Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Alexander C. Gatzimos MD, JD, LLC d/b/a Michiana Adult Medical Specialists
(NPI: 1154663763; PTAN: IN1507)[1]

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-1059

Decision No. CR4421

Date: November 10, 2015

DECISION

The effective date of Medicare enrollment of Petitioner, Alexander C. Gatzimos MD, JD, LLC d/b/a Michiana Adult Medical Specialists, is April 6, 2013, with retrospective billing privileges beginning April 1, 2013.

I. Background

Wisconsin Physicians Service Insurance Corporation (WPS), a Medicare contractor, notified Dr. Alexander Gatzimos by letter dated October 14, 2013, that the Medicare enrollment application for Alexander C. Gatzimos MD, JD, LLC d/b/a Michiana Adult

---

[1] This case was originally docketed Alexander Gatzimos, MD v. Centers for Medicare & Medicaid Services (CMS). After reviewing the file and the pleadings of the parties it become clear that the affected party in this case is not Alexander Gatzimos, MD (NPI: 1548476120) but rather Alexander C. Gatzimos MD, JD, LLC d/b/a Michiana Adult Medical Specialists (NPI: 1154663763), a new physician group that seeks an earlier effective date of enrollment in Medicare.

Medical Specialists (Petitioner) had been approved with an "effective date" of July 15, 2013.[2] CMS Exhibit (Ex.) 9. Petitioner requested reconsideration, specifically that the "effective date" be changed to April 1, 2013, the date Dr. Gatzimos first began treating Medicare beneficiaries at Petitioner. CMS Ex. 1 at 5-6; Petitioner's Exhibit (P. Ex.) 2.

WPS notified Petitioner by letter dated February 18, 2014, that the request for an earlier effective date was denied on reconsideration. The reconsideration determination refers to 42 C.F.R. §§ 424.520 and 424.521 as the bases for the denial. The determination explains that the effective date of Medicare enrollment was determined to be August 14, 2013, which is the date WPS received a valid application from Petitioner that was ultimately approved. CMS Ex. 1 at 1-3; P. Ex. 1.

Dr. Gatzimos, the sole owner of Petitioner, requested a hearing before an administrative law judge (ALJ) on April 17, 2014. The case was assigned to me on May 2, 2014, for hearing and decision and an Acknowledgement and Prehearing Order (Prehearing Order) was issued at my direction. CMS filed a combined motion for summary judgment and prehearing brief with its proposed exhibits on June 2, 2014. Petitioner opposed the motion. On August 14, 2014, I denied CMS's motion for summary judgment.

A hearing was conducted on January 15, 2015, and May 11, 2015, and a transcript was prepared.[3] CMS offered CMS Exs. 1 through 11 that were admitted as evidence. Tr. Vol. 1 at 25. Petitioner offered P. Exs. 1 through 5[4] that were admitted as evidence. Tr.

---

[2] WPS refers to July 15, 2013 as the "effective date." CMS Ex. 9 at 2. The terminology is incorrect. The record shows that July 15, 2013, is actually the beginning of the 30-day period for retrospective billing rather than the effective date of enrollment and billing privileges. 42 C.F.R. § 424.521(a)(1).

[3] The hearing in this case required two days of testimony. The court reporting service produced a volume of the transcript for each hearing-day. The pages in the two volumes were not numbered sequentially. Volume 1 for the transcript dated January 15, 2015 is numbered pages 1 through 288, and volume 2 of the transcript for May 11, 2015 is numbered pages 1 through 61. References to volume 1 are cited as "Tr. Vol. 1 at" and references to volume 2 are cited as "Tr. Vol. 2 at."

[4] Petitioner filed its exhibits with its request for hearing marked as "Attach" 1 through 5. The documents were not properly marked as required by the Prehearing Order and the Civil Remedies Division Procedures (CRDP). However, the exhibits were not returned to Petitioner for correction because there was no potential for confusion due to the incorrect
(Footnote continued next page.)

Vol. 1 at 26-27. CMS called one witness, Kelly Hartung, a Contract Coordination Manager for WPS. Petitioner called two witnesses, Kathryn Pribble, Petitioner's practice manager, and Crystal Clemons. Dr. Gatzimos also testified as the owner and operator of Petitioner.

CMS's post-hearing brief (CMS Br.) was filed July 13, 2015, and its post-hearing reply (CMS Reply) and Proposed Findings of Fact and Conclusions of Law were filed on August 12, 2015.[5] On July 27, 2015, CMS filed a motion for leave to amend its post-hearing brief by adding as an appendix a copy of chapter 15 of the Medicare Program Integrity Manual (MPIM), CMS Pub. 100-08. The motion is granted and the document is accepted as an appendix to the CMS brief.

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.[6] Act

_____

(Footnote continued.)

marking and the documents are treated as marked and referred to as P. Exs. 1 through 5. Tr. Vol. 1 at 26-27.

[5] Petitioner's post-hearing reply is incorrectly titled on the DAB E-file Item #30 as "CMS Post Hearing Reply Brief" but the brief itself is correctly titled. Petitioner's reply brief is not paginated, but is 30 pages.

[6] 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.

§§ 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 WPS. 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,[7] 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 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 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 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

---

[7] References are to the revision of the Code of Federal Regulations (C.F.R.) in effect at the time of agency action, unless otherwise indicated.

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), and include the effective date of enrollment in Medicare. 42 C.F.R. § 498.3(b)(15).

The Secretary's regulations do not address the allocation of the burden of proof or the standard of proof. However, the Departmental Appeals Board (the Board) has addressed the allocation of the burden of proof in many decisions. The standard of proof is a preponderance of the evidence. CMS has the burden of coming forward with the evidence and making a prima facie showing of a basis for revocation of Petitioner's enrollment. Petitioner bears the burden of persuasion to rebut the CMS prima facie showing by a preponderance of the evidence or to establish any affirmative defense. *Batavia Nursing & Convalescent Inn*, DAB No. 1911 (2004); *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd*, 129 F. App'x 181 (6th Cir. 2005); *Emerald Oaks*, DAB No. 1800 (2001); *Cross Creek Health Care Ctr.*, DAB No. 1665 (1998); *Hillman Rehab. Ctr.*, DAB No. 1611 (1997) (*remand*), DAB No. 1663 (1998) (*aft. remand*), *aff'd*, *Hillman Rehab. Ctr. v. United States*, No. 98-3789 (GEB), 1999 WL 34813783 (D.N.J. May 13, 1999).

"Prima facie" means generally that the evidence is "[s]ufficient to establish a fact or raise a presumption unless disproved or rebutted." *Black's Law Dictionary* 1228 (8th ed. 2004). Thus, CMS has the initial burden of coming forward with sufficient evidence to show that its decision regarding Petitioner's effective date of enrollment and billing privileges decision is legally sufficient under the statute and regulations. CMS makes a prima facie showing of noncompliance if the credible evidence CMS relies on is sufficient to support a decision in its favor absent an effective rebuttal by Petitioner.

B. Issues

The issue in this case is:

> Whether Petitioner's effective date of Medicare enrollment and billing privileges should be different than the date determined by CMS and WPS.

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

My conclusions of law are set forth in bold followed by my findings of fact and analysis. The findings of fact are based on the exhibits admitted and testimony received at hearing. I have carefully considered all the evidence and the arguments of both parties, though not all may be specifically discussed in this decision. I discuss in this decision the credible evidence given the greatest weight in my decision-making. I also discuss any evidence that I find is not credible or worthy of weight. The fact that evidence is not specifically discussed should not be considered sufficient to rebut the presumption that I considered all the evidence and assigned such weight or probative value to the credible evidence that

I determined appropriate within my discretion as an ALJ. There is no requirement for me to discuss the weight given every piece of evidence considered in this case, nor would it be consistent with notions of judicial economy to do so. *Charles H. Kock, Jr., Admin L. and Prac*. § 5:64 (3d ed. 2013).

1. Alexander C. Gatzimos, MD was enrolled in Medicare as a physician with billing privileges when he created Petitioner and he did not need to reapply or reenroll in Medicare as an individual physician supplier but he did need to report changes in his enrollment status as required by 42 C.F.R. §§ 424.516-.517.

2. Petitioner, a new physician practice group, had to enroll in Medicare and obtain billing privileges in order for Alexander C. Gatzimos, MD to reassign to Petitioner his right to claim reimbursement from Medicare. 42 C.F.R. § 424.80(a), (b), (d).

3. The current CMS interpretive rule or policy since December 5, 2014, is that the "date of filing" is the date a paper application is mailed by a physician, nonphysician practitioner, a physician or nonphysician practitioner group, or ambulance supplier to the appropriate CMS contractor.

4. Petitioner's Medicare-enrollment application that was ultimately approved by WPS was mailed to WPS on April 6, 2013; and that is the date of filing of the application and the effective date of Petitioner's Medicare enrollment and billing privileges. 42 C.F.R. § 424.520(d).

5. Pursuant to 42 C.F.R. § 424.521(a)(1), Petitioner's retrospective billing privileges could extend up to 30 days prior to Petitioner's effective date of enrollment, except that the earliest date services were delivered at Petitioner was April 1, 2013, and that is the earliest date for which Petitioner may retrospectively bill. 42 C.F.R. § 424.521(a).

a. Facts

I advised the parties at hearing that I would take official notice[8] that Dr. Gatzimos had an active National Provider Identifier (NPI) 1548476120 with an enumeration date of May 14, 2007, which was last updated May 14, 2007. These facts are readily available to the public on the CMS National Plan and Provider Enrollment System (NPPES).[9] Tr. Vol. 1 at 34-35. The parties did not request an opportunity to be heard or object to my taking judicial or official notice of the foregoing facts. Fed. R. Evid. 201. In fact, there is no dispute that prior to April 1, 2013, Dr. Gatzimos was enrolled in Medicare with billing privileges as a physician. Tr. Vol. 1 at 223-24. Until about April 1, 2013, Dr. Gatzimos had his Medicare claims reassigned to Unity Medical Association (Unity), a group practice where he was employed. Dr. Gatzimos left his employment at Unity on or about April 1, 2013. CMS Ex. 2 at 1; P. Ex. 2 at 1; P. Ex. 3 at 1; CMS Br. at 1; RFH at 3.

On about March 1, 2013, Dr. Gatzimos created the limited liability corporation with the name Alexander C. Gatzimos, MD, JD, LLC d/b/a Michiana Adult Medical Specialists, the Petitioner in this case. CMS Ex. 7 at 14, 46-48. It is the effective date of enrollment of Petitioner that is in issue before me. Dr. Gatzimos is the sole owner and authorized official for Petitioner. The address for the practice is 2050 East Ireland Road, South Bend, Indiana. CMS Ex. 2 at 1, 7, 14, 24; CMS Ex. 7; P. Ex. 2 at 1; P. Ex. 3 at 1. On about April 1, 2013, Dr. Gatzimos started furnishing services to Medicare beneficiaries at Petitioner. Tr. Vol. 1 at 225-26; CMS Ex. 2 at 14. Dr. Gatzimos was told correctly[10] by his office manager, Kathryn Pribble, and his credentialing specialist, Crystal Clemons, that it was necessary for him to enroll Petitioner as a new enrollee in Medicare, despite

---

[8] Official notice of material facts is recognized by 5 U.S.C. § 556(e). Judicial notice pursuant to Fed. R. Evid. 201 is equally applicable and is beneficial as the rule provides a specific procedure for taking judicial notice. The transcript reflects I referred to taking "administrative notice" which is in error, but there was no apparent confusion on the part of the parties that I intended to take official or judicial notice of the facts specified.

[9] The NPPES NPI registry website is https://npiregistry.cms.hhs.gov/.

[10] Dr. Gatzimos, who was already enrolled as a physician supplier, was required to file the appropriate CMS-855 form to notify the Medicare contractor of changes in his enrollment status, including a change of address. 42 C.F.R. §§ 424.515-.516. Petitioner had to be enrolled as a new supplier. 42 C.F.R. §§ 424.505-.514.

the fact he thought it sufficient to simply change his enrollment address. Tr. Vol. 1 at 224-26; Tr. Vol. 2 at 32-33.

About the same time he started Petitioner, Dr. Gatzimos also began working one day per week as a contract employee at Knox-Winamac Healthcare Center (Knox), a group practice that was unrelated to Petitioner. CMS Ex. 1 at 5-6; P. Ex. 2 at 1-2; CMS Br. at 2; RFH at 2. Knox-Winamac also filed an application on or about April 1, 2013, to reassign Dr. Gatzimos' Medicare claims for services delivered through its facility. Tr. Vol. 1 at 52, 123-24, 165; P. Ex. 2 at 1-2; CMS Br. at 2; RFH at 2. Both parties theorize that when Dr. Gatzimos and his staff made telephone inquiries between April and August 2013 regarding the status of Petitioner's enrollment application, WPS staff may have been referring to the status of the Knox-Winamac application. This speculation is not relevant to the issue before me because it does not make it more likely or not that the application for Petitioner was actually mailed in April 2013 or received by WPS prior to August 14, 2013. While I have no doubt that Dr. Gatzimos and his staff made multiple calls to WPS between April and August 2013, the fact those calls were made and answered is also not relevant to the issue before me. It would be relevant if during one of the calls between April and August 2013, WPS had acknowledged receipt of an enrollment application, specifically a CMS-855B form signed by Dr. Gatzimos and dated April 5, 2013, with Petitioner's NPI; but there is no allegation and no credible evidence that such a statement was ever made by WPS staff.

In April 2013, Crystal Clemons was hired by Dr. Gatzimos to assist with the Medicare enrollment application for Petitioner. Tr. Vol. 1 at 151; Tr. Vol. 2 at 9-10; CMS Br. at 2. Ms. Clemons advised Dr. Gatzimos that an enrollment application CMS-855 would need to be filed for Petitioner. Tr. Vol. 2 at 32; CMS Br. at 2. On April 5, 2013, Dr. Gatzimos signed the CMS-855 enrollment application for Petitioner, which Ms. Clemons testified she sent to WPS by regular mail on April 5 or 6, 2013. Tr. Vol. 2 at 33.

Dr. Gatzimos called WPS in August 2013 to inquire as to the status of the application for Petitioner and he was told by a WPS representative that WPS did not have an enrollment application for Petitioner. Tr. Vol. 1 at 226-27; CMS Ex. 2 at 2; P. Ex. 3 at 2; CMS Br. at 2-3. Dr. Gatzimos subsequently spoke with Jan Warner, supervisor of the WPS Medicare Part B, Provider Enrollment Unit on August 12, 2013. Ms. Warner advised Dr. Gatzimos that WPS had no enrollment application for Petitioner. On August 13, 2013, Dr. Gatzimos sent a copy of the enrollment application for Petitioner that he had signed and dated April 5, 2013, to Ms. Warner at WPS by overnight United States Postal Service priority mail. There is no dispute that WPS received the application dated April 5, 2013, on August 14, 2013. Tr. Vol. 1 at 47, 226-28; CMS Ex. 2 at 1-3, 31, 48; CMS Ex. 11 at 2 ¶ 8; P. Ex. 5; RFH at 2; CMS Br. at 3.

WPS staff reviewed the application dated April 5, 2013. On August 23, 2013, WPS staff informed Dr. Gatzimos that the application he submitted dated April 5, 2013, was the

wrong form, a CMS-855B, and he needed to submit a CMS-855I with various other documents within 30 days or his application would be rejected. WPS also sent Petitioner a letter dated August 26, 2013, advising him of the need to file the correct form and supporting documentation. Tr. Vol. 1 at 48-49, 128; CMS Ex. 3; CMS Ex. 6 at 2; CMS Br. at 4. Dr. Gatzimos submitted a CMS-855I application to WPS with supporting documentation as requested by WPS. CMS Ex. 6; CMS Ex. 7 (CMS-855I); CMS Br. at 4.

WPS advised Dr. Gatzimos by letter dated October 14, 2013, that Petitioner's enrollment application was approved. The CMS notice incorrectly states that the effective date of enrollment is July 15, 2013. The effective date of enrollment was actually August 14, 2013, the date WPS received Petitioner's enrollment application dated April 5, 2013, with retrospective billing privileges back to July 15, 2013, 30 days prior to the date WPS received the application. CMS Ex. 2 at 3, 31, 48; CMS Ex. 9.

The CMS witness, Kelly Hartung, confirmed that it was the application dated April 5, 2013 and received by WPS on August 14, 2013, that was approved and resulted in Petitioner's enrollment effective August 14, 2013. Tr. Vol. 1 at 46-47, 61-63, 132-33. Ms. Hartung credibly testified, consistent with her declaration (CMS Ex. 11), that she found no record that WPS received an application for Petitioner prior to August 14, 2013. Tr. Vol. 1 at 42-54, 60-61.

The reconsideration determination also states that "WPS received a valid application from Alexander Gatzimos, MD on August 14, 2013. This is the application that was approved and processed . . . . The effective date is determined by the receipt date of a valid application that is approved." CMS Ex. 1 at 2.

For reasons discussed hereafter, whether or not and when Crystal Clemons mailed the CMS-855B application for Petitioner, signed and dated by Dr. Gatzimos on April 5, 2013, is relevant and material to my determination in this case. Therefore, I make the following findings based on the testimony of Petitioner's witnesses.

Kathryn Pribble, Petitioner's practice manager and Dr. Gatzimos' wife, testified that Petitioner was established on April 1, 2013, and an initial enrollment application was submitted for Medicare enrollment. Tr. Vo1. 1 at 150. She testified that she contacted Ms. Clemons to handle Petitioner's credentialing. Tr. Vo1. 1 at 151. She testified that she provided Ms. Clemons information for the application; that Dr. Gatzimos signed the application on April 5, 2013; that Ms. Clemons was present when Dr. Gatzimos signed the application; that the enrollment application was complete and in an envelope on April 5, 2013; and Ms. Clemons took the application with her when she left Petitioner's office. Tr. Vo1. 1 at 156, 198, 204. Ms. Pribble testified that she believed that Ms. Clemons was going to mail the application to WPS. Tr. Vo1. 1 at 156-58, 198. However, in response to my questions and on cross-examination she admitted she did not know whether or not

Ms. Clemons was going to mail the application or submit it on-line. Tr. Vol. 1 at 175, 183, 206. When asked on cross- examination if Ms. Clemons told her what day she submitted the application, Ms. Pribble responded that Ms. Clemons had told her the application was mailed on April 5. Tr. Vo1. 1 at 190-91. When asked if she personally saw Ms. Clemons mail the application or enter it on-line Ms. Pribble admitted that she did not. Tr. Vo1. 1 at 190. Ms. Pribble testified that she did not obtain a certified mail receipt from Ms. Clemons. Tr. Vol. 1 at 191, 195-96. Ms. Pribble testified that she called WPS several times beginning in May 2013 to check on the status of the application. She testified that each time she was required to give an NPI number. Ultimately, in August 2013, Ms. Pribble was told that WPS staff was referring to the pending application for Dr. Gatzimos related to the Knox Winamac Clinic rather than Petitioner. She testified that when it was learned in August 2013 that WPS had no pending application for Petitioner, a copy of the enrollment application was sent through over-night delivery. Tr. Vo1. 1 at 159-68. In response to my questions and on cross-examination she testified that when asked for an NPI number by WPS staff she was giving staff Dr. Gatzimos' NPI rather than that of Petitioner. Tr. Vol. 1 at 177-78, 192.

Dr. Gatzimos testified at the hearing. He stated that both Ms. Clemons and Ms. Pribble were present when he signed the enrollment application on April 5, 2013. He testified that Ms. Pribble told him on about August 12, 2013, that WPS did not have Petitioner's application. He then called WPS that same day using the enrollment hotline number others in his office had been using to check the application status; he spoke with Debra who referred him to a supervisor at WPS, Jan Warner; and he spoke with Ms. Warner on August 12, 2013, to discuss the status of Petitioner's enrollment application. He testified that Ms. Warner called him back he believed on August 13, 2013, and advised him that WPS could not locate Petitioner's application. He recalled that he sent a letter to Ms. Warner with a copy of Petitioner's CMS-855B enrollment application dated April 5, 2013, by express delivery service. Tr. Vol. 1 at 223-28. On cross-examination he admitted that the only evidence he has that the CMS-855B he signed on April 5, 2013 was sent to WPS by Ms. Clemons is the oral statements of Ms. Clemons and Ms. Pribble. Tr. Vol. 1 at 229-31 (referring to P. Ex. 4; CMS Ex. 10).

I find the testimony of Dr. Gatzimos and Ms. Pribble fully credible. Both witnesses gave their testimony under oath. CMS has presented no evidence to rebut their testimony. The testimony of Ms. Hartung that she could find no record that WPS received the CMS-855B for Petitioner prior to August of 2013, is not inconsistent with and does not rebut the testimony that Dr. Gatzimos completed and signed the form and gave it to Ms. Clemons to be transmitted to WPS on April 5, 2013. Clearly Dr. Gatzimos and Ms. Pribble, his wife, have a pecuniary interest in the outcome of this case. However, the amount of unreimbursed Medicare claims that could have been submitted by Petitioner for the period April 1, 2013 to July 14, 2013, is not established by the evidence; and I will not infer that their pecuniary interest is so significant as to cause them to perjure

themselves.[11] The demeanor of Dr. Gatzimos and Ms. Pribble during their testimony revealed no sign of evasiveness or prevarication.

Crystal Clemons testified that Dr. Gatzimos hired her to assist with the Medicare credentialing for Petitioner. She testified that on April 5, 2013, she went to Petitioner's office to complete the enrollment application; that she was at the office for about five hours working on the application; and that the application was complete and she had it in her possession when she left Petitioner on April 5, 2013. She testified that she scanned the application into her computer and mailed it to WPS by first class mail. She testified that she made four or five follow-up phone calls to WPS and was not told there was no application pending or that there was a problem; to the contrary, she was told the application had been received and was pending. However, she testified that when she called she provided Dr. Gatzimos' NPI number and tax number when calling. Tr. Vol. 2 at 9-12, 15. She testified that she made contemporaneous notations of the conversations with the WPS representatives each time she called; and these notations were kept in a notebook at another clinic, where she was employed from April 2007 through January 2014. She stated that the notebook contained notes for "numerous" enrollment applications for "multiple doctors" employed by the other clinic; that the notes she took for Petitioner's application were kept in the back of the notebook; and when she left the other clinic in January 2014 she did not take the notebook with her as it was that clinic's property. Tr. Vol. 2 at 16-19, 21, 23. She could not recall the exact date she mailed the application and she did not send the application certified mail. Tr. Vol. 2 at 25. She testified in response to my questioning that the application was mailed either on April 5, 2013 or the next day. She did not submit the application online because the online system was not considered to be a good system at that time. Tr. Vol. 2 at 27-28. She testified that she had a receipt from mailing the application but she disposed of the receipt after recording the transaction in her check book. Tr. Vol. 2 at 29-30. Ms. Clemons testified that she emailed a scanned copy of the application to either Dr. Gatzimos or his practice manager when they requested a copy. Tr. Vol. 2 at 31-32.

I find that Ms. Clemons' testimony is fully credible. She testified by telephone and I was unable to observe her demeanor. However, she testified under oath, forthrightly, and her responses were fluid and without hesitation that might be associated with fabrication. Although it is possible that Dr. Gatzimos and Ms. Clemons practiced the questions and

---

[11] Dr. Gatzimos estimated the claims to amount to about $40,000. He explained that these claims were for services to patients of his from before he formed Petitioner and these patients simply followed him to his new practice. Tr. Vol. 2 at 43-45.

responses, there was nothing to indicate that responses had been practiced and memorized. I made Ms. Clemons aware of her obligation to answer truthfully and there was nothing about her testimony to indicate she did not do so. Ms. Clemons was paid to complete the Medicare enrollment application for Petitioner, but there is no indication that she was compensated for her testimony. There is also no evidence that she has any pecuniary interest in the outcome of this proceeding. The testimony of Ms. Hartung that she could find no record that WPS received the CMS-855B for Petitioner prior to August of 2013, is not inconsistent with and does not rebut the testimony of Ms. Clemons that she placed the application in the mail not later than April 6, 2013.

Based on the credible testimony of Dr. Gatzimos, Ms. Pribble, and Ms. Clemons, I find that on April 5, 2013, Dr. Gatzimos signed a Medicare enrollment application, a CMS-855B, to enroll Petitioner in Medicare. I further find that on April 6, 2013, Ms. Clemons purchased postage and deposited the application in the United States mail for delivery to WPS. I find, based on the testimony of Ms. Hartung that she could find no record that WPS received that CMS-855B application dated April 5, 2013 and mailed on April 6, 2013. However, also based on the testimony of Ms. Hartung, Dr. Gatzimos, and Ms. Clemons, and on the reconsideration determination, I find that on August 13, 2013, Dr. Gatzimos sent a copy of the CMS-855B application to WPS that was received by WPS on August 14, 2013. I further find that the CMS-855B dated April 5, 2013, was the application that WPS processed to completion. CMS agrees. CMS Reply at 4.

b. Analysis

WPS determined in this case that the effective date of enrollment of Petitioner was August 14, 2013, with retrospective billing privileges back to July 15, 2013. CMS Ex. 9; CMS Br. at 1, 4. The reconsideration determination dated February 18, 2014, is consistent with the CMS position before me, stating that "WPS received a valid application from Alexander Gatzimos, MD on August 14, 2013. This is the application that was approved and processed . . . . The effective date is determined by the **receipt date** of a valid application that is approved." CMS Ex. 1 at 2 (emphasis added). Petitioner seeks an earlier effective date of Medicare enrollment and billing privileges and argues that it should have retrospective billing privileges beginning no later than April 1, 2013. P. Br. at 1.

This case has proven to be confusing because there are two suppliers involved: (1) Dr. Gatzimos who is a physician supplier and has been enrolled in Medicare with billing privileges for many years; and (2) Petitioner, which in April 2013 was a new physician organization. There is no question that physicians, nonphysician practitioners, and physician or nonphysician organizations must be enrolled in Medicare; meet all program requirements, including state licensure requirements; and the services for which Medicare reimbursement is sought must have been provided at the enrolled practice location, to be eligible for reimbursement from Medicare for services provided to Medicare-eligible

beneficiaries. 42 C.F.R. § 424.521. Petitioner was created by Dr. Gatzimos in March 2013 as a limited liability corporation. A physician practitioner organization such as Petitioner is any physician entity that enrolls in Medicare as a sole proprietorship or organizational entity. 42 C.F.R. § 424.502. Dr. Gatzimos intended to provide services to Medicare-eligible beneficiaries for which bills would be submitted to Medicare by Petitioner. Therefore, Dr. Gatzimos wanted to enroll Petitioner in Medicare as a clinic or group practice of which he was the sole owner and authorized official. CMS Ex. 2 at 7, 24.

There is no question that at the time he left Unity Medical Association on about April 1, 2013, Dr. Gatzimos was enrolled in Medicare as a physician supplier with his right to receive reimbursement from Medicare reassigned to Unity. When he left Unity, Dr. Gatzimos needed to comply with Medicare requirements by reporting the change in his status to the appropriate Medicare contractor within either 30 or 90 days of the change. 42 C.F.R. §§ 424.515-.516.

> Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations must report the following reportable events to their Medicare contractor within the specified timeframes:
>
> (1) Within 30 days—(i) A change of ownership; (ii) Any adverse legal action; or (iii) A change in practice location.
>
> (2) All other changes in enrollment must be reported within 90 days.

42 C.F.R. § 424.516(d). There is no allegation before me that Dr. Gatzimos failed to comply with Medicare enrollment requirements in his capacity as an individual physician supplier when he left Unity in April 2013, which might have prevented him from billing Medicare using his NPI. However, that is not an issue I need to resolve and I express no opinion as to whether Dr. Gatzimos could have sought reimbursement in his own name as an enrolled physician after he left Unity and before the enrollment of Petitioner.

Dr. Gatzimos elected not to bill using his own enrolled supplier status. Rather, he decided, consistent with guidance of Ms. Clemons (Tr. Vol. 2 at 21, 32-33), to enroll Petitioner in Medicare so that Petitioner, a physician organization, could claim reimbursement for services rendered by Dr. Gatzimos. The evidence shows that Dr. Gatzimos intended to reassign his Medicare claims to Petitioner which is permitted. As an exception to the general prohibition on Medicare paying amounts due a supplier to another person or entity under an assignment, reassignment, or other arrangement, Medicare may pay an entity enrolled in Medicare if there is a contractual relationship between the entity and the supplier under which the entity bills for the supplier's services

to Medicare-eligible beneficiaries. 42 C.F.R. § 424.80(a), (b), (d). As the sole owner of Petitioner, it was not necessary for Dr. Gatzimos to file the CMS-855R, which is typically used to accomplish reassignment. The instructions on the 855I form submitted by Petitioner at WPS' request in September 2013, states: "[i]f you are the sole owner of a professional corporation, a professional association, or a limited liability company, and will bill Medicare through this business entity, you do not need to complete a CMS-855R that reassigns your benefits to the business entity." CMS Ex. 7 at 13; CMS Reply at 2-3. Regardless of the form, it is essential for reassignment that the entity to which Medicare claims are reassigned be enrolled in Medicare in order for the reassignment to be effective. Thus, it is the effective date of the enrollment of Petitioner, which is also the effective date of Dr. Gatzimos' reassignment to Petitioner, which is at issue before me.

My decision turns on the meaning of the phrase "date of filing" as used in 42 C.F.R. § 424.520(d). The "date of filing" of an enrollment application is the basis for determining the effective date of enrollment of physicians or nonphysician practitioners, their practice groups or organizations, and ambulance suppliers. I specifically requested at hearing that the parties address the definition of "date of filing" in their post-hearing briefing and specifically referred counsel to the apparently different definitions of that phrase used by CMS in 2008 when promulgating 42 C.F.R. § 424.520(d) and in 2014 when expanding the scope and application of that regulation. Tr. Vol. 2 at 47-49.

I have found as fact that the enrollment application ultimately approved by WPS was the CMS-855B enrollment application signed by Dr. Gatzimos on April 5, 2013, and mailed by Ms. Clemons on April 6, 2013. I have also found as fact that WPS did not receive Petitioner's CMS-855B enrollment application until August 14, 2013, after Dr. Gatzimos sent a copy of the original to WPS. The question to be resolved is a question of law – whether the date of mailing of the application or the date of receipt by WPS determines the effective date of Petitioner's Medicare enrollment and billing privileges.

The controlling regulation provides:

> Effective date of Medicare billing privileges.
>
> * * * *
>
> (d) Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations. 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 undisputed evidence shows that Dr. Gatzimos first began furnishing services at Petitioner on about April 1, 2013. The evidence shows that it was not until April 6, 2013, that Ms. Clemons mailed the CMS-855B application to WPS. Therefore, if April 6, 2013, the date of mailing, is treated as the date of filing, that is the later date and, under the regulation the effective date of enrollment. Of course, if as CMS argues, the date of filing is actually the date of receipt by WPS, which was August 14, 2013, then that is the later date and the date of enrollment.

The phrase "date of filing" is not defined in 42 C.F.R. pt. 424 or related regulations. Published CMS interpretive rules and policy also do not define "date of filing" related to paper applications for Medicare enrollment. The MPIM, CMS Pub. 100-08, chap. 15, sec. 15.17 (May 28, 2015), which guides Medicare contractors in processing enrollment applications, does not define "date of filing" related to the filing of a paper application by physicians, nonphysician practitioners, physician and nonphysician practice organizations, and ambulance suppliers. My review of prior editions of the MPIM reveals that no definition of "date of filing" related to paper applications has ever been included in the MPIM. Understanding the meaning of "date of filing" is important because it is the basis upon which the effective date of enrollment is determined. Why CMS has repeatedly failed in its regulations to define "date of filing" is inexplicable. Furthermore, it is not clear on what guidance Medicare contractors rely when determining effective date when processing a paper application for enrollment.

It is necessary to look to the regulatory history of 42 C.F.R. § 424.520 to determine what the drafters of that regulation intended by the phrase "date of filing." The drafters of 42 C.F.R. § 424.520 state that:

> We maintain that it is not possible to verify that a supplier has met all of Medicare's enrollment requirements prior to submitting an enrollment application. Therefore, the Medicare program should not be billed for services before the later of the two dates that a physician or NPP [nonphysician practitioner] organization, physician, or NPP has submitted an enrollment application that can be fully processed or when the enrolled supplier is open for business.

73 Fed. Reg. 69,725; 69,767 (Nov. 19, 2008).

The drafters further stated:

> We are also adopting the "date of filing" as the date that the Medicare contractor receives a signed provider enrollment application that the Medicare contractor is able to process to approval. If the Medicare contractor denies an enrollment application that is not later overturned during the appeals process, the new date of filing would be established when a physician or NPP organization submits a new enrollment application that the contractor is able to process to approval.

Id. at 69,773.

On December 5, 2014, CMS published a notice of final rule in the Federal Register modifying the regulations applicable to the enrollment of providers and suppliers in Medicare. The modification of the regulations was effective February 3, 2015. 79 Fed. Reg. 72,500 (Dec. 5, 2014). CMS modified 42 C.F.R. § 424.535(d) to add ambulance suppliers as regulated entities. The drafters stated in response to a comment to the notice of rulemaking:

> We agree that the 30-day and 90-day retroactive billing provisions in § 424.521(a), to which the commenter is referring, should apply to ambulance suppliers to the same extent that they do to physicians, physician groups, non-physician practitioners, and non-physician practitioner groups. This approach would ensure: (1) Consistent treatment between ambulance suppliers and the other supplier types covered under § 424.520(d); and (2) that ambulance suppliers can avail themselves of a brief retroactive billing period if they are able to show that urgent circumstances precluded the supplier from submitting its enrollment application earlier than it did. Therefore, we have revised the regulatory text in § 424.521(a) to include ambulance suppliers.

Id. at 72,521.

The drafters included the following comment and response:

> Comment: Several commenters requested CMS to clarify that the "date of filing" of a CMS-855 application is the date on which the contractor initially received the application, not the date on which the contractor deemed the application "complete."

> Response: The "date of filing" is the date on which the provider or supplier submitted its CMS-855 application via mail or Internet-based PECOS.

Id.[12] The "comment" recognized the prior definition of "date of filing" as the date of receipt by the contractor consistent with the drafter's definition from November 2008 at 73 Fed. Reg. at 69,773. The response, however, reflects a different definition, that is, the date of filing is the date the CMS-855 is mailed by the provider or supplier or the date it is submitted on-line. The drafters' response rejects the notion that the date of filing is the date of receipt by the CMS contractor when the application is submitted by mail.

The drafters included another comment and response that makes clearer what they intend to be the definition of "date of filing":

> Comment: Several commenters stated that a more definitive distinction must be made as to what is meant by the date of an application that is subsequently approved. One commenter stated that it is not uncommon for contractors to return applications with a request for supporting documentation. Another commenter requested an explicit statement that the date the application is entered into PECOS or a paper CMS-855B is mailed is the effective date of billing privileges, assuming the application is eventually accepted; this would make it clear that a request for additional documentation is part of the original process and does not begin an entirely new cycle.
>
> Response: We indicated earlier that the effective date of billing privileges under § 424.520(d) will be the later of: (1) The "date of filing"' of an enrollment application that is subsequently approved; or (2) the date the supplier began furnishing services at a practice location. **The "date of filing" is considered to be the date on which the supplier submitted its CMS-855 application via mail or Internet-based PECOS.**

---

[12] PECOS is the Medicare Provider Enrollment, Chain, and Ownership System. It permits online enrollment and changes in enrollment by Medicare providers and suppliers.

> The term "subsequently approved"' includes application submissions for which the contractor requested additional information from the supplier (or otherwise undertook developmental activities with respect to the application) and the application was ultimately approved. It does not include applications that were rejected under § 424.525 or returned pursuant to CMS Publication 100-08, chapter 15, and were later resubmitted. A contractor's request for additional information does not constitute a final disposition regarding the application; that is, the application is still in process. However, a rejection or return indicates that the contractor was unable to process the application to completion, meaning that the application processing cycle has ended and the supplier must submit a new application.

Id. at 72,521-22. Again, this more detailed explication of 42 C.F.R. § 424.520(d), includes a specific statement of the definition of date of filing that departs from the definition that the drafters mentioned in rulemaking in 2008. It is noteworthy that the drafters provide the definition in response to a specific request for a definition that the date of filing is the date the application is mailed or submitted by PECOS. The drafters clearly depart from a definition of "date of filing" based on the date of receipt of an application by a Medicare contractor.

Prior Board and ALJ decisions, including my own, that state that the date of filing is the date of receipt of the enrollment application by the Medicare contractor, were based on the Federal Register notice in 2008, which stated that date of receipt by the Medicare contractor was the "date of filing" of an enrollment application. 73 Fed. Reg. 69,726, 69, 769 (Nov. 19, 2008). *See, e.g.*, *Karthik Ramaswamy, MD*, DAB No. 2563 at 3 (2014); *Tri-Valley Family Medicine, Inc*., DAB No. 2358 at 6 (2010); *Middlesex Rheumatology*, CR3660 at 8-9 (2015) (all of which cite 73 Fed. Reg. 69,725, 69,769 (Nov. 19, 2008)). CMS has now adopted an interpretive rule or, at minimum, made a specific policy statement that the "date of filing" of a paper application is the date it is mailed.

CMS urges me to continue to apply the old definition of "date of filing" from the 2008 regulatory history and decisions based thereon. CMS argues that the risk of an application being lost in the mail (or in the contractor's mailroom) should be upon the applicant. CMS argues that CMS had no reason to change the definition in 2014. CMS argues that the CMS drafters only intended for the date of mailing to apply to ambulance suppliers and not change the long-standing rule that applied to the other suppliers listed in 42 C.F.R. § 424.520(d). CMS Br. at 15-18; CMS Reply at 10-11. However, the discussion by the drafters does not discriminate among the suppliers covered by 42 C.F.R. § 424.520(d) by establishing a different definition of "date of filing" for different

supplier types. Such discrimination would be nonsensical and inconsistent with the stated purpose of the drafters to treat physicians, nonphysician practitioners, and their practice groups and ambulance suppliers the same. I reject the CMS argument that the definition of "date of filing" contained in the December 2014 Federal Register notice applies only to ambulance suppliers. CMS argues unabashedly that it is implausible to think that CMS would announce such a significant policy change in a Federal Register response to comments to a draft regulation. CMS Br. at 16. The CMS argument that a major policy would not be announced in Federal Register comments, flies in the face of the fact that in 2008 and again in 2014, CMS failed to define "date of filing" in the regulation and only addressed the meaning of that phrase in responses to comments in the Federal Register. CMS argues that it is significant that there was no change in the way the MPIM defines "date of filing" after December 2014. CMS Br. at 18. CMS does not point to the section in chapter 15 of the MPIM that defines "date of filing" for paper applications and none of the prior editions I reviewed to 2008 included such a provision.

CMS argues that applying the definition of "date of filing" from December 2014 to this case would be retroactive application and also amount to equitable relief which I am not authorized to grant. CMS Br. at 19; CMS Reply at 11-16. I agree that I have no authority to grant Petitioner equitable relief. However, that is not the nature of the relief I grant in this case. Petitioner had a right to ALJ review of the reconsideration determination dated February 18, 2014. After the reconsideration determination was issued and before ALJ review is completed, CMS changed its definition of "date of filing." The interpretive rule or policy currently in effect is that articulated in the Federal Register notice published at the request of CMS on December 5, 2014. My application is not retroactive but is an application of the current CMS interpretative rule or policy. "One of the most firmly established principles in administrative law is that an agency must obey its own rules. . . . In general failure to follow its own rules will not nullify an agency's action unless the party is prejudiced by that failure." 1 Charles H. Koch, Jr., Richard Murphy, Admin. L. & Prac. § 4:22 (3d ed. 2010). This is clear with legislative rules, less so with interpretative rules, and debatable with policy statements. However, as an ALJ I am bound to follow the Constitution, the Act, and the Secretary's regulations and I give effect to the policies of the Secretary and CMS to the extent not inconsistent with the law. Accordingly, I conclude that Petitioner should receive the benefit of the current CMS interpretive rule or policy, which provides that the date of filing a paper enrollment application is the date the application is mailed.

Petitioner mailed its CMS-855B application dated April 5, 2013 to WPS on April 6, 2013. The application was not received by WPS until August 14, 2013, but it was the application dated April 5, 2013 that was processed to completion. Based on a date of filing of April 6, 2013, the effective date of Petitioner's enrollment was April 6, 2013. 42 C.F.R. § 424.520(d). Pursuant to 42 C.F.R. § 424.521(a)(1), Petitioner's retrospective billing privileges could extend up to 30 days prior to Petitioner's effective date of enrollment. However, because there is no dispute Dr. Gatzimos did not start

delivering services at Petitioner until April 1, 2013, Petitioner's retrospective billing privileges date only to April 1, 2013. 42 C.F.R. § 424.521(a) (retrospective billing only for service provided at the enrolled practice location).

III. Conclusion

For the foregoing reasons, I conclude that the effective date of Petitioner's Medicare enrollment and billing privileges was April 6, 2013, with retrospective billing privileges beginning April 1, 2013, the date services were first delivered to Medicare-eligible beneficiaries at Petitioner's facility.

/s/
Keith W. Sickendick
Administrative Law Judge