Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Julie Gallo, PA-C,
(PTAN: AH176X),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-426

Decision No.CR2919

Date: August 9, 2013

DECISION

Julie Gallo, PA-C, (Petitioner), appeals the Medicare enrollment determination of First Coast Service Options, Inc. (First Coast), a Medicare contractor. Petitioner seeks an earlier effective date of enrollment into the Medicare program with a retrospective billing date of January 1, 2012. For the reasons explained below, I determine that Petitioner's effective date of enrollment of June 29, 2012, was correctly determined by First Coast, as was the 30-day retrospective billing date of May 30, 2012.

I. Background

Petitioner, a physician assistant, was an approved participating Medicare provider since June 2010. In late 2011, Petitioner changed employers which resulted in a change in her practice location. Petitioner filed a CMS enrollment application with First Coast in December 2011 in order to change her practice location and to reassign her Medicare billing privileges to her new employer's group practice, Dermatology Institute of Brevard. She then began providing services to Medicare patients at the new practice location as of January 1, 2012. Petitioner's Stipulations of Fact outlined in her Report of Readiness (ROR) at 1.

By letter dated July 19, 2012, First Coast notified Petitioner that she was assigned a retrospective billing date of May 30, 2012, which was 30 days from First Coast's receipt of her enrollment application. CMS Ex. 12. Petitioner, dissatisfied with the retrospective billing date of May 30, 2012, sought review by filing *Provider Enrollment Corrective Action Plan (CAP) or Reconsideration Request.* CMS Ex. 13; P. Ex. 9. First Coast construed Petitioner's filing as a request for reconsideration and processed the request accordingly. On November 6, 2013, First Coast issued an unfavorable reconsideration decision, affirming the June 29, 2013 effective date and May 30, 2012 retrospective billing date. CMS Ex. 14; P. Ex. 10.

Petitioner filed a hearing request dated January 14, 2013, challenging the effective date determination[1] made by First Coast. Each party submitted a ROR and Petitioner's report was accompanied by 12 documents marked as Petitioner's Exhibits 1-12 (P. Exs. 1-12). Petitioner then filed her pre-hearing exchange on April 22, 2013. Her exchange included the same 12 proposed exhibits marked, as before, Petitioner's Exhibits 1-12 (P. Exs. 1-12),[2] and a motion titled *Motion to Request the Issuance of Subpoena for Record*.[3] Petitioner subsequently filed the written statement of her proposed expert witness Leslie Witkin, President, Physicians First, Inc. Petitioner had identified Ms. Witkin as a proposed expert witness. In her cover letter, Petitioner indicated that she intended to

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[1] First Coast and Petitioner both use the term "effective date" to refer to the date on which Petitioner could bill for Medicare services. *See, e.g.*, Hearing Request; CMS Ex. 12, at 1. Under the regulations, the effective date is the date the contractor received an application from the supplier that it subsequently approved. First Coast determined Petitioner's effective date of enrollment to be June 29, 2012, the date it claims to have received an application from Petitioner that it could ultimately approved. The May 30, 2012 date First Coast assigned to Petitioner's application is Petitioner's retrospective billing date. The regulation at 42 C.F.R. § 424.521(a)(1), allows a contractor to grant retrospective billing privileges 30 days prior to the date the application was received. For clarity, I use "effective date" in this decision to refer to the effective date of enrollment in Medicare and not the date on which retrospective billing begins.

[2] In comparing the 12 proposed exhibits submitted by Petitioner with her April 22, 2013 pre-hearing exchange to the 12 documents Petitioner filed with her ROR, I find that they are identical copies of the same documents. To avoid any potential confusion, any references in this decision to Petitioner's exhibits will be to the proposed exhibits Petitioner proffered with her April 22, 2012 pre-hearing exchange.

[3] I denied Petitioner's motion by Order of May 2, 2013. My Order also advised the parties that based on their pre-hearing exchanges and ROR's the case appeared suitable for disposition on the documentary record, but the parties could file objections. Both parties agreed that this case could be decided by summary disposition on the record.

submit the Witkin statement as Petitioner's Exhibit 13 (P. Ex. 13), but it was not so marked. To complicate matters, the Witkin statement was accompanied by eight supporting documents marked simply Exhibits 1-8. This system of marking P. Ex. 13 and its attachments had the obvious potential for creating confusion in this record, and so I have simply treated the Witkin statement and all of its attachments as a single unitary exhibit, P. Ex. 13. Petitioner could easily have avoided this confusion by proceeding in compliance with Civil Remedies Division Procedures § 9 (CRDP § 9). On May 3, 2013, CMS moved to exclude proposed P. Ex. 13 from the record. Petitioner filed a response objecting to CMS's motion. By Order of May 9, 2013, I advised the parties that CMS's motion to exclude proposed P. Ex. 13 from the record was denied, and the statement of Ms. Witkin was admitted into the record.[4]

On June 3, 2013, CMS filed its opening brief, a motion for summary judgment, and 15 exhibits identified as CMS Exs. 1-15. Petitioner filed her brief and a response to the CMS Motion (P. Br.). Both parties chose to forego filing response briefs. *See* email responses: Petitioner's is dated July 9, 2013 and CMS's is dated July 10, 2012. In the absence of objections and pursuant to my Order of May 9, 2013, I admit CMS Exs. 1-15 and P. Exs. 1- 13 into the record.

II. Applicable Law

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. 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).

Also, a "provider or supplier must submit a complete enrollment application and supporting documentation to the designated Medicare fee-for-service contractor," and the application must 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 physicians and nonphysician practitioners is set as follows:

[4] I repeat that although the eight supporting documents filed with the Witkin statement are marked as P. Exs. 1-8, for purposes of this decision they will be referenced as "attachments," not as exhibits, in order to avoid confusion with the exhibits (P. Exs. 1-12) Petitioner proffered with her pre-hearing exchange.

> 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 physician or nonphysician practitioner first began furnishing services at a new practice location.

42 C.F.R. § 424.520(d).

In order to maintain an active enrollment status in the Medicare program, suppliers already enrolled in the Medicare program much report a change in their practice location to their designated Medicare contractor within 30 days following the change. 42 C.F.R. § 424.516(d)(1)(i).

III. Issue

The issue in this case is whether CMS's contractor, First Coast, properly determined Petitioner's effective date of Medicare enrollment.

IV. Analysis

My findings of fact and conclusions of law are set forth in italics and bold in the discussion captions of this decision.

A. CMS's motion for summary judgment is denied. This case is being decided on the written record.

CMS moved for summary judgment. Summary judgment is not a procedure to be employed automatically upon request but is limited to certain specific conditions, the most important of which is the absence of genuine dispute as to any material fact. In resolving a motion for summary judgment, I am required to view the evidence in the light most favorable to Petitioner, drawing all reasonable inferences in Petitioner's favor. *Senior Rehabilitation and Skilled Nursing Center*, DAB No. 2300, at 3 (2010) (and cases cited therein). The standard for deciding a case on summary judgment differs from resolving a case after a hearing or on the written record. For example, on summary judgment, an ALJ does not make credibility determinations, weigh the evidence, or decide which inferences to draw from the evidence, as would be done when finding facts after a hearing or a decision on the record. Rather, on summary judgment an ALJ construes the evidence in a light most favorable to the non-movant and avoids deciding which version of the facts is more likely true. *Holy Cross Village at Notre Dame, Inc.*, DAB No. 2291, at 5 (2009).

During the pendency of this appeal, the parties agreed that this case could be decided on the written record, based on the documentary evidence and the parties' pleadings. *See* Order of May 2, 2013; P. Response to Order Dated May 2, 2013 (where Petitioner affirmatively waived the right to an in-person hearing in writing); *see also* May 6, 2013 email from CMS. Petitioner's waiver is acceptable and I conclude that an in-person hearing is not required. A decision based on the documentary evidence and pleadings of the parties without the need for an in-person hearing is permissible. 42 C.F.R. § 498.66. Therefore, there is no need to resort to the summary judgment procedure in this case.

B. On December 1, 2011, Petitioner submitted a CMS-855R, not a CMS-855I as required to report a change in her practice location.

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, including a change in practice location.[5] Form CMS-855R is titled *Medicare Enrollment Application – Reassignment of Medicare Benefits*. The instructions for CMS-855R 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.[6] Page 2 of CMS-855R, under the heading General Information, provides guidance to physician assistants such as Petitioner and advises as follows:

> NOTE: PHYSICIAN ASSISTANTS: This application should not be used to report employment arrangements. Employment arrangements must be reported in Sections 2E through 2G of the CMS-855I application.

Further guidance is available to Medicare suppliers who are attempting to file the appropriate CMS enrollment application. For example, Medicare enrollment application forms and their use are also described in the MPIM, CMS Pub. 100-08, Chap. 10, Medicare Provider/Supplier Enrollment. The relevant MPIM guidance in effect when

[5] CMS forms are available at: www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html.

[6] Reassignment means that an individual physician or non-physician practitioner, except physician assistants, has granted a clinic or group practice the right to receive payment for the practitioner's services. *See* Medicare Program Integrity Manual (MPIM), Chap. 15, § 1.1, Definitions.

Petitioner filed her Medicare enrollment application in December 2011 specifically states that "[s]ince [Physician Assistants] cannot reassign their benefits — even if they are reimbursed through their employer — they should not complete a CMS-855R." MPIM § 4.2.7(D) (rev. 173, eff. Nov. 13, 2006).

Petitioner maintains that on December 1, 2011, she initiated the submission of a CMS Form-855I enrollment application. P. Br. at 4; P. ROR at 2. She argues that First Coast should have processed that initial enrollment application and that First Coast should have considered the additional information she subsequently provided to be a modification of the initial application submitted on December 1, 2011, instead of requiring her to resubmit a new application form. P. Br. at 4; P. ROR; P. Ex. 13, at 2.

My review of the evidence establishes that on December 1, 2011, Petitioner submitted signature pages for a CMS-855R, not a CMS-855I. CMS Ex.1, at 3; P. Ex. 1, at 3. Petitioner attempts to explain this discrepancy by stating that she tried to comply with the enrollment application requirements but was not able to do so because of an error made by CMS. P. Br. at 3-4. Petitioner maintains that CMS incorrectly identified Petitioner as a physical therapist instead of a physician assistant on the enrollment record and that this error resulted in the internet-based PECOS (Provider Enrollment, Chain and Ownership System) program generating the incorrect form and signature page, which resulted in the eventual rejection of her initial application. P. Br. at 2; P. Ex. 13, at 2; *see also* CMS Ex. 2, at 2; P. Ex. 13, attachment 1, at 1(listing Petitioner's specialty designation as a physical therapist). Petitioner maintains that PECOS does not allow suppliers to select which application to use when enrolling. Instead, says Petitioner, the system poses questions and then populates the answers onto the application form selected by the system. Petitioner maintains that this error resulted in the CMS-855R being initially submitted instead of a CMS-855I. P. Br. at 2, 4; P. Ex. 13, at 2, 4.

(1) Petitioner submitted the incorrect enrollment application in December 2011.

Petitioner describes her attempt to simply modify her practice location and reassign benefits as "a protracted and convoluted process" and attributes this to First Coast's and CMS's "failure to provide timely and adequate clarity." Petitioner further states that there was "vague and incomprehensible direction" from First Coast representatives as to why the initial application was rejected. P. ROR at 2-3. Although there appears to have been some confusion surrounding Petitioner's December 2011 enrollment application process, the evidence is clear that Petitioner's first submission, whether intentional or in error, was a CMS-855R. When First Coast received that form, it could not process it to completion — it was the incorrect form, a form properly used to reassign benefits to another entity and, as a physician assistant, Petitioner was precluded from doing so. Additionally, the regulations require a provider or supplier seeking billing privileges under Medicare to "submit enrollment information on the *applicable* enrollment application. 42 C.F.R.

§ 424.510(a) (emphasis added). Petitioner's December 2011 enrollment application was simply not the correct form and consequently, First Coast could not process it to completion.

> *(2) Petitioner was responsible to have familiarized herself with the supplier enrollment application requirements.*

Although Petitioner concedes that it was her responsibility to ensure the correct application was submitted for her supplier type, she claims that she was precluded from doing so through PECOS because of CMS's error in incorrectly identifying her specialty designation as a physical therapist. Petitioner maintains that the error was not even discovered until she engaged Ms. Witkin to perform a review of her application. P. Br. at 3; *see generally* P. Ex. 13 (outlining the enrollment attempts Petitioner undertook). Further, Petitioner's witness Witkin quite remarkably and with no evidentiary support whatsoever asserts that PECOS would not have "intuitively" generated a CMS-855R for a physician assistant; rather, it would have generated a CMS-855I signature page for Petitioner had her specialty designation been correct. P. Ex. 13, at 3.

Although Petitioner blames both First Coast and CMS for the wrong CMS enrollment form being submitted in December 2011, I note that Petitioner proffered a document showing a PECOS screen that identifies the page where her specialty designation is located. A close examination of that screen reveals instructions that Petitioner could have followed in order to correct the specialty designation error:

> Your Primary Practitioner Specialty determines which questions and topics you must fill out to enroll in Medicare. For this reason, you may not change your Primary Practitioner Specialty on an application. *If your Primary Practitioner Specialty is incorrect or has changed, please contact your Fee-For-Service Medicare Contractor or go to the home page and create a new enrollment for the new type.*

P. Ex. 13, attachment 5 (emphasis added). Petitioner has presented evidence showing PECOS would have allowed her to correct or change her specialty designation by directing her to her designated Medicare contractor to effectuate the correction. This evidence rather obviously minimizes Petitioner's argument that she could not correct the error. Ms. Witkin attempts to explain that Petitioner was inexperienced in using PECOS and therefore unlikely to notice the specialty designation error. P. Ex. 13, at 4. I find Ms. Witkin's assertions on that point both unsupported and disingenuous, for they seem to ignore the basic principle to which I make reference in the paragraph immediately below.

Although I may be well aware of Petitioner's economic losses as the unforeseen outcome of her claims being denied, Petitioner simply should have reviewed the PECOS enrollment application carefully prior to submitting it. 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. *See, e.g., Heckler v. Community Health Services of Crawford County, Inc*., 467 U.S. 51, at 64 (1984); *Waterfront Terrace Inc*., DAB No. 2320 (2010); *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). Had Petitioner been so guided she would have noticed and corrected the error in her specialty designation.

C. First Coast correctly determined the effective date of Petitioner's Medicare enrollment.

It is undisputed that on December 1, 2011, Petitioner submitted a Medicare enrollment application through PECOS. Hearing Request; P. ROR at 1; CMS Exs. 1, at 3; 2. After reviewing Petitioner's enrollment application, First Coast sent Petitioner a letter dated January 6, 2012, informing her that she had submitted the incorrect application, and that as a physician assistant she was not eligible to reassign benefits. The letter further advised Petitioner that she would need to reapply using the correct application — a CMS-855I. CMS Exs. 3, at 1;15, at ¶ 7.

Petitioner then submitted a CMS-855I through PECOS on June 29, 2012. P. Br. at 2; CMS Ex. 7. First Coast notified Petitioner on July 10, 2012, that the enrollment application had been received but additional information was required before the application could be processed. CMS Ex. 9; P. Ex. 5; *see also* P. Ex. 13, at 2.

Petitioner submitted the requested information to First Coast by FAX on July 13, 2012. CMS Ex. 10. First Coast received Petitioner's July 13, 2012 updated information, and by letter dated July 19, 2012, First Coast advised Petitioner that her June 29, 2012 CMS-855I application was processed and assigned a retrospective billing date of May 30, 2012. CMS Ex. 12; P. Ex. 8.

It is important to note that in addition to assisting Petitioner with processing her application for a change in practice location, Petitioner's new group practice had also processed a CMS-855I form on February 24, 2012 for the revalidation of her Medicare enrollment. The revalidation enrollment application was still pending until March 6, 2012. CMS Ex. 5; P. Exs. 2, 3; *see also* P. Ex. 13, at 3; attachment 3 (showing that on February 24, 2012, Petitioner submitted an online PECOS application to revalidate her enrollment application that was subsequently processed by First Coast on March 7, 2012). The record further shows that the March 6, 2012 email First Coast sent to Petitioner was to advise her that it had received Petitioner's CMS-855I for her

revalidation on March 1, 2012, and that it was approved. CMS Ex. 5; P. Ex. 2; *see also* CMS Ex. 15, at ¶ 8. The email regarding the revalidation process was then followed by a letter to Petitioner dated March 7, 2012, where First Coast advised Petitioner that her CMS-855I enrollment application requesting revalidation of her Medicare enrollment information processed through PECOS had been received; that PECOS had been updated with her enrollment information; and that there were no changes to her enrollment information. CMS Ex. 6, at 1; P. Ex. 3, at 1; *see also* CMS Ex. 15, at ¶ 9. As CMS suggests, and I agree, that the simultaneous processing of these applications could have created confusion for Petitioner, and a situation where she was unable to distinguish the effective date of enrollment correspondence related to the change in her practice location from the correspondence related to Petitioner's revalidation application. CMS. Br. at 2 n.4.

However, Petitioner offers no evidence to counter the fact that it was not until June 29, 2012 that First Coast received an enrollment application from her that it could subsequently process to approval. As noted above, the effective date of Medicare enrollment for Petitioner depended on the date First Coast first received an enrollment application that it was able to process to approval. 42 C.F.R. § 424.520; 73 *Fed. Reg.* 69,725, 69,769 (Nov. 19, 2008).

Therefore, the correct effective date of Petitioner's enrollment remains June 29, 2012, with a retrospective billing date of May 30, 2012.

D. I am not authorized to grant Petitioner's requests for equitable relief.

Petitioner states that she began providing services to Medicare eligible beneficiaries at her new practice location as of January 1, 2012, and now seeks reimbursement for claims she processed for services rendered from January 1 through May 29, 2012. P. Br. at 1, 5. Petitioner states that First Coast's action of denying her payment for services she provided to Medicare beneficiaries for services rendered prior to May 30, 2012, constitutes a denial of her right to procedural due process. Petitioner also claims that First Coast's failure to timely respond to the PECOS online application along with Petitioner's repeated telephone requests should preclude CMS from setting an effective date of application that is adverse to Petitioner. P. ROR. Petitioner asks that I find that any outstanding claims must be processed for payment notwithstanding the 12-month timely filing rules for Medicare Part B claims. P. Br. at 4.

The arguments Petitioner advances to support an earlier billing date amount to claims of equitable estoppel, and provide no bases for me to provide Petitioner with the relief she seeks. It is well-established by federal case law, and in Departmental Appeals Board precedent, that: (1) estoppel cannot be the basis to require payment of funds from the federal government; (2) estoppel can lie against the government, if at all, only on 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., Oklahoma Heart Hospital*, 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); *Office of Personnel Management v. Richmond*, 496 U.S. 414 (1990); *Heckler v. Community Health Services of Crawford County, Inc.*, 467 U.S. 51. Petitioner alleges no affirmative misconduct against the government — and I can find none on my own inspection of this record — and so I cannot grant the relief Petitioner requests.

V. Conclusion

For the reasons explained above, I find that First Coast did not receive an enrollment application from Petitioner that it could process to approval until June 29, 2012. I conclude that Petitioner's effective date of enrollment was correctly determined by First Coast to be June 29, 2012, with a 30-day retrospective billing date starting May 30, 2012.

/s/
Richard J. Smith
Administrative Law Judge