Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Peter McCambridge, C.F.A.,	)	Date: June 16, 2009
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-09-215
	)	Decision No. CR1961
Centers for Medicare & Medicaid Services.	)	
	)	
	)	

DECISION

This matter is before me on the Centers for Medicare & Medicaid Services' (CMS's) Motion for Summary Affirmance. I find that the Provider Enrollment Appeals Department for First Coast Service Options (FCSO) (a CMS contracted intermediary and carrier) correctly determined that Petitioner *pro se* Peter S. McCambridge, as a certified first assistant, did not meet the requirements as a covered health care provider for purposes of Medicare enrollment. Therefore, I affirm the December 19, 2008 determination of FCSO to uphold the denial of Petitioner's application for a Medicare billing number.

I. Background

Petitioner received a certificate of completion for the First Assistant Course for Surgical Technologists from an organization known as the National Institute of First Assisting. Petitioner describes this designation as a "certified first assistant." Petitioner lives and works in the State of Florida, however, Florida law does not provide for the licensing of certified first assistants. Petitioner did not provide any additional information regarding his educational background or experience.

On August 13, 2008, Petitioner submitted an application for a Medicare billing number as a non-physician practitioner. Assignment of a Medicare billing number would allow Petitioner to bill Medicare directly for, and receive direct payment

for, services eligible for payment by the Medicare program. FCSO denied Petitioner's application for Medicare enrollment on September 22, 2008. On December 19, 2008 the Appeals Department for FCSO upheld the denial of Petitioner's enrollment application. Petitioner appealed the decision of FCSO by his January 8, 2009 Request for Hearing. On January 27, 2009 the case was assigned to me for hearing and decision.

I convened a prehearing conference with the parties by telephone on Wednesday, February 11, 2009 pursuant to 42 C.F.R. § 498.47. A summary of that conference appears in my Order of February 11, 2009.

CMS filed a motion for summary disposition and supporting brief, (CMS Br.) along with CMS Exhibits (CMS Exs.) 1-5. Petitioner filed an answer brief (P. Br.) and a brief in opposition to the CMS motion for summary disposition (P. Opp. Br.) Petitioner also filed a document dated January 28, 2009 entitled "Matters to be discussed during the Prehearing Conference" in support of his argument. Without objection from Petitioner, CMS Exs. 1-5 are admitted. Petitioner has proffered no additional exhibits of his own.

II. Applicable Law

Section 1866(j)(1) of the Social Security Act (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 Part B program of providers of services and suppliers. 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 by Administrative Law Judges (ALJs) and review of ALJ decisions by the Departmental Appeals Board (Board).

In provider appeals under 42 C.F.R. Part 498, the Board has determined that CMS must make a *prima facie* case that an entity has failed to comply substantially with federal requirements. *See MediSource Corporation*, DAB No. 2011 (2006). "*Prima facie*" means that the evidence is "[s]ufficient to establish a fact or raise a presumption unless disproved or rebutted." To prevail, the entity must overcome CMS's 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 F. App'x. 187 (6th Cir. 2005); *Emerald Oaks*, DAB No. 1800 (2001); *Cross Creek Health Care Center*, DAB No. 1665 (1998).

Section 1861(s) of the Act, 42 U.S.C. § 1395x(s), defines a broad range of medical and other health services that are eligible for Medicare Reimbursements, including services provided by a non-physician practitioner or an allied health professional. Under section 1842(b)(18)(C) of the Act, 42 U.S.C. § 1395u(b)(18)(C), 42 C.F.R. § 405.400, eligible "practitioners" include the following: physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical psychologist, clinical social worker, registered dietitian or nutrition professional.

Petitioner bases some of his arguments on his interpretations of certain provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and although they are, as matters of law, neither correct interpretations nor applicable to this controversy, they will be mentioned briefly below. In general, those HIPAA provisions appear at sections 1171-1179 of the Act.

III. Issue

The issue before me in this case is whether Petitioner satisfied the requirements necessary to obtain a Medicare billing number as a non-physician practitioner, as set forth in 42 C.F.R. § 405.400.

IV. Discussion

CMS has moved for summary disposition in its favor by its Motion for Summary Affirmance. 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 disposition 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).

Here, Petitioner opposes summary disposition and disagrees with CMS's contention that there are no genuine issues of material fact in dispute in this case. Petitioner believes that whether his services are reimbursable under Medicaid and whether there is a conflict in the HIPAA and Medicaid regulations are factual disputes, not legal ones. I disagree. There are no genuine issues of material fact in dispute in this case. The parties do not dispute the fact that Petitioner received a certificate for the completion of the first assistant course for surgical technologists. The dispute between the parties is over whether or not a "certified first assistant" meets the qualifications under the regulations to qualify for Medicare reimbursement. Thus, the parties' disagreement lies in the application of the law to the facts. Therefore, summary disposition is appropriate in this case.

CMS maintains that Petitioner is not qualified to enroll in the Medicare program because the Medicare Part B program does not recognize certified first assistants as non-physician practitioners eligible for Medicare enrollment under 42 C.F.R. § 405.400.

Petitioner contends that a certified first assistant is a qualified non-physician practitioner eligible for Medicare enrollment. Petitioner advances the following related arguments:

First, he asserts that he is eligible for enrollment because he is a health care provider as defined in 45 C.F.R. § 160.103 and 45 C.F.R. § 162.402;

Second, he argues that Medicaid regulations and The Health Insurance Portability and Accountability Act of 1996 are in conflict with each other. HIPAA is controlling, he says, and Congress intended that a certified first assistant be a covered practitioner eligible to enroll in Medicare;

Third, he claims that Medicare regulations at 42 C.F.R. 410.26, 410.26(7)(b), and 410.26(7)(b)(5), afford coverage for a certified first assistant; and

Finally, in culmination of his arguments, Petitioner maintains that Medicare is a health plan and as such it must obey the administrative simplification standards set out in HIPAA; that CMS Publication 100-8, Medicare Program Integrity Manual, Chapter 10 must be amended to reflect congressional intent; the Medicare Program Integrity Manual is flawed, causing the carrier to act *ultra vires*.

P. Br. 1-8; P. Opp. Br. 1-4.

The carrier denied Petitioner's Medicare enrollment application, stating that a certified first assistant is not a recognized category of non-physician practitioner eligible to enroll in the Medicare program as an individual practitioner, and that Petitioner does not have a license to qualify as a provider of services in the Medicare program.

Section 1171(3) of the Act defines "health care provider" as "a provider of services (as defined in section 1861(u)), a provider of medical or other health services (as defined in section 1861(s)), and any other person furnishing health care services or supplies." According to Petitioner, this section of the Act defines covered health care provider for purposes of Medicare enrollment. Thus Petitioner reasons that a certified first assistant is, "a provider of medical or other health services", and therefore is eligible for Medicare reimbursement as a person that furnishes medical services. Petitioner maintains that the authority for this position

is derived from HIPAA, defined by the Secretary in the regulations at 45 C.F.R. § 160.103 and 45 C.F.R. § 162.402. Petitioner states his argument as follows:

> The section 1171 of the HIPPA (*sic*) Act explicitly makes Medicare subject to the standards and implementation specifications promulgated by the Secretary, while entities carrying out others are implicitly covered by the scope of the term "health care provider." Congress' express inclusion of certain federal programs in the statute also has significance, as it constitutes an express Congressional statement that the HIPAA standards and implementation specifications apply to Medicare.

P. Br. 4.

Petitioner is incorrect. The Secretary has established a process for the enrollment of medical providers and suppliers. Only certain medical and other health services performed by participating suppliers are eligible for Medicare reimbursement. For purposes of Medicare participation and reimbursement, the term "supplier" means a physician or other practitioner, a facility, or other entity that furnishes items or services under this title. 42 U.S.C. § 1395x(d). Under 42 C.F.R. § 405.400, a non- physician practitioner is defined as a physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical psychologist, clinical social worker, registered dietitian, or nutritional professional, who is currently legally authorized to practice in that capacity by each state in which he or she furnishes services to patients or clients.

A certified first assistant simply is not included as a category in the definition of practitioners eligible for enrollment in the Medicare program, and it is significant that Congress declined to approve a statutory change that would have granted Certified Registered Nurse First Assistants the Medicare Part B status Petitioner now claims. See H.R. 822, 107th Congress (2001). It is also significant that Petitioner has been unable to show that he is "legally authorized to practice" as a certified first assistant in Florida or any other state. Thus, Petitioner, as a certified first assistant, is not a practitioner for purposes of Medicare enrollment and his services are not eligible for Medicare reimbursement.

Petitioner contends that he is a health care provider as defined in 45 C.F.R. § 160.103 and 45 C.F.R. § 162.402, that implements sections 1171 through 1179 of HIPAA. Petitioner argues that Congress intended that a "health care provider" as defined more broadly in the HIPAA regulations as, "a provider of medical or other health services . . . and any other person furnishing health care services or supplies," is controlling, and therefore he is eligible to participate in the Medicare program as a provider of medical services. P. Br. 3-8. Citing *Chevron U.S.A. v.*

Natural Resources Defense Council, Inc. 467 U.S. 837 (1984), Petitioner further argues that HIPAA and Medicare regulations are in apparent conflict with each other, and that the agency must give effect to the unambiguous expressed intent of Congress. According to Petitioner this "conflict" should be resolved in favor of the HIPAA regulations.

Petitioner's arguments are misguided. No such conflict exits. HIPAA simply is not applicable with respect to determining non-physician practitioner eligibility. Congress passed HIPAA in order to provide the first national standards for protecting the privacy of health information and for facilitating health care related electronic transactions. In this context, Congress intentionally broadly defined "health care provider" so that almost all health care workers who handle patient information would be subject to HIPAA requirements. *See* Pub. L. No. 104-191 §§ 261, 262 (1996). While the definition of a health care provider found in 45 C.F.R. § 160.103 and 45 C.F.R. § 162.402 may include the Petitioner, these definitions are only applicable to those specific regulations and HIPAA requirements. The regulations contained at 45 C.F.R. §§ 160, 162, and 164 specifically pertain to HIPAA administrative simplification rules which establish standards and requirements for the electronic transmission of certain heath information. These regulations do not affect or amend the requirements for Medicare enrollment and reimbursement set forth in 42 C.F.R. § 405.400. The regulation specifically delineates which non-physician practitioners are eligible for Medicare reimbursement. Appellate panels of the Board and Administrative Law Judges (ALJs) of this forum have consistently adhered to the rule that the plain language of a statute or regulation is always the best evidence of the meaning of that statute or regulation. *Florence Peters, D.P.M.*, DAB No. 1706 (1999); *Muhamad Salah Zoobi*, DAB CR1324 (2005). The ALJs of this forum have applied the relevant statues and regulations narrowly with respect to Medicare enrollment eligibility. *Revathi Bingi, Ed.D*., DAB CR1573 (2007); *Roger Aveyard*, DAB CR1558 (2007). Petitioner is not a physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical psychologist, clinical social worker, registered dietitian, or nutritional professional, as defined in 42 C.F.R. § 405.400, and therefore is not eligible to enroll as a non-physician practitioner.

Finally, I do not have the authority to amend the Medicare Program Integrity Manual (CMS Publication 100-8, Chapter 10, section 12.4) as Petitioner urges. The Program Integrity Manual, was created by CMS and was designed to protect the Medicare Trust Fund from fraud, waste and abuse. Congress (through the Secretary) granted CMS broad authority to achieve this goal, and CMS is not acting outside the scope of its authority by providing guidance to contractors and others to ensure that they pay the right amount for covered services rendered to eligible beneficiaries and providers.

V. Conclusion

For the reasons set out above, I grant CMS's motion for summary disposition. Having determined as a matter of law that Petitioner Peter McCambridge is not entitled to the relief he seeks, I conclude that the determination of FCSO to uphold the denial of Petitioner's application for a Medicare billing number should be, and it is, AFFIRMED.

/s/
Richard J. Smith
Administrative Law Judge