Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Eileen M. Rice, M.D.,

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-12-162

Decision No. CR2533

Date: May 3, 2012

DECISION

Eileen M. Rice, M.D. (Petitioner), appeals a reconsideration decision issued on October 9, 2011. I grant summary judgment and sustain the determination of the Centers for Medicare and Medicaid Services (CMS) finding that the undisputed evidence establishes that CMS properly enrolled Petitioner in the Medicare program effective May 18, 2011.

I. Background and Procedural History

Petitioner is a neurologist who started a solo practice on February 1, 2011. CMS Exhibit (CMS Ex.) 1. To obtain direct billing privileges from Medicare for care provided to beneficiaries, Petitioner sought to become enrolled as a solo practitioner in the Medicare program and submitted an enrollment application, CMS Form 855-I, which Highmark Medicare Services (Highmark), a CMS contractor, received on May 2, 2011. CMS Ex. 1, at 75-76. By letter dated May 4, 2011, Highmark informed Petitioner that Highmark was returning the enrollment application because Petitioner submitted an outdated CMS Form 855-I that was no longer valid. CMS Ex. 1, at 75-76. Petitioner filed another Medicare enrollment application on May 18, 2011, and submitted the current CMS Form 855-I. CMS Ex 1, at 21-63. By letter dated June 6, 2011, Highmark acknowledged that it had received Petitioner's application, informed Petitioner that the application was incomplete,

and requested Petitioner to provide certain revisions and supporting documentation within 30 days. CMS Ex. 1, at 64-65. Petitioner faxed the requested revisions and supporting documentation to Highmark on June 8, 2011. CMS Ex 1, at 66-74. CMS notified Petitioner by letter dated June 10, 2011, that her Medicare enrollment application had been approved effective April 18, 2011.[1] CMS Ex. 1, at 17-19. On July 9, 2011, Petitioner requested reconsideration of the initial decision and requested that her effective enrollment date be changed to February 1, 2011, the date Petitioner first began providing services to Medicare patients. CMS Ex. 1, at 6-7. On October 9, 2011, a contractor hearing officer issued a reconsideration decision denying Petitioner's request for an earlier effective date of enrollment. CMS Ex. 1, at 1-3.

Petitioner then filed a hearing request (HR) with the Civil Remedies Division of the Departmental Appeals Board, and the case was assigned to me for hearing and decision. In accordance with my Acknowledgment and Pre-hearing Order issued on December 6, 2011, CMS filed a Motion for Summary Judgment and supporting brief (CMS Br.), accompanied by three exhibits (CMS Exs. 1-3), on January 5, 2012. On February 7, 2012, Petitioner responded to the CMS Motion for Summary Judgment by letter (P. Response). I admit CMS Exs. 1-3 into the record.

II. Applicable Law

Section 1831 of the Social Security Act (the Act) (42 U.S.C. § 1395j) establishes the supplementary medical insurance benefits program for the aged and disabled known as Medicare Part B. Payment under the program for services rendered to Medicare beneficiaries may only be made to eligible providers of services and suppliers. Act §§ 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395u(h)(1)). The Act requires the Secretary of Health and Human Services (the Secretary) to issue regulations that establish a process for the enrollment of providers and suppliers, including the right to a hearing and judicial review of certain enrollment determinations. Act § 1866(j) (42 U.S.C. § 1395cc(j)).

Pursuant to 42 C.F.R. § 424.505, a supplier must be enrolled in the Medicare program and be issued a billing number to have billing privileges and to be eligible to receive payment for services rendered to Medicare eligible beneficiaries. The effective date of a provider or supplier's enrollment in Medicare is governed by regulations at 42 C.F.R. §

[1] The letter was in error as the January 4, 2012 letter from Diana L. Wert of Provider Enrollment Services at Highmark explained. CMS Ex. 2. CMS's determination was that the effective date of Petitioner's enrollment was May 18, 2011, the date the CMS contractor received her enrollment application. However, the CMS contractor authorized Petitioner to retrospectively file claims for services to April 18, 2011. CMS Ex. 2.

424.520(d). The effective date of enrollment for a supplier may only be the later of two dates: (1) the date when the supplier filed an application for enrollment that was subsequently approved by a Medicare contractor charged with reviewing the application on behalf of CMS; or (2) the date when the supplier first began providing services at a new practice location. *Id.* The date of filing of the enrollment application is the date when the designated Medicare contractor receives the complete enrollment application and supporting documentation. 42 C.F.R. § 424.510(d)(1); 73 Fed. Reg. 69,725, 69,769 (Nov. 19, 2008).

An outdated enrollment application cannot be processed to approval and Medicare contractors are directed to return enrollment applications to the provider or supplier if "the provider submits the outdated paper version of the paper CMS-855 application" in accordance with Chapter 15, Section 15.8.1 of the Medicare Program Integrity Manual (MPIM) (Rev. 356, Effective: October 26, 2010). *See also* 73 Fed. Reg. 69,725, 69,770 (Nov. 19, 2008). Additionally, an enrolled supplier may bill for services provided to Medicare eligible beneficiaries up to 30 days prior to the effective date of enrollment, if circumstances precluded enrollment before the services were provided. 42 C.F.R. § 424.521(a). Retrospective billing for up to 90 days prior to the effective date of enrollment is permitted only in the case of a Presidentially-declared disaster, pursuant to 42 C.F.R. § 424.521.

III. Analysis

A. Issue

The issue in this case is whether CMS's contractor and CMS had a legitimate basis for determining Petitioner's effective Medicare enrollment date, and retrospective billing date, for Medicare billing privileges.

B. Applicable Standard For Summary Judgment

The Departmental Appeals Board (Board) stated 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).

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 Vill. at Notre Dame, Inc.*, DAB No. 2291, at 5 (2009).

C. Finding of Fact and Conclusion of Law

1) CMS's contractor and CMS properly determined Petitioner's effective date of Medicare enrollment.

The relevant facts are not disputed, and I draw all reasonable inferences in favor of Petitioner. Petitioner began seeing patients at a new practice location on February 1, 2011. HR. Petitioner subsequently submitted a Medicare enrollment application to Highmark. CMS Ex. 1, at 21-63. Highmark received Petitioner's Medicare enrollment application, that was eventually approved, on May 18, 2011. On June 10, 2011, Highmark approved Petitioner's enrollment application with an effective date of May 18, 2011 and retrospective billing privileges commencing on April 18, 2011. CMS Ex. 1, at 17-19; CMS Ex. 2.

Petitioner contends that her effective date of enrollment should be February 1, 2011, the date she began rendering services to Medicare beneficiaries. Petitioner does not deny that CMS received her enrollment application on May 18, 2011. However, Petitioner argues that her effective date should be earlier because Petitioner's "application was in Medicare 'limbo' because new unrecognized visual problems caused my office manager to transpose numbers in the application. It required an extensive period of time until this last problem was recognized and corrected." HR. Petitioner further requests that "Medicare actually evaluate the circumstances" and states that "[t]he delay has led to extreme financial loss and debt, and I am still trying to recover as I provide ongoing care for my Medicare patients." HR. Petitioner also requests that I "consider the fact that [Petitioner has] a 32 year history of service to Medicare patients," and states that she understands "that there have been clerical errors made, but I stand behind my track record, quality of service and dedication to patient care." P. Response. Petitioner therefore contends that she should be reimbursed for services delivered during the time interval between February 1, 2011 and April 18, 2011. P. Response.

The effective date of Medicare enrollment and billing privileges is dictated by 42 C.F.R. § 424.520(d). The regulation provides:

> (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.

(Emphasis added).

The regulation is clear that the effective date for Medicare billing privileges is determined according to the latter of the two dates specified by the regulation. 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. 42 C.F.R. § 424.510(d)(1); 73 Fed. Reg. 69,725, 69,769 (Nov. 19, 2008). Despite the fact that Petitioner's May 18, 2011 application was deficient in several respects, CMS allowed Petitioner 30 days to provide the revisions and supporting documentation. CMS Ex. 1, at 64-65. Petitioner submitted the required information within the 30 day timeframe, and CMS properly determined that Petitioner's effective date was the date she originally filed the application, May 18, 2011. Because it is undisputed that the contractor received Petitioner's enrollment application on May 18, 2011, which is after the date Petitioner began providing services, the regulation dictates that this is the effective date of Petitioner's enrollment, and I have no discretion to ignore regulations and determine an earlier effective date.

Petitioner does not dispute that the May 2, 2011 application submitted was an outdated version of the CMS Form 855-I. A supplier must submit the current version of a CMS Form 855-I to participate in the Medicare program. CMS Ex. 3, at 3; MPIM § 15.8.1. Highmark properly returned the May 2, 2011 application to Petitioner as Highmark was unable to process this application to approval. *See, e.g., David Varlotta,* DAB CR2135 (2010); *Balaji Charlu, M.D.*, DAB CR2105 (2010); *Malorie Smith*, DAB CR1527 (2006). Thus, this application cannot determine Petitioner's effective date of enrollment pursuant to 42 C.F.R. § 424.520(d).

Petitioner made various arguments for equitable relief at the reconsideration level and during this appeal. Petitioner's arguments for not meeting the legal requirements of enrollment pertain to clerical errors made during the enrollment process, her history of service and dedication to Medicare patients, and her extreme financial hardship due to not

being compensated by CMS for over two months of providing services to Medicare beneficiaries. P. Response; HR. 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 Highmark 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), which are binding on me. I cannot alter or deviate from the regulations' explicit limitation on Petitioner's ability to bill for services up to 30 days prior to the date Highmark received Petitioner's complete application. *See Kate E. Paylo*, DAB CR2232, at 14-15 (2010). 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. *Id*. Even accepting all of Petitioner's assertions as true, Petitioner's equitable arguments give me no ground to grant Petitioner 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.").

I conclude that Petitioner's effective date of Medicare enrollment was May 18, 2011, the undisputed date on which she submitted an enrollment application that could be processed to approval. Petitioner was also properly authorized to bill Medicare for services provided to Medicare beneficiaries up to 30 days prior to her effective date of enrollment, *i.e.*, April 18, 2011. Accordingly, I grant summary judgment in favor of CMS.

/s/
Joseph Grow
Administrative Law Judge