**Department of Health and Human Services**
**DEPARTMENTAL APPEALS BOARD**
**Appellate Division**

Andrew J. Elliott, M.D.
Docket No. A-10-61
Decision No. 2334
September 27, 2010

# REMAND OF ADMINISTRATIVE LAW JUDGE DECISION

Andrew J. Elliott, M.D. (Dr. Elliott) requests review of the April 2, 2010 decision by Administrative Law Judge (ALJ) Steven T. Kessel. *Andrew J. Elliott, M.D.*, DAB CR2103 (2010) (ALJ Decision). The ALJ granted summary disposition in favor of the Centers for Medicare & Medicaid Services (CMS), upholding CMS's determination as to the effective date of reactivation of Dr. Elliott's Medicare billing privileges. On the basis of a reactivation enrollment application filed on February 13, 2009, CMS determined that Dr. Elliott's effective date of enrollment was February 13, 2009. Dr. Elliott had asserted that based on applications that he filed in August 2008 and October 2008 and the regulations in effect at that time, he should be allowed to bill Medicare for claims dated June 2007 through June 2009.

As explained below, we conclude that the ALJ erred in granting summary disposition in favor of CMS by basing the determination, in part, on a ground on which CMS did not rely in moving for summary judgment. In addition, the ALJ did not view the record evidence in the light most favorable to Dr. Elliott, as required under summary judgment standards. Furthermore, we conclude that the record in this case raises an issue as to whether Dr. Elliott took the necessary steps to reactivate his Medicare billing privileges on August 21, 2008, prior to the August 26, 2008 effective date of the amended regulations governing the processes for enrollment of all providers and suppliers in the Medicare program, and prior to the January 1, 2009 effective date of CMS's revised regulations governing retroactive billing. Therefore, we vacate the ALJ Decision and remand this case for further proceedings consistent with this decision.

Applicable Law

Title XVIII of the Social Security Act (the Act) governs the healthcare program for the aged and disabled known as Medicare.[1] Section 1866(j) of the Act requires the Secretary to promulgate regulations for "a process for the enrollment of . . . suppliers under [Medicare]." The implementing regulations at 42 C.F.R. Part 424, subpart P, set out the enrollment process Medicare uses to establish eligibility to submit claims for Medicare covered items and services.

To receive payment for items and services covered by Medicare, "a provider or supplier must be enrolled in the Medicare program." 42 C.F.R. § 424.505.[2] "Once enrolled, the provider or supplier receives billing privileges . . . ." *Id.* To enroll, "[p]roviders and suppliers must submit enrollment information on the applicable enrollment application. Once the provider or supplier successfully completes the enrollment process . . . CMS enrolls the provider or supplier into the Medicare program." 42 C.F.R. § 424.510(a).

In addition, a prospective "provider or supplier must submit a complete enrollment application and supporting documentation to the designated Medicare fee-for-service contractor." 42 C.F.R. § 424.510(d)(1). The application must include "[c]omplete, accurate, and truthful responses to all information requested within each section as applicable to the provider or supplier type." 42 C.F.R. § 424.510(d)(2)(i). The "certification statement found on the enrollment application must be signed" in the case of an "individual practitioner, [by] the applying practitioner." 42 C.F.R. §§ 424.510(d)(3), 424.510(d)(3)(i)(A).

Section 424.540(a)(1) of the regulations provides that "CMS may deactivate a provider or supplier's Medicare billing privileges" if "the provider or supplier does not submit any Medicare claims for 12 consecutive calendar months." A provider or supplier "deactivated for nonsubmission of a claim" is "required to recertify that the enrollment information currently on file with Medicare is correct and furnish any missing information as appropriate." 42 C.F.R. 424.540(b)(2).

Effective August 26, 2008, at "the time of enrollment . . . providers and suppliers must agree to receive Medicare payments via EFT" (electronic funds transfer) "if not already receiving payments through EFT," and "must submit the CMS-588 form" in order to receive electronic payments. 42 C.F.R. §§ 424.510(d)(2)(iv); 73 *Fed. Reg.* 36,448, 36,461 (June 27, 2008).

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[1] The current version of the Act can be found at www.ssa.gov/OP_Home/ssact/comp-ssa.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section.

[2] Unless noted otherwise, the regulations cited in this decision were in effect throughout the time period at issue.

As of January 1, 2009, the "effective date for billing privileges for physicians" and certain other practitioners 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); 73 Fed. Reg. 69,726, 69,940 (Nov. 19, 2008). Also effective January 1, 2009, once enrolled, physicians and certain other practitioners may retrospectively bill for services "30 days prior to their effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries." 42 C.F.R. § 424.521(a). Prior to January 1, 2009, "depending on their effective date of enrollment, [physicians were permitted to] retroactively bill the Medicare program for services that were furnished up to 27 months prior to being enrolled to participate in the Medicare program." 73 Fed. Reg. at 69,766; 42 C.F.R. §§ 424.44, 424.510 (2007).

Background

The following facts are drawn from the record below and are undisputed.

On June 30, 2007, Dr. Elliott's Medicare billing privileges were deactivated because he had not submitted any Medicare claims for a period of 12 consecutive months. On August 21, 2008, National Government Services (NGS), a Medicare contractor, received a Medicare reactivation enrollment application (form CMS-855I) for Dr. Elliott.[3] CMS Ex. 3, at 1-22; P. Ex. 3, at 1-22. In a letter dated September 18, 2008, NGS notified Dr. Elliott that NGS was "closing [the] request and returning [the] application" because "Section(s) of the application were incomplete or missing," as indicated on an attachment to the letter. CMS Ex. 4, at 1.

On October 6, 2008, NGS received another Medicare enrollment application for Dr. Elliott. CMS Ex. 2, at 3-4. On October 21, 2008, NGS mailed a letter to Dr. Elliott requesting necessary information and supporting documentation that was missing from that application. P. Ex. 1. On November 13, 2008, NGS received additional information and documentation from Dr. Elliott. CMS Ex. 2, at 3-4. NGS determined that the additional documentation submitted was insufficient, and NGS rejected that application. *Id.*

On February 13, 2009, NGS received another Medicare enrollment application for Dr. Elliott. CMS Exs. 5, 6. By letter dated March 30, 2009, NGS notified Dr. Elliott that NGS had approved that application and determined that Dr. Elliott's enrollment was effective February 13, 2009. CMS Ex. 6.

[3] Form 855I is the Medicare enrollment application form for physicians and non-physician practitioners. Dr. Elliott's application showed Dr. Elliott's "managing employee" and "contact person" to be Marinna J. Zamminer, "Business Manager." CMS Ex. 3, at 18, 20; P. Ex. 3, at 18, 20. Throughout this appeal, Dr. Elliott has been represented by Ms. Zamminer, who is not an attorney. *See, e.g.,* P. March 16, 2010 letter opposing CMS's Motion for Dismissal or Summary Judgment.

By letter dated June 11, 2009 and addressed to the New York Attorney General, Dr. Elliott requested that the decision regarding the effective date of his Medicare billing privileges be overturned. CMS Ex. 7. Copies of the June 11, 2009 letter were sent to NGS and CMS, and NGS treated the letter as a request for reconsideration of its March 30, 2009 determination. CMS Exs. 7, 8.

By letter dated August 17, 2009, NGS informed Dr. Elliott of its decision to deny the request for reconsideration because there were "no extenuating circumstances . . . to allow the effective date to be changed." CMS Ex. 8. NGS further stated that if Dr. Elliott believed that the determination was not correct, he "may request a final ALJ review" by filing an appeal with the Departmental Appeals Board, Civil Remedies Division. *Id*.

Dr. Elliott filed a timely request for an ALJ hearing. CMS thereafter submitted a Motion to Dismiss and/or Motion for Summary Judgment, which was opposed by Dr. Elliott. By decision dated April 2, 2010, the ALJ granted CMS's motion for summary disposition, upholding the February 13, 2009 effective date of Dr. Elliott's enrollment. Dr. Elliott timely appealed the ALJ Decision to the Board by letter dated May 27, 2010.[4]

Standard of Review

Whether summary judgment is appropriate is a legal issue that we address de novo. *DMS Imaging, Inc*., DAB No. 2313, at 2 (2010); *Lebanon Nursing and Rehabilitation Center*, DAB No. 1918 (2004). 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. *See Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986); *Everett Rehabilitation and Medical Center*, DAB No. 1628, at 3 (1997). In deciding a summary disposition motion, a tribunal must view the entire record in the light most favorable to the nonmoving party, drawing all reasonable inferences from the evidence in that party's favor. *Madison Health Care, Inc.*, DAB No. 1927 (2004). The standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. *See* Guidelines -- Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program at http://www.hhs.gov/dab/divisions/appellate/guidelines/prosupenrolmen.html.

[4] In addition to requesting review of the ALJ's determination as to Dr. Elliott's effective date of enrollment, Dr. Elliott requested the Board to rescind an April 19, 2010 CMS deactivation of Dr. Elliott's Medicare billing privileges due to 12 months of non-billing. The Board does not have authority to review the April 19, 2010 deactivation. *See* 42 C.F.R. §§ 424.540, 424.545(b), 498.3(b).

Analysis

The ALJ granted summary disposition, also referred to as summary judgment, in favor of CMS based on a series of facts that the ALJ characterized as undisputed.[5] The ALJ stated that it was undisputed that Dr. Elliott "filed an application for enrollment on February 13, 2009 that was subsequently approved by NGS effective that date." ALJ Decision at 4. Applying section 424.520(d) to this fact, the ALJ determined, "NGS and CMS correctly determined [Dr. Elliott's] effective date of enrollment to be February 13, 2009." *Id.* at 3. "As a matter of law," the ALJ continued, "NGS could not permit Petitioner to claim reimbursement for items or services that he provided earlier than that date." *Id.* at 4.

The ALJ next considered Dr. Elliott's contentions that the earlier, August 21 and October 6, 2008, enrollment applications had been complete and should have been accepted by NGS. The ALJ stated that Dr. Elliott had "not supplied facts that show that these applications were, in fact, complete and that NGS should have accepted them." *Id.* at 4. With respect to the August 21, 2008 enrollment application, the ALJ stated, NGS told Dr. Elliott that it had decided to return that application because it "was incomplete and lacked necessary information." *Id.* at 3, citing CMS Ex. 4. Specifically, the ALJ wrote, NGS told Dr. Elliott that the application lacked an EFT authorization agreement and a copy of a voided check. *Id.* Further, the ALJ stated, NGS told Dr. Elliott that "the application must be signed personally by [Dr. Elliott] and not by his office manager on his behalf." *Id.* The ALJ stated that Dr. Elliott had contended that the EFT authorization agreement and voided check were provided with the August 21, 2008 application. However, the ALJ determined, Dr. Elliott did "not deny that the original [August] application . . . in fact, lacked his signature, a necessary requirement." *Id.* at 4-5. Consequently, the ALJ determined, Dr. Elliott had "provided no basis for [the ALJ] to conclude that NGS improperly rejected and closed" that application. *Id.* at 4.

We conclude that the ALJ erred in basing his determination to grant summary disposition in favor of CMS, in part, on a ground on which CMS did not rely in moving for summary judgment. Specifically, CMS did not argue in support of its motion for summary judgment that the August 2008 Medicare enrollment application, form CMS-855I, lacked Dr. Elliott's signature. Rather, CMS argued, "the one application that is pertinent to the determination of Petitioner's effective date is Petitioner's third [January 15, 2009] application" because it was "this third and final application that resulted in NGS's approval of Petitioner's enrollment and acceptance into the Medicare program . . . ." Motion for Summary Judgment at 21-22. Thus, Dr. Elliott did not have prior notice that

[5] The ALJ determined as a threshold matter that Dr. Elliott was entitled to a hearing on the merits based on 42 C.F.R. § 498.3(b)(15). This threshold determination was consistent with the Board's recent decision in the case of *Victor Alvarez, M.D.*, DAB No. 2325 (2010). The Board held in *Alvarez* that a determination of a supplier's effective date of enrollment in Medicare is an initial determination subject to appeal rights under 42 C.F.R. Part 498.

summary judgment might be granted in part based on the issue of whether the August 21, 2008 enrollment application, form CMS-855I, included his personal signature. Consequently, Dr. Elliott did not have adequate opportunity to come forward with specific facts or to present legal arguments relating to that issue. As the Board previously has held, an order granting summary disposition in favor of the moving party on a ground independent of that on which the moving party relied contravenes applicable summary judgment standards. *Venetian Gardens*, DAB No. 2286, at 8-9 (2009). Such action is contrary to fundamental fairness because it denies the nonmoving party opportunity to respond to the ALJ's new basis for deciding the dispute in favor of the moving party. Accordingly, we conclude that the ALJ erred in relying on the issue of whether Dr. Elliott's August 2008 enrollment application lacked his personal signature in determining that summary judgment in favor of CMS was appropriate.

We note, moreover, that even if the issue of whether Dr. Elliott's signature was missing from the August 21, 2008 enrollment application had properly been before the ALJ on consideration of CMS's motion for summary judgment, the ALJ failed to view the entire record in the light most favorable to Dr. Elliott, as required under the summary judgment standard. CMS and Dr. Elliott each entered into the record a copy of Dr. Elliott's August 21, 2008 reactivation enrollment application, form CMS-855I. CMS Ex. 3; P. Ex. 3; *see also* third attachment to September 28, 2009 request for ALJ hearing. On review of the exhibits, we find that the certification statement on each copy of the August 21, 2008 enrollment application, form CMS-855I, is signed by Dr. Elliott. CMS Ex. 3, at 21; P. Ex. 3, at 21. Thus, viewing the record in the light most favorable to Dr. Elliott, a rational trier of fact could reasonably conclude that Dr. Elliott's August 21, 2008 application did in fact include the physician's signature, as required under section 424.510(d)(3)(i)(A). To the extent that the ALJ's analysis raised an issue of whether Dr. Elliott had in fact signed the August 21, 2008 application, the ALJ should not have resolved that issue in favor of CMS. Therefore, we additionally conclude, with respect the issue of whether the August 21, 2008 enrollment application included the physician's signature, that the ALJ failed to view the record in the light most favorable to Dr. Elliott.

Accordingly, we vacate the ALJ Decision and remand this matter for further proceedings consistent with this decision. On remand, the ALJ shall have the discretion to further develop the record as he deems necessary. However, we specifically direct the ALJ to consider whether the documents received by NGS on August 21, 2008 would support a determination of Dr. Elliott's reactivation of billing privileges prior to February 13, 2009. In so doing, the ALJ should consider CMS's contentions that the application "was returned because it lacked an **EFT** [authorization agreement, form CMS-588] signed by Petitioner and a voided check," and that Dr. Elliott "provide[d] no evidence that the missing information was actually included in [that] application." Motion for Summary

Judgment at 21, citing CMS Exs. 2, 4 (emphasis added).[6] We further direct the ALJ's attention to the record copies of the documents submitted with Dr. Elliott's August 21, 2008 enrollment application, which include multiple copies of an EFT authorization agreement (form CMS-588) dated August 15, 2008, and a blank check with Dr. Elliott's name on it. CMS Ex. 3, at 24-26; P. Ex. 3, at 24-26.

In evaluating the legal significance of the evidence relating to Dr. Elliott's August 21, 2008 enrollment application, the ALJ should note that CMS did not cite any specific authority to support a determination by a contractor not to process, but to instead return, a physician's reactivation enrollment application on the ground that the EFT authorization agreement (form CMS-588) submitted with the application did not include the physician's signature.[7] The ALJ should further note that the record copies of the form CMS-588 described above provided for the authorization agreement to be signed by an "Authorized/Delegated Official," and that the copies show the signature of "Marinna J. Zamminer," with the title "Business Manager." CMS Ex. 3, at 25; P. Ex. 3, at 25. In addition, while the regulations explicitly provide that the certification statement on an enrollment application must be signed, in the case of an individual practitioner, by the applying practitioner, 42 C.F.R. § 424.510(d)(3)(i)(A), the regulations do not address who, in the case of an individual practitioner, may sign an EFT authorization agreement. Further, while, as of *August 26, 2008*, a provider was required to submit a CMS-588 form in order to receive electronic payments, the regulations did not include this requirement prior to August 26, 2008. Thus, this requirement did not apply at the time Dr. Elliott's August 21, 2008 application was received by NGS. 42 C.F.R. §§ 424.510(d)(2)(iv), 424.510(e); 73 *Fed. Reg.* 36,448, 36,461 (June 27, 2008).

In addition, the ALJ should take note that under CMS's PIM instructions for processing enrollment applications in effect during the period in question here, contractors were required to "pre-screen" an application "to ensure that the provider . . . [c]ompleted all required data elements on the application" and "[f]urnished all required supporting documentation[.]" PIM, chapter 10, section 3.1.A (Rev. 173, issued 11-13-06, accessible

[6] The regulations that establish the procedures for providers and suppliers to enroll in Medicare set out circumstances under which CMS may reject or deny an enrollment application. The regulations do not provide for a contractor to "return" enrollment applications. 42 C.F.R. Part 424, subpart P.

[7] CMS suggested that since Dr. Elliott had no right to appeal NGS's return of the August 2008 application, the ALJ could not consider the August 2008 application for the purpose of determining the proper effective date of Dr. Elliott's enrollment reactivating his billing privileges. Motion for Summary Judgment at 20-22; *see also* CMS Br. at 10-11. The question of whether a provider or supplier may appeal a contractor's rejection or "return" of an enrollment application is separate from the issue of the scope of review on appeal of a determination regarding the effective date of a provider or supplier's Medicare enrollment. While the regulations provide that "[e]nrollment applications that are rejected are not afforded appeal rights," 42 C.F.R. § 424.525, the regulations do not bar an ALJ, on a properly filed appeal of an effective date of enrollment determination, from considering an earlier enrollment application in that process in order to determine the correct effective date for the provider or supplier. Thus, the ALJ in this case did not err in considering Dr. Elliott's August and October 2008 applications to be within the scope of review.

at http://www.cms.gov/transmittals/downloads/R173PI.pdf). The PIM stated that the contractor "shall immediately return an enrollment application to the provider" if, among other reasons, the "CMS-855I application was signed by someone other than the individual practitioner applying for enrollment." PIM, chapter 10, section 3.2.A (Rev. 218, issued 8-10-07, accessible at http://www.cms.gov/transmittals/downloads/R218PI.pdf). With respect to an EFT agreement authorization signature, however, the PIM stated:

> A non-signature on the CMS-588 EFT form (assuming that it is submitted in conjunction with a CMS-855 initial application or change request) *is not grounds for returning the entire application package*. The contractor shall simply develop for the signature using the procedures cited in section 5.3 of this manual.

*Id.* at 3.2.C (emphasis added). Section 5.3 of the PIM, in turn, stated that if the contractor determined that it needed additional information from the provider, the contractor "shall send a letter to the provider – preferably via e-mail or fax - that contains, at a minimum" a "list of all data to be clarified;" a "request that the provider submit the clarifying data within a contractor-specified timeframe;" and "a phone number and name of a contact person at the contractor site." PIM, chapter 10, section 5.3.A. (Rev. 173). Assuming that these provisions provide additional support for concluding that the August 21, 2008 application was complete, we direct the ALJ to consider the record evidence indicating that prior to returning the August 21, 2008 submission, NGS attempted unsuccessfully to contact Dr. Elliott only by telephone. CMS Ex. 4, at 5. Additionally, the ALJ should consider whether the August 21 application was complete and would have been processed to approval if the relevant regulations and PIM provisions in effect at the time had been properly followed.

Finally, the ALJ may, in the alternative, decide to further remand the case to CMS so that CMS can determine, consistent with this decision, whether a reactivation effective date earlier than February 13, 2009 should be approved for Dr. Elliott.

Conclusion

For the reasons stated above, we reverse and remand this appeal to the ALJ for further proceedings consistent with this decision.

_____/s/_____
Judith A. Ballard

_____/s/_____
Constance B. Tobias

_____/s/_____
Stephen M. Godek
Presiding Board Member