Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Bellmore Medical PLLC,

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-12-625

Decision No. CR2648

Date: October 17, 2012

DECISION

Petitioner, Bellmore Medical PLLC (Bellmore or Petitioner), appeals the Centers for Medicare and Medicaid Services (CMS) contractor reconsideration decision issued on April 12, 2012. I grant summary judgment and sustain the determination of CMS finding that the undisputed evidence establishes that CMS properly enrolled Petitioner in the Medicare program effective February 13, 2012.[1]

[1] Although the contractor erroneously referred to January 15, 2012 as Petitioner's "effective date" (P. Exs. 2-3), regulations require the contractor to assign the date of receipt of the application as the effective date of Petitioner's enrollment while permitting the contractor to grant retrospective billing privileges for up to 30 days prior to the effective date. 42 C.F.R. § 424.521(a)(1). Thus, I am treating the contractor's action as if it intended to set February 13, 2012, as the effective date of Petitioner's enrollment and permitting Petitioner to bill retrospectively for services provided beginning on January 15, 2012.

I. Background

Petitioner is a medical practice specializing in dermatology. On April 12, 2012, the CMS contractor issued an unfavorable reconsideration denying Petitioner's request that it change Petitioner's effective date for Medicare billing privileges to November 1, 2011, the date that Petitioner first began providing services to Medicare patients. Petitioner filed a hearing request (HR) with the Civil Remedies Division of the Departmental Appeals Board on April 20, 2012 and included five accompanying unmarked exhibits (three contractor notices dated January 17, 2012, March 20, 2012, and April 12, 2012; a copy of Petitioner's request for reconsideration; and a list of unpaid claims between November 2, 2011 and January 13, 2012) I have marked the exhibits as P. Exs. 1-6 respectively. The case was assigned to me for hearing and decision.

In accordance with my Acknowledgment and Pre-hearing Order issued on May 1, 2012, CMS filed a Motion for Summary Judgment and Pre-Hearing Brief (CMS Br.), accompanied by two exhibits (CMS Exs. 1-2), on June 5, 2012. On July 25, 2012, Petitioner responded to the CMS Motion for Summary Judgment (P. Br.). Petitioner did not submit additional proposed exhibits. In the absence of objection, I admit P. Exs. 1-6 and CMS Exs. 1-2 into the record.

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. Payment under the program for services rendered to Medicare beneficiaries may only be made to eligible providers of services and suppliers. Act §§ 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395(u)(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)).

A provider or supplier must be enrolled in the Medicare program and be issued a billing number to have billing privileges and to be eligible to receive payment for services rendered to Medicare eligible beneficiaries. 42 C.F.R. § 424.505.

II. Discussion

A. Issue

The issue in this case is whether CMS's contractor and CMS had a legitimate basis for determining the effective date of Petitioner's enrollment and retrospective billing privileges in the Medicare program.

B. Applicable Standard

The Departmental Appeals Board (Board) stated the standard for summary judgment:

> 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. . . . The party moving for summary judgment bears the initial burden of showing that there are no genuine issues of material fact for trial and that it is entitled to judgment as a matter of law. . . . To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact – a fact that, if proven, would affect the outcome of the case under governing 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.

Senior Rehab. & Skilled Nursing Ctr., DAB No. 2300, at 3 (2010) (citations omitted).

The role of an Administrative Law Judge (ALJ) in deciding a summary judgment motion differs from the ALJ's role in resolving a case after a hearing. The ALJ should not assess credibility or evaluate the weight of conflicting evidence. *Holy Cross Vill. at Notre Dame, Inc.*, DAB No. 2291, at 5 (2009).

C. Findings of Fact and Conclusions of Law

1) CMS's contractor and CMS and its contractor properly determined Petitioner's effective date of Medicare enrollment.

The material facts in this case are not disputed, and I draw all reasonable inferences in favor of Petitioner. On November 1, 2011, Petitioner began providing services to Medicare beneficiaries. HR. On December 15, 2011, Petitioner submitted an application to the Medicare contractor, National Government Services (NGS), to attain billing privileges for services performed by Dr. Morris Westfried on behalf of Bellmore. HR . However, on January 15, 2012, NGS informed Petitioner that the application for Dr. Westfried could not be processed because Bellmore itself was not yet enrolled in the Medicare program. HR; P. Ex. 1. Petitioner subsequently submitted an application for Bellmore to enroll as a supplier in the Medicare program. NGS received Bellmore's Medicare enrollment application on February 13, 2012. CMS Ex. 1. On March 20, 2012, NGS approved Petitioner's application to enroll as a supplier in the Medicare program with the effective date from which Bellmore could bill for services provided beginning January 15, 2012. P. Ex. 2.

Petitioner contends that the effective date of enrollment should be November 1, 2011, the date it began rendering services to Medicare beneficiaries. Bellmore does not deny that the CMS contractor received its completed enrollment application on February 13, 2012. However, Petitioner argues that the enrollment application did not properly warn applicants that it would "only be granted enrollment 30 days prior from the date the application was received." HR; P. Br. at 1. Petitioner notes that page 16 of the application requests the date that the applicant first saw a Medicare patient and as such believed that it would be permitted to retrospectively bill for services beginning the date that it began providing services to Medicare patients. HR. Further, Petitioner argues that they are a small but needed practice in the community and any loss of income would cause financial hardship. HR.

The effective date of Medicare enrollment and billing privileges is dictated by 42 C.F.R. § 424.520(d). The regulation provides:

> (d) *Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations.* The effective date for billing privileges for physician, nonphysician practitioners, and physician and nonphysician practitioner organizations is the later of the date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor or the date an enrolled physician or nonphysician practitioner first began furnishing services at a new practice location.

(Italics in original, emphasis added).

An enrolled provider or supplier may bill Medicare for services provided to Medicare eligible beneficiaries up to 30 days prior to the effective date of enrollment, if circumstances precluded enrollment before the services were provided. Retrospective billing for up to 90 days prior to the effective date of enrollment is permitted only in case of a Presidentially-declared disaster. 42 C.F.R. § 424.521.

The regulation is clear, and the effective date for Medicare billing privileges is determined according to the later of the two dates specified by the regulation. The "date of filing" is the date that the Medicare contractor receives a signed enrollment application that the Medicare contractor is able to process to approval. 42 C.F.R. § 424.510(d)(1); 73 Fed. Reg. 69,726, 69,769 (Nov. 19, 2008). Because it is undisputed that the contractor received Petitioner's enrollment application on February 13, 2012, which is after the date Petitioner began providing services, the regulation dictates that this is the effective date of Petitioner's enrollment, and I have no discretion to determine an earlier effective date.

2) I am unable to waive the legal requirements for Petitioner.

Petitioner made various arguments for equitable relief despite not meeting the legal requirements for an earlier effective date. Petitioner did not argue that it filed an application on an earlier date than CMS determined or that the contractor or CMS incorrectly applied the regulatory criteria. I am without authority to order either NGS or CMS to provide an exemption to Petitioner under the circumstances. Even accepting all of Petitioner's assertions as true, Petitioner's equitable arguments give me no ground to grant Petitioner an earlier effective date of enrollment. *See US Ultrasound*, DAB No. 2302, at 8 (2010) ("Neither 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."). Moreover, I have no authority to declare statutes or regulations invalid or ultra vires. *1866ICPayday.com, L.L.C.*, DAB No. 2289, at 14 (2009) ("An ALJ is bound by applicable laws and regulations and may not invalidate either a law or regulation on any ground."). Thus, I have no authority to change Petitioner's Medicare enrollment date based upon equitable considerations. Although it may be possible to sympathize with aspects of Petitioner's position, the regulations were promulgated with the understanding that limited retrospective billing periods were a necessary means to further program integrity. *See* 73 Fed. Reg. at 69,768.

Accordingly, I conclude that Petitioner's effective date of Medicare enrollment was February 13, 2012, the date on which NGS received Bellmore's complete enrollment application that could be processed to approval. Petitioner was also properly authorized to retrospectively bill Medicare for services provided to Medicare beneficiaries up to 30 days prior to the effective date of enrollment starting on January 15, 2012.

/s/
Joseph Grow
Administrative Law Judge