Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Robert Young, M.D.
(NPI: 1962649483)

Petitioner

v.

Centers for Medicare & Medicaid Services.

Docket No. C-10-615

Decision No. CR2227

Date: August 27, 2010

DECISION

I reject the motion of the Centers for Medicare & Medicaid Services (CMS) to dismiss the hearing request of Petitioner, Robert Young, M.D., for the reasons explained below. As to the merits of this case, I decide this case on the written record and find that Petitioner is entitled to an effective date of enrollment in the Medicare program of August 10, 2009, and is entitled to bill for services rendered as of July 11, 2009.

I. Background

This case arises from the efforts of Petitioner to enroll in Medicare with his payments reassigned to a new physician group, Radnet, Inc. The process involved a number of submissions by Petitioner to Palmetto GBA National Supplier Clearinghouse (NSC), a Medicare contractor, two reconsideration decisions issued by NSC hearing officers, and ultimate approval of Petitioner's supplier number but with an effective date later than Petitioner seeks. I outline first the chronological events in this process and address their legal significance in my analysis.

Petitioner first submitted a CMS 855R application form[1] on April 25, 2009 in order to reassign his payments to Radnet. Hearing Request, dated Apr. 8, 2010 (HR). Radnet alleges, and CMS nowhere disputes, that it inquired on behalf of Petitioner to NSC about the status of that application on July 27, 2009. *See* CMS Br. at 9. Again, it is undisputed that an NSC representative informed Radnet during that call that Petitioner needed to also submit a CMS 855I application form because Petitioner was not currently enrolled in Medicare.[2] *Id.* According to Petitioner, the NSC representative indicated that the CMS 855I had previously been requested via letter sent by NSC to Petitioner on June 30, 2009. CMS Ex. 1, at 10.[3] Petitioner alleges that he did not receive that letter from NSC and had no knowledge of the returned application prior to his telephone inquiry. CMS Ex. 1, at 2, 8, 10. The letter is in the record and indicates that Petitioner's April 2009 application was returned because it lacked forms needed to process a reassignment package, i.e., the CMS 855I. CMS Ex. 1, at 10.

On July 31, 2009, Petitioner submitted a request for reconsideration of the return of his CMS 855R for failure to provide requested information. CMS Ex. 1, at 7-8. Along with the reconsideration request, Petitioner sent new CMS 855R and CMS 855I applications to NSC. *Id.* The request was directed to NSC to "whom it may concern." *Id.* The postal service track and confirm results show receipt on August 10, 2009. CMS Ex. 1, at 6. Petitioner describes these applications as appropriately completed (CMS Ex. 1, at 7-8), and CMS has offered no disagreement with that characterization.

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[1] Form CMS 855R is the Medicare enrollment application for the reassignment of Medicare benefits. CMS Enrollment Applications, *available at* http://www.cms.hhs.gov/MedicareProviderSupEnroll ("Enrollment Applications").

[2] The form CMS 855I is the individual Medicare enrollment application for physicians and non-physician practitioners.

[3] CMS Exhibit 1 consists of Petitioner's hearing request and attached documents, namely: Petitioner's request for reconsideration letter dated February 3, 2010; NSC's reconsideration decision letter dated March 10, 2010; NSC's request for reconsideration form filled out by Petitioner, dated February 2010; U.S. Postal Service track and confirm results showing delivery date of August 10, 2010; NSC's request for reconsideration form filled out by Petitioner, dated July 31, 2009; letter dated July 31, 2009 from Radnet, Inc. to NSC stating that CMS 855I and CMS 855R forms are enclosed; letter dated April 25, 2009 from NSC indicating they received Petitioners enrollment application; letter dated June 30, 2009 from NSC returning Petitioner's application; letter dated October 28, 2009 from NSC indicating reconsideration request for the application returned on June 30, 2009 is denied; two letters dated December 18, 2009 from NSC indicating Petitioner's CMS 855 applications were received; letter dated January 27, 2010 from NSC indicating Petitioner's applications were processed to approval and an effective date of November 17, 2009 was given.

In response to the reconsideration request on October 28, 2009, the contractor issued an unfavorable decision. CMS Ex. 1, at 11. In regard to the CMS 855I and CMS 855R applications submitted with the reconsideration request, the Medicare hearing officer stated that they "cannot be considered in appeal decision. Once the approval [sic] decision has been received, the provider will need to submit new applications with all mandatory attachments for processing." *Id.*

On December 8, 2009, Petitioner resubmitted CMS 855R and CMS 855I applications which NSC acknowledged receiving on December 18, 2009. CMS Ex. 1, at 3, 13. These applications were processed to approval and an "effective date" of November 17, 2009 was given, which reflects the effective date of approval as the date of receipt by NSC along with the 30-day retrospective billing period pursuant to 42 C.F.R. § 424.521(a). CMS Ex. 1, at 15.

By letter dated February 3, 2010, Petitioner requested reconsideration of the effective date. CMS Ex. 1, at 2. NSC denied Petitioner's request for reconsideration on March 10, 2010 stating that physicians "cannot appeal the effective date decision made by the contractor." CMS Ex. 1, at 4.

By letter dated April 8, 2010, Petitioner requested review of the refusal to change the effective date and asked that I change his effective date of enrollment in the Medicare program to March 1, 2009. By order dated April 14, 2010, I acknowledged the receipt and docketing of Petitioner's hearing request and set out procedures for developing the record. In response to my order, CMS filed a motion to dismiss or, in the alternative, motion for summary judgment (which I have referred to as CMS Br.) accompanied by CMS exhibits (Exs.) 1 through 5.

Petitioner did not respond to CMS's motion in a timely manner. After being contacted, Petitioner's representative informed my office that she had been out caring for a gravely ill family member and was therefore behind in her work. Despite repeated calls and messages over the following three weeks, Petitioner's representative did not respond or indicate any intention to submit any further material. Upon balancing the personal circumstances of Petitioner's representative with the fact that time is of the essence in this case, rather than impose sanctions or summarily dismiss for abandonment, I ordered the record in the case closed. Order Closing Record, issued July 22, 2010. No further communication was received from Petitioner or his representative. Accordingly, I proceed to rule on CMS's motions based on the written record.

II. Applicable Law

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).

The regulations specify that 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).

The effective date of enrollment for physicians and physician groups is set by regulation 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).

A prospective supplier "that is denied enrollment in the Medicare program . . . may appeal CMS' decision" in accordance with 42 C.F.R. Part 498. 42 C.F.R. § 424.545(a). An appeal must be requested "in writing within 60 days from receipt of the notice of the initial, reconsidered or revised determination unless that period is extended" by the judge for "good cause shown" and receipt is presumed to be 5 days after the date on the notice absent a contrary showing. 42 C.F.R. § 498.40(a)(2).

III. Issues

The issues before me are whether Petitioner has a right to appeal his effective date determination and, if so, whether CMS properly determined the effective date of Petitioner's enrollment in the Medicare program.

IV. Findings of Fact and Conclusions of Law

My findings and conclusions are in the italicized headings supported by the subsequent discussions below.

A. I reject CMS's argument that Petitioner has no right to appeal the effective date determination.

CMS sought dismissal arguing that the regulations do not permit appeals of effective date determinations by suppliers whose enrollment is approved. CMS Br. at 11-17. I reject this argument for the reasons explained here.

The Departmental Appeals Board (Board) recently addressed CMS's argument about effective date appeals in *Victor Alvarez, M.D.*, DAB No. 2325 (2010). In *Alvarez*, the Board concluded that "a determination of a supplier's effective date of enrollment in Medicare is an initial determination subject to appeal rights under 42 C.F.R. Part 498." *Alvarez,* DAB No. 2325, at 1. The Board explained that this determination is consistent with the historical interpretation of hearing rights under section 1866(h)(1)(A) and as discussed in the rulemaking process. Further, "while section 498.3(b)(15) originally applied primarily to suppliers subject to survey and certification, the term 'supplier' as used in 42 C.F.R. Part 498 was amended to cover all Medicare suppliers, including physicians." *Id.* at 3.

In several prior decisions, I also came to the same conclusion. *See, e.g., Michael Majette, D.C.*, DAB CR2142 (2010); *Eugene Rubach, M.D.,* DAB CR2125 (2010); *Mobile Vision, Inc.*, DAB CR2124 (2010). I likewise concluded that the wording of section 498.3(b)(15) appears straightforward in providing that the "effective date of a Medicare provider agreement or supplier approval" is an appealable initial determination and includes no qualifying or limiting language. A legislative rule generally binds the agency that issues it, and the agency is legally bound to follow its own regulations as long as they are in force. *Cal. Dep't of Soc. Servs.*, DAB No. 1959 (2005); *Hermina Traeye Mem'l Nursing Home*, DAB No. 1810 (2002), citing Kenneth Culp Davis and Richard J. Pierce, Jr., *Administrative Law Treatise* § 6.5 (3rd ed. 1994), *aff'd Sea Island Comprehensive Healthcare Corp. v. U.S. Dep't of Health & Human Servs.,* 79 F. App'x 563 (4th Cir. 2003); 2 AM. JUR. 2d *Administrative Law* § 236 (2010), *available at* WL AM. JUR. ADMINLAW § 236. Absent further rulemaking, I am bound to follow the plain meaning of the regulation and, as the Board mandated, permit an appeal by any provider or supplier

dissatisfied with a determination as to the effective date of its provider agreement or supplier approval.

I therefore deny CMS's motion to dismiss on this basis.

B. *I conclude that the effective date of Petitioner's enrollment in the Medicare program under the governing regulations is August 10, 2009, with retroactive billing to July 11, 2009.*

Petitioner seeks an effective date of March 1, 2009, the date requested in his initial CMS 855R application that was filed on April 25, 2009. Petitioner argues that "the Medicare process for Provider Enrollment was adhered to as well as the several attempts made to correct any issues that occurred albeit without confirmed notification to the provider." HR.

That initial CMS 855R application submitted in April 2009, however, was returned to Petitioner because a CMS 855I application was necessary and not submitted. CMS Ex. 1, at 10. Petitioner's representative admitted in her request for reconsideration that Radnet did not know that Petitioner was not enrolled in Medicare at that time and thus did not submit a CMS 855I application. CMS Ex. 1, at 8. Petitioner therefore cannot claim that the April 2009 application was improperly returned or could have been processed to approval.

CMS states in its brief that "the only issue before this tribunal is to determine the date of filing of the Medicare enrollment application that was subsequently approved by Palmetto [GBA]." CMS Br. at 18. CMS argues that "[t]he undisputed facts in this case show that the only Medicare application approved by Palmetto was filed by [Petitioner] on December 18, 2009." *Id.*

It is not disputed, however, that Petitioner did submit both CMS 855R and CMS 855I applications on July 31, 2009 with his request for reconsideration. NSC apparently did not process those applications because they were sent to the wrong department. Specifically, NSC states in its reconsideration decision letter that the CMS 855I and CMS 855R applications "cannot be considered in the appeal decision. Once the approval [sic] decision has been received, the provider will need to submit new applications with all mandatory attachments for processing." CMS Ex. 1, at 11.

CMS further argues that "it is clear that the applications sent to the contractor's appeals department could not have been and were not processed and approved." CMS Br. at 20. I disagree. To begin with, CMS does not identify any respect in which the applications that were submitted on July 31, 2009 were incomplete or different from the copies later resubmitted and processed to approval in December 2009. In other words, it is *not* clear that the applications could not have been processed and approved in August 2009. The

only reason that was given as to why the applications submitted in July 2009 were not processed was that the applications were sent to the wrong department of the contractor. CMS Br. at 20; CMS Ex. 1, at 11. The documents submitted do not show that Petitioner directed the letter to a specific department, since CMS did not submit an envelope and the tracking document only establishes that it was received at the zip code for NSC in Augusta, Georgia.

Even assuming that the envelope was sent to the address on the reconsideration request form, i.e., to Provider Enrollment Appeals, I find, and CMS points to, nothing in the regulations that requires applications to be sent to a particular department of the contractor, or that state that applications sent to the wrong department are not considered "filed" with a Medicare contractor. Furthermore, the preamble of the regulation refers to guidelines for contractors handling applications, as follows:

> We fully expect that most enrollment applications will be processed in accordance with CMS processing requirements found in Publication 100–8, Chapter 10 of the Program Integrity Manual (PIM). The PIM establishes processing standards for initial applications, changes of information, and reassignments that all Medicare contractors must follow.

73 Fed. Reg. 36,448, 36,453 (June 27, 2008). The PIM states, in pertinent part:

> The processing of an application generally includes, but is not limited to, the following activities:
>
> • Receipt of the application in the contractor's mailroom and forwarding it to the appropriate office for review;

PIM, Ch. 10, § 2.9.

Here, it appears that the only reason the applications submitted on July 31, 2009 and received on August 10, 2009 were not processed to approval by the contractor was because the contractor did not forward them to the appropriate office for review, as the PIM required. CMS has not explained why the attachment of the new applications to the reconsideration request prevented the contractor from forwarding them for processing by the appropriate department. I conclude that, contrary to CMS's conclusory assertion, the record discloses no reason that the applications could not have been both processed and approved based on their receipt on August 10, 2009.

CMS also relies on *Vincent Pirri, M.D.*, DAB CR2065 (2010), as a reason to deny an earlier effective date, quoting the ALJ commenting "that Petitioner may have experienced some delays, including those caused by the contractor . . . is not a basis" for the ALJ to order Petitioner to be enrolled on a date that is earlier than the date when the contractor

received all of the information necessary to process Petitioner's application. CMS Br. at 20. This language is inapposite to the situation here. I do not order that Petitioner be enrolled on a date earlier than that on which the contractor received all of the information necessary to process his application. On the contrary, I order precisely that the date when the contractor received all the information necessary to process his application is the date on which the regulations provide that his approval to enroll takes effect. The undisputed evidence before me shows that that date was when the applications which he mailed on July 31, 2009, were received by the contractor, i.e., August 10, 2009. The contractor may have caused some delays in the processing of the applications by misdirecting them internally, but that is not the reason that I hold that Petitioner is entitled to an earlier effective date. I merely apply the regulations in determining the correct effective date.

It follows that the date on which Petitioner filed a Medicare enrollment application that was complete and was subsequently approved is August 10, 2009. CMS Ex. 1, at 7-8. Therefore, in accordance with 42 C.F.R. § 424.520(d), the "[e]ffective date for billing privileges" is August 10, 2009, the "date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor." Because CMS found it appropriate to grant Petitioner the 30-day retroactive billing period (CMS Ex. 1, at 15) under 42 C.F.R. § 424.521(a), I will do the same. Therefore, the first day of Petitioner's retroactive billing period is correspondingly adjusted to July 11, 2009.

V. Conclusion

For the reasons set forth above, I change the effective date of Petitioner's enrollment in the Medicare program to August 10, 2009, with a retroactive billing period to July 11, 2009.

/s/

Leslie A. Sussan
Board Member