Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Alpha Mobile Imaging, LLC,

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-10-110

Decision No. CR2096

Date: March 23, 2010

DECISION

This matter is before me on the Centers for Medicare & Medicaid Services' (CMS) Motion for Summary Judgment. Petitioner, Alpha Mobile Imaging, LLC, opposes the motion. I find that no material facts are in dispute and conclude that CMS's position is correct as a matter of law. I therefore grant CMS's Motion and affirm CMS's determination to approve Petitioner's Medicare participation effective May 26, 2009.

I. Background

Petitioner is a supplier of portable x-ray services in the greater Baton Rouge, Louisiana area. On May 26, 2009, the Louisiana Department of Health and Hospitals (state agency) conducted a survey of Petitioner to determine whether it was in compliance with Medicare participation requirements for suppliers of x-ray services. CMS Ex. 1. The state agency found that Petitioner met all requirements for Medicare participation on the date of the survey, specifically finding that Petitioner was in compliance with 42 C.F.R. Part 486, Subparts A-C, the conditions for coverage for suppliers of portable x-ray services. *Id.* By letter dated June 8, 2009, CMS notified Petitioner that the effective date of its Medicare participation was May 26, 2009, the date the state agency surveyed

Petitioner, as that was the earliest date that it determined that Petitioner met all participation requirements.

By letter dated November 2, 2009, Petitioner requested a hearing. Petitioner asserted that the effective date of its participation should be moved to July 10, 2008 (the date Petitioner started to provide portable x-ray services to Medicare beneficiaries) due to the state agency's failure to timely notify Petitioner of a moratorium on surveys and other circumstances beyond Petitioner's control (but in CMS's or the state agency's control) that unreasonably delayed the survey.

The case was assigned to me for hearing and decision on November 13, 2009. CMS filed a motion for summary judgment (CMS Br.) on December 14, 2009, accompanied by CMS exhibits (CMS Exs.) 1-3. Petitioner responded on January 26, 2010 (P. Br.), accompanied by Petitioner's exhibits (P. Exs.) 1-7. In the absence of objection, I admit into evidence CMS Exs. 1-3 and P. Exs. 1-7.

II. Issues

The issues in this case are:

1. Whether summary judgment is appropriate; and
2. Whether CMS's determination to approve Petitioner as a Medicare supplier effective May 26, 2009, is correct as a matter of law.

III. Controlling Statutes and Regulations

Regulations at 42 C.F.R. Part 424, subpart P, govern the process for the enrollment of providers and suppliers in the Medicare program. Completion of the enrollment process is a prerequisite for a provider or supplier to bill and to receive payment for Medicare covered services, to be granted Medicare privileges and to establish eligibility to submit claims. 42 C.F.R. §§ 424.500; 424.505; and 424.502. To be enrolled, a provider or supplier must meet the enrollment requirements specified in section 424.510(d), which incorporates by reference additional compliance and reporting requirements in section 424.520. CMS is responsible for validating the accuracy of the information submitted as part of the enrollment process, but uses Medicare contractors to verify information and to recommend approval or denial to CMS.

With respect to the effective date of Medicare reimbursement, the enrollment regulations incorporate by reference the regulation at 42 C.F.R. § 489.13, as well as other regulatory provisions. 42 C.F.R. § 424.510(b). The preamble to the 2006 final rule explained that, while CMS would not grant billing privileges until completion of the enrollment process and approval of the enrollment application, the effective date for reimbursement of

Medicare covered services would continue to be determined based on current Medicare regulations and policy based on the type of provider or supplier submitting the claims. 71 Fed. Reg. 20,754, 20,758 (April 21, 2006).

Part 489 of Title 42 applies generally to "providers" which must enter into provider agreements to participate in Medicare. However, section 489.13 also applies to "supplier" approval of entities such as portable x-ray services companies that, as a basis for participation in Medicare, are subject to survey and certification by CMS or a state agency. 42 C.F.R. § 489.13(a).

As a portable x-ray services company, Petitioner is designated a supplier under the Act and regulations and has to meet all of the requirements of participation relevant to that category of supplier. 42 C.F.R. Part 486, Subparts A-C. With regard to the effective date of approval for Petitioner as a supplier, the regulations state that:

> *(b) All Federal requirements are met on the date of the survey.* The agreement or approval is effective on the date the survey . . . is completed, if on that date the provider or supplier meets all applicable Federal requirements as set forth in this chapter.

42 C.F.R. § 489.13(b).

IV. Summary Judgment

In *Senior Rehabilitation and Skilled Nursing Center*, DAB No. 2300 (2010), the Departmental Appeals Board (Board) stated the standards 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. *Kingsville Nursing and Rehabilitation Center*, DAB No. 2234, at 3 (2009), citing *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986). While the Federal Rules of Civil Procedure (FRCP) are not binding in this administrative appeal, we are guided by those rules and by judicial decisions on summary judgment in determining whether the ALJ properly granted summary judgment. *See Thelma Walley*, DAB No. 1367 (1992) . . . . 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. *Kingsville* at 3, citing *Celotex*, 477 U.S. at 323. If the moving party carries its initial burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial.'" *Matsushita Elec. Industrial Co. v. Zenith Radio*, 475 U.S. 574, 587 (1986) (quoting FRCP 56(e)). 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. *Id.* at 586, n. 11; *Celotex*, 477 U.S. at 322. 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. *U.S. v. Diebold, Inc.*, 369 U.S. 654, 655 (1962). . . . Whether summary judgment is appropriate is a legal issue that we address de novo. *Lebanon Nursing and Rehabilitation Center*, DAB No. 1918 (2004). In reviewing whether there is a genuine dispute of material fact, we view the proferred evidence in the light most favorable to the non-moving party. *Kingsville* at 4, and cases cited therein.

Senior Rehabilitation, DAB No. 2300, at 3. The Board has also noted that 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 be assessing credibility or evaluating the weight of conflicting evidence. *Holy Cross Village at Notre Dame*, DAB No. 2291, at 4-5 (2009).

V. Findings of Fact and Conclusions of Law

1. The case can be decided based on CMS's motion for summary judgment.

2. The effective date of Petitioner's Medicare participation is May 26, 2009.

For purposes of summary judgment, I accept the material facts of the case set forth by Petitioner. Petitioner asserts that from September 18, 2008 until May 26, 2009, when the survey was performed, Petitioner was prepared for the survey, eligible for participation in Medicare, and in compliance with all federal law. I accept Petitioner's assertion that employees of the state agency and of Pinnacle Business Solutions, Inc., the Medicare carrier (carrier), either informed Petitioner that a survey would be forthcoming shortly after Petitioner submitted its Medicare enrollment application, or did not inform Petitioner that there was a moratorium on surveys or some other directive that would delay Petitioner's Medicare survey and enrollment. I accept that Petitioner was reassured by CMS or the carrier that it would be able to bill for services possibly as early as July 10, 2008, not later than August 15, 2008, and certainly not later than September 18, 2008. I accept that Petitioner expended money to lease its truck and equipment, obtain insurance, and contract for staffing and billing services. I accept Petitioner's assertion that it has sustained approximately $100,000 in lost reimbursements as a result of having the survey performed on May 26, 2009, instead of on an earlier date, and that Petitioner worked assiduously to have the survey performed, and that Petitioner acted in good faith during the entire enrollment process. P. Br. at 1-4; P. Ex. 1. Because I accept the material facts asserted by Petitioner as the material facts of this case, and because I have considered the facts in the light most favorable to Petitioner and have drawn all reasonable inferences in favor of Petitioner, I find there is no need for the in-person

hearing requested by Petitioner to demonstrate its assertion that it provided mobile x-ray services in good faith and should be reimbursed for them, or to demonstrate the extraordinary financial hardship that CMS and the state agency caused by failing to act reasonably and timely consistent with their obligations. P. Br. at 7, 9.

With regard to the legal issues involved, Petitioner argues that the only consistent enrollment requirement under 42 C.F.R. § 489.13 is that an applicant meet all federal requirements before billing privileges are extended. Petitioner contends that the extension of billing privileges is not dependent upon the survey, but upon the date that the applicant meets all federal requirements. While Petitioner acknowledges that approval may be effective on the date of the survey if all federal requirements are met on that date, it asserts the approval only relates to when billing privileges are extended and not to when services may be provided by the applicant that may be reimbursed by Medicare. P. Br. at 5-6. Petitioner references the Board's decision in *Renal CarePartners of Delray Beach, LLC*, DAB No 2271 (2009) for the proposition that it should be permitted to bill and be reimbursed for services prior to the effective date of its approval as long as it can demonstrate that all the services were provided in accordance with the applicable federal regulations. P. Br. at 7-8. Petitioner misconstrues the Board's decision. In its decision, while the Board found that the enrollment regulations do not treat CMS or contractor approval as an enrollment requirement that every provider or supplier must meet to provide reimbursable items or services, it specifically noted that enrollment regulations specify that the "effective date of reimbursement" is to be determined by regulations that apply according to the type of provider or supplier applying to enroll. *Renal CarePartners of Delray Beach, LLC,* DAB No. 2271, at 6. Here the language of the regulation at 42 C.F.R. § 489.13(b) is clear and plain and specifically requires that for a portable x-ray services provider the survey is the condition precedent to an effective date, and the earliest date that a supplier such as Petitioner can be approved (assuming that on the date of the survey it met all applicable federal requirements).

Petitioner also asserts that CMS and the state agency have an obligation to act timely in working through the application process. Failing to recognize their obligation to timely conduct a survey after an application is submitted creates an "unconscionable situation in which the applicant is required to incur prohibitive and substantial costs . . . to be prepared for the survey that will be scheduled on some date that no one can determine. The regulations cannot be so rigidly applied that they remove fairness and reasonableness from the application process, especially when CMS and the state survey agency do not timely inform an applicant that the state survey agency is prohibited or restricted from performing any surveys for new suppliers who seek to participate in Medicare." P. Br. at 6-7. Petitioner asserts CMS's directive permitted the state agency to continue licensing even if it could not perform the surveys timely. P. Br. at 7.

Petitioner's arguments regarding what it terms unreasonable delay in scheduling the survey, and its arguments regarding its reliance on the state agency or carrier representations that led it to believe it would be reimbursed for services prior to the survey date, are equitable arguments. However worthy those arguments may be, I have no authority under equitable principles to establish an effective date earlier than that contemplated by 42 C.F.R. § 489.13(b). *Oklahoma Heart Hospital,* DAB No. 2183 (2008)*; Forest Glen Skilled Nursing Center,* DAB No. 1887 (2003).

IV. Conclusion

For the reasons set forth above, I grant CMS's motion for summary judgment and affirm CMS's determination to approve Petitioner's Medicare participation effective May 26, 2009, the date the state agency survey found Petitioner to be in compliance with all applicable federal requirements.

/s/
Richard J. Smith
Administrative Law Judge