Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Rushita Patel, M.D.,
(NPI: 1588868749),

Petitioner

v.

Centers for Medicare & Medicaid Services.

Docket No. C-10-181

Decision No. CR2129

Date: May 13, 2010

DECISION AND REMAND

The Centers for Medicare and Medicaid Services (CMS) granted the Medicare enrollment application of Petitioner, Rushita Patel, M.D., effective June 17, 2009. Petitioner now challenges that effective date. CMS has moved to dismiss, arguing that Medicare regulations do not allow a supplier whose Medicare enrollment has been granted to appeal the effective date of her billing privileges. In the alternative, CMS seeks summary judgment, arguing that the undisputed evidence establishes that Petitioner's enrollment was approved as of the date of her application -- the earliest date allowed under the regulations. Petitioner has filed a cross-motion for summary judgment, complaining that Medicare contractor errors delayed her application and denied her appeal rights.

For the reasons discussed below, I find that I have the authority to review the effective date of a provider/supplier's enrollment application. Accordingly, I decline to dismiss.

On the merits, I agree with CMS that Medicare regulations preclude a supplier's enrollment any earlier than the date of her application. However, this matter involves multiple applications. Based on the record before me, I am neither satisfied that the Medicare contractor appropriately resolved those earlier applications nor that the contractor consistently provided the prospective supplier with accurate and timely notice of her right to review of its earlier determinations. I therefore remand this matter to CMS

with instructions that it revisit its November 15, 2008 denial of Petitioner's October 30, 2008 enrollment application, which the contractor mischaracterized as an enrollment approval, and that it revisit its premature denial of Petitioner's March 26, 2009 enrollment application. I direct CMS to consider whether an effective date based on one of these earlier mishandled applications might be more appropriate.

With its motions, CMS submitted 27 exhibits (CMS Exs. 1-27). Petitioner submitted a response and a cross-motion for summary judgment with no additional exhibits. CMS filed a response to Petitioner's motion, but not within the time provided for in my initial order. CMS counsel asked leave to file the late response, explaining that she misconstrued my order, which allows a party 30 days to respond to a motion for summary judgment, but says that I will not normally accept a reply from a moving party.[1] Counsel apparently did not initially understand that, with respect to Petitioner's motion, CMS was the responding (not the moving) party. Petitioner objects to my admitting CMS's response, because it was not timely filed. Petitioner has not shown that she was prejudiced by the late filing and has included with her objections a reply to CMS's response. I accept both CMS's response and Petitioner's objection/reply.

I. Discussion

A. The effective date of a Medicare provider agreement or supplier approval is an initial determination reviewable in this forum.[2]

Medicare regulations define as an "initial determination," subject to review in this forum, "[t]he effective date of a Medicare provider agreement or supplier approval." 42 C.F.R. § 498.3(b)(15). CMS has not identified any ambiguity in the language of the regulation that would oblige me to consider its regulatory history or any other extraneous factor to interpret its meaning. *Victor Alvarez, M.D.*, DAB CR2070 (2010); *Romeo Nillas, M.D.*, DAB CR2069 (2010); *see Jorge M. Ballesteros, CNRA*, DAB CR2067 (2010). Because the regulation is clear on its face, I am bound to follow it.

I recognize that section 498.3(b)(15) was drafted years before denials of provider and supplier enrollment applications were made appealable in this forum. *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, codified at 42 C.F.R. § 1395cc(j). *See also* 42 C.F.R. § 1395cc(h)(1)(A). But nothing suggests that the drafters

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[1] My order is more generous than the regulations, which allow 20 days for rebuttal briefs. With respect to filing a reply, my order reflects the regulatory standard, which allows for a reply "only if the party shows good cause." 42 C.F.R. § 498.17(b).

[2] My findings of fact/conclusions of law are set forth, in italics and bold, in the discussion captions of this decision.

of section 498.3(b)(15) intended to exclude from its provisions categories of providers and suppliers who might later gain appeal rights. Indeed, with the expansion of provider/supplier appeals, CMS has had ample opportunity to limit review of the effective date, but it has not done so. In fact, the opposite is true. When CMS adopted regulations setting out enrollment requirements for Medicare participation, 42 C.F.R. Part 424, Subpart P, it provided that a prospective provider or supplier whose enrollment is denied or revoked "may appeal CMS' decision in accordance with part 498, subpart A of this chapter." 42 C.F.R. § 424.545(a). Section 498.3(b)(15) is obviously part of subpart A, so it applies here.

Nor do I accept CMS's argument that Petitioner's appeal should not be considered an appeal of the "effective date of a . . . supplier approval" within the meaning of section 498.3(b)(15). CMS points to 42 C.F.R. § 489.13(a)(1), which discusses effective dates of agreement or approval for entities that, as a basis for Medicare participation, are either subject to survey and certification or are deemed to meet federal requirements based on accreditation by an approved organization. It does not follow, however, that "supplier approvals" are limited to the entities described in § 489.13(a)(1).[3] Other regulations also define "approval." Specifically, 42 C.F.R. § 424.502 says that "approval" means the enrolling provider or supplier has been determined to be eligible to receive a billing number and be granted billing privileges -- the determination made in this case.

For these reasons, I find that I have jurisdiction to review the effective date of Petitioner's Medicare enrollment.

B. The undisputed evidence establishes that the Medicare contractor denied Petitioner Patel's initial enrollment application, erroneously sent notice that it was granted, and thereafter refused to pay any of the claims she submitted.

CMS recently amended its regulations governing the effective date for provider/supplier enrollment in, and billing to, the Medicare program. 73 Fed. Reg. 69,940 (Nov. 19, 2008). The effective date for billing privileges "is the *later* of the date of filing" a subsequently approved enrollment application 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) (emphasis added). Nevertheless, if a practitioner meets all program requirements, CMS allows him to bill retrospectively for up to "30 days prior to their

[3] In logic, CMS's argument would be considered a syllogistic fallacy of the illicit major term: all A=B; no C=A; therefore, no C=B. More concrete examples illustrate the flaws in the reasoning: all dogs are mammals; no cats are dogs; therefore no cats are mammals; or, as here: all § 489.13(a)(1) effective date determinations are reviewable; supplier enrollment effective date determinations are not § 489.13(a)(1) effective date determinations; therefore, supplier enrollment effective date determinations are not reviewable.

effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries." 42 C.F.R. § 424.521(a)(1). Based on these provisions, CMS apparently sets enrollment effective dates 30 days prior to the date of application. CMS Ex. 7, at 4; CMS Ex. 22.

Here, Petitioner Patel is a physician employed by Dr. Deepak Amin's physician practice group, Deepak Amin, M.D., LLC.[4] On October 27, 2008, Petitioner Patel signed and submitted to the Medicare contractor, National Government Services, Inc., her Medicare enrollment application (CMS-855R), which the contractor received on October 30, 2008. CMS Ex. 8; CMS Ex. 11, at 1 (Brion Decl. ¶ 2). In that application, she asked that her benefits be reassigned to Dr. Amin's practice group. CMS Ex. 8.

Petitioner Patel's application was incomplete. CMS Form 855R only asks that a practitioner's benefits be reassigned to an eligible entity. Since Petitioner Patel was not herself enrolled in the Medicare program, she also had to submit the basic enrollment application, CMS-855I. Medicare Program Integrity Manual (MPIM) Chapter 10, ¶ 1.2 (CMS Ex. 1, at 1); MPIM Chapter 10, ¶ 4.20 (CMS Ex. 5) ("If the individual who wants to reassign . . . her benefits is not enrolled in Medicare, the person must complete a CMS-855I as well as the CMS-855R.").

Further, Dr. Patel was asking that her benefits be reassigned to an entity that was not then eligible to receive them. Although Dr. Amin was individually enrolled in the Medicare program, his practice group was not. It needed to apply for a group number (by submitting form CMS-855I), which it could have done at the same time Dr. Patel submitted her enrollment applications. MPIM Chapter 10, ¶ 1.2 (CMS Ex. 1, at 1); Chapter 10 ¶ 4.4.3 (CMS Ex. 2, at 1-2); CMS Ex. 3, at 2-3; CMS Ex. 11, at 2 (Brion Decl. ¶ 3).[5]

Pursuant to 42 C.F.R. § 424.525, the Medicare contractor could have rejected the application and instructed Drs. Patel and Amin to submit the missing documentation within 30 calendar days (extendable at CMS's discretion). 42 C.F.R. § 424.525. Instead, in a notice dated November 15, 2008, the contractor erroneously advised Petitioner that her enrollment application was *approved*, with an effective date of November 15, 2008.

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[4] Although this case is nominally an appeal of Dr. Patel's enrollment date, the fate of her enrollment applications is inextricably intertwined with that of her employer's.

[5] According to Petitioner Patel and Dr. Amin, they acted at the direction of the contractor's staff, who misinformed them about what enrollment applications to submit. CMS does not dispute the assertion but argues that the government may not be estopped from enforcing its rules based on the errors of its employees. In this instance, CMS's argument is essentially correct. And, although the contractor had the discretion to correct its errors in a way that would have been fair to the prospective supplier, its failure to do so is not reviewable by me. *See*, *e.g.*, 42 C.F.R. §§ 424.525(d), 498.3(b).

CMS Ex. 11, at 2 (Brion Decl. ¶ 4); CMS Ex. 12. On January 5, 2009, Dr. Patel began working for Dr. Amin's practice group, providing services to Medicare beneficiaries, and billing the Medicare program for those services. The Medicare contractor then denied reimbursement for the Medicare services she provided. CMS Ex. 9, at 2; CMS Ex. 11, at 2 (Brion Decl. ¶ 4).

CMS characterizes the contractor's November 15, 2008 determination as an "approval" (albeit an erroneous "approval") of Petitioner's enrollment application. I disagree. According to CMS, based on her enrollment application, Petitioner Patel could not participate in the Medicare program, and, therefore, none of her Medicare claims could or would be paid. CMS Ex. 11, at 2 (Brion Decl. ¶¶ 3, 4); CMS Br. 11-12. Thus, Dr. Patel's Medicare enrollment was essentially void ab initio. Where a prospective supplier does not satisfy Medicare enrollment requirements, and, as a result, all of her claims are denied, her enrollment application has been denied, notwithstanding the language of the contractor's notice letter.

But, because the contractor erroneously sent Petitioner Patel a notice of enrollment approval, it did not advise Petitioner of her appeal rights, as required by 42 C.F.R. § 498.20(a). *See* 42 C.F.R. §§ 424.545, 498.3(b)(17), 498.5(d).

C. Petitioner is entitled to review of CMS's denial of her March 26, 2009 application.

When Dr. Patel and Dr. Amin contacted the Medicare contractor about Dr. Patel's denied claims, the contractor advised them to file an additional application asking that the contractor terminate the reassignment and to file new applications for enrollment and reassignment of claims. P. Br. at 4. Accordingly, in an application (CMS-855R) dated March 31, 2009, Dr. Patel and Dr. Amin asked that the contractor terminate the reassignment retroactive to January 5, 2009, which was the date Petitioner Patel joined Dr. Amin's practice and started billing the Medicare program. CMS Exs. 9, 13. In a letter dated April 30, 2009, the contractor advised Petitioner Patel that it approved her request and terminated her reassignment, effective January 5, 2009. CMS Ex. 14.[6]

Also acting on the contractor's instructions, Dr. Patel and Dr. Amin submitted new enrollment applications on March 26 and 31, 2009. CMS Exs. 13, 15. However, the contractor determined that Dr. Amin did not qualify for enrollment, because he was not registered with the New York State Department of Education, as state law required. *See* 42 C.F.R. § 424.530(a)(5). In a letter dated April 8, 2009, the contractor denied his enrollment request and Dr. Patel's CMS-855R application asking for reassignment of her

[6] By following the contractor's instructions, Dr. Patel and Dr. Amin effectively resolved the contractor's error to the contractor's satisfaction but at a significant price to themselves, because they lost their October 2008 filing date.

benefits to Dr. Amin's practice group but invited them to submit a corrective action plan within 30 days. CMS Ex. 16. Dr. Amin apparently then registered with the New York State agency and, in a letter dated April 30, 2009, submitted to the contractor documentation of his registration. CMS Ex. 17. The contractor accepted the submission. CMS Ex. 18.[7]

However, the contractor apparently determined that Dr. Amin's application was still not complete. CMS submits a copy of a May 13, 2009 letter from the contractor to Dr. Amin that lists additional missing information (authorized signatures, voided check or confirmation of account information, practice location information, and certification statement). The letter instructs him to submit the requested information no later than *June 12, 2009*, or risk rejection of his application. CMS Ex. 18; *see* 42 C.F.R. § 424.525 (CMS may reject a supplier's enrollment application, if the prospective supplier fails to furnish complete information within thirty days of the contractor's request.).

Dr. Amin denies receiving the May 13, 2009 letter. P. Br. at 4, 6. As discussed below, I find this credible.

In any event, for reasons that CMS does not explain, the contractor then *did not* afford Dr. Amin thirty days in which to supplement his application.[8] In a letter dated June 1, 2009, the contractor denied Dr. Amin's application, claiming that he failed to furnish the corrected application "within 30 calendar days from the date of the contractor's request." The letter then refers to requests for information dated "May 13, 2009, and *June 1, 2009*." CMS Ex. 19 (emphasis added). The letter advises Dr. Amin of his appeal rights.

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[7] CMS claims that, because Dr. Amin was not appropriately registered with the state, he was not eligible to receive assigned claims, so he was not really harmed by the contractor's November 2008 errors. In fact, Dr. Amin's state registration difficulty is exactly the type of issue easily resolved by a corrective action plan – as it was here. But for the contractor error, the application deficiencies could have been resolved with a corrective action plan back in 2008, and Dr. Patel's October 2008 application date would have been preserved. In any event, Dr. Amin was obviously harmed, because his employee provided services for which he was denied reimbursement. Had he known that Dr. Patel was not legitimately enrolled, he could at least have avoided the expense of providing the services.

[8] CMS states that "because [Dr. Amin's] information was not provided *in a timely manner*," the contractor denied the enrollment application in a letter dated June 1, 2009. CMS Br. 13; CMS Ex. 19 (emphasis added). Similarly, CMS's witness declares that "because such information was not provided *in a timely manner*, [the contractor] denied the enrollment application and informed Dr. Amin of its denial by letter dated June 1, 2009." CMS Ex. 11, at 3 (Brion Decl. ¶ 9) (emphasis added). I find these statements disingenuous, since, as neither CMS nor its witness mentions, Dr. Amin's application was denied almost two weeks *before* his response was even due.

Dr. Amin claims that he did not receive the June 1, 2009 notice letter, either by mail or fax. He alleges that he found out about the denial when, in July, he inquired about the status of his application. P. Br. at 5. I find this credible. First, although we presume receipt of such correspondence within five days of the notice date (42 C.F.R. §§ 498.22(b)(3), 498.40(a)(2)), that presumption is rebuttable. CMS has come forward with no evidence that the contractor ever sent those notice letters. If, in the ordinary course of its business, the contractor faxed its notices (as Dr. Amin alleges contractor staff told him – and CMS has not disputed), it would have evidence in the form of a transmission verification report, or similar receipt, showing the date, time, number of pages, and the fax number for the machine to which it was sent. *See*, *e.g.*, *Ballesteros*, DAB CR2067, at 3 (noting contractor's procedures for processing enrollment applications leave both a paper and an electronic trail). But CMS has produced nothing. Second, I find it wholly credible that Dr. Amin and Dr. Patel did not receive the notice letters given: the speed with which Dr. Amin responded to the contractor requests that he acknowledges receiving; the minor nature of the information requested; the ease with which he could have provided it; and the strong incentive he had for doing so. In contrast, the evidence establishes multiple problems with the contractor's procedures, which makes it far more likely that its staff failed to send the notices than that Dr. Patel and Dr. Amin received them but failed to respond.

Finally, even though Dr. Amin learned of the denial in July, CMS offers no evidence that the contractor subsequently sent him notice of his appeal rights. *See Mark K. Mileski*, DAB No. 1945 (2004) (mere awareness of agency action does not substitute for actual notice).

Moreover, even if CMS established that Dr. Amin received the notices, I would find good cause for extending the time with which to appeal, because the notices themselves were so plainly error-ridden. 42 C.F.R. § 498.40(c)(2). By regulation and according to the May 13, 2009 notice, Dr. Amin was entitled to 30 days to complete his enrollment application – he had until June 12. 42 C.F.R. § 424.525. Yet, without further notice, the contractor cut him off on June 1. Moreover, the June 1 notice letter claims that Dr. Amin did not provide information that the contractor requested on *June 1, 2009*, yet another obvious error.

Dr. Amin and Dr. Patel submitted new enrollment applications, dated July 15 and July 17, 2009. CMS Ex. 11, at 3-4 (Brion Decl. ¶¶ 10, 11; CMS Ex. 20). Thereafter, the contractor asked Dr. Amin for some minor additional information, which he provided. CMS Ex. 21, at 3.[9] In a letter dated September 2, 2009, the contractor approved Dr. Patel's enrollment application, with an effective date of June 17, 2009. CMS Ex. 22.

[9] The voided check he submitted read Deepak Amin LLC, which was slightly different from his legal business name, Deepak Amin, M.D., LLC. Dr. Amin had to supply a letter from his bank confirming that the name on the account was the practice's legal business name. CMS Ex. 21, at 3.

Dr. Amin and Dr. Patel are understandably upset by the effective date, which is five months after Dr. Patel, with the contractor's written approval (CMS Ex. 12), began providing Medicare services and nearly eight months after Dr. Patel began her enrollment efforts.

I recognize that claims of equitable estoppel do not lie against the government, and, notwithstanding the overwhelming equities in Petitioner's favor here, I do not base this decision on equitable principles. Medicare contractors have broad authority to process enrollment applications, and much of what they do is not reviewable. But does this mean that a contractor can send the prospective supplier a section 424.525 notice affording him thirty days to submit supplemental information, then, without further notice or explanation, renege on that offer of time and then defend its actions by claiming that the prospective supplier has no recourse? I do not reach that issue here but remand the case to CMS to afford it the opportunity to correct its errors.[10]

At a minimum, of course, the contractor is required to send accurate notices of its determinations advising potential suppliers of their appeal rights, and its failure to do so is also reviewable in this forum.

By statute and regulation, CMS has broad discretion with respect to provider/supplier enrollment, and its actions are subject to limited review. But underlying this grant of unreviewable authority is the expectation that the agency will not abuse its authority and will act competently. I remand this case to give CMS the opportunity to do so here.

It is my hope that, on remand, the contractor exercises its discretion to consider this entire process part of a single application, filed October 30, 2008. *See* 42 C.F.R. § 424.525(b) (CMS may extend period for prospective supplier to furnish supplemental information "if CMS determines that the prospective . . . supplier is actively working with CMS to resolve any outstanding issues.").

II. Conclusion

I therefore **remand** this case to CMS for actions consistent with this decision. 42 C.F.R. § 498.78. Petitioner may file a new request for hearing before me if the decision on remand is unfavorable.

/s/
Carolyn Cozad Hughes
Administrative Law Judge

[10] With respect to whether I can review the contractor's actions, I note that they seem a relevant part of its decision to deny enrollment, which is plainly reviewable. 42 C.F.R. § 498.3(b)(17).