Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Richard Weinberger, M.D., and Barbara Vizy, M.D.
Docket Nos. A-16-130 and A-16-131
Decision No. 2823
September 29, 2017

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Richard Weinberger, M.D., and Barbara Vizy, M.D. (Petitioners) appeal the June 24, 2016 consolidated decision of Administrative Law Judge (ALJ) Steven T. Kessel sustaining the determination of a Medicare contractor of an effective date of Medicare reactivation. *Barbara Vizy, M.D., and Richard Weinberger, M.D.*, DAB CR4643 and CR4644 (2016) (ALJ Decision). The ALJ rejected Petitioners' request for an earlier effective date. We deny Petitioners' request for oral argument, finding that no beneficial purpose would be served, and affirm the ALJ Decision.

Relevant Authority

In order to receive payment by Medicare for services furnished to Medicare beneficiaries, "suppliers," such as Petitioners (physicians), must be approved by the Centers for Medicare & Medicaid Services (CMS) for "enrollment" in the program. *See* 42 C.F.R. §§ 424.500, 424.505. The regulations governing Medicare enrollment, 42 C.F.R. Part 424, subpart P (sections 424.500-.555), define enrollment as the process that CMS and its contractors (here, CGS Administrators, LLC., or "CGS") use to identify the prospective supplier, validate the supplier's eligibility to provide items or services to Medicare beneficiaries, identify and confirm a supplier's owners and practice location, and grant the supplier Medicare billing privileges. *See* 42 C.F.R. § 424.502.

The approved enrollment application for physicians is Form CMS-855I (855I) ("For individual health care practitioners billing carriers"). Final Rule, 71 Fed. Reg. 20,754, 20,756 (Apr. 21, 2006) (eff. June 20, 2006). The approved enrollment application for supplier organizations (such as Petitioners' physicians practice group) is Form CMS-855B (855B). *Id*. Form CMS-855R (855R) is the approved application for individual health care practitioners (such as a physician) to reassign benefits to an organization (such as a physicians practice group). *Id*. In designating these forms the applicable

enrollment applications for providers and suppliers, CMS stated that the Office of Management and Budget (OMB) had approved the CMS 855 for purposes of "uniquely identify[ing] the providers and suppliers for the purpose of enumeration and payment." *Id*. (internal citation omitted).

The effective date of enrollment in Medicare is the later of the following: the date when the supplier submits a Medicare enrollment application that is subsequently approved by a Medicare contractor, or the date when the supplier first begins practicing at a new practice location. 42 C.F.R. § 424.520(d).

CMS may deactivate the Medicare billing privileges of a provider or supplier if the provider or supplier does not furnish complete and accurate information and all supporting documentation within 90 calendar days of receipt of notification from CMS to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information. 42 C.F.R. § 424.540(a)(3).

If deactivated, a provider or supplier may reactivate billing privileges by meeting certain regulatory and CMS policy benchmarks. In order to reactivate billing privileges, the provider or supplier must complete and submit a new enrollment application; or when deemed appropriate, the provider or supplier must, at a minimum, recertify that the enrollment information currently on file with Medicare is correct. 42 C.F.R. § 424.540(b).

After Petitioners' Medicare enrollments were deactivated, CMS changed its policy to reflect that if a provider or supplier, who was deactivated for failing to respond timely to a revalidation request from the CMS contractor, submitted a revalidation application within 120 days of the notice of deactivation (sometimes referred to as a "grace period"), which CMS subsequently approved, the provider's or supplier's effective date of enrollment in Medicare would remain unchanged. Medicare Program Integrity Manual (MPIM)[1] § 15.29.4.3 (Rev. 578, effective May 15, 2015 to September 5, 2016).

If the CMS contractor received the provider's or supplier's revalidation application more than 120 days following the notice of deactivation (i.e., beyond the grace period), the contractor would calculate a new effective date of enrollment based on the date the CMS contractor received the revalidation request that the contractor was able to process to completion. *Id.*

[1] Provisions of chapter 15 of the MPIM, CMS Publication 100-08, are primarily intended as guidance or instructions for CMS fee-for-service contractors. *Viora Home Health, Inc.*, DAB No. 2690, at 8 (2016) (quoting introduction to MPIM Chapter 15). CMS internet-only manuals including the MPIM are available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html.

The determination of a supplier's effective date of enrollment in Medicare is an initial determination subject to appeal. 42 C.F.R. § 498.3(b)(15); *Victor Alvarez, M.D.*, DAB No. 2325 (2010). A supplier dissatisfied with a hearing decision issued by an ALJ may request Departmental Appeals Board review of the ALJ Decision. *See* 42 C.F.R. § 498.5(f).

A physician whose enrollment application has been approved may bill Medicare for services provided up to 30 days prior to the effective date called for under section 424.520(d). 42 C.F.R. § 424.521(a)(1). *See also* MPIM § 15.17 (Rev. 582, effective May 28, 2015). We refer to those 30 days as the "retrospective billing" or "look back" period.

A supplier requesting review by the Departmental Appeals Board of an ALJ decision must specify the issues, the findings of fact or conclusions of law with which the party disagrees, and the basis for contending that the findings and conclusions are incorrect. 42 C.F.R. § 498.82(b).

Procedural and Factual Background[2]

When CMS grants billing privileges to a supplier (such as a physician or physicians organization), it issues a billing number known as a Provider Transaction Access Number (PTAN), which is used by Medicare's claims processing system to identify the physician as an enrolled supplier and ensure that proper payments are made. 42 C.F.R. § 424.505 (stating that the granting of billing privileges entails the issuance of a "valid billing number effective for the date a claim was submitted" for an item or service). Petitioners are physicians who were enrolled in Medicare as physician suppliers in their individual capacities (CMS Ex. 3W [Dr. Weinberger's PTAN ending in 6686]; CMS Ex. 3V [Dr. Vizy's PTAN ending in 9256]), and as a family practice group (practice), "Drs. Weinberger & Vizy, L.L.C," (group practice PTAN ending in 2581). CMS Exs. 5W at 6, 15; 5V at 5, 14; P. Ex. 3V.

[2] The background information is drawn from the ALJ Decision and the record before him and is not intended to substitute for his findings. The ALJ issued a single decision in two separate appeals docketed by the DAB Civil Remedies Division respectively as C-16-367 (Dr. Vizy) and C-16-368 (Dr. Weinberger). ALJ Decision. The ALJ used the docket numbers "367" and "368" to denote for which record a particular exhibit was admitted. Here, for review of the ALJ's consolidated decision, we denote exhibits in the record in Dr. Weinberger's case by their exhibit number and the letter "W," and we denote those entered in Dr. Vizy's case by their exhibit number and the letter "V" only where they differ. Where there is no difference in the exhibits, we describe them collectively as "P. Ex.," with no distinction by letter.

A. *CGS notice to Petitioners to revalidate their Medicare enrollment*

CGS mailed Petitioners letters on September 12, 2014 notifying them of the need to revalidate their respective individual enrollments in the Medicare program either via the internet-based Provider Enrollment, Chain and Ownership System **(**PECOS)[3] or by submitting a paper version of Form CMS-855B or 855I, as applicable. CMS Ex. 3. By regulation, Petitioners were afforded 90 days from the date of the notice to submit the required enrollment applications and supporting documentation. *See* 42 C.F.R. § 424.540(a)(3). The 90-day deadline expired on December 13, 2014 without responses from Petitioners.

On March 6, 2015, having received no response from Petitioners, CGS telephoned Petitioners to ask them to submit revalidation applications. CMS Ex. 2, at 1; P. Ex. 1, ¶ 5. On March 12, 2015, Petitioners submitted to CGS a Form CMS-588 (588). CMS Ex. 8. Medicare requires providers and suppliers to agree, at the time of enrollment, revalidation, change in Medicare contractors, or submission of an enrollment change request, to receive payment through electronic funds transfer (EFT). *See* 42 C.F.R. § 424.510(e)(1). Enrollees must submit Form 588 to receive Medicare payment by EFT. *Id.* § 424.510(e)(2). Petitioners' office manager, M.M., contends that on March 10, 2015 she mailed "enrollment applications for Dr. Weinberger; Dr. Vizy; [E.D.], CNP (certified nurse practitioner); and Drs. Weinberger & Vizy, LLC . . . which included the 855B enrollment application, 855I enrollment applications, and 588 forms for electronic funds transfer authorization" to CGS.[4] P. Ex. 1, at 2, ¶ 6. On March 17, 2015, CMS acknowledged receipt of a Medicare enrollment application for the practice (but not for Petitioners as individual physician suppliers).[5] CMS Ex. 8, at 7.

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[3] PECOS is a web-based electronic enrollment process established under OMB System of Records Number (SORN) 09-70-0532. 66 Fed. Reg. 51,961-51,966 (Oct. 11, 2001); *see also* 71 Fed. Reg. 60,536-60,540 (Oct. 13, 2006); Privacy Act Issuances, Office of the Federal Register, 09-70-0532, available at https://www.federalregister.gov/documents/2006/10/13/E6-16954/privacy-act-of-1974-report-of-a-modified-or-altered-system (last visited Sept. 13, 2017). A provider or supplier may use PECOS to apply to enroll in Medicare or make changes to its enrollment information. 42 C.F.R. § 424.502 (definition of "enrollment application"). Petitioners did not use PECOS for their enrollment applications in this case.

[4] In their briefs to the ALJ, Petitioners contend that they never received the September 12, 2014 notices to revalidate their individual Medicare billing privileges. P. ALJ Briefs at 6-7. They reiterate this claim in their Request for Review of the ALJ Decision. RR at 9. However, neither Dr. Weinberger nor the office manager, M.M., testified that they did not receive the September 12, 2014 notices from CGS. Dr. Weinberger states: "Throughout *2015*, I was never specifically notified by a CGS representative that I needed to revalidate myself or Dr. Vizy with an 855I Medicare enrollment form." P. Ex. 2, at 8, ¶ 49 (italics added). Given the opportunity to do so under oath, neither Dr. Weinberger nor M.M. claimed not to have received the September 12, 2014 notice letters in 2014.

[5] Petitioners contend that CGS's letter acknowledges receipt of multiple applications. While it is true that Petitioners contend that they sent 855Is for each physician along with the other applications, no other evidence in the administrative record corroborates this claim. Moreover, the acknowledgement letter is addressed to the practice ("Drs. Weinberger and Vizy, LLC") and not to the individual Petitioners themselves. We address and resolve this and other factual disputes in the analysis section of this decision.

B. *CGS notice to Petitioners of deactivation*

By letters dated April 9 and 10, 2015, (209 and 210 days, respectively, after the original notice to revalidate) CGS notified the Petitioners of the deactivation of their individual Medicare billing privileges. CMS Ex. 4. The deactivation notices explained that the Petitioners' respective PTANs "ha[d] been deactivated effective [the date of the letter] due to the failure to respond to a revalidation request mailed on September 12, 2014." *Id.* The notice also contained the following instruction:

> IN ORDER TO RESUME BILLING, **IMMEDIATELY** SUBMIT AN UPDATED, PROVIDER ENROLLMENT PAPER APPLICATION 855 FORM OR REVIEW, UPDATE AND CERTIFY YOUR INFORMATION VIA THE INTERNET-BASED PECO SYSTEM.

Id. (Bold, capitalization and underlining in original.)

Once Petitioners were deactivated, CMS policy permitted them to regain their Medicare billing privileges with no change to their effective date of enrollment if they revalidated their enrollment within 120 days. *See* MPIM § 15.29.4.3. Therefore, if Dr. Weinberger successfully revalidated his Medicare enrollment with an application submitted by August 9, and Dr. Vizy by August 10, 2015, their respective effective dates of Medicare enrollment would remain unchanged. If they missed the 120-day deadline, CMS would establish new effective dates of enrollment for each physician supplier based on the dates their respective applications, which were later processed to completion, were submitted. *See* MPIM §§ 15.17; 15.29.4.3.

C. *Petitioners' attempts to revalidate their Medicare enrollment*

On April 21, 2015, M.M. spoke via telephone with a representative from CGS to clarify which forms "were needed to revalidate Dr. Weinberger or Dr. Vizy individually." P. Ex. 1, at 2, ¶ 11. On May 20, 2015, Petitioners submitted a paper 855B to CGS, captioned "MEDICARE ENROLLMENT APPLICATION Clinics/Group Practices and Certain Other Suppliers" for the practice. CMS Ex. 9; P. Ex. 1, at 3, ¶ 14. Despite CGS's notices to Petitioners dated April 9 and 10, 2015, Petitioners did not then submit 855I enrollment applications for reactivation as individual Medicare suppliers.

1. Petitioners contend that they submitted Form CMS-855Is for their practitioners.

Petitioners contend that M.M. submitted 855I applications for both Dr. Weinberger and Dr. Vizy to CGS on July 2, 2015. P. Ex. 1, at 4, ¶ 21. Among Dr. Weinberger's exhibits is a Form 855I, stamped "COPY" and bearing the hand-written notations "RW" and

"7/2/15." P. Ex. 4W. The July 2, 2015 855I names Dr. Weinberger as the enrollee and the certifying physician, however the certification statement is unsigned. *Id*. at 5, 24. The record does not contain a Form 855I dated July 2, 2015, for Dr. Vizy.[6]

2. Petitioners submitted three additional Form CMS-855Bs.

Petitioners submitted a series of 855B applications in July, August, and September 2015. CMS Ex. 11. The July 855B was submitted to reactivate and revalidate the practice and to add a new practice location. *Id*. at 5-9; 20.

The August Form 855B was evidently submitted in response to letters dated July 27 and August 5, 2015 from CGS seeking information to develop an earlier application. CMS Ex. 11, at 112-114, 254-257. The August 855B indicates that it was submitted to reactivate the group practice, to reactivate Dr. Vizy's and Dr. Weinberger's individual Medicare enrollments, and to "revalidate" Medicare enrollment for an unspecified provider or supplier. *Id*. at 64-67. [7]

On August 9, 2015, the 120-day deadline expired for Petitioners to revalidate their respective individual Medicare enrollments and retain their original effective dates of enrollment. *See* MPIM §§ 15.17; 15.29.4.3.

In September, Petitioners submitted another 855B, applying to reactivate Medicare enrollment for the group practice and for each individual Petitioner, as well as to revalidate an unspecified provider or supplier. CMS Ex. 11, at 198, 202-205. As with the August 6, 2015 Form CMS-855B, the group practice and Petitioners, along with E.D., were the named applicants, and their identifying information was listed. *Id*. at 208-211.

3. Petitioners submitted Form CMS-855I applications.

On September 29, 2015, Dr. Weinberger and Dr. Vizy, respectively, submitted 855I applications to CGS, seeking to "reactivat[e]" and "revalidat[e]" their individual Medicare enrollments. CMS Ex. 5; P. Ex. 5W. The ALJ found that this was the earliest date on which 855I applications were submitted to CGS for the Petitioners. ALJ Decision at 5. In letters dated October 6 (Dr. Weinberger) and October 9 (Dr. Vizy),

[6] On June 24, 2015, M.M. submitted a Form 855I for E.D., a Certified Nurse Practitioner (CNP) who had recently joined the group practice. CMS Ex. 10, at 6, 27; P. Ex. 1, at 4, ¶ 19.

[7] An additional Form 855B included in CMS Ex. 11 appears to be a duplicate of the August 6, 2015 application, with the additional designation of [M.M.] as a "delegated official" on September 8, 2015. *See id*. at 115-197. In addition, the September Form 855B reflected in CMS Ex. 11, at 198-253 is identical (apparently a photocopy) to CMS Ex. 14, at 1-56.

2015, CGS analysts acknowledged receipt of Petitioners' 855I applications submitted on September 29, 2015, and requested additional information. P. Ex. 6W; P. Ex. 4V.[8] On October 27, 2015, CGS notified Dr. Weinberger that his CMS-855I had been approved. CMS Ex. 7W. On October 29, 2015, CGS notified Dr. Vizy that her CMS 855I had been approved. CMS Ex. 7V. CGS established September 29, 2015 as the effective date of Medicare enrollment for both suppliers.

D. *Petitioners' request for reconsideration of the contractor's initial determinations*

By letter dated November 10, 2015, Petitioners requested reconsideration of CGS's effective date of enrollment determinations, contending that they were never fully made aware of the basis for their "remov[al] from the [. . .] Medicare program." CMS Ex. 1. In addition, Petitioners charged that they had continued to supply services to their Medicare patients but had been unable to order home health care or durable medical equipment (DME) as a result of the change to their Medicare enrollments. *Id*. Petitioners contended that CGS personnel informed them that, although their claims were being denied, they would be "able to resubmit and be reimbursed for claims dating back to the date on which we were removed from the program" (presumably, upon re-enrollment in Medicare). *Id*.

On December 31, 2015, CGS issued unfavorable reconsidered determinations to the Petitioners. CMS Ex. 2; P. Ex. 10. CGS concluded that it had correctly deactivated the Petitioners' Medicare enrollments according to the regulation at 42 C.F.R. § 424.515(a); had correctly determined the Petitioners' effective dates of Medicare re-enrollment in accordance with the Medicare Program Integrity Manual (MPIM), Chapter 15, Section 15.27.1.2.; Petitioners "had not provided evidence to definitely support an earlier effective date" of re-enrollment; and that it was correct to issue new PTAN numbers to the Petitioners based upon the dates of submission of their subsequently approved re-enrollment applications. *Id*.

[8] CGS asked each Petitioner to provide their Medicare number in section 1A of the CMS 855I; to provide the Petitioner's National Provider Number (NPI); to provide the "[n]ame of the Group/Organization, Medicare Number and NPI in section 4B" of the CMS-855I; and to provide an original signature (and not a photocopy) in Section 15 of the 855I. P. Ex. 6W; P. Ex. 4V. Petitioners were instructed to mail the revised, signed 855I to CGS. *Id.*

E. *Petitioners' request for ALJ review*

In their jointly-filed request for ALJ review, Petitioners essentially made three points in support of reversal of the unfavorable contractor determinations and the establishment of an earlier effective date of Medicare enrollment. *See* Petitioners' joint request for hearing (RFH).[9] First, Petitioners argued, in sum, that CGS personnel made errors when notifying Petitioners which re-enrollment forms to submit, causing Petitioners to submit multiple incorrect applications, and therefore Petitioners were unduly delayed in submitting the enrollment applications which were later accepted, and which resulted in a later effective date of enrollment. Second, Petitioners contended that CGS staff informed them that their Medicare payments "were being held and that upon reinstatement, [they] would be able to re-submit the claims for payment" and that CGS never notified them of "any CMS regulations to the contrary." Third, Petitioners argued that CMS's failure to update their status in PECOS following their re-enrollment in Medicare, resulting in denial of coverage for home health care, physical therapy and DME services Petitioners had provided, confirms that their re-enrollment in Medicare was delayed by errors committed by CGS personnel.

Petitioners also argued that Petitioners were entitled to summary judgment because CGS did not dispute that Petitioners "submitted revalidation enrollment information prior to 120 days after the date of deactivation on four separate occasions;" and their submission of partial re-enrollment information obligated CGS to request additional information to assist with the revalidation process. *See* Petitioners' Brief.[10] Specifically, Petitioners argue that the MPIM requires CGS to apply all revalidation information submitted for one PTAN associated with a group to all of the enrollments associated with the group, as part of CGS's duty to develop incomplete revalidation applications. Petitioners' Brief at 5-6. Therefore, Petitioners argued, CGS erred by not applying to the revalidation of their respective individual Medicare enrollments (despite Petitioners' failure to timely submit 855Is) all relevant revalidation information Petitioners had provided in the various 855Bs and 855Rs they had submitted for the practice group and other practitioners prior to 120 days following the deactivation notice. *Id*. at 15-18.

[9] Petitioners' request for hearing is a one-page document on "Drs. Weinberger & Vizy, L.L.C." letterhead, signed by Dr. Weinberger and by Dr. Vizy, and submitted as "an appeal of the decision noted in the letter dated December 31, 2015."

[10] The ALJ concluded that the briefs filed on behalf of Dr. Weinberger and Dr. Vizy are "essentially identical." ALJ Decision at 3 n.2. We agree. Accordingly, we too refer to the briefs collectively as "Petitioners' Brief."

CMS filed a Pre-Hearing Brief and Brief in Support of Summary Judgment as to each Petitioner and the briefs are practically identical (except for certain details that do not affect CMS's arguments or the outcome of the appeal). In addition, CMS filed an Amended Prehearing Brief and Brief in Support of Summary Judgment as to each Petitioner. CMS Amended Prehearing Brief. We refer to CMS's briefs here in the aggregate as the "CMS Brief," and cite to the Amended Brief. In sum, CMS argued that CGS correctly determined the Petitioners' effective date of enrollment by applying the regulation at 42 C.F.R. § 424.520(d) and that the Medicare policy on enrollment reactivation which CGS followed, as expressed in the MPIM, is consistent with the regulations (and therefore entitled to substantial deference). CMS Brief at 6-8. In addition, CMS contended that Petitioners' other arguments lie in equity, and principles of equity provide no basis for the Board to grant Petitioners earlier effective dates of enrollment. *Id.* at 10 (*citing, inter alia*, *US Ultrasound*, DAB No. 2302, at 8 (2010)). Petitioners opposed CMS's summary judgment motion on the grounds that a genuine issue of material fact existed regarding the effective date of Petitioners' enrollment. Petitioners' Brief at 21-22.

F. *The ALJ Decision*

In his consolidated decision, the ALJ did not grant summary judgment, and instead issued his decision based upon the written record noting that no party sought to cross-examine any witness so an in-person hearing was unnecessary. ALJ Decision at 2. The sole issue the ALJ considered was whether "CMS's contractor properly reactivated the Petitioner[s'] Medicare billing privileges effective September 29, 2015." *Id.* The ALJ found no support in the record for, and rejected, Petitioners' contentions that, i) Petitioners had "mailed the 'proper forms', [. . .] 'intending to revalidate not only their group practice but Petitioners, individually;'" ii) "[c]orrespondence with the contractor, on multiple occasions, 'indicated that' Petitioners' individual enrollments were 'occurring simultaneously' with that of their group practice"; and iii) "the contractor's representatives told Petitioners that their individual enrollments would be 'backdated' to the dates when their billing privileges were reactivated." *Id.* at 3-4. The ALJ also rejected Petitioners' argument that the information contained in the various 855Bs they submitted between March and July 2015, collectively was sufficient for CGS to revalidate their individual Medicare billing privileges. *Id*. The ALJ rejected this argument reasoning that, even if the 855Bs Petitioners submitted contained "some of the information" that "may have pertained to them as individuals [. . . Petitioners] [made] no effort to prove that [the 855B] contained all of the information needed to qualify either of them for re-enrollment." *Id*. at 5. The ALJ also rejected Petitioners' "equitable argument" that "they were misled by the contractor into believing that, by submitting [the 855B], they were providing adequate information to qualify for re-enrollment." *Id*. "Petitioners," the ALJ found, "have not proven that they applied as individual suppliers

for revalidation of their Medicare billing privileges on any date prior to September 29, 2015." *Id*. at 4. The ALJ concluded "[t]he regulation provides, in relevant part, that the *earliest effective date* of enrollment is the date on which a supplier files an application that CMS or its contractor finds to be acceptable and can approve." *Id*. at 5 (*citing* 42 C.F.R. § 424.520(d)) (italics in original).

The ALJ also found no support in the MPIM for Petitioners' arguments. He characterized the "grace period" provision in MPIM § 15.29.4.3 "a matter of largesse" on the part of CMS, although "entirely consistent with [the] regulatory requirements" in 42 C.F.R. § 424.520(d). *Id*. In any case, the ALJ found nothing in the MPIM that would support changing CMS's effective date determinations here based on the ALJ's factual findings.

The ALJ found no basis to reverse the contractor's determinations in Petitioners' arguments that they acted in good faith and should not be penalized for "honest errors or omissions on their part[.]" *Id*. at 6. As mentioned above, the ALJ rejected these as equity arguments, along with Petitioners' contention that "the contractor and its agents had an affirmative duty to instruct them as to what they should file," and that the "failure of the contractor and its agents to satisfy this duty, [. . .] excuses [Petitioners] from any failure on their part to file acceptable enrollment documents prior to September 29, 2015." *Id*. at 6. The ALJ explained his rejection of Petitioners' equity-based arguments thusly:

> Principles of equity do not apply here. I am not authorized to provide equitable relief by ordering re-enrollment of either Petitioner on a date when that Petitioner did not satisfy regulatory requirements. *U.S. Ultrasound*, DAB No. 2302, at 8 (2010). Moreover, even if I had such authority, equitable estoppel does not apply against the government in the absence of proof of affirmative misconduct, and the records in these two cases are devoid of any such proof. *Wade Pediatrics v. Dep't of Health & Human Servs.*, 567 F.3d 1202, 1206 (10th Cir. 2009). Mere erroneous advice is insufficient evidence of affirmative misconduct. *Id.*

Id. at 6. Having rejected Petitioners' equity arguments, the ALJ concluded "because they waited more than 120 days from their deactivation to file acceptable re-enrollment applications," "the *earliest date* when Petitioners could qualify for re-enrollment was September 29, 2015," (i.e., the date on which Petitioners filed applications which the CMS contractor found acceptable and later approved). *Id*.

G. *Petitioners' request for Board review*

Petitioners raise three issues in their Request for Review (RR), which we summarize this way: whether the ALJ Decision is supported by substantial evidence in the record and legally correct; whether Petitioners' argument that the MPIM imposes an affirmative burden on the CMS contractor to assist applicants once the applicants attempt to revalidate within 120 days of deactivation is an equitable argument upon which the ALJ could not base his decision; and whether, alternatively, if the applications establishing a new enrollment date are initial applications under 42 C.F.R. § 424.521(a)(1), and thus afford Petitioners retrospective billing privileges for 30 days prior to the effective date of enrollment. RR at 2.

Standard of Review

We review a disputed factual issue as to whether the ALJ Decision is supported by substantial evidence in the record as a whole. We review a disputed issue of law as to whether the ALJ Decision is erroneous. *See Departmental Appeals Board, Guidelines -- Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program* (*Guidelines*), at https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/enrollment/index.html.

Analysis

We resolve each issue in favor of CMS. Substantial evidence supports the ALJ Decision and it is free from legal error. The ALJ was correct that several of Petitioners' arguments are based on principles of equity and therefore provide no basis to overturn the agency's initial determination. Petitioners' re-enrollment applications constitute "initial applications," permitting them a 30-day retrospective billing, or "look-back" period, as a result of the establishment of new effective dates for their enrollment.[11] However, we find no evidence that CGS denied Petitioners the 30-day look-back period when it established their new effective enrollment date. Below we discuss each issue in detail.

[11] Effective January 1, 2009, CMS modified the MPIM to state that, for purposes of 42 CFR §§ 424.520(d) and 424.521(a), a CMS-855 reactivation application is treated as an initial enrollment application. This means that a reactivated provider will have a new effective date (i.e., the later of the date of filling or the date it first began furnishing services at a new practice location) and, per section 424.521(a), limited ability to bill retrospectively. *See* MPIM Rev. 289, issued April 15, 2009, effective January 1, 2009; *Arkady B. Stern*, M.D. DAB No. 2329, at 4 n.5 (2010).

1. The ALJ Decision is based upon substantial evidence in the record and is free from legal error.[12]

Petitioners contend that the ALJ Decision is "against the weight of the evidence . . . in this matter." RR at 2. We disagree. In order to reactivate billing privileges, the provider or supplier must complete and submit a new enrollment application; or when deemed appropriate, the provider or supplier must, at a minimum, recertify that the enrollment information currently on file with Medicare is correct. 42 C.F.R. § 424.540(b). The ALJ considered 16 Petitioners' exhibits (six essentially identical exhibits in common in the evidence offered by Drs. Weinberger and Vizy and 5 exhibits unique to each Petitioner) and 15 exhibits from CMS. ALJ Decision at 2. The ALJ reviewed these exhibits when he analyzed Petitioners' claims that they had mailed the "proper forms" to the Medicare contractor, examining the various Form 855Bs Petitioners submitted between March and September 2015. *Id*. at 3. Petitioners contend that they submitted "multiple enrollment applications" "within the 120 day timeframe following deactivation," and that "[d]uring the following months (after deactivation), numerous discussions and exchanges of information and documentation occurred between Petitioners and CGS." RR at 2, 9. The ALJ, however, found that Petitioners had "not proven that they applied as individual suppliers for revalidation of their Medicare billing privileges on any date prior to September 29, 2015," as the regulation requires. ALJ Decision at 4.

Petitioners claim that, after receiving the March 6, 2015 telephone call from CGS to revalidate their enrollment information, M.M. mailed 855I applications for Dr. Weinberger and Dr. Vizy to CGS on March 10, 2015. RR at 10. M.M. and Dr. Weinberger testified by affidavit that M.M. "mailed the Medicare enrollment applications for Dr. Weinberger [and] Dr. Vizy . . . via regular mail; which included . . . 855I enrollment applications" on March 10, 2015. P. Ex. 1, at 2, ¶ 6; P. Ex. 2, at 2, ¶ 7. However, the record does not contain a copy of such an application filed on March 10, 2015. As noted above, Petitioners also contend that M.M. submitted Form 855I applications for both Dr. Weinberger and for Dr. Vizy to CGS on July 2, 2015. P. Ex. 1, at 4, ¶ 21. However, M.M. testified that "CGS did not confirm receipt of these applications," *id.*, which further undermines M.M.'s testimony that the individual applications were in fact submitted to CGS. A supplier's application for Medicare enrollment pursuant to 42 C.F.R. § 424.520(d) is filed on the date a contractor *receives* it. *Alexander C. Gatzimos, MD, JD, LLC*, DAB No. 2730, at 17 (2016). Moreover, the administrative record reflects only one Form 855I associated with July 2, 2015, among Dr. Weinberger's exhibits, which bears the hand-written notations "RW" and "7/2/15"; but the certification statement is unsigned and it reflects no indicia that CGS ever

[12] Petitioners mistakenly describe the ALJ as having entered summary judgment for CMS. RR at 5. As noted above, however, the ALJ decided the case on the written record and did not enter summary judgment. Therefore, this is the correct standard of review. ALJ Decision at 2.

received it. P. Ex. 4W at 24. The contractor may only accept revalidation applications signed by the individual provider or the authorized official (AO) or delegated official (DO) of the provider/supplier organization. MPIM Ch. 15, §15.29.4. The administrative record in this case does not contain any Form 855I dated July 2, 2015 for Dr. Vizy.

The ALJ found that Petitioners offered nothing more than the allegation that they had "mailed the 'proper forms' for Medicare enrollment to the Medicare contractor," and noted in his analysis no documentation to support the allegation. ALJ Decision at 3-4. The ALJ reviewed the several Form 855Bs Petitioners filed in May, July and September 2015, and found no support in the record for Petitioners' assertion that they were entitled to earlier effective dates of enrollment based on those submissions, writing:

> Indeed, the documents submitted by Petitioners or their practice prior to September 29, 2015 were at best of tangential relevance to the issue of their re-enrollment as Medicare suppliers. These documents included electronic funds transfer authorization agreements, applications for Petitioners' group practice enrollment, and an application for enrollment of another individual besides Petitioners. They do not in any sense constitute completed individual re-enrollment applications for either Petitioner[.]

ALJ Decision at 5. The ALJ, having reviewed the evidence, correctly concluded that the record contains no individual enrollment applications submitted for Drs. Weinberger and Vizy until Petitioners submitted 855Is on September 29, 2015. The ALJ considered the evidence in the record; however, in the absence of corroborating documentation, Petitioners' witness testimony simply did not persuade him. Like the ALJ, we too find no support for Petitioners' contentions that they submitted earlier 855I applications.

Petitioners argue that they are entitled to credit for submitting to CGS, contained within the above-referenced 855B and other applications, the information necessary for CGS to have revalidated their individual Medicare billing privileges prior to September 29, 2015. Petitioners' argument is predicated upon the idea that the regulations and the MPIM obligated CGS to "develop" Medicare re-enrollment for Drs. Weinberger and Vizy from information contained in other enrollment applications (*i.e.*, 855B, 855R and 588) associated with Petitioners' practice. *See* RR at 23-25. Specifically, Petitioners contend that the Medicare contractor is required to "request additional information from a supplier as long as the supplier timely submits that information and the Medicare contractor is able to approve *the* application[.]" RR at 23 (italics added), citing *Tri-Valley Family Medicine, Inc.*, DAB No. 2358, at 7 (2010) (along with a non-precedential ALJ decision). Petitioners rely on MPIM Chapter 15 § 15.29.4.1, citing a passage describing CMS policy for how contractors should handle revalidation following deactivation: "In scenarios where a revalidation response is received for a single PTAN within an enrollment record that has multiple PTANs, ***the contractor shall develop for the remaining PTANs not accounted for."*** RR at 24.

Petitioners' reliance on this provision is misplaced. Section 15.29.4.1 gives contractors guidance generally where the contractor has *received* a revalidation application and the application requires development before it can be processed to completion. By the plain language of the manual provision, CGS was expected, when processing the revalidation application for the group practice [a single PTAN (ending in 2581) that has multiple PTANs (Weinberger ending in 6686; Vizy ending in 9256)], to develop for those PTANs in the practice which were not accounted for. This presumes that CGS received individual enrollment applications for Petitioners which CGS could develop. Section 15.29.4.3 of the MPIM states:

> If the deactivation resulted from the provider's or supplier's failure to respond to a development request, the contractor shall allow the provider or supplier to only submit the missing information/documentation to revalidate without requiring submission of a new application -- ***but only if the information is received prior to 120 days after the date of deactivation***. The contractor shall re-open and work from the previously submitted application. ***If the deactivation was a result of the provider or supplier failing to respond at all, it must submit a full application to revalidate***.

Petitioners' group practice was placed in "pend status" on April 29, 2015. P. Ex. 3 ("This is to inform you that all claims associated with your Medicare Provider Transaction Access Number (PTAN 9312581) has been placed in a Pend status effective April 29, 2015 due to the failure to respond to a revalidation development request mailed on December 30, 2014."). This action by CGS prohibited Petitioners' group practice from billing and receiving payments from Medicare and notified Petitioners that CGS required the practice to "complete and submit a Medicare enrollment application," and that [f]ailure to submit this information could result in the deactivation of [the practice's] Medicare billing privileges." *Id.* During the 120-day period (until August 9, 2015) during which Petitioners could have applied to revalidate their individual Medicare enrollments by submitting 855Is, Petitioners submitted only the following: an 855B for the group practice on May 20, 2015 (CMS Ex. 9); an 855I for E.D. on June 24, 2015 (CMS Ex. 10); and Form 855Bs on July 15 and August 6, 2015 (CMS Ex. 11). The record reflects that CGS worked to develop each of these applications, corresponding with Petitioners' representative in the process. *See, e.g.*, CMS Ex. 11, at 112, 254; and P. Exs. 10V and 11W (Petitioners' telephone log reflecting contact with CGS representatives on April 21, May 20, and June 19, 2015).

Petitioners' argument is predicated on the presumption that they submitted earlier 855I applications to CGS, something Petitioners have failed to establish as fact. Specifically, Petitioners set forth their argument thusly:

> Assuming arguendo that Petitioners did not submit the 855I Forms for the individual Petitioners on March 10, 2015, an allegation that Petitioners object to, Petitioners still submitted the same prior to the lapse of the 120 day post deactivation grace period, in accordance with 42 C.F.R. §424.540(b)(1). This is established from the fact that, *for a second time*, Petitioners mailed 8551 Forms to CGS on July 2, 2015, well within the 120 day grace period which would have been July 9, 2015 for Petitioner Dr. Weinberger and July 10, 2015 for Petitioner Dr. Vizy.

(Citation omitted.) RR at 24. First, Petitioners' claim that they submitted 855I applications on March 10, 2015 is irrelevant here because Petitioners were deactivated on April 9 and 10, 2015 after failing to respond to revalidation notices issued September 12, 2014. A contractor's deactivation decision is not an initial determination subject to ALJ or Board review. *See* 42 C.F.R. 498.3(b) (*"Initial determinations by CMS."). Accordingly, even if Petitioners could prove that they submitted individual Medicare re-enrollment applications to CGS in March 2015, it would have no bearing on the outcome of this appeal, as Petitioners were nonetheless deactivated in April 2015. In addition, as discussed above, Petitioners failed to prove that they submitted 855I applications for Drs. Weinberger and Vizy on July 2, 2015. Therefore, there were no earlier 855I applications from Drs. Weinberger and Vizy for CGS to develop from the information contained in the 855Bs and other submissions.

Petitioners can point to no authority to support their theory that they could satisfy the regulatory requirement to "complete and submit a new enrollment application" by the aggregation of information contained in several other applications in order to reactivate their billing privileges, or that CGS was required to aggregate information from other enrollment applications for that purpose. Even if the regulations provided for application in this manner, as the ALJ pointed out, Petitioners failed to prove in each instance where they submitted an enrollment application other than an 855I individual enrollment form that "the form contained all of the information needed to qualify them for re-enrollment," or that, taken together, all of the forms contained the necessary information. ALJ Decision at 4. Petitioners were given ample opportunity to submit evidence into the administrative record supporting their aggregate application argument and failed to produce any; thus their complaint that the ALJ ignored the weight of the evidence is unfounded. *See* RR at 17, 22. In any event, even if Petitioners could show that information contained in the 855B and 588 applications they submitted prior to

September 29, 2015 would satisfy the requirements of a Form 855I, Petitioners failed to show that CGS was authorized, much less required, to treat the aggregated information from other applications as a substitute for duly completed, signed and submitted 855I individual enrollment applications.

Further, evidence in the administrative record shows that, where CGS received an application in need of development, CGS communicated with Petitioners and their representative to obtain the information necessary to complete review. For example, on July 15, 2015, Petitioners submitted a Form 855B seeking to revalidate the group practice's enrollment in Medicare. CMS. Ex. 11, at 38. In response, CGS wrote to Petitioners on August 5, 2015 seeking additional information to develop the 855B application. *Id*. at 112-114. On August 7, 2015, Petitioners faxed information to CGS in response to the August 5, 2015 development letter. *Id*. at 96-99. In a series of e-mails from September 3 to September 10, 2015, CGS and Dr. Weinberger addressed outstanding information requests in an attempt to complete Petitioners' group practice 855B. P. Ex. 11. On September 8, 2015, Petitioners submitted an updated Form 855B containing the information identified by CGS as missing from the July 15 and August 7, 2015 submissions. CMS Ex. 11, at 198-253. On September 14, 2015, CGS notified Petitioners that their Form 855B revalidation application for the group practice had been approved. *Id*. at 258-260.

As with the group practice revalidation, the record also reflects that CGS complied with the manual provisions regarding revalidation when it reviewed the 855Is which CGS ultimately processed to completion by developing rather than rejecting the applications when they were found to lack required information. On October 6, CGS wrote to Petitioners seeking additional information to develop the 855Is submitted for Dr. Vizy and Dr. Weinberger on September 29, 2015. *See* P. Ex. 4V and 6W. On October 9, 2015, Petitioners submitted revised 855I applications, apparently to satisfy CGS's development requests. P. Exs. 6W (see handwritten notation "Redone 10/9/15"); and 6V. Thus the evidence in the administrative record does not support Petitioners' contention that CGS failed to follow CMS policy as expressed in the MPIM on developing incomplete enrollment applications.

Petitioners contend that the ALJ ignored their contention that forms included in Petitioners' Exhibit 11 reflect Petitioners' intent to reactivate and revalidate their individual Medicare enrollments along with that of the practice group. In the Request for Review, Petitioners state:

> [a]gain, these Medicare enrollment forms included a separate Section 1 for Petitioner Dr. Weinberger and Petitioner Dr. Vizy. [Citation omitted.] Each Section 1 clearly marked whether the provider was enrolling as a group practice or as an individual. Each Section 1 clearly stated that the provider was reactivating **and** revalidating the provider's Medicare enrollment.

RR at 18. Petitioners contend that they conveyed to CGS their intention to reactivate and revalidate their *individual supplier* (not "provider") enrollments by inserting additional Section 1 pages for each Petitioner and by making notations to the 855B group application expressing this intent. However, Petitioners cite no authority to support the contention that this method of submitting an individual enrollment application – appended to or contained in a group enrollment application – is authorized under the regulations and consistent with CMS policy.[13]

Therefore, we find that the ALJ considered all of the evidence in the record and based his decision on that evidence; the fact that he was not persuaded by the evidence does not mean he failed to consider it or that the available evidence was insufficient to support his findings of fact and conclusions of law. Moreover, the ALJ did not err when he afforded MPIM guidance substantial deference as CMS policy that is consistent with the applicable Medicare enrollment regulations. Further, the ALJ did not err when he rejected Petitioners' argument that CGS was obligated to aggregate into individual enrollment applications information furnished for group enrollment applications, or that CGS was obligated but failed to develop the enrollment applications Petitioners submitted.

2. The ALJ did not err when he rejected Petitioners' equity arguments.

Petitioners argue that the ALJ erred when he rejected Petitioners' claim to an earlier effective date of enrollment based on what the ALJ characterized as their claims of "good faith efforts," and "honest errors or omissions," and that they were misled by CGS's representatives into believing they were filing the correct documents. ALJ Decision at 6. In addition, Petitioners contend that the ALJ erred when he rejected as an equity argument their assertion that CGS had an "affirmative duty to instruct them as to what they should file[,]" and that CGS's failure to instruct them excuses them from any failure to file acceptable enrollment documents prior to September 29, 2015. ALJ Decision at 6; RR at 2 ("[R]ecent revisions to the Medicare Program Integrity Manual impose an affirmative burden on CGS to assist the provider") and 33 ("the systematic failure on behalf of CGS' employees to assist in the process"). The ALJ concluded that these are estoppel arguments which provide no basis for reversing the contractor's determination.

[13] In addition, we note that in the additional Section 1 pages annexed to the 855B application, Petitioners each indicated the group PTAN where the form required one, rather than their individual PTANs. While it might not have resolved the issue in their favor, it is inconsistent with Petitioners' position for them to claim their expressed intention to reactivate and revalidate their *individual* Medicare enrollments by listing their *group's* PTAN on a *group* enrollment application. *See* CMS Ex. 11, at 203-205. Petitioners also had the opportunity to list their individual PTANs in Section 6 ("OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS), but instead listed the group PTAN. *Id*. at 227.

Before the Board, Petitioners concede that they are arguing for relief based on the principle of equitable estoppel and argue that the record supports estoppel against CMS in this case. RR at 26-28. Below we discuss estoppel and explain why the record does not support estoppel here even were it available in these proceedings, which it is not.

The traditional requirements for estoppel are a factual misrepresentation, reasonable reliance on the misrepresentation by the party seeking estoppel, and resulting harm or detriment to that party; moreover, if estoppel lies against the government at all, courts have held that at a minimum the detrimental reliance must result from "affirmative misconduct" by agents of the government. *Oaks of Mid City Nursing & Rehab. Ctr.*, DAB No. 2375 at 31 (2011), *citing Office of Personnel Management v. Richmond*, 496 U.S. 414, 421 (1990)*; Linkous v. United States*, 142 F.3d 271, 277-78 (5th Cir. 1998); *Pacific Islander Council of Leaders*, DAB No. 2091, at 12 & n.11 (2007); *see also Foot Specialists of Northridge*, DAB No. 2773, at 19 (2017).

In their Request for Review, Petitioners argue that "[t]he Government is Estopped from Applying the September 29, 2015 Effective Date for Equitable Reasons and the ALJ was Permitted to Render an Equitable Decision in this Matter Given CMS and CGS' Conduct." RR at 26. Petitioners relate the various instances of contact between their representatives and CGS as Petitioners attempted to complete the re-enrollment process, alleging misconduct by CGS employees and direct violation of the regulations in the form of statements CGS employees allegedly made about the application process. RR at 28. Petitioners also claim that they suffered "losses from Medicare as a result of relying on the March 29, 2015 approval assurance from CGS, which CGS eventually retracted" as another basis for equitable relief. *Id*. Therefore, Petitioners argue, "as a result of the deliberate actions taken by CMS and CGS, the ALJ possessed the jurisdictional authority to render a decision regarding Petitioners' equitable arguments in this matter." *Id*. at 29.

We disagree. The ALJ correctly ruled that he was "not authorized to provide equitable relief by ordering re-enrollment of either Petitioner on a date when that Petitioner did not satisfy regulatory requirements." ALJ Decision at 6, citing *U.S. Ultrasound*, DAB No. 2302, at 8 (2010). The Board has repeatedly confirmed that neither it nor the ALJs have authority to overturn a legally valid agency action on equitable grounds or otherwise grant equitable relief. *See, e.g.*, *Orthopaedic Surgery Assocs.*, DAB No. 2594, at 7 (2014) (Board "lacks the authority to restore OSA's billing privileges on equitable grounds"); *Neb Grp. of Ariz. LLC*, DAB No. 2573, at 6 (2014) (Board "has consistently held that it (and the ALJs) lack the authority to restore a supplier's billing privileges on equitable grounds"); *Pepper Hill Nursing & Rehab. Ctr., LLC*, DAB No. 2395, at 11 (2011) (holding that the ALJ and Board were not authorized to provide equitable relief by reimbursing or enrolling a supplier who does not meet statutory or regulatory

requirements); *UpturnCare Co.*, DAB No. 2632, at 19 (2015) (Board may not overturn denial of provider enrollment in Medicare on equitable grounds). Further, the ALJ concluded that, even if he had the authority to order a different re-enrollment date, "equitable estoppel does not apply against the government in the absence of proof of affirmative misconduct, and the records in these two cases are devoid of any such proof." *Id*. *citing Wade Pediatrics v Dep't of Health & Human Servs.*, 567 F.3d 1202, 1206 (10th Cir. 2009). We agree with the ALJ; here, Petitioners have shown no affirmative misconduct. At most, the communications on which Petitioners rely suggest misunderstandings, miscommunications, or confusion on both sides.

a. *Petitioners have not proven CGS gave them false information.*

The United States Supreme Court in *Office of Personnel Management v. Richmond*, 496 U.S. 414, 419 - 421 (1990) recognized the principle that "equitable estoppel will not lie against the Government as it lies against private litigants[,]" but "that some type of 'affirmative misconduct' might give rise to estoppel against the Government." Although the Board has not defined it, while applying the rule in the *Richmond* decision, we have considered what could constitute affirmative misconduct. In *US Ultrasound,* we recognized that evidence of fraud might establish affirmative misconduct on the part of the government ("estoppel against the federal government, if available at all, is presumably unavailable absent 'affirmative misconduct,' such as fraud, by the federal government"). *US Ultrasound* at 8.

We applied this principle in *Hartford HealthCare at Home, Inc*. DAB No. 2787 (2017) and in *Foot Specialists of Northridge,* rejecting estoppel claims in the absence of any affirmative misconduct, such as fraud or deliberate misrepresentation. The Board similarly has recognized that affirmative misconduct "appears to require something more than failing to provide accurate information or negligently giving wrong advice." *Hartford HealthCare at Home, Inc*., at 10, *citing Traylor Prods. & Servs., Inc.*, DAB No. 1331, at 7 (1992).

Petitioners rely on our decision in *Southland Emergency Care Ctr.*, DAB No. 2402, at 8 (2011), in their Request for Review, alleging that the misconduct necessary for estoppel is present here. RR at 28. In *Southland*, the provider alleged that it followed CMS's advice and voluntarily surrendered its Clinical Laboratory Improvement Amendments (CLIA) certificate in order to avoid revocation proceedings. Notwithstanding the surrender, CMS revoked Southland's CLIA certificate. Southland claimed reasonable reliance and harm because it followed CMS's advice. We upheld the ALJ Decision because there was no evidence (or even allegation) of affirmative misconduct and because Southland's reliance on verbal advice from CMS employees was unreasonable in view of the written notifications CMS had provided containing correct information. *Southland* at 7-9.

Here, Petitioners allege that CGS employees advised that Petitioners "would be able to back bill for services provided since April 9, 2015" and that "this information and affirmative statement directly violates the Code of Federal Regulations." RR at 28, *citing* P. Ex. 2, at 2 (Weinberger affidavit). In his affidavit, Dr. Weinberger gives the following account of a telephone conversation with a representative from CGS about the status of his revalidation efforts:

> On May 20, 2015, I had a telephone conversation with a CGS Representative for the state of Ohio who stated that I only need to submit an 855B to successfully revalidate. I was also informed that the effective date of enrollment would be the date of termination so that we could "back bill" for services provided during the termination period.

P. Ex. 2, at 3, ¶ 15. Petitioners contend that, therefore, they "relied on this misrepresentation throughout their revalidation process and have now been harmed in the amount of $67,871.48, which is the total amount of services Petitioners were unable to bill from April 9, 2015 to September 29, 2015." RR at 28.

Having reviewed the administrative record, we conclude that Petitioners have offered no evidence that CGS employees committed affirmative misconduct while processing Petitioners' re-enrollment applications. It is unclear from the record that the advice on which Petitioners claim they relied was in fact erroneous. For example, on May 20, 2015, when a CGS employee advised Dr. Weinberger during a telephone call to submit a Form 855B application, it is not clear that the CGS employee and Dr. Weinberger both understood that he was discussing his *individual* Medicare enrollment. The 855B was the correct application for the enrollment of a group practice, and CGS had notified Petitioners in April 2015 to submit an 855B application for the group practice.[14] Moreover, had Petitioners successfully revalidated their individual Medicare enrollments before August 9, 2015, they would have maintained their original PTANs and effective dates and therefore would have been able to bill for services dating back to April 9, 2015. MPIM Ch. 15 § 15.29.4.3 – Revalidation Received After a Deactivation Occurs, states, in pertinent part:

> The contractor shall reactivate the deactivated PTAN(s) within 15-20 days of receiving the revalidation application or missing information, even though the revalidation has not been processed to completion. The PTAN and effective date shall remain the same if the revalidation application was received prior to 120 days after the date of deactivation.

[14] Dr. Weinberger stated that CGS notified Petitioners on April 29, 2015 that the group practice had been "deactivated" for failure to revalidate its Medicare enrollment. P. Ex. 2, at 2, ¶ 13. However, as noted above, the April 29, 2015 letter was actually notice that the practice's claims were being placed in "pend" status (rather than the practice being deactivated), terminating payments until Petitioners revalidated their group Medicare enrollment. P. Ex. 3.

Thus the information the CGS employee gave Petitioners on May 20, 2015, while Petitioners had more than two months to revalidate their Medicare re-enrollments, was not demonstrably false. Where other CGS employees gave Petitioners incorrect information or advice, Petitioners have failed to show (despite Petitioners' characterization of such errors as systematic and happening "on numerous occasions," RR at 29) that such errors constitute affirmative misconduct rather than simple mistakes.

b. *It was not reasonable for Petitioners to rely solely on verbal advice from CGS employees.*

Petitioners' reliance solely on advice from an ever-revolving cast of CGS employees (*see* RR at 28) on which Medicare enrollment application to file was not reasonable. As courts and the Board have recognized, Medicare providers and suppliers, as participants in the program, have a duty to familiarize themselves with Medicare requirements. *Gulf South Medical*, DAB No. 2400, at 9 (2011) (quoting *Heckler v. Cmty. Health Servs. of Crawford County, Inc.*, 467 U.S. 51, 63 (1984)); *John Hartman, D.O.*, DAB No. 2564, at 3 (2014). Medicare regulations at 42 C.F.R. § 424.510 set forth the requirements for enrolling in the Medicare program. Section 424.510(d)(2) sets forth the information that a Medicare enrollment application must contain. The MPIM provides guidance for revalidation of suppliers after they have been deactivated. Medicare enrollment applications contain instructions for applicants about which application to file and directions on what information to provide. In this case, Petitioners prepared several enrollment applications and each clearly indicated the purpose for which it was intended. *See* P. Exs. 4, 5; CMS Ex. 10 (captioned "MEDICARE ENROLLMENT APPLICATION/PHYSICIANS AND NON-PHYSICIAN PRACTITIONERS/CMS-855I").[15]

In view of such readily available written authority and guidance, as well as clear written instructions on the applications, versions of which Petitioners submitted several times, we cannot conclude that it was reasonable for Petitioners to rely only on its understanding of advice from CGS staff contradicting the written instructions.

[15] The first instruction on the cover of the 855I says "See Page 1 to determine if you are completing the correct application." Page one of the application advises that "[p]hysicians and non-physician practitioners can apply for enrollment in the Medicare program or make a change in their enrollment information" via PECOS or the "paper enrollment application process" using the 855I. Petitioners also prepared several 855B applications. *See* CMS Exs. 9, 11 and 14 (captioned "MEDICARE ENROLLMENT APPLICATION/Clinics/Group Practices and Certain Other Suppliers/CMS-855B"), which contain the same or substantially the same instructions as the 855I but relating to group practices.

c. *Petitioners have failed to prove any resulting harm.*

Even if it were reasonable for Petitioners to rely on verbal advice from CGS employees despite ample written regulations, guidance and instructions, there is no evidence in the administrative record documenting Petitioners' claimed financial losses. Petitioners allege the loss of nearly $68,000 in income as a result of their reliance on advice from CGS employees. RR at 28. However, the record contains no evidence documenting these claimed losses. There are no billing statements or other financial documents in the administrative record establishing the amount of revenue Petitioners lost following deactivation and prior to re-enrollment. Dr. Weinberger makes only the bald assertion of resulting "financial harm" in his affidavit, and does not provide a dollar figure or explain how he arrived at the conclusion that Petitioners suffered financial harm. P. Ex. 2 at 9, ¶ 53. Petitioners' bald assertion alone is insufficient to prove harm resulting from errant advice from CGS.

In short, Petitioners have failed to prove intentional misconduct, reasonable reliance on incorrect information from the government or any resulting harm. There can be no estoppel against the government absent those factors. Therefore, we conclude that the ALJ did not err when he rejected Petitioners' equity arguments, even had such equitable action been within his authority.

3. Retrospective billing

The regulation at 42 C.F.R. § 424.521(a)(1) provides that a physician may "retrospectively bill" Medicare for services that were provided up to 30 days (and, in certain disaster situations, for services provided up to 90 days) prior to the physician's "effective date" if the following circumstances are met: (1) the physician has met all program requirements (including those relating to state licensure); (2) the services rendered prior to the effective date were furnished at the enrolled physician's practice location; and (3) "circumstances precluded enrollment in advance of providing services to Medicare beneficiaries[.]" On appeal to us, for the first time, Petitioners imply that they have been denied the privilege to retroactively bill for services provided on or after August 30, 2015. RR at 30.

Generally, the Board will not consider issues which were not raised in the request for review or which could have been presented to the ALJ but were not. *See Guidelines* at "Completion of the Review Process"; *John M. Shimko, D.P.M.*, DAB No. 2689, at 11 (2016). Petitioners did not contend before the ALJ that CGS had denied them retrospective billing privileges afforded them by regulation. We therefore decline to address this issue. Moreover, even if denials of retrospective billing are appealable (an issue that we do not reach), nothing in the record shows that CGS denied Petitioners a retrospective billing period when it issued its initial and reconsidered determinations. *See Shalbhadra Bafna, M.D.*, DAB No. 2449, at 4-5 (2012).

Conclusion

For the foregoing reasons, we affirm the ALJ Decision upholding the CMS contractor's determinations that September 29, 2015 is the effective date of Petitioners' enrollment in Medicare.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Christopher S. Randolph
Presiding Board Member