Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Shalbhadra Bafna, M.D.
Docket No. A-12-6
Decision No. 2449
March 30, 2012

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Shalbhadra Bafna, M.D. (Petitioner) appeals the August 23, 2011 decision of Administrative Law Judge Steven T. Kessel (ALJ), *Shalbhadra Bafna, M.D.*, DAB CR2419 (2011) (ALJ Decision). Petitioner's Medicare billing privileges were deactivated by the Centers for Medicare & Medicaid Services (CMS) effective October 16, 2010. He later filed a Medicare enrollment application form seeking reactivation of his billing privileges and enrollment of a new practice location. CMS approved the application and determined that November 11, 2010 was the effective date of his billing privileges. The ALJ upheld CMS's effective date determination, rejecting Petitioner's request for an earlier effective date. We affirm the ALJ Decision for the reasons outlined below.

Legal Background

In order to be paid by Medicare for services furnished to a Medicare beneficiary, a physician or other "supplier" (the latter term encompasses several types of health care practitioners, including physicians) must be approved by CMS for "enrollment" in the program. *See* 42 C.F.R. §§ 424.500, 424.505. Medicare enrollment is governed by regulations in 42 C.F.R. Part 424, subpart P (sections 424.500-.555). Those regulations define "enrollment" as the process that CMS and its contractors use 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 (or, in some circumstances, to maintain or "validate" an existing enrollment), a physician must complete and submit an "enrollment application." *See* 42 C.F.R. §§ 424.510(a), 424.510(d)(1), 424.515(a). For physicians, the appropriate

enrollment application form is known as a CMS-855I, which we call the 855I.[1] *See* 71 Fed. Reg. 20,753, 20,756 (April 21, 2006); Medicare Program Integrity Manual (PIM), CMS Pub. 100-08, ch. 15, § 15.1.2.[2] A physician's 855I must specify a "practice location," the physical place where the physician delivers or intends to deliver services to Medicare beneficiaries. PIM, ch. 15, § 15.5.4.3.

Once CMS determines, based on information furnished during the application process, that a physician meets the applicable enrollment requirements (set out in section 424.510 and elsewhere), CMS grants the physician Medicare billing privileges – that is, authorization to submit claims and receive payment from Medicare for covered services provided to program beneficiaries.[3] 42 C.F.R. § 424.505. Section 424.520(d) states that for physicians, "[t]he effective date of billing privileges . . . 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."

Factual Background

The following facts are not in dispute. Petitioner first received Medicare billing privileges in August 2009 based on an enrollment application which identified his home address (in Farmington Hills, Michigan) as his sole practice location. *See* CMS Ex. 3, at 14. (A physician is instructed to use his home address when he intends to provide services in patients' homes. PIM, ch. 15, § 15.5.4.3(C).)

In September 2010, Petitioner began seeing patients at a psychiatric hospital in Warren, Michigan under an arrangement with City Medical, P.C. (a physician group). CMS Ex. 7, at 1; P. Ex. 5, at 2 (record of payment by City Medical to Petitioner for services furnished to 73 patients from September 21 through October 19, 2010). A dispute later

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[1] The term "enrollment application" is defined in the regulations to mean a "CMS-approved paper enrollment application or an electronic Medicare enrollment process approved by OMB [Office of Management and Budget]." 42 C.F.R. § 424.502. Medicare's electronic (internet-based) enrollment application process is known as the "Provider Enrollment, Chain and Ownership System" (PECOS).

[2] The PIM and other CMS program manuals are available at http://www. cms.gov/Manuals/IOM/list.asp.

[3] When CMS grants billing privileges to a physician, it issues the physician a billing number known as a Provider Transaction Access Number (PTAN), which is used by Medicare's claims processing system to identify the physician as an enrolled supplier and ensure that proper payments are made. 42 C.F.R. § 424.505 (stating that the granting of billing privileges entails the issuance of a "valid billing number effective for the date a claim was submitted" for an item or service); PIM, ch. 15, §§ 15.9.1, 15.14.9, 15.24.7

arose about whether City Medical was to bill Medicare for Petitioner's services and receive assignment of Petitioner's Medicare payments. *See* CMS Ex. 7, at 1; P. Exs. 2-4.

On October 18, 2010, Wisconsin Physicians Service Insurance Corporation (WPS), a Medicare contractor, notified Petitioner that his PTAN (Medicare billing number) had been deactivated effective October 16, 2010 on the ground that he had not submitted any Medicare claims for 12 consecutive calendar months. CMS Ex. 1, at 1.

On November 11, 2010, Petitioner filed an 855I with WPS (certain parts of the form were filed electronically, other parts on paper). *See* CMS Exs. 2-3. His form identified the psychiatric hospital in Warren, Michigan as a new practice location (in addition to his home address). CMS Ex. 2, at 2. Petitioner also indicated that he was seeking both a "new" enrollment and reactivation of an existing enrollment. CMS Ex. 3, at 12.

On February 17, 2011, WPS approved Petitioner's application, "end-dated" his original PTAN, issued him a new PTAN, and advised him that November 11, 2010 was the "effective date of reactivation." CMS Ex. 9, at 3.

Petitioner filed a request for reconsideration, stating that he needed an earlier effective date in order to receive payment for services that he provided at his new practice location (the psychiatric hospital) during September, October, and November 2010. CMS Ex.7. WPS denied the reconsideration request, stating that the effective date of his new billing number was the date he filed his post-deactivation 855I (November 11, 2010). CMS Ex. 10, at 1. WPS also noted that "[t]o maintain an active enrollment status," Petitioner needed to notify Medicare of changes to enrollment information "within specified time frames." *Id.* (Section 424.516(d) requires a physician to notify Medicare of certain changes to enrollment information, including a change in practice location, within 30 days, and to notify Medicare of other changes within 90 days.)

Petitioner then requested an ALJ hearing, renewing his plea for an earlier effective date. The ALJ, however, held that November 11, 2010 was the earliest effective date that Petitioner could have received under section 424.520(d), stating that "[n]one of petitioner's arguments show as a matter of fact that he filed a valid application" earlier than November 11 or that [WPS] or CMS incorrectly applied the regulatory criteria." *Id.* at 3-4.

In his request for review, Petitioner contends that the ALJ's decision is erroneous because it was "not based on all factual material presented" and asserts that WPS's effective date determination will prevent him from obtaining Medicare payment for covered services furnished prior to November 11, 2010. Oct. 7, 2011 Appeal Letter (Appeal) at 1.

Discussion

Although Petitioner's pro se appeal covers many issues, there is only one properly before the Board: whether the ALJ erred in upholding CMS's effective date determination. We find no error. In his November 11, 2010 855I, Petitioner identified the psychiatric hospital in Warren, Michigan as a new practice location. There is no question that the November 11th 855I was the first Medicare enrollment application filed by Petitioner to enroll at that practice location. Furthermore, neither party disputes that section 424.520(d) applies to the enrollment of a new practice location. Applying that regulation, we hold that CMS correctly determined that the effective date of Petitioner's billing privileges was November 11, 2010, which is the date he filed the application for enrollment of the new practice location, because that date was later than the date he first began furnishing services at that location. Because we hold that November 11, 2010 is the correct effective date based on Petitioner's application for enrollment of a new practice location, we need not decide whether the same effective date would apply if his November 11th application was solely one for reactivation of billing privileges at his old practice location.

Petitioner contends that the "special circumstances" of his Medicare billing and payment relationship with City Medical entitle him to an earlier effective date. Nov. 27, 2011 Reply Letter (Reply) at 2. However, none of those circumstances is relevant or material to a determination of the effective date under section 424.520(d). The effective date determination hinges on two facts unrelated to Petitioner's "special circumstances": the filing date of a Medicare enrollment application, and the date that a physician first starts furnishing services at a new practice location.

Petitioner further contends that when WPS issued him a new PTAN in February 2011, WPS did not consider that he had provided billable services to Medicare beneficiaries "before the expir[ation] of [the] old PTAN" on October 16, 2010. Appeal at 2. Petitioner suggests that by issuing a new PTAN with a November 11, 2010 effective date, WPS effectively (and wrongfully) cut off his eligibility to claim Medicare payment for services he provided at the psychiatric hospital prior to the deactivation – services for which he had one year to submit a valid payment claim. *Id.* at 1, 2, 4, 5. We find no merit in this argument because prior to the October 16, 2010 deactivation, Petitioner's billing privileges had not been expanded to include services provided at the psychiatric hospital. (Petitioner does not claim that he provided services at his previously approved practice location prior to the October 16, 2010 deactivation for which he was unable to bill.)

Finally, Petitioner asserts that CMS disregarded or otherwise departed from its "usual prevalent and customary practice" of setting an effective date 30 days prior to when it receives a supplier's enrollment application. Appeal at 3. Petitioner is referring to the

retrospective billing rule in section 424.521(a)(1). That regulation states that a physician may "retrospectively bill" Medicare for services that were provided up to 30 days (and, in certain disaster situations, for services provided up to 90 days) prior to the physician's "effective date" if the following circumstances are met: (1) the physician has met all program requirements (including those relating to state licensure); (2) the services rendered prior to the effective date were furnished at the enrolled physician's practice location; and (3) "circumstances precluded enrollment in advance of providing services to Medicare beneficiaries[.]"[4] We decline to address this issue because even if denials of retrospective billing are appealable (an issue that we do not reach), Petitioner has not alleged that he met all of the conditions for retrospective billing, and because nothing in the record shows that CMS or WPS denied Petitioner a retrospective billing period when it issued its initial and reconsideration determinations.

/s/
Stephen M. Godek

/s/
Sheila Ann Hegy

/s/
Judith A. Ballard
Presiding Board Member

[4] The preamble to the final rule that promulgated section 424.521(a) states that it "permits newly enrolled physician[s] . . . to submit claims for services that were furnished prior to the date of filing or the date the applicant received billing privileges to participate in the Medicare program." 73 Fed. Reg. at 69,766. Prior to January 1, 2009, "depending on their effective date of enrollment, [physicians were permitted to] retroactively bill the Medicare program for services that were furnished up to 27 months prior to being enrolled to participate in the Medicare program." *Id.*