Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Elizabeth Mynard, CP,
(PTANs: TXB116505; TXB142063; TXB147047;
TXB148070; TXB149841)
(NPI: 170484379)

Petitioner,

v.

Centers for Medicare & Medicaid Services

Docket No. C-15-3858

Decision No. CR4937

Date: September 13, 2017

DECISION

Petitioner, Elizabeth Mynard, CP, is a clinical psychologist, practicing in Texas, who, until recently, participated in the Medicare program. The Centers for Medicare & Medicaid Services (CMS) revoked her billing privileges, claiming that she was not in compliance with Medicare enrollment requirements because she did not properly supervise a licensed professional counselor who billed the program under her PTAN (provider transaction access number).

Petitioner appeals. The parties have filed cross-motions for summary judgment. Because CMS presents no material facts and submits no evidence in support of its position, I deny its motion for summary judgment. Because the undisputed evidence establishes that Petitioner directly supervised the services provided by a licensed professional counselor, I grant Petitioner's motion for summary judgment.

Background

By letter dated January 12, 2015, the Medicare contractor, Novitas Solutions, advised Dr. Mynard that her Medicare billing privileges were revoked, effective February 11, 2015. The contractor took this action pursuant to 42 C.F.R. § 424.535(a)(1) because, it charged, Dr. Mynard allowed a licensed professional counselor to bill the Medicare program under Petitioner's PTAN for services provided "incident to" Petitioner Mynard's services, but she did not directly supervise the counselor as required. CMS Exhibit (Ex.) 1.

Petitioner requested reconsideration and submitted a corrective action plan. CMS Exs. 2 and 5. By letter dated March 17, 2015, the contractor denied the corrective action plan, an action that is not reviewable. 42 C.F.R. § 405.809; CMS Ex. 6. In a reconsidered determination, dated June 15, 2015, the contractor upheld the revocation. CMS Ex. 3.

Petitioner appealed, and her appeal is now before me. CMS has filed a motion to dismiss, a motion for summary judgment (CMS MSJ), and six exhibits (CMS Exs. 1-6). Petitioner responded to CMS's motion to dismiss and to CMS's motion for summary judgment (P. Response) and filed her own cross-motion for summary judgment (P. MSJ), along with 13 exhibits (P. Exs. 1-13).

In the absence of any objection, I admit into evidence CMS Exs. 1-6 and P. Exs. 1-13.

Discussion

1. Petitioner's hearing request was filed timely.[1]

CMS moves to dismiss, arguing that Petitioner's hearing request was untimely.

Section 1866(h)(1) of the Social Security Act (Act) grants hearing rights to providers and suppliers of Medicare services "to the same extent as is provided in section 205(b)" of the Act. Section 205(b) dictates that a petitioner's hearing request "must be filed within sixty days" after he receives notice of an adverse decision. Act §205(b)(1); *accord* 42 C.F.R. § 498.40(a)(2).

The contractor's reconsidered determination is dated June 15, 2015, and Petitioner filed her hearing request seventy days later, on August 24, 2015. CMS Exs. 3, 4. The date a party receives its notice is presumed to be five days after the notice date "unless there is a showing that it was, in fact, received earlier or later." 42 C.F.R. §§ 498.22(b)(3); 498.40(a)(2). CMS argues that, because Petitioner presumably received the notice on June 20, her hearing request should have been filed no later than August 19. According

[1] My findings of fact/conclusions of law are set forth, in bold and italics, as captions in the discussion section of this decision.

to CMS, the request was untimely and must therefore be dismissed. CMS submits no evidence – in the form of a written declaration, a mail receipt, or other documentary evidence – indicating when the notice was mailed.

Petitioner, however, claims that she received the notice on June 25, 2015. The contractor mailed the notice to Petitioner's attorney, as provided for in 42 C.F.R. §§ 498.10 and 498.11. Petitioner submits an affidavit from that attorney declaring that she received the notice in her post office box on June 25. P. Ex. A. She declares that she checked the post office box on June 24, and had not received the notice as of that date. She also submits a copy of email correspondence she sent Petitioner on June 24, which indicates "No Novitas letter today." P. Ex. A-1.

I find Petitioner's submissions sufficient to establish that she received the notice on June 25, 2015, and that her hearing request, filed 60 days later, is timely.

2. Petitioner is entitled to summary judgment because she has come forward with evidence showing that she properly supervised the "auxiliary personnel" who billed the Medicare program under her PTAN, and CMS did not submit admissible evidence suggesting a dispute over any material fact.

Summary Judgment. The Departmental Appeals Board has, on multiple occasions, discussed the well-settled principles governing summary judgment. *See*, *e.g.*, *1866ICPayday.com, L.L.C.*, DAB No. 2289 at 2-3 (2009). Summary judgment is appropriate if a case presents no genuine issue of material fact, and the moving party is entitled to judgment as a matter of law. *Id.* at 2; *Illinois Knights Templar Home*, DAB No. 2274 at 3-4 (2009), and cases cited therein.

The moving party may show the absence of a genuine factual dispute by presenting evidence so one-sided that it must prevail as a matter of law, or by showing that the non-moving party has presented no evidence "sufficient to establish the existence of an element essential to [that party's] case, and on which [that party] will bear the burden of proof at trial." *Livingston Care Ctr. v. Dep't of Health & Human Servs.*, 388 F.3d 168, 173 (6th Cir. 2004) (quoting *Celotex Corp. v. Catrett*, 477 U.S. 317, 323-24 (1986)). To avoid summary judgment, the non-moving party must then act affirmatively by tendering evidence of specific facts showing that a dispute exists. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 n.11 (1986); s*ee also Vandalia Park*, DAB No. 1939 (2004); *Lebanon Nursing and Rehab. Ctr.*, DAB No. 1918 (2004). The non-moving party may not simply rely on denials, but must furnish admissible evidence of a dispute concerning a material fact. *Ill. Knights Templar*, DAB No. 2274 at 4; *Livingston Care Ctr.*, DAB No. 1871 at 5 (2003).

In examining the evidence for purposes of determining the appropriateness of summary judgment, I must draw all reasonable inferences in the light most favorable to the non-moving party. *Brightview Care Ctr.*, DAB No. 2132 at 2, 9 (2007); *Livingston Care Ctr.*, 388 F.3d at 172; *Guardian Health Care Ctr.*, DAB No. 1943 at 8 (2004); *but see Brightview*, DAB No. 2132 at 10 (entry of summary judgment upheld where inferences and views of non-moving party are not reasonable). However, drawing factual inferences in the light most favorable to the non-moving party does not require that I accept the non-moving party's legal conclusions. *Cf. Guardian Health Care Ctr.*, DAB No. 1943 at 11 ("A dispute over the conclusion to be drawn from applying relevant legal criteria to undisputed facts does not preclude summary judgment if the record is sufficiently developed and there is only one reasonable conclusion that can be drawn from those facts.").

Program rules. CMS regulates the Medicare enrollment of providers and suppliers. Social Security Act (Act) § 1866(j)(1)(A). It may revoke a supplier's billing privileges if she is not in compliance with Medicare enrollment requirements. 42 C.F.R. § 424.535(a)(1).

Medicare Part B provides medical insurance (covering, for example, physician services, lab tests and x-rays, emergency ambulance services, and mental health services). Part B will cover services furnished by a qualified clinical psychologist. 42 C.F.R. § 410.71; *see* 42 C.F.R. § 410.26(a)(6). It will also pay for services provided by auxiliary personnel "incident to" the practitioner's services, but those services must be provided, under the "direct supervision" of the practitioner. 42 C.F.R. §§ 410.26(b)(1), (b)(5); *see* Medicare Benefit Policy Manual, CMS Pub. 100-02, Ch. 15 § 60B.[2]

"Direct supervision" means that the practitioner is present in the "office suite" and "immediately available to furnish assistance and direction." It does not mean that the practitioner must be in the room when the services are provided. 42 C.F.R. § 410.32(b)(3)(ii); *see* 42 C.F.R. § 410.26(a)(2); Medicare Benefit Policy Manual, CMS Pub. 100-02, Ch. 15 § 160; "Physician Supervision of Diagnostic Tests," CMS

[2] Medicare Part A provides hospital insurance. Where an ancillary service is covered by Part A, a practitioner may not bill for it under Part B. For this reason, section 410.26(b)(1) provides that the "incident to" services must be furnished to non-institutional patients in a non-institutional setting. *See* Act § 1862(a)(18). However, there are exceptions. Part B will pay for services and supplies "incident to" a clinical psychologist's services in a nursing home if certain conditions are met, and they seem to have been met here. 42 C.F.R. §§ 410.27(a) and (g); 411.15(p); *see* Medicare Benefit Policy Manual, CMS Pub. 100-02, Ch. 15 § 60.1A (providing that services "commonly furnished in physicians' offices are covered under the incident to provision"). In any event, CMS does not fault Petitioner because she billed Medicare for services provided in an institution so that issue is not before me.

Transmittal B-01-28, HCFA-Pub. 60B at 1 (*eff*. July 1, 2001); Medicare Benefit Policy Manual, CMS Transmittal 169 at 7 (*eff*. April 1, 2013); *see also* Medicare Learning Network, MLN Matters No. SE0441 at 2 (rev. Aug. 23, 2016), *available at* https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0441.pdf (explaining that a physician "do[es] not have to be physically present in the patient's treatment room while [incident to] services are provided, but [the physician] must provide **direct supervision**, that is, [the physician] must be present in the office suite to render assistance, if necessary.").

Undisputed facts. Petitioner Mynard is a licensed clinical psychologist. She works for an organization called Senior Psychological Care Dallas and provides psychotherapy and related services to nursing facility residents. P. MSJ at 1; P. Ex. 3 (Mynard Decl.); *see* CMS MSJ at 1. The parties agree that the Medicare contractor hired an organization called "Health Integrity" to investigate Petitioner Mynard's billing practices, and, based on that investigation, the contractor determined that Petitioner Mynard billed Medicare for services provided by a licensed professional counselor but did not directly supervise that individual. CMS MSJ at 3; P. MSJ at 2.

CMS's case. CMS alleges as "undisputed fact" that Petitioner Mynard allowed a counselor to provide services without the required direct supervision. CMS MSJ at 7. This is not a fact; this is a conclusion. CMS has submitted no evidence in support of this conclusion (such as an investigator's report, if any, that "Health Integrity" produced when investigating Petitioner Mynard's billing practices). *See* CMS MSJ at 3. Indeed, neither the initial determination, the reconsidered determination, nor any of CMS's submissions shed much light on the level of supervision Petitioner Mynard provided nor on why that level of supervision was inadequate. The reconsidered determination says that both Petitioner Mynard and Licensed Professional Counselor Erika Nelson "confirmed that they see patients at the same time in separate locations within the nursing facility." CMS Ex. 3 at 2.

I find significant problems with CMS's reliance on this statement to prove its case. First, the finding is valid only if supported by underlying evidence, and CMS has not provided any evidence – admissible or otherwise – to support it. Second, even accepting as true that these individuals made the statement (which, in the absence of supporting evidence, I would not be required to do), the statement itself is unhelpfully ambiguous. Nothing in the regulations or manual provisions preclude Petitioner Mynard from working in a separate location – even seeing patients – while Counselor Nelson saw patients in a separate room. 42 C.F.R. § 410.32(b)(3)(ii). Whether Petitioner violated the billing rules would depend on how far apart the "separate locations" were and how immediately available Petitioner Mynard was if Counselor Nelson called upon her. CMS has not answered these questions.

Petitioner's case. Petitioner, however, has come forward with evidence that answers these questions. She submits affidavits from herself, Counselor Nelson, and a variety of others, establishing the following:

- Petitioner Mynard followed the policies of her employer, Senior Psychological Care, regarding services delivered under the "incident to" provisions. As billing provider, she personally evaluated the patient and initiated the course of psychotherapy. She monitored and supervised the trained therapist (Counselor Nelson), who provided follow-up services. She actively monitored the course of the therapy, documenting her review of clinical notes, and periodically having direct contact with the patient to confirm the findings. She was required to be on site whenever the counselor was seeing patients. P. Ex. 6 at 1, 6 (Rubinstein Decl.); P. Ex. 9 at 1 (Vela Decl.).

- Upon entering a nursing facility, Petitioner Mynard and Counselor Nelson would set up operations in a conference or other centrally-located room and would see patients residing in the same wing or hallway. When finished in that particular area, they would move together to the next wing or hallway. P. Ex. 7 at 1 (Nelson-Gammill Decl.).

- The two mental health professionals would see each other all day, passing in the hall, and returning to the designated room between patient visits. P. Ex. 7 at 1 (Nelson-Gammill Decl.).

- At the end of the day, the two would sit down together to enter their notes into the electronic medical records system, review any changes in patient status or symptoms, and discuss ways to address problems. Petitioner Mynard would review and counter-sign Counselor Nelson's notes. P. Ex. 7 at 2 (Nelson-Gammill Decl.).

- If a patient presented with new or worsening symptoms, Petitioner Mynard would accompany Counselor Nelson on the patient visit. P. Ex. 7 at 2 (Nelson-Gammill Decl.).

- Petitioner Mynard was "always immediately available to help [Counselor] Nelson with a patient and evaluate her services." P. Ex. 8 at 1 (Mynard Decl.); see P. Ex. 8 at 3-5 (documenting psychologist's supervision of "incident to" services).

CMS has not come forward with any admissible evidence establishing a dispute over any of these facts. Indeed, CMS has not challenged them at all. Thus, the undisputed evidence establishes that Petitioner Mynard directly supervised Counselor Nelson. If called upon, she was immediately available to furnish assistance and direction; she

actively monitored the services Counselor Nelson provided. She complied with Medicare enrollment requirements, and CMS had no basis for revoking her enrollment.

Conclusion

The undisputed evidence establishes that Petitioner Mynard properly supervised Counselor Nelson and complied with Medicare enrollment requirements. CMS improperly revoked her Medicare billing privileges. I therefore grant Petitioner's motion for summary judgment and deny CMS's.

/s/
Carolyn Cozad Hughes
Administrative Law Judge