Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Texas Outpatient Services, P.A.,

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-1353

Decision No. CR3200

Date: April 11, 2014

DECISION

Petitioner, Texas Outpatient Services, P.A. (TOS), appealed the effective date determination that it was not eligible for enrollment in the Medicare program as a supplier earlier than February 22, 2013 and could not submit retrospective claims for payment earlier than January 23, 2013. The Centers for Medicare & Medicaid Services (CMS) moved for summary judgment. It is undisputed that the earliest enrollment application, which was subsequently approved, was received by CMS's contractor on February 22, 2013, so I find that Petitioner's effective date of enrollment was February 22, 2013, with a retrospective billing period starting January 23, 2013. I do not have jurisdiction to consider the rejection of Petitioner's December 2012 enrollment application. I therefore grant summary judgment in favor of CMS.

Background and Procedural History

The material facts in this case are undisputed. On August 31, 2012, a newly formed entity, Evolution Health, bought the assets of the recently bankrupt American Physician HouseCalls (APH). Evolution Health owns and manages TOS, a group practice. TOS legally formed on September 6, 2012 and continued to provide services to Medicare beneficiaries previously served by APH. TOS created a Medicare National Provider

Identifier (NPI) number on October 5, 2012. In December 2012, TOS submitted a CMS-855B enrollment application to enroll the group practice into Medicare. On January 14, 2013, Novitas Solutions (Novitas), a Medicare contractor, requested that TOS provide additional information within 30 days consisting of the reassignment applications for all group members reassigning themselves to TOS and account information not previously attached to the Electronic Funds Transfer Authorization Agreement form. CMS Ex. 2. The January 14, 2013 letter stated that "Failure to provide all requested information will cause the application to be rejected." CMS Ex. 2. Petitioner did not timely submit the requested additional information, and on February 13, 2013, Novitas rejected Petitioner's December 2012 Medicare enrollment application. CMS Ex. 5.

Petitioner electronically submitted a second CMS-855B enrollment application on February 22, 2013 for the group practice. CMS Ex. 4. On May 28, 2013, Novitas approved Petitioner's group practice application with an effective date of February 22, 2013 and a retrospective billing date of January 23, 2013. CMS Ex. 5. Petitioner requested reconsideration of this determination. CMS Ex. 6. Novitas issued an unfavorable reconsideration decision on July 31, 2013. CMS Ex. 7.

Petitioner filed a request for hearing (RFH) on September 13, 2013. Following the issuance of my Acknowledgement and Pre-Hearing Order dated September 25, 2013, CMS moved for summary judgment and filed a supporting brief (CMS Br.) with seven proposed exhibits (CMS Exs. 1-7). Petitioner submitted a pre-hearing brief (P. Br.) with five proposed exhibits (P. Exs. 1-5) and three unmarked affidavits that appear in the electronic case file as document numbers 15, 16, and 16a. In the absence of any objections, I admit CMS Exs. 1-7, P. Exs. 1-5, and Petitioner's affidavits into the record.

Applicable Law

Suppliers, such as a group practice like 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 requirements for a supplier to enroll in the Medicare program. 42 C.F.R. § 424.510 *et seq.*; *see also* Social Security Act (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). 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 effective date of enrollment is an "initial determination" that a supplier may appeal by requesting reconsideration from the contractor within 60 days of receipt of the initial determination notice. 42 C.F.R. §§ 498.5(*l*)(1), 498.3(b)(15), 498.22(a). Any supplier dissatisfied with a reconsidered determination may file a request for hearing within 60 days of receipt of the reconsidered determination notice. 42 C.F.R. §§ 498.5(*l*)(2); 498.40(a)(2).

Issues

This case presents the following issues:

1. Whether summary judgment is appropriate; and

2. Whether CMS or its contractor correctly established the effective date for Petitioner's group practice enrollment in the Medicare program.

Findings of Fact and Conclusions of Law

1. Summary judgment is appropriate.

Summary judgment is appropriate if "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." *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 3 (2010) (citations omitted). The moving party must show that there are no genuine issues of material fact requiring an evidentiary hearing and that it is entitled to judgment as a matter of law. *Id.* If the moving party meets its initial burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial . . . .'" *Matsushita Elec. Indus. Co. v. Zenith Radio*, 475 U.S. 574, 587 (1986). "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." *Senior Rehab.*, DAB No. 2300, at 3. To determine whether there are genuine issues of material fact for hearing, an ALJ must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. *Id.* As discussed more specifically below, this case presents no genuine disputes of material fact and therefore may be decided as a matter of law.

2. Novitas rejected Petitioner's December 2012 enrollment application because Petitioner did not respond to Novitas's request for additional information within 30 days.

CMS may reject a provider's or supplier's enrollment application if a prospective provider or supplier fails to furnish complete information on its enrollment application

within 30 calendar days from the date that the contractor requests the missing information. 42 C.F.R. § 424.525(a). An applicant does not have appeal rights to challenge a rejected application. 42 C.F.R. § 424.525(d). Rather, the applicant must resubmit a new enrollment application. 42 C.F.R. § 424.525(c). CMS may extend the 30-day period provided for the applicant to comply before rejecting an application if CMS determines that the applicant is actively working with CMS to resolve any outstanding issues. 42 C.F.R. § 424.525(b). But this determination is purely a discretionary matter and also is not subject to appeal.

It is undisputed that TOS filed its first CMS-855B enrollment application in December 2012. CMS Ex. 1. On January 14, 2013, Novitas requested that TOS provide additional information within 30 days. The additional information requested was the reassignment applications for all group members reassigning benefits to TOS and account information not previously attached to the Electronic Funds Transfer Authorization Agreement form. CMS Ex. 2. The January 14, 2013 letter stated that "Failure to provide all requested information will cause the application to be rejected." CMS Ex. 2. After failing to receive a response to its request, Novitas left a message with Petitioner regarding the requested information on February 4, 2013. CMS Ex. 7, at 2. Despite this, Petitioner did not timely submit the requested additional information, and on February 13, 2013, 30 days after the January 14th letter, Novitas rejected Petitioner's December 2012 Medicare enrollment application. CMS Ex. 5.

Petitioner relies on 42 C.F.R. § 424.525(b) to argue that it should have been allowed more than 30 days to supply the additional information requested due to the complexities of the former group's bankruptcy proceedings. P. Br. at 3. Petitioner's argument is unavailing. Extending the 30-day period is discretionary. It is up to CMS or its contractor to determine when "the prospective provider or supplier is actively working with CMS to resolve any outstanding issues." I have no authority to review CMS's discretion. Even if I did, there is no evidence that Petitioner was actively working with Novitas. Petitioner provides a timeline of steps it took to obtain Medicare billing privileges after its formation. P. Ex. 2. The timeline starts with steps Petitioner took in September 2012 and ends with Petitioner's last step taken on December 20, 2012. P. Ex. 2. Novitas's request for additional information was dated January 14, 2013, and Petitioner's timeline lists no action after that date.

3. ***Based upon the receipt of its application that Novitas subsequently approved, Petitioner's effective date of enrollment in Medicare is February 22, 2013, with retrospective billing privileges starting January 23, 2013.***

It is undisputed that Novitas received Petitioner's second enrollment application on February 22, 2013. Novitas ultimately approved that application and notified Petitioner of its decision in a letter dated May 28, 2013. CMS Ex. 5.

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) (emphasis added). Here, Novitas received two enrollment applications from Petitioner. It rejected Petitioner's first enrollment application. It approved Petitioner's second enrollment application, which Novitas received on February 22, 2013. CMS Ex. 5. Therefore, the effective date of Petitioner's group practice enrollment must be February 22, 2013, the date Novitas received the enrollment application it subsequently approved.

The regulations permit retrospective billing for up to 30 days prior to the effective date of enrollment. 42 C.F.R. § 424.521(a). Here, 30 days prior to the effective date of February 22, 2013 is January 23, 2013. Accordingly, Petitioner's group practice may bill Medicare retrospectively for reimbursement of covered services starting no earlier than January 23, 2013. Novitas erroneously characterized January 23, 2013 as Petitioner's "effective date," rather than Petitioner's retrospective billing date. CMS Ex. 5. Thus, I am treating Novitas's action as if it intended to set January 23, 2013 as the earliest date for which Petitioner may submit retrospective claims, with the effective date of Petitioner's enrollment as February 22, 2013.

It is undisputed that TOS was not previously enrolled to participate in Medicare. Petitioner urges, however, that the date its NPI was created should create a right to bill Medicare for covered services. P. Br. at 5. However, the regulation at 42 C.F.R. § 424.520 does not authorize determining a supplier's effective date based on the creation of an NPI.

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

Petitioner asserts that it should be afforded an enrollment date of September 6, 2012, the date TOS was legally formed, because of unique circumstances in its case.[1] Petitioner also states that it provided almost $700,000 worth of medical services to Medicare beneficiaries, starting September 6, 2012, for which it will not be reimbursed. Petitioner claims that if it cannot get reimbursement from Medicare for services provided the financial burden will fall unfairly on the shoulders of Medicare beneficiaries. Petitioner's arguments are equitable in nature, and regardless of the accuracy of these statements, I simply do not have the authority to grant equitable relief. *US Ultrasound*, DAB No. 2302, at 8 (2010). I cannot grant an exemption to Petitioner under the regulation set forth at 42 C.F.R. § 424.520(d), which is binding on me. *See 1866ICPayday.com, L.L.C.*,

[1] Even Petitioner's first application, which Novitas rejected, would not support a September 6, 2012 effective date because it is undisputed that Novitas received that application in December 2012.

DAB No. 2289, at 14 (2009) ("[a]n ALJ is bound by applicable laws and regulations and may not invalidate either a law or regulation on any ground . . .").

Further Petitioner asserts that Novitas provided misinformation to TOS as the company was attempting to navigate the Medicare enrollment process. Petitioner specifically asserts that Novitas incorrectly advised TOS that all of its subsequent physician reassignment requests would assume the effective date assigned to the first reassignment request Novitas approved and TOS would be able to bill one year prior to the enrollment date. P. Br. at 4. Petitioner's argument amounts to a claim of equitable estoppel. I am unable to grant the relief that Petitioner requests. 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 fisc; (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. It is well settled that those who deal with the government are expected to know the law and may not rely on the conduct of government agents contrary to law. *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). Here, Petitioner does not allege any affirmative misconduct, and I am unable to grant the relief that Petitioner requests.

5. ***I am unable to change the effective dates that Novitas provided to individual physicians reassigned to Petitioner's group practice.***

Petitioner also appealed the part of the reconsideration decision that upheld the reassignment effective dates for ten of its physicians that appear in the table on page two of CMS Exhibit 7. The reconsideration decision did not disturb the effective dates Novitas assigned the individual physicians because the hearing officer concluded Petitioner did not come forward with any evidence supporting earlier effective dates. The reconsideration decision concluded:

> According to the date of filing of each reassignment request, the correct date of billing for those individuals was February 10, 2013 in accordance with the regulations cited above. Those individuals with an approved effective date of billing were provided a date in coordination with the effective date provided to the group practice. Although the reassignment requests were initiated via the internet-based PECOS on February 7, 8, or 11, 2013, the certification statements were not filed with the contractor until March 12, 2013.

CMS Ex. 7, at 3. Petitioner now still contests these effective dates and argues they should be earlier for the same reasons it argues for an earlier group practice date and

because these physicians were in good standing when they previously worked for APH. Petitioner also now argues that Novitas lost some of the physicians' enrollment applications, which allegedly caused later effective dates. P. Br. at 4. However, Petitioner still does not come forward with any specific evidence relating to the transmission or receipt of any individual reassignment applications. Even if Petitioner did come forward with new evidence, I am precluded from considering it without good cause because Petitioner did not present this evidence at the reconsideration level of review. 42 C.F.R. § 498.56(e). I am also not able to overlook regulatory requirements to consider the facts that these physicians may have been in good standing and that they previously worked for APH. Therefore, I am unable to disturb the Medicare effective dates of reassignment for these ten physicians.

Conclusion

Petitioner's earliest group enrollment application, which Novitas was able to subsequently approve, was received by Novitas on February 22, 2013. I therefore grant summary judgment in favor of CMS and affirm the CMS contractor's determination that Petitioner's group practice enrollment in the Medicare program is effective February 22, 2013, with retrospective billing privileges starting January 23, 2013.

/s/
Joseph Grow
Administrative Law Judge