Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Diane Kennedy, M.D.,

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-12-145

Decision No. CR2534

Date: May 3, 2012

DECISION

Dr. Diane Kennedy (Petitioner) appeals the determination of Wisconsin Physicians Service Insurance Corporation (WPS), a Medicare contractor, that she was not eligible to reassign her billing privileges as a supplier[1] to Sanford Health Network (Sanford), earlier than April 29, 2011 and could not submit claims for payment to Sanford earlier than March 30, 2011. I grant the Centers for Medicare & Medicaid Services' (CMS's) motion for summary judgment, finding that CMS could not approve Petitioner's request for reassignment of billing privileges until it received the appropriate completed application with Petitioner's signature.

I. Background

On December 22, 2010, Sanford mailed a CMS 855B application to WPS indicating that it was adding two practice locations at Luverne and Worthington, Minnesota, to the

[1] A physician is a Medicare "supplier," which is defined in the Medicare statute 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. Act § 1861(d), 42 U.S.C. § 1395x(d).

Sanford Health Network. Sanford also requested that WPS reassign Petitioner's billing privileges from Sanford Clinic, an affiliate, to Sanford effective December 1, 2010. With its request, Sanford submitted a list of the names of the suppliers whose billings it wanted reassigned. CMS Exhibit (CMS Ex.) 1, at 19. This list included Petitioner's name. However, Petitioner had not reassigned her billing privileges by completing the requisite application, a signed CMS 855R.

On April 19, 2011, WPS advised Sanford that its CMS 855B application adding the two practice locations had been approved. CMS Ex. 3. Also on April 19, 2011, WPS informed Sanford that it could not issue a new Provider Transaction Access Number (PTAN) for Petitioner without first receiving a completed CMS 855R. CMS Ex. 2. Sanford eventually submitted a completed CMS 855R, signed by Petitioner, on April 29, 2011. CMS Exs. 4, 5. On July 20, 2011, WPS informed Sanford that it was granting Petitioner Medicare billing privileges starting March 30, 2011, thirty days before April 29, 2011, the date of receipt of her CMS 855R application that was processed to approval. CMS Ex. 6.

Sanford requested reconsideration of WPS's determination on July 25, 2011. CMS Ex. 7. An unfavorable reconsideration decision was issued on October 6, 2011. CMS Ex. 8. Petitioner filed a timely hearing request on November 9, 2011. On November 29, 2011, this case was assigned to me for hearing and decision.

CMS filed a prehearing brief and Motion for Summary Judgment (CMS Br.) accompanied by eight exhibits, CMS Exs. 1-8. Petitioner filed a prehearing brief and opposition to CMS's Motion for Summary Judgment (P. Br.). Petitioner attached two items to its brief, emails to and from WPS, which Petitioner labeled as P. Ex. 9, but which I relabel as Petitioner's exhibit (P. Ex.) 1, and an unlabeled affidavit which I now label as P. Ex. 2. Neither party objected to any exhibit, and I admit all proffered exhibits into evidence.

II. Issue

The issue in this case is whether CMS had a legitimate basis for determining April 29, 2011 as the effective date of reassignment for Petitioner's Medicare billing privileges.[2]

[2] Petitioner only argues here about the ability to get reimbursed from Medicare under a third-party group reassignment. This decision does not consider Petitioner's eligibility for any individual direct-billing option that may have applied.

III. 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 seeks summary judgment. The Departmental Appeals Board (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 Administrative Law Judge (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*, DAB No. 2291, at 4-5 (2009).

It is undisputed that Sanford's December 22, 2010 CMS 855B application had a list attached to it that stated, "Please issue the following providers new PTAN numbers under group PTAN number C03080 effective 12/1/2010." Under this statement was a list of 10 individuals, including Petitioner, with their social security and National Provider Identifier (NPI) numbers. The vice president of Sanford signed his name below this list. CMS Ex. 1, at 19. Petitioner's signature does not appear on the December 22, 2010 application or the attached list. *Id*. It is also undisputed that Petitioner had not previously completed a reassignment application, CMS 855R, for Sanford's Luverne and Worthington locations prior to April 29, 2011 under Sanford's tax identification number. CMS Ex. 7. As the parties do not dispute any of these material facts, summary judgment is appropriate.

b. WPS properly required a completed CMS 855R application with Petitioner's signature before beginning the reassignment process.

Petitioner argues that Sanford's December 22, 2010 CMS 855B application should have been broadly construed and treated also as Petitioner's CMS 855R application. Petitioner states Stanford received inaccurate information from WPS staff when it inquired how to reassign Petitioner's billing privileges and was told to attach Petitioner's name with identifying information on a list, along with other individuals whose billing it wanted reassigned to Sanford's new business entity. November 19, 2011 Hearing Request; P. Ex. 2. The CMS 855B form is the Medicare enrollment application for group practices and not used to enroll individuals. The CMS 855R form is the Medicare enrollment application to reassign a physician's Medicare billing privileges. Providers and suppliers must submit enrollment information on the applicable enrollment application. 42 C.F.R. § 424.510. These forms serve different functions and require different information. One essential feature of each of these forms is that each form requires a signature of the applicant. A contractor must receive a CMS 855R form, including the provider or supplier's signature, before it can approve a reassignment of Medicare billing privileges. The 855B form may not substitute for the proper reassignment application. *See Crawford M. Barnett, M.D.*, DAB CR 2233, at 9 (2010).

42 C.F.R. § 424.510(d)(3) requires signature(s) on enrollment applications and states that the "signature attests that the information submitted is accurate and that the provider or supplier is aware of, and abides by, all applicable statutes, regulations, and program instructions." The signature certification serves an important legal function to bind the supplier, both legally and financially, and is not a mere formality. *See Jennifer Tarr*, DAB CR2299, at 5 (2010).

The requirement of a signature is also set forth plainly on the reassignment form, CMS 855R:

> Title XVIII of the Social Security Act prohibits payment for services provided by an individual practitioner to be paid to another individual or supplier unless the individual practitioner who provides the services *specifically authorizes* another individual or supplier (employer, facility, or health care delivery system) to receive said payments in accordance with 42 C.F.R. 424.73 and 42 C.F.R. 424.80. By signing this Reassignment of Benefits Statement, you are authorizing the supplier identified in Section 2 to receive Medicare payments on your behalf . . . . All individual practitioners who allow another supplier (employer, facility, or health care delivery system) to receive payment for their services *must sign* the Reassignment of Benefits Statement. The *signatures below acknowledge that you will abide by all the laws and regulations pertaining to the reassignment of benefits.*

CMS Ex. 4, at 3 (emphasis added). The form states that the provider or supplier will be certifying, among other things, that the contents of the application are "true, accurate and complete." *Id.* Also, the application has the applicant certify that, "I understand that any misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws." *Id.*

The CMS 855B form that was submitted on December 22, 2010, containing different information than the 855R form, merely included Petitioner's name on an attached list without Petitioner's signature. On April 29, 2011, WPS received the correct reassignment form completed and signed by Petitioner. CMS Ex. 4. WPS properly began processing the reassignment request as of April 29, 2011 and notified Petitioner of the approval of her application and the reassignment of her billing privileges by letter dated July 20, 2011. CMS Ex. 6.

c. WPS's receipt of Petitioner's signed application necessarily determines her effective date and retrospective billing privileges.

The determination of the effective date of Medicare billing privileges is governed by 42 C.F.R. §§ 424.520 and 424.521. Section 424.520(d) provides that the effective date for billing privileges 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." (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). In this case, the effective date of Medicare billing privileges depends on the date the contractor first receives an *approvable* application. This is consistent with the preamble to the final rule and the plain language of the regulation. 73 Fed. Reg. 69,769; 42 C.F.R. § 424.520(d). Therefore Petitioner's reassignment application was not approvable until WPS received her completed and signed application. I find that it is undisputed that Petitioner did not send a signed, complete, and approvable reassignment application to WPS before April 29, 2011.

Although WPS erroneously referred to March 30, 2011 as Petitioner's "effective date" (CMS Ex. 6), regulations actually 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 WPS's action as if it intended to set March 30, 2011 as the earliest date for which Petitioner may submit claims reassigned to Sanford based on an effective date of April 29, 2011.

Sanford argues that it relied on inaccurate information from the contractor's staff and that it should not be punished for that reliance. However, even assuming for purposes of

summary judgment that Sanford did receive incorrect information from WPS, Petitioner does not allege any affirmative misconduct. Petitioner's arguments amount to claims of equitable estoppel, and I am unable to grant the relief that Petitioner requests. 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); *U.S. Ultrasound*, DAB No. 2303 at 8 (2010).

Sanford also asserts that WPS did not perform a pre-screening of Sanford's December 22, 2010 application within the 20-day time limit specified in the Medicare Program Integrity Manual (MPIM). Sanford argues that WPS should be held to the MPIM deadline. However, the prescreening process is designed to identify missing information from a particular type of application. Sanford submitted the CMS 855B form to add two practice locations to the Sanford Health Network and the prescreening was performed with that purpose in mind, not for reassignment purposes. Petitioner claims that too much time elapsed between the December 22, 2010 CMS 855B application and the contractor notice in April 2011 informing her that she needed to file a signed reassignment application. This lapse in time does not allow me to disturb the contractor's determination. The MPIM is CMS's guidance for its affiliated contractors and does not have the force and effect of law and therefore is not binding upon me. I am bound by the regulations, and the effective date provision of 42 C F.R. § 424.520(d) is clear. I have no authority to grant Petitioner's request of an earlier reassignment effective date other than the date the regulations permit me.

IV. Conclusion

Based on the undisputed fact that it was not until April 29, 2011 when the Medicare contractor received a complete and signed reassignment application that it could successfully process, I agree with CMS that Petitioner's effective date of reassignment of billing privileges was April 29, 2011, with a retrospective billing period starting March 30, 2011. Therefore I grant CMS's motion for summary judgment.

/s/
Joseph Grow
Administrative Law Judge