Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Randolph Cook, M.D.
(NPI: 1740254192),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-1037

Decision No. CR3985

Date: June 26, 2015

DECISION

Randolph Cook, M.D. (Petitioner), challenges a determination by the Centers for Medicare & and Medicaid Services (CMS), through its administrative contractor, Noridian Healthcare Solutions (Noridian), that established the effective date of his Medicare enrollment and billing privileges as July 22, 2014, with retrospective billing to June 22, 2014. Petitioner argues that Noridian should not have given him a new effective date for Medicare enrollment because he was already enrolled in the Medicare program when he moved from a medical practice in Virginia to one in California. Essentially, Petitioner merely sought to reassign his Medicare benefits to the new practice in California, called Pacific Central Coast Health Centers (Pacific Central Coast), rather than to reenroll. CMS now moves for summary judgment, arguing that Petitioner was required to submit a new enrollment application when he moved Medicare contractor jurisdictions, and that the contractor undisputedly received that application on July 22, 2014. Petitioner cross-moves for summary judgment, arguing that CMS's interpretive guidelines in the Medicare Program Integrity Manual (MPIM) govern the effective dates for reassignments rather than the enrollment regulations that control the effective dates for new enrollees in the Medicare program.

Because Petitioner was already an enrolled supplier in the Medicare program when he began providing services with Pacific Central Coast on August 23, 2013, Petitioner did not need to reenroll in the Medicare program and the effective date of reassignment of Medicare benefits is controlled by the MPIM, rather than the enrollment regulations. Therefore, I reverse CMS's determination and order that Petitioner's effective date for the reassignment of benefits to Pacific Central Coast be August 23, 2013.

I. Background and Procedural History

Petitioner is a physician currently employed in California at Pacific Central Coast. Petitioner was previously employed in Virginia and enrolled in the Medicare program as a supplier.[1] Petitioner asserts, and CMS does not dispute, that he began providing services through Pacific Central Coast on August 23, 2013. CMS Exhibit (Ex.) 1 at 2. At that time, Pacific Central Coast was in the process of changing its name from Marian Community Clinics and had submitted the necessary applications to Palmetto GBA, another Medicare contractor. According to Petitioner, Palmetto GBA approved the name change for Pacific Central Coast on September 3, 2013. CMS Ex. 5. Noridian ultimately approved the name change for Pacific Central Coast on February 17, 2014. CMS Ex. 5.

On July 22, 2014, Petitioner filed with Noridian a CMS-855R application to reassign his Medicare benefits to Pacific Central Coast. CMS Ex. 2. On July 24, 2014, a provider enrollment representative with Noridian sent an e-mail to Pacific Central Coast's point of contact and directed Petitioner to file a CMS-855I "for initial enrollment with Medicare Part B in California." CMS Ex. 2 at 1. The Noridian representative wrote that "because [Petitioner] is not currently enrolled with Medicare Part B in California the reassignment cannot be processed until an initial enrollment application is submitted and approved." CMS Ex. 2 at 1. Petitioner subsequently filed a CMS-855I with Noridian, as directed. *See* CMS Ex. 7 at 1. On September 9, 2014, Noridian issued a letter that notified Petitioner his "initial Medicare enrollment application" was approved. CMS Ex. 4 at 1. The letter included a table under the heading "Medicare Enrollment Information," which provided Petitioner's "Participating status" as "Participating," and "Effective June 22, 2014." CMS Ex. 4 at 1.

Pacific Central Coast, on behalf of Petitioner, requested reconsideration of the effective date that Noridian stated in its September 9 letter. CMS Ex. 5. Pacific Central Coast stated that changing its practice's name took over seven months from when it submitted its application to Noridian, and during that time Pacific Central Coast "held physician enrollment and its account receivable for Medicare so as to not bill them under the incorrect name." CMS Ex. 5. Pacific Central Coast also said that it "had difficulty

[1] A "supplier" is a "physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare." 42 C.F.R. § 400.202.

obtaining timely electronic signatures" through the Provider Enrollment, Chain, and Ownership System (PECOS). CMS Ex. 5.

On November 10, 2014, Noridian issued a letter in response to the reconsideration request and cited 42 C.F.R. § 424.520(d) as the basis for the effective date stated in the September 9 letter. CMS Ex. 6. Noridian wrote that the "Carriers and Part A and Part B Medicare Administrative Contractors (A/B MACs) will establish the effective date of Medicare billing privileges (see 42 [C.F.R. §] 424.520(d)) for physicians . . . ." The letter noted that the effective date of billing privileges is "the later of the date of filing or the date [a supplier] first began furnishing services at a new practice location." CMS Ex. 6 at 1. Finally, the letter stated that Petitioner's CMS-855R was received on July 22, 2014. His effective date was made June 22, 2014, to reflect the "30 day [*sic*] from receipt of application that [retrospective billing] is allowed." CMS Ex. 6 at 2. The letter concluded that "Pacific Central Coast Health Centers has not provided evidence to definitely [*sic*] support an earlier effective date." CMS Ex. 6 at 2.

On January 21, 2015, Petitioner filed his request for a hearing to challenge the effective date of his Medicare enrollment and billing privileges that Noridian established.[2] The case was assigned to me to hear and decide, and I issued an Acknowledgment and Pre-hearing Order (Order) that directed the parties on presenting their evidence and argument. CMS subsequently moved for summary judgment and filed a supporting brief (CMS Br.) as well as eight proposed exhibits marked as CMS Exs. 1-8. Petitioner, through counsel, opposed summary judgment in favor of CMS and filed a cross-motion for summary judgment with supporting brief (P. Br.). Petitioner did not file any of his own exhibits, but relied on the same documentary exhibits that CMS proposed.

II. Issues

The issue in this case is whether Noridian, acting on behalf of CMS as the Medicare administrative contractor, properly determined June 22, 2014, as the effective date of Petitioner's Medicare enrollment and billing privileges, and as Petitioner's effective date for reassignment of Medicare benefits to Pacific Central Coast.

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[2] Pacific Central Coast initially attempted to file a single hearing request on behalf of several suppliers that are part of its medical practice. Civil Remedies Division management, however, contacted Pacific Central Coast and required each supplier to file a separate hearing request because Noridian issued a separate determination for each supplier. Petitioner's hearing request was ultimately filed 7 days after the 60 day deadline. *See* 42 C.F.R. § 498.40(a)(2). CMS did not move to dismiss Petitioner's hearing request as untimely, and there is no reason for me to exercise my discretion to do so. *See id.* § 498.70(c). Pacific Central Coast's first attempt to request a hearing on behalf of Petitioner is good cause to accept the January 21 hearing request out of time. *See id.* § 498.40(c)(2).

III. Decision on the Written Record

Petitioner did not object to the admission of CMS Exs. 1-8; therefore, I admit them into the record.

My Order advised the parties that they must submit written direct testimony for each proposed witness, and that an in-person hearing would be necessary only if the opposing party requested an opportunity to cross-examine a witness. Order ¶¶ 8-10; CRDP §§ 16(b), 19(b). Neither party submitted any written direct testimony. Therefore, a hearing in this case is unnecessary and I issue this decision based on the written record. Order ¶ 11; CRDP § 19(d).

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

The Social Security Act authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations governing the enrollment process for providers and suppliers in the Medicare program. 42 U.S.C. §§ 1302, 1395cc(j). The Secretary has set forth enrollment requirements in 42 C.F.R. Part 424, Subpart P. Under the Secretary's regulations, a provider or supplier seeking billing privileges under the Medicare program must "submit enrollment information on the applicable enrollment application. Once the provider or supplier successfully completes the enrollment process . . . . CMS enrolls the provider or supplier into the Medicare program." 42 C.F.R. § 424.510(a). For suppliers, CMS establishes the effective date for Medicare billing privileges pursuant to 42 C.F.R. § 424.520(d) and may permit limited retrospective billing under 42 C.F.R. § 424.521.

For Medicare Part B claims, a beneficiary may assign his or her benefits to an enrolled physician or non-physician supplier providing services to that beneficiary. 42 U.S.C. § 1395u(b)(3)(B)(ii). By statute, a supplier is generally prohibited from reassigning his or her Medicare benefits. 42 U.S.C. § 1395u(b)(6); *see* 42 C.F.R. § 424.80(a). There are exceptions to this prohibition, including, among other things, when a supplier must reassign his or her benefits to an employer as a condition of employment. 42 U.S.C. § 1395(u)(b)(6)(A)(i); *see* 42 C.F.R. § 424.80(b). For circumstances when reassignment is allowed, a supplier must submit a Form CMS-855R. *See* 71 Fed. Reg. 20754, 20767 (Apr. 21, 2006) (final rule formally adopting the use of the CMS-855R). Although not addressed by statute or regulation, CMS instructs its employees that reassignments of benefits may only occur between enrolled suppliers and that "[t]he effective date of reassignment is the date on which the individual began or will begin rendering services with the reassignee." MPIM § 15.5.20.

1. The regulation concerning the effective date of billing privileges, 42 C.F.R. § 424.520(d), does not apply to the reassignment of Petitioner's Medicare benefits to his new employer, Pacific Central Coast Health Centers.

After Petitioner filed a CMS-855R with Noridian on July 22, 2014, to reassign his Medicare benefits to Pacific Central Coast, the contractor directed Petitioner to submit a CMS-855I because he was not "currently enrolled" with "Medicare Part B in California." *See* CMS Ex. 2 at 1. Noridian later determined that Petitioner was "participating" in Medicare "effective June 22, 2014." CMS Ex. 3 at 1. In its reconsidered determination, the contractor specifically relied on 42 C.F.R. § 424.520(d) to affirm July 22, 2014 as the effective date of Petitioner's enrollment and billing privileges with retrospective billing to June 22, 2014. CMS Ex. 6 at 1-2. CMS maintains before me that Petitioner had to enroll with Noridian when he moved from Virginia to California because he was relocating to a different Medicare administrative contractor's jurisdiction. CMS Br. at 2-3. That separate enrollment with Noridian, in turn, triggered the regulatory provision in section 424.520(d) that establishes the effective date of billing privileges. CMS Br. at 3.

Under CMS's theory, Petitioner could not reassign benefits to Pacific Central Coast prior to the effective date of his enrollment with Noridian, which resulted in the effective date of both his billing privileges and reassignment to Pacific Central Coast as June 22, 2014. *See* CMS Br. at 2-3; CMS Ex. 2 at 1 ("[B]ecause you are not currently enrolled with Medicare Part B in California the reassignment cannot be processed . . . ."). CMS has not argued that the reassignment of Petitioner's benefits alone triggered a new effective date for Petitioner's Medicare billing privileges. *See* CMS Br. at 2-3. Therefore, this case turns on whether Petitioner was required to enroll with Noridian, the Medicare administrative contractor for California, even though he was undisputedly already enrolled in Medicare as a supplier in Virginia. *See* CMS Br. at 5; P. Br. at 4. Throughout this proceeding, however, CMS has not cited any statutory or regulatory authority that requires a separate or new Medicare enrollment when a supplier moves from one administrative contractor's jurisdiction to another. Below, I discuss separately each of the sources where such a requirement might be located.

a. The enrollment regulations.

As stated above, Congress authorized the Secretary to establish the enrollment process, which she has done in 42 C.F.R. Part 424, Subpart P. Any practitioner who wishes to obtain payment for a Medicare covered item or service must first be "enrolled in the Medicare program." 42 C.F.R. § 424.505. The regulations define "enroll/enrollment" as:

> the process that Medicare uses to establish eligibility to submit claims for Medicare covered services and supplies. The process includes—

> (1) Identification of a provider or supplier;
>
> (2) Validation of the provider's or supplier's eligibility to provide items or services to Medicare beneficiaries;
>
> (3) Identification and confirmation of the provider or supplier's practice location(s) and owner(s); and
>
> (4) Granting the provider or supplier Medicare billing privileges.

42 C.F.R. § 424.502. To enroll, a provider or supplier "must submit enrollment information on the applicable enrollment application." 42 C.F.R. § 424.510(a). After successfully completing the enrollment process, "CMS enrolls the provider or supplier into the Medicare program." *Id*.

The regulations provide that Medicare establishes eligibility to enroll and grants billing privileges, but do not make specific reference to individual administrative contractor jurisdictions with regard to enrollment generally. In addition, the regulations plainly state that CMS, not each individual contractor, enrolls a provider or supplier into the Medicare program. *See* 42 C.F.R. § 424.510(a). Indeed, each separate contractor works on behalf of CMS and may therefore initially enroll a provider or supplier, but had the Secretary intended to limit enrollment to each specific contractor, she would have said so, but did not. The enrollment regulations make several references to Medicare contractors. *See, e.g.*, 42 C.F.R. §§ 424.510(d)(1) (directing the submission of an application to "designated Medicare fee-for-service contractor") and 424.516(d) (directing suppliers to report changes to their "Medicare contractor"). But the Secretary established the enrollment process in terms of "Medicare" generally, not its administrative contractors. By including references to administrative contractors, the Secretary knew at the time of promulgating the enrollment regulations that fee-for-service contractors would be part of the enrollment process, but there is no regulatory language limiting enrollment to anything other than Medicare generally. There is no regulatory provision in 42 C.F.R. Part 424, Subpart P that requires a provider or supplier to enroll separately with each administrative contractor. From this, I conclude that the Secretary did not intend to limit enrollment to only one contractor at a time. Rather, "enrollment" is intended to be with the Medicare program overall, not CMS's administrative contractors.

b. The Medicare Program Integrity Manual.

The MPIM, which CMS has published as a guidance document for its administrative contractors, defines "enrollment" as "the process that Medicare uses to grant Medicare billing privileges." MPIM, Ch. 15, § 15.1.1 (Rev. 404, 2012). Like the enrollment regulations, the MPIM defines enrollment in terms of Medicare generally, not specific contractors. *See* 42 C.F.R. § 424.502.

The MPIM indirectly refers to a requirement that a supplier must enroll with each contractor rather than with Medicare generally, but there is no actual express requirement to that effect in Chapter 15, which explains the enrollment process for contractors. When discussing how contractors should process the CMS-855R, the MPIM explains that, 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." MPIM, Ch. 15, § 15.5.20(B). The phrase "enrolled with the same contractor" implies that "enrollment" is tied to a specific contractor, not just Medicare overall. In addition, when discussing the requirement that a provider or supplier list adverse actions in its enrollment application, the MPIM says that if "the practitioner is submitting an initial enrollment application (*e.g., is moving to a new State and contractor jurisdiction*) and did not report the adverse action in section 3 of the CMS-855I, the contractor shall deny the enrollment application and establish a 3-year enrollment bar." MPIM, Ch. 15 § 15.5.20(B) (emphasis added). The example of a new contractor jurisdiction is parenthetical, yet it tends to support CMS's premise that an entirely new enrollment application is required for a change in contractor jurisdictions. However, this parenthetical may also recognize that a supplier will need to submit a CMS-855I to report a change of information, such as a change of address.

The MPIM also discusses voluntary termination for suppliers and reminds CMS's contractors to determine whether the moving supplier needs to submit a "voluntary termination." MPIM, Ch. 15 § 15.7.5.1(B)(2). However, the term "enrollment" is not in this section of the MPIM, and it is not clear whether termination of a prior practice location in another state necessarily equates to a voluntary termination of enrollment, requiring re-enrollment with a new contractor. Critically, there is no express or otherwise unambiguous requirement that a supplier must enroll or re-enroll with Medicare when it moves contractor jurisdictions.

c. The CMS-855I Medicare Enrollment Application.

The instructions of the CMS-855I, which CMS refers to in its brief, provide that a supplier should use the CMS-855I if he or she is "currently enrolled with a Medicare fee-for-service contractor but need[s] to enroll in another fee-for-service contractor's jurisdiction . . . ." CMS Ex. 8 at 2; *see* CMS Br. at 5. The application's instruction recognizes an existing enrollment in the Medicare program, and then refers to a separate enrollment, albeit through a different contractor. However, the application does not cite any statutory or regulatory authority that supports the premise that a single supplier must go through multiple enrollments in the Medicare program. Further, it is unclear whether the word "enroll" in the application is intended to have the same meaning as that word is defined in 42 C.F.R. § 424.502, or whether it simply means something similar to "register with."

Petitioner argues that enrollment in a new contractor jurisdiction is for the "administrative convenience" of the contractor, and I agree. I find that the use of "enroll" on the application instructions must be read to mean "register with" or some other similar administrative meaning, because it would otherwise be contradictory to the Secretary's intent that the plain language of the regulation makes clear. The regulations only discuss one enrollment with Medicare. 42 C.F.R. § 424.510(a). Therefore, I do not accept that the ambiguous instruction in the CMS-855I establishes a legal requirement that a supplier must actually "enroll" with each contractor – as that word is defined in the regulation – in order to be enrolled in the Medicare program. If the Secretary meant that a supplier's movement from one CMS administrative contractor jurisdiction to another required suppliers to enroll again in the Medicare program, the Secretary surely would have indicated that in her regulations. Rather, the regulations establish only one Medicare enrollment per provider or supplier. *See* 42 C.F.R. § 424.502.

Neither the statute nor regulations that discuss reassignment of a supplier's Medicare benefits address the effective date of that reassignment. *See* 42 U.S.C. § 1395u(b)(6); 42 C.F.R. § 424.80(b). CMS and its contractor applied the "effective date of billing privileges" as the effective date of reassignment, but appear to have done so because they required Petitioner to "enroll" separately with Noridian first. There is no language in the regulation that permits the application of the enrollment effective date provision only to the reassignment of benefits. The definition of "enroll/enrollment" in 42 C.F.R. § 424.502 states that "[g]ranting the . . . supplier Medicare billing privileges" is a component of the enrollment process, not distinct from it. Regarding the "effective date of billing privileges" for suppliers, the regulation states:

> 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). Because the granting of billing privileges is part of the overall Medicare enrollment process, a supplier who is already enrolled cannot be granted new billing privileges without first terminating enrollment and re-enrolling in the Medicare program. As explained above, Petitioner was not required to enroll or re-enroll in the Medicare program simply because he was changing from one contractor's jurisdiction to another. Therefore, because the "effective date of billing privileges" in 42 C.F.R. § 424.520(d) is part of the Medicare enrollment process and requires that a supplier actually be enrolling in Medicare or re-enrolling, it also does not apply to the reassignment of Petitioner's Medicare benefits to Pacific Central Coast.

2. The effective date for Petitioner's reassignment of Medicare benefits to Pacific Central Coast is August 23, 2013, the date on which Petitioner commenced providing services with Pacific Central Coast.

Petitioner did not enroll or re-enroll with Noridian when he moved to California. He was already enrolled in Medicare through his prior employment in Virginia and never voluntarily terminated that enrollment. Therefore, the effective date of his Medicare billing privileges never changed from his initial enrollment in Medicare. The only change in Petitioner's status when he moved to California was the reassignment of his benefits to Pacific Central Coast. The regulations do not address the effective date of reassignment, only initial enrollment. *See* 42 C.F.R. § 424.520(d). The MPIM, however, provides a written policy from CMS that the effective date of reassignment is "the date on which the individual began or will begin rendering services with the reassignee." MPIM, Ch. 15, § 15.5.20(A). In this case, that date is August 23, 2013. In light of there being no alternative interpretations, CMS should have applied its written policy in favor of Petitioner.

I recognize the likelihood that Petitioner was required to submit a CMS-855I in addition to a CMS-855R because he moved contractor jurisdictions and presumably had changes to his enrollment information.[3] *See* 42 C.F.R. § 424.516(d) (requiring physicians to report changes in practice location within 30 days of the change). However, I do not conclude that the submission of an enrollment application for a reason other than initial enrollment or re-enrollment necessarily triggers the effective date regulation. While the CMS-855I is a "Medicare enrollment application," *see* 42 C.F.R. § 424.520(d), it is also used for purposes other than enrolling in the Medicare program for the first time. Enrolled suppliers such as Petitioner use the CMS-855I to notify CMS about any changes in information. CMS Ex. 8 at 2 (providing instruction on CMS-855I that says physicians can "make a change in their enrollment information" using that application form). Changing information to "maintain enrollment," however, is not the same as "enrollment," and, therefore, does not result in new billing privileges. *See* 42 C.F.R. § 424.515 (requiring a supplier to revalidate enrollment information by using an enrollment application, but not requiring the certifications necessary during initial enrollment). Therefore, simply filing a CMS-855I with CMS or its contractor for a reason other than initial enrollment does not necessarily trigger the effective date of

[3] CMS noted in its brief that Petitioner failed to comply with the reporting requirements in 42 C.F.R. § 424.516(d) by not notifying CMS of a change in address within 30 days of moving to California. *See* CMS Br. at 5 n.1. If true, that would provide a basis for revocation of billing privileges (42 C.F.R. § 424.535(a)(9)), but that is a separate determination that Noridian did not make in this case. Therefore, whether Petitioner complied with the reporting requirement is not at issue before me and has no impact on the outcome of this case.

billing privileges regulation in 42 C.F.R. § 424.520(d). *See John Heverin, Ph.D.*, ALJ Ruling 2013-6 at 7-8 (HHS 2013).

V. Conclusion and Order

For the reasons explained above, I reverse CMS's determination and order that Petitioner's effective date of reassignment of Medicare benefits to Pacific Central Coast be August 23, 2013.

/s/
Scott Anderson
Administrative Law Judge