Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Robert M. Barbati, M.D.,
(NPI: 1134219967),

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-12-786

Decision No. CR2670

Date: November 21, 2012

DECISION

Petitioner, Robert M. Barbati, M.D. appears *pro se* and appeals the Centers for Medicare and Medicaid Services (CMS) contractor reconsideration decision issued on March 27, 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 September 26, 2011.[1]

[1] CMS explains in a footnote to its brief that the Medicare contractor erroneously referred to August 27, 2011 as Petitioner's effective date of enrollment. The regulations require the contractor to assign the date of receipt of the application that is subsequently processed to approval 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. Thus, I am treating the contractor's action as if it intended to set September 26, 2011 as the effective date of Petitioner's enrollment, with the regulations permitting Petitioner to bill retrospectively for services provided beginning on August 27, 2011.

I. Procedural History

Petitioner is a gastroenterologist. On March 27, 2012, the CMS contractor, First Coast Service Options, Inc. (First Coast), issued an unfavorable reconsideration decision denying Petitioner's request that it change Petitioner's effective date for Medicare billing privileges to June 1, 2011. CMS Exhibit (CMS Ex.) 3.

Petitioner filed a hearing request (HR) with the Civil Remedies Division of the Departmental Appeals Board on May 19, 2012, and the case was assigned to me for hearing and decision. In accordance with my Acknowledgment and Pre-hearing Order issued on June 6, 2012, CMS timely filed its pre-hearing exchange, incorporating a Motion for Summary Judgment and brief (CMS Br.), with six exhibits (CMS Exs. 1-6), on July 9, 2012. Petitioner did not respond to the CMS Motion for Summary Judgment nor did Petitioner file a pre-hearing exchange as directed by my June 6, 2012 Order. I subsequently issued an Order to Show Cause to Petitioner on August 28, 2012.

On September 7, 2012, Petitioner submitted his response (P. Response) to the Order to Show Cause. Petitioner's response, which is virtually identical to his HR, does not dispute the facts set forth in the CMS motion. Therefore, this matter is appropriate for a decision on the written record by summary judgment.

II. Background 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. 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 the U.S. Department 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. Further, physicians must report a change in practice location to their Medicare contractor within 30 days. 42 C.F.R. § 424.516(d)(1)(iii).

III. 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 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. Petitioner submitted a Medicare enrollment application to First Coast to update his provider information, specifically, to submit a change in his practice

locations starting as of May 16, 2011. CMS Ex. 1. First Coast received Petitioner's Medicare enrollment application on September 26, 2011. CMS Ex. 5. On November 23, 2011, First Coast notified Petitioner that his Medicare enrollment application had been approved for direct reimbursement of services provided at the new locations starting as of August 27, 2011. CMS Ex. 4.

Petitioner has not contested the arguments CMS presents in its brief but contends that his effective date of enrollment should be June 1, 2011. Petitioner does not deny that the CMS contractor received his completed application on September 26, 2011. Petitioner argues, however, that his effective date should be earlier because he was unaware that he needed to update his provider information because he was already a Medicare provider, and he provided "medical care in the hospital setting to the Medicare recipients in good faith." CMS Ex. 2; HR; P. Response. Petitioner argues further that he "provided emergency on-call services to Medicare patients" without concern as to whether they were insured. CMS Ex. 2. He states that not receiving two months of revenue would be a "financial hardship." HR; P. Response.

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 September 26, 2011, which is after the date Petitioner began providing services at his new practice locations, 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. I am without authority to order either First Coast 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.").

Petitioner did not argue that he filed an application on an earlier date than CMS determined or that the contractor or CMS incorrectly applied the regulatory criteria. I have no authority to change Petitioner's Medicare enrollment date based upon equitable considerations. Although it is 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 September 26, 2011, the date on which First Coast received Petitioner'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 August 27, 2011.

/s/
Joseph Grow
Administrative Law Judge