Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Elizabeth Leen-Burns,
(NPI: 1871779561; PTAN: AQ882Z),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-2091

Decision No. CR4211

Date: September 14, 2015

DECISION

Petitioner, Elizabeth Leen-Burns, does not meet the requirements of 42 C.F.R. § 410.75(b)[1] to enroll in Medicare as a nurse practitioner, and her enrollment is denied pursuant to 42 C.F.R. § 424.530(a)(1).

I. Background

By letter dated January 8, 2015, First Coast Service Options, Inc., (First Coast), an administrative contractor for the Centers for Medicare & Medicaid Services (CMS), informed Petitioner's employer that Petitioner's Provider Transaction Access Number (PTAN) was deactivated effective November 22, 2014. First Coast cited as a basis for the action that Petitioner was "no longer assigned as Nurse Practitioner with Medicare." CMS Ex. 3 at 1. The letter advised that to obtain a new PTAN or to have her old PTAN reinstated Petitioner had to complete a new enrollment application. Request for Hearing

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[1] References are to the 2014 revision of the Code of Federal Regulations (C.F.R.), unless otherwise stated.

(RFH) at 23; CMS Ex. 3 at 1. Petitioner requested reconsideration. On March 10, 2015, First Coast concluded on reconsideration that while Petitioner "meets the requirements for the State of Florida as a nurse practitioner she does not meet CMS qualifications for a Nurse Practitioner that went into effect on January 1, 2009." CMS Ex. 1 at 3. The hearing officer cited 42 C.F.R. § 410.75(b). RFH at 7-21; CMS Ex. 1. [2]

Petitioner filed a request for hearing on April 16, 2015. On May 6, 2015, the case was assigned to me, and I issued an Acknowledgment and Prehearing Order (Prehearing Order). CMS filed a motion for summary judgment and brief, together with an exhibit list describing CMS Exhibits (Exs.) 1 through 6 on June 4, 2015. However, CMS failed to file its six exhibits. CMS also did not file a certificate that its exhibits were served upon Petitioner. Petitioner filed her response to CMS's motion and her brief (P. Br.) with Petitioner's exhibits (P. Exs.) 1 through 4 on July 2, 2015. On August 19, 2015, CMS filed another copy of its motion for summary judgment and brief, which appear to be substantially similar to the documents previously filed. CMS also filed on August 19, 2015, CMS Exs. 1 through 6. CMS again failed to file a certificate of service for the exhibits. Petitioner filed no objections to the late filing of the CMS exhibits or to the admissibility of the exhibits. CMS failed to file a reply brief or a waiver of reply as required by paragraph II.D.3 of the Prehearing Order. The parties have not objected to my consideration of CMS Exs. 1 through 6 and P. Exs. 1 through 4, and they are admitted as evidence.

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. Administration of the Part B program is through contractors such as First Coast. Act § 1842(a) (42 U.S.C. § 1395u(a)). Payment under the program for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of services and suppliers.[3] Act §§ 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1)

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[2] The hearing officer that conducted the reconsideration incorrectly characterizes the agency action in this case as a deactivation of Petitioner's billing privileges, which is clearly in error. The evidence shows that this case involves the denial of Petitioner's attempt to re-enroll in Medicare not a deactivation of billing privileges. Deactivation of billing privileges is not subject to review. 42 C.F.R. §§ 424.540, 424.545(b).

[3] A "supplier" furnishes services under Medicare, and the term supplier applies to physicians and other non-physician practitioners and facilities that are not included
(Footnote continued next page.)

(42 U.S.C. § 1395u(h)(1)). The Act requires the Secretary of Health and Human Services 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 supplier must be enrolled in the Medicare program to be reimbursed for services provided to Medicare beneficiaries. The Medicare program authorizes Medicare Part B payments for services provided by an enrolled nurse practitioner. 42 C.F.R. § 410.20. A nurse practitioner must meet the following requirements of 42 C.F.R. § 410.75(b) (the section cited by the hearing officer on reconsideration) to enroll in Medicare and be granted billing privileges:

> (b) *Qualifications*. For Medicare Part B coverage of his or her services, a nurse practitioner must be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with State law, and must meet one of the following:
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> (1) Obtained Medicare billing privileges as a nurse practitioner for the first time on or after January 1, 2003, and meets the following requirements:
>
> (i) Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners.
>
> (ii) Possess a master's degree in nursing or a Doctor of Nursing Practice (DNP) doctoral degree.
>
> (2) Obtained Medicare billing privileges as a nurse practitioner for the first time before January 1, 2003, and meets the standards in paragraph (b)(1)(i) of this section.
>
> (3) Obtained Medicare billing privileges as a nurse practitioner for the first time before January 1, 2001.

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(Footnote continued.)

within the definition of the phrase "provider of services." Act §1861(d); (42 U.S.C. § 1395x(d)).

A supplier's enrollment is considered denied when a supplier is determined to be "ineligible to receive Medicare billing privileges for Medicare-covered items or services provided to Medicare beneficiaries" for one or more of the reasons listed in 42 C.F.R. § 424.530. 42 C.F.R. § 424.502. When a supplier's enrollment application is denied, the CMS contractor notifies the supplier in writing and explains the reasons for the determination and provides information regarding the supplier's right to appeal. 42 C.F.R. § 498.20(a). The supplier submits a written request for reconsideration to CMS or its contractor. 42 C.F.R. § 498.22(a). CMS or its contractor must give notice of its reconsidered determination to the supplier, giving the reasons for its determination and specifying the conditions or requirements the supplier failed to meet, and the right to an ALJ hearing. 42 C.F.R. § 498.25. If the decision on reconsideration is unfavorable to the supplier, the supplier has a right to request a hearing by an ALJ and further review by the Departmental Appeals Board (Board). Act § 1866(j)(8) (42 U.S.C. § 1395cc(j)(8)); 42 C.F.R. §§ 424.545, 498.3(b)(17), 498.5. A hearing on the record, also known as an oral hearing, is required under the Act. *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743, 748-51 (6th Cir. 2004).

B. Issue

Whether there is a basis to deny Petitioner's application to reenroll as a Medicare supplier.

C. Finding of Fact, Conclusion of Law, and Analysis

1. Summary judgment is appropriate.

CMS requested summary judgment. Summary judgment is not automatic upon request but is limited to certain specific conditions. The Secretary's regulations that establish the procedures to be followed in adjudicating Petitioner's case are at 42 C.F.R. pt. 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 Board has long accepted that summary judgment is an acceptable procedural device in cases adjudicated pursuant to 42 C.F.R. pt. 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 recognizes that the Federal Rules of Civil Procedure (Fed. R. Civ. Pro.) do not apply in administrative adjudications such as this, but the Board has accepted that Fed. R. Civ. Pro. 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 the proceedings and made available to the parties in the litigation of this case by my

Prehearing Order dated May 6, 2015. 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. *Mission Hospital Reg'l Med. Ctr.*, DAB No. 2459, at 4 (2012) (and cases cited therein); *Experts Are Us, Inc.*, DAB No. 2452, at 4 (2012) (and cases cited therein); *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. pt. 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. pt. 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 in the Medicare program to the undisputed facts of this case. I have assumed all pertinent facts alleged by Petitioner are true, drawn all inferences in favor of Petitioner, and resolve this case as a matter of law against Petitioner. Accordingly, summary judgment is appropriate in this case.

2 Petitioner did not meet the qualifications for Medicare Part B coverage as a nurse practitioner under 42 C.F.R. § 410.75(b).

3. There is a basis for denial of Petitioner's enrollment in Medicare pursuant to 42 C.F.R. § 424.530(a)(1), because she did not meet the requirements of 42 C.F.R. § 410.75(b).

For purposes of summary judgment I accept the following assertions of fact by Petitioner drawing all inferences in her favor:

- Petitioner was granted enrollment in Medicare and billing privileges as a nurse practitioner on about July 14, 2008.

- In October 2014, Petitioner was notified that she was required to submit a reenrollment application to First Coast.

P. Br. at 1-2; CMS Ex. 2 at 1.

Petitioner submitted a CMS-855I as part of an enrollment revalidation project. The CMS-855I was signed October 27, 2014, and postmarked October 29, 2014. CMS Ex. 6 at 1, 6, 31, 45. Revalidation of enrollment is provided for by 42 C.F.R. § 424.515.[4] First Coast notified Petitioner by letter dated November 18, 2014, that it had received Petitioner's Medicare enrollment application. However, First Coast advised Petitioner that the application was incomplete, missing information, or contained inaccurate information that had to be corrected within 30 days. CMS Ex. 5. Petitioner signed a second CMS-855I on December 22, 2014, to revalidate her enrollment in Medicare. CMS Ex. 4 at 4. Petitioner

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[4] There is no evidence that Petitioner's prior enrollment and billing privileges were revoked. Rather, Petitioner's CMS-855I submitted on October 29, 2014, in response to the revalidation request was treated as a new application, and that application was ultimately denied. Petitioner's CMS-855I dated December 22, 2014, was also treated as a new application that was denied. This procedure for processing a revalidation application appears to be consistent with the regulations and is not challenged by Petitioner. Even if this case had proceeded as a revocation of enrollment under 42 C.F.R. § 424.535(a)(1) for noncompliance with 42 C.F.R. § 410.75(b), the due process accorded Petitioner and the resulting decision would have been no different.

attached to both of the CMS-855Is that she filed certifications from the Dermatology Nursing Certification Board and the American Midwifery Certification Board. CMS Ex. 4 at 32-33; CMS Ex. 6 at 39-40. Petitioner filed certifications from the same boards as part of P. Ex. 3.[5]

The board certifications Petitioner submitted with her applications and presented to me were not issued by organizations that are currently on the CMS list of recognized certifying bodies for nurse practitioners. On August 17, 2007, CMS issued a policy statement with respect to the Medicare program qualifications for nurse practitioners under 42 C.F.R. § 410.75, specifying the organizations recognized by CMS to be national certifying bodies for nurse practitioners at the advanced practice level. Medicare Benefit Policy Manual, CMS Pub. 100-02, § 200.A (eff. Nov. 19, 2007) provides:

> The following organizations are recognized national certifying bodies for NPs [nurse practitioners] at the advanced practice level:
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> - American Academy of Nurse Practitioners;
> - American Nurses Credentialing Center;
> - National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties;
> - Pediatric Nursing Certification Board (previously named the National Certification Board of Pediatric Nurse Practitioners and Nurses);
> - Oncology Nurses Certification Corporation;
> - AACN Certification Corporation; and
> - National Board on Certification of Hospice and Palliative Nurses.

Petitioner has not presented a board certification by one of the certifying organizations on the foregoing list. Petitioner does not dispute that she does not have a board certification from one of the certifying organizations on the CMS list. Accordingly, I conclude as a matter of law that Petitioner does not meet the requirements of 42 C.F.R. § 410.75(b)(1), as there is no dispute that she applied

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[5] Petitioner uploaded her exhibits with her brief rather than as separate documents. Also, Petitioner's exhibits were not marked in accordance with the Civil Remedies Division Procedures. Her exhibits were not excluded for either reason as there is little chance for confusion with the current marking and location of the exhibits.

for billing privileges for the first time after January 1, 2003; and she does not have the required certification from a CMS-recognized certifying body. Pursuant to 42 C.F.R. § 424.530(a)(1), a supplier's enrollment in the Medicare program may be denied when at any time a supplier is found not to be in compliance with Medicare enrollment requirements.

Petitioner does not deny any of the material facts. Rather, Petitioner raises an argument that I construe to be in the nature of estoppel. Petitioner argues that she was permitted to enroll in Medicare as a nurse practitioner in 2008 even though she was not certified by any of the specified national certifying bodies. P. Brief at 1, 4. Petitioner does not deny that under the regulations, only a nurse practitioner who obtained Medicare billing privileges prior to January 1, 2001, is excused from the requirement to be certified by a national certifying body recognized by CMS. Petitioner also does not deny that there is no evidence that she had Medicare Part B billing privileges prior to January 1, 2001. There is no dispute that when initially enrolled in 2008, Petitioner fit no exception to the requirement for board certification by an organization on the CMS list. Petitioner does not deny that she has never, from 2008 to the present, had a certification by one of the recognized bodies. Nevertheless, Petitioner argues that CMS should be estopped from denying her reenrollment because Petitioner was permitted to enroll in 2008 even though she did not meet the necessary qualifications, and she acted in reliance upon the CMS action. Petitioner's argument fails as a matter of law. ALJs and the Board are bound by and may not ignore properly promulgated and applicable regulatory requirements. *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."). Furthermore, "the government cannot be estopped absent, at minimum, a showing that the traditional requirements for estoppel are present (i.e., a factual misrepresentation by the government, reasonable reliance on the misrepresentation by the party seeking estoppel, and harm or detriment to that party as a result of the reliance) and that the government's employees or agents engaged in 'affirmative misconduct." *Oaks of Mid City Nursing & Rehab. Ctr.*, DAB No. 2375 at 31 (2011), citing *Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414, 421 (1990), and *Pacific Islander Council of Leaders*, DAB No. 2091 (2007) at 12 ("[e]quitable estoppel does not lie against the federal government, if indeed it is available at all, absent at least a showing of affirmative misconduct."). Here, Petitioner has not alleged or shown any affirmative misconduct by an agent of the government upon which she reasonably relied and estoppel, if available at all, does not apply in this case.

Accordingly, I conclude that Petitioner did not meet the requirements to enroll in Medicare as a nurse practitioner and there is a basis to deny her enrollment.

III. Conclusion

For the foregoing reason, Petitioner's enrollment in Medicare as a nurse practitioner is denied.

/s/
Keith W. Sickendick
Administrative Law Judge