Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Stephen Hirasuna, M.D.,
(CCN: 09295014100099),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-10-459

Decision No. CR2176

Date: July 07, 2010

DECISION REMANDING CASE

I deny the motion of the Centers for Medicare and Medicaid Services (CMS) for summary disposition, and I remand the case so that either CMS or its contractor, Palmetto GBA (Palmetto), may develop the record and make a determination based on the facts.

I. Background

Petitioner, Stephen Hirasuna, M.D., appeals the December 23, 2009 reconsideration decision granting Medicare enrollment to Petitioner, effective May 18, 2009.[1] Hearing Request (HR). On February 9, 2010, Petitioner filed a hearing request seeking to alter the effective date of participation to allow for billing for services rendered beginning January 1, 2008. *Id.*

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[1] As discussed later, the date Palmetto identified (May 18, 2009) is not Petitioner's "effective" date but, instead, is most likely the date CMS determined that Petitioner could retroactively bill for services in accordance with 42 C.F.R. § 424.521. This issue is discussed in greater detail *infra*.

This case was assigned for hearing and decision to Administrative Law Judge (ALJ) Richard J. Smith. The case was subsequently transferred to me, pursuant to 42 C.F.R. § 498.44, which permits a Member of the Departmental Appeals Board (Board) to be designated to hear appeals taken under Part 498. ALJ Smith issued an acknowledgment and initial docketing order (ALJ Order) on February 22, 2010, setting out procedures for the appeal. By letter dated March 5, 2010, Petitioner responded to the ALJ Order by "waiving an oral hearing and requesting that the case be decided on the written record."

On March 23, 2010, CMS moved that I dismiss Petitioner's hearing request. On May 5, 2010, I denied that motion in a ruling and set a schedule for further proceedings, including the submission of a motion for summary disposition (Ruling). I hereby incorporate that Ruling by reference into this action and attach it to this Decision. The gravamen of the Ruling was that CMS's argument that Petitioner had no right to challenge the effective date assigned to its enrollment application was contrary to the plain language of CMS's regulations at sections 498.3(b)(15), adopted by 424.545(a). *See Michael Majette, D.C.*, DAB CR 2142 (2010); *see also Eugene Rubach, M.D.,* DAB CR2125 (2010); *Mobile Vision, Inc.*, DAB CR2124 (2010).

On May 14, 2010, CMS filed a motion for summary disposition (CMS MSD), which is currently before me. CMS argues that the undisputed evidence establishes that Petitioner's enrollment was approved as of the date of filing of his application -- the earliest date allowed under the regulations.

CMS proffered no exhibits with its submissions. With his request for hearing, Petitioner included a copy of the contractor's December 23, 2009 reconsideration, a copy of a receipt for postage dated February 11, 2009, and a corresponding business request for reimbursement indicating the purchase of postage to mail the enrollment form to Palmetto. CMS expressly waived any objection to these materials. CMS MSD at 1 n.1. I mark these documents as Petitioner's Exhibits (P. Exs.) 1-3, respectively, and admit them into evidence for purposes of this decision.

II. Issue, Findings of Fact, and Conclusions of Law

A. Issue

The issue in this case is whether Palmetto and CMS properly determined Petitioner's effective enrollment date to be May 18, 2009.

B. Applicable Standard

CMS seeks summary disposition in the nature of summary judgment. The Departmental Appeals Board (Board) stated the standard for summary judgment as follows.

> 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 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. Analysis

CMS's motion consists of only 3 paragraphs. CMS asserts that the material facts are undisputed and characterizes them as that Palmetto received an enrollment application on behalf of Petitioner "on or about June 16, 2009" and granted enrollment with an "effective date of May 18, 2009, thirty days from the date it was received . . . the earliest date permissible under the regulations." CMS MSD at 1. CMS's argument reads in its entirety as follows: "[b]ecause petitioner's enrollment application was processed consistent with controlling federal regulations and procedural guidance, the enrollment date granted by the contractor should be upheld by this tribunal." *Id.* at 2 (citations to ALJ decisions omitted).

Petitioner asserts that he: (1) was enrolled as a contracted provider in the Medicare program; (2) was required to re-enroll in the program; and (3) began this process in the Fall of 2007. HR. Petitioner indicates that this re-enrollment process was particularly difficult due to a "lack of communication and technical support from Palmetto GBA's staff," which had just transitioned as the new program administrators. *Id*. However, on February 11, 2009, Petitioner submitted his CMS-855I application to Palmetto. At the crux of Petitioner's argument is that "[d]ue to miscommunication and extreme difficulty in connecting with knowledgeable staff at Palmetto GBA, *the application form for re-enrollment was mailed back and forth between my office and Palmetto GBA several*

times." *Id.* (emphasis added). According to Petitioner, he understands that the last time the application was sent to Palmetto it was received on June 18, 2009. HR; P. Ex. 1. Petitioner's approved application was initially provided an effective date of September 16, 2009. HR.

Petitioner timely sought reconsideration in October 2009. The reconsideration decision, issued December 23, 2009, provides no facts upon which the hearing officer based the decision and merely concludes that Petitioner "has provided evidence to show [he has] fully complied with the standards for which [his] effective date was established." P. Ex. 1. The effective date was changed to May 18, 2009, with the rationale that this date was "30 days prior to [the] date [the] application was received," but the decision does not state when the application was received or provide any other information upon which the determination was based. *Id*.

Presumably, CMS's reference in its motion to the correct processing of the application's effective date refers to this new date assigned in the reconsideration. CMS provides, however, no evidence to support the accuracy of the new effective date, such as, for example, a copy of the enrollment application showing date of receipt.[2] CMS simply asserts in its motion that Palmetto received the application "*on or about* June 16, 2009." CMS MSD at 1 (emphasis added).

The date upon which Palmetto received Petitioner's application is integral to the correct determination of Petitioner's effective date of Medicare billing privileges. Section 424.520 provides in pertinent part:

> (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 <u>the date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor</u> or the date an enrolled physician or nonphysician practitioner first began furnishing services at a new practice location.

(Emphasis added). The "date of filing" is the date that the Medicare contractor *receives* a signed provider enrollment application that the Medicare contractor is able to process to approval. 73 Fed. Reg. 69,725, 69,769 (Nov. 19, 2008) (emphasis added).

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[2] In many other cases CMS provided a copy of the approved enrollment application where each page of the application shows a stamp indicating the date of receipt. In this case, CMS has failed to submit a copy of the approved application or single piece of evidence.

It is evident that the date that Palmetto assigned as the "effective date," May 18, 2009, is not consistent with section 424.520(d), since it is described by CMS as "thirty days from the date [the application] was received by the contractor." CMS MSD at 1. Given the citation to section 424.521(a)(1), I might presume that CMS, and Palmetto, intended to assign an effective date based on the receipt date sometime on, or prior to, June 18, 2009, and grant a 30-day period of retroactive billing as that regulation permitted.[3]

Given the failure of CMS to document any date of receipt in this case and failure to explain the calculation of the May 18, 2009 purported effective date, however, I am unwilling to presume and correct the error on summary judgment. CMS's failure to obtain a proper date of receipt, instead indicating only "on or about" a particular date, is particularly egregious in this case, where it is the sole basis for CMS's argument and for the contractor's determination.

Furthermore, neither the reconsideration decision nor CMS in its motions and supporting memoranda provide any argument or explanation in response to Petitioner's account of events. This silence leaves me without the benefit of CMS's reasoning as to the legal significance of Petitioner's account. CMS offers no indication of whether the original February 11, 2009 application was flawed in any way or whether it differed at all from the approved application at the end of the back-and-forth mailing process.

A contractor may process an application in a number of ways. For example, if a signed application is submitted with deficiencies:

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[3] Confusion has been introduced by a muddling of the effective date for which a supplier is approved as eligible to bill Medicare, governed by 42 C.F.R. § 424.520(d), with the earliest date for which an approved supplier may be permitted to bill retroactively for services provided prior to the effective date, if the contractor finds that certain prerequisites are met, governed by 42 C.F.R. § 424.521(a). The contractor and counsel for CMS in this matter contributed to this confusion by conflating the two date determinations and setting out as the "effective date" the earliest date for which it would permit Petitioners to bill retroactively for services provided. P. Ex. 1, at 1; CMS MSD. A careful reading of the regulations and preamble discussions, however, makes clear that the grant of a retroactive billing period of up to 30 days does <u>not</u> constitute a change in the <u>effective date of the supplier's approval of eligibility</u> to participate in Medicare and is based on a showing of circumstances precluding timely enrollment, not a determination of an earlier date of eligibility.

> As a general rule, applicants are given at least 30 days to cure any deficiencies/technicalities before a contractor rejects an enrollment application (see § 424.525). During the application review process, contractors notify applicants about missing information and documentation and afford the applicant at least 30 days to correct deficiencies.

73 Fed. Reg. at 69,769.[4] If the prospective provider or supplier fails to correct these deficiencies, CMS, at its discretion, may provide a 30-day extension "if CMS determines that the prospective provider or supplier is actively working with CMS to resolve any outstanding issues." 42 C.F.R. § 424.525(b). If the prospective provider or supplier fails to supply the requested documentation or missing information, CMS may then reject an enrollment application. 42 C.F.R. § 424.525(a). Once an enrollment application is rejected, however, the provider or supplier must submit a new application for enrollment which, if approved, will be assigned the effective date of the later approved application. On the other hand, if the application is still in the process of remedy, it will be provided the effective date of the original date of receipt.

In this case, neither party presented evidence of whether Petitioner's applications were rejected or whether the identical application that was ultimately approved was literally mailed back and forth. Neither party presented argument as to whether the contractor's receipt of a signed, fully complete application would have triggered the effective date, which would not be defeated by subsequent mailing of additional copies of the application back and forth.

Given the sparse record and pleadings, I do not find it appropriate to grant summary judgment. Moreover, in light of CMS's inadequate response to repeated orders to provide all relevant materials for my consideration, I do not believe that further proceedings before me will generate a clearer record. Without the benefit of evidence or explanation as to the contractor's receipt and processing of the application(s) in this case, I will not make findings of fact.

I remand the matter to CMS so that CMS or its contractor may review all relevant files and materials and issue a new determination addressing the facts.

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[4] CMS also permits a contractor to "return" an application for certain defects, such as an unsigned application. The Medicare Program Integrity Manual (MPIM) clarifies that the "difference between a 'rejected' application and a 'returned' application" is that "the former is based on the provider's failure to respond to the contractor's request for missing or clarifying information," whereas "[a] 'returned' application is considered a non-application." MPIM Chapter 10, ¶ 3.2. No allegation was made here that Petitioner's February 11, 2009 application was returned or unsigned.

III. Conclusion

I therefore deny the CMS motion for summary disposition. I remand this case to CMS for actions consistent with this decision and dismiss the appeal without prejudice to Petitioner. 42 C.F.R. §§ 498.68, 498.78(b). Thus, Petitioner may file a new request for hearing before me if the decision on remand is unfavorable.

/s/
Leslie A. Sussan
Board Member