Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Darryl Camp, M.D., and Darryl Camp, M.D., PA,
(NPI # 1366464745 and 1801127535),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket Nos. C-10-1005 and C-10-1006

Decision No. CR2342

Date: March 21, 2011

DECISION

Darryl Camp, M.D., a physician, appeals the determination of Trailblazer Health Enterprises, LLC (Trailblazer), the Medicare contractor, granting his applications for enrollment as an individual supplier and for his practice, "Darryl Camp, M.D., PA." Trailblazer granted enrollment effective March 23, 2010 and authorized billing for services beginning February 23, 2010. [1] Petitioner contends that it submitted all appropriate enrollment forms on February 9, 2010 to create the group, "Darryl Camp

[1] The parties use the term "effective date" to refer to the date on which Petitioner could bill for Medicare services. *See, e.g.,* CMS Ex. 5 (Trailblazer letter dated June 24, 2010 assigning "Effective Date" of February 23, 2010). Under the regulations, the effective date would ordinarily be the date Trailblazer received Petitioner's application that it subsequently approved and therefore the same as the date of Petitioner's enrollment in Medicare. CMS and Trailblazer are authorized, however, to permit Petitioner to "retrospectively bill" for services for up to 30 days prior to that effective date, as they did here. 42 C.F.R. § 424.521(a). For clarity, I use "effective date" in this decision to refer to the effective date of Petitioner's enrollment in Medicare and not the date on which retrospective billing begins.

M.D., PA," but that Trailblazer returned those forms and told Petitioner that it submitted the wrong application.

I decide this case on the written record and find that, based on the particular circumstances presented here, Petitioner is entitled to an effective date of enrollment in the Medicare program of February 10, 2010, and entitled to retrospectively bill for services rendered as of January 11, 2010.

I. Background

This case arises from the efforts of Petitioner to enroll in Medicare.

The following facts are undisputed. Dr. Darryl Camp is a physician. He enrolled in Medicare through the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) for physicians. CMS does not dispute this assertion.[2] Dr. Camp wanted to enroll his practice, "Darryl Camp M.D., PA" in Medicare. Therefore, on February 9, 2010, he submitted forms CMS 855B, CMS 588, CMS 460, and CMS 855R for that purpose. Trailblazer received this application packet on February 10, 2010.[3] Another CMS 855I form was not submitted for his individual application because it was verified that he was enrolled as an individual physician in Medicare through PECOS.

By letter dated March 17, 2010, Trailblazer informed Petitioner that "[a]n application(s) CMS 855 I and R for Medicare enrollment was received on 2/10/2010" and that "the enrollment application(s) and supporting documentation are being returned." Trailblazer stated that, during the prescreening, missing or incomplete data was identified, which was marked on the attached list. The letter on the one hand indicates the Petitioner need only submit the missing or incomplete data identified by completing the section of the CMS 855 application where changes are being reported and are required to be submitted. The next paragraph states that, in addition to the completed CMS 855 application, the applicant must include a new signed and dated certification page and a CMS Form 588. The letter states that the verification and validation process will begin when a completed enrollment application with the required supporting documentation is received. The checklist attached stated that the reason for the immediate return of Petitioner's application was that, pursuant to Chapter 10, Section 3.2 of the CMS Medicare Program

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[2] Neither Trailblazer nor CMS addressed the fact that Dr. Camp had submitted the 855I application for himself as an individual on PECOS at the time of or prior to the submission for his practice on February 10, 2010.

[3] CMS uses form 855B as a Medicare enrollment application for group practices. Form 855R is the Medicare enrollment application for the reassignment of Medicare benefits. The form CMS 855I is the individual Medicare enrollment application for physicians and non-physician practitioners and physician and non-physician practitioner organizations.

Integrity Manual (PIM), "the applicant submitted the wrong application. An 855I should be submitted instead of a 855B" and the "CMS 855R is not needed for the transaction in question since the 855B is returned." CMS Ex.3.

Upon receipt of the returned documents on March 22, 2010, Petitioner's credentialing contact consulted Trailblazer. Trailblazer informed her that the CMS 855B form is for group practices with more than one owner and that only a CMS 855I, CMS 588, and CMS 460 are required for sole proprietors regardless of plans to expand the group at a later date. On the very next day, Petitioner submitted to Trailblazer forms CMS 855I, CMS 588, and CMS 460 to correct the original submission. In its cover letter, Petitioner requested that its corrected submission receive the effective date its original CMS 855B application would have received, *i.e.*, February 10, 2010. Petitioner further stated that it had initially submitted the CMS Form 855B because the form plainly states:

> *Who should submit this application*
>
> *Complete and submit this application if you are an organization/group that plans to bill Medicare and you are:*
>
> *A medical practice or clinic that will bill for Medicare Part B services (e.g. group practices, clinics, independent laboratories, portable e-ray suppliers.)*

CMS Ex. 1 at 2.

Petitioner explained that it only learned upon the return of its initial application that CMS had recently changed its policy. Petitioner argued that Dr. Camp should not be penalized for a change that is not apparent from the face of the forms.

On June 24, 2010, Trailblazer informed Petitioner that it approved its Medicare enrollment applications for both the group "Darryl Camp M.D., PA" and for Dr. Camp, individually, with an "effective date of February 23, 2010."

On July 15, 2010, Petitioner submitted to Trailblazer a request for reconsideration of the enrollment effective date. Petitioner requested an effective date of February 10, 2010 because on that date it filed an appropriate application for enrollment of a group practice. Petitioner further contended that its February 10 submission was an approvable application.

On September 9, 2010, Trailblazer answered Petitioner's reconsideration request. CMS Ex. 7. It stated that it reviewed Petitioner's request, the specific facts associated with enrollment application, and the effective date it established. Trailblazer determined it "was not able to make a change to the effective date of filing" and, therefore, returned Petitioner's reconsideration request. Trailblazer stated two reasons for its determination.

First, the applicable regulations at 42 C.F.R. §§ 424.520 and 424.521 establish an effective billing date for physicians and limit retrospective billing for physicians and physician organizations to 30 days prior to the date Trailblazer received the Medicare enrollment application. Second, 42 C.F.R. § 405.874 does not afford a physician with the right to appeal the effective date made by a Medicare contractor. The letter does not state any further appeal rights.[4]

By letter dated September 20, 2010, Petitioner timely requested a hearing regarding the assigned Medicare effective date and asked that I change the effective date for billing to January 10, 2010, approximately one month and a half earlier, to reflect that Petitioner submitted its application on February 10, 2010.[5] By Order dated October 12, 2010, I acknowledged the receipt and docketing of Petitioner's hearing request and set out procedures for developing the record.[6] In response to my order, CMS filed its exchange of evidence, CMS Exhibits (Exs.) 1 through 7 and moved for summary disposition, claiming, as a matter of undisputed fact and law, that CMS is entitled to summary disposition on the ground that CMS properly determined the effective date of Petitioner's enrollment in Medicare. Petitioner timely submitted its response and argued that it submitted on February 10, 2010, appropriate forms (CMS 855B, CMS 588, CMS 460 and CMS 855R) for enrollment to create the group, "Darryl Camp M.D., PA," as well as to reassign the benefits of the individual physician, Darryl Camp, MD, to the group.

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

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[4] As I discuss below, the determination of a supplier or provider's effective date of enrollment in Medicare is actually an initial determination subject to appeal rights under 42 C.F.R. Part 498. *Victor Alvarez, M.D.*, DAB No. 2325 (2010).

[5] Although Petitioner requests a retrospective billing date of January 10, 2010, under the regulations Petitioner is only allowed to bill for services up to 30 days prior to the enrollment effective date which in this case would be January 11, 2010.

[6] My office docketed the hearing request for Dr. Darryl Camp as Docket No. C-10-1006 and the hearing request for the practice entity, "Darryl Camp M.D., PA," as Docket No. 10-1005. Because the individual physician and the physician organization here are inextricably linked both as to the facts and legal issues, these two cases were consolidated without objection from the parties, and I issue this decision for both hearing requests.

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 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 physician groups is set as follows:

> The effective date for billing privileges for physicians . . . and physician . . . 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 . . . 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 . . . and physician . . . organizations may retrospectively bill for services when a physician or . . . a physician . . . 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 [in certain emergencies.]

42 C.F.R. § 424.521(a).

A prospective supplier "that is denied enrollment in the Medicare program . . . may appeal CMS' decision" in accordance with 42 C.F.R. Part 498. 42 C.F.R. § 424.545(a). An appeal must be requested "in writing within 60 days from receipt of the notice of the initial, reconsidered or revised determination unless that period is extended" by the judge for "good cause shown" and receipt is presumed to be 5 days after the date on the notice absent a contrary showing. 42 C.F.R. § 498.40(a)(2).

The Departmental Appeals Board (Board) addressed CMS's argument about effective date appeals in *Victor Alvarez, M.D.*, DAB No. 2325 (2010). In *Alvarez*, the Board concluded that "a determination of a supplier's effective date of enrollment in Medicare is an initial determination subject to appeal rights under 42 C.F.R. Part 498." *Alvarez*, DAB No. 2325, at 1. The Board explained that this determination is consistent with the historical interpretation of hearing rights under section 1866(h)(1)(A) and as discussed in the rulemaking process. Further, "while section 498.3(b)(15) originally applied primarily

to suppliers subject to survey and certification, the term 'supplier' as used in 42 C.F.R. Part 498 was amended to cover all Medicare suppliers, including physicians." *Id.* at 3.

Several other Civil Remedies Division decisions also came to the same conclusion. *See, e.g., Michael Majette, D.C.*, DAB CR2142 (2010); *Eugene Rubach, M.D.*, DAB CR2125 (2010); *Mobile Vision, Inc.*, DAB CR2124 (2010). In those decisions, the Judge concluded that the wording of section 498.3(b)(15) appears straightforward in providing that the "effective date of a Medicare provider agreement or supplier approval" is an appealable initial determination and includes no qualifying or limiting language. A legislative rule generally binds the agency that issues it, and the agency is legally bound to follow its own regulations as long as they are in force. *Cal. Dep't of Soc. Servs.*, DAB No. 1959 (2005); *Hermina Traeye Mem'l Nursing Home*, DAB No. 1810 (2002) (*citing* Kenneth Culp Davis and Richard J. Pierce, Jr., ADMINISTRATIVE LAW TREATISE § 6.5 (3rd ed. 1994)), *aff'd Sea Island Comprehensive Healthcare Corp. v. U.S. Dep't of Health & Human Servs.*, 79 F. App'x 563 (4th Cir. 2003); 2 AM. JUR. 2d ADMINISTRATIVE LAW § 236 (2010), *available at* WL AM. JUR. ADMINLAW § 236.

Absent further rulemaking, I am bound to follow the plain meaning of the regulation and, as the Board affirmed, permit an appeal by any provider or supplier dissatisfied with a determination as to the effective date of its provider agreement or supplier approval.

III. Issue

The issue before me is whether Petitioner is entitled to a February 10, 2010 enrollment effective date.

IV. Findings of Fact and Conclusion of Law

My findings and conclusion are in the italicized and bolded headings supported by the subsequent discussions below.

1. Petitioner is entitled to review.

Trailblazer's September 9, 2010 letter erroneously informed Petitioner that it had no right to appeal the effective date. CMS never addresses this error or the inaccuracies in Trailblazer's notice letters to Petitioner. CMS seems to concede, as it must, that Petitioner is entitled to review. CMS then moves for summary disposition. While I agree with CMS that this case does not warrant an in-person hearing (nor does Petitioner contend that an in-person hearing is necessary), I disagree that CMS is entitled to judgment as a matter of law. *See Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 3 (2010) ("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."). I find that the parties are disputing a material fact regarding the date

CMS received an enrollment application that it could subsequently process to approval from Petitioner.

2. I conclude that the effective date of Petitioner's enrollment in the Medicare program is February 10, 2010.

Clearly, no one disputes that Dr. Camp or "Darryl Camp, M.D., PA" should be enrolled in Medicare. No one disputes that once enrolled Dr. Camp and "Darryl Camp M.D., PA" should receive reimbursement for Medicare services rendered. Dr. Camp claims that he submitted an approvable application with all the required information which was received by Trailblazer on February 10, 2010. Petitioner therefore contends that his Medicare enrollment should be effective as of that date and that, as a result, he should be allowed to bill retrospectively for services provided from January 11, 2010 onwards.

Trailblazer and CMS failed to explain what information was missing from Dr. Camp's PECOS 855I application together with the CMS Forms 855B and 855R, as well as the other forms comprising his February 10, 2010 enrollment packet, which Trailblazer needed to enroll this practice. At no time did Trailblazer contend that Petitioner did not supply any required information or the required certification statements; its only contention is that Petitioner was not required to submit the CMS Forms 855B and 855R and should have submitted only the 855I. All the information required on the 855B was also provided on the resubmitted 855I. *Compare* CMS Ex. 1 with CMS Ex. 2. Moreover, the face of the 855B could lead a reasonable person to believe that if a group practice was being created, the 855B form was the correct form to so use. All the information that Petitioner completed on the 855B form was merely copied and completed on the 855I. And, although CMS contends otherwise, I do not find that the PIM provisions prohibit submission of the 855B form. In fact, the PIM indicates that it had been the custom to do so previously.[7] CMS Ex. 5, at 2. Consequently, in the absence of a well-articulated rationale for why the particular format of the 855I form was necessary, other than merely that this was the wrong form, when all the required data elements were included as necessary in the original application, I consider CMS's actions to be elevating form over substance.

Moreover, the problems here were compounded when Trailblazer returned the application treating it as a non-application.[8] This is the very kind of situation where

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[7] The PIM is issued by CMS to provide instructions to its contractors such as Trailblazer. Unlike the Medicare statute and regulations, however, the PIM does not have the force and effect of law and are not binding on me. *See Fady Fayad, M.D.*, DAB No. 2266, at 9 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).

Trailblazer should have processed the application and, if necessary, requested that the application packet be corrected with 30 days, allowing Petitioner to submit the information. The initial application would have been processed to approval because it was not deficient in any other way. Congress specifically directed the Secretary to establish *by regulation* the procedures for actions on applications, rather than relying merely on instruction manuals. The regulations do not provide for "returning" an application as part of the enrollment process. The regulations authorize CMS only to reject or deny an enrollment application. *See* 42 C.F.R. §§ 424.525 and 424.530. At the very least, before CMS can reject or deny an application, it must give the provider an opportunity to correct the application. By returning the application, Trailblazer did not give Petitioner that opportunity. Nevertheless, within five days of the letter returning the application, Petitioner sufficiently addressed Trailblazer's requests well within the 30 days normally afforded a provider for submittal of corrections.[9]

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[8] Trailblazer's handling of this matter is problematic. First, the March 17 letter is riddled with misstatements and its instructions appear inconsistent; as a result, I find this letter inherently unreliable. The very first sentence states, "[a]n application(s) CMS 855I and 855 R [were] received on 02/10/2010," yet states later that the reason for the immediate return of the application is that the applicant submitted the wrong application—the 855I should be submitted instead of the 855B. CMS counsel repeats this error in the background section of his brief and does not reconcile the inconsistency and errors. CMS Br. at 1. The March 17 letter also cites the PIM, Chapter 10, Section 3.2, but that actual section is never supplied, and I have been unable to find it. Also, while that letter states that Trailblazer found that there was missing or incomplete information, the letter does not provide the applicant with the 30-day opportunity to provide that information. To this day, neither Trailblazer nor CMS has identified the missing or incomplete information. Trailblazer also mishandled the reconsideration request. CMS Ex. 7. It failed to address Petitioner's contention that Trailblazer erred when: it could have processed Petitioner's February 10, 2010 enrollment application to approval; it contended that Petitioner had no right to appeal the effective date; it "returned your request for reconsideration;" and it failed to inform Petitioner of its further appeal rights.

[9] Recent PIM instructions would indicate this is what Trailblazer should have done. PIM, Chapter 10.3.1.2 (Rev. 329, Issued 3-19-10, accessible at http://www.cms.gov/transmittals/downloads/R329PI.pdf). Those instructions, which are applicable to physicians and physician organizations, state that a contractor may deny a provider's application if the provider fails to furnish complete information on the enrollment application within 30 days from the date of the contractor's request for the missing information and documents. That period may also be extended if the contractor determines that the provider is actively working to resolve any outstanding issues.

I reject CMS's allegations that Petitioner asserted equitable claims, and I do not base my conclusions on equitable principles. I base my conclusions on the applicable regulations which bind Trailblazer and CMS.

Thus, I conclude that Petitioner's application, which Trailblazer received on February 10, 2010, was able to be processed to approval, thus preserving that date as Petitioner's enrollment effective date with a retroactive billing date to begin starting January 11, 2010.

/s/
Joseph Grow
Administrative Law Judge