Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Island Nephrology, P.C.,

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-11-281

Decision No. CR2405

Date: August 1, 2011

DECISION

Island Nephrology, P.C., on behalf of Dr. Ashfaq Hussain (Petitioner), appeals the Medicare enrollment determination of the National Government Services (NGS), a Medicare contractor, and argues that Petitioner's Medicare enrollment date should be effective from the practice start date of March 29, 2010. However, I grant the Centers for Medicare and Medicaid Services' (CMS's) motion for summary judgment and find that Petitioner's effective date of enrollment was June 3, 2010, with a retrospective billing period starting on May 4, 2010, which is based on the date NGS received an application from Petitioner, on a current form, which it could process to completion.

I. Background

On April 15, 2010, NGS received an obsolete version of form CMS-855I (Medicare enrollment form) and a CMS-855R (Medicare reassignment form) from Petitioner. CMS Ex. 8. NGS informed Petitioner, by letter dated May 19, 2010, that Petitioner had submitted an outdated version of the Medicare enrollment form and that CMS required filing of the current revised version, which became effective July 2009. CMS Ex. 9. NGS informed Petitioner that it was closing the enrollment request and that Petitioner could download all current versions of enrollment applications from its website. *Id.* By letter dated June 1, 2010, NGS informed Petitioner that it was returning the reassignment

form because there was no accompanying current version of the Medicare enrollment form. CMS Ex. 10. On June 3, 2010, NGS received a current enrollment application from Petitioner. CMS Ex. 11.

By letter dated July 19, 2010, NGS informed Petitioner that it was denying the June 3, 2010 enrollment application. CMS Ex. 12. NGS stated that a provider must be licensed and authorized to perform the services that it intends to render. NGS notified Petitioner that Island Nephrology was not registered with the New York State Department of Education (NYSDE) and that, under Article 15 of the New York State Business Corporation Law, licensed professionals that form a corporation must file with the NYSDE. NGS provided Petitioner with contact information for the NYSDE. *Id.* NGS further notified Petitioner that, to correct this deficiency and establish eligibility in the Medicare program, Petitioner could submit a corrective action plan within 30 days, or Petitioner could request reconsideration before a Hearing Officer. On August 5, 2010, NGS received Petitioner's proof of registration with the NYSDE. CMS Ex. 13. Upon receipt, NGS requested additional information, which Petitioner provided on August 27, 2010. CMS Ex. 14. By letter dated September 14, 2010, NGS informed Petitioner that it had approved the Medicare enrollment application it received on June 3, 2010, with an effective date of May 5, 2010. CMS Ex. 15.

Petitioner requested a reconsideration review to change the retrospective billing date to March 29, 2010, the date the solo nephrology practice began. CMS Ex. 16. NGS informed Petitioner that the reconsideration review was unfavorable and that NGS had correctly calculated Petitioner's enrollment date and retrospective billing date. CMS Ex. 17. On February 12, 2011, Petitioner filed a hearing request with the Civil Remedies Division. An Acknowledgment and Pre-hearing Order was sent to the parties on February 24, 2011. On March 31, 2011, CMS filed a Motion for Summary Judgment and brief (CMS Br.), accompanied by 19 proposed exhibits (CMS Exs. 1-19). On May 3, 2011, Petitioner filed his response (P. Response) accompanied by six proposed exhibits (P. Exs. 1-6). On May 18, 2011, CMS filed a reply (CMS Reply). On June 20, 2011, Petitioner filed a reply (P. Reply). Absent any objection, I admit all proposed exhibits into evidence.

II. General Authority

The Social Security Act (Act) authorizes the Secretary of the Department 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).

A "provider or supplier must submit a complete enrollment application and supporting documentation to the designated Medicare fee-for-service contractor," and the application should 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 is established 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, such that:

> 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).

III. Issue

The issue in this case is whether CMS had a legitimate basis for determining June 3, 2010 as the effective date for Petitioner's Medicare enrollment and billing privileges.

IV. Discussion

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 argues that it is entitled to summary judgment. The Departmental Appeals Board (Board) explained 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). An Administrative Law Judge's (ALJ's) role in deciding a summary judgment motion differs from its 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). The Board has further stated, "[i]n addition, it is appropriate for the tribunal to consider whether a rational trier of fact could regard the parties' presentation as sufficient to meet their evidentiary burden under the relevant substantive law." *Dumas Nursing and Rehab., L.P.*, DAB No. 2347, at 5 (2010).

CMS argues that it is entitled to summary judgment because there "are no material facts in dispute." CMS Br. at 12. Petitioner has not disputed the material facts in this case, specifically, that until June 3, 2010, NGS did not receive a processable Medicare enrollment application that used the current form. Therefore, I agree with CMS that summary judgment is appropriate.

b. NGS's April 15, 2010 receipt of Petitioner's enrollment application, which used the obsolete form, was properly returned to Petitioner unprocessed

A physician must submit a current version of a completed enrollment application form, CMS-855I, to participate in the Medicare program as a supplier. *See, e.g.*, CMS Exhibit 5, "Tips to Facilitate the Medicare Enrollment Process" (stating that applicants should **"[s]ubmit the current version of the Medicare enrollment application (CMS-855)**) (emphasis in the original)." [1]

Petitioner does not dispute that on April 15, 2010, NGS received an outdated version of form CMS-855I from Petitioner. Petitioner's Hearing Request at 1. CMS revised its enrollment application in 2009 and notified all carriers and contractors of these revisions. In a memorandum dated September 9, 2009, CMS announced the revision of the

[1] CMS Ex. 5 can also be found on CMS's official website at www.cms.gov/MedicareProviderSupEnroll.

enrollment CMS-855I application for physicians and the CMS-855B form.[2] CMS Ex. 6. The memorandum stated that contractors should continue to accept the outdated versions of form CMS-855I through November 30, 2009. However, if a contractor received an outdated version of the enrollment application after December 1, 2010, the contractor was directed to return the enrollment application in accordance with Chapter 10, Section 3.2 of the Medicare Program Integrity Manual (MPIM).[3] *Id.*

Chapter 10, section 3.2, of the MPIM stated that the contractor should immediately *return* the enrollment application in certain defined circumstances such as when an outdated version of the application is submitted. CMS's MPIM distinguishes between rejection and return of applications. Rejection "means that the provider or supplier's enrollment application was not processed due to incomplete information or that additional information or corrected information was not received from the provider or supplier in a timely manner." MPIM, Ch. 10, § 1.1; 42 C.F.R. §§ 424.502, 424.525(a). All applications, however, are returned "immediately" if an "outdated paper version of the paper CMS-855 is submitted." *Id.* at § 3.2A. A 'returned' application is considered a non-application." *Id.*

It is well-settled that those who seek to participate in the Medicare program have a duty to familiarize themselves with its requirements. *See Heckler v. Cmty. Health Servs. of Crawford County, Inc.*, 467 U.S. 51, 64 (1984). Petitioner should have known the application that NGS received April 15, 2010 did not use the current form. The current Medicare enrollment form was effective since July of 2009, and from since at least September 9, 2009, CMS made the form accessible on its website after the formal decision to revise the form. CMS Ex. 6. Petitioner did not allege any difficulty or confusion in accessing the current version of the application form.

Upon receipt of Petitioner's outdated Medicare application, NGS properly returned the application to Petitioner in accordance with CMS policy. Prior Civil Remedies Division cases also support the return of the application when a CMS contractor receives an obsolete enrollment application form. *See, e.g., David Varlota*, DAB CR2135 (2010); *Balaji Charlu, M.D.*, DAB CR2105 (2010); *Malorie Smith*, DAB CR1527 (2006). Therefore, I find NGS properly returned this outdated application as it was unable to be processed to approval, and I find also that it was thus immaterial to a determination of Petitioner's effective date of enrollment. *See* 42 C.F.R. § 424.520(d).

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[2] The revisions were based on the publication of a final rule that made changes to payment policies under the physician fee schedule, among other things. CMS Ex. 6.

[3] MPIM is CMS's guidance for affiliated contractors. Chapter 10, section 3.2 of the MPIM was subsequently redesignated as Chapter 15, Section 8.1. *See* CMS Ex. 4.

c. NGS's June 3, 2010 receipt of Petitioner's enrollment application, which used the current form, necessarily determines Petitioner's effective date and retrospective billing date.

The effective date for enrollment 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." 42 C.F.R. § 424.520(d) (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). It is undisputed that NGS did not receive a signed, complete, and approvable enrollment application CMS-855I before June 3, 2010. Although CMS requested more information about Petitioner's registration with regard to this application, this was the application that NGS subsequently approved.

NGS erroneously characterized May 5, 2010 as Petitioner's "effective date," rather than Petitioner's retrospective billing date (CMS Exs. 15 and 17). Regulations 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 treat NGS's action as if it intended to set May 5, 2010 as the earliest date for which Petitioner may submit retrospective claims, with the effective date of Petitioner's enrollment as June 3, 2010. CMS now also asserts that Petitioner's retrospective billing date should have been May 4, 2010, thirty days prior to the enrollment date of June 3, 2010. CMS has thus instructed NGS to revise this date (CMS Br. at 2 n.1), and I concur.

Petitioner argues that he cannot collect reimbursement for services from March 29, 2010, when he began furnishing Medicare covered services, through May 3, 2010. Petitioner contends that he has been a physician for 14 years and could not abandon his long-time patients and discontinue his patients' care. Petitioner also takes issue with the fact that NGS did not immediately return the outdated form. NGS received the outdated form on April 15, 2010 and returned it to Petitioner on May 19, 2010. Petitioner states that it took NGS too long to determine that Petitioner submitted an outdated application, and NGS did not comply with the MPIM instruction to immediately return an outdated application. Petitioner contends that, had NGS returned the outdated application immediately, he could have submitted the correct application form sooner, thereby effectuating an earlier effective and retrospective dates.

Although I am not unsympathetic to Petitioner's position, I am unable to grant the relief that Petitioner requests. Petitioner's argument amounts to a claim of equitable estoppel. Federal case law and Board precedent establish: (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,* 467 U.S. at 51; *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). Petitioner has not alleged, or come forward with any evidence of affirmative misconduct which would be attributed to CMS's 34 day turnaround time that it took to return Petitioner's original application using the obsolete form.

V. Conclusion

I conclude that it is undisputed that CMS did not receive a processable Medicare enrollment application on a current form from Petitioner until June 3, 2010. I am thereby obliged to find Petitioner's effective date of enrollment is June 3, 2010, with a retrospective billing period starting thirty days prior, on May 4, 2010. Therefore, I grant CMS's motion for summary judgment.

/s/
Joseph Grow
Administrative Law Judge