Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Barbara Vizy, M.D.,
(PTAN: H461440),

and

Richard Weinberger, M.D.,
(PTAN: H459530)

Petitioners,

v.

Centers for Medicare and Medicaid Services.

Respondent

Docket Nos. C-16-367 and C-16-368

Decisions CR4643 and CR4644

Date: June 24, 2016

DECISIONS

Petitioners Barbara Vizy, M.D. (Docket No. C-16-367) and Richard Weinberger, M.D. (Docket No. C-16-368) challenged the effective dates of their reactivation of Medicare billing privileges. I am issuing a consolidated decision in the two cases although the Petitioners filed separate appeals that were not consolidated. I explain my reasons for doing so, below. In each case I sustain the determination of a Medicare contractor, as affirmed on reconsideration and adopted by the Centers for Medicare & Medicaid Services (CMS), to reactivate the Petitioner's Medicare billing privileges effective September 29, 2015.

I. Background

As I note above, these cases are two individual challenges of CMS's determination to assign each Petitioner an effective reactivation date of September 29, 2015. However, it makes sense to issue a consolidated decision in these cases. Petitioners are members of the same group medical practice. The facts in these cases are identical as are the parties' arguments. The identical legal principles apply in each case.

My consolidated decisions do not constrain the parties' appeal rights. Any party that is dissatisfied with my decision in that party's case may individually appeal it to the Departmental Appeals Board.

In each case CMS filed exhibits. In Docket No. C-16-367 (Vizy) CMS filed exhibits that it identified as CMS Ex. 1-CMS Ex. 15. In Docket No. C-16-368 (Weinberger) CMS filed exhibits that it identified as CMS Ex. 1-CMS Ex. 15. I receive these exhibits into the record. Petitioners also filed exhibits in each case. In Docket No. C-16-367 (Vizy) Petitioner filed exhibits that she identified as P. Ex. 1-P. Ex. 11. In Docket No. C-16-368 (Weinberger) Petitioner filed exhibits that he identified as P. Ex. 1-P. Ex. 12. I receive these exhibits into the record as well.[1]

In each case CMS moved for summary judgment and Petitioner cross-moved for summary judgment. I need not decide whether the criteria for summary judgment are met in either case inasmuch as none of the parties has provided me with a basis for convening an in-person hearing to receive testimony. CMS did not file written direct testimony in either case. In each case Petitioner filed the written direct testimony of two witnesses (Dr. Weinberger and Mary Mason). 367 P. Ex. 1, 367 P. Ex. 2; 368 P. Ex. 1, 368 P. Ex. 2. CMS did not request to cross-examine either of these witnesses. Therefore, I decide these cases on their written records and resolve any disputed issues of fact without convening in-person hearings.

II. Issues, Findings of Fact and Conclusions of Law

A. Issues

The sole issue in each of these cases is whether CMS's contractor properly reactivated the Petitioner's Medicare billing privileges effective September 29, 2015.

[1] For purposes of efficiency I refer to the exhibits in each case using the three-digit docket number prefix of that case. For example, in Docket No. C-16-367 (Vizy) I refer to P. Ex. 1 as "367 P. Ex. 1."

B. Findings of Fact and Conclusions of Law

CMS relies on the following facts in support of the determination to assign each Petitioner the September 29, 2015 reactivation date. A Medicare contractor sent each Petitioner a letter on September 12, 2014, requesting that he/she file an application to revalidate his/her Medicare billing privileges. 367 CMS Ex. 3; 368 CMS Ex. 3. The contractor did not receive responses to the requests, so on March 6, 2016, the contractor called the Petitioners' office and advised them that it had not received revalidation applications from Petitioners.

On April 10, 2015, the contractor still had not received applications and it deactivated each Petitioners' Medicare billing privileges. 367 CMS Ex. 4; 368 CMS Ex. 4. During the months that ensued, the contractor received several documents from Petitioners' group practice but did not receive reactivation applications from either Petitioner. Finally, the contractor received applications for re-enrollment (reactivation of billing privileges) from each Petitioner on September 29, 2015. 367 CMS Ex. 5; 368 CMS Ex. 5. The contractor found these applications to be acceptable and on October 27, 2015, it approved them and assigned each Petitioner an effective date of reactivation of billing privileges of September 29, 2015. 367 CMS Ex. 7; 368 CMS Ex. 7.

Petitioners dispute these facts. They contend that there are "additional facts and circumstances that make this matter more complex and support [each] Petitioner's position that [each] Petitioner's provider enrollment date should remain unaffected and that [each] Petitioner should be allowed to bill for the services provided to Medicare beneficiaries during the time in which . . . [each Petitioner's Medicare billing privileges] was deactivated." Petitioners' pre-hearing brief and motion for summary judgment (Petitioners' brief) at 2.[2] In support of their assertion Petitioners make the following allegations:

- On March 10, 2015, Petitioners mailed the "proper forms" for Medicare enrollment to the Medicare contractor;
- On May 20, 2015, Petitioners mailed CMS form 855B to the Medicare contractor, "intending to revalidate" not only their group practice but Petitioners, individually;
- On July 2, 2015, Petitioners mailed the "proper forms" for Medicare enrollment to the contractor;
- On July 16, 2015, Petitioners mailed forms 855B to the contractor "intending to revalidate" not only their group practice but Petitioners, individually;
- On September 8, 2015, Petitioners again mailed forms 855B to the contractor "intending to revalidate" not only their group practice but Petitioners, individually;

[2] Although each Petitioner filed a brief the two briefs are essentially identical so I refer to them collectively as "Petitioners' brief."

- Correspondence with the contractor, on multiple occasions, "indicated that" Petitioners' individual enrollments were "occurring simultaneously" with that of their group practice; and
- The contractor's representatives told Petitioners that their individual enrollments would be "backdated" to the dates when their billing privileges were reactivated.

Petitioners' brief at 2.

I have examined closely these fact allegations and I find them to be unsupported. Petitioners have not proven that they applied as individual suppliers for revalidation of their Medicare billing privileges on any date prior to September 29, 2015.

Petitioners did not prove that they mailed individual re-enrollment forms to the contractor on March 10, 2015, notwithstanding their assertions that they mailed the "proper forms" on that date. They rest their assertion that they mailed "proper forms" on the fact that they sent in forms other than the 855B re-enrollment forms. Petitioners' brief at 7. In fact, they have not even provided analysis of the information contained in these forms in order to prove that they satisfied re-enrollment requirements, relying instead on affidavits asserting baldly that the forms were adequate. *Id.*; *see* 367 P. Ex. 1, 367 P. Ex. 2; 368 P. Ex. 1, 368 P. Ex. 2. I find those contentions to be insufficient to establish that Petitioner mailed individual re-enrollment forms to the contractor on March 10, 2015.

By Petitioners' own admissions the CMS form 855B that Petitioners mailed to the contractor on May 20, 2015 was not an individual re-enrollment form for either Petitioner Vizy or Petitioner Weinberger. Rather, it was a re-enrollment form for their group practice, a separate entity. 367 P. Ex. 1 at 3, 367 P. Ex. 2 at 3; 368 P. Ex. 1 at 3, 368 P. Ex. 2, at 3. Petitioners argue that this form contained information that pertains to them as individuals. That may be so, but Petitioners do not aver, nor did they prove that the form contained all of the information needed to qualify them for re-enrollment. Petitioners also argue that they submitted what they thought would be sufficient information based on conversations that they or their agents had with the contractor's representatives. That is, in effect, an assertion that they were misled. As I discuss in more detail below, this is an equitable argument that I have no authority to consider because principles of equity and in particular, estoppel, do not apply here.

As to Petitioners' assertion that they mailed "proper" forms to the contractor on July 2, 2015, they again refer to forms that are not individual supplier re-enrollment forms. Petitioners' brief at 10. Petitioners did not prove that they submitted individual provider re-enrollment forms on July 2, 2015, nor did they prove that whatever information they submitted on that date was sufficient to qualify them for re-enrollment.

Petitioners' assertions about the 855B form that they submitted on July 16, 2015, relate to a form that they submitted on behalf of their group practice. Petitioners' brief at 10-11.

This was not an individual re-enrollment form for either Petitioner. Once again, Petitioners argue that some of the information in that form may have pertained to them as individuals but they make no effort to prove that it contained all of the information needed to qualify either of them for re-enrollment. Petitioners also make the equitable argument that they were misled by the contractor into believing that, by submitting this form, they were providing adequate information to qualify for re-enrollment.

Petitioners make very similar arguments about the 855B form that they submitted to the contractor on September 8, 2015. Petitioners' brief at 12. Once again, this form was not an individual re-enrollment form filed on behalf of either Petitioner but a form that was filed on behalf of their group practice.

Indeed, the documents submitted by Petitioners or their practice prior to September 29, 2015 were at best of tangential relevance to the issue of their re-enrollment as Medicare suppliers. These documents included electronic funds transfer authorization agreements, applications for Petitioners' group practice enrollment, and an application for enrollment of another individual besides Petitioners. They do not in any sense constitute completed individual re-enrollment applications for either Petitioner

Thus, the evidence does not establish that either Petitioner filed an individual re-enrollment form with the contractor at any time prior to September 29, 2015. That date was the earliest date on which the contractor received a completed form from each Petitioner that it could approve to qualify that Petitioner for re-enrollment.

Policy and regulations govern the determination of a supplier's effective re-enrollment date. CMS will allow a supplier to re-enroll effective the date of the deactivation of his or her billing privileges if the supplier submits a reactivation application within 120 days of the deactivation date. This is a matter of Departmental policy, expressed in the Medicare Program Integrity Manual (MPIM). MPIM § 15.29.4.3. However, if a supplier submits a re-enrollment application more than 120 days from the date of deactivation, then the effective date of re-enrollment will be governed by 42 C.F.R. § 424.520(d). MPIM §§ 15.17, 15.29.4.3. The regulation provides, in relevant part, that the *earliest effective date* of enrollment is the date on which a supplier files an application that CMS or its contractor finds to be acceptable and can approve.

CMS's policy does not carry the force of law but in this case it is entirely consistent with regulatory requirements that generally establish that the earliest effective date of participation is the date on which a supplier submits an application that is acceptable and can be approved. 42 C.F.R. § 424.520(d). Indeed, allowing a grace period of 120 days to file an application for re-enrollment after deactivation of billing privileges is a matter of largesse because nothing in the regulations requires CMS to do so. CMS could have

established the earliest effective date of all applications for re-enrollment as the date when an acceptable application is submitted and remained true to the regulatory requirements.

Administrative Law Judges are instructed to give substantial deference to Departmental policy where it applies in a particular case. 42 C.F.R. § 405.1062(a). I defer to Departmental policy here because it is, as I have found, entirely consistent with regulatory requirements.

Thus, the *earliest date* when Petitioners could qualify for re-enrollment was September 29, 2015. That is because they waited more than 120 days from their deactivation to file acceptable re-enrollment applications.

Petitioners argue that they should have retained authority to bill Medicare for their services even if the documents that they submitted to the contractor between March and September 29, 2015 were inadequate to qualify as acceptable re-enrollment applications. They essentially make two assertions: first, that they acted at all times in good faith and should not be penalized for honest errors or omissions on their part; and second, that they were often misled by what they were told by the contractor's agents into believing that they were filing the correct documents. Indeed, they take this second argument further, asserting that the contractor and its agents had an affirmative duty to instruct them as to what they should file. The asserted failure of the contractor and its agents to satisfy this duty, according to Petitioners, excuses them from any failure on their part to file acceptable re-enrollment documents prior to September 29, 2015.

These arguments are all equitable arguments and are unavailing. Principles of equity do not apply here. I am not authorized to provide equitable relief by ordering re-enrollment of either Petitioner on a date when that Petitioner did not satisfy regulatory requirements. *U.S. Ultrasound*, DAB No. 2302, at 8 (2010). Moreover, even if I had such authority, equitable estoppel does not apply against the government in the absence of proof of affirmative misconduct, and the records in these two cases are devoid of any such proof. *Wade Pediatrics v. Dep't of Health & Human Servs.*, 567 F.3d 1202, 1206 (10th Cir. 2009). Mere erroneous advice is insufficient evidence of affirmative misconduct. *Id.*

/s/
Steven T. Kessel
Administrative Law Judge