Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Cindy M. Cohen, APRN,

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-986

Decision No. CR3023

Date: December 5, 2013

DECISION

Palmetto GBA (Palmetto), an administrative contractor for the Centers for Medicare & Medicaid Services (CMS), determined that the effective date of Medicare billing privileges for Petitioner, Cindy M. Cohen, APRN, is December 19, 2012. Petitioner appealed. For the reasons stated below, I affirm Palmetto's determination.

I. Case Background

Petitioner is an advanced practice registered nurse (APRN) licensed in Hawaii. On or around November 28, 2011, she joined a group practice of nonphysician practitioners called Ocean View Family Health Clinic (Ocean View). On August 1, 2012, the Ocean View clinic manager sent a letter to Palmetto's Jurisdiction 11 office that said he sent a CMS-855I form (one of several Medicare enrollment applications) to that Palmetto office on December 1, 2011, seeking to change Petitioner's practice location on file with Palmetto. CMS Exhibit (Ex.) 1. The letter stated that "[a]pparently this form [the December 1, 2011 CMS-855I] has been lost, so we are resubmitting the form, and supporting documentation." CMS Ex. 1. Petitioner purportedly signed the CMS-855I included with the August 1, 2012 letter on November 28, 2011. CMS Ex. 3, at 15. By letter dated August 21, 2012, Palmetto informed the Ocean View clinic manager that he

sent Petitioner's CMS-855I to the wrong Palmetto jurisdiction; he needed to resend the CMS-855I to Palmetto's Jurisdiction 1 office, which processes enrollment applications for Hawaii.[1] CMS Ex. 2.

The clinic manager subsequently sent Petitioner's CMS-855I to the correct Palmetto office. The exact date he sent the enrollment application is unclear from the record, but by letter dated October 22, 2012, Palmetto informed the clinic manager that additional information was needed to process Petitioner's enrollment application. CMS Ex. 4. Palmetto determined that Petitioner needed to submit a newly signed certification statement as well as a CMS-855R enrollment application to reassign her Medicare benefits to Ocean View. CMS Ex. 4, at 1. Petitioner sent a new certification and CMS-855R, but the CMS-855R did not include a certification signature for Ocean View. CMS Ex. 5, at 4. By letter dated November 28, 2012, Palmetto notified Petitioner that her application was "being closed" because Palmetto "tried to contact [the clinic manager] for additional information needed to process [the CMS-855I] application," but did not received an "appropriate response." CMS Ex. 6, at 1. The notice also stated that the CMS-855R that the Ocean View clinic manager sent had been rejected. CMS Ex. 6, at 1.

On December 19, 2012, Palmetto received a new CMS-855I enrollment application from Petitioner (with a cover letter from the Ocean View clinic manager). CMS Ex. 7. On the CMS-855I, Petitioner indicated that she was using that form to change her Medicare information. CMS Ex. 7, at 3. By letter dated January 4, 2013, Palmetto again requested additional information from the Ocean View clinic manager, including a completed CMS-855R enrollment application to reassign Petitioner's Medicare benefits to Ocean View. CMS Ex. 8. Petitioner submitted the CMS-855R form, but, just as before, there was no certification signature on behalf of Ocean View. CMS Ex. 9, at 2. The CMS-885R sent to Palmetto also did not include Section 1, but rather started at Section 2. CMS Ex. 9, at 1. On January 31, 2013, Palmetto sent a notice to Petitioner that requested she submit Section 1 of the CMS-855R form along with the appropriate signatures within 30 days. CMS Ex. 10. Petitioner apparently did not respond because by notice dated March 4, 2013, Palmetto advised Petitioner and the Ocean View clinic manager that Petitioner's enrollment application had again been "closed." CMS Ex. 11, at 1.

Soon after, Palmetto received a third CMS-855I enrollment application from Petitioner. On March 25, 2013, Palmetto again notified Petitioner that Palmetto needed a completed CMS-855R enrollment application from Petitioner and Ocean View in order to approve her application and reassign her Medicare billing privileges to Ocean View. *See* CMS Ex. 12. Finally, Petitioner submitted a complete CMS-855R that included the appropriate signatures. CMS Ex. 13, at 2. By notice dated April 9, 2013, Palmetto advised Petitioner

---

[1] Medicare administrative contractors (MACs) are divided into "jurisdictions" based on the states that each MAC covers.

that her enrollment application had been approved and her Medicare billing privileges were effective December 19, 2012. CMS Ex. 14, at 1.

Petitioner filed a corrective action plan requesting an earlier effective date for her billing privileges, but Palmetto rejected it. CMS Ex. 16. On May 14, 2013, Petitioner requested reconsideration from Palmetto, stating her initial enrollment application had been sent on December 1, 2011, but was "denied for various reasons . . . ." CMS Ex. 17. Petitioner requested an effective date of December 1, 2011, based on her initial application and because she had been treating Medicare beneficiaries at Ocean View since that time. CMS Ex. 17. On June 3, 2013, Palmetto issued a reconsidered determination that upheld the effective date for Petitioner's billing privileges. CMS Ex. 18, at 1. One day later, on June 4, 2013, Palmetto issued a letter that stated Petitioner's "effective date" was November 19, 2012, because this is "30 days from the receipt date of the [enrollment] application, per Title 42 CFR § 424.521(a)(1)."[2] CMS Ex. 19.

On June 12, 2013, Petitioner requested a hearing to challenge the effective date of her billing privileges. Following the directives in my Acknowledgement and Pre-hearing Order dated July 10, 2013 (Order), the parties submitted their respective prehearing briefs (CMS Br. and P. Br.). CMS filed a motion for summary judgment along with its prehearing brief. CMS submitted 19 proposed exhibits (CMS Exs. 1-19), and Petitioner submitted three proposed exhibits as attachments to her brief (P. Exs. 1-3).

II. Decision on the Record

Neither party has objected to any of the proposed exhibits submitted. Therefore, I admit CMS Exhibits 1-19 and Petitioner Exhibits 1-3 into the record.

---

[2] It is not clear whether the June 4, 2013 letter was a revised initial determination or an amendment to Palmetto's reconsidered determination that granted Petitioner 30 days of retrospective billing privileges. *See* CMS Ex. 19. In its brief, CMS treated the June 4 letter as simply granting retrospective billing privileges, but not amending the actual "effective date" of her billing privileges. CMS Br. at 5. Indeed, the June 4 letter cites only 42 C.F.R. § 424.521, which addresses retrospective billing, and does not cite the regulation for the actual "effective date" of billing privileges, which is addressed in 42 C.F.R. § 424.520(d). CMS Ex. 19. Further, CMS's interpretation is consistent with the practice among CMS's MACs to incorrectly label the date that retrospective billing privileges begin as the "effective date." *See e.g., Rizwan Sadiq, M.D.*, DAB CR2401, at 5-6 (2011). Finally, Petitioner does not dispute this interpretation of the June 4 letter. Accepting CMS's interpretation of the June 4 letter, it appears that Palmetto permissibly decided to provide Petitioner with 30-days of retrospective billing based on Palmetto's determination that Petitioner's Medicare billing privileges were effective December 19, 2012.

Neither party offered the written direct testimony of any witnesses. Accordingly, the record is closed and I will issue this decision based on the written record. *See* Order ¶ 11.

III. Issue

The issue in this case is whether Palmetto, acting on behalf of CMS, properly determined December 19, 2012 as the effective date for Petitioner's Medicare billing privileges.

IV. Jurisdiction

I have jurisdiction to decide this issue. 42 C.F.R. §§ 498.3(b)(15), 498.5(l)(2); *see also* 42 U.S.C. § 1395cc(j)(8).

V. Findings of Fact, Conclusions of Law, and Analysis[3]

The Social Security Act authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations governing the enrollment process for providers and suppliers.[4] 42 U.S.C. §§ 1302, 1395cc(j). The Secretary promulgated enrollment regulations for providers and suppliers at 42 C.F.R. Part 424, Subpart P. Under the Secretary's regulations, a provider or supplier that seeks Medicare billing privileges 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). Upon enrollment, the provider or supplier "receives billing privileges" so that it can receive payment for covered Medicare items or services. *Id.* § 424.505. For suppliers who are physicians or nonphysician practitioners, the effective date for billing privileges is based on the date of filing of en enrollment application that a MAC subsequently approves. *Id.* § 424.520(d).

1. *Palmetto received Petitioner's CMS-855I Medicare enrollment application that it subsequently approved on December 19, 2012.*

After at least one unsuccessful attempt, the Ocean View clinic manager mailed a CMS-855I enrollment application to Palmetto, which Petitioner signed on December 16, 2012. CMS Ex. 7, at 16. Palmetto received the CMS-855I form on December 19, 2012. Petitioner does not dispute this date of receipt. CMS Br. at 3-4; P. Br. at 1 (unnumbered). Because the CMS-855I was not able to be approved as received, Palmetto sent two letters to the Ocean View clinic manager that requested more information (including a

---

[3] My numbered findings of fact and conclusions of law appear in bold and italics.

[4] For Medicare enrollment purposes, Petitioner is considered a "supplier." *See* 42 U.S.C. §§ 1395x(d); 42 C.F.R. §§ 400.202 (definition of *Supplier*), 410.75.

completed CMS-855R form) from Petitioner. CMS Exs. 9-10. By letter dated March 4, 2013, Palmetto notified the Ocean View manager that it "closed" Petitioner's enrollment application after not receiving sufficient responses to Palmetto's request for more information. CMS Ex. 11, at 1. However, after receiving a new CMS-855I enrollment application on March 25, 2013, and after Petitioner submitted complete responses to Palmetto's request for more information, Palmetto apparently determined that it would reopen the CMS-855I enrollment application Palmetto had received December 19, 2012, and approve it.[5] *See* CMS Ex. 14, at 1; CMS Br. at 4-5. The initial determination granting Petitioner Medicare billing privileges effective December 19, 2012, did not explain why Palmetto determined to reopen Petitioner's prior enrollment application, although such action appears to be within Palmetto's discretion.[6] *See* CMS Ex. 14.

Therefore, the evidence demonstrates that on December 19, 2012, Palmetto received Petitioner's CMS-855I enrollment application that it subsequently approved.

2. *Palmetto properly concluded that the effective date for Petitioner's Medicare billing privileges was December 19, 2012.*

By letter dated April 9, 2013, Palmetto notified Petitioner and the Ocean View clinic manager that Petitioner's Medicare enrollment application was approved. CMS Ex. 14. Palmetto set December 19, 2012, as the effective date for Petitioner's billing privileges, which is when Palmetto received one of Petitioner's incomplete CMS-855I from the Ocean View clinic manager. CMS Ex. 14, at 1.

The relevant regulation concerning the effective date of Medicare enrollment states:

> The effective date for billing privileges for physicians, nonphysician practitioners, and physician 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

---

[5] As explained above, the CMS-855I form received on March 25, 2013 was incomplete, and Palmetto required more information from the Ocean View manager and Petitioner. *See* CMS Ex. 12, at 1. It was Petitioner's *third* CMS-855I that Palmetto received from the Ocean View clinic manager that was incomplete.

[6] It is unclear what Palmetto meant when it said that it had "closed" the application it received on December 19, 2012, though it referred to its authority to reject an enrollment application under 42 C.F.R. § 424.525. CMS Ex. 11, at 1. To the extent that Palmetto's action was an unartfully worded rejection and subsequent reopening, it is not reviewable. *See* 42 C.F.R. § 424.525(d) ("Enrollment applications that are rejected are not afforded appeal rights.").

> physician or 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 enrollment application that the Medicare contractor is able to process to approval. The effective date for enrollment is the date the enrollment application was received. *See Tri-Valley Family Medicine, Inc.*, DAB No. 2358, at 7 (2010).[7] Because Palmetto received an enrollment application from Petitioner on December 19, 2012, which it later approved, Palmetto properly considered this date as the effective date for Petitioner's Medicare billing privileges.

3. *Petitioner's equitable arguments are unavailing in this appeal.*

In the current appeal, Petitioner raises a number of reasons why I should grant her billing privileges effective November 28, 2011, nearly one year prior to the date Palmetto established. P. Br. at 1. Petitioner claimed that the clinic manager who submitted the incomplete enrollment applications was responsible for "credentialing, referrals to other providers, prior authorization requests for diagnostic testing, services, durable medical equipment and prescriptions, among many other things," and was "doing the work of at least five employees." P. Br. at 1. She explains that the clinic manager effectively enrolled Petitioner as a practitioner with "all the various insurance companies" in the fall of 2011. P. Br. at 1. Further, Petitioner asserted that she provided services for several months in "good faith" and for the benefit of Medicare beneficiaries while Petitioner's Medicare enrollment was still pending. P. Br. at 1-2. Finally, Petitioner requests that I permit her to bill Medicare beginning November 28, 2011 to avoid "extreme financial hardship on my family." P. Br. at 2. Petitioner's arguments, however, are not legal and amount to an appeal to equity.

I do not have the authority to grant equitable relief. *See US Ultrasound*, DAB No. 2302, at 8 (2010). I cannot grant an exemption to Petitioner under the regulation set forth at 42 C.F.R. § 424.520(d), which is binding on me. *See 1866ICPayday.com, L.L.C.*, DAB No. 2289, at 14 (2009) ("[a]n ALJ is bound by applicable laws and regulations and may not invalidate either a law or regulation on any ground . . ."). Therefore, I cannot provide Petitioner with the equitable relief she seeks.

---

[7] Administrative decisions cited in this decision are accessible on the internet at: http://www.hhs.gov/dab/decisions/index.html.

VI. Conclusion

For the reasons explained above, I affirm CMS's determination that the effective date for Petitioner's Medicare billing privileges is December 19, 2012.

/s/
Scott Anderson
Administrative Law Judge