Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Parthasarathy Srinivasan, M.D.,
(PTAN: 613790004),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-365

Decision No. CR2875

Date: July 30, 2013

DECISION

The effective date of the reassignment of Medicare Part B claims and payment for those claims from Petitioner, Parthasarathy Srinivasan, M.D., to RenalCare Associates, S.C. (RenalCare) was July 1, 2012, the date on which Petitioner began delivering Medicare-covered services with RenalCare. Petitioner was enrolled in Medicare as a supplier prior to July 1, 2012. Petitioner did not voluntarily terminate his enrollment in Medicare; his enrollment in Medicare was not involuntarily terminated by the Centers for Medicare & Medicaid Services (CMS) or its contractor; and reassignment of Medicare Part B claims and payment for those claims does not require voluntary or involuntary termination of enrollment and reenrollment in Medicare. Petitioner's effective date of enrollment in Medicare and retroactive billing are not at issue in this case and Petitioner's effective date of enrollment in Medicare is unchanged.

I. Background and Jurisdiction

Wisconsin Physicians Service Insurance Corporation (WPS), the Medicare contractor, notified Petitioner's group practice, RenalCare, by letter dated October 15, 2012, that the

application for reassignment of Petitioner's Medicare claims to the practice was received on September 12, 2012;[1] that the application was approved; and that Petitioner's "effective billing date" was August 13, 2012. CMS Exhibit (Ex.) 3 at 5-7.

On October 29, 2012, Petitioner filed a request for reconsideration in which he requested that the "effective date" of August 13, 2012, be changed to July 1, 2012, the date he joined RenalCare. CMS Ex. 5. The reconsideration decision issued by WPS on January 2, 2013, denied Petitioner the relief requested. Petitioner requested review by an Administrative Law Judge (ALJ) by letter dated January 21, 2013. The case was assigned to me for hearing and decision on February 1, 2013, and an Acknowledgement and Prehearing Order (Prehearing Order) was issued at my direction. There is no issue that I have jurisdiction.

On March 4, 2013, CMS filed a motion for summary disposition that I construe to be a motion for summary judgment (CMS Br.). CMS also filed CMS Exs. 1 through 5. On April 29, 2013, Petitioner filed a response to the CMS motion for summary judgment (P. Br.). Petitioner did not file any exhibits; stated that he had no objections to the CMS exhibits; and waived an oral hearing. P. Br. at 2. CMS filed a reply brief (CMS Reply) on May 14, 2013. CMS Exs. 1 through 5 are admitted as evidence. Petitioner's waiver of oral hearing is accepted. Pursuant to section II.D.1 of the Prehearing Order, the CMS brief is treated as the brief on the merits. Pursuant to section II.D.2 of the Prehearing Order, Petitioner's brief is treated as the brief on the merits.

II. Discussion

A. Applicable Law

Section 1831 of the Social Security Act (the Act) (42 U.S.C. § 1395j) establishes the supplementary medical insurance benefits program for the aged and disabled known as Medicare Part B. Payment under the program for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of services and suppliers.[2] Act

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[1] The application was submitted through the internet-based PECOS (Provider Enrollment, Chain and Ownership System) by Alice Musselman, on behalf of Petitioner and RenalCare. CMS Exs. 2, 3.

[2] A "supplier" furnishes services under Medicare and the term supplier applies to physicians or other practitioners and facilities that are not included within the definition of the phrase "provider of services." Act § 1861(d) (42 U.S.C. § 1395x(d)). A "provider of services," commonly shortened to "provider," includes hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities,
(Footnote continued next page.)

§§ 1835(a) (42 U.S.C. § 1395n(a)), 1842(h)(1) (42 U.S.C. § 1395(u)(h)(1)). Administration of the Part B program is through contractors. Act § 1842(a) (42 U.S.C. § 1395u(a)).

Subject to some limitations, qualified physician services are covered by Medicare Part B for those physicians enrolled in Medicare. Act §§ 1832(a) (42 U.S.C. § 1395k(a)), 1861(s)(1) (42 U.S.C. § 1395x(s)(1)); 42 C.F.R. § 410.20.[3] "Physician's services" are professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls subject to some exceptions. Act § 1861(q) (42 U.S.C. § 1395x(q)); 42 C.F.R. § 410.20.

The Act requires the Secretary of Health and Human Services (the Secretary) to issue regulations that establish a process for the enrollment of providers and suppliers, including the right to a hearing and judicial review of certain enrollment determinations. Act § 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to 42 C.F.R. § 424.505, a provider or supplier must be enrolled in the Medicare program and be issued a billing number to have billing privileges and to be eligible to receive payment for services rendered to a Medicare-eligible beneficiary. The effective date of a physician's enrollment in Medicare is governed by regulations at 42 C.F.R. § 424.520(d). The effective date of enrollment for a physician may only be the later of two dates: the date when the physician filed an application for enrollment that was subsequently approved by a Medicare contractor charged with reviewing the application on behalf of CMS; or the date when the physician first began providing services at a new practice location. *Id.* The date of filing of the enrollment application is the date when the complete enrollment application and supporting documentation is received by the designated Medicare contractor. 42 C.F.R. § 424.510(d)(1); 73 Fed. Reg. 69,725, 69,769 (Nov. 19, 2008). An enrolled physician may bill Medicare for covered services provided to Medicare-eligible beneficiaries up to 30 days prior to the effective date of enrollment, if circumstances precluded enrollment before the services were provided. Retroactive billing for up to 90 days prior to the effective date of enrollment is permitted only in case of a Presidentially-declared disaster pursuant to 42 U.S.C. §§ 5121-5206. 42 C.F.R. § 424.521.

(Footnote continued.)

home health agencies, hospice programs, and a fund as described in sections 1814(g) and 1835(e) of the Act. Act § 1861(u) (42 U.S.C. § 1395x(u)). The distinction between providers and suppliers is important because they are treated differently under the Act for some purposes.

[3] Citations are to the revision of the Code of Federal Regulations (C.F.R.) in effect at the time of the initial determination, unless otherwise indicated.

B. Issue

Whether the effective date of Petitioner's reassignment of Medicare claims and payment for those claims was correctly determined in this case.

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

My conclusions of law are set forth in bold text followed by my findings of fact and analysis.

1. Summary judgment procedures do not apply in this case because Petitioner has waived oral hearing and agreed to a decision on the merits based on the documentary evidence and the parties' pleadings.

CMS requested summary judgment. Summary judgment is not automatic upon request but is limited to certain specific conditions. The Secretary's regulations that establish the procedure to be followed in adjudicating Petitioner's case are at 42 C.F.R. Part 498. 42 C.F.R. § 424.545(a)(1). The regulations do not establish a summary judgment procedure or recognize such a procedure. However, the Departmental Appeals Board (the Board) has long accepted that summary judgment is an acceptable procedural device in cases adjudicated pursuant to 42 C.F.R. pt. 498. *See, e.g., Ill. Knights Templar Home*, DAB No. 2274, at 3-4 (2009); *Garden City Med. Clinic*, DAB No. 1763 (2001); *Everett Rehab. & Med. Ctr.*, DAB No. 1628, at 3 (1997). The Board also has recognized that the Federal Rules of Civil Procedure do not apply in administrative adjudications such as this, but the Board has accepted that Fed. R. Civ. Pro. 56 and related cases provide useful guidance for determining whether summary judgment is appropriate. Furthermore, a summary judgment procedure was adopted as a matter of judicial economy within my authority to regulate the course of proceedings and made available to the parties in the litigation of this case by my Prehearing Order dated February 1, 2013. The parties were given notice by the Prehearing Order that summary judgment is an available procedural device and that the law as it has developed related to Fed. R. Civ. Pro. 56 will be applied.

In this case, Petitioner affirmatively waived the right to an oral hearing in writing as required by 42 C.F.R. § 498.66. P. Br. at 2. The waiver is acceptable and I conclude that an oral hearing is not required. Therefore a decision based on the documentary evidence and pleadings of the parties without an oral hearing is permissible and there is no need to resort to a summary judgment procedure.

2. Reassignment of Medicare claims and receipt of reimbursement for those claims does not require a new application to enroll where the provider or supplier is already enrolled, with limited exceptions not applicable in this case.

3. The effective date of Petitioner's reassignment to RenalCare was July 1, 2012.

Petitioner merged his solo practice with RenalCare, an Illinois practice group, on July 1, 2012. Prior to joining RenalCare Petitioner was enrolled as a Medicare provider who was authorized to provide services to Medicare-eligible beneficiaries and file claims for Medicare covered services. Petitioner desired to reassign his Medicare billing privileges to RenalCare. The application for reassignment was filed through PECOS on September 12, 2012. WPS granted the reassignment effective September 12, 2012 and advised Petitioner and RenalCare that RenalCare could bill for services pursuant to the reassignment retroactively to August 13, 2012. Request for Hearing; P. Br. at 1; CMS Br. at 2-3; CMS Exs. 2-5.

The CMS-855I filed by Petitioner through PECOS on September 12, 2012, reflects that it was for a "change of information" it also states more specifically that it is for "[a] Medicare Part B practitioner . . . currently enrolled in the Medicare program . . . [and] the practitioner is adding, deleting, or changing general Medicare enrollment information." CMS Ex. 2 at 3, 5, 7. The CMS-855I was not for a change of practice location. CMS Ex. 2 at 2. The application also shows that it is for a reassignment of benefits with a requested effective date of July 1, 2012. CMS Ex. 2 at 8. On September 12, 2012, Petitioner also filed a CMS-855R through PECOS. The CMS-855R reflects that it is for an enrolled provider or supplier, filed in order to add a new reassignment from Petitioner to RenalCare. CMS Ex. 3 at 1, 3, 8, 10.

Form CMS-855I is titled Medicare Enrollment Application – Physicians and Non-Physician Practitioners. The instructions for CMS-855I state that the form is to be used for enrollment and it is also to be used by those currently enrolled who need to make changes to enrollment information. The instructions state that a form CMS-855R must also be filed for a reassignment of benefits. Form CMS-855R is titled Medicare Enrollment Application –Reassignment of Medicare Benefits. The instructions for CMS855R specify that it is the form to be used by an enrolled physician or non-physician practitioner to: reassign Medicare payments, change a reassignment, or terminate a reassignment. Form CMS-855R refers to "reassigning Medicare payments," "reassignment of Medicare benefits," and "reassigning [the] right to bill the Medicare program and receive Medicare payments." [4] The various phrases used in the form all

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[4] CMS forms are available at: www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html. Enrollment application forms and their use are described in the Medicare Program Integrity Manual (MPIM), CMS pub. 100-08, chap. 15, Medicare Enrollment, § 15.1.1 (rev. 404, eff. Apr. 22, 2012). The MPIM § 15.1.2 (rev. 412, eff.
(Footnote continued next page.)

refer to the same concept that an enrolled physician or non-physician practitioner may provide services to a Medicare beneficiary for covered services but, rather than file a claim directly with Medicare and receiving payment from Medicare, the physician or practitioner may reassign the right to bill Medicare and receive payment from Medicare to his or her employer, clinic, group practice, or other eligible supplier. MPIM 15.5.4.3 (rev. 435, eff. Nov. 20, 2012) provides that a solely-owned physician or practitioner organization, such as Petitioner, uses the CMS-855I to report changes of information to CMS, but if not all data related to the change is captured on the CMS-855I, then the applicable form should be filed, for example a reassignment requires the filing of the CMS-855R in addition to the CMS 855I, as Petitioner did in this case. Both the CMS-855I and CMS-855R may be filed through PECOS, as they were in this case.

Petitioner argues that he was already enrolled and participating in Medicare when he joined RenalCare on July 1, 2012 and his application through PECOS was only to reassign his billing privileges to RenalCare. Petitioner argues that a distinction exists and should be recognized between initial enrollment in Medicare and simply changing information or reassigning billing privileges. Therefore, Petitioner argues that the correct effective date for his reassignment of billing privileges should be July 1, 2012, when he started providing services with RenalCare. Petitioner asserts that WPS and CMS erred by treating Petitioner as if he initially enrolled effective September 12, 2012, with 30-days for retroactive billing with RenalCare as assignee of his billing privileges. P. Br. at 2, 4-5. Petitioner also argues that CMS's action is "unjust and inequitable" and operates as a temporary denial of enrollment for the period July 1, 2012 to August 13, 2012, without the due process protections provided by the Act and regulations.[5] P. Br. at 6-7.

(Footnote continued.)

April 30, 2012) provides that "[p]roviders or suppliers, including physicians, may enroll or update their Medicare enrollment using" PECOS or the paper enrollment forms.

[5] Petitioner apparently concluded that during the period July 1 to August 13, 2012, he was unable to file claims for reimbursement from Medicare even though he was enrolled at the time. Petitioner does not offer an explanation or support for that conclusion and I have no basis on which to judge its validity. I have no evidence as to the amounts that Petitioner was prevented from billing during the period for Medicare-eligible services rendered to Medicare-eligible beneficiaries and no evidence that that any claims to Medicare were denied based on his status during the period. However, such evidence is not relevant to any issue I may decide and standing to maintain this action is not dependent upon any actual loss.

CMS argues in its reply brief that Petitioner is wrong in his interpretation of the applicable regulation and its regulatory history. CMS Reply at 2. The gist of the CMS argument is that there is no difference between enrollment applications and reassignment applications for purposes of effective date determinations. CMS argues that the Board is not bound to follow CMS policy set forth in the MPIM. CMS Reply at 1-4. Regarding Petitioner's argument that he was effectively denied enrollment for the period July 1 to August 13, 2012, CMS argues that I have no authority to grant equitable relief but I am bound to follow the regulations. CMS Reply at 4-7.

I conclude that Petitioner is correct that in this case that there is a difference between enrollment and reassignment. Further, there is a difference between the effective date of enrollment and the earliest date for retroactive billing, and the effective date of a reassignment by an enrolled supplier such as Petitioner. In this case, WPS erred by treating Petitioner's application for the reassignment to RenalCare and the notice of change of enrollment information as a new enrollment by Petitioner, even though he was already enrolled and there was no basis on which to terminate his prior enrollment and no requirement that he voluntarily do so. Therefore, the effective date of enrollment and the authorized period for retroactive billing are not at issue in this case. Rather, the issue to be resolved is the correct effective date of the reassignment. The issue is resolved based upon the Act, regulations, and CMS's implementation of the Act and regulations and it is not necessary to address equitable arguments raised by Petitioner.

The definitions of "enrollment" and "reassignment" in the Act, the applicable regulations, and CMS policies must be considered. The Act provides that "[a]ny physician or supplier may voluntarily enter into an agreement with the Secretary to become a participating physician or supplier." Act § 1842(h)(1). A participating physician or supplier is one who agrees to accept payment under Medicare Part B on an assignment basis for all items and services delivered to a Medicare Part B beneficiary. *Id.* The Act does not define the term enrollment. However, the processes for provider and supplier enrollment, re-enrollment, revalidation of enrollment,[6] and termination of enrollment, in addition to Secretarial authority to effectuate and administer these processes, are established by section 1866 of the Act. The assignment and reassignment of benefits under Medicare are not discussed in section 1866.

The Act provides for assignment and reassignment in subsections 1842(b)(3)(B)(ii), (b)(6) and (h)(3)(B). Section 1842 of the Act relates to the administration of Medicare Part B. Subsection 1842(b)(6) provides, generally, that payments for covered services

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[6] The terms "re-enrollment," "renewal of enrollment" and "revalidation of enrollment" are used synonymously in section 1866 of the Act. Act § 1866(j)(1)(B), (2)(D)(iii)-(iv), (5).

under Medicare Part B may only be paid to the Medicare beneficiary or, pursuant to an assignment, to the beneficiary's physician or other person who delivered the service. Subsection 1842(b)(6) also provides that payment may be made to the employer of the physician or other person who delivered the service if the physician or other person is required as a condition of employment to turn-over the fee to his or her employer, or pursuant to a contractual arrangement that meets program integrity and other safeguards established by the Secretary. Assignment involves the Medicare beneficiary and a physician or other supplier agreeing to the payment of Medicare payment directly to the physician or other supplier. Reassignment, as pertinent to the case before me, is the agreement of the physician or supplier to have the Medicare benefits assigned to him paid to his employer or practice group.

Generally, a provider or supplier must be enrolled in Medicare to receive payment from Medicare for covered Medicare items or services delivered to a Medicare beneficiary. When a provider or supplier is enrolled they receive billing privileges. 42 C.F.R. § 424.505. The terms enroll and enrollment are defined in the applicable regulation as follows:

> *Enroll/Enrollment* means the process that Medicare uses to establish eligibility to submit claims for Medicare covered services and supplies. The process includes —
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> (1) Identification of a provider or supplier;
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> (2) Validation of the provider's or supplier's eligibility to provide items or services to Medicare beneficiaries;
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> (3) Identification and confirmation of the provider or supplier's practice location(s) and owner(s); and
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> (4) Granting the provider or supplier Medicare billing privileges.

42 C.F.R. § 424.502 (emphasis in original). The requirements for enrolling and re-enrolling in Medicare are set forth at 42 C.F.R. § 424.510. The drafters did not define reassignment in 42 C.F.R. § 424.502 or address the requirements for reassignment in 42 C.F.R. § 424.510.

Although reassignment is not specifically defined by the regulation, the procedure to reassign Medicare benefit payments is established by regulation. Pursuant to 42 C.F.R. § 424.55, Medicare pays a supplier for covered services if the Medicare beneficiary assigns the claim to the supplier and the supplier accepts the assignment subject to the limitations specified in the regulation. Generally, reassignment of Medicare payments by a supplier, including a physician such as Petitioner, is prohibited, except that reassignment for fees for services to an employer is permitted if required as a condition of employment. Reassignment for a supplier's services to an entity enrolled in Medicare pursuant to a contractual arrangement; reassignment to a government agency or entity;

reassignment pursuant to court order; and payment to a billing and collection agent of a suppler are also permitted exceptions to the rule against reassignment by suppliers. 42 C.F.R. § 424.80(a), (b). Petitioner's reassignment of claims for his services to Medicare beneficiaries to RenalCare is permissible under section 1842(b)(3)(B)(ii) and (b)(6) and 42 C.F.R. § 424.80(b)(1), (2), or (5).

The MPIM § 15.1.1 defines enrollment as the process that Medicare uses to grant billing privileges. Section 15.1.1 of the MPIM defines reassignment as the situation when "an individual physician, non-physician practitioner, or other supplier grants another Medicare-enrolled provider or supplier the right to receive payment for the physician's, non-physician practitioner's or other supplier's services."

Once enrolled in Medicare a supplier must meet specific regulatory requirements to maintain enrollment, including reporting change of enrollment information. 42 C.F.R. pt. 424, subpt. P. Requirements for reporting changes and updates, and periodic revalidation of enrollment information are established by 42 C.F.R. § 424.515. The regulation specifies that:

> To maintain Medicare billing privileges, a provider or supplier (other than a DMEPOS supplier) must resubmit and recertify the accuracy of its enrollment information every 5 years. All providers and suppliers currently billing the Medicare program or initially enrolling in the Medicare program are required to complete the applicable enrollment application. The provider or supplier then enters a 5-year revalidation cycle once a completed enrollment application is submitted and validated.

42 C.F.R. § 424.515. For reporting changes and updates, and for revalidation, the regulation requires that the provider or supplier submit an enrollment application and supporting documentation, and meet the same requirements of 42 C.F.R. § 424.510 as when initially enrolling in Medicare. However, a new certification of program compliance and a new provider agreement are not required for resubmission and certification for revalidation of enrollment information. CMS reserves the right to do an on-site inspection to validate information and to do off-cycle revalidations. 42 C.F.R. § 424.515(b)-(e). The plain language of 42 C.F.R. § 424.515 shows that reporting changes and updates and revalidation are not the same as enrolling or reenrolling after a period of not being enrolled in Medicare. Further, 42 C.F.R. § 424.516(d), which establishes additional provider and supplier requirements for enrolling and maintaining active enrollment status, requires that physicians report any change in practice location, change in ownership, or adverse legal action legal action within 30 days and all other changes in enrollment within 90 days. The regulation does not state that such changes or reporting those changes results in voluntary or involuntary termination of enrolled status

so that reenrollment is necessary. Failure to report is, however, a basis for CMS to revoke enrollment and billing privileges. 42 C.F.R. § 424.535(a)(9); 73 Fed. Reg. 69,725, at 69,780 (Nov. 19, 2008). The regulations do not specifically list reassignment of claims as a change that requires reporting but it is clear that reassignment is treated as a change that triggers a requirement to notify CMS. As already noted, the instructions for Form CMS-855I state that it is to be used for changes and CMS-855R must also be filed for a reassignment of benefits.

The effective date of Medicare enrollment and billing privileges for physicians is dictated by 42 C.F.R. § 424.520(d). The regulation provides:

> (d) *Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations.* The effective date for billing privileges for physician, 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 physician or nonphysician practitioner first began furnishing services at a new practice location.

42 C.F.R. § 424.520(d) (emphasis added). The "effective date for billing privileges" is the effective date of enrollment based on the definition of enrollment found in 42 C.F.R. § 424.502.[7] The plain language of this section establishes two possible points in time when a physician, nonphysician practitioner or organizations of either (hereafter referred to as practitioner or practitioners) is enrolled in Medicare with billing privileges and may begin to file claims with the Medicare contractor for covered services delivered to Medicare beneficiaries: (1) the date an enrollment application is submitted that is subsequently approved; or (2) the date the newly enrolled supplier actually begins delivering services at his practice location. The regulation provides that the later date controls, i.e., no claim can be made if no services are provided even though one is enrolled; and one cannot be considered for enrollment before the date that the successful enrollment application is filed and received by the Medicare contractor.

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[7] MPIM § 15.17 uses the phrase "effective date of Medicare billing privileges" and "effective date of enrollment" synonymously. MPIM § 15.17, subsec. C, discusses the legal distinction between "effective date of enrollment" determined under 42 C.F.R. § 424.520(d) and "retrospective billing date" which is determined under 42 C.F.R. § 424.521 and is dependent upon the effective date of enrollment.

The regulatory history for this section is consistent with my reading of the regulation. The drafters considered but rejected the approach of establishing the enrollment date as the date on which the Medicare contractor approved the practitioner's enrollment application, which would prohibit practitioners from billing for services to Medicare beneficiaries prior to enrollment and receipt of billing privileges. 73 Fed. Reg. at 69,766. The drafters adopted the approach reflected by the current regulation. The drafters stated that pursuant to this approach,

> [T]he *initial enrollment date* for physician and NPP [non-physician practitioners] organizations and individual practitioners, including physician and NPPs, as the later of: (1) The date of filing of a Medicare enrollment application that was subsequently approved by a fee-for-service (FFS) contractor; or (2) the date an enrolled supplier first started furnishing services at a new practice location. The date of filing the enrollment application is the date that the Medicare FFS contractor received a signed Medicare enrollment application that the Medicare FFS contractor is able to process to approval. This option would allow a supplier that is already seeing non-Medicare patients to start billing for Medicare patients beginning on the day they submit an enrollment application that can be fully processed. In contrast to the first option, newly enrolling physicians and NPP organizations, and individual practitioners or physicians and NPP organizations and individual practitioners that are establishing or changing a practice location would be allowed to bill the Medicare program for services furnished to Medicare beneficiaries on or after the date of filing if a Medicare contractor approves Medicare billing privileges. . . .

73 Fed. Reg. at 69,766-67 (emphasis added). The drafters explained:

> We maintain that it is not possible to verify that a supplier has met all of Medicare's enrollment requirements prior to submitting an enrollment application. Therefore, the Medicare program should not be billed for services before the later of the two dates that a physician or NPP organization, physician, or NPP has submitted an enrollment application that

> can be fully processed or when the enrolled supplier is open for business.

73 Fed. Reg. at 69,767.

It is clear from the language of 42 C.F.R. § 424.520(d) and its history that it applies to those supplier practitioners who are newly enrolling or re-enrolling in Medicare or those enrolling to establish a new practice location, not to those practitioners already enrolled. In this case Petitioner was already enrolled and not establishing a new practice location but was simply reassigning his right to payment and providing WPS notice of that change. There is no evidence that Petitioner voluntarily terminated his enrollment in conjunction with the reassignment of Medicare claims and CMS has cited no authority that he was required to do so. There is also no evidence that Petitioner's enrollment was involuntarily terminated by CMS or that there were grounds to do so.

The CMS policy on reassignment is reflected in its instruction to the Medicare contractor for processing a reassignment applications. CMS plainly states that the effective date of reassignment of an already enrolled supplier is determined only by the date that the supplier began or will begin providing services with the reassignee. MPIM § 15.5.20, titled "Processing Form CMS-855R Applications" (rev. 416, eff. Feb. 27, 2012), is set forth here in its entirety:

> A. General Information
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> A CMS-855R application must be completed for any individual who will: (1) reassign his/her benefits to an eligible entity, or (2) terminate an existing reassignment.
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> If the individual who wants to reassign his or her benefits is not enrolled in Medicare, the person must complete a CMS-855I as well as the CMS-855R. (The CMS-855I and CMS-855R can be submitted concurrently.) Moreover, if the entity to which the person's benefits will be reassigned is not enrolled in Medicare, the organization must complete a CMS-855B. (See section 15.7.6 for additional instructions regarding the joint processing of CMS-855Rs, CMS-855Bs, and CMS-855Is.)
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> Note that benefits are reassigned to a supplier, not to the practice location(s) of the supplier. As such, the contractor shall not require each practitioner in a group to submit a CMS-855R each time the group adds a practice location.

In addition:

- An individual can receive reassigned benefits. The most common example of this is a physician or practitioner who reassigns his/her benefits to a physician who is either: (1) a sole proprietor, or (2) the sole owner of an entity listed in section 4A of the CMS-855I. Here, the only forms that will be required are the CMS-855R, and separate CMS-855Is from the reassignor and the reassignee. (No CMS-855B is implicated.) The reassignee himself/herself must sign section 4B of the CMS-855R, as there is no authorized or delegated official involved.
- The contractor shall follow the instructions in Pub. 100-04, chapter 1, section 30.2 to ensure that a group or person is eligible to receive reassigned benefits.
- If the individual is initiating a reassignment, both he/she and the group's authorized or delegated official must sign section 4 of the CMS-855R. If either of the two signatures is missing, the contractor may return the application per section 15.8.1 of this chapter.
- If the person (or group) is terminating a reassignment, either party may sign section 4 of the CMS-855R; obtaining both signatures is not required. If no signatures are present, the contractor may return the application per section 15.8.1 of this chapter.
- A CMS-855R is required to terminate a reassignment. The termination cannot be done via the CMS-855I.
- The authorized or delegated official who signs section 4 of the CMS-855R must be someone who is currently on file with the contractor as such. If this is a new enrollment, with a joint submission of the CMS-855B, CMS-855I, and CMS-855R, the person must be listed on the CMS-855B as an authorized or delegated official.
- **The effective date of a reassignment is the date on which the individual began or will begin rendering services with the reassignee.**
- The contractor need not verify whether the reassigning individual is a W-2 employee or a 1099 contractor.
- There may be situations where a CMS-855R is submitted and the group practice is already enrolled in Medicare. However, the authorized official is not on file. In this case, the contractor shall return the CMS-855R, with a

> request that the group submit a CMS-855B change request adding the new authorized official.
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> • In situations where the supplier is both adding and terminating a reassignment, each transaction must be reported on a separate CMS-855R. The same CMS-855R cannot be used for both transactions.
>
> • In situations where an individual is reassigning benefits to a person/entity, both the reassignor and the reassignee must be enrolled with the same contractor.[8]

(Emphasis added.) Two critical policy statements are made by MPIM § 15.5.20: (1) there is no requirement that an enrolled supplier voluntarily terminate an existing enrollment as a supplier in order to accomplish a reassignment; and (2) the contractor is instructed by CMS that the effective date of the reassignment is the date on which the reassignor began or will begin delivering covered services to Medicare beneficiaries with the reassignee.

CMS errs arguing that there is no distinction between a new enrollment and a reassignment request received from a currently enrolled supplier such as Petitioner. CMS Reply at 2. The CMS argument advanced before me is contrary to CMS policy. CMS argues that the MPIM does not have the force and effect of law and is not binding upon the Board. CMS Reply at 3. It is not clear whether CMS intends to suggest that its policy is also not binding upon CMS. But CMS may not so easily disavow its own

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[8] CMS also provides the following interpretation in its Frequently Asked Questions page at https://questions.cms.gov in response to the question "[h]ow do physicians join or leave a group:"

> If both the physician and the group are already enrolled with the same carrier, the physician and the group together are required to complete a CMS 855R showing the date the physician joined the group and reassigned benefits to the group. If a physician leaves a group, the physician or the group should complete the CMS 855R, showing the date the physician left the group. When leaving the group, the CMS 855R does not need to be signed by both the physician and the group. If either the physician or the group have not enrolled with the carrier, they must first complete the appropriate CMS 855 for either an individual (CMS 855I) or group (CMS 855B) before the reassignment can be effective. (FAQ1983).

policies and CMS will be held to its public pronouncements of its interpretations and applications of the Act and controlling regulations to the extent that they can be harmonized. MPIM § 15.1.3 (rev. 356, Sep. 24, 2010) requires that Medicare contractors adhere to the processing guidelines established by the MPIM chap. 15. In this case, I conclude that WPS did not comply with the requirements of MPIM chap. 15 and I do not accept the implication of CMS that it should not be bound by its instructions to WPS as reflected in the MPIM, to the extent that those instructions do not conflict with the Act and regulations.

Petitioner filed a CMS-855I and a CMS-855R. As already noted, CMS requires that the CMS-855I form be used by physicians for enrolling in Medicare and for reporting any change in enrollment information. A CMS-855R is used to report a reassignment of Medicare claims and payment of benefits.

CMS cites to no provision of the Act, the regulations, or another policy that requires voluntary termination of Petitioner's existing enrollment in connection with the reassignment to RenalCare. MPIM § 15.10 (rev. 416, eff. Apr. 13, 2012) does not require that a voluntary termination be submitted with a request for change of information, including a reassignment, except in three cases: a change of Tax Identification Number (TIN), a change of practice location to a different state or to the geographic location of a different Medicare Administrative Contractor or when there may be different rates applicable, and certain changes of ownership (CHOW). MPIM §§ 15.5.1 (rev. 414, eff. May 7, 2012) and 15.7.6B (rev. 423, eff. Jul. 2, 2012) require that when a supplier reports a change in TIN, the supplier must file a form voluntarily terminating enrollment and must also file an application for a new enrollment. MPIM § 15.7.6B also provides that if a supplier is adding or changing a practice location and the new location is in another state within the contractor's jurisdiction, the contractor verifies that the supplier meets all requirements to practice in the state; a new application to enroll is not required, but the contractor is required to create a new enrollment record for the supplier for the new state. In some but not all CHOWs the old owner must voluntarily terminate a facility's enrollment and the new owner must file an initial enrollment. If a contractor determines that a CHOW has not occurred but there was a change in ownership such as a minor stock transaction, the change is reported as a change of information, unless there is a change in TIN, which would require voluntary termination of the existing enrollment and a new enrollment. MPIM § 15.7.8.2.1.1B (rev. 416, eff. Feb. 27, 2012). If a new owner proposes to relocate a supplier concurrent with a CHOW to a different geographic area, serving different clients than previously served, and with different personnel, the transaction is treated as an initial enrollment by a new supplier rather than an address change of an existing supplier. MPIM§ 15.7.8.2.1.1C (rev. 416, eff. Feb. 27, 2012 and State Operations Manual CMS Pub. 100-7, chap. 3, § 3210.1B5 (rev. 1, May 21, 2004).

Reasons for which CMS is authorized to involuntarily revoke enrollment and billing privileges are set forth in 42 C.F.R. § 424.535. Reassignment is not listed as a basis for

involuntary revocation. CMS may deactivate a provider or supplier's Medicare billing privileges if the provider or supplier does not report a change to the information provided on the enrollment application within 90 days. Examples that must be reported in 90 days are change in practice location, change in managing employee, and a change in billing services. A change in ownership or control must be reported within 30 calendar days. 42 C.F.R. §§ 424.540, 424.550(b). Although a reassignment of Medicare benefit payments may trigger a requirement to report a change to the Medicare contractor, there is no allegation by CMS that Petitioner's billing privileges were either revoked or deactivated because he failed to timely report the change related to his reassignment to RenalCare.

The evidence shows that Petitioner was enrolled prior to July 1, 2012. The evidence does not show any of the three circumstances specified by the MPIM when voluntary termination is necessary, i.e., a CHOW, change of practice location to a new state or geographic area, or change of TIN. There is also no evidence that CMS had authority to involuntarily terminate Petitioner's enrollment pursuant to 42 C.F.R. § 424.535. Although evidence shows that Petitioner did not file the CMS-855I and CMS-855R until September 12, 2012, the highlighted language of MPIM § 15.5.20A provides that the effective date is the day that the delivery of services began and there is no statement that indicates the date of filing affects the effective date.

CMS asserts that other ALJs have not recognized a distinction between an initial enrollment or a reassignment in the application of 42 C.F.R. §§ 424.520 and 424.521, but have found themselves bound to apply the regulation, citing *Bernard Farzin, M.D.* DAB CR2566 (2012), *Judith Kramer, M.D.* DAB CR2183 (2010); and *Michael Majette, D.C.*, DAB CR2142 (2010). The CMS argument and the rationale stated in the cited cases may be persuasive in a case where 42 C.F.R. §§ 424.520 and 424.521 applied, i.e. a case in which a new application for enrollment or reenrollment was required. However, in all three cases the ALJ or Board Member concluded that a new enrollment was required without specifically stating why. Therefore, none of the cases address the situation of a reassignment that does not require a new enrollment such as this case.

CMS has established as a matter of policy in the MPIM that certain situations trigger a requirement for an enrolled supplier to voluntarily terminate an existing enrollment and to file a new enrollment, but none for those situations are reflected by the facts of this case. Therefore, I conclude that Petitioner was enrolled and continued to be enrolled in Medicare as a physician prior to and on July 1, 2012 and thereafter. Petitioner did not voluntarily terminate his enrollment in conjunction with the reassignment to RenalCare; and CMS did not involuntarily terminate Petitioner's enrollment. Nothing in the Act or the regulations suggests that reassignment automatically terminates one's participation or billing privileges so that reenrollment is required. I further conclude that the CMS-855I and the CMS-855R filed by Petitioner were not for enrollment, but simply to report the reassignment to WPS and CMS. Accordingly, I conclude that 42 C.F.R. § 424.520(d)

and 42 C.F.R. § 424.521 simply have no application in this case. In this case, the effective date of the reassignment is determined pursuant to CMS policy articulated in MPIM § 15.5.20A, which provides that the effective date is the date the reassignee began or is expect to begin providing Medicare covered services to Medicare beneficiaries for the reassignor. In this case the correct effective date of the reassignment was July 1, 2012.

III. Conclusion

For the foregoing reasons, I conclude that the effective date of Petitioner's reassignment to RenalCare was July 1, 2012.

/s/
Keith W. Sickendick
Administrative Law Judge