Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Better Sunrise Corporation,

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-12-638

Decision No. CR2628

Date: September 28, 2012

DECISION

Petitioner, Better Sunrise Corporation (Better Sunrise), applied for enrollment in the Medicare program, but, according to the Centers for Medicare & Medicaid Services (CMS), it was not capable of providing the services listed on its application. The Medicare contractor, acting on behalf of CMS, therefore denied the application. Petitioner now appeals, and CMS has moved for summary judgment.

For the reasons discussed below, I grant CMS's motion.

Background

On July 27, 2011, Petitioner applied to the Medicare program as an independent diagnostic testing facility (IDTF). In its enrollment application, Petitioner indicated that it would provide certain types of sleep studies and polysomnography that must be performed at the testing facility. CMS Ex. 1; *see* CMS Ex. 7 at 10. The Medicare contractor, Wisconsin Physicians Service Insurance Corporation, denied the enrollment application, finding that Better Sunrise did not qualify as an IDTF, because it was not capable of performing the studies listed in its application. CMS Ex. 9.

Petitioner sought reconsideration. In a decision dated April 2, 2012, a contractor hearing officer affirmed the denial. CMS Ex. 10. Petitioner timely appealed.

CMS moves for summary disposition. With its motion, CMS submits ten exhibits (CMS Exs. 1-10).

As discussed below, Petitioner did not comply with my pre-hearing order. It belatedly submitted its response to CMS's motion (P. Br.), along with seven exhibits (P. Exs. 1-7).

Discussion

I. Because no good cause justifies Petitioner's failure to comply with my prehearing order or its failure to respond timely to CMS's motion, it is subject to sanction under 42 C.F.R. § 498.69(b)(2).[1]

In a pre-hearing order, dated May 2, 2012, I directed the parties to file their prehearing exchanges (exhibits, witness lists and declarations, pre-hearing briefs). My order also gave a nonmoving party 30 days in which to respond to motions for summary disposition and explicitly warned that I might impose the sanctions authorized by section 1128A(c)(4) of the Social Security Act if a party failed to comply with my order. Acknowledgment and Initial Prehearing Order at 2, 5, 9 (¶¶ 1, 2, 8, 11, 22).[2] Among other sanctions, section 1128A(c)(4) allows me to dismiss the action or enter a default judgment.

CMS filed its submissions, including its motion for summary disposition, on June 5, 2012, as ordered. Petitioner, however, did not comply with my order; it did not file its pre-hearing exchange on or before the July 10, 2012 due date. Nor did it respond to CMS's motion within 30 days of receipt.

On July 23, 2012, I issued an order to show cause why this case should not be dismissed. In that order I warned that, unless Petitioner showed good cause for its disregard of my pre-hearing order, I would dismiss the case pursuant to 42 C.F.R. § 498.69(b)(2).

Petitioner responded in a submission dated August 2, 2012, received in this office on August 3, 2012. In that submission, Petitioner says that, late in the afternoon on July 3, its counsel left a message for CMS counsel, hoping to amend its application and thus

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

[2] My order is more generous to the nonmoving party than the regulations, which allow a party just 20 days to respond to a motion. 42 C.F.R. § 498.17(b).

resolve the matter without pursuing an appeal. July 4 was, of course, a holiday, and the weekend intervened, so the attorneys did not speak until the morning of July 9. Dissatisfied with CMS's ultimate response, Petitioner then decided to pursue the appeal, but did not request additional time in which to file its submissions or otherwise inform this office of its plans. P. Resp. to Order to Show Cause at 2.[3]

Petitioner thus deliberately ignored my order and missed the deadline for responding to CMS's motion. Adhering to deadlines is particularly important in enrollment appeals, such as this, because the regulations impose such strict and unforgiving timeframes. My decision must be issued within 180 days from the *date the appeal was filed*; the regulation does not provide for exceptions or extensions. 42 C.F.R. § 498.79.

Moreover, that Petitioner hoped to resolve the matter by means other than this appeal does not constitute good cause. *Quality Total Care, LLC. d/b/a The Crossings*, DAB No. 2242 (2009) (engaging in informal efforts to resolve a dispute and requesting a hearing are not mutually exclusive alternatives); *Hillcrest Healthcare, L.L.C.*, DAB No. 1879 (2003) (election to resolve dispute by other means does not excuse failure to file a timely hearing request).

II. In the alternative, CMS is entitled to summary disposition because the undisputed evidence establishes that Petitioner lacked the space and equipment necessary to conduct the attended, in-facility sleep studies listed in its application.

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. *1866ICPayday*, DAB No. 2289, at 2; *Illinois Knights Templar Home*, DAB No. 2274, at 3-4 (2009), and cases cited therein.

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[3] CMS points out other problems with Petitioner's assertions. First, when Petitioner's counsel contacted CMS counsel, she had not even filed an appearance in this case. Second, although she suggests that she filed an appearance and other submissions on July 20 (still well after the date they were due), neither this office nor CMS received any such submissions. Finally, Petitioner had ample opportunities to amend its application while the application was pending and after its denial. In fact, the contractor explicitly offered Petitioner the opportunity to correct its deficiencies and to establish its eligibility, but the applicant did not do so. CMS's Reply to Petitioner's Response to Order to Show Cause (August 8, 2012); *see* CMS Ex. 5 at 8-9; CMS Ex. 6; CMS Ex. 9 at 2.

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 Services,* 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 & Rehab. Ctr.,* DAB No. 1918 (2004).

Program requirements. To enroll in the Medicare program, a prospective provider or supplier must submit an enrollment application, which, in this case, was form CMS-855. CMS Ex. 1. The application must include accurate responses, and the applicant must submit all requested documentation. 42 C.F.R. § 424.510(d)(1) and (2). A prospective IDTF must certify that it meets the standards and related requirements listed in 42 C.F.R. section 410.33(g). If it fails to meet even one of those standards, its application will be denied. 42 C.F.R. § 410.33(h).

Among the requirements of section 410.33(g), the prospective IDTF must enroll for "any diagnostic testing services that it furnishes to a Medicare beneficiary." 42 C.F.R. § 410.33(g)(16). It must maintain a physical facility, and that facility must "contain space for equipment appropriate to the services designated on the enrollment application [and] facilities for . . . adequate patient privacy accommodations . . . ." 42 C.F.R. § 410.33(g)(3)(i). The supplier is exempt from the privacy accommodations requirement if it provides its services remotely. 42 C.F.R. § 410.33(g)(3)(ii).

Application of law to undisputed facts. Here, the parties agree that on July 27, 2011, Petitioner filed its Medicare application. In that application, it listed, by CPT (Common Procedural Terminology) Code, the tests that it would perform: 95806, 95810, 95811. CMS Ex. 1 at 33; P. Br. at 4. Published by the American Medical Association, the CPT codes describe medical, surgical, and diagnostic services in order to communicate uniform information about those services and procedures. The codes are widely used by insurers, including the Medicare program, to determine reimbursement.

Sleep medicine services include diagnostic procedures that evaluate patients for a variety of sleep disorders using in-laboratory and portable technology. The procedure codes listed in Petitioner's application all describe services that include recording, interpretation of results, and reporting. Two of the procedure codes listed – 95810 and 95811 – describe "polysomnography," sleep tests that involve "continuous, simultaneous, recording of physiological parameters for a period of at least 6 hours that is performed *in a sleep laboratory* and *attended* by a technologist or qualified health care professional." The parameters measured must include "a frontal, central, and occipital lead of EEG,

submental EMG lead[,] and a left and right EOG" plus at least four additional parameters (ECG, nasal and/or oral airflow, respiratory effort, oxyhemoglobin saturation, bilateral anterior tibialis, EMG).[4] American Medical Association, *Current Procedural Terminology, 4th ed.* at 507-09 (2012) (emphasis added); *see* CMS Ex. 8 at 1-2 (NCD (National Coverage Determinations) Manual, Pub. No. 100-3, 240.4.1 (designating tests that meet these criteria as "Type I")).[5]

CPT 95806, on the other hand, describes an "unattended" sleep study that records heart rate, oxygen saturation, respiratory airflow, and respiratory effort. American Medical Association, *Current Procedural Terminology, 2012* at 508.

According to the CPT, "attended" means that a technologist or qualified health care professional is "physically present," which means that he/she is within "sufficient proximity" to "physically respond to emergencies, to other appropriate patient needs or to technical problems at the bedside . . . throughout the recording session." *Id.* at 507. "Unattended" means that the technologist or qualified health care professional is *not* physically present with the patient during the recording session. *Id.* at 508. If the site of the service is distant from the monitoring center, it is considered "remote" (as opposed to on-site), and neither a technologist nor qualified healthcare professional is physically present at the testing site. *Id.* at 508.

Medicare reimbursement rules incorporate the CPT definitions. *See* CMS Ex. 7 (Local Coverage Determination (LCD) L31082[6]); CMS Ex. 8 (NCD Pub. No. 100-02, 240.4.1). They allow reimbursement for sleep studies and polysomnography performed in a "facility based sleep study laboratory and not in the home or mobile facility." CMS Ex. 7 at 10. An attendant must be physically present and able to intervene, if necessary. CMS Ex. 7 at 1, 2, 3, 10; CMS Ex. 8 at 2.

Although Medicare may sometimes pay for home-testing, those tests generally fall under different procedure codes, G0398, G0399, and G0400, and are reimbursed at a substantially lower rate. CMS Ex. 6; CMS Ex. 7 at 5-6.

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[4] An EEG (electroencephalogram) measures and records the brain's electrical activity. An EMG (electromyograph) measures the electrical activity of muscles. EOG (electrooculography) measures the resting potential of the retina.

[5] An NCD is the Secretary of HHS's determination as to "whether or not a particular item or service is covered nationally" by Medicare. 42 U.S.C. § 1395ff(f)(1)(B).

[6] An LCD is a determination by the Medicare contractor that a particular item or service is covered and applies in the area administered by the contractor. 42 U.S.C. § 1395ff(f)(2)(B).

Better Sunrise occupies a space of about 150 square feet. It has no sleep-room, no bed, nor other equipment necessary for in-facility testing. CMS Ex. 3 at 2, 5. The parties agree that the patient remains in his/her home during the test. A Better Sunrise employee takes equipment, including a video camera, to the residence and hooks it up. The sleep study technologist remains in the facility and monitors the test remotely, by means of a laptop computer. When the test is complete, an employee retrieves the equipment and returns it to the facility. CMS Ex. 3 at 5; P. Br. at 7. If technical or other problems arise (which seems to occur with some frequency), the "attending" technologist leaves the facility, travels to the patient's home, makes the necessary corrections, and returns to the facility to continue monitoring the test. P. Ex. 1; P. Br. at 5.

I note first that Petitioner has not come forward with evidence of specific facts showing that a dispute exists. Rather, based on the undisputed facts, Petitioner argues that its sleep studies are "attended, in-facility studies," because the monitoring technologist remains in the facility, watching the patient in real time on a computer monitor, and, "can intervene if needed." P. Br. at 5-6. But this argument does not establish that a material fact is in dispute. Whether this undisputed situation means that the facility is able to perform the tests listed in its application -the dispositive issue here- is a question of law, not of fact. This case can therefore properly be resolved on summary disposition.

Based on the undisputed facts, Petitioner is obviously incapable of performing the sleep studies listed in its application – CPT codes 95810 and 95811. "In-facility" means that both patient and technologist must be in the facility. Better Sunrise's patients receive its services at their residences, which the CPT defines as a "remote" location. American Medical Association, *Current Procedural Terminology, 2012* at 508. The sleep study is not "attended" by the sleep technologist if he/she is not present in the same building and able to physically respond to the patient's needs throughout the recording session. *Id*. at 507. Where the technologist has to leave the facility and travel to a different location in order to respond, he cannot be considered "in attendance." Moreover, as Better Sunrise's "intervention log" shows, it is not unusual for the sleep technologist to lose contact with the patient – sensors fall off or are removed or disconnected from the amplifier box, internet signals are lost. P. Ex. 1. During these periods, the sleep technologist has no contact with the patient.

Conclusion

Without good cause, Petitioner disregarded my prehearing order, interfering with the speedy and orderly conduct of these proceedings, and is therefore subject to sanction under section 1128A(c)(4) of the Act. I may therefore dismiss its appeal or enter a default judgment against it. In the alternative, CMS is entitled to summary disposition,

because the undisputed evidence establishes that Better Sunrise lacked the space and equipment necessary to conduct the attended, in-facility sleep studies listed in its Medicare enrollment application. I therefore grant CMS's motion.

/s/
Carolyn Cozad Hughes
Administrative Law Judge