DAB No. CR1982 (2009), Med & Med GD (CCH) P 121929, 2009 WL 3353352 (H.H.S.)

Department of Health and Human Services (H.H.S.)
Departmental Appeals Board

Civil Remedies Division
IN THE CASE OF: US ULTRASOUND, PETITIONER
v.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Docket No. C-09-428
Decision No.
CR1982

July 31, 2009

DECISION

This case is before me on the Centers for Medicare & Medicaid Services' (CMS) motion for summary disposition. I find and conclude that CMS properly denied Medicare supplier status and billing privileges to Petitioner, US Ultrasound, which sought to participate in the Medicare program as an Independent Diagnostic Testing Facility (IDTF). Accordingly, I uphold the April 17, 2009 decision of the Medicare Hearing Officer.

I. Procedural History

Medicare carrier Wisconsin Physicians Service Insurance Corporation (WPS) received applications from Petitioner to enroll two IDTFs, [FN1] one in Kansas and one in Missouri. The applications were reviewed together and had the same information except as to geographical area for services provided, although separate provider transaction access numbers (PTANs) were to be issued for the Kansas and Missouri locations. *See* CMS Exhibit (Ex.) 6. The control number for the Kansas location was 1708120239000 and the

control number for the Missouri location was 2608148239000. *See* CMS Exs. 1, 3; Petitioner Exhibits (P. Exs.) 1, 2; P. Ex. 4 (WPS letters of January 6, 2008).[FN2]

By letters dated September 11, 2008, WPS informed Petitioner that it had approved its enrollment applications and provided PTANs for the Kansas and Missouri locations. WPS specifically informed Petitioner that the September 11, 2008 letters were the only notification letters that WPS would be sending. WPS stated that Petitioner's effective date of participation was June 15, 2008. WPS then notified Petitioner of what it needed to do to maintain its active enrollment status in the Medicare program. CMS Ex. 3; P. Ex. 1; P. Ex. 4 (September 11, 2008 letters referencing the control numbers for the Kansas and Missouri locations). Petitioner began providing services and, before being informed that the approval of its enrollment had been made in error, provided services to Medicare beneficiaries totaling approximately $11,600. Petitioner's Brief (P. Brief) at 2; P. Ex. 3.

By letters dated November 20, 2008 (over two months after Petitioner was notified that it had been approved for

enrollment), Petitioner was notified by WPS that it would not be taking any action to process its applications because:

> After further review of your application, it was determined that we cannot issue/release your Medicare PTAN. The equipment that you are listing on your application is owned by Alliance Radiology, they are also responsible for the calibration and maintenance of the equipment. The agreement that was inclosed [sic] indicates that Alliance Radiology provides the technical and professional services. Alliance Radiology provides technical staff, equipment and the transportation. US Ultrasound pays Alliance Radiology a professional fee for the professional services (billing, scheduling and patient records). Alliance Radiology is the entity that will need to be set up as the Independent Diagnostic Testing Facility.

CMS Ex. 4; P. Ex. 2. The letters did not refer to the fact that WPS had notified Petitioner two months previously that its applications had been approved. Both the September and November letters were signed by the same individual — WPS employee Jessica Foglia.

By letter dated January 6, 2009, signed by Ms. Foglia, WPS informed Petitioner that its request to enroll in Medicare for the Kansas location was denied because it did not "meet the conditions of enrollment or meet the requirements to qualify as a Medicare provider/supplier" because the "[e]ntity performing the services on the Kansas application is not the entity who is enrolling."CMS Ex. 1.

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On January 22, 2009, in a letter signed by Janice Warner, WPS informed Petitioner that the September 11, 2008 letters with PTANs assigned were sent to Petitioner "in error as the processing of your applications was not completed."Instead, letters sent to Petitioner on January 6, 2009, titled "Denial of Medicare Provider/Supplier Enrollment Application," were, according to Ms. Warner, "the letters you should have originally received."CMS Ex. 5.

Petitioner requested reconsideration of the January 6, 2009 determination. A Medicare Hearing Officer upheld the January 6, 2009 determination with regard to control number 170812039000, the Kansas location. The Medicare Hearing Officer referenced 42 C.F.R. § 424.530(a)(1) in finding that "[t]he entity performing the services on the Kansas application to add additional equipment is not the entity that is enrolling."[FN3] The Medicare Hearing officer wrote:

> Alliance Radiology owns the equipment that is listed on the application; they are also responsible for the calibration and maintenance of the equipment. The agreement that was enclosed indicates that Alliance Radiology provides the technical and professional services. Alliance Radiology provides technical staff, equipment and the transportation. US Ultrasound pays Alliance Radiology a professional fee for the professional services (billing, scheduling and patient records). Alliance Radiology is the entity that will need to be set up as the Independent Diagnostic Testing Facility.

CMS Ex. 2; P. Ex. 4 (April 17, 2009 Medicare Hearing Officer decision).

By letter dated April 28, 2009, Petitioner requested a hearing. Petitioner asserted that after being "very open" about how it intended to provide services, its "services were ... approved to start on 6/15/08 ... later we received notice that our approval was rescinded, after we had already start[ed] providing services."Petitioner believed that it had been treated "unfairly, slowly, [and] unprofessionally," and "WPS does not understand that they cannot say that it is alright to start services, then retract it and say no back to the start."April 28, 2009 hearing request.

The case was assigned to me for hearing and decision on May 5, 2009. I held a prehearing conference in the case, by telephone, on May 18, 2009. By Order dated May 19, 2009, I set a schedule for the parties to brief the case. On June 9, 2009 (with a corrected copy filed on June 12, 2009), CMS filed a motion for summary disposition and supporting brief (CMS Brief), accompanied by CMS Exs. 1-6. On June 30, 2009, Petitioner filed its response (P. Brief), accompanied by P. Exs. 1-3, and, as noted, I have

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marked the attachments to Petitioner's hearing request as P. Ex. 4. CMS filed its reply (CMS Reply) on July 9, 2009. In the absence of objection, I admit CMS Exs. 1-6 and P. Exs. 1-4.

II. Legal Background

Section 1866(j)(1) of the Act, 42 U.S.C. § 1395cc(j)(1), authorizes the Secretary of Health and Human Services (Secretary) to establish a process for the enrollment in the Medicare program of providers of services and suppliers. The Secretary published a final rule governing the enrollment of providers and suppliers, with an effective date of June 20, 2006 (71 Fed. Reg. 20754, 20776 (April 21, 2006)). These regulations are found at 42 C.F.R. Part 424, subpart P, and establish requirements for enrollment:

> To receive payment for covered Medicare items or services from either Medicare (in the case of an assigned claim) or a Medicare beneficiary (in the case of an unassigned claim), a provider or supplier must be enrolled in the Medicare program. Once enrolled, the provider or supplier receives billing privileges and is issued a valid billing number effective for the date a claim was submitted for an item that was furnished or a service that was rendered.

42 C.F.R. § 424.505.

The Medicare enrollment process begins with submission of an enrollment application on the form CMS-855. A prospective provider or supplier must provide all documentation required by CMS to ascertain whether the provider or supplier is eligible to furnish services. 42 C.F.R. § 424.510(d)(2). Prospective providers and suppliers may also be subject to specific enrollment requirements relative to their particular specialization. Applicable certification standards for IDTFs are found at 42 C.F.R. § 410.33(g).

Regulations define the circumstances in which CMS may reject the application of a provider or supplier to participate in the Medicare program, or may revoke an enrollment already granted. CMS may deny a provider or supplier's enrollment in Medicare if "[t]he provider or supplier at any time is found not to be in compliance with the Medicare enrollment requirements described in this section or on the applicable enrollment application to the type of provider or supplier enrolling, and has not submitted a plan of corrective action as outlined in part 488 of this chapter."42 C.F.R. § 424.530(a)(1).

Section 1866(j)(2) of the Act, 42 U.S.C. § 1395cc(j)(2), gives providers and suppliers appeal rights for certain determinations involving enrollment, using the procedures that apply under section 1866(h)(1)(A) of the Act, 42 U.S.C. § 1395cc(h)(1)(A). These procedures are set out at 42 C.F.R. Part 498, *et seq.*, and provide for hearings before administrative law judges (ALJs) of this forum, and for review of the resulting ALJ decisions by the Departmental Appeals Board (Board).

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In provider and supplier appeals under section 1866(j)(1) of the Act and 42 C.F.R. Part 498, CMS must make a *prima facie* showing that the provider or supplier has failed to comply substantially with federal requirements. *See Medisource Corporation*, DAB No. 2011 (2006). To prevail, the provider or supplier must overcome CMS's *prima facie* showing by a preponderance of the evidence. *Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004), *aff'd, Batavia Nursing and Convalescent Center v. Thompson*, 129 Fed. Appx. 181 (6th Cir. 2005).

III. Issues

The issues before me are whether:

1. Petitioner satisfied the requirements necessary to participate in the Medicare program as an IDTF; and

2. CMS's approval of Petitioner's enrollment on September 11, 2008 entitles it to reimbursement for the approximately $11,600 Petitioner billed in reliance on that approval.

IV. Findings of Fact and Conclusions of Law

1. Summary judgment is appropriate.
2. Petitioner did not satisfy the requirements necessary to participate in Medicare as an IDTF.
3. Petitioner is not entitled to reimbursement for services provided to Medicare beneficiaries during the period that CMS erroneously approved its enrollment application.

V. Discussion

CMS has moved for resolution of the issues in its favor by its motion for summary disposition. While FED. R. CIV. P. 56 is not directly applicable to proceedings under 42 C.F.R. Part 498, it does provide guidance for the standard of review for motions seeking summary disposition. Summary judgment is generally appropriate when the record reveals that no genuine dispute exists as to any material fact and the undisputed facts clearly demonstrate that one party is entitled to judgment as a matter of law. *White Lake Family Medicine, P.C.*, DAB No. 1951 (2004). In evaluating whether there is a genuine issue as to a material fact, an ALJ must view the facts and the inferences reasonably to be drawn from the facts in the light most favorable to the nonmoving party. *See Pollock v. American Tel. & Tel. Long Lines*, 794 F.2d 860, 864 (3rd Cir. 1986); *Oklahoma Heart*

Hospital, DAB No. 2183, at 9 (2008); *Brightview Care Center*, DAB No. 2132, at 9-10 (2007); *Madison Health Care, Inc.*, DAB No. 1927, at 3-7 (2004). I employ that standard here.

The parties do not disagree concerning the material facts in the case. Their disagreement lies in their views with regard to their position on the application of the law to the facts. Thus, in this case, decision by summary disposition is appropriate.

Petitioner argues that while CMS has characterized the case as one of a supplier [FN4] who anticipated approval of enrollment and rendered services only to learn that the anticipated approval was not forthcoming (whether or not in reliance on a government employee), the case really involves an attempt by CMS to revoke an approved supplier's (Petitioner's) status. Petitioner notes the consequences with respect to a case where an approval is revoked and a pending application is ultimately denied. In the case where a supplier's status is revoked, the supplier may still charge for services rendered. *See*42 C.F.R. § 424.535(g); 42 C.F.R. § 405.874. In contrast, a supplier who was never approved for enrollment is unable to submit charges and cannot be paid for services rendered. In light of this, Petitioner asks that I find, based on the undisputed facts:

> (i) that U.S. Ultrasound was approved as a [supplier] on September 11, 2008; (ii) that U.S. Ultrasound provided services in accordance with that approved status; (iii) that CMS sought to revoke such status by its letters in November of 2008 and January of 2009; but, (iv) that even assuming *arguendo* that such revocation was effective, U.S. Ultrasound is entitled to payment for services rendered while it was an approved [supplier].

P. Brief at 6. I sympathize with Petitioner's position, and note that Petitioner applied to enroll in Medicare in good faith and then provided its services in good faith and in reliance on CMS's explicitly-expressed, if erroneous, acceptance of its enrollment application. However, where a provider or supplier does not meet Medicare enrollment requirements Medicare cannot reimburse the provider or supplier. Significantly, Petitioner has not asserted that it did, in fact, meet Medicare enrollment requirements for IDTFs — asserting only that while CMS offered an alleged basis for revoking eligibility, CMS did not offer any reason why the initial action approving participation was not valid. *See* P. Brief at 1-6.

CMS asserts that Petitioner's enrollment application was properly denied because Petitioner failed substantially to

comply with federal requirements applicable to enrollment as an IDTF. An IDTF is considered a supplier under Medicare, and a supplier is defined by regulation as "a physician or other practitioner, or an entity other than a

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provider that furnishes health care services under Medicare." 42 C.F.R. § 400.402. CMS asserts that Petitioner cannot establish that it *furnishes* a health care service. This is because WPS's review of Petitioner's application showed Petitioner did not own any equipment, was not responsible for the calibration and maintenance of any equipment, and was not responsible for either technical (actually performing or administering a test) or professional (reading or interpreting the data obtained by a test) services. CMS Ex. 2. CMS asserts that under Petitioner's contract with Alliance Radiology, Petitioner did nothing that could be construed as *furnishing* a service, citing CMS Ex. 6, at 244-45.

CMS asserts specifically in support of its position that an IDTF certifies in its enrollment application that it meets certain standards and related requirements. 42 C.F.R. § 410.33(g). An IDTF is required to "maintain a catalogue of portable diagnostic equipment," to "[m]ake portable diagnostic testing equipment available for inspection," and to "[m]aintain a current inventory of diagnostic testing equipment, including serial and registration numbers ...."42 C.F.R. § 410.33(g)(4). CMS asserts that under the contract with Alliance Radiology, Petitioner only received lists of equipment maintained by Alliance and there was no provision in the contract for making equipment available, citing CMS Ex. 6, at 253. CMS asserts the reasonable conclusion is that Alliance Radiology is the entity performing the services, not Petitioner. CMS Ex. 2. CMS notes that although supplier regulations for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) allow for contracting Medicare items or services, the absence of such recognition of contracting in the IDTF regulations supports a conclusion that such contracting is not contemplated for IDTF suppliers. CMS Brief at 7. CMS also notes that the Medicare Claims Processing Manual (MCPM), at Pub. 100-04, Ch. 13, § 20.2.4.2. (in a section related to radiology services) allows a physician to submit a claim for the technical component of diagnostic tests purchased from another provider or supplier, and for a diagnostic test supplier to make a claim for the purchase of a physician's test interpretation. However, the provisions require the claiming entity to have provided either the technical or professional element of the service, as applicable. CMS avers this is consistent with the general view that a potential enrollee must furnish a service and supports CMS's denial of enrollment to Petitioner who furnished neither the technical or the professional element here. CMS Brief at 7.

CMS also asserts that Petitioner's request for reimbursement for the services it provided based on CMS's apparent acceptance of its enrollment application is in the nature of equitable relief, which relief cannot be granted in this forum. I agree with CMS that as an ALJ my authority is limited and does not extend to awarding money damages based on equitable theories or deciding claims against CMS based on equitable estoppel. *See Oklahoma Heart Hospital*, DAB CR1719, at 10 (2008), *aff'd, Oklahoma Heart Hospital*, DAB No. 2183. Nothing in the Act or the regulations obligates or enables CMS to certify an applicant to participate in Medicare based on the communication of erroneous information given to the facility by an employee of a contractor. *See University Behavioral Health of El Paso*, DAB CR1880, at 6 (2009); *Danville HealthCare Surgery*

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Center, DAB CR892 (2002). As stated by another ALJ, "[i]t is well-settled that erroneous information from government employees does not rise to estoppel against the government or entitle the recipient of incorrect information to monetary payments not otherwise permitted by law."*Surgery Center of Southwest Kansas*, DAB CR619, at 7 (1999).

Petitioner asserts that the cases cited by CMS in support of its position (*Oklahoma Heart Hospital*, DAB CR1719 and *Danville HealthCare Surgery Center*, DAB CR892), dealt with services provided prior to the effective date of the provider or supplier's participation or based on verbal assurance from a WPS employee. Petitioner asserts that, in contrast, Petitioner was approved as a supplier. But, Petitioner did not establish its substantial compliance with participation requirements, and CMS has explained why Petitioner did not, and could not, establish as constituted its

substantial compliance with IDTF enrollment requirements due to the nature of its contract with Alliance Radiology.

There need be no misunderstanding: this is an unfortunate result. Through no mistake or misstatement of its own, Petitioner was erroneously assured by WPS that it had been enrolled in Medicare. Petitioner acted perfectly reasonably in relying on that erroneous assurance. Later, when WPS's error was discovered and Petitioner was told that it was not eligible for enrollment, it sustained losses because of its perfectly-reasonable reliance on WPS's error. But nothing in the Act or regulations obligates or permits CMS to certify Petitioner to participate in Medicare where Petitioner does not meet IDTF enrollment requirements. Moreover, I do not have the authority to enroll Petitioner in the program at a time when it did not meet IDTF enrollment requirements or to require CMS to pay Petitioner where such payment is not permitted by law. However heavily the equities in this case may favor Petitioner, and however poorly WPS may have served the Medicare program in this case, I simply lack the authority to make Petitioner whole.

VI. Conclusion

For the reasons set out above, I grant CMS's motion for summary disposition.

Richard J. Smith
Administrative Law Judge

FN1. The Social Security Act (Act) identifies an IDTF as a "supplier" furnishing items or services under Medicare as opposed to a "provider" of services. Act, sections 1861(d) and 1861(u); 42 U.S.C. §§ 1395x(d) and 1395x(u).

FN2. Petitioner appended a number of documents to its hearing request. I am marking these documents as P. Ex. 4.

FN3. The parties did not provide the Medicare Hearing Officer decision with respect to the Missouri location. I note there are no material differences in the facts regarding the two locations and Petitioner's enrollment has been denied for both locations.

FN4. Petitioner refers to itself as a "provider." However, as "provider" and "supplier" are terms of art under the regulations, I refer to Petitioner as a "supplier."

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