**Department of Health and Human Services**

**DEPARTMENTAL APPEALS BOARD**

**Civil Remedies Division**

June A. Esser, CNS,

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-480

Decision No. CR2913

Date: August 29, 2013

June A. Esser (Petitioner), a Clinical Nurse Specialist, appeals a reconsideration decision determining the effective date of her Medicare billing privileges, which were previously deactivated. Novitas Solutions, Inc. (Novitas), an administrative contractor acting on behalf of the Centers for Medicare & Medicaid Services (CMS), processed Petitioner's June 2012 Medicare enrollment application and determined that the effective date of Petitioner's Medicare billing privileges was June 11, 2012, with a retrospective billing period commencing on May 12, 2012. For the reasons stated below, I find that Novitas properly established the effective date for Petitioner's Medicare billing privileges based on its receipt of her June 2012 enrollment application.

## I. Background and Procedural History

Petitioner enrolled in the Medicare program in 2004. CMS Ex. 12, at 2 (Ritter Decl. ¶ 5-6). On her 2004 Medicare enrollment application, Petitioner listed her practice location in Indianola, Pennsylvania. CMS Ex. 2, at 9. On April 4, 2007, CMS deactivated Petitioner's Medicare billing privileges because she had not submitted any Medicare claims for twelve consecutive calendar months.[1] *See* CMS Ex. 7, at 2. In April 2011,

[1] There is a discrepancy in the record regarding the date Petitioner's Medicare account was deactivated. Linda Ritter, a Provider Relations Hearing Specialist at Novitas, states that Petitioner's provider number was deactivated on April 7, 2007. CMS Ex. 12, at 2 (Ritter Decl. ¶6). I do not find this discrepancy to be material to my decision.

Petitioner moved her office location to Creighton, Pennsylvania. CMS Ex. 3, at 2; CMS Ex. 5, at 3. It is undisputed that Petitioner did not notify CMS that she had changed her practice location before December 2011. CMS Ex. 5, at 3. Petitioner recommenced claims to Medicare for reimbursement of services she provided in December 2011. Request for Hearing (RFH); *see* CMS Ex. 3, at 2. However, Medicare rejected the claims based on Petitioner's deactivated status. On June 11, 2012, Petitioner submitted a CMS Form 855I, an enrollment application, to reactivate her Medicare billing number. CMS Ex. 3, at 12. Petitioner indicated that she had a "change of practice location" and listed her new address in Creighton, Pennsylvania, effective as of April 1, 2011. CMS Ex. 3, at 2, 11. By letter dated June 22, 2012, Novitas requested that Petitioner, within 30 days, provide additional information to complete the processing of her application. CMS Ex. 3, at 26-27. Petitioner timely submitted the requested information to Novitas via fax. CMS Ex. 3. By letter dated July 24, 2012, Novitas informed Petitioner that it approved her Medicare enrollment application and determined the "effective date" to be May 13, 2012.[2] CMS Ex. 4, at 2.

On September 4, 2012, Petitioner requested Novitas to reconsider this date and contended that the date should instead be December 7, 2011. CMS Ex. 5, at 5. Petitioner explained that she called CMS in December 2011 to "double check" the protocols of authorization and filing claims and was not told that her account had been deactivated. CMS Ex. 5, at 3-4. Petitioner stated that, in May 2012, she submitted claims for services she had provided to two Medicare beneficiaries between December 7, 2011 and May 10, 2012, and Novitas rejected reimbursement of these claims. CMS Ex. 5. Petitioner then discovered that her Medicare account had been deactivated in 2007 because she "had not submitted a claim." CMS Ex. 5, at 4. CMS reportedly informed her that it did not issue notification letters. CMS Ex. 5, at 4. On December 12, 2012, Novitas issued an unfavorable reconsideration decision, finding that Petitioner's Medicare billing privileges

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[2] Novitas inaccurately characterized May 13, 2012 as Petitioner's "effective date" rather than Petitioner's "retrospective billing date." CMS Ex. 4. In this case, the "effective date" is the date a contractor receives a required enrollment application that it later is able to process to approval. *See* 42 C.F.R. § 424.520(d). However, CMS and its contractors may grant retrospective billing privileges up to 30 days prior to the effective date. *See* 42 C.F.R. § 424.521(a)(1). Here, Novitas determined the date it received Petitioner's enrollment application was June 11, 2012, which is the date it should have properly referenced as the effective date. Thus, the earliest date for retrospective billing privileges that could be granted to Petitioner was 30 days prior to June 11, 2012, which is May 12, 2012. To be consistent with the relevant regulations, this decision uses "effective date" in later sections to refer to Petitioner's effective date of enrollment, not the date when Petitioner's retrospective billing began.

were deactivated appropriately because she had not submitted any claims for four consecutive quarters and that additional retrospective billing privileges could not be approved. Novitas indicated, however, that the retrospective billing date would be adjusted to May 12, 2012.[3] CMS Ex. 7.

Petitioner filed a request for hearing with the Civil Remedies Division of the Departmental Appeals Board on February 8, 2013. The case was assigned to me for hearing and decision. On March 1, 2013, I issued an Acknowledgment and Pre-hearing Order (March 1 Order), which directed the parties to file written briefs and documentary evidence. On April 5, 2013, CMS timely filed its pre-hearing exchange, incorporating a Motion for Summary Judgment and brief (CMS Br.), with twelve proposed exhibits (CMS Exs. 1-12), including the written direct testimony of one witness (CMS Ex. 12). Petitioner did not respond to the CMS Motion for Summary Judgment nor did Petitioner file a pre-hearing exchange as directed by my March 1 Order. I subsequently issued an Order to Show Cause to Petitioner on May 24, 2013. My Order to Show Cause stated, among other things, that should Petitioner fail to comply with its directives or fail to show good cause, I would dismiss the case for abandonment.

On May 31, 2013, Petitioner submitted her response (P. Response) to the Order to Show Cause. In her response, Petitioner stated that she did not have any further documents or evidence she wished to submit and "did not think [she] needed to respond." P. Response at 2. Petitioner stated that she "adamantly disagree[d] with the CMS Motion" and "would still like [her] case to be heard." P. Response at 2. Petitioner reiterated that she should have received a letter informing her that her account was deactivated. Petitioner stated that when she called CMS in reference to her account, she was not informed that her account had been deactivated and "[t]hat also would have prevented the problem of providing services under a deactivated account." P. Response at 1. I accept Petitioner's explanations in her response to the Order to Show Cause and find that she has not abandoned her case.

In the absence of any objections from Petitioner, I admit CMS Exs. 1-12 into the record. My March 1 Order advised the parties that they must submit written direct testimony for each proposed witness and that an in-person hearing would only be necessary if the opposing party requested an opportunity to cross-examine a witness. March 1 Order at ¶¶ 8, 9, and 10. Petitioner did not present any witness testimony subject to cross-examination, and Petitioner did not request a hearing to cross-examine CMS's witness.

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[3] In its reconsideration decision, Novitas realized that May 13, 2012 was incorrect as the commencement date for the 30-day retrospective billing period and thus informed Petitioner that it corrected the date to May 12, 2012. CMS Ex. 7, at 2; *see* CMS Ex. 9.

Accordingly, I find that there is no need to convene a hearing, and I issue this decision based upon the full merits of the written record.

## II. Background Law

A provider or supplier must enroll in the Medicare program to "receive payment for covered Medicare items or services from either Medicare (in the case of an assigned claim) or a Medicare beneficiary (in the case of an unassigned claim) . . . ." 42 C.F.R. § 424.505. The regulations at 42 C.F.R. Part 424, subpart P, establish the requirements for a provider or supplier to enroll in the Medicare program. *Id.* §§ 424.510 – 424.516; *see* Social Security Act § 1866(j)(1)(A) (authorizing the Secretary of the U.S. Department of Health and Human Services to establish by regulation the process for enrolling providers and suppliers in the Medicare program). Prospective providers or suppliers must, among other things, submit an enrollment application in order to begin the enrollment process. 42 C.F.R. § 424.510(a).

Medicare regulations require physicians and nonphysician practitioners to report changes to their enrollment information in order to maintain active enrollment status in the program. 42 C.F.R. § 424.516(d). Physicians and nonphysician practitioners who move their practice are required to report the change in practice location within 30 days of that event. 42 C.F.R. § 424.516(d)(1)(iii).

CMS may deactivate a provider or supplier's Medicare billing privileges if the provider or supplier does not submit any Medicare claims for 12 consecutive calendar months. 42 C.F.R. § 424.540(a)(1). CMS may also deactivate a provider or supplier's billing privileges if the provider or supplier does not report certain changes of information, such as a change in practice location or change of any managing employee, within 90 calendar days of when the change occurred, or does not provide complete and accurate information within 90 days of CMS's request for such information. 42 C.F.R. § 424.540(a)(2), (3).

A provider or supplier "deactivated for any reason other than nonsubmission of a claim" is required to "complete and submit a new enrollment application to reactivate its Medicare billing privileges or, when deemed appropriate, at a minimum, recertify that the enrollment information currently on file with Medicare is correct." 42 C.F.R. § 424.540(b)(1). A provider or supplier who is "deactivated for nonsubmission of a claim" is "required to recertify that the enrollment information currently on file with Medicare is correct and furnish any missing information as appropriate. The provider or supplier must meet all current Medicare requirements in place at the time of reactivation, and be prepared to submit a valid Medicare claim." 42 C.F.R. § 424.540(b)(2).

The decision of CMS or its contractor to deactivate the billing privileges of a provider or supplier is not an "initial determination" subject to review by an administrative law judge

(ALJ). *See* 42 C.F.R. § 498.3(b). By regulation, only an "initial determination" by CMS or its contractor triggers the appeal rights to an ALJ for an affected provider or supplier. 42 C.F.R. § 498.5(*l*)(1). The regulations provide that a provider or supplier whose billing privileges are deactivated may submit a rebuttal pursuant to 42 C.F.R. § 405.374. 42 C.F.R. § 424.545(b).

## III. Discussion

### A. Issue

The issue in this case is whether Novitas, acting on behalf of CMS, properly established the effective date for the reactivation of Petitioner's Medicare billing privileges.

### B. Findings of Fact and Conclusions of Law

#### *1. Petitioner was required to submit a new enrollment application to update her practice information on file with Medicare after Novitas deactivated her Medicare billing privileges.*

Petitioner does not challenge the deactivation of her Medicare billing privileges on April 4, 2007. In fact, Petitioner appears to concede that her account was inactive because she states in her hearing request that "I was aware of the fact that I had not had a straight Medicare enrollee for a long period of time." RFH at 1. Even if Petitioner were challenging her deactivation, I would have no authority to review Novitas' action because a contractor's decision to deactivate Medicare billing privileges is not an initial determination subject to ALJ review.

Petitioner admits, moreover, that she changed practice locations in 2011. When she enrolled in the Medicare program in 2004, she stated on her application that her practice was located in Indianola, Pennsylvania. CMS Ex. 2, at 9. In April 2011, Petitioner moved her office location to Creighton, Pennsylvania but claims she did not notify CMS of this change in practice location until December 2011. CMS Ex. 3, at 2, 11; CMS Ex. 5, at 3.

Upon deactivation "for nonsubmission of a claim," a petitioner is "required to recertify that the enrollment information currently on file with Medicare is correct and furnish any missing information as appropriate." 42 C.F.R. § 424.540(b)(2). However, in Petitioner's case, due to the fact that she had moved to another location in 2011, it is evident that her enrollment information that was "currently on file with Medicare," would not have been correct. Thus, the option to simply "recertify that the information currently on file with Medicare is correct" was not the appropriate avenue for Petitioner to take to reactivate her billing privileges. When a provider or supplier is deactivated "for any reason other than the nonsubmission of a claim," the regulations require the submission

of a new enrollment application to reactivate Medicare billing privileges or, if appropriate, at a minimum, recertification that the enrollment information Medicare currently has on file is correct. 42 C.F.R. § 424.540(b)(1). I recognize that Novitas does not claim to have deactivated Petitioner's Medicare billing privileges for a reason other than the nonsubmission of claims. However, considering that Petitioner had changed her practice location in 2011 and failed to notify the contractor of her new address within the required time frame under the regulations, it is another valid basis for deactivation. In Petitioner's case, recertifying that the information Medicare had on file was correct would not have accomplished the objective of ensuring that Medicare had correct and current enrollment information. *See* 42 C.F.R. § 424.516(d). Accordingly, I find that, under the circumstances, Petitioner was required to file a new Medicare enrollment application to reactivate her billing privileges. *See* 42 C.F.R. § 424.540(b)(1). Petitioner did in fact submit that enrollment application to reactivate her Medicare billing privileges in June 2012.

***2. Novitas properly established the effective date of Petitioner's Medicare billing privileges as June 11, 2012, with retrospective billing privileges commencing May 12, 2012.***

The regulation addressing the effective date of practitioners' Medicare enrollment and billing privileges states:

> (d) *Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations.* 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.

42 C.F.R. § 424.520(d) (emphasis added).

The "date of filing" is the date that the Medicare contractor "receives" a signed enrollment application that the Medicare contractor is able to process to approval. 73 Fed. Reg. 69,726, 69,769 (Nov. 19, 2008).

In addition, under the regulations, CMS may permit limited retrospective billing if a practitioner meets all program requirements.

> Physicians, nonphysician practitioners and physician and nonphysician practitioner organizations may retrospectively

> bill for services when a physician or nonphysician practitioner or a physician or a nonphysician practitioner 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 prior to the effective date [in certain emergencies not applicable here].

42 C.F.R. § 424.521(a).

As discussed above, Novitas received Petitioner's application, that was eventually approved, on June 11, 2012. On July 24, 2012, Novitas approved Petitioner's enrollment application, setting May 13, 2012 (this date was adjusted to May 12, 2012 in the reconsideration decision) as the commencement of the retrospective billing period.

Petitioner does not deny that CMS received her Medicare enrollment application on June 11, 2012. However, Petitioner asks that I change the retrospective billing date to December 7, 2011, so that she can be reimbursed for services she rendered between December 7, 2011 and May 10, 2012, even though her account was deactivated during that period. *See* September 4, 2012 request for reconsideration. According to Petitioner, had she known that her account was deactivated, she would not have provided care to Medicare enrollees until her account was reactivated. RFH. Petitioner states that she is a sole proprietor and is suffering extreme financial hardship because she has not been reimbursed for her services.

The Medicare contractor, CMS, and I are bound to follow the Secretary's regulations. It is undisputed that the contractor received Petitioner's enrollment application on June 11, 2012, which is later than the date Petitioner has stated she began furnishing services to patients in April 2011. CMS Ex. 3, at 2, 11. Accordingly, the regulation dictates that June 11, 2012 is the effective date of Petitioner's enrollment, with retrospective billing privileges commencing on May 12, 2012. 42 C.F.R. § 424.520(d). I have no discretion to ignore the regulations and determine an earlier effective date.

### *3. I am not authorized to grant Petitioner's request for equitable relief.*

At the reconsideration level and during this appeal, Petitioner makes various arguments as to why she should be granted a greater period of retrospective billing than that afforded under the regulations. Her arguments are not legal in nature but amount to a request for equitable relief. Petitioner contends that her "account was not managed fairly." RFH at 1. Petitioner states that she provides valuable services to patients outside of Pittsburgh who otherwise would not receive them because they would not seek psychiatric help if they had to travel into the city. Petitioner, who is self-employed, claims that she has suffered extreme financial hardship because Medicare has not paid her claims.

I am not without sympathy for Petitioner's predicament. Petitioner did not argue, however, that she filed a complete application on an earlier date than CMS determined or that the contractor or CMS incorrectly applied the regulatory criteria. I am without authority to order either Novitas or CMS to provide an exemption to Petitioner under the regulations set forth at 42 C.F.R. §§ 424.520(d) and 424.521(a). I have no authority to extend the retrospective billing period for Petitioner in this circumstance or ignore the clear requirements of the regulations governing her enrollment in Medicare. *See Kate E. Paylo*, DAB CR2232, at 14-15 (2010). Even accepting all of Petitioner's assertions as true, Petitioner's equitable arguments give me no ground to grant her an earlier effective date of enrollment. *See US Ultrasound*, DAB No. 2302, at 8 (2010) ("[n]either the ALJ nor the Board is authorized to provide equitable relief by reimbursing or enrolling a supplier who does not meet statutory or regulatory requirements.").

Additionally, Petitioner's claim that she received possibly misleading or incomplete information from a CMS representative may also be construed to be a claim of equitable estoppel. It is well-established by federal case law, and in Departmental Appeals 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. *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, 63 (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); *US Ultrasound*, DAB No. 2302, at 8 (2010). Here, Petitioner has not alleged affirmative misconduct by the government. It is also well-settled that those who deal with the government are expected to know the law. *See Heckler v. Cmty. Health Servs. of Crawford County, Inc.*, 467 U.S. 51, 63. Accordingly, I must reject any equitable estoppel argument here.

## IV. Conclusion

I conclude that Petitioner's effective date of Medicare enrollment was June 11, 2012, the date on which Novitas received Petitioner's enrollment application that could be processed to approval. Petitioner was also properly authorized to retrospectively bill Medicare for services provided to Medicare beneficiaries up to 30 days prior to the effective date of enrollment, *i.e.*, May 12, 2012.

_____/s/_____
Joseph Grow
Administrative Law Judge