Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Brett Sachse, M.D.
(NPI No. 1518975317),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-12-46

Decision No. CR2524

Date: April 6, 2012

DECISION

The effective date of Medicare enrollment of Petitioner, Brett Sachse, M.D., is January 3, 2011.

I. Background

The Centers for Medicare and Medicaid Services (CMS) notified Petitioner's practice group[1] by letter dated April 11, 2011, that the Medicare enrollment application of Petitioner reassigning benefits to the group had been approved effective December 4, 2010.[2] CMS Exhibit (CMS Ex.) 1 at 1-3.

[1] Daniel G. Turgeon, M.D., F.A.C.S., P.L.L.C., Reston Surgical Associates.

[2] The letter was in error as explained by the contractor letter dated November 14, 2011. CMS Ex. 2. The contractor determination was that the effective date of Petitioner's enrollment was January 3, 2011, the date his enrollment application was received by the contractor. However, as explained by the November 14 letter, Petitioner was authorized to file claims for services retroactive to December 4, 2010. CMS Ex. 2.

On May 30, 2011, Petitioner requested reconsideration of the initial decision and requested that his effective enrollment date be changed to August 1, 2010, the date he first began treating Medicare patients. CMS Ex. 1 at 11. On August 28, 2011, a contractor hearing officer issued a reconsideration decision denying Petitioner's request for an earlier effective date of enrollment.[3] CMS Ex. 1 at 4-9.

On October 17, 2011, Petitioner requested a hearing before an Administrative Law Judge (ALJ). This case was assigned to me for hearing and decision. I issued an Acknowledgment and Prehearing Order on October 24, 2011. On November 18, 2011, CMS filed a Motion for Summary Judgment (CMS Br.) with CMS Exs. 1 through 3. On December 8, 2011, Petitioner filed a letter in response to CMS's Motion for Summary Judgment (P. Response) with one exhibit (P. Ex. A). On January 25, 2012, CMS notified me that a reply brief was waived. The parties have filed no objections to CMS Exs. 1 through 3 and P. Ex. A, and they are admitted.

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.[4] 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. Act § 1842(a) (42 U.S.C. § 1395u(a)).

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[3] In the decision paragraph, the contract hearing officer erroneously refers to a different provider and group name. CMS Ex. 1 at 9. Although there is no apparent prejudice due to the error, my de novo review remedies any possible prejudice.

[4] 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.

Qualified physician services are covered by Medicare Part B, subject to some limitations, 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. "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 regulations at 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. *Id.* The date of filing of the enrollment application is the date when the complete enrollment application and supporting documentation is received by the designated Medicare contractor. 42 C.F.R. § 424.510(d)(1); 73 Fed. Reg. 69,725, 69,769 (Nov. 19, 2008). 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. Part 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. Part 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 October 24, 2011. 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 parties' 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. Part 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, as discussed hereafter, 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. Petitioner's effective date of Medicare enrollment was January 3, 2011, the date on which he submitted a complete enrollment application that could be processed to approval pursuant to 42 C.F.R. § 424.520(d).

3. Petitioner was authorized to bill Medicare for services provided to Medicare eligible beneficiaries up to 30 days prior to his effective date of enrollment.

The facts are not disputed and all inferences are drawn in favor of Petitioner. Petitioner is a general surgeon and is employed by Reston Surgical Associates, Daniel G. Turgeon, M.D., F.A.C.S., P.L.L.C. Hearing Request (HR). Petitioner began seeing patients on August 1, 2010. CMS Ex. 1 at 14. Petitioner subsequently submitted a Medicare enrollment application to the Medicare contractor, Highmark Medicare Services ("Highmark"). CMS Ex. 1 at 14-58. Petitioner does not dispute that Highmark received Petitioner's Medicare enrollment application on January 3, 2011. On April 11, 2011, Highmark approved Petitioner's enrollment application with an effective date of January 3, 2011 with retroactive billing privileges commencing on December 4, 2010. CMS Ex. 1 at 1-3; CMS Ex. 2.

Petitioner contends that his effective date of enrollment should be August 1, 2010, the date he began rendering services to Medicare beneficiaries. Petitioner does not deny that CMS received his completed enrollment application on January 3, 2011. However, Petitioner argues that his effective date should be earlier because CMS and its contractors made errors in the processing of Petitioner's enrollment application, and he was unable to submit his application electronically. HR; P. Response. Petitioner also argues that it is a hardship for Petitioner to forgo payment for services he provided to Medicare beneficiaries prior to the date his Medicare enrollment became effective; the enrollment process was confusing and not "user-friendly;" and that CMS should be held accountable for delays caused by flaws in the automated enrollment process. HR; P. Response.

The effective date of Medicare enrollment and billing privileges for physicians is dictated by 42 C.F.R. § 424.520(d). The regulation provides:

> (d) *Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations.* The effective date for billing privileges for physician, nonphysician practitioners, and physician and nonphysician practitioner organizations is the <u>later of the date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor</u> or the date an enrolled physician or nonphysician practitioner first began furnishing services at a new practice location.

(Emphasis added).

The regulation is clear. A physician's effective date for Medicare billing privileges is determined according to the latter of the two dates specified by the regulation. The "date of filing" is the date that the Medicare contractor receives a signed enrollment application that the Medicare 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 Medicare contractor, CMS, and I are bound to follow the Secretary's regulations. Because it is undisputed that Petitioner's enrollment application was received by the contractor on January 3, 2011, which is after the date Petitioner began providing services, the regulation dictates that January 3, 2011 is the effective date of Petitioner's enrollment. I have no discretion to determine an earlier effective date. Further, because there is no dispute that there was no emergency declared by the President between August 1, 2010 and January 3, 2011, 42 C.F.R. § 424.521(a) limits to 30 days the period for which Petitioner may retroactively bill for services provided to Medicare eligible beneficiaries.

Petitioner's arguments regarding flaws in the electronic enrollment system and confusion in the enrollment process are equitable in nature and do not show as a matter of fact that Petitioner filed an application on an earlier date than CMS determined or that the contractor or CMS incorrectly applied the regulatory criteria. Even accepting Petitioner's assertions as true, Petitioner's equitable arguments give me no ground to grant Petitioner an earlier effective date of enrollment. *See 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.”). Thus, I have no authority to change Petitioner’s Medicare enrollment date based upon equitable considerations.

Petitioner’s arguments regarding errors by CMS employees and contractors may also be construed to be an estoppel argument. Estoppel against the federal government, if available at all, is presumably unavailable absent “affirmative misconduct,” such as fraud. *See, e.g.*, *Pacific Islander Council of Leaders*, DAB No. 2091, at 12 (2007); *Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414, 421 (1990). None of the circumstances Petitioner describes fit that standard or permit me to ignore the requirements of the regulations governing Petitioner’s enrollment in Medicare.

Accordingly, I conclude that Petitioner’s effective date of Medicare enrollment was January 3, 2011, the date on which he submitted a complete enrollment application that could be processed to approval pursuant to 42 C.F.R. § 424.520(d). 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, i.e. December 4, 2010.

III. Conclusion

For the foregoing reasons, I conclude that Petitioner’s effective date of Medicare enrollment was January 3, 2011, and that Petitioner could bill for service provided to Medicare eligible beneficiaries for up to 30 days prior to his effective date.

/s/
Keith W. Sickendick
Administrative Law Judge