Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

West Norman Endoscopy Center, LLC
Docket No. A-10-69
Decision No. 2331
September 23, 2010

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

West Norman Endoscopy Center, LLC (WNEC) appealed the decision of Administrative Law Judge (ALJ) Richard J. Smith in West Norman Endoscopy Center, LLC, DAB CR2120 (2010) (ALJ Decision). The ALJ granted summary judgment in favor of the Centers for Medicare & Medicaid Services (CMS), holding that the effective date of approval for WNEC's participation in the Medicare program as an ambulatory surgical center (ASC) is March 18, 2009, not one of the earlier dates to which WNEC claimed it was entitled.

As explained below, we conclude that the ALJ erred in granting summary judgment in favor of CMS and in not granting summary judgment to WNEC. Based on the undisputed facts in the record, we conclude that WNEC met all applicable requirements for participation in Medicare on December 23, 2008, the date WNEC provided information missing from its CMS Form 855B enrollment application. We find no basis for the ALJ's treating WNEC's enrollment application as incomplete on that date. We further conclude that, under section 489.13(d) as currently in effect, WNEC is entitled to an effective date retroactive to September 2, 2008, the date WNEC first began furnishing covered services to Medicare beneficiaries for which it has not been paid.

Legal Background

Section 1832(a)(2)(F) of the Social Security Act[1] authorizes Medicare Part B coverage for services furnished in connection with specified surgical procedures at an ambulatory

[1] The current version of the Social Security Act can be found at http://www.socialsecurity.gov /OP_Home/ssact/ssact.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross-reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp Table.

surgical center (ASC) that meets health, safety, and other standards if the ASC has entered into agreement with the Secretary of Health and Human Services to accept payment as an ASC. Title 42 C.F.R. Part 416, subpart C, sets forth specific conditions for ASC participation. CMS "may deem an ASC to be in compliance with any or all of the conditions set forth in subpart C . . . if—(1) The ASC is accredited by a national accrediting body, or licensed by a State agency, that CMS determines provides reasonable assurance that the conditions are met," (2) the ASC complies with any State licensure requirements, and (3) the ASC authorizes the release to CMS of the findings of the accreditation survey. 42 C.F.R. § 416.26(a). Alternatively, CMS may determine that a facility is in compliance with the conditions in subpart C based on a survey conducted by the State survey agency. 42 C.F.R. § 416.26(b). "If CMS determines, after reviewing the survey agency recommendation and other evidence relating to the qualification of the ASC, that the facility meets the requirements" of Part 416, CMS sends the ASC written notice of its determination and copies of the "ASC agreement." 42 C.F.R. § 416.26(c). After the ASC's authorized representative has signed the agreement and filed it with CMS, CMS sends the ASC "a notice of acceptance specifying the effective date." 42 C.F.R. § 416.26(d) and (e).

Section 1866(j) of the Act provides that the Secretary "shall establish by regulation a process for the enrollment of providers of services and suppliers under this title." Title 42 C.F.R. Part 424, subpart P, governs the process for enrollment of all providers and suppliers in the Medicare program. Subpart P describes completion of the enrollment process as a prerequisite for a provider or supplier "to bill" and "to receive payment" for Medicare covered services. 42 C.F.R. §§ 424.500, 424.505. Section 424.510, titled "Requirements for enrolling in the Medicare program," provides in pertinent part:

> (a) Providers and suppliers must submit enrollment information on the applicable enrollment application. Once the provider or supplier successfully completes the enrollment process, including, if applicable, a State survey and certification or accreditation process, CMS enrolls the provider or supplier into the Medicare program. . . .
>
> * * * * * * *
>
> (d) Providers and suppliers must meet the following enrollment requirements:
>
> (1) *Submittal of the enrollment application*. A provider or supplier must submit a complete enrollment application and supporting documentation to the designated Medicare fee-for-service contractor.
>
> (2) *Content of the enrollment application*. Each submitted enrollment application must include the following:
>
> * * * * * * *
>
> (iv) At the time of enrollment, . . . providers and suppliers must agree to receive Medicare payments via EFT, if not already receiving payments

> through EFT. . . . In order to receive Medicare payments via EFT, providers and suppliers must submit the CMS-588 form.[2]

Section 424.525(a) provides that CMS may reject an enrollment application if the "prospective provider or supplier fails to furnish complete information on the provider/supplier enrollment application within 30 calendar days from the date of the contractor request for the missing information" (or within any extension of that period granted by CMS in its discretion).

The effective date for Medicare participation and reimbursement for providers and suppliers seeking accreditation from a CMS-approved accreditation organization is set out in 42 C.F.R. § 489.13(d). That section provides:

> Accredited provider or supplier requests participation in the Medicare program—(1) General rule. If the provider or supplier is currently accredited by a national accrediting organization whose program had CMS approval at the time of accreditation survey and accreditation decision, and on the basis of accreditation, CMS has deemed the provider or supplier to meet Federal requirements, the effective date depends on whether the provider or supplier is subject to requirements in addition to those included in the accrediting organization's approved program.
>
> (i) Provider or supplier subject to additional requirements. If the provider or supplier is subject to additional requirements, the effective date of the agreement or approval is the date on which the provider or supplier meets all requirements, including the additional requirements.
>
> (ii) Provider or supplier not subject to additional requirements. For a provider or supplier that is not subject to additional requirements, the effective date is the date of the provider's or supplier's initial request for participation if on that date the provider or supplier met all Federal requirements.
>
> (2) Special rule: Retroactive effective date. If a provider or supplier meets the requirements of paragraphs (d)(1) and (d)(1)(i) or (d)(1)(ii) of this section, the effective date may be retroactive for up to one year to encompass dates on which the provider or supplier furnished, to a Medicare beneficiary, covered services for which it has not been paid. [3]

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[2] Section 474.510 was adopted in 2006. 71 Fed. Reg. 20,776 (Apr. 21, 2006). Subsection (d)(2)(iv) was added effective August 26, 2008. 73 Fed. Reg. 36461 (June 27, 2008).

[3] Section 489.13(d) has been in effect since 1997. 62 Fed. 43936 (Aug. 18, 1997). However, an amendment to section 489.13 that becomes effective October 10, 2010 deletes subsection (d) and revises subsection (b) to include language concerning accredited facilities, among other changes. 75 Fed. Reg. 50042, 50420 (Aug. 16, 2010).

Factual Background[4]

On July 29, 2008, the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) conducted an initial survey of WNEC. ALJ Decision at 1. By letter dated August 25, 2008, AAAHC notified WNEC that it had recommended WNEC for participation in the deemed status program and awarded WNEC a six-month term of accreditation effective July 29, 2008. *Id*. AAAHC re-surveyed WNEC on January 29-30, 2009. *Id*. at 2. On March 20, 2009, AAAHC notified WNEC that it had awarded it a three-year accreditation effective January 30, 2009. *Id*. at 2.

On September 3, 2008, WNEC submitted a Medicare enrollment application, CMS Form 855B, to TrailBlazer, a Medicare contractor. ALJ Decision at 2. By letter to WNEC dated December 22, 2008, TrailBlazer stated that during "the screening of the application, missing or incomplete data elements were identified" and requested that WNEC "provide the information needed in order to process the application[.]" P. Ex. F at 1. The letter included a list of nine items with a checkbox to the left of each item, two of which were checked. The two checked items read:

> Section 6 and/or sections 15 and 16 (855B) for authorized/delegated official was not submitted, is incorrect, or incomplete. You must have a completed section 6 for each authorized/delegated official listed in sections 15 & 16.
>
> Other: Section 4A: Please provide the Add date

Id. at 1. The items that were not checked included the following item:

> The CMS 588 EFT was not submitted or is incorrect. CMS mandates that all new providers and existing providers making a change to their enrollment participate in Electronic Funds Transfer. You must include a voided check or deposit slip that matches the legal business name. (The business name must match IRS documentation)

Id. WNEC made several attempts "to discover what it needed to complete its application." ALJ Decision at 7.[5] WNEC's Administrator, Melissa Kepner, contacted TrailBlazer by e-mail on December 22, 2008 after receiving TrailBlazer's letter and requested clarification of the "Add date" (one of the two checked items). WNEC Motion for Summary Disposition (MSD) at 4 (citing P. Exs. G and A). WNEC provided the information identified in the two checked items to TrailBlazer by facsimile on December

[4] The facts below, which are undisputed, are drawn from the ALJ Decision and the record for that decision.

[5] The ALJ stated that for purposes of summary disposition he accepted WNEC's allegations to this effect. CMS did not dispute these allegations, which WNEC first made in its Motion for Summary Disposition.

23, 2008. MSD at 4 (citing P. Ex. A).[6] Ms. Kepner also contacted TrailBlazer by telephone after making an online status inquiry on January 12, 2009, the results of which stated that WNEC's "enrollment application has missing data or support documentation that requires the submission of a complete CMS-855 or Electronic Funds Transfer (EFT) agreement." WNEC MSD at 5 (citing P. Exs. I and A). TrailBlazer's employee told Ms. Kepner on January 14 "that there was a 'general error' notation, but she could not describe what the error was." *Id.*

By letter dated January 29, 2009, TrailBlazer notified WNEC that its enrollment application had "been closed" because "[a]dditional information was requested but not received within the allotted time." CMS Ex. 4. The January 29 letter also stated that a "new completed application will need to be submitted." *Id*. In addition, the letter noted that a "completed CMS-588 form (Electronic Funds Transfer-EFT) is required with the application." *Id*. WNEC was informed by TrailBlazer on January 30, 2009, the day after TrailBlazer "closed" its September 3, 2008 enrollment application, that WNEC should have submitted with that application a voided check for the bank account identified on the CMS-588.[7] ALJ Decision at 7 (accepting for purposes of summary disposition WNEC's undisputed allegation to this effect at MSD at 6). WNEC submitted a second Form 855B to TrailBlazer on February 2, 2009. ALJ Decision at 2. On May 14, 2009, CMS notified WNEC that its "**agreement** for participation in the Medicare program" had been accepted and that its effective date of participation was March 18, 2009, "the date your facility met **all** Federal requirements." CMS Ex. 7, at 1 (emphasis in original), cited in ALJ Decision at 2. WNEC requested reconsideration of that effective date, asking for an effective date of July 29, 2008, the date of its AAAHC accreditation. *Id*. On August 17, 2009, CMS affirmed its determination that the effective date was March 18, 2009, finding that WNEC did not meet all applicable federal requirements for participation in Medicare on July 29, 2008 because TrailBlazer "had not yet approved Form CMS-855." *Id.* at 3.

WNEC requested an ALJ hearing on the matter pursuant to 42 C.F.R. Part 498. In the proceedings before the ALJ, both parties moved for summary disposition.

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[6] WNEC alleged in its Motion for Summary Disposition that it faxed the information in question to TrailBlazer on December 23, 2008. CMS did not dispute this allegation. Thus, it appears that a March 3, 2009 letter from TrailBlazer to WNEC stating that TrailBlazer received this information on January 23, 2009 (Petitioner Exhibit M) meant to refer to the same date in the previous month.

[7] Because TrailBlazer requested only the voided check and not the CMS-588, we infer that WNEC submitted the latter with its September 3, 2008 enrollment application. However, the record does not include a copy of the CMS-588 submitted by WNEC. The May 2010 version of the form is available on CMS's website at http://www.cms.gov/cmsforms/downloads/CMS588.pdf . It includes a section titled "Financial Institution Information" with spaces for the "Depositor Account Number" and "Type of Account," below which the following statement appears: "Please include a confirmation of account information on bank letterhead or a voided check. . . . This information will be used to verify your account number."

The ALJ Decision

The ALJ granted summary judgment for CMS, concluding that, viewing the material facts in the light most favorable to Petitioner, . . . the law compels [the] conclusion that Petitioner's effective date is March 18, 2009." ALJ Decision at 5. Relying on the analysis of another ALJ in *Innovative Pain Treatment Surgery Center of Temecula, Inc.*, DAB CR1932 (2009), the ALJ determined that the effective date provision in 42 C.F.R. § 489.13(d)(1)(i) applied here. ALJ Decision at 7. In DAB CR1932, the ALJ concluded that the submission of "information that is required to be provided in" CMS Form 855B is an additional requirement under the terms of 42 C.F.R. § 489.13(d)(1)(i). DAB CR1932, at 6 (quoted in ALJ Decision at 6). In reaching this conclusion, the ALJ stated in relevant part that the absence of any provision in the regulations—

> specifying CMS Form 855B as an "additional requirement". . . is not determinative. 42 C.F.R. Part 416 gives CMS the authority to set requirements for an ASC's participation in the Medicare program. And Part 416 specifically provides that CMS will review whatever other evidence relat[es] to the qualification of the ASC for enrollment. 42 C.F.R. §416.26(c). It would be impracticable, indeed impossible, to specify all forms and information requirements necessary in the regulation.

DAB CR1932, at 7 (quoted in ALJ Decision at 7).

The ALJ proceeded to reject WNEC's argument that, because TrailBlazer "unreasonably delayed processing its enrollment application" and failed "to notify it regarding what it needed to provide to complete its enrollment application," WNEC was entitled to an effective date earlier than March 18, 2009. ALJ Decision at 7. The ALJ stated:

> For purposes of this summary disposition analysis, I accept that: Petitioner attempted to discover what it needed to complete its application . . . . and Petitioner was not informed by a TrailBlazer employee that it needed to submit a voided check or deposit slip until the day after TrailBlazer denied its first enrollment application.

Id. The ALJ concluded, however, that, even accepting WNEC's view of the material facts, WNEC was not entitled to an earlier effective date because WNEC "did not meet all federal requirements until it had submitted a complete CMS Form 855B enrollment application." *Id*. Characterizing WNEC's arguments as "unmistakably equitable arguments," the ALJ stated that he had "no authority under equitable principles to establish an earlier effective date." *Id*. at 8.

Standard of Review

Whether summary judgment is appropriate is a legal issue that we address *de novo*. *Lebanon Nursing and Rehabilitation Center*, DAB No. 1918 (2004). Summary judgment is appropriate when the record shows that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. *See Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986); *Everett Rehabilitation and Medical Center*, DAB No. 1628, at 3 (1997). The standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. *Departmental Appeals Board, Guidelines-- Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program*, http://www.hhs.gov/dab/divisions/appellate/guidelines/prosupenrolmen.html.

Analysis

1. The submission of a completed enrollment application is an additional requirement within the meaning of section 489.13(d)(1); however, the ALJ erred in treating as an additional requirement the provision of a voided check for the bank account shown on the EFT agreement.

The ALJ concluded generally, and WNEC does not now dispute, that the submission of a completed enrollment application, including supporting documentation, is an additional requirement within the meaning of section 489.13(d)(1), i.e., a requirement "in addition to those included in the accrediting organization's approved program." The decision on which the ALJ relies, *Innovative Pain Treatment Surgery Center of Temuculah*, cites to section 416.26(c) as authority for this interpretation, seemingly implying that that section permits CMS to require, on an ad hoc basis, whatever documentation it wishes. We read section 416.26(c) as simply stating that CMS will determine whether an ASC meets the conditions for coverage in subpart C of Part 416 based on the survey agency recommendation (where applicable) and other evidence required by the regulations. We nevertheless find express authority for the ALJ's general conclusion in section 424.510(d)(1), which makes the submission of "a complete enrollment application and supporting documentation" a requirement for enrolling in the Medicare program.[8]

Innovative Pain Treatment Surgery Center of Temuculah addressed only whether a completed Form 855B enrollment application was an additional requirement within the meaning of section 489.13(d)(1). As just noted, the additional requirement in section 424.510(d)(1) encompasses not only the 855B but also "supporting documentation." The ALJ found that WNEC did not meet this additional requirement because it failed to provide a voided check for the bank account shown on its EFT agreement. Thus, the ALJ concluded, in effect, that "supporting documentation" for the enrollment application

[8] Although this requirement did not exist at the time section 489.13(d) was promulgated, there is nothing in section 489.13(d) which limits its application to only those requirements then in existence.

included not only the EFT agreement referred to in the regulations, but also the voided check. For the following reasons, we find no support for that conclusion.

- Nothing in section 424.510 or elsewhere in CMS's regulations identifies a voided check as part of the "supporting documentation" that section 424.510(d)(1) requires for an enrollment application. Section 424.510(d)(2) (titled "*Content of the enrollment application*") states in subsection (d)(2)(iv) that "providers and suppliers must submit the CMS-588 form." Thus, the regulations identify the CMS-588 as supporting documentation for the enrollment application. The regulations do not state that supporting documentation for the CMS-588 (which would include a voided check) is required to be submitted.

- The preamble to the final rule adopting Part 424 states that "[t]o assist providers and suppliers in determining what documentation must be submitted with an enrollment application, we are revising section 17 of the provider/supplier enrollment application to clarify what documents must be submitted with the enrollment application." 71 Fed. Reg. 20754, 20767 (2006). Section 17 of Form 855B, the enrollment application for ASCs, is titled "Supporting Documents" and lists "Completed Form CMS-588, Authorization Agreement for Electronic Funds Transfer," as "Mandatory For All Provider/Supplier Types." CMS Ex. 1, at 31. Section 17 does not state that any supporting documentation must be submitted with the CMS-588.

- CMS's Program Integrity Manual (PIM) in effect during the period in question states that the contractor shall "ensure that the provider has completed and signed the CMS-588," but makes no reference to supporting documentation for that form. PIM, chapter 10, section 4.4.C. (Rev. 218, issued 8-10-07, accessible at http://www.cms.gov/Transmittals/Downloads/R218PI.pdf).

- The procedures established in the PIM for processing enrollment applications, as in effect during the time in question here, required that, within 15 days after receipt of the application, the contractor "pre-screen" the application to ensure that the provider "[c]ompleted all required data elements on the application" and furnished "all required supporting documentation[.]" PIM, chapter 10, section 3.1.A (Rev. 150, issued 6-30-06, accessible at http://www.cms.gov/transmittals/downloads/R150PI.pdf). The PIM further stated:

  > If the provider: (1) files an application with at least one missing required data element, or (2) fails to submit all required supporting documentation, the contractor shall send a letter to the provider . . . that contains, at a minimum, the elements listed below. (The letter must be sent within the aforementioned 15-day period.)
  >
  > - A list of all missing data or documentation;

> - A request that the provider submit the data within a contractor-specified timeframe . . . .
>
> * * * * *
>
> - A fax number and mailing address to which the missing data or documentation can be sent.
>
> *Id*. Even if a CMS contractor could impose an additional requirement through the letter described in the PIM (which is questionable), TrailBlazer failed to do so here. The only items of missing information checked on TrailBlazer's December 22, 2008 letter to WNEC were data elements on the Form 855B itself.

CMS asserted before the ALJ that TrailBlazer's December 22, 2008 letter clearly identified a missing supporting document for the EFT agreement as a deficiency in WNEC's enrollment application. ALJ Decision at 7, n.5. CMS may have been referring to the following sentence in that letter, which appears below the nine items that have a checkbox: "On the CMS588 EFT Agreement please prov[id]e the legal business name and supporting document." P. Ex. F at 1. Even if this sentence had appeared next to a checkbox that was checked to indicate missing information, however, it was not adequate to put WNEC on notice as to what "supporting document" was required.

CMS does not point to any document indicating that CMS's official interpretation of section 424.525(d)(1) is that a voided check must be included with the CMS-588 in order for the enrollment application to be considered complete, nor did CMS allege it gave WNEC notice of such a requirement. Accordingly, we conclude that the ALJ erred in determining that submission of a voided check was an additional requirement within the meaning of section 489.13(d)(1).

2. The effective date of WNEC's Medicare participation under 42 C.F.R. § 489.13(d)(1)(i) is December 23, 2008, the date on which WNEC provided information that was missing from its CMS Form 855B; however, under 42 C.F.R. § 489.13(d)(2), WNEC was entitled to an effective date retroactive to September 2, 2008, the date WNEC first began furnishing covered services to Medicare beneficiaries.

We nevertheless conclude that section 489.13(d)(1)(i) is the applicable effective date provision here since there remained an additional requirement of which WNEC did have timely notice. WNEC does not dispute that the Form 855B it submitted on September 3, 2008 was missing the data elements identified in TrailBlazer's December 22, 2008 letter. As discussed above, WNEC's failure to submit a completed enrollment application, as required by section 424.510(d)(1), was a failure to meet an additional requirement. However, it is undisputed that WNEC provided the missing required information to TrailBlazer on December 23, 2008. Accordingly, December 23, 2008 was "the date on

which" WNEC met all requirements, including this additional requirement, in accordance with the plain language of section 489.13(d)(1)(i).[9]

WNEC argued both before the ALJ and on appeal that it was entitled to an effective date of either July 29, 2008, the date of its AAAHC accreditation, or September 3, 2008, the date of its initial enrollment application. According to WNEC, it is entitled to an earlier effective date because: (1) TrailBlazer was at fault for not advising WNEC that a voided check was required to complete its September 30, 2008 enrollment application, and (2) TrailBlazer violated its own procedures by waiting until December 22, 2008 to notify WNEC that that application was incomplete instead of notifying it within 30 days after receipt of the application. WNEC disputes the ALJ's conclusion that, because "neither the Act nor the regulations require that CMS, or its contractor, process an enrollment application within a specific time frame," WNEC was making only "equitable arguments" that provide no authority to establish an earlier effective date. *See* ALJ Decision at 7-8. According to WNEC, "[b]asic notions of due process," which WNEC claims were violated here, "apply as a matter of law." WNEC Reply Br. at 4. In view of our conclusion below, however, we need not consider WNEC's due process arguments.

WNEC asserts that both of the earlier effective dates for which it argues, July 29, 2008, and September 3, 2008, "are within the one year retroactive period permitted by 42 C.F.R. § 489.13(d)(2)." RR at 6. That section provides an exception to the normal effective date rule under which the effective date may be retroactive one year back from the effective date of approval under section 489.13(d)(1)(i). This exception, designated in section 489.13(d)(2) as a "Special rule," encompasses dates within this one-year period "on which the provider or supplier furnished, to a Medicare beneficiary, covered services for which it has not been paid." The special rule "was adopted to provide authority to make payment under special conditions that assured that the providers in question were in compliance with the participation requirements at the time the services were provided, e.g., because they were already participating in one State's Medicaid program or because they had already been accredited by an approved organization." *Puget Sound*, DAB No. 1944, at 14 (2004); see also 62 Fed. Reg. 43,931 (Apr. 18, 1997) (preamble to final rule, quoted in *Puget Sound* at 13).

We conclude that, under the special rule, WNEC is entitled to an effective date of September 2, 2008, which was within the one-year period preceding WNEC's effective

[9] Even under the ALJ's view of what constituted an additional requirement within the meaning of section 489.13(d)(1), the March 18, 2009 effective date adopted by the ALJ was incorrect. The ALJ concluded that WNEC's effective date "is March 18, 2009, as that is the date that CMS has determined it met all federal participation requirements." ALJ Decision at 8. It appears that the ALJ was referring to the date CMS made its determination that WNEC met all federal requirements. As the Board discussed in Renal CarePartners, DAB No. 2271 (2009), however, approval of an enrollment application is not a requirement for a supplier to meet. The ALJ's determination that the date CMS approved WNEC's enrollment application, rather than the date WNEC met all federal requirements, was the effective date of WNEC's enrollment application is inconsistent with the plain language of section 489.13 (as currently in effect) as well as the preamble language in the rules adopting the effective date provisions in that section.

date of approval under section 489.13(d)(1)(i) (December 23, 2008). WNEC's Vice President of Operations alleged, and CMS did not dispute, that WNEC began performing endoscopy procedures eligible for Medicare reimbursement on September 2, 2008. P. Ex. R (Affidavit of Caroline M. Jeffreys) at 2.[10] Since WNEC was accredited by AAAHC when it began providing these services, this assured that WNEC was in compliance with the conditions for coverage at the time the services were provided. To the extent that the Board's decision in *Puget Sound* could be read as stating that CMS has discretion to determine whether to apply the special rule regardless of whether such assurances are present, we note that this statement is dicta and that the facts in *Puget Sound* were different from those in this case.

Conclusion

For the reasons stated above, we conclude that the ALJ erred in determining that the effective date of approval for WNEC's participation in Medicare is March 18, 2009. We further conclude based on the undisputed facts that the effective date is September 2, 2008.

/s/
Judith A. Ballard

/s/
Constance B. Tobias

/s/
Stephen M. Godek
Presiding Board Member

[10] The affidavit states that "WNEC first applied on September 2, 2008." *Id.* However, WNEC admitted and the ALJ found it undisputed that WNEC submitted its initial enrollment application to TrailBlazer on September 3, 2008. ALJ Decision; P. Brief in Response to CMS' Motion for Summary Disposition, at 3. It is possible that Ms. Jeffreys meant that WNEC began providing the services in question on whatever date WNEC submitted its enrollment application and that she simply got the date wrong. If, however, WNEC began providing services on September 2, 2008, the day before it submitted its enrollment application, it would be entitled to a September 2 effective date under section 489.13(d)(2).