Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Brian P. Rajca, M.D.,
(NPI: 1083876197 / PTAN: IN311Z),
Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-16-787

Decision No. CR4752

Date: December 7, 2016

DECISION

The effective date of Medicare enrollment and billing privileges of Petitioner, Brian P. Rajca, M.D., is January 11, 2016, with the 30-day period for retrospective billing beginning December 12, 2015.

I. Background and Procedural History

First Coast Service Options, Inc. (First Coast), a Medicare administrative contractor, notified Petitioner's employer by letter dated April 21, 2016, that Petitioner's Medicare enrollment application and his reassignment of benefits application were approved with an "effective date" of December 12, 2015.[1] Centers for Medicare & Medicaid Services

---

[1] First Coast refers to Petitioner's effective date as December 12, 2015. CMS Ex. 1 at 40. However, for reasons discussed hereafter, January 11, 2016, the date Petitioner's application was received by First Coast, is Petitioner's effective date, and December 12, 2015 is the first date of the 30-day period allowed for retrospective billing. 42 C.F.R. § 424.521(a)(1) (citations are to the 2015 revision of the Code of Federal Regulations (C.F.R.), unless otherwise indicated).

(CMS) Exhibit (Ex.) 1 at 40. On May 17, 2016, Petitioner requested reconsideration of the initial determination. Petitioner claimed that he submitted his Medicare application on July 27, 2015, and it was lost by First Coast. CMS Ex. 1 at 44. First Coast notified Petitioner by letter dated June 3, 2016, that his request for reconsideration was denied. CMS Ex. 1 at 1-3. The hearing officer on reconsideration determined that First Coast checked its system for applications received between July 27, 2015 and August 5, 2015, and no application for Petitioner was received until the one received on January 11, 2016. The hearing officer also incorrectly characterized December 12, 2015, as the effective date of Petitioner's enrollment. Based on the hearing officer's findings, the effective date of enrollment was January 11, 2016, the date First Coast received the application, and December 12, 2015 was the first day of the 30-day period for retrospective billing. 42 C.F.R. §§ 424.520(d)(1), 424.521(a)(1). CMS Ex. 1 at 1-2.

Petitioner filed a request for hearing before an administrative law judge (ALJ) on August 2, 2016 (RFH). On August 8, 2016, the case was assigned to me for hearing and decision and an Acknowledgment and Prehearing Order (Prehearing Order) was issued at my direction.

CMS filed a motion for summary judgment and prehearing brief with CMS Exhibits 1 and 2 on September 7, 2016. On October 7, 2016, Petitioner requested that I add a document to the record for consideration. Although Petitioner did not mark that document as an exhibit, I treat that document as if marked as Petitioner's Exhibit (P. Ex.) 1. On October 24, 2016, CMS filed its reply and its objection to P. Ex. 1.

Petitioner has not objected to my consideration of CMS Exs. 1 and 2 and they are admitted. Petitioner asserts that P. Ex. 1 is a record of an incoming call to Petitioner on October 7, 2015, purportedly from "Medicare Provider Enrollment." CMS does not object to the authenticity of the document but does object that it is not relevant and is new evidence offered for the first time before me without a showing of good cause as required by 42 C.F.R. § 498.56(e). I may only admit and consider documents that are relevant and material. 42 C.F.R. §§ 498.60(b), 498.66(d)(1). Evidence is relevant if it has any tendency to make the existence of a fact of consequence more or less probable than without the evidence. Fed. R. Evid. 401. I conclude that Petitioner has not established that P. Ex. 1 is relevant. Petitioner has not offered a declaration, affidavit, or other evidence to show that the incoming telephone number on the document had any connection to "Medicare Provider Enrollment." Even if I accept for purposes of summary judgment that P. Ex. 1 shows that Petitioner received a call from "Medicare Provider Enrollment," Petitioner has presented no evidence by anyone involved in that call of the substance of the call. Therefore, it is not possible to determine that P. Ex. 1 is relevant to the fact issue before me, that is, on what date did First Coast actually receive an application from Petitioner.

II. Discussion

A. 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-eligible 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. § 1395(u)(h)(1)). Administration of the Part B program is through contractors such as First Coast. Act § 1842(a) (42 U.S.C. § 1395u(a)).

Qualified physician services, subject to some limitations, are covered by Medicare Part B for those physicians enrolled in Medicare. Act §§ 1832(a) (42 U.S.C. § 1395k(a)); 1861(s)(1) (42 U.S.C. § 1395x(s)(1)); 42 C.F.R. § 410.20. "Physicians' services" are professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls (with certain exceptions). Act § 1861(q) (42 U.S.C. § 1395x(q)); 42 C.F.R. § 410.20.

The Act requires the Secretary of Health and Human Services (the Secretary) 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)). Pursuant to 42 C.F.R. § 424.505, a provider or supplier must be enrolled in the Medicare program and be issued a billing number to have billing privileges and to be eligible to receive payment for services rendered to a Medicare-eligible beneficiary.

Petitioner, a doctor, is a physician practitioner. The effective date of enrollment in Medicare of a physician, nonphysician practitioner, and physician and nonphysician

---

[2] Petitioner is a "supplier" under the Act and the regulations. A "supplier" furnishes services under Medicare and the term supplier applies to physicians or other 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 "provider of services," commonly shortened to "provider," includes hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, hospice programs, and a fund as described in sections 1814(g) and 1835(e) of the Act. Act § 1861(u) (42 U.S.C. § 1395x(u)). The distinction between providers and suppliers is important because they are treated differently under the Act for some purposes.

practitioner organizations is governed by 42 C.F.R. § 424.520(d). The effective date of enrollment for a physician or nonphysician practitioner may only be the **later** of two dates: the date when the physician **filed** an application for enrollment that was subsequently approved by a Medicare contractor charged with reviewing the application on behalf of CMS; or the date when the physician 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 on which the Medicare contractor receives a signed enrollment application that the 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);*Alexander C. Gatzimos, M.D.,J.D., LLC, d/b/a Michiana Adult Medical Specialists*, DAB No. 2730, at 1 (2016). An enrolled physician or nonphysician practitioner may retrospectively bill Medicare 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. Retrospective billing for up to 90 days prior to the effective date of enrollment is permitted only in case of a Presidentially-declared disaster pursuant to 42 U.S.C. §§ 5121-5206. 42 C.F.R. § 424.521. The latter provision has no application in this case.

The Secretary has issued regulations that establish the right to a hearing and judicial review of certain enrollment determinations. Act § 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to section 1866(h)(1) and (j)(8), a provider or supplier whose enrollment application or renewal application is denied is entitled to an administrative hearing and judicial review. Pursuant to 42 C.F.R. § 498.3(b)(15), a provider's effective date is an initial determination that is subject to administrative review by an ALJ. Appeal and review rights are specified by 42 C.F.R. § 498.5.

B. Issues

The issues in this case are:

> Whether or not summary judgment is appropriate; and
>
> Whether Petitioner's effective date for Medicare enrollment and billing privileges is January 11, 2016, with retrospective billing permitted beginning on December 12, 2015.

C. Findings of Fact, Conclusions of Law, and Analysis

My conclusions of law are set forth in bold followed by my findings of fact and analysis.

1. Summary judgment is appropriate.

CMS has requested summary judgment. Summary judgment is not automatic upon request but is limited to certain specific conditions. The Secretary's regulations that

establish the procedure to be followed in adjudicating Petitioner's case are at 42 C.F.R. pt. 498. The regulations do not establish a summary judgment procedure or recognize such a procedure. However, the Departmental Appeals Board (the Board) has long accepted that summary judgment is an acceptable procedural device in cases adjudicated pursuant to 42 C.F.R. pt. 498. *See, e.g.*, *Illinois Knights Templar Home*, DAB No. 2274, at 3-4 (2009); *Garden City Med. Clinic*, DAB No. 1763 (2001); *Everett Rehab. & Med. Ctr*., DAB No. 1628, at 3 (1997). The Board also has recognized that the Federal Rules of Civil Procedure do not apply in administrative adjudications such as this, but the Board has accepted that Federal Rule of Civil Procedure 56 and related cases provide useful guidance for determining whether summary judgment is appropriate. Furthermore, a summary judgment procedure was adopted as a matter of judicial economy within my authority to regulate the course of proceedings and made available to the parties in the litigation of this case by my Prehearing Order dated August 8, 2016, paragraph II.G. The parties were given notice by the Prehearing Order that summary judgment is an available procedural device and that the law as it has developed related to Federal Rule of Civil Procedure 56 will be applied. The parties were advised that a fact alleged and not specifically denied, may be accepted as true for purposes of ruling upon a motion for summary judgment. The parties were also advised that on summary judgment evidence is considered admissible and true unless a specific objection is made. Prehearing Order ¶ II.G.

Summary judgment is appropriate when there is no genuine dispute as to any issue of material fact for adjudication and/or the moving party is entitled to judgment as a matter of 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. The party requesting summary judgment bears the burden of showing that there are no genuine issues of material fact for trial and/or that it is entitled to judgment as a matter of law. Generally, the non-movant may not defeat an adequately supported summary judgment motion by relying upon the denials in its pleadings or briefs but must furnish evidence of a dispute concerning a material fact, i.e., a fact that would affect the outcome of the case if proven. *Senior Rehab. & Skilled Nursing Ctr*., DAB No. 2300, at 3 (2010) (and cases cited therein); *Anderson v. Liberty Lobby, Inc*., 477 U.S. 242, 248 (1986).

The standard for deciding a case on summary judgment and an ALJ's decision-making in deciding a summary judgment motion differs from resolving a case after a hearing. On summary judgment, the ALJ does not make credibility determinations, weigh the evidence, or decide which inferences to draw from the evidence, as would be done when finding facts after a hearing on the record. Rather, on summary judgment, the ALJ construes the evidence in a light most favorable to the non-movant and avoids deciding which version of the facts is more likely true. *Holy Cross Vill. at Notre Dame, Inc*., DAB No. 2291, at 5 (2009). The Board also has recognized that on summary judgment it is appropriate for the ALJ to consider whether a rational trier of fact could find that the

party's evidence would be sufficient to meet that party's evidentiary burden. *Dumas Nursing & Rehab., L.P.*, DAB No. 2347, at 5 (2010). The Secretary has not provided for the allocation of the burden of persuasion or the quantum of evidence in 42 C.F.R. pt. 498. However, the Board has provided some persuasive analysis regarding the allocation of the burden of persuasion in cases subject to 42 C.F.R. pt. 498. *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 Fed. App'x 181 (6th Cir. 2005).

The material facts in this case are not disputed and there is no genuine dispute as to any material fact that requires a trial. The issues in this case that require resolution are issues of law related to the interpretation and application of the regulations that govern enrollment and billing privileges in the Medicare program to the undisputed facts of this case. Accordingly, summary judgment is appropriate.

2. Pursuant to 42 C.F.R. § 424.520(d), Petitioner's effective date of Medicare enrollment is January 11, 2016, the date First Coast received the Medicare enrollment application that was processed to approval.

3. Pursuant to 42 C.F.R. § 424.521(a)(1), Petitioner was authorized to bill Medicare for services provided to Medicare-eligible beneficiaries up to 30 days prior to his effective date of enrollment, that is, beginning on December 12, 2105.

a. Facts

The material facts are not disputed and any inferences are drawn in Petitioner's favor on summary judgment.

Petitioner, a physician, asserts that he should be authorized to bill Medicare as of July 1, 2015, rather than December 12, 2015, as determined by the hearing officer on reconsideration. Petitioner asserts that applications were submitted to First Coast on July 27, 2015 and October 7, 2015. RFH. I accept as true for purposes of summary judgment that the applications, copies of which were filed with the request for hearing, were sent to First Coast as alleged by Petitioner. However, Petitioner has offered no documents such as certified or registered mail receipts or receipts from a courier service to show receipt by First Coast. Petitioner does not assert that any applications were filed on-line using the Medicare Provider Enrollment, Chain, and Ownership System (PECOS).

Petitioner admits that his representative checked on the status of his July 2015 application by phone on October 7, 2015. The representative was informed that no application could be found. Petitioner asserts that he resubmitted his Forms CMS-855I (Medicare enrollment application) and CMS-855R (reassignment of Medicare claims) on October 9,

2015. Petitioner's representative subsequently called First Coast in January 2016, and was informed that there was no application for Petitioner on file. RFH.

There is no dispute that First Coast received enrollment and reassignment applications for Petitioner on January 11, 2016, that were subsequently processed to approval. CMS Ex. 1 at 2; CMS Ex. 2; RFH.

b. Analysis

The regulations controlling the effective date of enrollment of a physician and the application of those regulations are clear. The effective date of enrollment in Medicare of a physician, nonphysician practitioner, and physician and nonphysician practitioner organizations is governed by 42 C.F.R. § 424.520(d). The effective date of enrollment for a physician or nonphysician practitioner may only be the later of two dates: (1) the date when the physician 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 physician 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 on which the Medicare contractor receives a signed enrollment application that the 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); *Gatzimos*, DAB No. 2730, at 1. The burden is on Petitioner, not the government, to demonstrate that CMS received the requisite enrollment forms and that Petitioner complied with all relevant policies. 42 C.F.R. § 424.545(c). An enrolled physician or nonphysician practitioner may retrospectively bill Medicare 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).

Petitioner requests that his effective date of enrollment be changed to July 1, 2015. RFH. Although I accept as true for summary judgment that Petitioner began providing services on July 13, 2015 (CMS Ex. 1 at 59), the regulation provides that it is the ***later*** of the date of filing a Medicare enrollment application or the date services were first provided that controls. 42 C.F.R. § 424.520(d). The undisputed evidence shows that Petitioner submitted Medicare enrollment and reassignment applications and that they were received by First Coast on January 11, 2016, and subsequently approved. Applying the regulations to the undisputed evidence, I conclude that Petitioner's effective date of enrollment is January 11, 2016, which is the date First Coast received applications that it processed to approval. January 11, 2016 is clearly later than July 13, 2015, the date Petitioner began providing services. The first day of the 30-day period of retrospective billing privileges is December 12, 2015, under 42 C.F.R. § 424.521(a)(1).

I accept as true for purposes of summary judgment that Petitioner submitted applications in July and October 2015. However, Petitioner has pointed to no evidence that First

Coast either received or processed those earlier applications. I decline to infer from the fact that Petitioner mailed applications that they were actually received by First Coast. Petitioner offers no legal authority that requires such an inference. Therefore, Petitioner has failed to show that there is a genuine dispute as to the material facts of whether or not First Coast received and processed the earlier applications.

Petitioner argues that he submitted a corrective action plan that seems to have been ignored. Petitioner also argues it is unfair for him to be penalized because the July and October 2015 applications were lost in the First Coast mailroom. Petitioner takes no responsibility for failing to use the PECOS system which would have acknowledged receipt of the applications or for failing to obtain certified or registered mail receipts or other evidence of receipt by First Coast. RFH. Petitioner cites no legal authority that shows he is entitled to any relief under the law based on his arguments, even if accepted as true for summary judgment. Even if Petitioner's arguments are construed as requests for equitable relief, I do not have the authority to grant equitable relief in the form of an earlier effective date of enrollment. *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."). Petitioner points to no authority by which I may grant him relief from the applicable regulatory requirements. 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.").

III. Conclusion

For the foregoing reasons, the effective date of Petitioner's Medicare enrollment and billing privileges is January 11, 2016, with a 30-day period for retrospective billing beginning on December 12, 2015.

/s/
Keith W. Sickendick
Administrative Law Judge