Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Crawford F. Barnett, M.D.,
(NPI #1720051014)
Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-10-529

Decision No. CR2233

Date: September 1, 2010

DECISION

Crawford F. Barnett, M.D., Petitioner, appeals the determination of Palmetto, GBA (Palmetto), a Medicare contractor, granting his application for enrollment as a Medicare supplier and authorizing billing privileges beginning September 21, 2009, 30 days prior to its receipt of his approved application on October 21, 2009. I deny the Centers for Medicare & Medicaid Services' (CMS's) motion for dismissal or, in the alternative, for summary affirmance. I decide the case on the written record and sustain CMS's determination about the effective date of Petitioner's enrollment and grant of retroactive billing privileges.[1]

[1] The parties use the term "effective date" to refer to the date on which Petitioner could bill for Medicare services. *See, e.g.,* CMS Ex. 5 (Palmetto letter to ADO Oct. 31, 2009 assigning "Effective Date" of Sept. 10, 2009). Under the regulations, the effective date would ordinarily be the date Palmetto received Petitioner's application that it approved and therefore the same as the date of Petitioner's enrollment in Medicare. CMS and Palmetto are authorized, however, to permit Petitioner to "retrospectively bill" for services for up to 30 days prior to that effective date, as they did here. 42 C.F.R. § 424.521(a). For clarity, I use "effective date" to refer to the effective date of enrollment, and not the date on which retrospective billing begins.

I. Applicable law

The effective dates of Medicare enrollment and billing privileges are established by 42 C.F.R. §§ 424.520 and 424.521. Section 424.520(d) provides that the effective date of enrollment for physician, nonphysician practitioners, and their 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. 69,726, 69,769 (Nov. 19, 2008) (emphasis added). Certain suppliers, including physicians, may be permitted to bill retrospectively for up to 30 days prior to the effective date of their enrollment "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).

II. Background

Petitioner, a physician practitioner with Anesthesiologists D.O., Inc. d/b/a Doctors Pain Clinic (ADO),[2] states that on July 27, 2009, ADO submitted to Palmetto, by certified mail, a package containing six Medicare applications: individual enrollment application forms (CMS-855I) for Petitioner and another physician practitioner with ADO, and four application forms (CMS-855R) to enroll Petitioner and the other practitioner as suppliers with both ADO and Doctors Pain Center, LLC, another corporate entity. Petitioner Request for Hearing (RH); Petitioner Brief (P. Br.). Petitioner states that Palmetto received this package on July 30, 2009, and Petitioner submitted a certified mail return receipt card as evidence of the receipt date. Petitioner states that ADO's employee in charge of credentials called Palmetto Provider Enrollment and was told that the contractor did not have the applications, and that ADO thus resubmitted these applications with new signatures in September 2009. *Id*. In a letter dated November 4, 2009, Palmetto advised that Petitioner had been "added to the roster" of ADO with billing privileges effective September 21, 2009 (i.e., 30 days prior to Palmetto's alleged date of receipt of his application). CMS Ex. 10. Palmetto sustained that determination in a reconsideration decision dated January 20, 2010, on the grounds that the date assigned for the beginning of billing privileges was 30 days prior to Palmetto's receipt of

[2] The request for hearing was submitted on letterhead of Doctors Pain Clinic by the practice administrator for "Anesthesiologists D.O./Doctors Pain Clinic" who stated that it was filed by Anesthesiologists D.O. For the sake of convenience, we refer to these entities simply as ADO.

Petitioner's application, and that Petitioner did not have a right to appeal the effective date determination.[3] CMS Ex. 16.

Petitioner filed a hearing request seeking billing privileges based on the application submitted to Palmetto July 27, 2009. On April 1, 2010 I issued an Acknowledgment and Pre-Hearing Order (Order) setting procedures for the appeal, and CMS, in accord with my Order, submitted on May 3, 2010 its motion for dismissal or summary affirmance and supporting brief (CMS Br.), and its proposed exhibits 1 through 18, including the declaration of one proposed witness. On May 28, 2010, Petitioner submitted his brief, his proposed exhibits designated I through VII, and a proposed witness list. Petitioner did not submit any written direct testimony of his proposed witnesses, as required by my Order.

In its brief, CMS argues that there is no right for a supplier to appeal the effective date of Medicare enrollment and billing privileges, and, alternatively, that the effective date determination here is entitled to summary affirmance in the nature of summary judgment. For the reasons discussed below, I deny CMS's motion to dismiss. I also deny CMS's motion for summary affirmance, as I find that Petitioner has raised a dispute about a material fact. However, I further find that no hearing is necessary to resolve any disputed facts, and I conclude based on the record that Palmetto correctly determined the effective date and that Petitioner is not entitled to the July 30, 3009 effective date he seeks. Specifically, CMS offered convincing evidence, which Petitioner did not rebut, that the package Palmetto received from ADO on July 30, 2009 did not contain Petitioner's enrollment applications to establish his eligibility to participate in Medicare as a supplier for ADO, and, moreover, that Palmetto received no such applications in July or August 2009, the time period during which an application submitted in July 2009 would have been received.

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[3] Palmetto approved the enrollment of the other ADO physician practitioner with retrospective billing privileges beginning September 10, 2009. The other ADO practitioner appealed that determination, and the appeal was assigned CRD Docket No. C-10-528. CMS moved for dismissal or, in the alternative, summary affirmance in that appeal on grounds identical to those CMS advances here. With my consent, CMS submitted a single set of exhibits covering both appeals, and ADO submitted in response a single combined brief and set of exhibits. The appeals were not consolidated, however. I am this day also issuing a decision in the other appeal, *Kate E. Paylo,* DAB CR2232 (2010).

Petitioner with his request for hearing submitted the following materials: a letter from Petitioner dated March 5, 2010 (including his attestation that he "signed two Medicare form 855Is. I signed the original form in July 2009. . . . the second duplicate form for the first form was signed in July of 2009 and the second was signed in September/October of 2009."); a copy of a USPS Domestic Return Receipt for certified mail showing receipt by Palmetto on July 30, 2009; and a form CMS-855I signed by Petitioner dated July 24, 2009 that Petitioner says was sent to Palmetto. I designate these materials as Petitioner's Exhibits 1 through 3, respectively. CMS objected to the admission of these materials as barred by 42 C.F.R. § 498.56(e), which requires a supplier appealing an enrollment determination to have "good cause" for submitting "new documentary evidence . . . for the first time at the ALJ level." Petitioner in his brief did not respond to CMS's objections nor allege having submitted these materials previously to Palmetto during reconsideration.

I consider Petitioner's March 5, 2010 letter offering his attestation (P. Ex. 1) to be in the nature of an offer of testimony and thus not the "documentary evidence" addressed by section 498.56(e). I agree with CMS that Petitioner failed to demonstrate (or allege) good cause for his failure to submit the other two exhibits to Palmetto on reconsideration, and I thus decline to admit Petitioner's Exhibits 2 and 3. My ruling has little practical effect, however, because CMS, which is not subject to the evidentiary restriction in section 498.56(e), submitted these materials among its proposed exhibits. *See* CMS Ex. 18, at 8-37. In any event, however, the July 24, 2009 enrollment application and the return receipt card are ultimately immaterial to my decision as they do not establish that the application was mailed, let alone received by Palmetto, and CMS's evidence that no such document was received in July or August 2009 is persuasive.

With his combined brief and appeal file, Petitioner submitted his Exhibits I – VII, consisting of the following: enrollment applications for the other physician and for Petitioner, signed July 24, 2009 (P. Exs. I and II, respectively), their joint hearing request (P. Ex. III), lists of their unbilled charges (P. Exs. IV and V), a document Petitioner identifies as a Palmetto notice, containing instructions for implementing regulatory changes to the effective date regulations (P. Ex. VI), and monthly Medicare Advisories for November 2008 through April 2009 (P. Ex. VII). Petitioner's representative, the ADO practice manager, reports being advised by the CRD staff attorney that the July 24, 2009 application (P. Ex. II) would not be considered "new" evidence because Petitioner had submitted it with his request for hearing. P. Br. at 1-2. As noted above, this document is in the record in CMS's exhibits in any case, and I do not discuss it further.[4]

[4] The advice Petitioner's representative reports receiving from the staff attorney obviously played no role in Petitioner's earlier failure to have submitted this document to Palmetto during reconsideration, and thus, even if I accepted that such advice was given, it provides neither "good cause" for that failure nor a basis to ignore the strictures of section 498.56(e).

Petitioner made no allegation of good cause for the failure to have submitted the other exhibits on reconsideration. The exhibits that were issued by Palmetto or CMS (P. Exs. VI and VII) are arguably not documentary evidence of disputed facts and are within CMS's control without a need for Petitioner to have submitted them to the contractor. In any event, Petitioner's Exhibits IV – VIII ultimately are not material either as they provide no basis to grant the relief he seeks. As I explain further below, these exhibits go to Petitioner's argument that he did not have sufficient notice of a change to the enrollment regulations that significantly shortened the period during which physicians may retroactively bill for services. As that change was effected by regulation, I am bound to apply it, notwithstanding Petitioner's assertions that he and ADO were unaware of it and that he incurred Medicare charges during the period before the beginning date of his billing privileges.

III. Issues

1. Does Petitioner have a right to a hearing on the determination of the effective date of his enrollment in Medicare?

2. Is CMS entitled to summary judgment that the assigned effective date is correct as a matter of law based on undisputed facts?

3. Does the record support an earlier effective date?

IV. Analysis

1. I deny CMS's motion to dismiss.

a. Standard of review

Pursuant to 42 C.F.R. § 498.70(b), I may dismiss a hearing request in the circumstance where a party requesting a hearing "does not otherwise have a right to a hearing."

b. Applicable regulation

The regulations governing ALJ hearings in provider/supplier appeals at Part 498 of 42 C.F.R. include among the "initial determinations" subject to appeal, "[t]he effective date of a Medicare provider agreement or supplier approval." 42 C.F.R. § 498.3(b)(15).

c. Discussion

CMS argues that I should dismiss the appeal because section 498.3(b)(15) permits appeals only of denials of applications and not an appeal by a supplier like Petitioner whose application is approved. CMS argues that this provision is meant to apply only to those suppliers or providers subject to survey and certification (or accreditation by a

CMS-approved accrediting organization) as a basis for determining their participation in Medicare and whose effective dates are governed by 42 C.F.R. § 489.13. CMS Br. at 13-17. I reject that argument the reasons explained here.

The Departmental Appeals Board (Board) recently rejected CMS's argument that suppliers under Part 424 may not appeal effective date determinations, in *Victor Alvarez, M.D.*, DAB No. 2325 (2010), issued after CMS submitted its motion to dismiss in this case. In *Alvarez*, the Board concluded 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." *Alvarez*, DAB No. 2325, at 1. The Board explained that this determination is consistent with the historical interpretation of hearing rights under section 1866(h)(1)(A) and as discussed in the rulemaking process. Further, "while section 498.3(b)(15) originally applied primarily to suppliers subject to survey and certification, the term 'supplier' as used in 42 C.F.R. Part 498 was amended to cover all Medicare suppliers, including physicians." *Id.* at 3.

In several prior decisions, I also came to the same conclusion. *See, e.g., Michael Majette, D.C.*, DAB CR2142 (2010); *Eugene Rubach, M.D.*, DAB CR2125 (2010); *Mobile Vision, Inc.*, DAB CR2124 (2010). I likewise concluded that the wording of section 498.3(b)(15) appears straightforward in providing that the "effective date of a Medicare provider agreement or supplier approval" is an appealable initial determination and includes no qualifying or limiting language. I also concluded that the regulatory history of section 498.3(b)(15) did not support CMS's argument. I moreover noted that CMS, in adopting section 498.3(b)(15), recognized that approving participation at a date later than that sought amounts to a denial of participation during the intervening time and generally involves the same kind of compliance issues that arise from initial denials. *See, e.g., Michael Majette, D.C.*, DAB CR2142, at 4.

A legislative rule generally binds the agency that issues it, and the agency is legally bound to follow its own regulations as long as they are in force. *Cal. Dep't of Soc. Servs.*, DAB No. 1959 (2005); *Hermina Traeye Mem'l Nursing Home*, DAB No. 1810 (2002), citing Kenneth Culp Davis and Richard J. Pierce, Jr., *Administrative Law Treatise* § 6.5 (3rd ed. 1994), *aff'd Sea Island Comprehensive Healthcare Corp. v. U.S. Dep't of Health & Human Servs.*, 79 F. App'x 563 (4th Cir. 2003); 2 AM. JUR. 2d *Administrative Law* § 236 (2010), *available at* WL AM. JUR. ADMINLAW § 236. Absent further rulemaking, I am bound to follow the plain meaning of the regulation and, as the Board mandated, permit an appeal by any provider or supplier dissatisfied with a determination as to the effective date of its provider agreement or supplier approval.

I therefore deny CMS's motion to dismiss on this basis.

2. I deny CMS's motion for summary affirmance.

a. Applicable standard

CMS's motion makes clear that the summary affirmance it seeks is in the nature of summary judgment. 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, 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 Village at Notre Dame, Inc.*, DAB No. 2291, at 4-5 (2009).

b. Discussion

CMS argues that summary judgment is warranted because the documents Petitioner submitted with his hearing request "do not create an issue of material fact" and "Palmetto correctly determined the effective date." CMS Br. at 17-18. CMS cites the declaration of Robert Lash, an Operations Analyst with Palmetto's Medicare Providers Enrollment Department, describing Palmetto's procedures for scanning and labeling each page of incoming mail with identifiers that include the date of receipt. CMS Ex. 1. Mr. Lash states that Palmetto's mail records show that a package Palmetto received from ADO on July 30, 2009 did not contain Petitioner's application, and, further, that no application was received from Petitioner in July or August 2009. *Id.*

Nonetheless, CMS recognizes that the materials Petitioner cites on appeal and CMS included among in is exhibits, when viewed most favorably to Petitioner, could tend to support his assertion that a package containing his enrollment application was submitted to Palmetto in July 2009. CMS Br. at 18; CMS Ex. 18, at 8-37 (return receipt and CMS 855I for Petitioner dated July 24, 2009). From this evidence, which includes a certified mail receipt, one could reasonably infer that Petitioner's enrollment application was

mailed by certified mail and received by Palmetto on July 30, 2009. (I do not make such a finding here; I only acknowledge that the record does not make such a finding beyond reason.)

In considering whether to grant CMS's motion for summary judgment, I do not weigh the relative persuasiveness or strength of the evidence presented by the parties on a disputed issue of material fact. I must instead view all evidence in the light most favorable to Petitioner and draw all reasonable inferences in his favor. As the record and the parties' contentions require me to analyze and address potentially conflicting evidence regarding the content of the submission that Palmetto received on July 30, 2009, summary judgment is not appropriate.

I therefore deny CMS's motion for summary affirmance.

3. I conclude that, on the record before me, the regulations support the effective date Palmetto assigned.

a. Further proceedings including a hearing are not necessary to resolve the appeal on its merits.

I next consider whether further proceedings are needed to decide the case on the merits. My Order required all parties to "exchange as a proposed exhibit the complete written direct testimony of any proposed witness" which would generally serve as the witness's "statement in lieu of in-person testimony." Order at 3. My Order further stated that an in-person hearing to cross-examine witnesses would be held ***only*** if admissible written direct testimony was submitted "***and*** a party desires to cross-examine a witness or witnesses." *Id*. (emphasis added). Neither party raised any objection to this process or requested an exception.

CMS identified as its one witness Mr. Lash, the Palmetto Operations Analyst. Petitioner identified four witnesses, consisting of himself, the other ADO physician practitioner appealing an effective date determination, and three ADO employees. Petitioner did not provide the written direct testimony of any of his proposed witnesses, although he did submit his letter stating that he signed his enrollment application in July 2009. As discussed above, I view this letter (and a similar letter from the other physician practitioner) as a proffer of testimony.[5] However, since neither party requested the

[5] The combined brief on behalf of Petitioner and the other physician practitioner does not indicate whether the other physician would testify on Petitioner's behalf, or only in her own appeal.

opportunity to cross-examine each other's named witnesses, I find no need or purpose to convene an in-person hearing. I therefore proceed to consider the merits of the case based on the written record before me.

b. The record does not support an earlier effective date.

For the reasons explained below, I find that the unrebutted evidence establishes that the package Palmetto received from ADO on July 30, 2009, with the certified mail receipt Petitioner says accompanied his application, did not contain any application to enroll Petitioner. Although Petitioner may have intended that his application (i.e., forms CMS 855I and 855R) be submitted at that time, the evidence establishes that what ADO submitted under that certified mail receipt was a form used to update its own enrollment information (CMS 855B) that did not concern Petitioner's enrollment. The evidence also establishes that Palmetto did not receive an application to enroll Petitioner in July or August 2009, the period in which Palmetto would have received an application mailed in July 2009, when Petitioner asserts his was mailed, and, moreover, that Palmetto did receive his approved application on October 21, 2009. Indeed, Petitioner now concedes that the certified mail receipt was for a submission that did not contain his application, and that he cannot demonstrate that Palmetto received his application at any time prior to October 21, 2009.

As stated above, CMS may permit Petitioner to bill Medicare beginning 30 days prior to the effective date of his enrollment, which is set as "the date of filing" (i.e., the date of receipt) of an enrollment application "that was subsequently approved" by Palmetto (or the date he first began furnishing services at a new practice location, if later, which was not the case here). 42 C.F.R. §§ 424.521(a), 424.520(d); 73 Fed. Reg. at 69,769. I note that this language could be interpreted to mean either the date the contractor received the actual application it later approved, or the date it first received a complete application that it later approved, even if duplicate copies of the application had to be submitted in the interim. *See* 73 Fed. Reg. at 69,769 (date of filing is date contractor received an application it "is able to process to approval"); *Tri-Valley Family Medicine, Inc.*, DAB CR2179, at 10-11 (2010) (regulatory language susceptible of either interpretation). Based on the evidence showing that Palmetto did not receive Petitioner's complete, approvable enrollment application prior to October 21, 2009, I conclude that, under either interpretation, there was no error in Palmetto's determination of the effective date.

In making these findings, I give great credence to the declaration of Mr. Lash, the Palmetto Operations Analyst. Mr. Lash provided a detailed and unrebutted explanation of Palmetto's procedures for processing and tracking incoming mail. CMS Ex. 1 (Lash decl.). I find that his explanation convincingly supports my findings above. Accordingly, I quote from his declaration at length.

Mr. Lash stated that Palmetto mail room workers "open each envelope received in the mailroom" and "manually stamp the first page of each document contained in the envelope with the last digit of the year and the day of year on which the document was received, and with the clerk number of the mail room clerk who opens and scans the item." *Id.* at 2. Mr. Lash used as an example a CMS-855B application that Palmetto received from ADO on July 30, 2009, which CMS submitted as its Exhibit 2.[6] The first page of this exhibit bears, at the bottom, the stamped number 9211-673. CMS Ex. 2, at 1. As explained in the declaration, "'9' means the year 2009. 211 means the 211th day of the year, or July 30 . . . . Finally, 673 means it was scanned by clerk 673 . . . ." *Id*; CMS Ex. 1, at 2. After the first page of each document in an envelope is manually stamped--

> [t]he mail room worker then scans each document contained in a given envelope with an image scanner. The image scanner automatically assigns each document a Document Control Number (DCN) and places it into Palmetto's workflow system (called iFlow) as an item to be indexed. Each item contained in a given envelope receives its own DCN. The DCN is a unique 14-digit number that appears at the top of each page of the item. The year and day of year Palmetto received the document also appears at the top of the image of each page, along with the page number, with the first page typically being P000. For example, with respect to CMS Ex. 2, page 1 [the CMS 855B from ADO], the unique 14-digit DCN that appears of the top of the page is 09215303100019. Also at the top of the page is 09211 (the year and day of year on which the document was received) and P000 to indicate that it is the first page of the document.

CMS Ex. 1, at 2-3. Mr. Lash also stated that a scanned image of the envelope in which a submission arrives "typically becomes either the first or last page of the image of the item contained in the envelope." *Id*. at 3. "When multiple items are contained in a single envelope," he explained, "the envelope is scanned one time only, and included as an image with only one of the items contained in that envelope." *Id.* The absence of an image of an envelope with a particular item "means that the provider sent more than one item that day and an image of the envelope is included with another item that was sent on that day." *Id*.

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[6] The CMS 855B application is used by "[s]upplier groups and supplier organizations [to] apply for Medicare enrollment" and "is not used to enroll individuals." CMS Medicare Program Integrity Manual, ch. 15, §§ 15.1.2, 15.3. The form CMS 855B that Mr. Lash stated Palmetto received from ADO on July 30, 2009 "sought to delete one practice address and to add another practice address." CMS Ex. 1, at 5. Mr. Lash reported that Palmetto processed this change by letter to ADO dated September 23, 2009. *Id*.; CMS Ex. 3 (Palmetto letter to ADO Sept. 23, 2009).

I note that, consistent with Mr. Lash's declaration, the form CMS 855B from ADO that CMS submitted as its Exhibit 2 indeed bears at the top of the first page the inscription "09215303100019 09211 P000" and that subsequent pages bear consecutive page numbers P001 through P046, with page P046 being an image of an envelope from ADO addressed to Palmetto in Columbus, Ohio, bearing the metered postmark date July 28, 2009. CMS Ex. 2, at 1-47. The envelope was sent by certified mail, return receipt requested, and bears certified mail tracking number 7009 0820 0000 3157 7973. *Id*. at 47. As CMS notes, this is the same certified mail tracking number as appears on the return receipt card that Petitioner submitted with the request for hearing and which, according to the request for hearing, accompanied the package that included his enrollment application form CMS 855I. RH at 1; CMS Br. at 6; CMS Ex. 18, at 8 (receipt card).

Mr. Lash further stated that after an item is received, stamped, and scanned--

> the mail room worker enters the iFlow system and keys in the DCN and provider name associated with each item. When the mail room worker finishes keying in the item in iFlow, the image of each item is placed into the Prescreen phase. . . . A provider enrollment worker . . . then opens each image in the Presceen phase, keys the information associated with it (DCN, date received, provider name, etc.) into the tracking system (called Proven Track) and assigns it to an enrollment analyst for processing. Typically, the provider enrollment worker assigns documents involving the same provider to the same enrollment analyst. Items involving the same provider names are manually linked together in the Proven Track system.

CMS Ex. 1, at 3-4. The scanned images of items received, he reported, can be searched for by provider name or date received. *Id*. at 3.

Based on this background information, Mr. Lash explained how he determined that no other documents besides the CMS 855B for ADO were contained in the envelope received on July 30, 2009, and, further, that no applications on behalf of Petitioner were received in July or August 2009 (which, as noted above, was when Palmetto would presumably have received Petitioner's application if it had been mailed on July 27, 2009, as Petitioner asserts). Mr. Lash stated:

> On April 16, 2010, I entered the Proven Track system to search for any items received from [ADO] on July 30, 2009. . . the only item received from [ADO] on July 30, 2009 is marked as CMS Ex. 2. That item is a 46-page CMS-855B application . . . the item was assigned DCN 09215303100019. . . . No other items were imaged or documented as having been received from [ADO] on July 30, 2009. Specifically, no CMS-855I or CMS-855R applications relating to [Petitioner or the other physician practitioner] were imaged or documented as being received by

> Palmetto on July 30, 2009. **I also confirmed that, aside from the CMS-855B application, Palmetto did not receive any items from either [ADO] or Doctors Pain Center, LLC during July 2009 and August 2009. I also confirmed that Palmetto did not receive any items relating to [Petitioner or the other physician practitioner] in July 2009 or August 2009.**

Id. at 4 (emphasis added).

As to Petitioner's enrollment, Mr. Lash stated that, "[o]n October 21, 2009, Palmetto received three applications for [Petitioner] from [ADO] and Doctors Pain Center, LLC." *Id*. at 6-7. These applications comprised "a CMS-855I application to enroll [Petitioner] in the Medicare program . . . a CMS-855R application to enroll [Petitioner] as a supplier for Doctors Pain Center, LLC . . . [and] a CMS-855R application to enroll [Petitioner] as a supplier for [ADO]." *Id*. citing CMS Exs. 9, 11, 13 (CMS 855I and two CMS 855Rs for Petitioner, plus scan of envelope). The three documents were assigned consecutive DCNs (09299303100021, 09299303100022, 09299303100023, respectively) and each "was stamped 9294, indicating that it was received in 2009 on the 294th day of the year (October 21)." *Id*. at 7-8. Palmetto processed the CMS 855I for Petitioner and the CMS 855R to enroll Petitioner as a supplier for ADO and Petitioner "received an effective date of September 21, 2009." *Id*. at 8, citing CMS Ex. 10 (Palmetto letter Nov. 4, 2009 to ADO stating that Petitioner had been "added to the roster" of ADO effective September 21, 2009 and was approved to bill the Medicare program under his NPI). The CMS 855R to enroll Petitioner as a supplier for Doctors Pain Center, LLC was returned "for failure to date his signature in section 4A." *Id*. at 7, citing CMS Ex. 12 (Palmetto letter Oct. 28, 2009 to Doctors Pain Center, LLC).[7]

Notably, Mr. Lash stated that the envelope Palmetto received from ADO on July 30, 2009 containing the CMS 855B for ADO shows postage of $7.34. CMS Ex. 1, at 4-5, citing CMS Ex. 2, at 47 (envelope). The envelope Palmetto received from ADO on October 21, 2009, containing the three applications for Petitioner, shows postage of $7.85. CMS Ex. 1, at 8, citing CMS Ex. 13, at 17. This difference in postage supports Mr. Lash's report that the later submission consisted of more documents (three applications totaling 34, 5 and 16 pages, respectively) than the earlier submission (one application totaling 46 pages). CMS Ex. 1, at 4, 6-8, citing CMS Exs. 9, 11, 13. This is consistent with my finding that the package received July 30, 2009 did not contain an application for Petitioner.

[7] Petitioner's request for hearing did not address the application to enroll as a supplier for Doctors Pain Center, LLC.

I also note that of the three applications for Petitioner that Mr. Lash reported were received on October 21, 2009, only the last one (DCN 09299303100023) contains a scan of an envelope. CMS Ex. 13. The presence of one envelope in three items with consecutive DCNs is consistent with Mr. Lash's statement that the envelope received on October 9, 2009 contained the three applications that ADO submitted for Petitioner. The applications that CMS submitted as exhibits are also consistent with the descriptions in Mr. Lash's declaration. I find that the information in Mr. Lash's declaration and CMS's exhibits convincingly establishes that the package ADO sent to Palmetto by certified mail that Palmetto received on July 30, 2009 did not contain any enrollment applications for Petitioner.

Finally, in Petitioner's response to CMS's motion for summary affirmance, Petitioner appears to have abandoned the assertion that the package sent with the certified mail receipt dated July 20, 2009 contained his enrollment application. He states instead that "[t]he original certified mail tracking number we had originally thought belonged to the July applications was incorrect" and that the certified mail tracking number on the receipt belonged to another submission, which Petitioner states was "another application we had sent during the same time period." P. Br. at 2. Presumably, Petitioner here refers to the CMS-855B for ADO (but not Petitioner) that Palmetto received on July 30, 2009. Petitioner concedes that "ADO cannot prove Palmetto CMS received the original applications with the July 24, 2009 signature due to administrative clerical errors on our part." *Id*. As discussed, a supplier's effective date is conditioned upon the contractor's receipt of the supplier's enrollment application. In light of the acknowledged absence of any evidence that Palmetto actually received an approvable application on behalf of Petitioner at any time prior to October 21, 2009, and in light of CMS's evidence that Palmetto received no such application during July or August 2009, I have no choice but to sustain CMS's and Palmetto's determination of Petitioner's effective date. Petitioner's statement that he signed an original form CMS 855I in July 2009 and duplicates in July and "September/October 2009," which CMS does not dispute, does not establish that Palmetto actually received any such application prior to October 21, 2009.

c. Petitioner's equitable arguments provide no basis to set an earlier effective date.

Petitioner states that he has over $94,000 of unbilled charges with ADO for patient visits prior to his billing date and that the resulting lack of funds has resulted in "severe hardship" for ADO. P. Br. at 3-4. He also states that ADO was not aware of the changes to the enrollment regulations that reduced the available period for retrospective billing for physician suppliers from up to 27 months to 30 days, the period granted him. Petitioner complains that monthly Medicare Advisories for Ohio and West Virginia providers during the period November 2008 through April 2009 failed to mention this change. *Id*. at 3, citing P. Ex. VII ("Medicare Advisory" tables of contents).

Previous regulations no longer in effect did authorize CMS to grant physician suppliers up to 27 months of retroactive billing privileges; however, the current regulations, which became effective January 1, 2009, removed that provision and the authority it provided. 73 Fed. Reg. at 69,940. The availability of the former, lengthier period for retrospective billing meant that issues relating to the effective dates of supplier enrollments and billing privileges were unlikely to arise in appeals such as this. With the shorter time frame for retrospective billing, the applicable effective date has obviously become more important.

The current regulations at section 424.520(d) and 424.521(a) that establish effective dates and limit retrospective billing, however, are binding on me. I can neither alter nor deviate from their explicit limitation on Petitioner's ability to bill for services to 30 days prior to the date that Palmetto received his approved application. Even if Petitioner could show that he received erroneous advice on retrospective billing, 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.*, *Pac. Islander Council of Leaders*, DAB No. 2091, at 12 (2007); *Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414, 421 (1990). While I understand Petitioner's confusion over what he perceives as an unanticipated change in the way Medicare had done business, I have no authority to extend the retroactive billing period for Petitioner in a manner contrary to the regulations. 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.[8]

[8] CMS did not seek an opportunity to respond to Petitioner's brief and thus did not address Petitioner's claim that Medicare publications failed to provide adequate notice of the reduction in the available period of retrospective billing. I note, however, that as a Medicare supplier, Petitioner was charged with knowing, and had constructive notice of, the requirements for billing for services. *See Waterfront Terrace, Inc.*, DAB No. 2320, at 7 (2010), citing *Heckler v. Cmty. Health Servs. of Crawford County*, 467 U.S. 51, 64 (1984) ("As a participant in the Medicare program, respondent had a duty to familiarize itself with the legal requirements" of the program.); *see also Manor of Wayne Skilled Nursing & Rehab.*, DAB No. 2249, at 10-11 (2009) and *Regency on the Lake*, DAB No. 2205, at 5-6 (2008) ([F]acilities participating in Medicare had constructive notice of regulations.).

IV. Conclusion

The evidence provides no basis to find that an approvable application for Petitioner's enrollment was received prior to October 21, 2009. I therefore sustain the determination of the effective date of Petitioner's enrollment and the grant of retrospective billing privileges.

/s/
Leslie A. Sussan
Board Member