Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Joseph Michaels V, M.D.,

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-11-632

Decision No. CR2473

Date: December 9, 2011

DECISION

I find that the Centers for Medicare and Medicaid Services (CMS) and its contractor, Highmark Medicare Services (Highmark), incorrectly assigned Petitioner, Joseph Michaels V, M.D., a retrospective Medicare billing date of September 4, 2010. I find that the status that Petitioner had as a Medicare participating provider continued from the date he established his new practice, August 1, 2010, and on subsequent dates. Therefore, Petitioner is entitled to claim reimbursement for services that he provided between August 1 and September 4, 2010.

I. Background

Petitioner is a physician who participates in the Medicare program. On February 3, 2011, Highmark informed Petitioner that he had been accepted to participate in Medicare effective September 14, 2010.[1] Petitioner, dissatisfied with that determination, requested reconsideration. The determination was affirmed on reconsideration, and Petitioner requested a hearing. The case was assigned to me for a hearing and a decision.

[1] Apparently, the contractor meant to tell Petitioner that his retrospective billing date was September 4, and not September 14, 2010.

I directed the parties to exchange proposed exhibits and briefs. CMS filed a brief and five proposed exhibits that are identified as CMS Exhibit (Ex.) 1 - CMS Ex. 5 on August 25, 2011. Petitioner replied to this brief on October 21, 2011 and filed six proposed exhibits of its own that are identified as P. Ex. 1 – P. Ex. 6.

I reviewed the parties' briefs and concluded that CMS had not explained its position coherently. Consequently, I ordered CMS to re-brief its arguments. Order Directing Centers for Medicare and Medicaid Services to File Additional Brief (Oct. 31, 2011). CMS filed a new brief on November 16, 2011. Petitioner filed a reply to CMS's new brief on December 6, 2011. Petitioner also filed five additional exhibits identified as P. Ex. 1 – P. Ex. 5.

I receive CMS Ex. 1 – CMS Ex. 5 and P. Ex. 1 – P. Ex. 6 into the record. I also receive the five exhibits Petitioner filed on December 6, 2011, which I have renumbered as P. Ex. 7 – P. Ex. 11 into the record. I note that CMS re-filed its exhibits with its second brief. However, these are identical to its initial exhibit proffer, and, thus, I need not admit the second set of exhibits in addition to the first set.

II. Issue, Findings of Fact, and Conclusions of Law

A. Issue

The issue is whether Petitioner's effective date of participation should be September 4, 2010, as CMS contends, or whether Petitioner's status as a participating Medicare provider was unaffected by his change of employment and opening a new practice location.

B. Findings of Fact and Conclusions of Law

The material facts of this case are undisputed. Petitioner participated in the Medicare program prior to August 1, 2010 as an employee of another physician to whom Petitioner had assigned his Medicare benefits. In July 2010, Petitioner decided to separate his practice from that of his former employer. Effective August 1, 2010 Petitioner began seeing patients under a new practice arrangement and at a new office location.

CMS contends that Petitioner was obligated not only to report his change of employment and practice location but that Petitioner was required to file a new application to enroll in the Medicare program by virtue of that employment and practice location change. CMS asserts that Petitioner was obligated to apply to participate in Medicare by filing a Form CMS 855I with Highmark. Petitioner

filed that form on October 4, 2010. CMS argues that, based on the filing date, the earliest retrospective billing date that the contractor, and CMS, could have assigned to Petitioner was September 4, 2010. That was the date that was assigned to Petitioner, and, consequently, CMS contends that he may not be assigned an earlier retrospective billing date.

CMS premises its case on two contentions. First, it contends that, as a matter of law, Petitioner was required to file a new enrollment application, consisting of a CMS Form 855I, with Highmark to enroll in the Medicare program. CMS asserts that Petitioner incurred this obligation when he left his previous employment and opened a new practice. According to CMS, there was no other mechanism available by which Petitioner could have attained the status of an enrolled physician.

Second, CMS relies on the language of two regulations, 42 C.F.R. §§ 424.520(d) and 424.521. Section 520(d) states that the effective date for billing privileges for a Medicare-participating physician will be the later of the following dates: the date that the physician files a Medicare enrollment application that is subsequently approved by a Medicare contractor; or the date when the physician first begins furnishing services at a new practice location. Section 521 states, in relevant part, that a physician may claim reimbursement for services provided up to 30 days prior to the date when the physician first meets all program requirements.

CMS argues that Petitioner filed an application that was approved by Highmark effective October 4, 2010, the date when he filed the CMS Form 855I. Thus, according to CMS, Petitioner may not – as a matter of law – claim reimbursement for any services that he provided prior to September 4, 2010.

The problem with CMS's argument – that I pointed out in my October 31, 2011 order – is that Petitioner *already was* enrolled in the Medicare program on October 4, 2010. The undisputed facts are that Petitioner enrolled in the Medicare program in 2009 and was accepted as a participating provider at that time. CMS has offered no explanation for its assertion that Petitioner had to reapply to participate in Medicare when he severed his relationship with his former employer and opened a new practice. It has cited to no law, no regulation, and no policy document whatsoever supporting that argument. In my October 31, 2011 order, I pointed out to CMS that it had not provided me with any legal authority for its assertion, and I directed it to do so. CMS, in its November 16, 2011 brief, filed in response to my October 31 order, simply states baldly that Petitioner was required to file the CMS Form 855I so that his new practice could be reimbursed by Medicare. Again, it has provided me with no legal authority of any kind to support this argument.

I have given CMS two opportunities to explain why Petitioner had to reapply to participate in Medicare and file a CMS Form 855I to inform the contractor of his status as a provider. CMS failed to provide me with anything, and I am unwilling to accept its naked assertion without some legal authority to support it.

Moreover, the regulations do not appear to support CMS's argument. A provider or supplier who seeks to participate in Medicare must be enrolled in the program. 42 C.F.R. § 424.505. That provider must submit his or her application on the "applicable enrollment application." 42 C.F.R. § 424.510(a). There is no exception to these requirements, and CMS clearly has the authority to determine what form of application a provider must complete to enroll in Medicare. Thus, a provider seeking for the first time to enroll must file an appropriate form with the contractor, and CMS has created the CMS Form 855I for that purpose.

But, there is nothing in the regulations to suggest that Petitioner, when he changed his employment, reverted to the status of an unenrolled provider who sought to participate in Medicare. The undisputed facts are that Petitioner *was enrolled in Medicare as a participating provider* on all applicable dates, including August 1, 2010 and thereafter. There is nothing in the regulations that suggests that Petitioner was required to submit an entirely new application for enrollment when he changed his employment status and practice location.

Clearly, Petitioner's status changed as of August 1, 2010. He was no longer an employee of his former employer, and he opened a new practice location effective August 1. Medicare regulations provide that Petitioner was required to inform Highmark of that change in his employment status and practice location. A participating physician must report a change of ownership of his or her practice and a change of practice location within 30 days of the event. 42 C.F.R. § 424.516(d).

There is nothing in this regulation that specifies the form that a provider must use to satisfy the regulatory requirements. There is nothing, for example, that precludes a provider from filing that information with the contractor by letter or even by phone. CMS has not argued that there is a specific form that is required to communicate the information required by 42 C.F.R. § 424.516(d). Indeed, CMS did not discuss the requirement at all, in either of its two briefs, despite my specific request that it explain its position as to this issue.

In the absence of any argument or explanation from CMS, one could reasonably interpret the regulation as not affecting a provider's effective date of participation. This regulation appears on its face to apply to those providers who are already enrolled in Medicare. It says that a provider who already enrolled must keep the

contractor apprised of certain information. It does not suggest that filing that information will establish a new effective Medicare participation date.

Petitioner's October 4, 2010 filing with Highmark apparently was intended by him to satisfy these regulatory requirements. On that date, he filed a CMS Form 855I containing information concerning his new employment status and practice location. It is, however, totally unclear why Petitioner opted to use this particular form for that purpose. It also appears that Petitioner's submission was untimely in that he provided Highmark with information that he should have filed by the end of August, 2010. However, the regulations do not suggest that a provider who fails to timely report a change in certain information will automatically be disenrolled from participation in Medicare, and CMS has not made that argument. Thus, and absent any argument from CMS as to the effect of an untimely filing by Petitioner, I cannot conclude that Petitioner's October 4, 2010 filing should be used to establish a "new" participation status as opposed to the one that he previously occupied.

/s/
Steven T. Kessel
Administrative Law Judge