Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Guireida Rivera Colon, M.D.,

Petitioner

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-642

Decision No. CR3109

Date: February 7, 2014

DECISION

Petitioner, Guireida Rivera Colon, M.D., appeals a reconsideration decision regarding the commencement date of her Medicare enrollment and billing privileges, which were deactivated due to an untimely revalidation. First Coast Service Options, Inc. (First Coast), an administrative contractor acting on behalf of the Centers for Medicare & Medicaid Services (CMS), processed Petitioner's October 2012 Medicare enrollment applications and determined that the effective date of her Medicare enrollment was October 4, 2012, with retrospective billing privileges commencing on September 4, 2012. For the reasons stated below, I find that First Coast properly established the commencement date of Petitioner's retrospective billing privileges based on its receipt of October 2012 enrollment applications from Petitioner that First Coast could process to approval. Further, Petitioner is not entitled to bill Medicare for medical services she provided beneficiaries, from the period March 13, 2012 through September 3, 2012, which occurred during her period of deactivation as a participating supplier in the Medicare program.

I. Background and Procedural History

Petitioner, a licensed physician practicing in Puerto Rico, had been enrolled in the Medicare program since 2001. Request for Hearing (RFH) at 2. It is undisputed that on September 30, 2011, First Coast notified Petitioner that, in accordance with the Patient Protection and Affordable Care Act (ACA), all new and existing providers were being reevaluated under new screening guidelines that became effective March 23, 2011. The noticed explained that any supplier or provider that enrolled in the Medicare program prior to March 23, 2011 was required to revalidate their enrollment. CMS Ex. 1, at 1, 4; *see also* Pub. L. No. 111-148, §§ 6028, 6401, 124 Stat. 119 (2010). The notice further advised Petitioner that she could revalidate her enrollment through either the Internet-based PECOS system or through the paper application process, but she would need to do so within 60 days of the date of the notice. CMS Ex. 1, at 1, 2. Petitioner timely responded by filing paper enrollment applications CMS-855I, CMS-855R and CMS-588[1] in November 2011. When First Coast reviewed Petitioner's CMS-855R, it found the application to be incomplete because necessary signatures were missing. First Coast contacted Petitioner by letter dated November 15, 2011, noting the missing information, advising Petitioner that the application could not be processed, and advising her that she could reapply. CMS Ex. 3. In December 2011, Petitioner filed another CMS-855R. CMS Ex. 4.

When First Coast reviewed the CMS-855I and CMS-588 enrollment applications Petitioner submitted in November 2011, it was unable to process the applications because they were incomplete. By two separate letters, each dated February 7, 2012, First Coast advised Petitioner to submit the additional information. CMS Exs. 5, 6. Petitioner responded to First Coast's request for additional information. However, by letters dated March 16, 2012, First Coast advised Petitioner that because Petitioner's response to its request for additional information did not contain all of the information requested, First Coast was denying Petitioner's enrollment application and deactivating both of Petitioner's Provider Transaction Access Numbers (PTANs) effective March 13, 2012. The letters further advised Petitioner that she could submit a corrective action plan (CAP) or she could request reconsideration. CMS Exs. 7-9.

Petitioner filed two CAPs in April 2012 regarding both PTANs at issue. CMS Exs. 10, 11. Because the CAPs were neither signed nor dated, First Coast returned both CAPs to

[1] CMS-855I is the enrollment application for individual physicians and non-physician practitioners; CMS-855R is used when a supplier or provider wants to reassign Medicare benefits; and CMS-588 is the Electronic Funds Transfer (EFT) Authorization Agreement form. *See* http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html?redirect=/MedicareProviderSupEnroll/

Petitioner. CMS Exs. 12, at 2; 18, at 1. Petitioner then filed a reconsideration request on May 9, 2012 for both PTAN deactivations, but First Coast returned the request because it was not dated. CMS Exs. 12 at 1; 15; 18, at 1. Petitioner subsequently filed two additional reconsideration requests, one that First Coast received on May 23, 2012 and another on May 30, 2012. First Coast rejected these because Petitioner did not file them in a timely manner. CMS Exs. 14, 15, 16, 17; 18, at 1.

Petitioner filed new CMS-855I and CMS-588 applications in July 2012. CMS Ex. 19. Upon review, First Coast found that the CMS-855I enrollment application was incomplete, and it advised Petitioner on August 15, 2012 of the application status and requested that she provide all the required documentation by September 14, 2012. CMS Exs. 20; 21, at 2. Petitioner responded by faxing additional information on August 16, 2012 (CMS Ex. 21), but upon review First Coast found the application was still incomplete because Petitioner's most recent submission did not include a current Letter of Good Standing. CMS Ex. 22, at 1. Consequently, First Coast notified Petitioner by letter dated September 17, 2012, that it had attempted to contact Petitioner for additional information in order to process her July 2012 application, but Petitioner had not responded within the timeframe afforded, and it was therefore closing her application.[2] CMS Ex. 22.

In October 2012, Petitioner submitted another set of enrollment applications (CMS-855I and CMS-855R), which First Coast received on October 4, 2012. CMS Ex. 23. Following review of the submission, First Coast advised Petitioner in November 2012 that the applications were incomplete. CMS Exs. 24, 25. Petitioner responded with additional information. CMS Exs. 26, 27. After reviewing Petitioner's response, First Coast was able to process Petitioner's October 4, 2012 enrollment application to completion. CMS Ex. 28. By letter dated December 11, 2012, First Coast notified Petitioner that her enrollment application had been verified and that her new Medicare PTAN would be activated as of September 4, 2012, thus allowing her to commence billing privileges as of that date. CMS Ex. 28.

Petitioner was not satisfied with the September 4, 2012 commencement date determination because she could not bill for medical services she provided to Medicare patients from March 13, 2012 through September 3, 2012, the period when her billing privileges were deactivated. Petitioner asked First Coast to reconsider its determination and allow her retroactive billing privileges back to the date of her deactivation − March 13, 2012. CMS Exs. 30, 31, 32. On March 5, 2013, First Coast issued a decision

[2] If an applicant fails to furnish complete information to the contractor within 30 calendar days from the date the contractor requests the missing information, the contractor may reject the enrollment application and the applicant will need to complete and submit a new enrollment application. *See* 42 C.F.R. § 424.525.

upholding its initial determination.[3] CMS Ex. 33. Petitioner now appeals First Coast's unfavorable reconsideration decision.

Petitioner filed a hearing request dated March 20, 2013 along with two exhibits (P. Exs. 1 and 2), with the Civil Remedies Division of the Departmental Appeals Board. An Acknowledgment and Pre-hearing Order was sent to the parties on April 15, 2013. On May 20, 2013, CMS filed a Motion for Summary Judgment and a brief in support of its motion (CMS Brief), accompanied by 39 proposed exhibits (CMS Exs. 1-18, 19I and II, 20-22, 23I-III, 24-36). CMS filed the written direct testimony of one witness, Ms. Marian Love, Provider Enrollment Manager with First Coast, as CMS Ex. 36. On July 18, 2013, Petitioner filed her responsive brief titled "Preliminary Statement" without exhibits or listing any witnesses (P. Br.). CMS filed a reply on July 29, 2013. Petitioner did not object to CMS's witness or any of CMS's proposed exhibits, nor did CMS object to P. Exs. 1 and 2. I admit CMS Exs. 1-36 and P. Exs. 1 and 2 into the record.

In my prehearing order, I directed the parties to request a hearing if necessary to cross-examine witnesses. *See* April 15, 2013 Order at ¶¶ 9, 10. Petitioner did not present any witness testimony subject to cross-examination, and Petitioner did not request a hearing to cross-examine CMS's witness. Accordingly, I find there is no need to convene a hearing and decide this case on the written record.

II. Discussion

A. Issue

The issue in this case is whether First Coast, acting on behalf of CMS, properly established the effective date of Petitioner's Medicare enrollment and the commencement of her retrospective Medicare billing privileges.

[3] First Coast used the term "effective date" to refer to the date when Petitioner may retrospectively bill for Medicare services. CMS Ex. 33, at 1. The "effective date" would ordinarily be the date First Coast received Petitioner's application that it eventually approved. *See* 42 C.F.R. § 424.520(d). CMS may, however, permit Petitioner to "retrospectively bill" for services for up to 30 days prior to that effective date. 42 C.F.R. § 424.521(a). For clarity, this decision uses "effective date" in later sections to refer to the effective date of enrollment that is established by regulation, not the date when Petitioner's retrospective billing begins.

B. Applicable Law

Suppliers[4] such as Petitioner must enroll in the Medicare program to receive payment for covered Medicare items or services from either Medicare (in the case of an assigned claim) or a Medicare beneficiary (in the case of an unassigned claim) . . . ." 42 C.F.R. § 424.505. The regulations at 42 C.F.R. Part 424, subpart P, establish the requirements for a supplier to enroll in the Medicare program. *Id*. §§ 424.510- 424.516; *see* Social Security Act § 1866(j)(1)(A) (authorizing the Secretary of the U.S. Department of Health and Human Services to establish by regulation the process for enrolling providers and suppliers in the Medicare program). 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." *Id.* § 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 the application should include "complete . . . responses to all information requested within each section as applicable to the provider or supplier type." *Id.* § 424.510(d)(1)-(2).

When CMS contacts a supplier for a revalidation of its enrollment application, the supplier must submit the appropriate enrollment application to CMS with complete and accurate information and supporting documentation within 60 calendar days of CMS's notification to resubmit and certify the accuracy of the supplier's enrollment application. 42 C.F.R. § 424.515(a)(2). CMS may deactivate a supplier's billing privileges and enrollment in Medicare if the supplier fails to comply with revalidation requirements, including the requirement to timely submit complete and accurate information within 90 days of CMS's notification to submit an enrollment application and supporting documentation. *Id.* § 424.540(a). If this happens, CMS cannot make payment to the supplier for services provided to Medicare beneficiaries. *Id.* § 424.555(b).

If a supplier's billing privileges are deactivated for an untimely revalidation, it generally must submit a new enrollment application to reactivate its Medicare billing privileges. *See* 42 C.F.R. § 424.540(a)(3), (b)(1). The decision of CMS or its contractor to deactivate the billing privileges of a provider or supplier is not an "initial determination" subject to review by an administrative law judge (ALJ). *See* 42 C.F.R. § 498.3(b). By regulation, only an "initial determination" by CMS or its contractor triggers the appeal rights to an ALJ review for an affected provider or supplier. *Id.* § 498.5(l)(1). The regulations provide that a provider or supplier whose billing privileges are deactivated may submit a rebuttal pursuant to 42 C.F.R. § 405.374. *Id.* § 424.545(b).

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[4] 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.

C. Findings of Fact and Conclusions of Law

1. First Coast properly established the effective date of Petitioner's Medicare enrollment as October 4, 2012, based upon its receipt of applications that it could process to approval.

The effective date of enrollment 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). The "date of filing" is the date that the Medicare contractor "receives" a signed enrollment application that the Medicare contractor is able to process to approval. 73 Fed. Reg. 69,726, 69,769 (Nov. 19, 2008).

First Coast deactivated Petitioner's Medicare billing privileges based on Petitioner's failure to furnish First Coast with a complete revalidation enrollment application and supporting documentation within the required timeframes. *See* 42 C.F.R. § 424.540(a)(3). Although Petitioner does not dispute that First Coast requested this information, she argues that the information she sent to First Coast "always was correct, complete and accurate." P. Br. at 3. However it was not until October 4, 2012 that First Coast received a complete enrollment application from Petitioner that could be processed to approval.

Specifically, before October 4, 2012, Petitioner's submissions were not complete and First Coast properly rejected those applications. Following her deactivation, Petitioner submitted enrollment applications in July 2012, which First Coast received on July 9, 2012. CMS Exs. 19, 20. On August 15, 2012, First Coast advised Petitioner that required information was missing, including a letter of Good Standing from the Puerto Rico Board of Licensing, which needed to be issued within six months of the contractor receiving her application. CMS Exs. 20, 35, 36. On August 16, 2012, First Coast received additional information from Petitioner, but it was still not complete because the letter of Good Standing Petitioner submitted was not current as it had been issued in October 2011. CMS Exs. 21, at 9; 22, at 1. Consequently, on September 17, 2012, the contractor rejected Petitioner's July 2012 application. CMS Exs. 21, 22, 36; 42 C.F.R. § 424.525.

2. First Coast properly determined Petitioner was eligible for retrospective billing privileges as of September 4, 2012.

Once it approved the October 2012 applications, First Coast notified Petitioner that she was authorized to bill for services provided as early as September 4, 2012. CMS may

permit limited retrospective billing if a practitioner meets all program requirements. Specifically:

> 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—
>
> (1) 30 days prior to their effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries, or
>
> (2) 90 days prior to the effective date [in certain emergencies not applicable here].

42 C.F.R. § 424.521(a).

Here, CMS received an application, that it could eventually process to approval, on October 4, 2012, which determined Petitioner's effective date for Medicare enrollment and billing privileges. Therefore it properly calculated Petitioner's retrospective billing privileges to commence on September 4, 2012, which is 30 days earlier.

3. I am unable to consider the reasons for Petitioner's deactivation, and she is not eligible for reimbursement during her deactivation period.

Petitioner asks that I restore her billing privileges retroactively to March 13, 2012, so she can be reimbursed for medical services she rendered from March 13, 2012 through September 3, 2012, even though her account was deactivated during that period. *See* RFH at 2 citing P. Ex. 1. Petitioner maintains she has 123 medical claims, totaling $7,170.80, for which she is not being reimbursed. RFH at 2; P. Ex. 2.

Deactivation is not an initial determination, and an ALJ is authorized only to hear disputes involving initial determinations. 42 C.F.R. §§ 424.545; 498.3. If a contractor deactivates a supplier's Medicare billing privileges, the supplier's only option is to submit a rebuttal to the contractor under 42 C.F.R. § 424.545(b), in accordance with 42 C.F.R. § 405.374. Accordingly, I am not authorized to hear Petitioner's arguments with regard to the deactivation of her billing privileges, including whether or not Petitioner received notice of the deactivation. Considering Petitioner's claims are from services Petitioner provided during the time when her billing privileges were deactivated due to an untimely revalidation, she is not entitled to reimbursement for them. 42 C.F.R. § 424.555(b).

Petitioner also contends that she had already undergone a revalidation review in January 2011 and that she had continued complying with all Medicare requirements since that time. P. Br. at 3. However, the ACA required contractors to revalidate any provider or supplier who had not undergone the new screening guidelines that went into effect on March 23, 2011. CMS Ex. 1, at 4; *see also* 42 U.S.C. § 1395cc(j)(2); Pub. L. No. 111-148, § 6401, 124 Stat. 119 (2010); 76 Fed. Reg. 5862 (Feb. 2, 2011). Therefore, First Coast had a legal basis to revalidate Petitioner's enrollment.

4. I am not authorized to grant Petitioner's request for equitable relief.

Petitioner contends that although she attempted to complete the enrollment process several times, her enrollment efforts were hampered by mail delays considering she could neither fax nor e-mail her responses to First Coast. P. Br. at 2. Petitioner states that "'technically' [First Coast] did apply correctly the Medicare regulation," but she also asks that I take certain facts into consideration when reviewing First Coast's determination regarding the commencement of her billing privileges. RFH at 1; P. Br. at 2-3.

Petitioner asserts that while enrolled as a Medicare supplier she continued to comply with all program requirements in order to provide services to Medicare beneficiaries from her January 2011 revalidation date through to her March 16, 2012 deactivation, she was never subjected to a revocation or suspension or ever penalized by any government agency that regulates health care practitioners in Puerto Rico or any other state, and she states that even after her re-enrollment in Medicare in October 2012, the information that she submitted to the contractor had not changed in comparison to the information she submitted for her January 2011 revalidation. *Id*. at 2, 3.

However, entities seeking to participate in Medicare as providers or suppliers are responsible for making themselves aware of, and for complying promptly and carefully with, all the regulatory provisions that govern their eligibility. *Manor of Wayne Skilled Nursing & Rehab.*, DAB No. 2249, at 11 (2009). Petitioner has not provided any compelling evidence that she filed a complete application on an earlier date than that which First Coast determined. Further, Petitioner has neither specifically argued nor provided any evidence that First Coast incorrectly applied the regulatory criteria. Petitioner has simply not shown any basis in fact or in law that would support an earlier effective enrollment date and consequently, an earlier commencement date for billing privileges, than that which First Coast has established.

Petitioner's equitable arguments give me no ground to grant her an earlier effective date of enrollment. *See US Ultrasound*, DAB No. 2302, at 8 (2010) ("[n]either the ALJ nor the Board is authorized to provide equitable relief by reimbursing or enrolling a supplier who does not meet statutory or regulatory requirements.").

III. Conclusion

For the foregoing reasons, I conclude that First Coast properly determined that the effective date of Petitioner's enrollment started on October 4, 2012, the date First Coast received an enrollment application from Petitioner that could be eventually processed to approval. Consequently, as First Coast also properly determined, Petitioner may bill for services rendered from September 4, 2012, her retrospective billing date.

/s/
Joseph Grow
Administrative Law Judge