Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Bernard Farzin, M.D.,

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-12-306

Decision No. CR2566

Date: July 13, 2012

DECISION

Bernard Farzin, M.D. (Petitioner), appeals a reconsideration decision issued on November 30, 2011. I grant summary judgment and sustain the determination of the Centers for Medicare and Medicaid Services (CMS) finding that the undisputed evidence establishes that CMS properly enrolled Petitioner in the Medicare program effective August 10, 2011.

I. Background and Procedural History

Petitioner is a licensed physician employed by Providence Health & Services (Providence) in Anchorage, Alaska. To obtain direct billing privileges from Medicare for care provided to beneficiaries while working for Providence, Petitioner submitted a reassignment enrollment application, CMS Form 855-R dated July 22, 2011. CMS Exhibit (CMS Ex.) 1. Noridian Administrative Services (Noridian), a CMS contractor, received Petitioner's enrollment application on August 10, 2011. CMS Ex. 5, at 1. By letter dated September 13, 2011, Noridian formally notified Petitioner that his Medicare

enrollment application had been approved effective July 12, 2011.[1] CMS Ex. 3. Petitioner timely requested reconsideration of the initial decision and requested that his effective enrollment date be changed to April 18, 2011. CMS Ex. 4. On November 30, 2011, a contractor hearing officer issued a reconsideration decision denying Petitioner's request for an earlier effective date of enrollment. CMS Ex. 5.

Petitioner then filed a hearing request 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 issued on January 26, 2011, CMS filed a Motion for Summary Judgment and supporting memorandum (CMS Br.), accompanied by five exhibits (CMS Exs. 1-5) on February 29, 2012. Petitioner did not respond to the CMS Motion for Summary Judgment, and I subsequently issued an Order to Show Cause on April 23, 2012. On May 7, 2012, Petitioner responded to my Order to Show Cause by letter (P. Response) and explained that "[the Petitioner does] not dispute the facts set forth in the CMS Motion and . . . would like for you to decide this case based upon the written record of all documents previously submitted." Petitioner also stated "[p]lease accept my apology for not filing the pre-hearing exchange in accordance with your . . . order. It was not evident to me that I should file an exchange." In the absence of objection, I admit CMS Exs. 1-5 into the record.

II. 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 beneficiaries may only be made to eligible providers of services and suppliers.[2] 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)).

---

[1] Noridian erroneously characterized July 12, 2011 as Petitioner's "effective date" rather than Petitioner's "retrospective billing date." Noridian determined the date the CMS contractor received his enrollment application was August 10, 2011, which is his actual effective date. Noridian then authorized Petitioner to retrospectively file claims for services from July 12, 2011. CMS Br. at 2; CMS Ex. 5.

[2] A "supplier" furnishes services under Medicare, and the term supplier applies to physicians and other non-physician 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 supplier must be enrolled in the Medicare program and be issued a billing number to be eligible to receive direct payment from Medicare for services rendered to its beneficiaries. 42 C.F.R. § 424.505. The effective date of enrollment for a supplier may only be the later of two dates: (1) the date when the supplier filed an application for enrollment that was subsequently approved by a Medicare contractor charged with reviewing the application on behalf of CMS; or (2) the date when the supplier first began providing services at a new practice location. 42 C.F.R. § 424.520(d). The date of filing of the enrollment application is the date when the designated Medicare contractor receives the complete enrollment application and supporting documentation. 42 C.F.R. § 424.510(d)(1); 73 Fed. Reg. 69,725, 69,769 (Nov. 19, 2008).

Additionally, an enrolled supplier may bill for 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. 42 C.F.R. § 424.521(a)(1). Retrospective billing for up to 90 days prior to the effective date of enrollment is permitted only in the case of a Presidentially-declared disaster. 42 C.F.R. § 424.521(a)(2).

III. Analysis

A. Issue

The issue in this case is whether CMS's contractor and CMS had a legitimate basis for determining Petitioner's effective Medicare enrollment date and retrospective billing date for Medicare 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).

C. Finding of Fact and Conclusion of Law

1) The undisputed evidence shows CMS's contractor and CMS properly determined Petitioner's effective date of Medicare enrollment and Petitioner's retrospective billing date for Medicare privileges.

The relevant facts are not disputed, and I draw all reasonable inferences in favor of Petitioner. Petitioner began providing services to Medicare beneficiaries on behalf of Providence in April of 2011. CMS Ex. 4. Petitioner subsequently submitted a Medicare enrollment application to Noridian. CMS Ex. 1. Noridian received Petitioner's Medicare enrollment application on August 10, 2011. On September 13, 2011, Noridian approved Petitioner's enrollment application with an effective date of August 10, 2011 and retrospective billing privileges commencing on July 12, 2011. CMS Ex. 3.

Petitioner contends that his effective date of enrollment should be April 18, 2011, the date he began rendering services to Medicare beneficiaries while employed at Providence. Petitioner does not deny that CMS received his enrollment application on August 10, 2011. However, Petitioner argues that his effective date should be earlier because:

> This enrollment was late due to a breakdown in communication between our clinic and business office. [Petitioner] started his employment in 2010 at another one of our clinics . . . Because he was already employed, the enrollment and reassignment of Medicare benefits process was overlooked in error. [Petitioner] actually treated numerous Medicare Beneficiaries during the months from April until July when the oversight was discovered and his initial applications were submitted. We are respectfully asking for a retroactive effective date to bill for services that were performed in good faith and for the benefit of many Medicare Beneficiaries.

CMS Ex. 4.

The effective date of Medicare enrollment and billing privileges 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.

(Emphasis added).

The effective date for Medicare billing privileges is determined according to the later of the two dates specified by the regulation. The "date of filing" is the date that the Medicare contractor receives a signed enrollment application that the Medicare contractor is able to process to approval. 42 C.F.R. § 424.510(d)(1); 73 Fed. Reg. 69,725, 69,769 (Nov. 19, 2008). Because it is undisputed that the contractor received Petitioner's approvable enrollment application on August 10, 2011, which is after the date Petitioner began providing services, the regulation dictates that this is the effective date of Petitioner's enrollment.

2) I am unauthorized to grant Petitioner's requests for equitable relief despite not meeting the legal requirements of Medicare enrollment.

Petitioner made various arguments for equitable relief at the reconsideration level and during this appeal. Petitioner's arguments for not meeting the legal requirements of enrollment pertain to administrative errors made during the enrollment process, a breakdown in communication between Petitioner's clinic and business office, and the fact that Petitioner provided services to Medicare beneficiaries for several months prior to his enrollment with Providence. CMS Ex. 4. I am not without sympathy for Petitioner's predicament. Petitioner did not argue, however, that he filed a complete application on an earlier date than CMS determined or that the contractor or CMS incorrectly applied the regulatory criteria.

I am without authority to order either Noridian or CMS to provide an exemption to Petitioner under the regulations set forth at 42 C.F.R. §§ 424.520(d) and 424.521(a), which are binding on me. I cannot alter or deviate from the regulations' explicit limitation on Petitioner's ability to bill for services up to 30 days prior to the date Noridian received Petitioner's complete application. I also have no authority to extend the retrospective billing period for Petitioner in this circumstance or ignore the clear requirements of the regulations governing his enrollment in Medicare. *Id*. Even accepting all of Petitioner's assertions as true, Petitioner's equitable arguments give me no ground to grant Petitioner an earlier effective date of enrollment. *See US Ultrasound*,

DAB No. 2302, at 8 (2010) ("[n]either the ALJ nor the Board is authorized to provide equitable relief by reimbursing or enrolling a supplier who does not meet statutory or regulatory requirements."). Moreover, I have no authority to declare statutes or regulations invalid or ultra vires. *1866ICPayday.com, L.L.C.*, DAB No. 2289, at 14 (2009) ("[a]n ALJ is bound by applicable laws and regulations and may not invalidate either a law or regulation on any ground.").

I conclude that Petitioner's effective date of Medicare enrollment was August 10, 2011, the undisputed date on which he submitted a reassignment enrollment application that could be processed to approval. Petitioner was also properly authorized to bill Medicare for services provided to Medicare beneficiaries as of July 12, 2011, or 30 days prior to his effective date of enrollment, which is the maximum amount of retrospective billing permitted under the relevant regulations. Accordingly, I grant summary judgment in favor of CMS.

/s/
Joseph Grow
Administrative Law Judge