Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Modesto Radiology Imaging, Inc.,
(PTAN: GV704A),
(NPI: 1588954929),

Petitioner,

v.

Centers for Medicare & Medicaid Services

Docket No. C-14-1279

Decision No. CR3483

Date: November 25, 2014

DECISION

Petitioner, Modesto Radiology Imaging, Inc. is an independent diagnostic testing facility (IDTF) located in Modesto, California that has been enrolled in the Medicare program since April 1, 2012. It applied to add certain diagnostic services to its enrollment. The Medicare contractor approved the application, with an effective billing date of April 20, 2013. Petitioner challenges that effective date.

For the reasons discussed below, I affirm the April 20, 2013 billing date.

Background

Petitioner is enrolled in the Medicare program as an IDTF and, since April 1, 2012, has been authorized to bill for certain approved services, including CT abdominal scans and CT pelvic scans. P. Ex. 3. On July 19, 2013, it applied to add a purportedly additional testing service – combined abdominal-pelvic scans – to its enrollment (although the parties dispute whether this was a new service).[1] In a letter dated July 30, 2013, the then

[1] Neither party submitted a copy of the July 19 application, but they seem to agree that an acceptable application was filed on that date. *See* CMS Br. at 2.

Medicare contractor, Palmetto GBA, approved the additional service with the effective billing date of April 20, 2013. CMS Ex. 1. Petitioner requested reconsideration.

In a reconsidered determination, dated April 9, 2014, a representative from the new Medicare contractor, Noridian Healthcare Solutions, affirmed the April 20 date. Petitioner timely filed this appeal.

The parties have submitted briefs (CMS Br.; P. Br.) and CMS moves for summary judgment. However, because neither party has any witnesses to present, an in-person hearing would serve no purpose.[2] *See* Acknowledgment and Pre-hearing Order at 5 (¶ 8) and 6 (¶ 10). CMS submits two exhibits (CMS Exs. 1 and 2). In the absence of any objection, I admit into evidence CMS Exs. 1 and 2.

Petitioner's Exhibits. Petitioner submits five exhibits (P. Exs. 1-5). Citing 42 C.F.R. § 498.56(e), CMS objects to my admitting two of those documents: P. Ex. 1, an affidavit signed by the IDTF's coding specialist; and P. Ex. 2, a list of claims for services that were not covered because they were provided prior to the April 20, 2013 effective date. Section 498.56(e)(1) directs the administrative law judge (ALJ) to examine any new *documentary* evidence to determine whether the supplier has good cause for submitting the evidence for the first time at the ALJ level. If the ALJ finds no good cause, she must exclude the evidence from the proceeding and may not consider it in reaching a decision. 42 C.F.R. § 498.56(e)(2)(ii).

Because P. Ex. 1 is testimony and not documentary evidence, the regulation does not apply. *Arkady B. Stern, M.D.*, DAB No. 2329 at 4 n.4 (2010) (Observing that "[t]estimonial evidence that is submitted in written form in lieu of live in-person testimony is not 'documentary evidence' within the meaning of 42 C.F.R. § 498.56(e).").

With respect to P. Ex. 2, Petitioner concedes that it did not submit the document at reconsideration but argues that good cause justifies my admitting it here. Petitioner points out that neither Medicare contractor provided any notice that Petitioner could or should submit any documents at the reconsideration level. In the July 30 notice letter, Palmetto provided a number to call "[i]f you disagree with this initial determination." The letter says nothing about submitting documentary evidence. CMS Ex. 1. Worse, Noridian sent Petitioner a letter dated December 20, 2013, that effectively instructed Petitioner *not* to submit any documents: "You will receive a letter within 30 calendar days, if we need any additional information." P. Ex. 5. Because the contractors offered Petitioner neither notice nor opportunity to submit evidence, I find good cause to allow its admission at this level.

[2] Petitioner submits a single affidavit, but CMS has not asked to cross-examine the affiant.

However, CMS also objects to my admitting P. Exs. 1 and 2 because they are not relevant or material. I agree. Petitioner offers these documents to establish that Medicare should reimburse for services it provided prior to April 20, 2013, arguing that those services are, in fact, the same services for which it was already enrolled. As discussed below, I have no authority to address this issue. Because the documents are neither relevant nor material to any issue over which I have jurisdiction, I decline to admit them. 42 C.F.R. § 498.60(b). I admit P. Exs. 3-5.

Discussion

To enroll in the Medicare program, a prospective provider or supplier must submit an enrollment application. Among other requirements, a prospective IDTF must certify that it meets the standards and related requirements listed in 42 C.F.R. § 410.33(g). Among those requirements, the prospective IDTF must enroll for "any diagnostic testing services that it furnishes to a Medicare beneficiary." 42 C.F.R. § 410.33(g)(16). With some exceptions not applicable here, it must report any changes to its enrollment application within 90 days. 42 C.F.R. § 410.33(g)(2).

After enrolling in April 2012, Petitioner billed the Medicare program for combined abdominal-pelvic scans. The contractor apparently denied those claims, finding that the facility was not enrolled to perform that service. Although the facility was enrolled to provide abdominal scans and pelvic scans separately, the combined abdominal-pelvic scan is considered a "bundled" service and is billed under a separate CPT code.[3] In response, on July 19, 2013, Petitioner applied to add the additional service to its enrollment, and the contractor approved its application and advised the facility that it could submit claims under the new code starting July 30, 2013. Citing 42 C.F.R. § 410.33(g)(2), the contractor set the "date of approval" as April 20, 2013. CMS Ex. 1.

In its appeal, Petitioner "seeks an earlier effective date" so that it may bill for the combined abdominal-pelvic scans it provided prior to April 20, 2013. To the extent that the issue before me is the effective date, I have jurisdiction and the matter is easily resolved. 42 C.F.R. § 498.3(b)(15). The effective date of an IDTF's billing privileges is the *later* of: 1) the date it filed its subsequently-approved application; or 2) the date it first started furnishing services. 42 C.F.R. § 410.33(i). Thus, the effective date can be no earlier than July 19, 2013.

By regulation, some suppliers (physicians, nonphysician practitioners, and their organizations) may retrospectively bill for services provided prior to their effective date of enrollment. 42 C.F.R. § 424.521. The regulations do not include a comparable

[3] CPT (current procedural terminology) codes are used to describe medical procedures and physician services.

provision for IDTFs. Nevertheless, citing 42 C.F.R. § 410.33(g)(2), the contractor designated the "date of approval" as April 20, 2013, and the reconsidered determination agrees. CMS Ex. 1. No one has explained how a reporting requirement, like section 410.33(g)(2), can be used to authorize retrospective billing, but the parties do not dispute that aspect of the reconsidered determination, so I will not disturb it. The effective date of enrollment is July 19, 2013, and the retrospective billing date can be no earlier than April 20, 2013.

I question whether this case is truly an effective-date challenge, however. Beyond articulating that as the issue, no one has treated this as an effective-date case. Neither the reconsidered determination nor either party even mentions 42 C.F.R. § 410.33(i). I don't know how anyone can review the effective date without referring to the regulation that governs effective dates.

At bottom, Petitioner thinks that it should be reimbursed for the combined scans based on its initial enrollment and makes some compelling arguments in support of its position.[4] But I am not authorized to hear such matters. If a supplier is unhappy with the Medicare contractor's denial of a claim, it may appeal to the Office of Medicare Hearings and Appeals (OMHA) and then the Medicare Appeals Council. 42 C.F.R. § 405.1000-1140; *see* 42 C.F.R. § 498.3(b) (listing "initial determinations" that are reviewable in this forum).

Conclusion

I affirm the July 19, 2013 effective date (with billing retrospective to April 20, 2013). I have no jurisdiction to review the denials of claims.

/s/
Carolyn Cozad Hughes
Administrative Law Judge

[4] CMS points out that it requires enrollment for each testing service in order to insure that compensation for the service is authorized and that the IDTF has the appropriate equipment, has trained its technicians properly, and provides appropriate supervision. CMS Br. at 6. It seems that these criteria were met when CMS enrolled the facility to perform the individual scans. On the other hand, CMS may have legitimate reasons for tying enrollment to the CPT codes. But these are issues for a different forum.