Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Mushtaq A. Sheikh, M.D.
(PTAN: J300085637; NPI: 1356422349),

Petitioner

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-1329

Decision No. CR3160

Date: March 18, 2014

DECISION

The effective date of Medicare enrollment of Petitioner, Mushtaq A. Sheikh, M.D., was February 12, 2013, with a 30-day retrospective billing period from January 13, 2013 to February 12, 2013.

I. Background

National Government Services (NGS), a Medicare contractor, notified Petitioner by letter dated May 21, 2013, that his Medicare enrollment application had been approved with an effective date of January 13, 2013.[1] Centers for Medicare & Medicaid Services (CMS) Exhibit (Ex.) 12.

[1] NGS erroneously refers to Petitioner's "effective date" as January 13, 2013, in both the initial and the reconsideration determinations. CMS Exs. 1, 12. January 13, 2013, is actually the retrospective billing date as explained hereafter. CMS Motion for Summary Judgment (CMS Br.) at 1.

On July 16, 2013, Petitioner requested reconsideration of the initial determination and requested that his "effective date" be changed to January 2, 2013, the date he first began treating Medicare beneficiaries at a nursing home. CMS Ex. 13 at 2. NGS notified Petitioner by letter dated July 27, 2013, that his request for an earlier effective date was denied on reconsideration. CMS Ex. 1. On September 13, 2013, Petitioner filed a request for hearing (RFH) before an administrative law judge (ALJ). This case was assigned to me for hearing and decision, and I issued an Acknowledgment and Prehearing Order (Prehearing Order) on September 27, 2013.

On October 28, 2013, CMS filed a motion for summary judgment with CMS Exs. 1 through 16. Petitioner failed to file his prehearing exchange as directed by my Prehearing Order. On December 13, 2013, I issued an order for Petitioner to show cause why his case should not be dismissed for abandonment. Petitioner responded by email on December 26, 2013, stating that he wanted his case heard and decided. On December 31, 2013, I issued an order extending the time for Petitioner to respond to the order to show cause and the CMS motion for summary judgment, advising him that email was not an acceptable way to respond. On January 14, 2014, Petitioner again responded by email. Because Petitioner's email was not responsive to my December 31 Order, the attorney advisor assisting me with this case contacted Petitioner. Petitioner informed my attorney advisor that he would not be filing further documents and that he wished for the case to be decided on the documents he previously submitted. I conclude that Petitioner has not abandoned his request for hearing and his waiver of further submissions is accepted. Petitioner has not objected to CMS Exs. 1 through 16, which are admitted as evidence. Petitioner's request for hearing filed on September 13, 2013 and admitted as CMS Ex. 15, is treated as Petitioner's written argument. The NGS letter dated July 27, 2013 filed by Petitioner with the request for hearing is in evidence as CMS Ex. 1. The customer copy of the "Express Mail" receipt addressed to Medicare Division at P.O. Box 5302 in ZIP Code™ 13902, with a shipping date of January 30, 2013 that was filed with the request for hearing, is admitted as P. Ex. 1 and is considered so marked.

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]

[2] 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
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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 NGS. 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.[3] "Physician's 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.

The effective date of a physician's enrollment in Medicare is governed by 42 C.F.R. § 424.520(d). The effective date of enrollment for a physician 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). The date of filing is not the date on which

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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.

[3] References are to the 2012 revision of the Code of Federal Regulations (C.F.R.), unless otherwise indicated.

an enrollment application is mailed or otherwise transmitted. An enrolled physician may bill Medicare for services provided Medicare-eligible beneficiaries up to 30 days prior to the effective date of enrollment, if circumstances precluded enrollment before the services were provided. Retroactive 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.

B. Issues

The issues in this case are:

Whether summary judgment is appropriate;

Whether CMS properly determined the effective date of Petitioner's Medicare enrollment and billing privileges.

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

My conclusions of law are set forth in bold text 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. 42 C.F.R. § 424.545(a)(1). 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., Ill. 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 September 27, 2013. 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 Fed. R. Civ. Pro. 56 will be applied.

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). *See also 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 and 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. Part 498. *Batavia Nursing and 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 was February 12, 2013, the date on which NGS received a signed Medicare enrollment application from Petitioner that could be 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 Petitioner's effective date of enrollment, i.e. beginning on January 13, 2013.

The facts are not disputed and all inferences are drawn in favor of Petitioner. Petitioner is a physician practicing internal medicine and geriatric medicine. CMS Ex. 5 at 11. Petitioner submitted a Medicare enrollment application to the Medicare contractor, NGS. CMS Ex. 5. NGS received Petitioner's application on February 12, 2013. CMS Ex. 5 at 1-2; CMS Ex. 16 at 2. Petitioner does not dispute that NGS received his enrollment application on February 12, 2013. RFH; CMS Ex. 15 at 1. Although Petitioner has offered the "Express Mail" receipt dated January 30, 2013, which I treat as P. Ex. 1, that customer copy does not show receipt by NGS prior to February 12, 2013. On April 18, 2013, NGS requested additional information from Petitioner in order to complete the processing of his application. CMS Ex. 6; CMS Ex. 16 at 2. Petitioner sent NGS the requested information on April 25, 29, and 30, 2013, and May 1 and 16, 2013. CMS Exs. 7-11; CMS Ex. 16 at 2. NGS notified Petitioner by letter dated May 21, 2013, that Petitioner's enrollment application was approved with an effective date of January 13, 2013. CMS Ex. 12. The NGS letter was clearly in error to the extent it suggested that the effective date of Petitioner's enrollment in Medicare and billing privileges was January 13, 2013. The effective date of enrollment is the later of the date the Medicare contractor received a signed enrollment application it could process to approval or the date the enrolled physician began providing services at the new location. 42 C.F.R. §§ 424.510(d)(1), 424.520(d); 73 Fed. Reg. 69,725, 69,769 (Nov. 19, 2008). In this case, there is no dispute that the signed enrollment application that was ultimately processed to completion was received by NGS on February 12, 2013. Therefore, January 13, 2013, is actually the beginning of the period for which retrospective billing is permitted, not the effective date of enrollment. 42 C.F.R. § 424.521(a)(1).

Petitioner contends that he should be permitted to bill for services he began providing on January 2, 2013, to Medicare beneficiaries in a nursing home. He argues in his request for hearing that he sent his Medicare enrollment application by Express Mail to an address for a Medicare office in Binghamton, New York that previously served his area. Petitioner asserts that a postal clerk gave him the wrong address for the Medicare office. Petitioner states that the application was returned to him on February 8, 2013, and he sent it by certified mail the next morning to NGS in Indianapolis, Indiana. Petitioner does not dispute that NGS actually received his enrollment application on February 12, 2013. Petitioner contends that the "delay was due to extenuating circumstances beyond [his] control due to wrong address, provided by the postal clerk." RFH; CMS Ex. 15 at 1.

There are no material issues of fact in dispute. I accept as true that Petitioner first sent his application to an incorrect Medicare office based on an erroneous address given him by a postal clerk. But that fact has no impact on the decision in this case. Petitioner's enrollment application was not received by NGS until February 12, 2013, which was after Petitioner began providing services at his new practice location. The enrollment

application received by NGS on February 12, 2013, was the application that NGS was able to process to completion. Pursuant to 42 C.F.R. § 424.520(d), the receipt of the application was after the date Petitioner began delivering services at his new location, and the earliest possible effective date for Petitioner's enrollment and billing privileges was February 12, 2013, the date of receipt of the application. Retrospective billing is only permitted for 30 days prior to the effective date of enrollment and billing privileges, in the absence of a Presidentially-declared disaster. 42 C.F.R. § 424.521. Therefore, Petitioner can bill for qualified services to Medicare-eligible beneficiaries delivered on and after January 13, 2013.

I have no authority to grant Petitioner 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 source of authority for me to grant him an exemption from regulatory compliance. 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.").

Petitioner's assertion that he received erroneous information from a postal clerk, ostensibly a federal employee, may be construed to be an estoppel argument. However, it is well-established that: (1) estoppel cannot be the basis to require payment of funds from the federal fisc; (2) estoppel cannot lie against the government, if at all, absent a showing of affirmative misconduct, such as fraud; and (3) I am not authorized to order payment contrary to law based on equitable grounds. It is well-settled that those who deal with the government are expected to know the law and may not rely on the conduct of government agents contrary to law. *See, e.g., Office of Personnel Mgmt. v. Richmond*, 496 U.S. 414 (1990); *Heckler v. Cmty. Health Servs. of Crawford County, Inc.*, 467 U.S. 51 (1984); *Oklahoma Heart Hosp.*, DAB No. 2183 at 16 (2008); *Wade Pediatrics*, DAB No. 2153 at 22 n.9 (2008), *aff'd*, 567 F.3d 1202 (10th Cir. 2009); *US Ultrasound*, DAB No. 2302 at 8 (2010). Here, Petitioner has not alleged affirmative misconduct on behalf of CMS's representatives, and any argument that amounts to a claim of equitable estoppel must be rejected.

III. Conclusion

For the foregoing reasons, I conclude that the effective date of Petitioner's Medicare enrollment and billing privileges was February 12, 2013, with a period for retrospective billing beginning on January 13, 2013.

/s/
Keith W. Sickendick
Administrative Law Judge