Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Judith A. Kramer, M.D.,

Petitioner

v.

Centers for Medicare & Medicaid Services.

Docket No. C-10-397

Decision No. CR2183

Date: July 14, 2010

DECISION

I grant the motion of the Centers for Medicare & Medicaid Services (CMS) for summary judgment and sustain its determination setting the effective date of Petitioner's, Judith A. Kramer, M.D., enrollment in Medicare as August 17, 2009, with billing privileges retroactive for 30 days to July 18, 2009.

I. Background

Petitioner seeks billing privileges effective May 1, 2009, when she began seeing patients as a new member of Partners in Internal Medicine, LLP (Partners). CMS Ex. 7, at 1-4. By letter dated September 2, 2009, National Government Services (NGS), a CMS contractor, enrolled Petitioner as a "Group Member" of Partners, with an effective date of July 19, 2009.[1] CMS Ex. 6. The letter does not state the basis of that effective date determination and provides no appeal rights.

[1] The NGS letter also approved Partners' Medicare enrollment with an effective date of December 28, 1989, which is consistent with Petitioner's description of Partners as a longstanding medical practice. CMS Ex. 6; CMS Ex. 7, at 1.

By letter of October 6, 2009, Petitioner and Partners' practice manager requested that NGS "backdate" Petitioner's effective date to May 1, 2009. CMS Ex. 7, at 1-2. They stated that they began enrolling Petitioner as a Partner's practitioner sometime in March 2009, when Petitioner accepted a position with Partners, and were told by Medicare that Petitioner "did not need to apply as a new physician," because she was "already participating" with Medicare. *Id*. at 1. In response, NGC issued a reconsideration decision dated November 30, 2009, denying the request but adjusting the effective date of Petitioner's billing privileges from July 19 to July 17, 2009, on the ground that NGS had received Petitioner's approved application on August 17, 2009.[2] CMS Ex. 8. NGS cited 42 C.F.R. §§ 424.520(d) and 424.521(a) as providing that "the effective date can be up to 30 days prior to the date of filing the Medicare enrollment applications. Therefore, 30 days prior to the receipt date of August 17, 2009 is July 17, 2009." *Id*. at 2. Before me, however, CMS states that Petitioner's billing privileges began July 18, 2009, which, as CMS correctly notes, is 30 days prior to August 17, 2009. CMS Br. at 5 n.2.[3]

Petitioner filed a timely hearing request (HR), in which she seeks billing privileges beginning May 1, 2009 and states that the process of enrolling as a practitioner for Partners "has been unduly challenging, involved multiple different Medicare contacts with no seeming accountability, and has resulted in denial of payment for my primary care services for Medicare patients." HR. This case was originally assigned to Administrative Law Judge (ALJ) Carolyn Cozad Hughes. On February 24, 2010, ALJ Hughes issued an Acknowledgment and Initial Pre-Hearing Order (Pre-Hearing Order), setting a schedule for briefing the appeal. The case was transferred to me for hearing and decision on March 23, 2010, pursuant to 42 C.F.R. § 498.44, which permits a Member of the Departmental Appeals Board (Board) to be designated to hear appeals taken under Part 498. In a submission dated March 26, 2010, CMS filed a brief containing its motion for summary judgment and submitted its exhibits 1 through 10. On May 21, 2010, Petitioner's representative stated that Petitioner had already submitted all information with the hearing request and would not file a response to CMS's brief.

---

[2] Although the NGS determination letter dated September 2, 2009 provided no notice of Petitioner's right to appeal NGS's effective date determination, CMS does not argue, as it has in other cases, that Petitioner has no right to challenge the effective date determination. *See, e.g., Michael Majette, D.C.*, DAB CR 2142 (2010); *Eugene Rubach, M.D.*, DAB CR2125 (2010); *Mobile Vision, Inc.*, DAB CR2124 (2010).

[3] As CMS points out, under section 424.520(d), Petitioner's actual enrollment date was August 17, 2009, the date that NGS received the application it approved. Under 42 C.F.R. § 424.521(a), Petitioner was permitted to bill retroactively for 30 days prior to the effective date of her enrollment. CMS Br. at 5 n.2. NGS's use of the term "effective date" to refer to the earliest date for which retroactive billing is permitted (as well as its numerical error) created some confusion. In granting summary judgment to CMS, I uphold the dates as CMS corrected in its briefing.

With the hearing request, Petitioner submitted twelve pages of documents not numbered as exhibits. I assign the following exhibit numbers to those documents: an October 6, 2009 letter from Petitioner and the Partners' office manager to NGS requesting the ability to bill Medicare beginning May 1, 2009 (P. Ex. 1; 2 pages); a Partners' "charge summary" listing charges for services that Petitioner apparently rendered to eight individuals during the period of May 1 though July 18, 2009 (P. Ex. 2, 1 page); a web page printout, dated April 8, 2009, reflecting receipt and processing of an unidentified request from Partners by the CMS "PECOS" system (P. Ex. 3, 1 page);[4] a May 22, 2009 fax to Partners from the Internal Revenue Service (IRS) providing Partners' Employer Identification Number (P. Ex. 4; 1 page); a "National Provider Identifier (NPI) Application/Update Form" from Partners dated June 22, 2009 and an envelope addressed to "NPI Enumerator" and postmarked June 24, 2009 (P. Ex. 5; 4 pages); a July 15, 2009 letter from CMS returning to Partners its application "to either establish or update information in the National Plan & Provider Enumeration System," because "[t]he signature in Section 4A (Individual Practitioner's Signature) or Section 4B (Authorized Official's Information and Signature) is a non-original signature" (P. Ex. 6; 2 pages); and a fax cover sheet, dated October 7, 2009, reflecting the submission of 13 pages to the NGS provider enrollment specialist who rendered NGS's November 30, 2009 reconsideration decision (P. Ex. 7; 1 page; *see* CMS Ex. 8 (reconsideration decision)). All of these materials, except for Petitioner's Exhibit 2, are also included among CMS's exhibits.

Absent any objection to the admission of any exhibits, or any indication from CMS that Petitioner's Exhibit 2 constitutes new documentary evidence, the admission of which is limited by 42 C.F.R. § 498.56(e), I admit both parties' exhibits.

II. Issues, Findings of Fact, Conclusions of Law

A. Issue

The issue in this case is whether CMS is entitled to summary disposition on the ground that undisputed facts demonstrate that CMS properly determined the effective date of Petitioner's enrollment in Medicare.

B. Findings of Fact and Conclusions of Law

I grant CMS summary disposition on the ground that it properly determined the effective date of Petitioner's participation in Medicare.

---

[4] "PECOS" is the "Provider Enrollment, Chain and Ownership System," a "[w]eb-based enrollment process, which is based off of the information collected on the CMS-855 forms." CMS Medicare Program Integrity Manual (MPIM), ch. 10, § 1.2.

a. Applicable Regulations

The determination of the effective date of Medicare enrollment and the commencement of the ability to bill Medicare are governed by 42 C.F.R. §§ 424.520 and 424.521. Section 424.520(d) provides that the effective date for billing privileges for physician, 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." (Emphasis added). The "date of filing" is "the date that the Medicare contractor receives a *signed provider enrollment application that the Medicare contractor is able to process to approval*." 73 Fed. Reg. 69,769 (Nov. 19, 2008) (emphasis added). Certain suppliers, including physicians, may be permitted to bill retrospectively for certain services provided before the effective date of approval of their enrollment application, if they have met all program requirements. Current regulations limit retrospective billing to 30 days prior to the effective date, "if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries," or 90 days in the event of certain Presidentially-declared disaster situations. 42 C.F.R. § 424.521(a).

b. Parties' Arguments

Petitioner's hearing request refers to the October 6, 2009 letter to NGS from her and Partners' practice manager for a description of "the extensive process" Partners engaged in to "add a new address to my already existing credentialing with Medicare at the time I started seeing patients" with Partners. HR; *see* CMS Ex. 7, at 1-2 (letter Oct. 6, 2009). In that letter, the practice manager states that she called Medicare in April 2009 and was told that Petitioner "did not need to apply as a new physician," because she was already participating with Medicare. *Id*. The practice manager also states that Partners were told to "add a new location" for Petitioner at a Medicare web site and that attempts of Partners' biller to do so in April "ended up in a series of requests from your [Medicare] office and things going wrong every step of the way." *Id*. The practice manager further describes efforts to obtain for Medicare a federal tax coupon bearing Partners' correct name.

The practice manager goes on to state in the October 6, 2009 letter that Partners was then told to fill out "an NPI application/update form, which we filled out, signed and mailed on 6/24/09," but that the form was returned, because the signature page was missing, and "we had to re-mail the application immediately upon your request (7/9/09)." *Id*. The letter reports that further phone calls resulted in the "new information . . . that a full application needed to be filled out and submitted and it could only be backdated 30 days" due to "the 30 day rule [that] went into effect on 4/1/09 and was not posted till 4/21/09 . . .." *Id*. Finally, it states that following "[n]ew requests from [the] enrollment office

[for] forms CMS 855R, 855B and 588 in early August," Partners submitted the application for Petitioner that NGS approved.[5] *Id.*

With the October 6, 2009 letter is a 2-page handwritten statement from Partner's biller. CMS Ex. 7, at 3-4. She states that, on April 8, 2009, Partners applied online at the PECOS website and were told by "ext. user services" that they had to submit an IRS document with their official name, and she describes delays in obtaining from IRS a copy of the document bearing Partners' correct name. CMS Ex. 7, at 3-4. She describes further delays caused by difficulty in accessing the NPI website, because she was not an authorized user and states that a paper application Partners subsequently submitted was returned twice for missing information. *Id.*

CMS disputes that an application for Petitioner was submitted in April or June 2009. CMS states that what Partners filed at those times, first online and then by mail, was an NPI "Application/Update Form" for Partners, for "the purpose of changing and/or replacing information related to the group entity" and "was unrelated to Petitioner's enrollment application." CMS Br. at 8. CMS states that the submission of this NPI Application "was separate and apart from the actions of Petitioner to reassign benefits to the practice, via enrollment applications CMS 855I and CMS 855R."[6] *Id.* CMS states that the applications required "to change her enrollment information and reassign her benefits to Partners," CMS forms 855I and 855R, were submitted online via PECOS on August 12, 2009 but "were not considered submitted by NGS until it received the Web Certifications Statements containing Petitioner['s] original signature on August 17, 2009." *Id.* at 4, 8, citing CMS Exs. 2, 3.

c. Applicable Standard

The Board stated the standard for summary judgment as follows.

> 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,

---

[5] The CMS 855B is for a supplier organization that will bill Medicare for Part B services furnished to Medicare beneficiaries. The CMS 855R is the application for an individual who renders Medicare services to reassign his or her benefits to an eligible entity, such as a supplier organization. The CMS 588 is an Electronic Funds Transfer agreement. MPIM, ch. 10, § 1.2

[6] The CMS 855I application is for individual practitioners, including physicians, who render Medicare services. *Id.*

> the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact – a fact that, if proven, would affect the outcome of the case under governing law. . .. In determining whether there are genuine issues of material fact for trial, the reviewer must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor.

Senior Rehab. & Skilled Nursing Ctr., DAB No. 2300, at 3 (2010) (citations omitted). The role of an ALJ in deciding a summary judgment motion differs from the ALJ's role in resolving a case after a hearing. The ALJ should not assess credibility or evaluate the weight of conflicting evidence. *Holy Cross Vill. at Notre Dame*, DAB No. 2291, at 4-5 (2009).

d. Analysis

The date of Petitioner's enrollment to provide Medicare services at Partners is fixed by regulation as the date NGS received the application it subsequently approved for Petitioner to provide services at Partners (or, the date Petitioner began providing those services for Partners, had it been later, which was not the case). 42 C.F.R. §§ 424.520(d), 424.521(a). The undisputed evidence and CMS's unchallenged statements indicate that this application comprised the forms that Petitioner and Partners submitted in August 2009 to enroll Petitioner as a supplier with Partners and to assign her Medicare benefits to Partners and that NGS received these forms, with the appropriate signature, on August 17, 2010.

The evidence reflects that the earliest filing with NGS that specifically mentions ***Petitioner*** (as opposed to simply Partners) consists of a PECOS "application data report" of an application to enroll Petitioner and reassign her benefits to Partners, and two "PECOS Web Certification Statements," one for form 855I, that Petitioner signed on August 12, 2009, and one for form 855R, that Petitioner signed on August 12, 2009 and Partners' "Authorized or Delegated Official" signed on August 14, 2009. CMS Ex. 2. CMS states that NGS received the signed certification statements on August 17, 2009, as indicated by a Julian-format date stamp on the statements; additionally, a "PECOS screen print" indicates that a form 855I for Petitioner submitted via the web was received on August 12, 2009, with a "certification date" of August 17, 2009. CMS Br. at 4, 7 n.4; CMS Ex. 3. The date NGS received Petitioner's signature is critical, as the "date of filing" to determine the effective date is "the date that the Medicare contractor receives a *signed* provider enrollment application that the Medicare contractor is able to process to approval." 73 Fed. Reg. at 69,769 (emphasis added).

Petitioner declined the opportunity to respond to CMS's brief and motion and did not dispute CMS's description of the evidence. Petitioner also did not dispute CMS's report that: (1) the signed forms necessary to complete Petitioner's application were received August 17, 2009; and (2) the forms Partners filed during April and June 2009 were NPI update forms for Partners that were not related to the enrollment of Petitioner.

Indeed, all materials in record dated prior to August 2009, including the form updating Partners' NPI information, relate to Partners only and contain no reference to Petitioner. *See* CMS Ex. 10; P. Exs. 5, 6. During August 2009, around the same time that Partner submitted the forms 855I and 855R to enroll Petitioner as a physician with Partners and assign her benefits to that practice, Partners also filed a CMS 855B revalidating its own enrollment. This form, dated August 13, 2009, also does not mention Petitioner.[7] CMS Br. at 4; CMS Ex. 4.

Given this record, and absent any dispute with CMS's representation in its brief that *Petitioner's* application for enrollment as a physician with Partners was received August 17, 2009, or any proffer of evidence showing an earlier date of receipt, I conclude that no dispute of any material fact exists and that CMS is entitled to summary judgment on the ground that the effective date of Medicare enrollment is August 17, 2009 as a matter of law. CMS also properly granted a 30-day period of retrospective billing as the regulations authorized.

That Petitioner began providing Medicare services with Partners on May 1, 2009, which CMS does not dispute, does not authorize me to grant Medicare billing privileges beginning on that date. The regulations set the effective date as the date of receipt of Petitioner's approved application and limit retrospective billing privileges to the 30-day period that was granted here (no indication exists that the provision authorizing a 90-day period in the case of certain Presidentially-declared disasters applies here). No regulations currently authorize me to consider challenges to the period for retroactive billing beyond hearing an appeal that the effective date of approval itself was wrongly determined. Furthermore, the regulation at section 424.521(a) binds me. I can neither alter nor deviate from its explicit limitation on retroactive billing to the 30 days already granted to Petitioner. Thus, I have no authority to extend the retroactive billing period for Petitioner. For these reasons, the Partners "charge summary" that Petitioner submitted listing charges for services she rendered at Partners for the period of May 1 through July 18, 2009 (P. Ex. 2) is not material.

I note that previous regulations did authorize CMS to grant physician suppliers up to 27 months of retroactive billing privileges; however, that provision and the authority it provided were eliminated when the current regulations became effective on January 1, 2009 (and not on April 1 or 21, 2009, as the practice manager reported being told). 73 Fed. Reg. at 69,726, 69,940; CMS Ex. 1, at 1-2. As physicians previously could be permitted to bill Medicare up to 27 months prior to the effective date of Medicare enrollment, issues relating to the effective dates of their enrollments were unlikely to arise. With the shorter time frame for retrospective billing, the applicable effective date

[7] Presumably, it was in response to this CMS 855B from Partners that NGS, in its September 2, letter, approved Partners' Medicare enrollment with an effective date of December 28, 1989. CMS Ex. 6.

has obviously become more important. The law as to when approval is effective, however, links the commencement of that shortened period of retrospective billing to the receipt of the approved application.

The practice manager's report in the October 2, 2009 letter that she was told, presumably by someone at NGS, that Petitioner did not need to apply as a new physician, because she was already participating with Medicare, does not provide any basis for me to grant an earlier enrollment date. CMS Ex. 7, at 1-2. For one thing, the practice manager reported also being told, correctly, of the need to "add a new location" for Petitioner; that is, enroll her as a physician practicing with Partners. *Id*. at 1. While she states that such efforts were made, no documentation exists of any submissions to NGS from Partners that mentioned Petitioner, prior to the forms submitted online in August 2009. For another thing, the information was correct in that, while Petitioner was not a "new" Medicare physician, she still needed to fill an application to reassign her payments to the new practice group.

Even had NGS given incorrect advice to Petitioner, that would not permit me to grant an earlier effective date. Estoppel against the federal government, if available at all, is presumably unavailable absent "affirmative misconduct," such as fraud. *See, e.g.*, *Pacific Islander Council of Leaders*, DAB No. 2091, at 12 (2007); *Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414, 421 (1990). None of the circumstances they describe fit that standard. The frustration that Petitioner and the practice manager describe does not permit me to ignore the unmistakable requirements of the regulations governing his enrollment in Medicare, by which I am bound.

III. Conclusion

Because no genuine issue to any material fact exists, and for the foregoing reasons, I grant CMS's motion for summary disposition and sustain its determination setting the effective date of Petitioner's Medicare enrollment as August 17, 2009, with a retrospective billing period beginning July 18, 2009.

/s/
Leslie A. Sussan
Board Member