Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

East Cooper Surgical Associates,
(PTAN: 2193; NPI 1265442958),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-335

Decision No. CR3235

Date: May 20, 2014

DECISION REMANDING AND DISMISSING CASE

This case is remanded to the Centers for Medicare & Medicaid Services (CMS) pursuant to 42 C.F.R. § 498.56(d),[1] for processing of Petitioner's application for reactivation of its billing privileges in accordance with 42 C.F.R. § 424.540 and the CMS policies discussed in the following opinion. This case is dismissed pursuant to 42 C.F.R. § 498.70(b) to permit action by CMS in accordance with current CMS policy and because Petitioner does not presently have a right to a hearing. This dismissal is without prejudice to any right of Petitioner to request a hearing as to a determination by CMS on remand that triggers such a right.

Either party may request in writing that I vacate, for good cause, the dismissal within 60 days of the date of this Order. 42 C.F.R. § 498.72. Any other objection to this Order must be filed within ten days of the date of this Order.

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

I. Procedural History and Findings of Fact

Palmetto GBA (Palmetto) is a Medicare contractor. Petitioner is East Cooper Surgical Associates. On September 30, 2011, Palmetto sent Petitioner a letter requesting that Petitioner revalidate its Medicare enrollment information and stating that if Petitioner failed to submit a complete enrollment application and all supporting documentation within 60 days, Petitioner's Medicare billing privileges may be deactivated. CMS Exhibit (Ex.) 1. On April 5, 2012, Palmetto notified Petitioner by letter that its Medicare billing privileges were deactivated effective April 5, 2012, because Petitioner failed to timely submit a complete Medicare enrollment application in response to the September 30, 2011 Palmetto revalidation request. The April 5, 2012 Palmetto deactivation letter states:

> The deactivation of Medicare billing privileges is considered an action to protect from the misuse of your billing number and to protect the Medicare Trust Funds from unnecessary overpayments. This deactivation does not have any effect on your participation agreement and/or any conditions of participation.

CMS Ex. 4 at 3.

On May 9, 2013, Palmetto received an enrollment application from Petitioner. CMS Ex. 10 at 7; CMS Ex. 3 ¶ 10. Palmetto notified Petitioner by letter dated July 2, 2013, that Petitioner's enrollment application was approved with a period for retroactive filing of claims beginning April 23, 2013. CMS Exs. 7, 9.

Petitioner requested reconsideration of Palmetto's initial determination. CMS Ex. 8. On October 3, 2013 a Palmetto hearing officer notified Petitioner by letter that the request for an earlier effective date was denied. The hearing officer cited 42 C.F.R. §§ 424.520-.521 as the basis for her decision and she reasoned that Petitioner's effective date of Medicare enrollment could be no earlier than Palmetto's receipt on May 23, 2013, of Petitioner's application that could be processed to completion. CMS Ex. 9. The hearing officer's reasoning is fatally flawed. Petitioner submitted the CMS-855I application received by Palmetto on May 9, 2013, not for the purpose of enrollment as it was already enrolled in Medicare and its enrollment was never revoked. Rather, the CMS-855I was submitted by Petitioner to reactive its billing privileges that had been deactivated on April 5, 2012.

Petitioner requested a hearing before an administrative law judge (ALJ) on November 29, 2013. The case was assigned to me for hearing and decision and on December 6, 2013, an Acknowledgment and Prehearing Order (Prehearing Order) was issued at my direction.

On January 6, 2014, CMS filed a motion for summary judgment with CMS exhibits (CMS Exs.) 1 through 10. On January 28, 2014, Petitioner filed a response in opposition to the CMS motion for summary judgment with Petitioner's exhibits (P. Exs.) 1 through 3.[2] On February 20, 2014, CMS filed a reply brief with CMS Exs. 11 and 12. The parties have not objected to my consideration of the proffered exhibits and all are admitted and considered.

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 Palmetto. 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)).

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[2] CMS failed to assemble and mark its exhibits and failed to submit a list of exhibits as directed by the Prehearing Order ¶ II.D.1. Petitioner also failed to mark its exhibits in accordance with the Prehearing Order ¶ II.D.2 and failed to submit a list of exhibits. I will not delay this case simply to impose sanctions or otherwise compel counsel to comply with procedural regulations, the CRDP, and my Prehearing Order. However, counsel for the parties are admonished to read and comply with the regulations, the Prehearing Order, and the CRDP in every case.

[3] 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.

Pursuant to 42 C.F.R. § 424.505, a provider or supplier must be enrolled in the Medicare program and be issued a billing number to have billing privileges and to be eligible to receive payment for services rendered to a Medicare eligible beneficiary. The effective date of enrollment in Medicare of a physician, nonphysician practitioner, and physician and nonphysician practitioner organizations is governed by 42 C.F.R. § 424.520(d). The 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.* The date of filing of the enrollment application is the date when a signed enrollment application that is ultimately process to completion is received by the designated Medicare contractor. 42 C.F.R. § 424.510(d)(1); 73 Fed. Reg. 69,725; 69,769 (Nov. 19, 2008). 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 authorized CMS to deactivate a provider or supplier's Medicare billing privileges if the provider or supplier does not submit any Medicare claims for 12 consecutive calendar months. 42 C.F.R. § 424.540(a)(1). CMS may also deactivate a provider or supplier's billing privileges if the provider or supplier does not report certain changes of information, such as a change in practice location or change of any managing employee, within 90 calendar days of when the change occurred, or does not provide complete and accurate information within 90 days of CMS's request for such information. 42 C.F.R. § 424.540(a)(2), (3). A provider or supplier "deactivated for any reason other than nonsubmission of a claim" is required to "complete and submit a new enrollment application to reactivate its Medicare billing privileges or, when deemed appropriate, at a minimum, recertify that the enrollment information currently on file with Medicare is correct." 42 C.F.R. § 424.540(b)(1). A provider or supplier who is "deactivated for nonsubmission of a claim" for 12 months is "required to recertify that the enrollment information currently on file with Medicare is correct and furnish any missing information as appropriate. The provider or supplier must meet all current Medicare requirements in place at the time of reactivation, and be prepared to submit a valid Medicare claim." 42 C.F.R. § 424.540(b)(2). Deactivation of Medicare billing privileges is to protect the provider or supplier from misuse of their billing privileges and the Medicare Trust Funds. Deactivation does not have any effect upon the provider's or supplier's participation in Medicare. 42 C.F.R. § 424.540(c).

B. Analysis

The CMS evidence shows that on about September 30, 2011, Palmetto requested that the Petitioner revalidate its Medicare enrollment. Palmetto also advised Petitioner that if it failed to submit the requested information in 60 days, its Medicare billing privileges may be deactivated. Palmetto then notified Petitioner by letter dated April 5, 2012, that its billing privileges were deactivated on that date because it had not submitted the requested revalidation information. CMS Ex. 4. There is no evidence that Palmetto advised Petitioner that its enrollment in Medicare would be revoked if it failed to timely submit the requested information. Petitioner submitted the information requested by Palmetto using a new CMS-855I, which Palmetto received on May 9, 2013. CMS Ex. 7; CMS Ex. 3 ¶ 10. The evidence shows that Palmetto treated the CMS-855I as an application to enroll in Medicare rather than an application to reactivate billing privileges and to complete the revalidation initiated by Palmetto in September 2011. I infer from the fact that Palmetto requested Petitioner to revalidate its Medicare enrollment information in September 2011, that it was enrolled at that time. There is no evidence that CMS ever revoked Petitioner's Medicare enrollment or was authorized to do so by 42 C.F.R. § 424.535 or any other provision of the Act or regulations. Therefore, Palmetto erred by attempting to determine a new effective date for Petitioner's enrollment in Medicare. The issue that must be decided is the effective date for the reactivation of Petitioner's billing privileges. The issue should be resolved favorably for Petitioner under current CMS policy.

The relevant CMS policy is found in the Medicare Program Integrity Manual (MPIM), ch. 15, § 15.27 (rev. 474, issued July 5, 2013, effective October 8, 2013).[4] The substantial revision to MPIM, ch. 15, § 15.27 significantly clarifies and refines the CMS policy regarding deactivations and reactivations of provider and supplier billing privileges. On its face, the new policy seems to be consistent with and supportive of the Secretary's regulation which provides that deactivation of Medicare billing privileges is to protect the provider or supplier from misuse of their billing privileges and the Medicare Trust Funds and **does not have any effect upon the provider's or supplier's participation in Medicare**. 42 C.F.R. § 424.540(c) (emphasis added). Because the new policy was issued prior to my decision in this case it is appropriate to remand to ensure that CMS has the opportunity to apply its interpretation of the applicable regulations and provisions of the Act. I note some important provisions of the revised policy to facilitate

[4] Although the MPIM is a statement of policy that does not have the force or effect of a statute or regulation, it is important to ensure that the agency interpretation of its regulations and enabling statutes is given appropriate weight. Therefore, it is appropriate to treat CMS and its counsel as being bound by public statements of CMS policy to the extent the policy is consistent with the law.

prompt action by Petitioner and CMS or its contractor related to reactivation of Petitioner's billing privileges. MPIM, ch. 15, § 15.27.1.1 sets forth CMS policy regarding deactivations and § 15.27.1.2 sets forth policy regarding reactivations. CMS policy states:

> If the contractor approves a provider or supplier's reactivation application or reactivation certification package (RCP), **the reactivation effective date shall be the provider or supplier's date of deactivation.**

MPIM, ch. 15 § 15.27.1.2 (emphasis added). According to CMS policy, a deactivated provider or supplier reactivates its billing privileges by submitting a complete Medicare enrollment application or by recertifying that enrollment information currently on file with Medicare is correct. MPIM, ch. 15, § 15.27.1.2.1-2. The documents that must be submitted for reactivation following deactivation for reasons other than nonsubmission of a claim are specified in MPIM, ch. 15, § 15.27.1.2.1 B and are referred to as the "reactivation certification packages" (RCPs). Pursuant to MPIM, ch. 15, § 15.27.1.2.1, a provider or supplier may elect to reactivate its billing number by submitting a completed Form CMS-855 enrollment application rather than a RCP. The supplier must also submit a copy of the claim or information for the claim it plans to submit when billing privileges are reactivated. MPIM, ch. 15, § 15.27.1.2.3 B. The Medicare contractor is required to permit an opportunity for a supplier or provider requesting reactivation to correct any deficient or incomplete RCP, and I infer, any enrollment application submitted in lieu of a RCP. MPIM, ch. 15, § 15.27.1.2.1.A.2 and B.2.

Pursuant to 42 C.F.R. § 498.56(d), I may remand a case to CMS for consideration of a new issue and a new determination. In this case, the new CMS policy must be considered and effectuated consistent with the dictates of the Act and the Secretary's regulations. The new issue that requires determination is the effective date of Petitioner's reactivation of its billing privileges. CMS should apply its current policy when making the determination.

Accordingly, this case is remanded to CMS for processing in accordance with the Act, regulations, and the current CMS policy controlling deactivation and reactivation of Petitioner's billing privileges. The parties may request that an order dismissing a case be vacated within 60 days for good cause shown pursuant to 42 C.F.R. § 498.72. If CMS completes its action on this case more than 60 days from the date of this Order and Petitioner desires my further review, Petitioner will file a request for hearing referring to this case with a copy of this Order attached.

III. Conclusion

For the foregoing reasons, this case is remanded to CMS pursuant to 42 C.F.R. § 498.56(d), for processing of Petitioner's application for reactivation of its billing privileges in accordance with 42 C.F.R. § 424.540 and current CMS policies regarding deactivation and reactivation of billing privileges. This case is dismissed.

/s/
Keith W. Sickendick
Administrative Law Judge