regulations establish restrictions upon the ability of physicians and physician and nonphysician practitioner organizations to submit claims for items or services delivered prior to the effective date of their enrollment in Medicare and being granted billing privileges. 42 C.F.R. § 424.44(e).

> The effective date for billing privileges for physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations is **the later** of the date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor or the date an enrolled physician or nonphysician practitioner first began furnishing services at a new practice location.

42 C.F.R. § 424.520(d) (emphasis added). The "effective date for billing privileges" is the effective date of enrollment based on the definition of enrollment found in 42 C.F.R. § 424.502.[4] The date of filing of the enrollment application is the date on which the

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[4] Medicare Program Integrity Manual (MPIM), CMS pub. 100-08, chap. 15, § 15.17 (eff. Jan. 7, 2014) uses the phrase "effective date of Medicare billing privileges" and

(Footnote continued next page.)

Medicare contractor receives a signed enrollment application that the contractor is able to process to approval. 42 C.F.R. § 424.510(d)(1); 73 Fed. Reg. 69,725, 69,769 (Nov. 19, 2008). The date of filing is not the date on which an enrollment application is mailed or otherwise transmitted. Pursuant to 42 C.F.R. § 424.521(a), an enrolled physician, nonphysician practitioners, and physician and nonphysician practitioner organizations may retrospectively bill Medicare for services provided Medicare-eligible beneficiaries up to 30 days prior to the effective date of enrollment, if circumstances precluded enrollment before the services were provided. Not applicable in this case is the provision that allows retroactive billing for up to 90 days prior to the effective date of enrollment in case of a Presidentially-declared disaster pursuant to 42 U.S.C. §§ 5121-5206. 42 C.F.R. § 424.521(a). The plain language of this section establishes two possible points in time when a physician, nonphysician practitioner, or organizations of either is enrolled in Medicare with billing privileges and may begin to file claims with the Medicare contractor for covered services delivered to Medicare beneficiaries: (1) the date an enrollment application is submitted that is subsequently approved; or (2) the date the newly enrolled supplier actually begins delivering services at his or her new practice location. The regulation provides that the later date controls, i.e., no claim can be made if no services are provided even though one is enrolled; and one cannot be considered for enrollment before the date that the successful enrollment application is filed and received by the Medicare contractor.

The enrollment application NGS received on November 20, 2013 was the application that NGS was able to process to completion. Petitioner Middlesex filed the application through the on-line system and so the date that NGS received the application was also the date that Petitioner Middlesex submitted it. Pursuant to 42 C.F.R. § 424.520(d), receipt of the application was after the date Petitioner Abarientos began delivering services at Petitioner Middlesex. Accordingly, the earliest possible effective date for Petitioner Middlesex's enrollment and billing privileges was November 20, 2013, the date of receipt of the application. Retrospective billing is only permitted for 30 days prior to the effective date of enrollment and billing privileges, in the absence of a Presidentially-declared disaster. 42 C.F.R. § 424.521. Therefore, Petitioner Middlesex can bill for reassigned claims for qualified services to Medicare-eligible beneficiaries delivered on and after October 21, 2013.

(Footnote continued.)

"effective date of enrollment" synonymously. MPIM § 15.17, subsec. C, discusses the legal distinction between "effective date of enrollment" determined under 42 C.F.R. § 424.520(d) and "retrospective billing date" which is determined under 42 C.F.R. § 424.521 and is dependent upon the effective date of enrollment.

2. Petitioner Abarientos' Effective Date of Reassignment to Petitioner Middlesex

Once enrolled in Medicare a supplier must meet specific regulatory requirements to maintain enrollment, including reporting change of enrollment information. 42 C.F.R. pt. 424, subpt. P. Requirements for reporting changes and updates, and periodic revalidation of enrollment information are established by 42 C.F.R. § 424.515. The regulation specifies that:

> To maintain Medicare billing privileges, a provider or supplier (other than a DMEPOS supplier) must resubmit and recertify the accuracy of its enrollment information every 5 years. All providers and suppliers currently billing the Medicare program or initially enrolling in the Medicare program are required to complete the applicable enrollment application. The provider or supplier then enters a 5-year revalidation cycle once a completed enrollment application is submitted and validated.

42 C.F.R. § 424.515. For reporting changes and updates, and for revalidation, the regulation requires that the provider or supplier submit an enrollment application and supporting documentation, and meet the same requirements of 42 C.F.R. § 424.510 as when initially enrolling in Medicare. However, a new certification of program compliance and a new provider agreement are not required for resubmission and certification for revalidation of enrollment information. CMS reserves the right to do an on-site inspection to validate information and to do off-cycle revalidations. 42 C.F.R. § 424.515(b)-(e). The plain language of 42 C.F.R. § 424.515 shows that reporting changes and updates and revalidation are not the same as enrolling or reenrolling after a period of not being enrolled in Medicare. Further, 42 C.F.R. § 424.516(d), which establishes additional provider and supplier requirements for enrolling and maintaining active enrollment status, requires that physicians report any change in practice location, change in ownership, or adverse legal action within 30 days and all other changes in enrollment within 90 days. The regulation does not state that such changes or reporting those changes results in voluntary or involuntary termination of enrolled status so that reenrollment is necessary. Failure to report is, however, a basis for CMS to revoke enrollment and billing privileges. 42 C.F.R. § 424.535(a)(9); 73 Fed. Reg. 69,725, 69,780 (Nov. 19, 2008). The regulations do not specifically list reassignment of claims as a change that requires reporting but it is clear from published CMS policies that reassignment is treated as a change that triggers a requirement to notify CMS.

In this case, Petitioner Abarientos formed Petitioner Middlesex as a sole practitioner physician organization. Petitioner then attempted to reassign his billing privileges to Petitioner Middlesex so that Petitioner Middlesex could bill Medicare for services

rendered by Petitioner Abarientos. The Act provides for assignment and reassignment in subsections 1842(b)(3)(B)(ii), (b)(6) and (h)(3)(B). Section 1842 of the Act relates to the administration of Medicare Part B. Subsection 1842(b)(6) provides, generally, that payments for covered services under Medicare Part B may only be paid to the Medicare beneficiary or, pursuant to an assignment, to the beneficiary's physician or other person who delivered the service. However, subsection 1842(b)(6) also provides that payment may be made to the employer of the physician or other person who delivered the service if the physician or other person is required as a condition of employment to turn-over the fee to his or her employer, or pursuant to a contractual arrangement that meets program integrity and other safeguards established by the Secretary. Assignment involves the Medicare beneficiary and a physician or other supplier agreeing to the payment of Medicare payment directly to the physician or other supplier. Reassignment, as pertinent to the case before me, is the agreement of the physician or supplier to have the Medicare benefits assigned to him or her paid to his or her employer or practice group.

The Secretary promulgated regulations governing assignment and reassignment of the right to receive Medicare payments. 42 C.F.R. pt. 424, subpt. F. The regulations recognize the basic prohibition on reassignments. 42 C.F.R. § 424.80(a). Limited exceptions to the prohibition are recognized by the regulation, including the exception specified by section 1842(b)(6) of the Act. Pursuant to 42 C.F.R. § 424.80(b)(1), "Medicare may pay the supplier's employer if the supplier is required, as a condition of employment, to turn over to the employer the fee for his or her services." Medicare may also pay "an entity enrolled in the Medicare program if there is a contractual arrangement between the entity and the supplier under which the entity bills for the supplier's services. . . ." 42 C.F.R. § 424.80(b)(2). The other three exceptions to the prohibition on reassignments relate to payment to governmental agencies or entities, reassignment pursuant to a court order, and payment to an agent, and are not implicated in this case. 42 C.F.R. § 424.80(b)(3)-(5). The regulations do not establish a procedure for the initial review and approval or denial of reassignments or the determination of the effective date of a reassignment. The regulations specify that a contractor is required to approve an application to change information or reassign payments within 90 days, but a contractor is allowed 180 days to process an initial application to enroll, a further distinction between a reassignment and a new enrollment. 42 C.F.R. § 405.818(a), (c). The regulations do establish a procedure for revocation of the right to receive assigned benefits but revocation of reassignment is not at issue in this case. 42 C.F.R. § 424.82-.84.

Pertinent CMS policy is found in the MPIM. MPIM § 15.1.1 (eff. Apr. 22, 2012) defines enrollment as the process that Medicare uses to grant billing privileges. Section 15.1.1 of the MPIM defines reassignment as the situation when "an individual physician, non-physician practitioner, or other supplier grants another Medicare-enrolled provider or supplier the right to receive payment for the physician's, non-physician practitioner's or other supplier's services."

The CMS policy on reassignment is reflected in its instruction to Medicare contractors for processing reassignment applications. CMS plainly states that the effective date of reassignment of an already enrolled supplier is determined only by the date that the supplier began or will begin providing services with the reassignee. However, reassignment may only be made to an enrolled entity. MPIM § 15.5.20, titled "Processing Form CMS-855R Applications" (eff. Feb. 27, 2012), is set forth here in its entirety:

> A. General Information
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> A CMS-855R application must be completed for any individual who will: (1) reassign his/her benefits to an eligible entity, or (2) terminate an existing reassignment.
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> If the individual who wants to reassign his or her benefits is not enrolled in Medicare, the person must complete a CMS-855I as well as the CMS-855R. (The CMS-855I and CMS-855R can be submitted concurrently.) **Moreover, if the entity to which the person's benefits will be reassigned is not enrolled in Medicare, the organization must complete a CMS-855B.** (See section 15.7.6 for additional instructions regarding the joint processing of CMS-855Rs, CMS-855Bs, and CMS-855Is.)
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> Note that benefits are reassigned to a supplier, not to the practice location(s) of the supplier. As such, the contractor shall not require each practitioner in a group to submit a CMS-855R each time the group adds a practice location.
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> In addition:
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> - An individual can receive reassigned benefits. The most common example of this is a physician or practitioner who reassigns his/her benefits to a physician who is either: (1) a sole proprietor, or (2) the sole owner of an entity listed in section 4A of the CMS-855I. Here, the only forms that will be required are the CMS-855R, and separate CMS-855Is from the reassignor and the reassignee. (No CMS-855B is implicated.) The reassignee himself/herself must sign section 4B of the CMS-855R, as there is no authorized or delegated official involved.
> - The contractor shall follow the instructions in Pub. 100-04, chapter 1, section 30.2 to ensure that a group or person is eligible to receive reassigned benefits.

- If the individual is initiating a reassignment, both he/she and the group's authorized or delegated official must sign section 4 of the CMS-855R. If either of the two signatures is missing, the contractor may return the application per section 15.8.1 of this chapter.
- If the person (or group) is terminating a reassignment, either party may sign section 4 of the CMS-855R; obtaining both signatures is not required. If no signatures are present, the contractor may return the application per section 15.8.1 of this chapter.
- A CMS-855R is required to terminate a reassignment. The termination cannot be done via the CMS-855I.
- The authorized or delegated official who signs section 4 of the CMS-855R must be someone who is currently on file with the contractor as such. If this is a new enrollment, with a joint submission of the CMS-855B, CMS-855I, and CMS-855R, the person must be listed on the CMS-855B as an authorized or delegated official.
- **The effective date of a reassignment is the date on which the individual began or will begin rendering services with the reassignee.**
- The contractor need not verify whether the reassigning individual is a W-2 employee or a 1099 contractor.
- There may be situations where a CMS-855R is submitted and the group practice is already enrolled in Medicare. However, the authorized official is not on file. In this case, the contractor shall return the CMS-855R, with a request that the group submit a CMS-855B change request adding the new authorized official.
- In situations where the supplier is both adding and terminating a reassignment, each transaction must be reported on a separate CMS-855R. The same CMS-855R cannot be used for both transactions.
- **In situations where an individual is reassigning benefits to a person/entity, both the reassignor and the reassignee must be enrolled with the same contractor.**

(Emphasis added.). CMS provides the following interpretation in its Frequently Asked Questions page at https://questions.cms.gov in response to the question "[h]ow do physicians join or leave a group:"

> If both the physician and the group are already enrolled with the same carrier, the physician and the group together are

> required to complete a CMS 855R showing the date the physician joined the group and reassigned benefits to the group. If a physician leaves a group, the physician or the group should complete the CMS 855R, showing the date the physician left the group. When leaving the group, the CMS 855R does not need to be signed by both the physician and the group. If either the physician or the group have not enrolled with the carrier, they must first complete the appropriate CMS 855 for either an individual (CMS 855I) or group (CMS 855B) before the reassignment can be effective. (FAQ1983).

MPIM § 15.10 (eff. Apr. 13, 2012) does not require that a voluntary termination be submitted with a request for change of information, including a reassignment, except in three cases: a change of Tax Identification Number (TIN), a change of practice location to a different state or to the geographic location of a different Medicare Administrative Contractor or when there may be different rates applicable, and certain changes of ownership (CHOW). MPIM §§ 15.5.1 (rev. 414, eff. May 7, 2012) and 15.7.6B (rev. 423, eff. Jul. 2, 2012) require that when a supplier reports a change in TIN, the supplier must file a form voluntarily terminating enrollment and must also file an application for a new enrollment. MPIM § 15.7.6B also provides that if a supplier is adding or changing a practice location and the new location is in another state within the contractor's jurisdiction, the contractor verifies that the supplier meets all requirements to practice in the state; a new application to enroll is not required, but the contractor is required to create a new enrollment record for the supplier for the new state. In some but not all CHOWs the old owner must voluntarily terminate a facility's enrollment and the new owner must file an initial enrollment. If a contractor determines that a CHOW has not occurred but there was a change in ownership such as a minor stock transaction, the change is reported as a change of information, unless there is a change in TIN, which would require voluntary termination of the existing enrollment and a new enrollment. MPIM § 15.7.8.2.1.1B (rev. 416, eff. Feb. 27, 2012). If a new owner proposes to relocate a supplier concurrent with a CHOW to a different geographic area, serving different clients than previously served, and with different personnel, the transaction is treated as an initial enrollment by a new supplier rather than an address change of an existing supplier. MPIM§ 15.7.8.2.1.1C (rev. 416, eff. Feb. 27, 2012 and State Operations Manual, CMS Pub. 100-7, chap. 3, § 3210.1B5 (rev. 1, May 21, 2004). In this case, Petitioner Abarientos formed Petitioner Middlesex as a new sole practitioner physician organization. Petitioner Abarientos was previously enrolled in Medicare as a physician. However, Petitioner Middlesex was a new entity that had to be enrolled in Medicare. The regulations and CMS policy in the MPIM do not permit a reassignment of Medicare claims to an entity that is not enrolled in Medicare. Therefore, Petitioner Abarientos' reassignment to Petitioner Middlesex could not be effective before the effective date of Petitioner Middlesex's enrollment and billing privileges.

Petitioner Abarientos faults NGS staff for not providing accurate information and not being helpful. Petitioner describes a long process of attempting to enroll in the Medicare program during which NGS staff provided incorrect or misleading information. RFH; P. Br. at 1-3. Petitioner Abarientos' consternation is understandable and regrettable. I am willing to accept these facts as true. However, even if true, the facts are not material to my decision in this case as I have no authority to grant equitable relief in the form of an earlier effective date of enrollment. *US Ultrasound*, DAB No. 2302 at 8 (2010), ("[n]either the ALJ nor the Board is authorized to provide equitable relief by reimbursing or enrolling a supplier who does not meet statutory or regulatory requirements."). Petitioners point to no authority for me to grant an exemption from regulatory compliance. Moreover, I have no authority to declare statutes or regulations invalid or ultra vires. *1866ICPayday.com, L.L.C.*, DAB No. 2289 at 14 (2009) ("[a]n ALJ is bound by applicable laws and regulations and may not invalidate either a law or regulation on any ground.").

Furthermore, Petitioners are not entitled to relief if I construe the argument to be that the government should be estopped from giving Petitioner Middlesex the November 20, 2013 enrollment date. It is well-established that: (1) estoppel cannot be the basis to require payment of funds from the federal fisc; (2) estoppel cannot lie against the government, if at all, absent a showing of affirmative misconduct, such as fraud; and (3) I am not authorized to order payment form the public fisc contrary to law based on equitable grounds. It is well-settled that those who deal with the government are expected to know the law and may not rely on the conduct of government agents contrary to law. *See, e.g., Office of Personnel Mgmt. v. Richmond*, 496 U.S. 414 (1990); *Heckler v. Cmty. Health Servs. of Crawford Cty, Inc.*, 467 U.S. 51 (1984); *US Ultrasound*, DAB No. 2302 at 8 (2010); *Oklahoma Heart Hosp.*, DAB No. 2183 at 16 (2008); *Wade Pediatrics*, DAB No. 2153 at 22 n.9 (2008), *aff'd*, 567 F.3d 1202 (10th Cir. 2009). Here, Petitioners have not alleged affirmative misconduct on behalf of the CMS contractor, and any argument that amounts to a claim of equitable estoppel must be rejected.

III. Conclusion

For the foregoing reasons, I conclude that the effective date of Petitioner Middlesex's Medicare enrollment and billing privileges was November 20, 2013, with a 30-day period for retrospective billing beginning on October 21, 2013. I further conclude that the earliest effective date for Petitioner Abarientos' reassignment of Medicare claims to Petitioner Middlesex was October 21, 2013.

/s/

Keith W. Sickendick
Administrative Law Judge