Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Mound City Inpatient Services,

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-12-299

Decision No. CR2569

Date: July 18, 2012

DECISION

Mound City Inpatient Services (Petitioner) appeals a reconsideration decision issued on November 28, 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 denied Petitioner's enrollment in the Medicare program.

I. Background and Procedural History

To obtain direct billing privileges from Medicare for care provided to beneficiaries, Petitioner submitted a group practice enrollment application, CMS Form 855B, and several individual and reassignment physician applications, CMS Forms 855I and 855R, respectively. CMS Exhibits (Exs.) 4 and 5. Petitioner sought to enroll in the Medicare program as a multi-specialty group clinic that provided physicians' services. CMS Ex. 4 at 4. Wisconsin Physicians Service Insurance Corporation (WPS), a CMS contractor, received the enrollment application on July 15, 2011. CMS Exs. 3 and 4.

WPS notified Petitioner, by letter dated July 19, 2011, that it was denying Petitioner's enrollment application because Petitioner was not operational and did not meet Medicare

requirements to furnish Medicare covered items or services. CMS Ex. 2 at 1. Petitioner requested reconsideration of this initial decision. CMS Ex. 3. On November 28, 2011, a WPS hearing officer issued Petitioner an unfavorable reconsideration decision finding Petitioner was not operational to furnish Medicare covered items or services or did not meet Medicare enrollment requirements. CMS Ex. 1.

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 six exhibits (CMS Exs. 1-6). Petitioner filed a response to CMS's Motion for Summary Disposition and Supporting Brief (P. Br.) accompanied by thirteen exhibits (P. Exs. 1-13). Thereafter, CMS filed a Response Brief (CMS Response). In the absence of objection, I admit CMS Exs. 1-6 and P. Exs. 1-13 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 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).

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 and direct 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 as an operational supplier.

Petitioner applied for Medicare enrollment as a multi-specialty clinic and defines itself through a "partnership agreement" submitted with its Medicare enrollment application. CMS Ex. 4 at 37-41. 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. 4 at 37. The agreement also

indicates that Petitioner does not employ any of the physicians for which Petitioner is acting as the billing entity. CMS Ex. 4 at 38. The partnership agreement does not indicate that Petitioner would furnish health care services under Medicare, but instead it states that Petitioner is an entity formed solely to act as a billing entity. CMS Ex. 4 at 38-41.

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 has simply provided no evidence to show it is a supplier that furnishes health care services or is operational to furnish health care services covered by Medicare as a multi-specialty group clinic which provides physicians' services. Nor does Petitioner dispute that it is not a multi-specialty group clinic or an employer of health care practitioners. Petitioner, however, contends it is a subsidiary under the control and ownership of a related entity (Inpatient Services of Missouri, P.C., or "ISM") that does provide physicians' health care services. Petitioner argues it cannot act independently of this related entity. P. Br. at 5-6. Nonetheless, Petitioner does not dispute it is a separate legal entity from the entity furnishing the physicians' health care services:

> [Petitioner] is under the 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, 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 5.

I will assume for purposes of summary judgment, 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.

Yet, I find CMS's enrollment denial here similar to that in *US Ultrasound*, DAB No. 2302 (2010). CMS Br. at 9-10. 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, I find Petitioner does not meet the definition of a Medicare supplier and cannot be enrolled in the Medicare program. 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. Thus, Petitioner does not directly provide Medicare covered physician health care services just as US Ultrasound did not directly provide Medicare covered testing services.

Further, considering CMS denied Petitioner's CMS Form 855B because Petitioner did not meet the Medicare definition of an operational supplier, there would be no basis to approve any Medicare enrollment reassignments to Petitioner. *See* 42 C.F.R. § 424.80(b).

2. CMS's determination to deny Petitioner's enrollment application was consistent with the regulatory purpose of Medicare enrollment requirements.

Petitioner makes a policy argument in support of its approval for enrollment in the Medicare program and contends that Medicare revised its enrollment requirements in order to better safeguard Medicare funds and to limit or eliminate improper payments. Petitioner argues its enrollment would facilitate the reimbursement process and that no

part of Petitioner's and its related entities' corporate structure prejudices the government's interest in assuring that Medicare payments are properly made. P. Br. at 5-6. Petitioner states that its organizational structure falls within the scope of the Medicare enrollment requirements for a supplier of services and that "[t]he form of the organization in this context should not eclipse the substance." P. Br. at 6.

However, 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. 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.

Therefore, CMS's enrollment determination must be upheld. Petitioner is an admitted billing entity which does not provide the intended Medicare services described in Petitioner's enrollment application for a multi-specialty group clinic. 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 suppliers accountable and to protect the Medicare Trust Fund.

IV. Conclusion

The undisputed evidence establishes that CMS had a legitimate basis to deny Petitioner's Medicare enrollment as a supplier considering that Petitioner, as a separate billing entity, was not operational and did not otherwise meet the requirements of an eligible supplier. Accordingly, I grant summary judgment in favor of CMS.

/s/
Joseph Grow
Administrative Law Judge