Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Robert Young, M.D.
Docket No. A-11-14
Decision No. 2359
January 13, 2011

FINAL DECISION ON REVIEW OF HEARING OFFICIAL DECISION

Robert Young, M.D. (Petitioner) appealed the decision of Board Member Leslie A. Sussan (Board Member).[1] *Robert Young, M.D.*, DAB CR2227 (2010) (DAB CR2227). The Board Member determined that Petitioner is entitled to an effective date of enrollment in the Medicare program of August 10, 2009, and is entitled to bill for services rendered as of July 11, 2009. In doing so, the Board Member rejected an argument by the Centers for Medicare & Medicaid Services (CMS) that Petitioner had no right to appeal an effective date determination. On the merits, the Board Member concluded that, contrary to what CMS argued, CMS's contractor could have processed to approval enrollment applications the contractor received on August 10, 2009, if the contractor's mailroom had forwarded those applications to the appropriate office for review, as required. The Board Member rejected an argument by Petitioner that the effective date should be March 1, 2009, which is the date the contractor received a form assigning Petitioner's billing rights to his practice group.

CMS appealed the Board Member's decision. For the reasons stated below, we affirm the Board Member's decision.

Analysis

CMS first argues that the Board Member's determination that Petitioner was entitled to an effective date of August 10, 2009 was legally erroneous and was not supported by substantial evidence in the record as a whole. CMS does not dispute that its contractor received enrollment applications on August 10, 2009 that were identical to the applications that were ultimately processed and approved, but argues that the applications received on August 10 were in fact "forwarded to the appropriate office for review" by the contractor's mailroom, as required by CMS's

[1] Pursuant to 42 C.F.R. § 498.44, Board Member Sussan was designated as the hearing official to hear provider supplier enrollment appeals under 42 C.F.R. Part 498, Subpart P and was assigned this case to issue an initial decision.

manual instructions to contractors. RR at 10. CMS's basis for this assertion is that "Petitioner admits that he sent the applications to the [contractor's] Provider Appeals Department, along with a request for a reconsideration" of the contractor's action on a March 2009 application for assignment of benefits, and that the applications were in fact forwarded to the Provider Appeals Department. *Id.* This assertion has no merit. CMS admits that the hearing officer from the contractor's Provider Appeals Department stated in her reconsideration determination that she could not consider the new applications. *Id.* Thus, substantial evidence supports the Board Member's finding that the Provider Appeals Department was **not** the appropriate office for review of the applications.

CMS also argues that Petitioner should have known that it should send the applications to the particular department listed on CMS's website because the instructions on the enrollment form state that the form should be sent to the applicant's fee-for-service contractor, with instructions on how to locate the address on the website. *Id.* CMS does not deny, however, that its contractor told Petitioner's representative to send the applications with the reconsideration request. *Id.* Taking this undisputed fact into account would not amount to improperly applying the principle of equitable estoppel, as CMS argues. CMS points to no governing law about how to submit an application that CMS would be estopped from applying. In any event, CMS does not deny that the applications at issue were received in the contractor's **mailroom**, and the record shows that the contractor used the same post office box number for enrollment applications and appeals. CMS Ex. 1, at 10, 7. CMS's own instructions directed the contractor to forward any application received in its mailroom to the appropriate office **for review.** Had the contractor done this, as required, it would have been able to process the applications to approval, as the Board Member found.

CMS also argues that the Board Member's grant of a 30-day retrospective billing period, pursuant to 42 C.F.R. § 424.521(a), was legally erroneous. According to CMS, that regulation "clearly vests the decision to grant a retroactive billing period in CMS's discretion," and the regulations do not provide for any review of the determination. RR at 12. We note that the Board Member applied the 30-day retroactive period because CMS's contractor had notified Petitioner that he could bill for a period 30 days prior to the date of receipt of applications in December 2009. DAB CR2227, at 8. We need not decide here whether the Board Member erred in holding that Petitioner was similarly entitled to bill for services rendered within 30 days of August 10, 2009. While CMS says the determination about retroactive billing should be left to its discretion, it does not assert that it would reach a different result if it exercised that discretion under the circumstances of this case. Absent such an assertion, we see no reason to disturb the determination.

Finally, in his response, Petitioner argues that he did not, as CMS asserts, acknowledge that he was not enrolled in Medicare on March 10, 2009, the date CMS's contractor first received a form CMS-855R assigning Petitioner's billing rights to his practice. Response at 1. CMS replies that "Petitioner's representative admitted in her request for reconsideration that Radnet [Petitioner's physician practice] did not know that Petitioner was not enrolled in Medicare at that time and thus did not submit a CMS-855I application." CMS Ex. 1. Admitting that one did not know a particular thing is not necessarily tantamount to admitting that the thing is a fact. Even if neither Petitioner nor his representative conceded that Petitioner was not enrolled in Medicare in March 2009, however, that would not entitle Petitioner to an effective date earlier than the one the Board Member granted. Without evidence showing that Petitioner was in fact enrolled in Medicare in March 2009, we have no basis on which we could grant an effective date of billing privileges of March 10, 2009, as Petitioner requests. Petitioner points to no such evidence in the record. Moreover, Petitioner does not explain why, if he was in fact enrolled when the first CMS-855R was submitted, that application includes the entry "pending" in the space for providing Petitioner's Medicare identification number. CMS Ex. 2, at 5. Presumably, if he were already enrolled, the number would not have been merely pending, but would have been assigned.

Conclusion

For the reasons stated above, we affirm the Board Member's decision.

/s/
Stephen M. Godek

/s/
Constance B. Tobias

/s/
Judith A. Ballard
Presiding Board Member