Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Rosa Lamerson, NP
(NPI: 1538320346)
(PTAN: 483820YS2L),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-16-822

Decision No. CR4783

Date: February 1, 2017

DECISION

The Centers for Medicare & Medicaid Services (CMS), through an administrative contractor, determined that the effective date for the reactivation of the Medicare billing privileges for Rosa Lamerson, NP (Ms. Lamerson or Petitioner) was January 14, 2016, with a retrospective billing period commencing December 15, 2015. The CMS administrative contractor also determined that the effective date for Petitioner's reassignment of her Medicare benefits was December 15, 2015. Ms. Lamerson requested a hearing before an administrative law judge to dispute these effective date determinations.

Because CMS's administrative contractor approved Ms. Lamerson's enrollment application that it received on January 14, 2016, the CMS administrative contractor correctly determined that the effective date for the reactivation of billing privileges is January 14, 2016, with a retrospective billing period commencing December 15, 2015. Further, based on that date of reactivation of billing privileges, Petitioner's reassignment cannot be effective before December 15, 2015. Therefore, I affirm CMS's reconsidered determination.

I. Background and Procedural History

Ms. Lamerson is a nurse practitioner who enrolled in the Medicare program prior to August 2015. CMS (Exhibit) Ex. 7 at 1; CMS Ex. 9 at 4; Petitioner Brief at 5. In August 2015, Ms. Lamerson began to work for Homedica of Louisiana, LLC (Homedica). CMS Ex. 5 at 4, 17, 18.

On September 21, 2015, the CMS administrative contractor received a CMS-855I enrollment application from Ms. Lamerson. CMS Ex. 1 at 1. Petitioner indicated on the application that she was reassigning her Medicare benefits to Homedica. CMS Ex. 1 at 15-16.

In an October 29, 2015 letter, the CMS administrative contractor informed Ms. Lamerson that she needed to file a CMS-855R (application to reassign Medicare benefits) within 30 days and warned that the CMS administrative contractor may reject her CMS-855I application if she did not comply with the request. CMS Ex. 2. The CMS administrative contractor sent this notice to the email address Petitioner provided on her CMS-855I. CMS Ex. 20 at 2. On November 30, 2015, the CMS administrative contractor rejected Petitioner's CMS-855I application for failing to provide the requested CMS-855R application. CMS Ex. 3; CMS Ex. 20 at 2.

In a January 11, 2016 letter, Petitioner informed the CMS administrative contractor that neither she nor Homedica ever received the October 29, 2015 letter requesting the submission of a CMS-855R. Petitioner recounted that in August 2015, Homedica was advised by a representative of the CMS administrative contractor that Petitioner "needed to apply for a new Medicare number since she had moved from Texas to Louisiana" and that the purpose of the CMS-855I "was to establish a Medicare number so that Ms. Lamerson could reassign her Medicare benefits to Homedica." CMS Ex. 4 at 1. Although Petitioner questioned "whether Ms. Lamerson indeed needs a new Medicare number," Petitioner submitted a new CMS-855I and CMS-855R, and requested reassignment to be effective on August 1, 2015, which was the day Petitioner started working for the group practice. CMS Ex. 4 at 1; CMS Ex. 5.

Following Petitioner's submission of the CMS-855I and CMS-855R, significant correspondence between Petitioner and the CMS administrative contractor ensued in order to ensure that the applications were complete. CMS Exs. 6-13. On May 12, 2016, the CMS administrative contractor issued an initial determination in which it informed Petitioner that "your reactivation request is approved" and that the "[e]ffective date of change" is January 11, 2016. CMS Ex. 14 at 1. On May 12, 2016, the CMS administrative contractor also approved Petitioner's request to reassign her Medicare benefits to the group practice with an effective date of December 15, 2015. CMS Ex. 15 at 1-2.

In a May 26, 2016 letter, Petitioner requested reconsideration of the effective dates provided in the CMS administrative contractor's initial determinations. Petitioner asserted that she started to see patients at Homedica in August 2015 and that Petitioner wanted an effective date of August 1, 2015. Petitioner again recounted how, in August 2015, a representative from the CMS administrative contractor informed Homedica that Petitioner needed to file a CMS-855I, but not a CMS-855R, because Petitioner had moved from Texas to Louisiana. Petitioner also stated that the CMS-855I had been rejected, leading to the filing of a new CMS-855I along with a CMS-855R. In support of an effective date of August 1, 2015, Petitioner submitted redacted patient visit records showing that she had seen patients at Homedica since August 2015. CMS Ex. 16 at 1, 3; Petitioner (P.) Ex. 4.

On July 29, 2016, the CMS administrative contractor issued a reconsidered determination. CMS Ex. 18. The reconsidered determination stated that the CMS administrative contractor received Petitioner's CMS-855I and CMS-855R on January 14, 2016. CMS Ex. 18 at 2. The reconsidered determination concluded that December 15, 2015, was the correct "Medicare effective date of billing."[1] CMS Ex. 18 at 3. In coming to this conclusion, the reconsidered determination applied the provisions in the regulations governing the effective dates for Medicare billing privileges for physician and non-physician practitioners (42 C.F.R. § 424.520(d)) and the retrospective billing provisions (42 C.F.R. § 424.521(a)). CMS Ex. 18 at 1-3. The reconsidered determination went on to explain that:

> As stated in the Internet-Only Manuals (IOM) Publication 100-08, Program Integrity Manual (PIM) Chapter 15 Medicare Enrollment, Section 15.5.20 Processing Form CMS-855R Applications, if the reassignor currently has an active Form CMS-855I on file and is only submitting a Form CMS-855R to establish a new reassignment, the effective date shall be the date the practitioner began or will begin rendering services with the reassignee. If the Form CMS-855R is accompanied by a Form CMS-855I, the effective date of the enrollment and the reassignment shall be consistent with the

[1] In the reconsidered determination, the CMS administrative contractor characterized the beginning of the retrospective billing period as the effective date for billing. *See Jorge M. Ballesteros*, DAB CR2067, at 2 (2010) ("CMS apparently sets enrollment effective dates 30 days prior to the date of application"). Therefore, I interpret the determination to mean that the "effective date" is the beginning of the retrospective billing period and not the enrollment effective date. *Rizwan Sadiq, M.D.*, DAB CR2401, at 5-6 (2011).

> 30-day rule (i.e., the later of the date of filing or the date the reassignor first began furnishing services at the new location) specified in 42 CFR §424.521(a).

CMS Ex. 18 at 2.

Petitioner requested a hearing before an administrative law judge to dispute the reconsidered determination. On August 24, 2016, I issued an Acknowledgment and Pre-Hearing Order (Order) that established a prehearing exchange schedule for the parties. In response to the Order, CMS filed a prehearing brief (CMS Br.) and 20 proposed exhibits. Petitioner submitted a brief (P. Br.) and six proposed exhibits.

II. Decision on the Written Record

I admit all of the proposed exhibits into the record because neither party objected to any of them. Order ¶ 7; Civil Remedies Division Procedures (CRDP) § 14(e).

My Order advised the parties to submit written direct testimony for each witness and that I would only hold an in-person hearing if a party requested to cross-examine a witness. Order ¶¶ 8-10; CRDP §§ 16(b), 19(b). CMS offered written direct testimony for a witness (CMS Ex. 20); however, Petitioner did not request to cross-examine that witness. Petitioner did not offer any written direct testimony. Therefore, I issue this decision based on the written record. Pre-Hearing Order ¶ 10; CRDP § 19(d).

III. Issue

Whether CMS had a legitimate basis to assign January 14, 2016, as the effective date for reactivation of Petitioner's Medicare billing privileges and December 15, 2015, as the effective date for Petitioner's reassignment of Medicare benefits to Homedica and the date on which Petitioner's retrospective billing privileges commenced.

IV. Jurisdiction

I have jurisdiction to hear and decide this case. 42 U.S.C. § 1395cc(j)(8); 42 C.F.R. §§ 424.545(a), 498.3(b)(15), (17), 498.5(*l*)(2).

V. Findings of Fact, Conclusions of Law, and Analysis

My findings of fact and conclusions of law are set forth in italics and bold font.

The Social Security Act (Act) authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations governing the enrollment process for providers and suppliers. 42 U.S.C. §§ 1302, 1395cc(j). A "supplier" is "a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes

items or services" under the Medicare provisions of the Act. 42 U.S.C. § 1395x(d); *see also* 42 U.S.C. § 1395x(u). For Medicare program purposes, nurse practitioners provide medical or other health services. 42 U.S.C. § 1395x(s)(2)(H)(i). Consequently, as a nurse practitioner, Petitioner is a supplier.

A supplier must enroll in the Medicare program to receive payment for covered Medicare items or services. 42 C.F.R. § 424.505. The terms "*Enroll/Enrollment* means the process that Medicare uses to establish eligibility to submit claims for Medicare covered services and supplies." 42 C.F.R. § 424.502. A provider or supplier seeking billing privileges under the Medicare program 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). CMS then establishes an effective date for billing privileges under the requirements stated in 42 C.F.R. § 424.520(d) and may permit limited retrospective billing under 42 C.F.R. § 424.521.

1. ***On January 14, 2016, the CMS administrative contractor received Petitioner's enrollment application (CMS -855I), which the CMS administrative contractor ultimately approved.***

Petitioner submitted CMS-855I and CMS-855R applications that the CMS administrative contractor received on January 14, 2016. CMS Ex. 5 at 6, 26; CMS Ex. 18 at 2. After requesting and receiving further information from Petitioner (CMS Exs. 6-13), on May 12, 2016, the CMS administrator approved the applications. CMS Exs. 14, 15.

2. ***Petitioner's effective date for the reactivation of Petitioner's Medicare billing privileges is January 14, 2016, Petitioner's retrospective billing period began on December 15, 2015, and Petitioner's effective date for the reassignment of Medicare billing privileges to Homedica is December 15, 2015.***

In its brief, CMS argues that the CMS administrative contractor correctly applied 42 C.F.R. §§ 424.520(d) and 424.521(a)(1) to conclude January 14, 2016, was the correct effective date of billing privileges and that December 15, 2015, was the correct date for the commencement of retrospective billing privileges. CMS Br. at 7-10.

Petitioner, in her brief, asserts that the CMS administrative contractor incorrectly informed her group practice that she needed to submit a CMS-855I. Petitioner stated that she "had an existing individual Medicare number in 2015" and that it appears that the representative of the CMS administrative contractor indicated that Petitioner needed to submit a CMS-855I based on the mistaken assumption that Petitioner's move from Texas to Louisiana was a change from one administrative contractor's geographic territory to another. P. Br. at 5-6. As further stated by Petitioner:

> All that Petitioner actually needed to submit was an 855-R reassigning her benefits since she had an existing individual Medicare number and the fee-for-service contractor for Texas and Louisiana was the same. In sum, this entire series of events stemmed from [the CMS administrative contractor's] faulty direction given to Homedica to submit an 855-I when an 855-I was unnecessary. Had [the CMS administrative contractor] correctly instructed Homedica that an 855-R needed to be submitted, an 855-R would have been submitted, processed, and approved . . . .

P. Br. at 6.

I disagree with Petitioner's argument because Petitioner needed to submit a CMS-855I, although for a reason that is different than that which the CMS administrative contractor's representative allegedly told Petitioner in August 2015.

CMS's witness was the Provider Relations Hearing Specialist who rendered the reconsidered determination in this case. CMS Ex. 18 at 4; CMS Ex. 20 at 1. The Provider Relations Hearing Specialist testified that Petitioner was not actively enrolled in the Medicare program when she sought reassignment of her Medicare benefits to Homedica. *See* CMS Ex. 20 at 1. I give weight to the witness' testimony concerning Petitioner's deactivated enrollment status because: Petitioner did not dispute the witness' testimony or seek to cross-examine the witness; the witness testified that she relied on the Petitioner's enrollment records when preparing her written testimony (CMS Ex. 2 at 1); and the witness' testimony is consistent with the reconsidered determination, which referred to both of the CMS-855I applications that Petitioner submitted in September 2015, and January 2016, as "enrollment/reactivation applications" (CMS Ex. 18 at 2, 3), and the initial determination that stated "your reactivation request is approved." CMS Ex. 14 at 1.

Because Petitioner's enrollment was not active in August 2015, Petitioner needed to submit a CMS-855I enrollment application to reactivate her billing privileges. *See* CMS Ex. 20 at 1; *see also* CMS Ex. 5 at 9 (indicating that a use for the CMS-855I is to reactivate Medicare enrollment); 42 C.F.R. § 424.540(b)(1) (stating that an enrolled provider or supplier may apply for CMS to reactivate its Medicare billing privileges by completing a new enrollment application or, if deemed appropriate, recertifying its enrollment information that is on file.). This is consistent with the regulation that prohibits CMS from paying a deactivated supplier even if the supplier provided Medicare covered items or services to a Medicare beneficiary. 42 C.F.R. § 424.555(b). Therefore, until Petitioner reactivated her enrollment and billing privileges, she would have no Medicare benefits to reassign to Homedica.

As the reconsidered determination states, the effective date for Medicare billing privileges for physicians, non-physician practitioners, and physician or non-physician practitioner organizations is the later of the "date of filing" or the date the supplier first began furnishing services at a new practice location. 42 C.F.R. § 424.520(d). The "date of filing" is the date that the Medicare contractor "receives" a signed enrollment application that the Medicare contractor is able to process to approval. 73 Fed. Reg. 69,726, 69,769 (Nov. 19, 2008); *Donald Dolce, M.D.*, DAB No. 2685 at 8 (2016). CMS's published guidance for its contractors states that the effective date for the reactivation of Medicare billing privileges is the date on which the contractor received the enrollment application. Medicare Program Integrity Manual (MPIM) § 15.27.1.2.

In the present case, the reconsidered determination properly determined that Petitioner's effective date for reactivation of her enrollment and Medicare billing privileges is January 14, 2016, because that is the date that Petitioner filed an enrollment application that the CMS administrative contractor ultimately approved. Further, the reconsidered determination properly upheld December 15, 2015, as the beginning of the retrospective billing period because this is 30 days before the date the CMS administrative contractor received the enrollment application.

3. I have no jurisdiction to review the CMS administrative contractor's decision to reject Petitioner's September 2015 application or to equitably estop CMS.

Petitioner asserts that in August 2015 the CMS administrative contractor's representative gave Petitioner incorrect information regarding the applications she needed to file. Petitioner also alleges that she never received the October 29, 2015 letter that warned her to submit a CMS-855R within 30 days or the CMS administrative contractor would reject her CMS-855I enrollment application. Petitioner does not believe that the CMS administrative contractor's actions should preclude Petitioner from obtaining an August 2015 effective date that Petitioner sought in both her September 2015 and January 2016 applications. P. Br. at 3, 4, 6-7.

Although it is disturbing that Petitioner may have received incorrect instructions from the CMS administrative contractor and may not have received the October 29, 2015 notice, I do not have jurisdiction to consider those issues. As indicated above, the effective date for billing privileges is governed by the filing date of an enrollment application processed to completion. 42 C.F.R. § 424.520(d). The CMS administrative contractor rejected Petitioner's September 2015 enrollment application. CMS Ex. 3. Therefore, that application can play no role in determining the effective date for billing privileges.

Despite Petitioner's allegation that her application was rejected without notice to correct the enrollment application, the Secretary has precluded review of the CMS administrative contractor's rejection of an enrollment application. I only have jurisdiction to review a matter that is an "initial determination." *See* 42 C.F.R. § 498.3*; see also* 42 U.S.C.

§§ 405(b) 1395cc(j)(8). CMS's decision to reject an enrollment application is not listed as an initial determination (42 C.F.R. § 498.3(b)), and the regulations expressly prohibit further review of a decision to reject an enrollment application. 42 C.F.R. § 424.525(d).

I am also without authority to grant equitable relief based on alleged incorrect information that the CMS administrative contractor's representative provided to Petitioner in August 2015. It is well-established 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., Office of Personnel Mgmt. v. Richmond*, 496 U.S. 414 (1990); *Heckler v. Cmty. Health Servs. of Crawford County, Inc.*, 467 U.S. 51 (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); *U.S. Ultrasound*, DAB No. 2303, at 8 (2010). Petitioner does not assert or provide evidence of affirmative misconduct by the CMS administrative contractor's representative. Therefore, I must reject Petitioner's equitable estoppel argument.

V. Conclusion

I affirm CMS's reconsidered determination.

/s/
Scott Anderson
Administrative Law Judge