Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Sue A. Sherrod, M.D.,
(NPI No. 1376731695),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-11-461

Decision No. CR2463

Date: November 8, 2011

DECISION

Petitioner, Sue A. Sherrod, M.D., appeals the determination of TrailBlazer Health Enterprises (TrailBlazer), a Medicare contractor, that she is not eligible for payment of services she rendered to Medicare-eligible beneficiaries earlier than June 14, 2010. I grant the Centers for Medicare and Medicaid Services's (CMS's) motion for summary judgment and uphold TrailBlazer's reconsideration determination. Consequently, Petitioner is not entitled to bill for services provided from May 1, 2010 through June 14, 2010, while she was involved with a group practice to which she had reassigned her Medicare benefits. Neither the group practice nor Petitioner submitted any claims, and the time permitted in which to do so has expired.

I. Background

Petitioner is a licensed psychiatrist practicing in Dallas, Texas. She filed a CMS-855I application requesting enrollment in the Medicare program as a solo practitioner. CMS Ex. 5. TrailBlazer received this enrollment application on June 16, 2010. By letter dated September 2, 2010, TrailBlazer notified Petitioner that it approved her enrollment application as a solo practitioner with an effective date of June 14, 2010, the date she first

began seeing Medicare patients at her current practice location. CMS Ex. 2, at 4. Petitioner requested reconsideration review, asking that her effective date be changed to May 1, 2010. CMS Ex. 1, at 1. On April 8, 2011, TrailBlazer upheld its initial determination and denied Petitioner's request. CMS Ex. 2.

On May 13, 2011, Petitioner filed a hearing request with the Civil Remedies Division of the Departmental Appeals Board (DAB). An Acknowledgment and Pre-hearing Order was sent to the parties on May 19, 2011. On June 22, 2011, CMS filed a Motion for Summary Judgment and a brief in support of its motion (CMS Brief), accompanied by 10 proposed exhibits (CMS Exs. 1-10). On August 21, 2011, Petitioner filed her responsive brief (P. Brief). Neither party submitted any written direct testimony pursuant to my prehearing order. Absent any objection, I admitted all proposed exhibits in the record.

I determined that a telephone conference with the parties was necessary to clarify some issues. The conference was held on October 3, 2011, the summary of which is documented in my Order Following Telephone Conference (Order) issued October 5, 2011. I advised the parties that questions still remained as to the billing period of May 1, 2010 through June 14, 2010, when Petitioner was working with the group practice Innovative Housecalls, LLC (Innovative). I asked CMS to further brief the issue of whether Petitioner would be precluded, under her individual billing number, from seeking Medicare reimbursement for the services she provided to Medicare beneficiaries for the time period of May 1 through June 14, 2010, when she was working with Innovative. Petitioner was afforded opportunity to submit further argument and evidence in response. On October 13, 2011, CMS filed its supplemental brief (CMS Supp. Br.). On October 20, 2011, Petitioner filed her response (P. Response).

II. Issue

The issue in this case is whether CMS had a legitimate basis to determine Petitioner's effective date as June 14, 2010 for Medicare enrollment and billing privileges.

III. Analysis

This case involves two Medicare enrollment applications. The most recent is Petitioner's enrollment application as a solo practitioner, when she was assigned a Medicare Provider Transaction Access Number (PTAN) with an effective date of June 14, 2010. The other application involves the Medicare benefit reassignment application to Innovative that was approved and assigned both group and individual PTANs with effective dates of May 1, 2010. While she was under contract at the Innovative group practice location, Petitioner provided services to Medicare beneficiaries from May 1, 2010 through June 14, 2010.

My findings of fact and conclusions of law are set forth below in italics and bold.

A. Summary judgment is appropriate in this case as a matter of law.

CMS argues that it is entitled to summary judgment because no genuine dispute exists as to any material fact. CMS Brief at 3. The DAB Board members (Board) explained:

> [s]ummary 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. . . . The party moving for summary judgment bears the initial burden of showing that there are no genuine issues of material fact for trial and that it is entitled to judgment as a matter of law. . . . 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. . . . In determining whether there are genuine issues of material fact for trial, the reviewer must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor.

Senior Rehab. & Skilled Nursing Ctr., DAB No. 2300, at 3 (2010) (citations omitted).

The Board has further explained that the role of an Administrative Law Judge (ALJ) in deciding a summary judgment motion differs from the ALJ's role in resolving a case after a hearing. The ALJ should not assess credibility or evaluate the weight of conflicting evidence. *Holy Cross Vill. at Notre Dame, Inc.*, DAB No. 2291, at 5 (2009).

Having accepted all of Petitioner's factual assertions as true and having drawn all reasonable inferences in her favor, I find that Petitioner has not disputed the key material facts in this case: the date on which Petitioner began furnishing services at her new practice location as a solo practitioner; and the fact that neither she nor Innovative submitted any Medicare reimbursement claims for services she provided from May 1, 2010 through June 14, 2010, while her Medicare billing privileges were reassigned to the Innovative group practice. Accordingly, for the reasons set forth below, I agree with CMS that summary judgment is appropriate in this case.

B. TrailBlazer correctly determined June 14, 2010 as Petitioner's effective date of enrollment as a solo practitioner.

The effective date for enrollment for physicians 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) (emphasis added). The filing date is when TrailBlazer receives a signed application that is able to be processed to approval. *See* 73

Fed. Reg. 69,726, 69,769 (Nov. 19, 2008). In addition, CMS permits limited retrospective billing privileges:

> Physicians … may retrospectively bill for services when a physician . . . [has] 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 which do not apply to the case before me.]

42 C.F.R. § 424.521.

On June 16, 2010, Petitioner submitted a CMS-855I to TrailBlazer to enroll in the Medicare program as a solo practitioner. On the application, Petitioner noted that she first began providing services to Medicare beneficiaries at her new location in Dallas, Texas as of June 14, 2010. CMS Ex. 5, at 9. TrailBlazer then received Petitioner's enrollment application, which it subsequently approved with – in effect – a retrospective billing date of June 14, 2010.[1] CMS Ex. 9, at 4; CMS Ex. 2, at 4. I find this billing date determination is consistent with the regulatory requirements at 42 C.F.R. §§ 424.520 (d) and 424.521 and is the earliest date for which Petitioner is eligible.

C. Petitioner is precluded from receiving reimbursement from Medicare for services she provided for the period from May 1 to June 14, 2010 because neither Petitioner nor her previous group practice submitted any timely claims.

Petitioner seeks to challenge her assigned enrollment effective date as a solo practitioner to receive reimbursement for services she provided while with Innovative's group practice. CMS Ex. 10; P. Response. Upon joining the practice, Petitioner submitted an individual Medicare enrollment application form CMS-855I to enroll into the Medicare program and an application form CMS-855R for reassignment of her right to bill the Medicare program and to receive Medicare reimbursement payments. Petitioner submitted both of these applications on April 13, 2010. At that time, Petitioner requested a May 1, 2010 effective enrollment date, which TrailBlazer granted. CMS Ex. 4, at 4, 5, 9.

Petitioner started providing services with the understanding that Innovative would bill Medicare for the services she provided. Innovative did not, however, establish billing

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[1] TrailBlazer characterized June 14, 2010 as the effective date rather than the retrospective billing date. CMS Ex. 2, at 4.

capability under Medicare and did not reimburse Petitioner. CMS Ex. 1, at 1, 2; CMS Ex. 2, at 1-3; CMS Ex. 4; CMS Ex. 10. Petitioner never submitted the claims to Medicare under her individual PTAN either. CMS Ex. 1, at 2; CMS Ex. 4, at 3; Order issued October 5, 2011.

Starting January 1, 2010, the Patient Protection and Affordable Care Act (PPACA), PUBL. L. NO. 111-148, prohibits a Medicare contractor from providing reimbursement for claims that are filed more than one year from the date the practitioner provided the service. PPACA § 6404 (reducing maximum period of time claims can be submitted to Medicare for reimbursement from three calendar years). Petitioner argues she challenged the enrollment date assigned to her as a solo practitioner in December 2010, which was less than one year from the May 1 through June 14, 2010 time period for which she now seeks to receive reimbursement. P. Response at 1. Petitioner further argues generally that section 6404 of the PPACA allows for exceptions to the one-year rule for filing claims.

I am uncertain why Innovative did not submit Petitioner's reimbursement claims pursuant to their private agreement, and I do not need to resolve that issue for them. Although I may be sympathetic to Petitioner's predicament, the PPACA's one-year bar precludes Petitioner or Innovative from now filing these claims and provides a legitimate basis for CMS to refuse to consider reimbursing Petitioner during the May 1 through June 14, 2010 period. Although Section 6404 of PPACA gives CMS *the authority* to specify exceptions to the one calendar year time limit for filing claims, I am not aware of any exception that currently exist for which Petitioner qualifies, including any exception for filing a challenge to a Medicare effective date determination.

Petitioner states that she acted in good faith and that she should be able to recover compensation for 142 patient visits, which total $9,199.10, even though Innovative did not bill Medicare for her services. P. Response at 1-2. However, Petitioner has not shown any basis that would support a different eligibility than that which TrailBlazer has established. I am bound by the applicable statute and regulations and am not authorized to provide Petitioner with the equitable relief she seeks. *See, e.g., Pepper Hill Nursing & Rehab. Ctr., LLC,* DAB No. 2395, at 10-11 (2011) (holding that an ALJ is bound by the applicable statute and regulations and is not authorized to provide equitable relief by enrolling a supplier that does not meet Medicare statutory and regulatory requirements).

Petitioner also argues that, prior to December 10, 2010, she placed a call to Medicare for advice on how to recoup payment for the services she rendered from May 1 to June 14, 2010. Petitioner states that a Medicare employee recommended that she file a solo practitioner enrollment application and then attempt to pursue retroactive reimbursement through that application process. CMS Ex. 10. For the purposes of summary judgment, I will accept these claims as true. Nonetheless, Petitioner's argument amounts to a claim of equitable estoppel, and I do not find that a defense exists where either CMS or

TrailBlazer can be estopped from enforcing valid regulations based on the misrepresentations of government employees or their agents. 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 treasury; (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. Erroneous oral advice is inadequate, as a matter of law, to estop the government from enforcing federal law. *See, e.g., Office of Personnel Mgmt. v. Richmond*, 496 U.S. 424 (1990); *Heckler v. Cmty. Health Servs. of Crawford County*, *Inc.,* 467 U.S. 51 (1984); *Wade Pediatrics*, DAB No. 2153, at 22 n.9 (2008) (citing 467 US. 51 at 61 n.10), *aff'd*, 567 F.3d 1202 (10th Cir. 2009). Petitioner has not alleged any affirmative misconduct regarding TrailBlazer's actions.

IV. Conclusion

For the reasons described above, I find that CMS is entitled to summary judgment. Petitioner's date of enrollment started on June 14, 2010, the date she began providing services to Medicare-eligible beneficiaries at her new practice location in Dallas, TX. Consequently, Petitioner may timely bill for services rendered from June 14, 2010 forward as a solo practitioner. I find CMS had a legitimate basis to deny Petitioner's eligibility for Medicare reimbursement from May 1 through June 14, 2010, considering neither Petitioner nor her previous billing group submitted any claims before the statutory deadline.

/s/

Joseph Grow
Administrative Law Judge