Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Caroline Lott Douglas, PA,

(NPI Number 1295061208)

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-11-329

Decision No. CR2406

Date: August 3, 2011

DECISION

Surgical Group of Gainesville (Surgical Group) on behalf of Petitioner Caroline Lott Douglas appeals the determination of First Coast Service Options, Inc. (FCSO), a Medicare contractor, that she was not eligible for enrollment in the Medicare program earlier than October 5, 2010 and could not submit claims for payment for services performed or delivered earlier than September 6, 2010. I grant the Centers for Medicare and Medicaid Services' (CMS's) motion for summary judgment finding that Petitioner's effective date of enrollment was October 5, 2010 and the retrospective billing period started on September 6, 2010.

I. Background

Petitioner is a Certified Physician's Assistant employed by the Surgical Group in Florida. On Petitioner's behalf, the Surgical Group attempted to complete a Medicare application

online through the Provider Enrollment, Chain and Ownership System (PECOS).[1] Because of a system error or problem due to system maintenance, Surgical Group was unable to complete the online enrollment application and subsequently submitted a paper application through the mail. On October 5, 2010, FCSO received Petitioner's new enrollee Medicare application form. CMS Ex. 1. FCSO processed and approved Petitioner's application. By letter dated December 7, 2010, FCSO notified Petitioner that her application had been approved with an effective date of September 6, 2010,[2] thirty days before October 5, 2010, the date of receipt of her application that was processed to approval. CMS Ex. 3.

By letter dated December 10, 2010, Petitioner requested reconsideration review. CMS Ex. 4. Petitioner requested that her effective date be changed to August 1, 2010, the date she started working at Surgical Group. On February 9, 2011, FCSO informed Petitioner that her request for reconsideration of her effective date of her Medicare enrollment had been denied. CMS Ex. 5.

On February 28, 2011, Petitioner filed a hearing request with the Civil Remedies Division (CRD) of the Departmental Appeals Board (Board). An Acknowledgment and Initial Docketing Order was sent to the parties on March 8, 2011. On April 15, 2011, CMS filed a Motion for Summary Judgment and brief (CMS Br.), accompanied by five exhibits (CMS Ex. 1-5). On April 14, 2011, Petitioner filed a Report of Readiness accompanied by two exhibits (P. Exs. 1-2) claiming there had been a system error in the PECOS system that prevented Petitioner from filing an earlier Medicare enrollment application. On April 20, 2011, Petitioner filed a Response brief (P. Response) accompanied by two additional exhibits labeled P. Ex 3 and P. Ex. 4. Subsequently, a fifth exhibit, a recorded CD, was offered by Petitioner. On May 3, 2011, I sent a letter to the parties directing them to submit further briefs on the issue of the materiality, if any, of any alleged malfunction in the PECOS system. I also directed Petitioner to submit any additional exhibits it wished to proffer including a typed transcript of the conversation recorded on the proffered CD and an affidavit concerning whether the other party or parties were aware that a recording was being made. Petitioner ultimately submitted a total of eight exhibits (P. Ex. 1-8) on May 12, 2011, including the exhibits previously offered. CMS's reply brief (CMS Reply) was filed on June 24, 2011. Petitioner's

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[1] PECOS is a "web-based enrollment process, which is based off of the information collected on the CMS-855 forms." CMS Medicare Program Integrity Manual (MPIM), Ch. 10, § 1.2.

[2] I disagree with September 6, 2010 being described as the "effective date," as I explain later in my analysis.

rebuttal brief (P. Rebuttal) was filed on July 1, 2011. I admit all proffered exhibits into evidence.[3]

II. Applicable Law

The Social Security Act (Act) authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations governing the enrollment process for providers and suppliers. Act §§ 1102, 1866(j); 42 U.S.C. §§ 1302, 1395cc(j). Under the Secretary's regulations, a provider or supplier that seeks billing privileges under Medicare 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).

A "provider or supplier must submit a complete enrollment application and supporting documentation to the designated Medicare fee-for-service contractor," and that the application must include "complete . . . responses to all information requested within each section as applicable to the provider or supplier type." 42 C.F.R. § 424.510(d)(1)-(2).

The effective date of enrollment for physicians and nonphysician practitioners is set as follows:

> 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). In addition, CMS permits limited retrospective billing as follows:

> Physicians, nonphysician practitioners and physician and nonphysician practitioner organizations may retrospectively bill for services when a physician or nonphysician practitioner or a physician or a nonphysician practitioner organization have met all program requirements, including State licensure requirements, and services were provided at the enrolled practice location for up to—

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[3] I admit the telephone transcripts and the CD since both parties were aware that the call was being recorded. The call center's greeting warned the caller that the telephone call might be recorded. Petitioner, since she provided the recorded CD, was of course aware of the recording.

> (1) 30 days prior to their effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries, or
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> (2) 90 days [in certain emergencies.]

42 C.F.R. § 424.521(a).

III. Issue

The issue in this case is whether CMS had a legitimate basis for finding that October 5, 2010 was the effective date for Petitioner's Medicare enrollment and billing privileges.

IV. Analysis

My findings of fact and conclusions of law are set forth in italics and bold in the discussion captions of this decision.

A. This case is appropriate for summary judgment.

CMS argues that it is entitled to summary judgment. The Departmental Appeals Board (Board) stated the standard for summary judgment:

> Summary judgment is appropriate when the record shows that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. . . . The party moving for summary judgment bears the initial burden of showing that there are no genuine issues of material fact for trial and that it is entitled to judgment as a matter of law. . . . To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact – a fact that, if proven, would affect the outcome of the case under governing law. . . . In determining whether there are genuine issues of material fact for trial, the reviewer must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor.

Senior Rehab. & Skilled Nursing Ctr., DAB No. 2300 at 3 (2010) (citations omitted). An Administrative Law Judge's (ALJ's) role in deciding a summary judgment motion differs from its role in resolving a case after a hearing. The ALJ should not assess credibility or evaluate the weight of conflicting evidence. *Holy Cross Vill. at Notre Dame, Inc.*, DAB No. 2291, at 5 (2009). The Board has further stated, "[i]n addition, it is appropriate for the tribunal to consider whether a rational trier of fact could regard the parties'

presentation as sufficient to meet their evidentiary burden under the relevant substantive law." *Dumas Nursing and Rehab., L.P.*, DAB No. 2347, at 5 (2010).

I must accept evidence in the light most favorable to the non-moving party and draw all reasonable inferences in that party's favor. Therefore, I accept Petitioner's claim that Sharon Manger, an employee of Surgical Group, "attempted to use the automated PECOS internet system the week of September 20, 2010 and the system failed to work . . . resulting in the PECOS help desk personnel requesting that a mailed in application be sent instead. This delayed CMS receiving the application on or about September 20, 2010 until October 5, 2010." P. Response at 3. Petitioner does not dispute any of the other material facts presented by CMS. P. Response at 2. Petitioner's evidence does not place in dispute any fact material to my resolution of the case. Therefore, summary judgment is appropriate for this case.

The admission of new documentary evidence is limited by 42 C.F.R. § 498.56(e), and a party must show good cause for submitting evidence for the first time at the ALJ level. It appears Petitioner's exhibits are documentary evidence submitted for the first time at the ALJ level, and this evidence was not available to CMS at the time of the reconsideration decision. Petitioner appears *pro se* and has not explicitly argued that good cause exists to submit this new evidence. However, in this case, in order to fully consider the evidence in the light most favorable to the non-moving party, and because I am not certain whether the evidence Petitioner submitted is new because of the lack of any objection from CMS, I will not exclude any evidence Petitioner has submitted.

B. FCSO's October 5, 2010 receipt of Petitioner's enrollment application necessarily determines her effective date and retrospective billing privileges.

It is undisputed that on October 5, 2010, FCSO received Petitioner's paper Medicare enrollment application. This application was processed and subsequently approved by FCSO.

The determination of the effective date of Medicare enrollment is governed by 42 C.F.R. § 424.520. Section 424.520(d) provides that the effective date for enrollment for nonphysicians, among others, 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." (Emphasis added). The "date of filing" is the date that the Medicare contractor "receives" a signed provider enrollment application that the Medicare contractor is able to process to approval. 73 *Fed. Reg.* 69,725, 69,769 (Nov. 19, 2008). It is well settled that the date of filing is the date the Medicare contractor receives an approvable application. *Jennifer Tarr, M.D.*, DAB CR2142 (2010); *Michael Majette, D.C.*, DAB CR2142 (2010); *Roland J. Pua, M.D.*, DAB CR2163 (2010); *Rizwan Sadiq, M.D.*, DAB CR2401 (2011).

Although FCSO erroneously referred to September 6, 2010 as Petitioner's "effective date" (CMS Ex. 3), regulations actually require the contractor to assign the date of receipt of the application as the effective date of Petitioner's enrollment while permitting the contractor to grant retrospective billing privileges for 30 days prior to the effective date. 42 C.F.R. § 424.521(a)(1). Thus, I am treating FCSOs action as if it intended to set September 6, 2010 as the earliest date for which Petitioner may submit claims, with the effective date of Petitioner's enrollment as October 5, 2010.

Petitioner attempted to submit an enrollment application through the PECOS system but that attempt was not successful. In the hearing request, Petitioner conceded that the application was not successfully submitted or received electronically by CMS. Petitioner states in the hearing request that "the PECOS system failed to function properly thus preventing [Ms. Manger] from retrieving the verification of acceptance of the application . . . [a manual application was submitted] since the PECOS system was not working at the time or that the data submitted could not be retrieved by the EUS support staff."[4] Petitioner's Exhibit 1 is a statement in lieu of testimony from Ms. Manger in which she asserts "[a]fter completion of the application online, I hit the submit button, and immediately an error occurred, which stated that there had been a system error. I tried to go back in and see if the application had been saved and, to my disappointment, it had not. . . . [The EUS help desk] said that if I received an error message that I could reenter it or submit it manually. They even mentioned that they were having problems with the system. Therefore, I printed a blank Medicare application and filled it out manually." P. Ex. 1. An individual from the Medicare Part B provider customer service told Ms. Manger, "It is a real possibility that you're caught in . . . [a] system maintenance and your information may be lost . . . ." P. Ex. 7, at 3.

Petitioner relies on the MPIM which states that "[t]he submission of a PECOS Internet application will immediately place the L & T (logging and tracking) record into a 'Received' status." MPIM, Ch. 10, § 4.15; P. Ex. 4. Petitioner asserts that her application was received on or around September 20, 2010, the date Ms. Manger used the PECOS system.

Petitioner's reliance on the MPIM is misplaced for two reasons. First, Petitioner has tried to frame her argument as if she had actually successfully submitted the Medicare application through the PECOS but that is a mischaracterization of the facts. The MPIM only applies to successfully-submitted PECOS applications. Petitioner merely attempted to submit an application but that attempt was not successful. It is evident that CMS never received the PECOS application electronically and that the first application that it did actually receive was the paper application received on October 5, 2010. A malfunction of the PECOS provides no legal justification to allow Petitioner to be enrolled on a date

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[4] EUS stands for the External User Services.

earlier that the date specified in 42 C.F.R. § 424.520(d). The date that governs Medicare enrollment is the date CMS "receives" the Medicare enrollment application.

Second, I am bound by applicable statute and regulations. Unlike the Medicare statute and regulations, however, the MPIM, which is merely CMS guidance to its contractors, does not have the force and effect of law and is not binding on me. *See Fady Fayad, M.D.,* DAB No. 2266, at 10 n.6. (2009) (*citing Massachusetts Executive Office of Health and Human Servs.*, DAB No. 2218, at 12 (2008)); *Foxwood Springs Living Ctr.*, DAB No. 2294, at 8-9 (2009).

Petitioner argues that the date of filing is not equivalent to the date of receipt. Petitioner does not point to any case law to support that position. The sole support for Petitioner's position is the definition of "filing" in Black's Law Dictionary. Petitioner asserts that "filing" means to "record or deposit something in an organized retention system or container for preservation and future reference." P. Rebuttal at 2. Petitioner asserts that it took every step required to "record or deposit" the application into the PECOS system. Unfortunately the attempt to record or deposit Petitioner's Medicare application online was not successful and CMS never received the enrollment application electronically. As stated above, the "date of filing" is the date that the Medicare contractor "receives" a signed provider enrollment application that the Medicare contractor is able to process to approval. 73 *Fed. Reg.* 69,725, 69,769 (Nov. 19, 2008).

Petitioner also attempts to apply contract law to this case and uses terms such as offeree, acceptance, mailbox rule, common business practice, good faith, and reasonable accommodation. All of Petitioner's arguments are unavailing because I am bound by applicable stature and regulations.

Last, Petitioner argues that Medicare has received a benefit without reimbursing Petitioner for her services. I am unable to grant the relief that Petitioner requests. Petitioner's argument amounts to a claim of equitable estoppel. It is well-established by federal case law, and in Board precedent, that: (1) estoppel cannot be the basis to require payment of funds from the federal government; (2) estoppel cannot lie against the government, if at all, absent a showing of affirmative misconduct, such as fraud; and (3) I am not authorized to order payment contrary to law based on equitable grounds. *See, e.g., Office of Personnel Mgmt. v. Richmond*, 496 U.S. 414 (1990); *Heckler v. Cmty. Health Servs. of Crawford County, Inc.*, 467 U.S. 51 (1984); *Oklahoma Heart Hosp.*, DAB No. 2183, at 16 (2008); *Wade Pediatrics*, DAB No. 2153, at 22 n.9 (2008), *aff'd*, 567 F.3d 1202 (10th Cir. 2009).

V. Conclusion

For the reasons explained above, based on the undisputed facts that FCSO did not receive a completed enrollment application from Petitioner until October 5, 2010, I conclude that

Petitioner's effective date of enrollment was October 5, 2010 and the retroactive billing period started on September 6, 2010.

/s/
Richard J. Smith
Administrative Law Judge