Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Deryck D. Richardson, Ph.D., LLC,

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-662

Decision No. CR2914

Date: September 4, 2013

DECISION

CGS Administrators, LLC (CGS), an administrative contractor acting on behalf of the Centers for Medicare & Medicaid Services (CMS), determined that Deryck D. Richardson, Ph.D., LLC, Petitioner, was not eligible for enrollment in the Medicare program earlier than September 17, 2012, and that Petitioner could not submit claims for payment of services performed or delivered earlier than August 18, 2012.[1] Petitioner appealed. For the reasons stated below, I affirm CGS's determination.

I. Case Background and Procedural History

Petitioner had been previously enrolled in Medicare as a supplier. On September 27, 2011, CGS issued a revalidation request to Petitioner requiring him to resubmit complete

[1] CMS initially assigned August 19, 2012 as Petitioner's retrospective billing date. I note that 30 days prior to September 17, 2012 was actually August 18, 2012. CMS acknowledges that CGS received Petitioner's approvable reactivation application on September 17, 2012 and granted him a 30-day period of retrospective billing prior to the receipt of his application. I assume the assignment of August 19, 2012 for the retrospective billing date was a clerical error. *See* CMS Br. at 3 n.1. Therefore, I correct the date of retrospective billing from August 19 to August 18, 2012 without further discussion. *See Kate Paylo*, DAB CR2232, at 3 n.4 (2010).

enrollment information within 60 days. CMS Ex. 1. On December 9, 2011, upon receiving no response from Petitioner, CGS issued a "Do Not Forward" letter to Petitioner warning that claims would not be forwarded for payment because of his failure to respond to the revalidation request, and repeating the need for Petitioner to complete the revalidation request. CMS Ex. 2. On December 28, 2011, CGS notified Petitioner that Petitioner's enrollment was deactivated because no revalidation application had been received. CMS Ex. 3.

Nine months later, on September 17, 2012, CGS received Petitioner's Medicare reactivation enrollment application. CMS Ex. 4. CGS requested additional information on September 27 and October 9, 2011. CMS Exs. 5, 6. On October 23, 2012, CGS approved Petitioner's Medicare enrollment application with an effective date of September 17, 2012, and a retrospective billing date of August 19, 2012. CMS Ex. 7.

By letter dated October 29, 2012, Petitioner requested reconsideration of his effective date. CMS Ex. 8. In a February 13, 2013 reconsideration determination, CGS affirmed its initial decision concerning Petitioner's effective date and explained that Petitioner's valid approvable reactivation application was received on September 17, 2012, and that August 19, 2012 was the retrospective billing date.[2] CMS Ex. 9, at 2. By letter dated April 16, 2013, Petitioner timely filed a request for a hearing with the Departmental Appeals Board (Board), Civil Remedies Division.

Following my April 18, 2013 Acknowledgment and Initial Docketing Order, CMS filed a Motion for Summary Disposition (CMS Br.) and ten exhibits (CMS Exs. 1-10). Petitioner did not file a response. On June 11, 2013, I issued an Order to Show Cause. Petitioner responded to the Order to Show Cause on June 17, 2013. Petitioner stated in his response to the Order to Show Cause that it was not his intent to abandon the request

[2] CGS inaccurately characterized August 19, 2012 as Petitioner's "effective date" rather than Petitioner's "retrospective billing date." CMS Exs. 7, 9. In this case, the "effective date" is the date a contractor receives a required enrollment application that it later is able to process to approval. *See* 42 C.F.R. § 424.520(d). However, CMS and its contractors may grant retrospective billing privileges up to 30 days prior to the effective date. *See* 42 C.F.R. § 424.521(a)(1). Here, CGS determined the date it received Petitioner's enrollment application was September 17, 2012, which is the date it should have properly referenced as the effective date. Thus, the earliest date for retrospective billing privileges that could be granted to Petitioner was 30 days prior to September 17, 2012, which is August 18, 2012. To be consistent with the relevant regulations, this decision uses "effective date" in later sections to refer to Petitioner's effective date of enrollment, not the date when Petitioner's retrospective billing began and hereafter corrects the retrospective billing date from August 19 to August 18, 2012.

for hearing but that he had "nothing further to add." Petitioner's Response to Order to Show Cause. Since Petitioner did not object to CMS's exhibits, I admit CMS Exs. 1-10.

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 nonphysician practitioners is established as follows:

> The effective date for billing privileges for . . . nonphysician practitioners . . . 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 . . . nonphysician practitioner 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:

> [N]onphysician practitioners . . . and nonphysician practitioner organizations may retrospectively bill for services when a . . . nonphysician practitioner or . . . a nonphysician practitioner 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 provider or supplier "deactivated for any reason other than nonsubmission of a claim" is required to "complete and submit a new enrollment application to reactivate its

Medicare billing privileges or, when deemed appropriate, at a minimum, recertify that the enrollment information currently on file with Medicare is correct." 42 C.F.R. § 424.540(b)(1).

III. Issue

Whether CMS had a legitimate basis for finding that September 17, 2012, was the effective date for Petitioner's Medicare enrollment and that Petitioner could retrospectively bill for services rendered to Medicare beneficiaries on or after August 18, 2012.

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 Board has 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 Rehabilitation and Skilled Nursing Center, DAB No. 2300, at 3 (2010) (citations omitted). An Administrative Law Judge's (ALJ) role in deciding a summary judgment motion differs from the ALJ's role in resolving a case after a hearing. In the context of summary judgment, the ALJ should not assess credibility or evaluate the weight of conflicting evidence. *Holy Cross Village 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 Rehabilitation, L.P.*, DAB No. 2347, at 5 (2010).

CMS argues that it is entitled to summary judgment in this case "because the material facts are undisputed." CMS Br. at 5. Petitioner has not disputed the material fact in this case, specifically, that CGS received an approvable reactivation application on September 17, 2012 and not before. Therefore, I agree with CMS that summary judgment is appropriate.

b. CGS's September 17, 2012 receipt of Petitioner's reactivation enrollment application necessarily determines Petitioner's effective date and retrospective billing date.

After a supplier is deactivated for any reason other than nonsubmission of claims, a new application is required to reactivate the supplier's participation in Medicare. 42 C.F.R. § 424.540(b)(1). For a reactivation application, the effective date and retrospective billing privileges date are determined in accordance with 42 C.F.R. §§ 424.520(d) and 424.521(a)(1). *Mobile Vision, Inc.*, DAB CR2124 (2010); *Shalbhadra Bafna, M.D.*, DAB CR2419 (2011). "The regulation does not distinguish between 'new enrollee' and 'reactivation' applications, when determining the effective date of a . . . [supplier's] participation in Medicare. *Shalbhadra Bafna, M.D.*, DAB CR2419, at 3.

The effective date for enrollment for nonphysician practitioners and nonphysician practitioner organizations, 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 . . . nonphysician practitioner 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 or supplier 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 CGS received an approvable enrollment application on September 17, 2012. Under the regulations, Petitioner's effective date is September 17, 2012, and his retrospective billing date is August 18, 2012, 30 days before his enrollment application was received. 42 C.F.R. §§ 424.520(d) and 424.521(a)(1).

In Petitioner's reconsideration request he states that he was 'terminated on 12-09-2011 after I had not responded to a revalidation request on a timely basis . . . in early October 2012 . . . mailed in the 855I with supporting documents." CMS Ex. 8, at 1-2 (referring to CGS's request for additional information in October of 2012 after receiving Petitioner's application of September 17, 2012). Petitioner admits that he was indeed terminated for failure to respond to a revalidation request and Petitioner does not dispute the date that his reactivation enrollment application was received. CMS Ex. 4. Therefore, I conclude that Petitioner's effective date of September 17, 2012 was correctly determined. I also correct the date of retrospective billing from August 19 to August 18, 2012, as I previously mentioned in this decision.

c. I am unable to grant Petitioner's request for an earlier effective date based on equitable estoppel.

Petitioner admits in his hearing request that "my application was filed too late to have the most favorable effective date." CMS Ex. 10. Petitioner claims that he "anticipated" that all billing privileges would be retroactively restored to the deactivation date. CMS Ex. 8. In his hearing request, he claims that this belief was based on information obtained from an unnamed person "in charge of applications." CMS Ex. 10.[3] Further, Petitioner claims that the delay in filing the reactivation application was due to his need to care for his wife due to her poor health and the complexity of the enrollment process. Finally, Petitioner asserts that he continued seeing his Medicare clients and that he provided "thousands of dollars of services" to them that have not been reimbursed. CMS Ex. 10.

Petitioner's arguments amount to a claim of equitable estoppel or equitable relief. It is well-established by federal case law, and in Board precedent, that: (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., Armin Aalami Harandi*, DAB CR2682 (2013); *Office of Personnel Mgmt. v. Richmond*, 496 U.S. 414 (1990); *Heckler v. Community Health Services of Crawford County, Inc.*, 467 U.S. 51, 63 (1984); *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 does not allege any affirmative misconduct here and I cannot grant the relief that Petitioner requests.

I am not without sympathy for Petitioner's predicament, but it must be noted that a good portion of that predicament is of his own making. Entities that would participate in Medicare as providers or suppliers are responsible for making themselves aware of, and for complying promptly and carefully with, all the regulatory provisions that govern their eligibility. Such entities may choose to ignore or disregard those provisions as trivial or bothersome, but they do so at peril of that eligibility. *Manor of Wayne Skilled Nursing and Rehabilitation*, DAB No. 2249, at 11 (2009); *Cary Health and Rehabilitation Center*, DAB No. 1771, at 21 n.5 (2001); *Kids Med (Delta Medical Branch)*, DAB CR2494 (2012); *Brookside Rehabilitation and Care Center*, DAB CR1541 (2006); *The Heritage Center*, DAB CR1219 (2004).

Petitioner cannot argue, in any event, that he filed a complete application on an earlier date than CMS determined or that the contractor or CMS incorrectly applied the

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[3] A claim that a provider or supplier received incorrect information from an unidentified Medicare contractor's employee does not amount to a credible showing of affirmative misconduct.

regulatory criteria. I am without authority to order either CGS 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). I have no authority to extend the retrospective billing period for Petitioner in this circumstance or ignore the clear requirements of the regulations governing his enrollment in Medicare. *See Kate E. Paylo*, DAB CR2232, at 14-15. Even accepting all of Petitioner's assertions as true, Petitioner's equitable arguments give me no grounds to grant him 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.").

V. Conclusion

I conclude that it is undisputed that CMS received Petitioner's application on September 17, 2012. I am thereby obliged to find Petitioner's effective date of enrollment is September 17, 2012, with a retrospective billing period starting 30 days prior, on August 18, 2012. Therefore, I grant CMS's motion for summary judgment.

/s/
Richard J. Smith
Administrative Law Judge