Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Rizwan Sadiq, M.D.,

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-11-256

Decision No. CR2401

Date: July 19, 2011

DECISION

Dr. Rizwan Sadiq (Petitioner) appeals the determination of Trailblazer Health Enterprises (Trailblazer), a Medicare contractor, that he was not eligible for enrollment in the Medicare program as a supplier[1] earlier than August 23, 2010 and could not submit retrospective claims for payment earlier than July 25, 2010. I grant the Centers for Medicare and Medicaid Services' (CMS's) motion for summary judgment finding that Petitioner's effective date of enrollment was August 23, 2010, with a retroactive billing period starting on July 25, 2010.

I. Background

Petitioner became licensed to practice in Virginia on February 11, 2010 and joined a practice group, Medics USA, on May 1, 2010. CMS Exs. 1-2. On June 1, 2010, through Medics USA, Petitioner submitted a Medicare enrollment application for reassignment,

[1] The Medicare statute defines "supplier" to mean "a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services" under the Medicare statute. Social Security Act § 1861(d), 42 U.S.C. § 1395x(d).

form CMS-855R, to Trailblazer. CMS Ex. 3. On June 3, 2010, Trailblazer acknowledged receipt of the June 1, 2010 application for reassignment. *Id.* However, Petitioner was not previously enrolled in Medicare to provide services to Medicare beneficiaries, and Petitioner did not submit the required initial enrollment application form, CMS-855I. Therefore, on August 3, 2010, Trailblazer returned Petitioner's reassignment application. CMS Brief at 2. On August 23, 2010, Trailblazer received both a CMS-855I enrollment form and a CMS-855R reassignment form to enroll Petitioner into the Medicare program and to reassign his benefits to Medics USA. CMS Ex. 4. Trailblazer processed and approved these applications and informed Petitioner of his approval by letter dated September 20, 2010. CMS Ex. 5. Trailblazer granted Petitioner an effective date of July 25, 2010,[2] thirty days before August 23, 2010, the date of receipt of his application that was processed to approval. *Id.*

Petitioner requested reconsideration review. CMS Ex. 6. Trailblazer informed Petitioner that he did not provide evidence to show justification for Trailblazer to change his effective date for Medicare enrollment. CMS Ex. 8, at 2. On February 7, 2011, Petitioner filed a hearing request with the Civil Remedies Division of the Departmental Appeals Board. An Acknowledgment and Pre-hearing Order was sent to the parties on February 14, 2011. On March 21, 2011, CMS filed a Motion for Summary Judgment and brief (CMS Br.), accompanied by 10 proposed exhibits (CMS Ex. 1-10). On May 5, 2011, Petitioner filed his response (P. Response). Absent any objection, I admit all proposed exhibits into evidence.

II. General Authority

The Social Security Act (Act) authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations governing the enrollment process for providers and suppliers. Act §§ 1102, 1866(j); 42 U.S.C. §§ 1302, 1395cc(j). Under the Secretary's regulations, a provider or supplier that seeks billing privileges under Medicare 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).
A "provider or supplier must submit a complete enrollment application and supporting documentation to the designated Medicare fee-for-service contractor," and that the application include "complete . . . responses to all information requested within each section as applicable to the provider or supplier type." 42 C.F.R. § 424.510(d)(1)-(2).

[2] I disagree with Trailblazer's characterization of July 25, 2010 as the "effective date," rather than the "retrospective billing date," as I explain later in my analysis.

The effective date of enrollment for physicians is set as follows:

> The effective date for billing privileges for physicians . . . and physician . . . 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 . . . first began furnishing services at a new practice location.

42 C.F.R. § 424.520(d). In addition, CMS permits limited retrospective billing as follows:

> Physicians . . . and physician . . . organizations may retrospectively bill for services when a physician or . . . a physician . . . organization have met all program requirements, including State licensure requirements, and services were provided at the enrolled practice location for up to—
> (1) 30 days prior to their effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries, or
> (2) 90 days [in certain emergencies.]

42 C.F.R. § 424.521(a).

III. Issue

The issue in this case is whether CMS had a legitimate basis for determining August 23, 2010 as the effective date for Petitioner's Medicare enrollment and billing privileges.

IV. Analysis

My findings of fact and conclusions of law are set forth in italics and bold in the discussion captions of this decision.

a. This case is appropriate for summary judgment.

CMS argues that it is entitled to summary judgment. The Appellate Division of the Departmental Appeals Board (Board) explained 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). An Administrative Law Judge's (ALJ's) role in deciding a summary judgment motion differs from its 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, Inc*, DAB No. 2291 at 5 (2009). The Board has further stated, "[i]n addition, it is appropriate for the tribunal to consider whether a rational trier of fact could regard the parties' presentation as sufficient to meet their evidentiary burden under the relevant substantive law." *Dumas Nursing and Rehab., L.P.*, DAB No. 2347, at 5 (2010).

CMS argues that it is entitled to summary judgment because there "are no material facts in dispute." CMS Br. at 9. Petitioner's filings are limited to his hearing request and his May 5, 2011 Response. In his Response, Petitioner's representative states:

> [W]e would like to contest CMS's argument . . . . We believe that. . . our former employee that processed the application—was aware that we need to do an initial enrollment application for Dr. Sadiq . . . . We believe that [she] knew specifically that we needed to apply for him for initial enrollment. It is very likely that she simply confused the forms precisely because CMS representatives typically have confusing, contradicting and often erroneous answers over the phone.
>
> [She] is no longer working for Medics USA and we cannot involve her in this at this time, however, we strongly believe that [she] asked CMS over the telephone which form we needed to fill out for initial enrollment, and was told, erroneously, that it was form CMS-855R (the form for reassignment).
>
> Based on these facts—that we knew we needed to apply for Dr. Sadiq for initial enrollment, that we did this in a timely manner, and that we provided the services in good faith that we will be compensated by Medicare, we hereby petition that the enrollment date for Dr. Sadiq be moved . . . .

Even if I make the inference, in the light most favorable to Petitioner, that CMS provided erroneous information, Petitioner's evidence does not place in dispute any fact material to the resolution of the case. Therefore, summary judgment is appropriate here.

b. Trailblazer's receipt of Petitioner's complete enrollment application necessarily determines his effective date and retrospective billing privileges.

Agency policy requires a physician to submit a completed enrollment application form, CMS-855I, in order to participate in the Medicare program as a supplier. *See, e.g.*, CMS Ex. 10, at 1, 7, 9. On June 1, 2010, Petitioner only submitted form CMS-855R, a reassignment form, even though he was not yet enrolled in the Medicare program. CMS Ex. 3. The general instructions on form CMS-855R specifically explain that a form CMS-855I is required for practitioners who are not currently enrolled. CMS Ex. 10, at 13. The Medicare Program Integrity Manual (MPIM), CMS's guidance for affiliated contractors, similarly states:

> A CMS-855R application must be completed for any individual who will: (1) reassign his/her benefits to an eligible entity, or (2) terminate an existing reassignment.
>
> *If the individual who wants to reassign his or her benefits is not enrolled in Medicare, the person must complete a CMS-855I as well as the CMS-855R.* (The CMS-855I and CMS-855R can be submitted concurrently.) Moreover, if the entity to which the person's benefits will be reassigned is not enrolled in Medicare, the organization must complete a CMS-855B.

MPIM, Chapter 10, § 4.20 (emphasis added).

On August 3, 2010, Trailblazer properly returned Petitioner's reassignment application because Petitioner had failed to submit the enrollment application form, CMS-855I, along with the reassignment application form. It is undisputed that, on August 23, 2010, Trailblazer received both a CMS-855I form and a CMS-855R form to enroll Petitioner into the Medicare program and to reassign his benefits to the Medics USA. Trailblazer subsequently approved the applications.

The effective date for enrollment for physicians, among others, 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 . . . first began furnishing services at a new practice location." 42 C.F.R. § 424.520(d) (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.* 69,725, 69,769 (Nov. 19, 2008). It is undisputed that Trailblazer did not receive a signed, complete, and approvable enrollment application CMS-855I before August 23, 2010.

Trailblazer erroneously characterized July 25, 2010 as Petitioner's "effective date," rather than Petitioner's retrospective billing date (CMS Ex. 5). Regulations require the

contractor to assign the date of receipt of the application as the effective date of Petitioner's enrollment while permitting the contractor to grant retrospective billing privileges for 30 days prior to the effective date. 42 C.F.R. § 424.521(a)(1). Thus, I am treating Trailblazer's action as if it intended to set July 25, 2010 as the earliest date for which Petitioner may submit retrospective claims, with the effective date of Petitioner's enrollment as August 23, 2010.

Petitioner argues that CMS instructions over the telephone were confusing, that CMS agents erroneously told a former employee to file the wrong form for Dr. Sadiq, and that Petitioner provided services to Medicare beneficiaries for which he should be compensated. CMS Ex. 6. Even assuming Petitioner accurately described what transpired during the former employee's telephone conversations with CMS, Petitioner does not allege any affirmative misconduct, and I am unable to grant the relief that Petitioner requests. Petitioner's argument amounts to a claim of equitable estoppel. It is well-established by federal case law, and in Board precedent, that: (1) estoppel cannot be the basis to require payment of funds from the federal fisc; (2) estoppel cannot lie against the government, if at all, absent a showing of affirmative misconduct, such as fraud; and (3) I am not authorized to order payment contrary to law based on equitable grounds. It is well settled that those who deal with the government are expected to know the law and may not rely on the conduct of government agents contrary to law. *See, e.g., Office of Personnel Mgmt. v. Richmond*, 496 U.S. 414 (1990); *Heckler v. Cmty. Health Servs. of Crawford County, Inc.*, 467 U.S. 51 (1984); *Oklahoma Heart Hosp.*, DAB No. 2183, at 16 (2008); *Wade Pediatrics*, DAB No. 2153, at 22 n.9 (2008), *aff'd*, 567 F.3d 1202 (10th Cir. 2009).

V. Conclusion

Based on the undisputed fact that Trailblazer did not receive a complete enrollment application that it could process from Petitioner until August 23, 2010, I conclude that Petitioner's effective date of enrollment was August 23, 2010 with a retroactive billing period starting on July 25, 2010. Therefore, I grant CMS's motion for summary judgment.

/s/
Joseph Grow
Administrative Law Judge