Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Parallel Parkway Emergency Physicians,

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-12-367

Decision No. CR2582

Date: August 8, 2012

DECISION

Parallel Parkway Emergency Physicians[1] (Petitioner) appeals a December 14, 2011 reconsideration decision. I grant summary judgment and sustain the determination of the Centers for Medicare and Medicaid Services (CMS) finding that the undisputed evidence establishes Petitioner does not qualify as a supplier for Medicare purposes and that CMS properly denied Petitioner's enrollment in the Medicare program.

I. Background and Procedural History

To obtain billing privileges from Medicare for care provided to beneficiaries, Petitioner submitted a Medicare enrollment application. Petitioner sought to enroll in the Medicare program as an ambulatory surgical center clinic/group practice that provided physicians' services. P. Ex. 7 at 7.

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[1] This case was originally captioned as Mark J. Slepin, M.D.; however, Petitioner's Hearing Request and the Hearing Officer's December 14, 2011 reconsideration decision clearly relate to Parallel Parkway Emergency Physicians (PPEP), an entity Mark J. Slepin, M.D. owns. I amend the case caption to clarify this.

Wisconsin Physicians Service Insurance Corporation (WPS), a CMS contractor, notified Petitioner by letter dated October 25, 2011 that it was denying Petitioner's enrollment application because Petitioner was not operational or did not meet Medicare requirements to furnish Medicare covered items or services. CMS Ex. 1. Petitioner requested reconsideration of this initial decision, and a WPS hearing officer issued Petitioner an unfavorable reconsideration decision. The hearing officer found Petitioner was not operational to furnish Medicare covered items or services, or it did not meet Medicare enrollment requirements. CMS Ex. 2.

Petitioner then requested a hearing with the Civil Remedies Division of the Departmental Appeals Board, and the case was assigned to me for hearing and decision. In accordance with my Acknowledgment and Pre-hearing Order, CMS filed a Motion for Summary Disposition and Supporting Brief (CMS Br.), accompanied by three exhibits (CMS Exs. 1-3). Petitioner filed a response to CMS's Motion for Summary Disposition and Supporting Brief (P. Br.) accompanied by eleven exhibits (P. Exs. 1-11). Thereafter, CMS filed a Response Brief (CMS Response). In the absence of objection, I admit CMS Exs. 1-3 and P. Exs. 1-11 into the record.

II. Background 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 beneficiaries may only be made to eligible providers of services and suppliers. Act §§ 1835(a) (42 U.S.C. § 1395n(a)), 1842(h)(1) (42 U.S.C. § 1395u(h)(1)). The Act requires the Secretary of Health and Human Services 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)).

The Act and regulations establish that a supplier is an individual or entity that furnishes health care services under Medicare. Act § 1861(d), (42 U.S.C. § 1395x(d)); 42 C.F.R. § 400.202. Medicare Part B pays for physicians' services, including diagnosis, therapy, surgery, consultations, and home, office, and institutional calls. *See* 42 C.F.R. § 410.20. A supplier must be enrolled in the Medicare program and be issued a billing number to be eligible to receive payment from Medicare. 42 C.F.R. § 424.505. Medicare may pay a supplier's employer if the supplier is required, as a condition of employment, to turn over the fees from the supplier's services. 42 C.F.R. § 424.80(b). Medicare will also pay an entity billing for a supplier's services if the entity is enrolled in Medicare and there is a contractual arrangement between the entity and the supplier. 42 C.F.R. § 424.80(b)(2).

III. Analysis

A. Issue

The issue in this case is whether CMS's contractor and CMS had a legitimate basis for denying Petitioner's Medicare enrollment for billing privileges.

B. Applicable Standard for Summary Judgment

Board Members of the Appellate Division of the Departmental Appeals Board (the Board) stated the standard for summary judgment:

> Summary judgment is appropriate when the record shows that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. . . . The party moving for summary judgment bears the initial burden of showing that there are no genuine issues of material fact for trial and that it is entitled to judgment as a matter of law. . . . To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact – a fact that, if proven, would affect the outcome of the case under governing law. . . . In determining whether there are genuine issues of material fact for trial, the reviewer must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor.

Senior Rehab. & Skilled Nursing Ctr., DAB No. 2300, at 3 (2010) (citations omitted).

The role of an Administrative Law Judge (ALJ) in deciding a summary judgment motion differs from the ALJ's role in resolving a case after a hearing. The ALJ should not assess credibility or evaluate the weight of conflicting evidence. *Holy Cross Vill. at Notre Dame, Inc.*, DAB No. 2291, at 5 (2009). Here, the material facts are not disputed, and I draw all reasonable inferences in favor of Petitioner.

C. Finding of Facts and Conclusions of Law

1) CMS had a legitimate basis for denying Petitioner's Medicare enrollment because Petitioner was not eligible for Medicare enrollment as an operational supplier.

Petitioner applied for Medicare enrollment as an ambulatory surgical center clinic/group practice and defines itself through a "partnership agreement" submitted with its Medicare enrollment application. CMS Ex. 3. The agreement states that "[t]he sole purpose of the Partnership is to provide a 'pay to' address when billing third party payors to facilitate

the bookkeeping of the payments received from such payors." CMS Ex. 3 at 1. The agreement also indicates that Petitioner does not employ any of the physicians for which Petitioner is acting as the billing entity. CMS Ex. 3 at 2. The partnership agreement does not indicate that Petitioner would furnish health care services under Medicare, but instead states that Petitioner is an entity formed solely to act as a billing entity. CMS Ex. 3.

For Medicare purposes, "[*s*]*upplier* means a physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare." 42 C.F.R. § 400.202. A supplier must be operational to furnish Medicare covered items or services before being granted Medicare billing privileges. *See* 42 C.F.R. § 424.510(d)(6). "*Operational* means the provider or supplier has a qualified physical practice location, is open to the public for the purpose of providing health care related services, is prepared to submit valid Medicare claims, and is properly staffed, equipped, and stocked (as applicable, based on the type of facility or organization, provider or supplier specialty, or the services or items being rendered), to furnish these items or services." 42 C.F.R. § 424.502. "*Services* means medical care or services and items, such as medical diagnosis and treatment, drugs and biologicals, supplies, appliances, and equipment, medical social services, and use of hospital, [critical access hospital], or [skilled nursing] facilities." 42 C.F.R. § 400.202. In order to enroll in the Medicare program, a supplier must demonstrate that it has the ability to furnish health care items or services. If CMS determines upon reliable evidence that an entity is not operational or is not meeting Medicare enrollment requirements, CMS may deny enrollment. *See* 42 C.F.R. § 424.530(a)(5).

A supplier must be enrolled in the program before receiving payment for services covered by Medicare Part B. *See* 42 C.F.R. §§ 410.20, 424.505. Moreover, lawmakers' concerns about enrollment in the Medicare program by unqualified or fraudulent suppliers resulted in CMS establishing the current enrollment requirements with stringent controls on supplier entry into the Medicare program. 71 Fed. Reg. 20,754, 20,755-6 (April 21, 2006). The Medicare enrollment requirements are designed to ensure that Medicare only conducts business with legitimate suppliers and enables CMS to verify that it is paying an entity that actually exists and is providing the services that it represented it would provide in its Medicare enrollment application. *Id.* at 20,754-55.

Petitioner provided no evidence to show it qualifies as a supplier that furnishes health care services or is operational to furnish health care services covered by Medicare as an ambulatory surgical center clinic/group practice that provides physicians' services. Nor does Petitioner dispute that it is not an ambulatory surgical center clinic/group practice or an employer of health care practitioners.

Petitioner, however, contends it is a subsidiary under the control and ownership of a related entity (Kansas Emergency Room Services, P.A. or "KERS") that does provide physicians' health care services. Petitioner argues it meets the statutory definition set

forth in 42 C.F.R. § 400.202 because "[Petitioner] furnishes items and services through its general partner, which is under the common control and management with [Petitioner]." P. Br. at 5. Petitioner contends it has "satisfied the plain terms of the Medicare Part B supplier enrollment regulations." P. Br. at 5. Nonetheless, Petitioner does not dispute it is a separate legal entity from the entity furnishing the physicians' health care services:

> To facilitate efficient and effective billing and collecting for the professional medical services of KERS's contracted physicians at Hospital and to avoid potential issues with billing and collecting for services provided at KERS's current and future client sites in Kansas, KERS created [Petitioner], a Kansas general partnership with KERS and Kansas Account Management, Inc. (KAMI) as its partners. P. Ex. 5. KAMI is a Kansas professional corporation also owned by Petitioner. As a result, [Petitioner] is under common ownership and control with KERS.

P. Br. at 2.

I will assume for purposes of summary judgment that Petitioner's partner does in fact provide health care services and would qualify as a supplier under Medicare requirements. Yet, I find that Petitioner did not meet the applicable Medicare enrollment requirements because Petitioner itself does not furnish healthcare services. CMS's enrollment denial here is similar to that in *US Ultrasound*, DAB No. 2302 (2010). In that case, US Ultrasound sought to enroll as an independent diagnostic testing facility; however, a contract submitted with the enrollment application indicated that US Ultrasound did not own any ultrasound equipment and was not responsible for any technical or professional services. *Id.* at 6. The agreement between US Ultrasound and another entity that actually furnished services provided that US Ultrasound pay that entity a professional services fee for billing, scheduling, and patient records. *Id.* at 4. The Board found that CMS had the legal authority to deny US Ultrasound's enrollment application because it failed to comply with Medicare enrollment requirements in that it did not furnish services and thus failed to meet the definition of a Medicare "supplier."

Here, Petitioner is a general partnership established solely to receive payments for the services of a physician group. Petitioner does not employ physicians, have a contractual arrangement with physicians, and does not furnish health care services in any capacity. Petitioner does not directly provide Medicare covered physician health care services just as US Ultrasound did not directly provide Medicare covered testing services. Thus, CMS had a legitimate basis for denying Petitioner's Medicare enrollment application because it did not meet the definition of a Medicare supplier.

If CMS granted Petitioner's enrollment application and later needed to revoke Petitioner's Medicare enrollment for fraudulent activity or for not meeting Medicare requirements, the related entity providing the actual health care services would not be subject to the revocation or the related reenrollment bar, actions intended to hold entities accountable and to protect the Medicare Trust Fund.

2) Petitioner received due process.

Petitioner also claims that CMS failed to articulate a rational basis for denying Petitioner's enrollment in Medicare. Petitioner claims that *US Ultrasound* can be distinguished because the CMS contractor in this case did not provide Petitioner with an explanation of why its enrollment could not be approved in either the CMS contractor's initial determination or in the reconsideration decision. P. Br. at 7-8. However, a Petitioner is not deprived of due process when CMS provides Petitioner sufficient notice of the legal basis for the denial and a reasonable opportunity to respond at the ALJ hearing level. *See Green Hills Enters.*, LLC, DAB No. 2199, at 8 (2008)("The Board has consistently held that after an administrative appeal has commenced, a federal agency may assert and rely on new or alternative grounds for the challenged action or determination as long as the non-federal party has notice of and a reasonable opportunity to respond to the asserted new grounds during the administrative proceeding.").

Here I find that CMS, through its brief, provided Petitioner sufficient notice of the legal basis for the Medicare enrollment denial, and I provided a reasonable opportunity for Petitioner to respond. Moreover, both the initial determination and the CMS contractor's reconsideration decision accurately stated, albeit generally, that Petitioner was not "operational" pursuant to 42 C.F.R. § 424.530(a)(5) and explained that Petitioner was not meeting Medicare enrollment requirements to furnish Medicare-covered items or services. CMS Exs. 1 and 2.

IV. Conclusion

The undisputed evidence establishes that Petitioner is a billing entity which does not provide the intended Medicare services described in Petitioner's enrollment application for an ambulatory surgical center clinic/group practice. Accordingly, I uphold the enrollment denial and grant summary judgment in favor of CMS.

/s/
Joseph Grow
Administrative Law Judge