Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Wolverine State Inpatient Services,

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-12-819

Decision No. CR2671

Date: November 26, 2012

DECISION

This matter is before me on the Motion for Summary Disposition filed by the Centers for Medicare and Medicaid Services (CMS) on July 27, 2012. For the reason set out below, I GRANT the CMS Motion and AFFIRM the denial of Petitioner Wolverine State Inpatient Services' (WSIS) Medicare application.

I. Background and Procedural History

Petitioner sought to enroll in the Medicare program as a multi-specialty group clinic. CMS Exhibit (Ex.) 4 at 6. To that end, Petitioner submitted enrollment applications to enroll itself as a "supplier" and to enroll a number of individual physicians who would practice with Petitioner's group clinic and reassign their Medicare payments to Petitioner. CMS Exs. 4, 6-8. Wisconsin Physicians Service Insurance Corporation (WPS), a Medicare contractor, denied Petitioner's applications stating that Petitioner did not qualify as a supplier in the Medicare program and was not operational to furnish Medicare covered items or services. CMS Ex. 2 at 3. Petitioner requested contractor reconsideration and on April 5, 2012, WPS found that Petitioner did not meet the requirements to enroll in the Medicare program on the same bases. CMS Ex. 1.

On June 4, 2012, Petitioner filed a hearing request challenging the WPS redetermination. CMS submitted a Motion for Summary Disposition and a brief in support of its motion (CMS Br.), along with eight exhibits identified as CMS Exs. 1-8. Petitioner filed its Memorandum of Law in Opposition to the CMS Motion (P. Br.), along with three exhibits marked as P. Exs. 1-3. In the absence of objection, I admit CMS Exs. 1-8 and P. Exs. 1-3 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. Act §§ 1835(a), 42 U.S.C. § 1395n(a); 1842(h)(1), 42 U.S.C. § 1395u(h)(1). The Act authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations governing the enrollment process for providers and suppliers, including the right to a hearing and judicial review of certain enrollment determinations. Act §§ 1102, 1866(j), 42 U.S.C. §§ 1302, 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 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 direct payment from Medicare. 42 C.F.R. § 424.505.

Medicare pays a supplier directly for covered services if a beneficiary assigns a claim to the supplier and the supplier accepts assignment. 42 C.F.R. § 424.55(a). 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).

A supplier "must be operational to furnish Medicare covered items or services before being granted Medicare billing privileges." 42 C.F.R. § 424.510(d)(6). A supplier is "operational" when it 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 . . . to furnish these items and services." 42 C.F.R. § 424.502. Prospective suppliers must provide all documentation required by CMS to ascertain whether the provider or supplier is eligible to furnish Medicare-covered items or services. *See* 42 C.F.R. § 424.510. Federal regulations define the circumstances in which CMS may deny the application of a

supplier to participate in the Medicare program. *See generally* 42 C.F.R. § 424.530. CMS may deny a supplier's enrollment in Medicare if "[t]he provider or supplier at any time is found not to be in compliance with the Medicare enrollment requirements described in this section or on the applicable enrollment application to the type of provider or supplier enrolling, and has not submitted a plan of corrective action as outlined in part 488 of this chapter." 42 C.F.R. § 424.530(a)(1). CMS may also deny a supplier's enrollment if, upon on-site review, CMS determines that a "supplier is no longer operational to furnish Medicare covered items or services, or the supplier has failed to satisfy any or all of the Medicare enrollment requirements, or has failed to furnish Medicare covered items or services as required by the statute or regulations." 42 C.F.R. § 424.530(a)(5)(ii).

When CMS denies the enrollment of a supplier in the Medicare program, CMS will also review other related enrollment files associated with the denied supplier to determine if the denial warrants an adverse action on the associated suppliers. 42 C.F.R. § 424.530(d).

III. Issue

The issue in this case is whether CMS, or its contractor, was authorized to deny Petitioner's request to enroll in the Medicare program.

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. ***This case is appropriate for summary judgment***

CMS argues that it is entitled to summary judgment. The Departmental Appeals Board (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 Rehabilitation & Skilled Nursing Center, DAB No. 2300, at 3 (2010) (citations omitted).

The Board has further explained that the role of an Administrative Law Judge (ALJ) in deciding a summary judgment motion differs from its role in resolving a case after a hearing. The ALJ should not assess credibility or evaluate the weight of conflicting evidence. *Holy Cross Village at Notre Dame, Inc.*, DAB No. 2291, at 5 (2009). I find that Petitioner has not disputed any fact material to my resolution of the case. Accordingly, I conclude that summary judgment is appropriate in this case. Here, the material facts are not disputed, and I draw all reasonable inferences in favor of Petitioner.

B. *CMS was authorized to deny Petitioner's request to enroll in the Medicare program because Petitioner did not meet the definition of a supplier and is not operational to furnish Medicare covered items or services.*

WSIS is a wholly-owned subsidiary of the partnership between Inpatient Services of Michigan, P.C. (ISM) and its wholly-owned subsidiary, Michigan EM-II, Inc. (EM-II). Douglas Webster, D.O. is the owner and authorized official of ISM, the owner of EM-II, and is licensed to practice osteopathy in Michigan. EmCare, Inc. (EmCare) provides various management and administrative services to ISM, its affiliated entities, and employees under a management agreement. Reimbursement Technologies, Inc. (RTI), is the billing entity for ISM. ISM contracts with physicians to supply services to hospitals with which it also contracts. ISM has created a separate billing entity for each of the hospitals with which it contracts. WSIS is one of those created billing entities. P. Br. at 1-3; P. Ex. 1 at 1-2 (Hufstetler Decl. at ¶¶ 1, 5-7); CMS Ex. 2 at 6; CMS Ex. 5 at 2.

WSIS defines itself through the ISM and EM-II partnership agreement which states: "The 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. 5 at 1. The agreement also shows that Petitioner itself does not employ any of the physicians for which Petitioner is acting as the billing entity. CMS Ex. 5 at 2. The partnership agreement does not purport to assert that Petitioner would furnish health care services under Medicare, but instead plainly asserts that Petitioner is an entity formed solely to act as a billing entity. CMS Ex. 5.

WSIS does not qualify for enrollment in the Medicare program because it does not meet the definition of a "supplier" under Medicare, and also because it is not operational to furnish Medicare covered items or services. 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. 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).

Petitioner does not argue that WSIS furnishes health care services or that it has a qualified physical practice location open to the public, providing health care related services. Instead, Petitioner concedes that a separate legal entity (ISM) employs physicians. Rather, Petitioner admits WSIS was created to be a separate general partnership simply to serve as a billing entity to facilitate the bookkeeping of payments received from third party payers.

Petitioner argues that "[n]either the definition of a supplier in 42 C.F.R. § 400.202, nor the definition of operational in 42 C.F.R. § 424.502, expressly excludes arrangements under which an entity under the ownership and direct control of the physician(s) furnishing covered services enrolls at the direction of the physician group." P. Br. at 9. Although the definitions may not specifically exclude Petitioner's business structure, it does not change the fact that WSIS does not qualify as a supplier that is operational under the regulations. 42 C.F.R. §§ 400.202, 424.502. Certainly, Petitioner is free to contract and make billing arrangements with any range of entities it desires; however, enrollment in Medicare and entities Medicare will pay for covered health care services are not based on those arrangements, but on the regulatory definitions and requirements that Petitioner overlooks.

Petitioner asserts that:

> WSIS is under the complete ownership and control of ISM, and cannot act independently of ISM. Under this model, EmCare contracts with a hospital to arrange for hospitalist services. EmCare contracts with ISM to provide the necessary physicians to support the contractual requirements regarding this hospitalist coverage at the Hospital. ISM employs physicians to support EmCare's obligations to all of its client hospitals in Missouri [sic], and ISM forms a general partnership - in which it is one of two general partners - through which ISM's employed physicians will bill for services provided at the specific hospital. Under this structure, although the billing function is performed by a separate legal entity from the entity that employs the

> hospitalist physicians who render services, as a practical matter they are linked.

P. Br. at 9.

I will assume for purposes of this summary disposition analysis that Petitioner is "linked" to a separate legal entity that does in fact provide health care services and that would qualify as a supplier under Medicare requirements. Petitioner argues that although it does not provide health care services, it is linked as a practical matter to a legal entity that does.

However, the regulations prohibit the reassignment of Medicare payments to affiliates of a supplier's employer. 42 C.F.R. § 424.80(a). In other words, unless an exception applies, Medicare does not directly pay a supplier's benefits to a reassigned entity if the supplier has already assigned the benefits to the supplier's employer. Thus, absent an exception, ISM cannot reassign to Petitioner the suppliers' benefits that those suppliers assigned to ISM. Clearly, none of the exceptions apply to Petitioner's case. 42 U.S.C. § 1395u(b)(6); 42 C.F.R. § 424.80(b)(1). The contractual exception under 42 C.F.R. § 424.80(b)(2) does not apply to this case because it only provides for Medicare to pay an entity pursuant to a contractual arrangement if the entity is enrolled in Medicare, and there is a contractual arrangement between the entity and the supplier. However, WSIS does not contract with physicians, only ISM contracts with physicians. Simply having a billing or reassignment arrangement with a supplier does not meet the legal requirements for enrolling in the Medicare program as a supplier. Without the assignee having previously enrolled in Medicare, CMS or its contractor will not directly pay the assignee of the arrangement with a supplier. The exception allowing Medicare to pay an agent "who furnishes billing and collection services" to the supplier or the supplier's employer if certain conditions are met, including that the agent receives payment under an agency agreement with the supplier also does not apply. 42 C.F.R. § 424.80(b)(5); 42 C.F.R. § 424.73(b)(3). In this case, Petitioner insists that RTI is its billing agent. CMS Ex. 4 at 32; CMS Ex. 2. WSIS is not able to receive reassigned benefits from physicians in accordance with the Medicare reassignment provisions.

Although Petitioner would distinguish the case, I believe that the enrollment denial here is similar to that in *US Ultrasound*, DAB No. 2302 (2010). 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. *US Ultrasound*, DAB No. 2302 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. *US Ultrasound*, DAB No. 2302 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." *Id.* at 5-6. Similarly, in *Briarwood Community Mental Health Center*, DAB No. 2414 (2011), the Board stated that "[t]he word 'operational' is a term of art specific to Medicare, and it means that a provider or supplier must have a qualified physical practice location and actually be furnishing the types of covered Medicare services that it holds itself out as furnishing." There is no argument that Petitioner does not meet those qualifications.

Arguing against summary disposition, Petitioner asserts that the "history of EmCare's meetings with CMS plainly establish that there are material facts in dispute." P. Br. at 6-8. Whether CMS or its agents at some point gave some sort of tacit or expressed approval to Petitioner's business structure does not create a material fact at issue. Similarly, although Petitioner asks for equitable relief based on the actions of other Medicare contractors, "[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." *US Ultrasound*, DAB No. 2302 (2010); *see also Peter McCambridge, C.F.A. v. CMS*, Ruling No. 2010-1 on Request to Reopen Decision No. 2290, 2010 WL 744489 (February 2, 2010) ("The Board does not have the legal authority to require CMS to take an action (i.e., enrolling Petitioner in Medicare as a surgical first assistant) that would be inconsistent with the Medicare statute and regulations.").

As a matter of law, Petitioner does not meet the definition of a Medicare supplier and cannot be enrolled in the Medicare program.[1] 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. Whatever motivated or guided the establishment of the business structure discussed above, its result included — and for all present purposes dictated — the result I announce here.

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[1] I note that because WSIS is not enrolled in the Medicare program, there is no basis to approve any Medicare enrollment reassignments to Petitioner. *See* 42 C.F.R. § 424.80(b).

V. Conclusion

The undisputed evidence establishes that CMS was authorized to deny Petitioner's Medicare enrollment as a supplier because it was not operational and did not otherwise meet the requirements of an eligible supplier. Accordingly, I GRANT summary judgment in favor of CMS. The denial of Petitioner Wolverine State Inpatient Services' Medicare application must be, and it is, AFFIRMED.

/s/
Richard J. Smith
Administrative Law Judge