Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Primary Care Redmond, PLLC
(NPI No. 279954521),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-12-922

Decision No. CR2675

Date: December 13, 2012

DECISION

The effective date of Medicare enrollment of Petitioner, Primary Care Redmond, PLLC, is December 12, 2011, with billing privileges retroactive to November 12, 2011.

I. Background

Noridian Administrative Services, LLC (Noridian), a Medicare contractor for the Centers for Medicare and Medicaid Services (CMS), notified Petitioner by letter dated February 2, 2012, that Petitioner's Medicare enrollment application was approved with an effective date of December 12, 2011.[1] CMS Exhibit (CMS Ex.) 1 at 9-10.

[1] The Noridian form letter is confusing. In a box titled "Medicare Enrollment Information" there is an entry for an "effective date" of 11/13/2011, but there is also an entry that states Petitioner's status was participating effective December 12, 2011. The correct interpretation of the letter is that Noridian determined that Petitioner's effective date of enrollment was December 12, 2011 with billing privileges retroactive to November 13, 2011. On April 18, 2012, Noridian sent Petitioner another notice correcting the date for retroactive billing to November 12, 2011. CMS Ex. 2 at 1.

On February 14, 2012, Petitioner requested reconsideration of the initial decision arguing that its effective date of Medicare enrollment should be changed to September 1, 2011. CMS Ex. 1 at 4. On April 16, 2012, Noridian issued a reconsideration decision denying Petitioner's request for an earlier effective date for enrollment and billing privileges. CMS Ex. 1 at 1-3.

Petitioner filed a request for hearing before an administrative law judge (ALJ) that was received at the Civil Remedies Division of the Departmental Appeals Board on June 26, 2012. The case was assigned to me for hearing and decision and an Acknowledgment and Prehearing Order (Prehearing Order) was issued on July 18, 2012. On August 17, 2012, CMS filed its prehearing brief and motion for summary judgment (CMS Br.) with CMS Exs. 1 through 3. No objection has been raised to my consideration of CMS Exs. 1 through 3 and they are admitted as evidence. On September 17, 2012, Petitioner filed a prehearing brief and response to CMS's motion for summary judgment (P. Br.) with six proposed exhibits marked CMS Ex. 4, CMS Ex. 5, TS (Transaction Summary) Ex. 6, CMS Ex. 7, and Petitioner's Attachments (P. Atts.) A, B, and C.[2] On October 1, 2012, CMS filed a reply brief (CMS Reply). CMS objects to my consideration of Petitioner's proposed exhibits and argues that they should be excluded because they are new evidence and Petitioner has not shown good cause for them being offered for the first time before the ALJ, as required by 42 C.F.R. § 498.56(e). CMS Reply at 1, 4. The Noridian reconsideration decision states that "[a]ll documentation in the file for this case has been reviewed." CMS Ex. 1 at 2. Petitioner's Attachment B, CMS Ex. 4, CMS Ex. 5, TS Ex. 6, and CMS Ex. 7 all appear on their face to be documents that should have been in the file reviewed on reconsideration or otherwise in the government's control. Accordingly, P. Att. B, CMS Ex. 4, CMS Ex. 5, TS Ex. 6, and CMS Ex. 7 are admitted as evidence. P. Atts. A and C, may be new documents, but more importantly they are not relevant because they do not help me resolve any issue in dispute before me. To the extent Attachments A and C have been offered as bearing upon Petitioner's credibility, Petitioner's credibility is not in issue on summary judgment, and Attachments A and C are not relevant for that reason. Petitioner's Attachments A and C are not relevant and not admitted as evidence.

[2] Petitioner's exhibits were not marked in accordance with my July 18, 2012 Prehearing Order and the Civil Remedies Division Procedures (CRDP). Petitioner's exhibits have not been returned to Petitioner for correct marking as the exhibits are distinguishable despite the incorrect marking.

II. Discussion

A. Applicable 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-eligible beneficiaries may only be made to eligible providers of services and suppliers.[3] Act §§ 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395(u)(h)(1)). Administration of the Part B program is through contractors. Act § 1842(a) (42 U.S.C. § 1395u(a)).

The Act requires that the Secretary of Health and Human Services (the Secretary) 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)). Pursuant to 42 C.F.R. § 424.505,[4] 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 a Medicare eligible beneficiary. The effective date of enrollment in Medicare for physicians, non-physician practitioners, and physician and non-physician practitioner organizations, such as Petitioner, is governed by 42 C.F.R. § 424.520(d). The effective date of enrollment for these suppliers may only be the later of two dates: the date when the supplier filed an application for enrollment that was subsequently approved by a Medicare contractor charged with reviewing the application on behalf of CMS; or the date when the supplier first began providing services at a new practice location. 42 C.F.R. § 424.520(d). The date of filing of the enrollment application is the date when the complete enrollment application and supporting documentation is received by the designated Medicare contractor. 42 C.F.R. § 424.510(d)(1)-(3); 73 Fed. Reg. 69,726,

[3] A "supplier" furnishes services under Medicare, and the term supplier applies to physicians or other practitioners and facilities that are not included within the definition of the phrase "provider of services." Act § 1861(d) (42 U.S.C. § 1395x(d)). A "provider of services," commonly shortened to "provider," includes hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, hospice programs, and a fund as described in sections 1814(g) and 1835(e) of the Act. Act § 1861(u) (42 U.S.C. § 1395x(u)). The distinction between providers and suppliers is important because they are treated differently under the Act for some purposes.

[4] Citations are to the version of the Code of Federal Regulations (C.F.R.) in effect at the time of Petitioner's applications, unless otherwise indicated.

69,769 (Nov. 19, 2008) (date of filing is the date that the Medicare contractor receives a signed provider enrollment application that the Medicare contractor is able to process to approval). An enrolled 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. Retroactive billing for up to 90 days prior to the effective date of enrollment is permitted only in case of a Presidentially-declared disaster pursuant to 42 U.S.C. §§ 5121-5206. 42 C.F.R. § 424.521.

B. Issues

Whether summary judgment is appropriate;

Whether CMS properly determined the effective date of Petitioner's Medicare enrollment and billing privileges.

C. Findings of Fact, Conclusions of Law, and Analysis

My conclusions of law are set forth in bold text followed by my findings of fact and analysis.

1. Summary judgment is appropriate.

A provider or supplier denied enrollment in Medicare or whose enrollment had been revoked has a right to a hearing and judicial review pursuant to section 1866(h)(1) and (j) of the Act and 42 C.F.R. §§ 424.454(a), 498.3(b)(1), (5), (6), (8), (15), (17), 498.5. A hearing on the record, also known as an oral hearing, is required under the Act. Act §§ 205(b), 1866 (h)(1) and (j); *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743, 748-51 (6th Cir. 2004). A party may waive appearance at an oral hearing, but must do so affirmatively in writing. 42 C.F.R. § 498.66. In this case, Petitioner has not waived the right to oral hearing or otherwise consented to decision based only upon the documentary evidence or pleadings. Accordingly, disposition on the written record alone is not permissible, unless the CMS motion for summary judgment has merit.

Summary judgment is not automatic upon request but is limited to certain specific conditions. The procedures established by 42 C.F.R. pt. 498 do not include a summary judgment procedure. However, appellate panels of the Departmental Appeals Board (the Board) have long recognized the availability of summary judgment cases subject to 42 C.F.R. pt. 498, and the Board's interpretative rule has been recognized by the federal courts. *See, e.g.*, *Crestview*, 373 F.3d at 749-50. Furthermore, a summary judgment procedure was adopted as a matter of judicial economy within my authority to regulate the course of proceedings and made available to the parties in the litigation of this case by my Prehearing Order.

Summary judgment is appropriate and no hearing is required where either: there are no disputed issues of material fact and the only questions that must be decided involve application of law to the undisputed facts; or, the moving party must prevail as a matter of law even if all disputed facts are resolved in favor of the party against whom the motion is made. The Board follows the general approach of the federal courts in evaluating whether or not summary judgment in lieu of a hearing is appropriate. The movant bears the initial burden of demonstrating that there are no genuine issues of material fact for trial and that the movant is entitled to judgment as a matter of law.

When confronted with a properly supported motion for summary judgment, the nonmoving party "may not rest upon the mere allegations or denials of his pleading, but . . . must set forth specific facts showing that there is a genuine issue for trial." *Anderson v. Liberty Lobby, Inc*., 477 U.S. 242, 248 (1986) (quoting *First Nat'l Bank of Az. v. Cities Serv. Co.*, 391 U.S. 253, 249 (1968)); *see also* Fed. R. Civ. P. 56(c); *Venetian Gardens*, DAB No. 2286, at 10-11 (2009); *Ill. Knights Templar Home*, DAB No. 2274, at 3-4 (2009); *Garden City Med. Clinic*, DAB No. 1763 (2001), *Everett Rehab. & Med. Ctr.*, DAB No. 1628, at 3 (1997) (in-person hearing required where nonmovant shows there are material facts in dispute that require testimony); *Big Bend Hosp. Corp., d/b/a Big Bend Hosp. Ctr.*, DAB No. 1814, at 13 (2002) (in some cases, any factual issue is resolved on the face of the written record because the proffered testimony, even if accepted as true, would not make a difference). In opposing the motion for summary judgment, the nonmovant bears the burden of showing that there are material facts that are disputed either affecting the movant's prima facie case or that might establish a defense. It is insufficient for the nonmovant to rely upon mere allegations or denials to defeat the motion and proceed to hearing. The nonmovant must, by affidavits or other evidence that sets forth specific facts, show that there is a genuine issue for trial. If the nonmovant cannot show by some credible evidence that there exists some genuine issue for trial, then summary judgment is appropriate and the movant prevails as a matter of law. *Anderson*, 477 U.S. at 247. A test for whether an issue is regarded as genuine is if "the evidence [as to that issue] is such that a reasonable jury could return a verdict for the nonmoving party." *Id*. at 248. In evaluating whether there is a genuine issue as to a material fact, an ALJ must view the facts and the inferences to be drawn from the facts in the light most favorable to the nonmoving party. *Pollock v. Am. Tel. & Tel. Long Lines*, 794 F.2d 860, 864 (3rd Cir. 1986).

The standard for deciding a case on summary judgment and an ALJ's decision-making in deciding a summary judgment motion differs from resolving a case after a hearing. On summary judgment, the ALJ does not make credibility determinations, weigh the evidence, or decide which inferences to draw from the evidence, as would be done when finding facts after a hearing on the record. Rather, on summary judgment the ALJ construes the evidence in a light most favorable to the non-movant and avoids deciding which version of the facts is more likely true. *Holy Cross Vill. at Notre Dame, Inc*, DAB

No. 2291, at 5 (2009). The Board also has recognized that on summary judgment it is appropriate for the ALJ to consider whether a rational trier of fact could find that a party's evidence would be sufficient to meet that party's evidentiary burden. *Dumas Nursing and Rehab., L.P.*, DAB No. 2347, at 5 (2010); *Ill. Knights Templar Home*, DAB No. 2274, at 8.

The material facts in this case, as discussed hereafter, are not in dispute and there is no genuine dispute as to any material fact that requires a trial. The issues in this case that require resolution are issues of law related to the interpretation and application of the regulations that govern enrollment and billing privileges in the Medicare program to the undisputed facts of this case. The issues in this case must be resolved against Petitioner as a matter of law. Accordingly, summary judgment is appropriate.

2. Pursuant to 42 C.F.R. § 424.520(d), Petitioner's effective date of Medicare enrollment was December 12, 2011, the date on which Petitioner submitted an enrollment application that could be processed to approval.

3. Pursuant to 42 C.F.R. § 424.521(a)(1), Petitioner was authorized to bill Medicare for services provided to Medicare eligible beneficiaries up to 30 days prior to Petitioner's effective date of enrollment.

a. Facts

The facts are not disputed and any inferences are drawn in favor of Petitioner.

Petitioner is a clinic in Redmond, Washington owned and operated by two nurse practioners. The clinic opened for patient visits on September 1, 2011. Hearing Request (HR); P. Br. at 2; CMS Ex. 1 at 4. Petitioner attempted to apply for Medicare enrollment in August of 2011, but was unable to complete the Medicare enrollment application. P. Br. at 2. Petitioner sent a CMS Form 855S, an application to enroll in Medicare as a supplier of durable medical equipment with documents dated October 31, 2011, to the National Supplier Clearinghouse Palmetto GBA (Palmetto), which processes such applications. CMS Ex. 4, at 1, 35, 48, 51; P. Br at 2; CMS Reply at 2. Palmetto notified Petitioner by letter dated November 10, 2011, that Petitioner's application to enroll as a supplier of durable medical equipment was received, but the application could not be processed because it could not be verified that the application fee had been paid. CMS Ex. 5. Petitioner paid the $505 application fee; obtained proof of payment; and submitted the proof of payment to Palmetto by facsimile on November 10, 2011. TS Ex. 6. Palmetto advised Petitioner by letter dated November 15, 2011, that Petitioner's application to enroll as a durable medical equipment supplier could not be processed as the application did not show that Petitioner met accreditation and surety bond requirements. Palmetto directed that Petitioner submit a corrected application. CMS Ex.

7. Petitioner contacted Palmetto by telephone after receiving the November 15 Palmetto letter and was told that the CMS Form 855B was the correct enrollment application for Petitioner's supplier type and also that Petitioner needed a National Provider Identifier (NPI) number. P. Br. at 2-3. Petitioner mailed CMS Forms 855B and 855R[5] on December 8, 2011 and they were received by Noridian, the Medicare Part B contractor, on December 12, 2011. CMS Ex. 1 at 11-89; P. Br. at 3-4; CMS Br. at 2-3. Noridian subsequently notified Petitioner that its Medicare enrollment applications were approved with an effective date of December 12, 2011 and retroactive billing privileges to November 12, 2011. CMS Ex. 1 at 5-10; CMS Ex. 2.

b. Analysis

Petitioner does not dispute that Noridian received Petitioner's Medicare enrollment application on December 12, 2011. P. Br. at 4. Petitioner also does not dispute that the application received by Noridian on December 12, was the application that Noridian subsequently approved. Therefore, pursuant to 42 C.F.R. § 424.520(d), the effective date of Petitioner's Medicare enrollment can be no earlier than December 12, 2011. Furthermore, pursuant to 42 C.F.R. § 424.521(a)(1), Petitioner could not be authorized to bill Medicare for services provided to Medicare eligible beneficiaries prior to November 12, 2011, 30 days prior to Petitioner's effective date of enrollment.[6]

Petitioner argues that its effective date of enrollment should be either September 1, 2011 or October 31, 2011. I accept, based upon Petitioner's representations, that September 1, 2011, was the date Petitioner began rendering services to Medicare beneficiaries. Petitioner's argument appears to be based upon the second clause of 42 C.F.R. § 424.520(d), i.e., "the date an enrolled physician or nonphysician practitioner first began furnishing services at a new practice location." However, Petitioner points to no facts that would support a conclusion that Petitioner and its owner/operator nurse practitioners were previously enrolled and had simply relocated to a new practice location. Even if I accept for purposes of summary judgment that Petitioner and its owner operators were

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[5] Petitioner submitted a Medicare enrollment application, CMS 855B, and CMS 588 EFT for group billing privileges to Noridian. Petitioner also submitted a CMS 855R, Reassignment of Medicare Benefits, application for each of Petitioner's two nurse practitioners, Petitioner's owners and operators. CMS Ex. 1. Petitioner received its NPI on December 8, 2011. P. Att. B.

[6] Petitioner does not argue that there was any disaster declared by the President that precluded enrollment, which might have justified retroactive billing for 90 days pursuant to 42 C.F.R. § 424.521(a)(2).

previously enrolled and moved to a new location, Petitioner's argument overlooks that 42 C.F.R. § 424.520(d) provides that the effective date of enrollment in Medicare for physicians, non-physician practitioners, and physician and non-physician practitioner organizations, is the **later** of the two dates: the date when the supplier filed an application for enrollment that was subsequently approved by a Medicare contractor charged with reviewing the application on behalf of CMS; or the date when the supplier first began providing services at a new practice location. 42 C.F.R. § 424.520(d). There is no dispute that Petitioner submitted its applications after September 1, 2011. Petitioner appears to recognize in its prehearing brief that the second clause of 42 C.F.R. § 424.520(d) simply has no application to this case. P. Br. at 5.

October 31, 2011, is the date Petitioner sent the incomplete application to be enrolled as a durable medical equipment supplier to Palmetto. Petitioner argues that, although the October 31, 2011 application was incomplete, the incorrect form, and never approved; an application to enroll Petitioner was ultimately approved by Noridian and October 31, 2011 should be Petitioner's effective date. HR; P. Br. Petitioner cites the decision of another ALJ in *Darryl Camp, M.D., and Darryl Camp, M.D., PA*, DAB CR2342 (2011), and the decision of the Board in *Tri-Valley Family Medicine, Inc.*, DAB No. 2358 (2010) in support of its argument. The facts in the *Camp* case are distinguishable from Petitioner's case. In the *Camp* case the ALJ found that Dr. Camp's first application could have been processed to approval with corrections. *Camp* at 8. The facts in the *Tri-Valley* case are also distinguishable from Petitioner's case because the Board found that the first application filed could have been processed to approval with corrections. *Tri-Valley* at 1.[7] In Petitioner's case the application to enroll as a supplier of durable medical equipment was the wrong application, submitted to the wrong Medicare contractor, and no amount of correction of that application could lead to Petitioner's approval as a non-physician's practice organization.

Petitioner argues in its hearing request that it was difficult to locate information regarding filing either on the internet or from other resources and the Medicare contractors were not helpful. Petitioner also argues that its business has been adversely affected because it cannot file claims with Medicare for services provided between September 1, 2011 and November 12, 2011. Petitioner argues in its prehearing brief and response to the motion for summary judgment that: Petitioner was initially misinformed about the need for a NPI; the application to enroll as a supplier of durable medical equipment was submitted due to a misunderstanding related to Petitioner providing prefabricated splints and walking boots for management of acute injury and unclear information on the website;

[7] The regulations applicable in the *Tri-Valley* case were also different than those applicable in this case because 42 C.F.R. § 520(d) was not in effect when Tri-Valley filed its initial application. *Tri-Valley* at 3, 6-7.

Petitioner had technical difficulties completing the initial application and Petitioner's staff was very busy serving patients so the application to enroll as a supplier of durable medical equipment was not mailed until October 31, 2011; and Petitioner was not aware until on about November 15, 2011 based on communication with Palmetto, that it had filed the incorrect enrollment application. Even though I accept Petitioner's assertions as true for purposes of ruling on the motion for summary judgment, Petitioner's arguments are essentially equitable in nature and I have no authority to grant Petitioner relief on equitable grounds. *US Ultrasound*, DAB No. 2302, at 8 (2010), ("[n]either 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."). Petitioner points to no source of authority for me to grant it an exemption from regulatory compliance. Furthermore, I am bound by the regulations and have no authority to declare statutes or regulations invalid or ultra vires. *1866ICPayday.com, L.L.C.*, DAB No. 2289, at 14 (2009) ("[a]n 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.

Petitioner's arguments regarding erroneous advice from CMS employees and contractors or the internet may be construed to be an estoppel argument against CMS. Estoppel against the federal government, if available at all, is presumably unavailable absent "affirmative misconduct," such as fraud. *See, e.g.*, *Pacific Islander Council of Leaders*, DAB No. 2091, at 12 (2007); *Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414, 421 (1990). None of the circumstances Petitioner describes fit that standard or permit me to ignore the requirements of the regulations governing Petitioner's enrollment in Medicare.

Accordingly, I conclude that Petitioner's effective date of Medicare enrollment was December 12, 2011, the date on which Petitioner submitted an enrollment application that could be processed to approval pursuant to 42 C.F.R. § 424.520(d). Pursuant to 42 C.F.R. § 424.521(a)(1), Petitioner was authorized to bill Medicare for services provided to Medicare eligible beneficiaries up to 30 days prior to its effective date of enrollment, i.e. November 12, 2011.

III. Conclusion

For the foregoing reasons, I conclude that Petitioner's effective date of Medicare enrollment was December 12, 2011, and that Petitioner could bill for service provided to Medicare eligible beneficiaries for up to 30 days prior to Petitioner's effective date.

/s/
Keith W. Sickendick
Administrative Law Judge