Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Ian Smalling, N.P.,
(NPI: 1114971033),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-1016

Decision No. CR2971

Date: October 28, 2013

DECISION

Petitioner, Ian Smalling, N.P., is a family nurse practitioner who applied for enrollment in the Medicare program. The Centers for Medicare & Medicaid Services (CMS) granted his application, effective October 9, 2012. Petitioner now challenges that effective date.

For the reasons set forth below, I find that CMS appropriately granted Petitioner's enrollment effective October 9, 2012.

Background

Petitioner is a family nurse practitioner and member of the Oakbend Medical Group. On December 27, 2011, he submitted an enrollment application (form CMS 855R) to the (then) Medicare contractor, Trailblazer Health Enterprises, LLC, and asked that his benefits be reassigned to the group practice. CMS Ex. 1. The application was signed by Petitioner and by Donna Ferguson, as the "authorized official" for the group practice, i.e., the individual whose signature legally and financially binds that supplier. CMS Ex. 1 at 4. However, according to the contractor's records, Donna Ferguson was not the practice's authorized official. She had tried to add her name to the supplier's approved list, but the form she signed and submitted to the contractor was outdated and therefore

unacceptable. For this reason, and because the contractor had not received some additional requested information, the contractor denied the application, although it offered Petitioner the opportunity to submit a corrective action plan. CMS Ex. 9.

Petitioner submitted a second application (form CMS 855R), which the current contractor, Novitas Solutions, Inc., received on October 9, 2012. CMS Ex. 2. The practice's regional practice manager signed as the authorized official. CMS Ex. 2 at 9. The contractor approved this application, with an effective date of October 9, 2012.

Petitioner sought reconsideration challenging that effective date. In a reconsidered determination dated May 17, 2013, a contractor hearing specialist affirmed the October 9 effective date. CMS Ex. 3. Petitioner requested a hearing before an administrative law judge (ALJ), and the matter was assigned to me. I issued a prehearing order directing the parties to submit written briefs, lists of proposed witnesses and proposed exhibits. I directed the parties to include, as an exhibit, the written direct testimony of any proposed witness. Acknowledgment and Pre-hearing Order (July 18, 2013). With its brief, CMS submitted nine exhibits (CMS Exs. 1-9). CMS listed no witnesses and provided no witness declarations.

In the absence of any objections, I admit into evidence CMS Exhibits 1-9.

Petitioner submitted three exhibits (P. Exs. 1-3), including the written declaration of one proposed witness (P. Ex. 3). CMS has objected to my admitting Petitioner's Exhibits 1 and 2, because these documents were not submitted at the contractor level of review. Under the regulations governing these proceedings, I may admit new documentary evidence only if I find good cause for the Petitioner's submitting the evidence for the first time at the ALJ level. 42 C.F.R. §498.56(e). I need not rule on the good cause question, however, because the regulations also direct me to admit only evidence that is relevant and material; I find that Petitioner's proposed exhibits are not relevant or material. 42 C.F.R. 498.60. Petitioner's Exhibits 1 and 3 challenge the contractor's denial of Petitioner's December 27, 2011 enrollment application. As discussed below, I have no authority to review that determination.

Petitioner's Exhibit 2 is a list of claims for services the practice provided before the effective date of Petitioner's (and his colleagues') Medicare enrollments. That he may have provided otherwise-reimbursable services to Medicare beneficiaries for which the practice will not be reimbursed is irrelevant. A prospective supplier is simply not entitled to Medicare payment for those services because he was not enrolled in the program when he provided them. *See US Ultrasound*, DAB No. 2302, at 8 (2010).

I therefore decline to admit Petitioner's Exhibits 1-3.

Because there are no witnesses to cross-examine, an in-person hearing would serve no purpose, I close the record and decide the case. *See* Acknowledgment and Pre-hearing Order at 6 ¶¶ 10-11.

Discussion

1. CMS properly determined the effective date for Petitioner's Medicare enrollment, because the evidence establishes that he submitted his subsequently-approved enrollment application on October 9, 2012, and his effective date can be no earlier than the date he filed that enrollment application.[1]

To receive Medicare payments for services furnished to program beneficiaries, a Medicare supplier must be enrolled in the Medicare program. 42 C.F.R. § 424.505. "Enrollment" is the process used by CMS and its contractors to: 1) identify the prospective supplier; 2) validate the supplier's eligibility to provide items or services to Medicare beneficiaries; 3) identify and confirm a supplier's owners and practice location; and 4) grant the supplier Medicare billing privileges. 42 C.F.R. § 424.502. To enroll in Medicare, a prospective supplier must complete and submit an enrollment application. 42 C.F.R. §§ 424.510(d)(1), 424.515(a). An enrollment application is either a CMS-approved paper application or an electronic process approved by the Office of Management and Budget. 42 C.F.R. § 424.502.

When CMS determines that a physician or nonphysician practitioner meets the applicable enrollment requirements, it grants him Medicare billing privileges, which means that he can submit claims and receive payments from Medicare for covered services provided to program beneficiaries. For physicians and nonphysician practitioners, the effective date for billing privileges "is the *later* of the date of filing" a subsequently approved enrollment application 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).[2]

Thus, pursuant to 42 C.F.R. 424.520(d), Petitioner's effective date of enrollment is October 9, 2012, the date he filed the application.

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[1] My findings of fact/conclusions of law are set forth, in italics and bold, in the discussion captions of this decision.

[2] If a physician meets all program requirements, CMS allows him to bill retrospectively for up to "30 days prior to their effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries." 42 C.F.R. § 424.521(a)(1).

2. I have no authority to review the contractor's denial of Petitioner's December 27, 2011 application, because Petitioner did not request reconsideration of that denial, and I may only review reconsidered determinations.

Petitioner nevertheless argues that, when his December 2011 application was signed and filed, Donna Ferguson was, in fact, the duly appointed authorized or delegated official. According to Petitioner, the contractor should therefore have approved that application, which would have made Petitioner's Medicare enrollment effective December 27, 2011. But Petitioner has waived his right to challenge the contractor's denial of his December 27 application, because he did not timely appeal that determination.

CMS's determination to deny a supplier's Medicare enrollment is an "initial determination" that is subject to review under the procedures set forth in 42 C.F.R. Part 498. 42 C.F.R. §§ 498.3(a)(1), (b)(17). An initial determination is binding unless reconsidered or otherwise reversed or modified. 42 C.F.R. § 498.20(b).

A supplier or prospective supplier dissatisfied with an initial determination may request reconsideration by filing a written request within 60 days from receipt of the notice of the initial determination. 42 C.F.R. §§ 498.5(d)(1), 498.5(l)(1), 498.22. If CMS (or its contractor) receives a properly-filed request for reconsideration, it makes a reconsidered determination affirming or modifying the initial determination. 42 C.F.R. § 498.24(c). A supplier or prospective supplier dissatisfied with a reconsidered determination is entitled to a hearing before an ALJ. 42 C.F.R. §§ 498.5(d)(2), 498.5(l)(2). The regulations do not provide for a hearing in the absence of a reconsidered determination. *Denise A. Hardy*, D.P.M., DAB No. 2464, at 4-5 (2012); *Hiva Vakil*, DAB No. 2460, at 4-5 (2012).

In its February 28, 2012 notice, which advised Petitioner that his application was denied, the contractor also told Petitioner that, if he disagreed, he could request reconsideration before a contractor hearing officer. It warned that "[f]ailure to timely request a reconsideration is deemed a waiver of all rights to further administrative review." CMS Ex. 9. Petitioner did not request reconsideration. The contractor's denial of his December 2011 application is therefore binding and not reviewable in this forum.

Conclusion

Because Petitioner's approved enrollment application was filed on October 9, 2012, the contractor properly granted his Medicare enrollment effective that date.

/s/
Carolyn Cozad Hughes
Administrative Law Judge