Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Nevena Lucic, M.D.
(PTAN: A400148280),
Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-17-45

Decision No. CR4848

Date: May 24, 2017

DECISION

The effective date of the Medicare enrollment and billing privileges of Petitioner, Nevena Lucic, M.D., is June 9, 2016, with retrospective billing privileges beginning May 10, 2016.

I. Background and Procedural History

Petitioner is an oncologist. Centers for Medicare & Medicaid Services (CMS) Exhibit (Ex.) 9 at 2. Petitioner had been enrolled as a Medicare supplier at Park Slope Hematology Oncology, a practice located on 6th Street in Brooklyn, NY.[1] *See* CMS Exs. 1 at 1; 2 at 3-4; Petitioner Brief (P. Br.) at 2. Petitioner left Park Slope Hematology Oncology in July 2012, at which time she began a fellowship. CMS Exs. 4 at 28; 6 at 2. A site visit contractor attempted to conduct a site verification visit at Petitioner's former practice at Park Slope Hematology Oncology on

---

[1] A CMS enrollment report, dated August 12, 2015, indicates that Petitioner practiced at Park Slope Hematology Oncology. CMS Ex. 1 at 1. Petitioner explained that she practiced at Park Slope Internal Medicine, and later, Park Slope Infusion Center, at the 6th Street address. CMS Ex. 6 at 2. For purposes of this decision, I will refer to Petitioner's place of employment prior to July 1, 2012, as Park Slope Hematology Oncology.

April 21, 2015. CMS Ex. 2 at 3. At that time, the site investigator determined, through discussion with the manager of the medical practice that was operating at that location, which was not Park Slope Hematology Oncology, that Petitioner's former practice was no longer located at that address and that Petitioner no longer provided services at that location.[2] CMS Ex. 2 at 3, 7. On August 11, 2015, a Medicare administrative contractor, National Government Services (NGS), sent Petitioner an initial determination revoking her Medicare enrollment and billing privileges because she had failed to notify CMS of a change in practice location "as required under 42 [C.F.R. §]424.516." CMS Ex. 3 at 1. The letter, which was sent to her former office location on 6th Street, explained that "a site visit was conducted and it was determined that a different, unrelated business was occupying the location" and that "[t]he manager of the current business clarified that they had never known nor worked with [Petitioner]." CMS Ex. 3 at 1. NGS also noted that "there have been no claims submitted under [Petitioner's] rendering number since 2012." CMS Ex. 3 at 1. The letter informed Petitioner that she would be barred from reenrollment for a period of one year, beginning 30 days from the postmark date of the letter. CMS Ex. 3 at 2.

On September 8, 2015, NGS received a Medicare enrollment application from Petitioner, dated August 25, 2015.[3] CMS Ex. 4. On November 12, 2015, NGS sent Petitioner a letter informing her it was "closing this request" and that her application "was returned because the provider has

---

[2] The site investigator's report discussed that the site visit was related to ongoing program integrity efforts in Petitioner's region. The report discussed a history of "longstanding problems encountered when trying to effectuate administrative actions in the NYC High Risk Area due to providers in this area obtaining multiple [Provider Transaction Access Numbers (PTANs)], [National Provider Identifiers (NPIs)], and addresses which they held in reserve to utilize when their active PTANs were shut down as a result of . . . investigative actions." CMS Ex. 2 at 4. The report explained that "[t]he Blitz Project was developed with CMS to address those suspect providers who met specific fraud indicators of a scheme in the New York High Risk Area." The site visit report stated that Phase 2 of the Blitz Project "involved site verifications being conducted at all of the known addresses of those individual providers who had active PTANs but for whom no claims had been submitted for the past six months. The goal of this phase was to gather evidence in support if [sic] revocations for any providers found to be no longer operational." CMS Ex. 2 at 4-5.

[3] Being that the revocation letter had been mailed to her former practice address, the evidence does not suggest that Petitioner was aware of the revocation and reenrollment bar at the time she submitted the September 8, 2015 enrollment application. *See* CMS Ex. 4 at 7-88 (Petitioner's response that she had no final adverse legal action history, to include "[a]ny Medicare revocation of any Medicare billing number.").

an Enrollment Bar that expires on September 8, 2016." CMS Ex. 5 (emphasis omitted). Petitioner submitted a letter, dated November 20, 2015, and received on December 16, 2015, in which she requested reconsideration of the revocation determination. CMS Ex. 6 at 2. Petitioner explained that she left Park Slope Hematology Oncology on June 30, 2012, and did not receive the initial determination that was mailed to that address, and that the Provider Transaction Access Numbers [PTANs] associated with Park Slop Hematology Oncology and a previous practice at the same address "should have been deactivated by enrollment/billing staff when [she] left those programs." CMS Ex. 6 at 2. In a letter dated January 20, 2016, NGS, citing 42 C.F.R. § 498.22, dismissed Petitioner's request for reconsideration because it was submitted more than 60 days after the date of receipt of the initial determination. CMS Ex. 6 at 6.

On April 15, 2016, Petitioner, through counsel for her employer, again requested reconsideration of the initial determination revoking her Medicare enrollment. CMS Ex. 8 at 2-4. On May 17, 2016, NGS informed Petitioner that "[t]he enrollment bar has been removed from the Provider's enrollment. The Provider will need to resubmit the appropriate applications to enroll into the Medicare Program." CMS Ex. 8 at 5. The letter did not state that it had reversed the revocation, nor did it explicitly provide an effective date for the removal of the reenrollment bar. CMS Ex. 8 at 5.

Petitioner submitted a new enrollment application on June 9, 2016.[4] CMS Ex. 9 at 1. In a letter dated July 20, 2016, NGS granted Petitioner's application, at which time it assigned a PTAN. CMS Ex. 9. NGS favorably assigned a May 10, 2016 effective date of billing privileges based on its apparent interpretation that 42 C.F.R. § 424.521(a) allowed for an earlier effective date of billing privileges based on the 30-day retrospective billing provision contained in that regulation. CMS Ex. 9 at 6; *see* 42 C.F.R. § 424.521(a).

That same day, July 20, 2016, Petitioner requested reconsideration of the initial determination, and requested that the effective date of her enrollment be changed to September 1, 2015, "the effective date indicated on the original submitted Medicare application . . . ." CMS Ex. 10 at 1.

NGS issued a reconsidered determination on August 16, 2016, at which time it did not fully address the specific arguments Petitioner raised in her July 20, 2016 request for reconsideration. CMS Ex. 10 at 3-5. NGS determined that "the effective date cannot reflect a date any further back than 30 days from the received date of the reactivation application(s)." CMS Ex. 10 at 4.

---

[4] Petitioner again denied that she had a history of any final adverse actions. CMS Ex. 9 at 2. NGS did not reject or deny Petitioner's application.

Petitioner submitted a request for a hearing by an administrative law judge (ALJ) that was dated October 14, 2016, and received that same day. I issued an Acknowledgment and Pre-Hearing Order (Order) on October 21, 2016, in which I directed the parties to file their respective pre-hearing exchanges, to include briefs and supporting exhibits, by specified deadlines. I also gave notice in Section 4 of my Order that a party may file a motion for summary judgment with its pre-hearing exchange.

CMS filed a motion for summary judgment and a pre-hearing brief (CMS Br.), along with CMS Exs. 1 through 12, on November 28, 2016.[5] Petitioner filed a brief in opposition to CMS's motion for summary judgment.

In the absence of any objections, I admit CMS Exs. 1 to 12. Neither party has requested an in-person hearing for the purpose of obtaining testimony or cross-examination. *See* Order, §§ 9, 10. The matter is ready for a decision on the merits.[6]

II. Issue

Whether the effective date of Petitioner's Medicare enrollment and billing privileges is June 9, 2016, with a retroactive effective date of billing privileges of May 10, 2016.

III. Jurisdiction

I have jurisdiction to decide this case. *See* 42 C.F.R. §§ 498.3(b)(15), 498.5(*l*)(2).

IV. Findings of Fact, Conclusions of Law, and Analysis[7]

> ***1. Pursuant to 42 C.F.R. § 424.520(d), the effective date of Petitioner's Medicare enrollment is June 9, 2016, the date of filing of the Medicare enrollment application that NGS was able to process to approval.***
>
> ***2. Petitioner was authorized pursuant to 42 C.F.R. § 424.521(a)(1) to bill Medicare for services provided to Medicare-eligible beneficiaries up to 30***

---

[5] I note that several of CMS's exhibits contain multiple documents. *See* Order, § 5 (requiring each exhibit to be filed as a separate document in DAB E-File).

[6] CMS has argued that summary disposition is appropriate. It is unnecessary in this instance to address the issue of summary disposition, as neither party has requested an in-person hearing.

[7] Findings of fact and conclusions of law are set forth in bold and italics.

days prior to her effective date of enrollment, i.e., beginning on May 10, 2016.

Section 1831 of the Social Security Act (the Act) (42 U.S.C. § 1395j) establishes the supplementary medical insurance benefits program for the aged and disabled known as Medicare Part B. Payment under the program for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of services and suppliers. Act §§ 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395u(h)(1)). Petitioner is a "supplier" of services under the Act and the regulations. A "supplier" furnishes services under Medicare, and the term "supplier" applies to physicians or other practitioners and facilities that are not included within the definition of the phrase "provider of services." Act § 1861(d) (42 U.S.C. § 1395x(d)). Pursuant to 42 C.F.R. § 424.505, a provider or supplier must be enrolled in the Medicare program and be issued a billing number to have billing privileges and to be eligible to receive payment for services rendered to a Medicare-eligible beneficiary.

The effective date of enrollment in Medicare of a physician, nonphysician practitioner, and physician and nonphysician practitioner organizations is governed by 42 C.F.R. § 424.520(d). Pursuant to section 424.520(d), the effective date of enrollment for a physician or nonphysician practitioner may only be the later of two dates: the date when the practitioner filed an application for enrollment that was subsequently approved by a Medicare contractor charged with reviewing the application on behalf of CMS; or, the date when the practitioner first began providing services at a new practice location. As applicable here, an enrolled physician or nonphysician practitioner may retrospectively bill Medicare for services provided to Medicare-eligible beneficiaries up to 30 days prior to the effective date of enrollment, if circumstances precluded enrollment before the services were provided. 42 C.F.R. § 424.521(a).

Petitioner, in her request for hearing, seeks an earlier date of September 8, 2015, as the effective date for her Medicare enrollment and billing privileges. There is no dispute that NGS received the enrollment application that it ultimately processed to approval on June 9, 2016. CMS Ex. 3. Therefore, the earliest possible effective date for Petitioner's Medicare enrollment and billing privileges is June 9, 2016, the date Petitioner filed the application, as the regulation specifically provides that the effective date is the later of the date of filing a Medicare enrollment application that was subsequently approved or the date services were first provided. 42 C.F.R. § 424.520(d). Retrospective billing may be permitted for 30 days prior to the effective date of enrollment and billing privileges pursuant to 42 C.F.R. § 424.521, and NGS allowed Petitioner to bill for services 30 days prior to the submission of the application, effective May 10, 2016. CMS Ex. 4 at 1. Accordingly, I conclude that, pursuant to 42 C.F.R. § 424.520(d), the effective date of Petitioner's Medicare enrollment and billing privileges is June 9, 2016, with an earliest possible billing date beginning May 10, 2016, in accordance with 42 C.F.R. § 424.521(a)(1).

Petitioner contends that the effective date of her enrollment should be September 8, 2015, the date she submitted her application. P. Br. at 4-6. Petitioner argues that because her enrollment bar was "reversed," she should be given the effective date of her previous September 8, 2015

application. P. Br. at 2. However, the evidence before me does not indicate that the enrollment bar was reversed; rather, the enrollment bar was "removed," and the September 8, 2015 enrollment application that had been submitted while the reenrollment bar was in effect was returned without being processed. CMS Exs. 5, 8 at 5.

Petitioner's September 8, 2015 application was not processed to approval, as contemplated by 42 C.F.R. § 424.520(d). Rather, Petitioner's September 8, 2015 application was "returned," and Petitioner was provided written notice, on November 12, 2015, that her enrollment request would be "closed." CMS Ex. 5 at 1. *See* Medicare Program Integrity Manual, § 15.8.1(A) (directing that an application submitted prior to the expiration of a reenrollment bar will be returned, and that a "'returned' application is effectively considered a non-application).

In order to determine whether CMS had a legitimate basis to grant a June 9, 2016 effective date of Medicare enrollment, I need not adjudicate whether CMS properly revoked Petitioner's enrollment on August 11, 2015. However, for the sake of completeness, I will briefly address Petitioner's arguments. Although Petitioner has argued that it was unnecessary to report a change in practice location because she did not bill Medicare after June 30, 2012 (*see* CMS Ex. 8 at 3), she fails to recognize that she continued to be *enrolled* in Medicare after she left Park Slope Hematology Oncology and entered a fellowship. It is not determinative that she did not *bill* Medicare after June 30, 2012; rather, the issue that matters, with respect to the revocation of her enrollment in August 2015, is that she continued to be *enrolled* as a supplier at a location where she no longer practiced, did not update her enrollment information to reflect her current practice location, and continued to maintain her PTAN for Park Slope Hematology Oncology when she no longer worked at that practice and had not updated her practice location information. While Petitioner argues that "[s]he has essentially done nothing wrong here . . . " (P. Br. at 4), she previously acknowledged, in a letter dated November 20, 2015, that she knew that she should have notified CMS or its contractor of her departure from Park Slope Hematology Oncology, stating: "Those PTANs should have been deactivated by enrollment/billing staff when I left those programs." CMS Ex. 6 at 2. Petitioner has presented no evidence that, when she left Park Slope Hematology Oncology and continued to be enrolled in Medicare as a supplier, she updated her practice location with CMS, or alternatively, "deactivated" her billing number.[8]

---

[8] In fact, Petitioner should have been aware if "billing staff" deactivated her PTANS, because she would have signed the CMS forms that must be filed in order to terminate a billing number and any reassignments of benefits. *See, e.g.*, Form CMS-855I (directing an enrollee who is voluntarily terminating Medicare enrollment to, *inter alia*, complete Section 15, Certification Statement), *https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855i.pdf* (last visited May 4, 2017); Form CMS-855R (CMS Ex. 4 at 32-322) (directing an "individual

(Footnote continued next page.)

Aside from being an enrolled supplier with no current practice location information on file in the event that CMS or NGS needed to contact her at her practice location, the continued enrollment under a billing number for a former practice risks the potential for misuse of the billing number. This is evidenced by the site visit inspector's discussion of the "Blitz Project" in Petitioner's region, "the NYC High Risk Area," that was in response to problems with "providers in this area obtaining multiple PTANs, NPIs, and addresses which they held in reserve to utilize when their active PTANs were shut down as a result of . . . investigative actions." CMS Ex. 2 at 4. Specifically, the operation had targeted suppliers, such as Petitioner, who maintained active PTANs and had not submitted claims in the prior six months. CMS Ex. 2 at 4-5. Even though Petitioner had left Park Slope Hematology Oncology, she continued to be an enrolled Medicare supplier at that same location because she neither reported a new practice location nor voluntarily terminated her billing number.

Petitioner did not initially receive notice of her revocation and enrollment bar because she did not provide CMS with her current enrollment information and NGS sent the correspondence to her last address of record. Had Petitioner reported a change of location, or alternatively, terminated her billing number, she would have provided an updated address to NGS. *See* Form CMS-855I (directing an enrollee to provide practice location information, and if voluntarily terminating enrollment, to, *inter alia*, provide a contact person and contact information). By not providing a change of location, or alternatively, terminating her billing number, NGS did not have a contact address to reach Petitioner regarding enrollment issues, to include any issues that arose during the time she practiced at Park Slope Hematology Oncology.

NGS acted properly when it returned Petitioner's enrollment application on November 12, 2015. CMS Ex. 5. An enrollment bar was in effect at the time of submission of her September 8, 2015 application. CMS Ex. 3 at 1-2. Further, Petitioner had not requested reconsideration of the August 11, 2015 initial determination revoking her enrollment.[9] 42 C.F.R. § 498.22(b)(3) (providing 60 days to request reconsideration of an initial determination). Petitioner's enrollment application was returned; it was not accepted for filing. MPIM, § 15.8.1(A).

_____

(Footnote continued.)

practitioner terminating a reassignment with an organization/group" to complete, *inter alia*, Section 6, Individual Practitioner Certification Statement and Signature).

[9] While I recognize that Petitioner did not appeal the initial determination because she did not receive it, this is due to Petitioner's failure to notify CMS of either a new practice location, or alternatively, a request that her billing number be terminated. NGS sent the initial determination to the address contained in Petitioner's enrollment record, and Petitioner continued to be enrolled in Medicare until her revocation on September 11, 2015.

Therefore, there was no existing and pending enrollment application that could be processed to approval when NGS "removed" the reenrollment bar on May 17, 2016. CMS Ex. 8 at 5. In fact, at the time NGS informed Petitioner that it had removed the reenrollment bar, it instructed Petitioner to "resubmit the appropriate application to enroll in the Medicare Program." CMS Ex. 8 at 5.

NGS's removal of the reenrollment bar simply means that NGS removed the reenrollment bar; the determination does not indicate that the revocation, itself, was found to be erroneous, nor is there any determination that the removal of the reenrollment bar was retroactive. CMS Ex. 8 at 5. Petitioner has not demonstrated that NGS should have processed her September 8, 2015 application to completion. To the contrary, NGS returned the September 8, 2015 application because, at the time of the application, Petitioner's enrollment had been revoked and she was subject to a reenrollment bar. An application that is returned "is effectively considered a non-application," and therefore, there was no application, prior to June 9, 2016, that could be processed to approval. MPIM, § 15.8.1(A). Petitioner has not identified any error in the assignment of a June 9, 2016 effective date of billing privileges, with retrospective billing beginning May 10, 2016. *See* 42 C.F.R. § 424.520(d) (directing earliest possible effective date for enrollment); 42 C.F.R. §§ 498.3, 498.5 (addressing initial determinations that may be appealed to an ALJ).

Petitioner contends that it is "unequitable that . . . she is barred from enrolling for the period September 8, 2015 through May 9, 2016" and that she had not been paid for $70,000 in claims. P. Br. at 4. This amounts to request for equitable relief, and I do not have the authority to grant equitable relief in the form of an earlier effective date of enrollment. *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."). Petitioner points to no authority by which I may grant it relief from the applicable regulatory requirements, and I have no authority to declare statutes or regulations invalid or ultra vires. *1866ICPayday.com, L.L.C.*, 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.").

V. Conclusion

For the foregoing reasons, I conclude that the effective date of Petitioner's Medicare enrollment and billing privileges is June 9, 2016, with a 30-day period for retrospective billing beginning on May 10, 2016.

Leslie C. Rogall
Administrative Law Judge