Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Leila Reed, PA-C,
(PTAN: M172643008),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-16-377

Decision No. CR4702

Date: September 13, 2016

DECISION

Wisconsin Physicians Service (WPS), an administrative contractor acting on behalf of the Centers for Medicare & Medicaid Services (CMS), determined that the effective date for reactivation of Medicare billing privileges for Leila Reed, PA-C (PA Reed or Petitioner), was January 22, 2016, with retrospective billing permitted as of December 23, 2015. Petitioner appealed. Because Petitioner filed her enrollment application seeking reactivation of billing privileges on January 22, 2016, and that application was ultimately approved, I affirm CMS's determination.

I. Background

Petitioner is a physician assistant (PA) who was enrolled in the Medicare program as a supplier. CMS Exhibit (Ex.) 1. On March 12, 2015, WPS sent PA Reed a request to revalidate (i.e., update and recertify) her Medicare enrollment information within 60 days. CMS Ex. 1 at 36-41. WPS sent two copies of the revalidation request. One copy was addressed to 3000 Woodcreek Dr., Suite 200B, Downers Grove, IL 60515-9600 (Downers Grove address). CMS Ex. 1 at 36. A second copy was addressed to Post

Office Box 37974, Philadelphia, PA 19101-0574 (Philadelphia P.O. Box address).[1] CMS Ex. 1 at 39. WPS's notice explained that failure to submit a timely and complete revalidation enrollment application might result in the deactivation of Petitioner's Medicare billing privileges. *See, e.g.,* CMS Ex. 1 at 41. A WPS employee also documented leaving a telephone message on May 27, 2015, at the number provided on the Form CMS-855I and in the body of the accompanying cover letter. CMS Ex. 1 at 4, 10, 42. WPS did not receive a response.

In a letter dated June 11, 2015, WPS stated that it had deactivated PA Reed's Medicare billing privileges (Provider Transaction Access Numbers (PTANs) IN1659090, MI72643001) because she had failed to respond to WPS's March 12, 2015 letter.[2] CMS Ex. 1 at 43-45. The June 11 letter stated that PA Reed could reactivate her billing privileges by filing a new Medicare enrollment application. CMS Ex. 1 at 43.

PA Reed signed a new enrollment application (Form CMS-855I) on January 12, 2016. CMS Ex. 1 at 86. The practice group with which PA Reed is affiliated transmitted the application to WPS by letter dated January 19, 2016. CMS Ex. 1 at 93. WPS received the application on January 22, 2016. CMS Ex. 1 at 46; *see also* Hearing Request. In a letter dated January 28, 2016, WPS approved the application and issued a new PTAN to PA Reed. CMS Ex. 1 at 95-97. WPS stated that the "effective date" of PA Reed's enrollment was December 23, 2015.[3] CMS Ex. 1 at 95.

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[1] This address appears on the letterhead of a cover letter, dated September 9, 2014, transmitting the Form CMS-855I (Petitioner's Medicare enrollment application) to CMS. CMS Ex. 1 at 4. The body of the cover letter reiterated that WPS should use the Downers Grove address for mailing confirmation. *Id.*

[2] WPS addressed the June 11, 2015 letter to the Downers Grove address and zip code, but identified the State as "IN" rather than "IL." CMS Ex. 1 at 43.

[3] Although WPS identified December 23, 2015 as the "effective date," this is inconsistent with the regulations. By regulation, the "effective date" would ordinarily be the date WPS received an application from PA Reed that it eventually approved, in this case January 22, 2016. *See* 42 C.F.R. § 424.520(d). CMS may, however, permit a supplier to "retrospectively bill" for services for up to 30 days prior to that effective date. 42 C.F.R. § 424.521(a). Because December 23, 2015 is 30 days prior to the date WPS received Petitioner's application, it appears that WPS used the term "effective date" to refer to the date from which PA Reed was authorized to retrospectively bill for Medicare services. For clarity, I use the term "effective date" in later sections of this decision to refer to the effective date of enrollment that is established by regulation (January 22, 2016), not the date from which retrospective billing is authorized (December 23, 2015).

By letter dated February 11, 2016, the practice group requested that WPS reconsider its determination as to the effective date of PA Reed's billing privileges. The letter stated:

> We were never notified that [PA Reed] was in revalidation or deactivated. Had we been informed we would have submitted the proper form and documentation to get [PA Reed] revalidated. We have not received any letters in our office regarding [PA Reed]. Please consider reinstating her back to the date you deactivated her so that she does not have a lapse in coverage.

CMS Ex. 1 at 98. On March 2, 2016, a WPS hearing officer issued a reconsidered determination upholding WPS's determination that Petitioner's effective date for Medicare billing privileges was December 23, 2015. CMS Ex. 1 at 1-3. The hearing officer noted that, while PA Reed claimed to be unaware of the revalidation request, WPS had sent the revalidation notice to the only addresses it had on file. CMS Ex. 1 at 1.

In a letter dated March 8, 2016, PA Reed's practice group filed a request for hearing on her behalf. The case was initially assigned to Administrative Law Judge Keith Sickendick. On July 14, 2016, the case was reassigned to me. Pursuant to Judge Sickendick's Acknowledgment and Pre-Hearing Order, CMS filed a motion for summary judgment and pre-hearing brief (CMS Br.) and one exhibit (CMS Ex. 1). Petitioner did not respond to CMS's motion, but in response to an Order to Show Cause, filed a letter dated June 2, 2016 (P. Resp.), reiterating the factual representations and arguments stated in the hearing request. Petitioner did not cross-move for summary judgment or request an in-person hearing.[4] Petitioner did not offer any exhibits. On June 30, 2016, CMS declined to file a reply brief.

In the absence of objection, I admit CMS Ex. 1 into the record. As explained more fully below, I conclude that there are no material facts in dispute and CMS is entitled to judgment as a matter of law. I therefore grant CMS's motion for summary judgment.

[4] I interpret Petitioner's response as waiving an in-person hearing, because it states, "Notification of your decision can be mailed to my attention . . . ." P. Resp.

II. Discussion

A. Issue

Whether CMS had a legitimate basis for determining that Petitioner's Medicare enrollment and billing privileges are effective January 22, 2016, with retrospective billing permitted as of December 23, 2015.

B. Jurisdiction

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

C. Findings of Fact, Conclusions of Law, and Analysis[5]

1. Summary judgment is appropriate.

CMS argues that it is entitled to summary judgment in its favor. The Departmental Appeals Board (Board) has stated the standard for summary judgment:

> 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. . . . 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).

In the present case, CMS has met its initial burden. By contrast, Petitioner has not meaningfully disputed any fact material to my resolution of the case. In particular, although Petitioner asserts that the address to which WPS sent the revalidation request

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[5] My findings of fact and conclusions of law are set forth in italics and bold font.

was "never tied to this PTAN at any time" (P. Resp.), Petitioner did not submit any evidence to support this assertion. As noted above, a non-moving party may not defeat a summary judgment motion by relying on the denials in its pleadings. Accordingly, I conclude that summary judgment in favor of CMS is appropriate.

2. WPS received Petitioner's Medicare enrollment application seeking reactivation of billing privileges on January 22, 2016, and WPS approved this application.

The Social Security Act (Act) authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations governing the enrollment process for suppliers.[6] 42 U.S.C. §§ 1302, 1395cc(j). The Secretary's regulations provide that suppliers must submit enrollment applications to revalidate and reactivate their enrollment and billing privileges when the supplier's billing privileges were deactivated for any reason other than a failure to submit a claim within 12 months.[7] 42 C.F.R. §§ 424.515, 424.540(b). For suppliers that are physicians or non-physician practitioners, or physician or non-physician practitioner organizations, the effective date for Medicare billing privileges is the date on which the supplier files an enrollment application that is subsequently approved or the date on which the supplier first began providing services at a new location, whichever is later. 42 C.F.R. § 424.520(d).

WPS deactivated PA Reed's Medicare billing privileges on June 11, 2015, because WPS received no response to its request that PA Reed revalidate her enrollment information.[8] CMS Ex. 1 at 43. WPS informed Petitioner that she was required to file an enrollment application to reactivate her Medicare billing privileges. *Id.* On January 22, 2016, WPS received Petitioner's enrollment application (Form CMS-855I). CMS Ex. 1 at 46. Petitioner does not dispute that WPS received the application on January 22, 2016. P. Resp. WPS approved the application on January 28, 2016. CMS Ex. 1 at 95.

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[6] Petitioner, as a PA, is considered a "supplier" for purposes of the Act and the regulations. *See* 42 U.S.C. §§ 1395x(d), 1395x(u); 42 C.F.R. § 498.2.

[7] As discussed in the following section, the regulations give CMS discretion to allow a supplier to "recertify that the enrollment information currently on file with Medicare is correct" when CMS deems it appropriate. *See* 42 C.F.R. § 424.540(b)(1). There is no provision for administrative review of CMS's exercise of discretion regarding when it is appropriate to require a supplier to submit a new enrollment application rather than permit the supplier to recertify that its enrollment information is correct.

[8] The decision of CMS or its contractor to deactivate a supplier's Medicare billing privileges is not an initial determination that may be appealed to an administrative law judge. *See* 42 C.F.R. § 424.545(b); *see also* 42 C.F.R. §§ 405.374, 405.375(c). In any event, Petitioner has not challenged her deactivation in this proceeding.

Therefore, I find that WPS received Petitioner's application on January 22, 2016, and that this application was subsequently approved.

3. WPS properly established January 22, 2016, as the effective date of Petitioner's reactivated billing privileges, with retrospective billing authorized from December 23, 2015.

WPS deactivated Petitioner's Medicare billing privileges effective June 11, 2015, because WPS had received no response to its March 12, 2015 request that PA Reed complete a revalidation enrollment application. CMS Ex. 1 at 43. Once WPS deactivated Petitioner for any reason other than failing to submit a claim during a 12-month period, Petitioner had to "complete and submit a new enrollment application to reactivate [her] Medicare billing privileges or, when deemed appropriate, at a minimum, recertify that the enrollment information currently on file with Medicare is correct." 42 C.F.R. § 424.540(b)(1). In the present case, WPS's June 11, 2015 letter deactivating Petitioner made it clear that she "must complete and submit a Medicare enrollment application," in order for WPS to reactivate Petitioner's Medicare billing privileges. CMS Ex. 1 at 43. The fact that WPS, on behalf of CMS, required Petitioner to submit a new enrollment application is significant because the date of filing an enrollment application directly impacts the effective date for Medicare billing privileges. As stated in the regulations:

> The effective date for billing privileges for physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations is the later of the date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor or the date an enrolled physician or nonphysician practitioner first began furnishing services at a new practice location.

42 C.F.R. § 424.520(d). The "date of filing" is the date that the Medicare contractor "receives" a signed enrollment application that the Medicare contractor is able to process to approval. *Tri-Valley Family Medicine, Inc.,* DAB No. 2358 at 6-7 (2010) (citing 73 Fed. Reg. 69,725, 69,769 (November 19, 2008)); *see also Alexander C. Gatzimos, MD, JD, LLC* , DAB No. 2730 at 5-15 (2016), citing 79 Fed. Reg. 72,500, 72,521 (December 5, 2014) (explaining that CMS did not change the definition of the date of filing when it stated that "[t]he 'date of filing' is the date on which the provider or supplier submitted its CMS-855 application via mail or Internet-based PECOS").

Petitioner's enrollment application for reactivation of her Medicare billing privileges was filed, i.e. received by WPS, on January 22, 2016. WPS approved the enrollment application on January 28, 2016. *See* CMS Ex. 1 at 95. Therefore, WPS properly determined that the effective date for reactivating Petitioner's Medicare billing privileges was January 22, 2016, with retrospective billing permitted as of December 23, 2015.

In its reconsidered determination, WPS reaffirmed that Petitioner's Medicare billing privileges were reactivated effective with the approval of her revalidation enrollment application. CMS Ex. 1 at 1-3. WPS cited 42 C.F.R. § 424.520(d) as authority for this determination. CMS Ex. 1 at 1. The reconsidered determination additionally stated that the effective date was correct because the revalidation application had been received more than 120 days after the date of deactivation. CMS Ex. 1 at 2. WPS did not explain why it was significant that Petitioner filed her revalidation application beyond 120 days. However, I take notice of the fact that, as of the date of the reconsidered determination, the Medicare Program Integrity Manual (MPIM) at section 15.29.4.3 provided, "[i]f the revalidation is received more than 120 days after deactivation, a new PTAN and effective date shall be issued to the provider or supplier, consistent with the effective date requirements in section 15.17 of this chapter."[9] As an appellate panel of the Departmental Appeals Board observed in *Viora Home Health, Inc.,* DAB No. 2690 at 8 (2016), "the MPIM provision . . . is sub-regulatory guidance, and as the introduction to chapter 15 of MPIM . . . suggests, chapter 15 provisions are primarily intended as guidance or instructions for CMS fee-for-service contractors." Petitioner has not argued that this guidance is inapplicable or invalid and I find that, as applied to her, the MPIM provision is consistent with 42 C.F.R. § 424.520(d). *See, e.g., Barbara Vizy, M.D. & Richard Weinberger, M.D.*, DAB CR4643 & DAB CR4644 at 5-6 (2016).

Petitioner requests that the effective date of her Medicare enrollment and billing privileges be retroactive to August 7, 2012. P. Resp. The record does not reveal the significance of this specific date; however, it is apparent that Petitioner seeks to avoid any lapse in her Medicare billing privileges. *See* CMS Ex. 1 at 98. As discussed above, WPS deactivated Petitioner's Medicare enrollment and billing privileges based on her failure to revalidate her enrollment information timely. WPS determined that Petitioner must submit a new enrollment application to revalidate and reactivate her Medicare enrollment and billing privileges. Because Petitioner must essentially reenroll as a Medicare supplier in order to reactivate her billing privileges, she cannot bill Medicare for services from the date of deactivation until she is reactivated with a new effective date for Medicare billing privileges. 42 C.F.R. § 424.520(d). The issuance of a new PTAN reflects this. *See Shalbhadra Bafna, M.D.*, DAB No. 2449, at 2 n.3 (2012) (indicating that under 42 C.F.R. § 424.505, CMS issues PTANs to suppliers when they are granted billing privileges).

[9] By revision 666, effective September 6, 2016, CMS amended MPIM § 15.29.4.3. The revised provision no longer considers whether providers and suppliers apply for reactivation more than 120 days after deactivation. Instead, CMS directs contractors to require every deactivated provider or supplier to file a complete new application to reactivate enrollment. The effective date of reactivation will be based on the date the contractor receives the new application. Reactivated providers and suppliers will be permitted to retain their existing PTANs, but will have a gap in their Medicare billing privileges from the date of deactivation to the date of reactivation.

This conclusion is further reinforced by 42 C.F.R. § 424.555(b), which provides that no Medicare payment may be made for services furnished by a supplier whose billing privileges are deactivated:

> No payment may be made for otherwise Medicare covered items or services furnished to a Medicare beneficiary by a provider or supplier if the billing privileges of the provider or supplier are deactivated, denied, or revoked. The Medicare beneficiary has no financial responsibility for expenses and the provider or supplier must refund on a timely basis to the Medicare beneficiary any amounts collected from the Medicare beneficiary for these otherwise Medicare covered items or services.

42 C.F.R. § 424.555(b). Therefore, once CMS or its contractor deactivated Petitioner's Medicare enrollment and billing privileges and determined that she must submit a new enrollment application, she could not resume billing for Medicare items or services until she submitted a new enrollment application which was approved. *See Paramjit Fagoora, M.D.*, DAB CR4617 at 5-9 (2016). In the present case, this means that Petitioner cannot bill for Medicare covered items or services furnished from June 11, 2015, until December 23, 2015.

4. Petitioner's arguments do not provide a basis to set an earlier effective date for reactivating her billing privileges.

Petitioner argues that she never received either of WPS's letters requesting revalidation. P. Resp. She contends that the revalidation requests were mailed to addresses that were not valid for her. *Id.* She argues that, had WPS sent the revalidation request to the correct address, she would have responded timely and her billing privileges would not have been deactivated. *See, e.g.,* CMS Ex. 1 at 98. For purposes of this decision, I accept that neither PA Reed nor her practice group received copies of the revalidation request.[10] However, Petitioner fails to point to any evidence that, prior to the date of the revalidation request, she or her practice group notified CMS or WPS of any addresses other than the ones to which WPS sent the revalidation request. To the contrary, in her 2014 application for Medicare

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[10] It appears that the practice group with which Petitioner is affiliated uses a number of addresses. Petitioner's January 2016 Form CMS-855I lists addresses in Indianapolis, IN; Falls Church, VA; Durham, NC; Dallas, TX; Downers Grove, IL; and Horsham, PA. CMS Ex. 1 at 51, 68-82. Significantly, Petitioner's practice group does not assert that none of the practice group's offices received the revalidation request for PA Reed. Rather, the response states, "we were not notified *at the correspondence address for this PTAN*," which Petitioner asserts was the Horsham, PA address. P. Resp. (emphasis added).

enrollment, PA Reed (or someone on her behalf) completed section 2.B of Form CMS-855I by entering “3000 Woodcreek Drive, Suite 200B, Downers Grove, IL 60515.” CMS Ex. 1 at 10. Section 2.B requests the applicant’s “correspondence address” and states, “[o]nce enrolled, the information provided below will be used by the . . . contractor if it needs to contact you directly.” *Id.* PA Reed signed the enrollment application on August 1, 2014, and her practice group sent the application to WPS on her behalf on or about September 9, 2014. CMS Ex. 1 at 4, 31.

By contrast, the address to which Petitioner argues the revalidation request should have been sent, “100 Witmer Road, Ste. 220, Horsham, PA 19044” (Horsham address), does not appear anywhere on the 2014 enrollment application. CMS Ex. 1 at 5-35. Moreover, although Petitioner asserts that the Downers Grove address has never been “associated with this PTAN” at any time (P. Resp.), Petitioner included that address, among others, on the revalidation application submitted in January 2016.[11] CMS Ex. 1 at 72. Similarly, the Philadelphia P.O. Box address is identified in Petitioner’s reconsideration request as the “Pay-To” address of Petitioner’s practice group. CMS Ex. 1 at 98. I therefore conclude that both the Downers Grove and the Philadelphia P.O. Box addresses, to which WPS sent copies of the revalidation request, were, and continue to be, among a number of addresses used by the practice group with which PA Reed is affiliated.

Petitioner has not shown, or even alleged, that she or her practice group provided CMS or WPS with the Horsham address at any time prior to submitting the revalidation application in January 2016. Petitioner has offered no explanation of how, in March or June 2015, WPS could have known that it should send correspondence for PA Reed to the Horsham address. Based on the information available to WPS in 2015, WPS proceeded in accordance with the instructions in section 2.B of the Form CMS-855I; it sent the revalidation request to the correspondence address Petitioner had provided and WPS had on file, i.e., the Downers Grove address. CMS Ex. 1 at 36. And yet, WPS went further in its attempts to contact PA Reed: it sent another copy of the revalidation request to the Philadelphia P.O. Box address and called the telephone number listed on the Form CMS-855I. CMS Ex. 1 at 39, 42. The fact that these efforts were ultimately unsuccessful is not due to any fault of CMS or WPS, but rather, resulted from PA Reed’s (or her practice group’s) failure to complete or update the Form CMS-855I using the Horsham address.

To the extent that Petitioner requests that I consider the equities of her situation as a basis to direct that the reactivation of her Medicare billing privileges be made effective earlier

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[11] The address is associated with one of a number of “contact persons” listed in section 13 of the January 2016 Form CMS-855I. CMS Ex. 1 at 67-82. I note that section 2.B of the January 2016 Form CMS-855I lists neither the Downers Grove address nor the Horsham address as PA Reed’s “correspondence address,” instead listing an address in Indianapolis, IN. CMS Ex. 1 at 51.

than December 23, 2015, I am unable to do so. I have no authority to grant equitable relief or an exception to the applicable regulations discussed above. *See US Ultrasound*, DAB No. 2302, at 8 (2010); *1866ICPayday.com, L.L.C.,* DAB No. 2289, at 14 (2009) ("[a]n ALJ is bound by applicable laws and regulations and may not invalidate either a law or regulation on any ground . . . .").

III. Conclusion

For the reasons explained above, I affirm CMS's determination that the effective date of reactivation of Petitioner's Medicare billing privileges is January 22, 2016, with retrospective billing permitted as of December 23, 2015.

/s/
Leslie A. Weyn
Administrative Law Judge