Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Dawn Sea Kahrs, DC,

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-12-60

Decision No. CR2528

Date: April 16, 2012

DECISION

Petitioner, Dawn Sea Kahrs, DC (Petitioner), appeals a reconsideration decision issued on August 26, 2011. I grant summary judgment and sustain the determination of the Centers for Medicare and Medicaid Services (CMS) finding that the undisputed evidence establishes that CMS properly enrolled Petitioner in the Medicare program effective June 7, 2011.

I. Background and Procedural History

CMS notified Petitioner by letter dated July 27, 2011 that her Medicare enrollment application had been approved effective May 9, 2011.[1] CMS Exhibit (CMS Ex.) 6, at 1. On August 8, 2011, Petitioner requested reconsideration of the initial decision and requested that her effective enrollment date be changed to March 7, 2011, the date

[1] The letter was in error as the Declaration of Denise Bossingham explained. CMS Ex. 1, at 2. CMS's determination was that the effective date of Petitioner's enrollment was June 7, 2011, the date the CMS contractor received her enrollment application. However, the CMS contractor authorized Petitioner to file claims for services retrospective to May 9, 2011. CMS Ex. 1, at 2.

Petitioner first began providing services to Medicare patients. CMS Ex. 7. On August 26, 2011, a contractor hearing officer issued a reconsideration decision denying Petitioner's request for an earlier effective date of enrollment. CMS Ex. 8.

Petitioner then filed a hearing request (HR) with the Civil Remedies Division of the Departmental Appeals Board, and the case was assigned to me for hearing and decision. In accordance with my Acknowledgment and Pre-hearing Order issued on October 26, 2011, CMS filed a Motion for Summary Judgment and Pre-Hearing Brief (CMS Br.), accompanied by eight exhibits (CMS Exs. 1-8), on November 29, 2011. Petitioner did not respond to the CMS Motion for Summary Judgment, and I subsequently issued an Order to Show Cause on February 1, 2012. On February 6, 2012, Petitioner responded to my Order to Show Cause (P. Response) and explained that she did not realize she "was supposed to respond to CMS's pre-hearing brief and motion." P. Response at 2. At this time, Petitioner filed a Pre-Hearing Brief and Motion for Summary Judgment, Proposed Witness List, Proposed Exhibit List, and three exhibits (P. Exs. 1-3). On February 24, 2012, CMS responded to Petitioner's Motion for Summary Judgment and submitted a Motion to Exclude New Documentary Evidence (CMS Response) and a Supplemental Witness List accompanied by three additional exhibits (CMS Exs. 9-11). CMS did not object to Petitioner's submission as untimely and did not suggest that I dismiss this case; however, CMS moved to exclude Petitioner's new documentary evidence, namely P. Ex. 3. In the event I were to deny the CMS Motion to Exclude New Documentary Evidence, CMS requests the admission of its supplemental exhibits in response to Petitioner's new documentary evidence. On March 15, 2012, Petitioner replied to the CMS Motion to Exclude New Documentary Evidence (P. Reply) and submitted one additional exhibit.[2]

CMS argues that Petitioner did not present any documentary evidence or raise any allegations relating to a Presidentially-declared disaster exception during the reconsideration review and that Petitioner has not shown good cause for submitting new evidence for the first time at this late date. As discussed in more detail below, I sustain CMS's objection to Petitioner's new evidence and exclude from evidence P. Ex. 3 and Petitioner's supplemental exhibit, P. Ex. 10. I also exclude CMS Exs. 9-11. In the absence of further objections, I admit CMS Exs. 1-8 and Petitioner's Exs. 1-2 into the record.

II. 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 beneficiaries may only be made to eligible providers of services and suppliers. Act

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[2] Petitioner labeled this exhibit in a non-sequential manner as P. Ex. 10.

§§ 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 (the Secretary) 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)).

Pursuant to 42 C.F.R. § 424.505, 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. The effective date of a provider or supplier's enrollment in Medicare is governed by regulations at 42 C.F.R. § 424.520(d). The effective date of enrollment for a supplier may only be the later of two dates: (1) 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 (2) the date when the supplier first began providing services at a new practice location. *Id.* The date of filing of the enrollment application is the date when the designated Medicare contractor receives the complete enrollment application and supporting documentation. 42 C.F.R. § 424.510(d)(1); 73 Fed. Reg. 69,725, 69,769 (Nov. 19, 2008). 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, pursuant to 42 C.F.R. § 424.521.

III. Issue, Findings of Fact, Conclusions of Law

A. Issue

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

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 relevant facts are not disputed, and I draw all reasonable inferences in favor of Petitioner. Petitioner is the owner and operator of Graceful Waves Chiropractic in Wheeler, Oregon. HR; CMS Ex. 2. Petitioner began seeing patients on March 7, 2011. HR. Petitioner subsequently submitted a Medicare enrollment application to the Medicare contractor, Noridian Administrative Services ("Noridian"). CMS Ex. 2. It is undisputed that Noridian received Petitioner's Medicare enrollment application on June 7, 2011. On June 27, 2011, Noridian approved Petitioner's enrollment application with an effective date of June 7, 2011 with retrospective billing privileges commencing on May 9, 2011. CMS Ex. 1 at 2; CMS Ex. 6.

Petitioner contends that her effective date of enrollment should be March 7, 2011, the date she began rendering services to Medicare beneficiaries. Petitioner does not deny that CMS received her completed enrollment application on June 7, 2011. However, Petitioner argues that her effective date should be earlier because Petitioner believed she had 90 days to submit her enrollment application. She further argues the refusal of CMS to compensate Petitioner for the 60 days she provided services to Medicare beneficiaries prior to submitting her enrollment application caused an extreme financial hardship. HR; P. Response.

Petitioner states that she provided services "in good faith to the American people in my medically under-served rural area." HR. Petitioner further argues that she found the Medicare enrollment application to be misleading and believed she had 90 days to submit the enrollment application. Petitioner further asserts that completing the application

"early" was not the highest priority due to her challenging personal circumstances and pressures related to starting a new business. P. Response at 3-4. Petitioner also states that she recalls speaking to a Noridian staff member over the phone prior to submitting an enrollment application, and this employee of the CMS contractor told her "that it wasn't a problem for me to go ahead and provide care to Medicare beneficiaries. [The employee] emphasized that I should just indicate the actual 'effective date' on the forms, and I would be paid for the work I did. [The employee] did not suggest that I rush to complete the application, nor did [the employee] disclose to me that I only had 30 days to submit the application *or I would not be paid*." P. Response at 5. (Emphasis in original).

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 <u>later of the date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor</u> or the date an enrolled physician or nonphysician practitioner first began furnishing services at a new practice location.

(Emphasis added).

The regulation is clear, and the effective date for Medicare billing privileges is determined according to the latter 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. 69,725, 69,769 (Nov. 19, 2008). Because it is undisputed that the contractor received Petitioner's enrollment application on June 7, 2011, 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.

Petitioner made various arguments for equitable relief at the reconsideration level, and during this appeal, despite not meeting the legal requirements for an earlier effective date. These arguments pertained to her personal circumstances, her extreme financial hardship for not being compensated by CMS for 60 days of providing services to Medicare beneficiaries, the ambiguity of the CMS enrollment application and relevant regulations, and "misguidance and misinformation from Noridian Medicare staff prior to beginning the application process." *See* P. Response at 11. Petitioner did not argue that she 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 Noridian

or CMS to provide an exemption to Petitioner under the circumstances, even though I may sympathize with Petitioner's predicaments. 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) ("[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."). 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) ("[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.

Additionally, Petitioner's claims regarding misleading advice given to her by CMS employees and contractors may also be construed to be equitable estoppel arguments. Even assuming Petitioner accurately described what transpired during Petitioner's telephone conversations with a Noridian staff member, Petitioner does not allege any affirmative misconduct, and I am unable to grant the relief that Petitioner requests. Federal case law and Board precedent establishes that: (1) estoppel cannot be the basis to require payment of funds from the federal fisc; (2) estoppel cannot lie against the government, if at all, absent a showing of affirmative misconduct, such as fraud; and (3) I am not authorized to order payment contrary to law based on equitable grounds. It is well-settled that those who deal with the government are expected to know the law and may not rely on the conduct of government agents contrary to law. *See, e.g., Office of Personnel Mgmt. v. Richmond*, 496 U.S. 414 (1990); *Heckler v. Cmty. Health Servs. of Crawford County*, *Inc.*, 467 U.S. 51 (1984); *Oklahoma Heart Hosp.*, DAB No. 2183, at 16 (2008); *Wade Pediatrics*, DAB No. 2153, at 22 n.9 (2008), *aff'd*, 567 F.3d 1202 (10th Cir. 2009).

Accordingly, I conclude that Petitioner's effective date of Medicare enrollment was June 7, 2011, the date on which she submitted a complete enrollment application that could be processed to approval. Petitioner was also properly authorized to bill Medicare for services provided to Medicare beneficiaries up to 30 days prior to her effective date of enrollment, *i.e.*, May 9, 2011.

2) Petitioner has not shown good cause pursuant to 42 C.F.R. § 498.56(e) for submitting new evidence.

I sustain CMS's objection to Petitioner's new evidence that was not provided at the reconsideration level regarding Petitioner's eligibility for retrospective Medicare billing

for up to 90 days prior to the effective date of enrollment due to a Presidentially-declared disaster.[3]

In her letter requesting reconsideration of the initial decision dated August 8, 2011, Petitioner did not mention anything regarding a Presidentially-declared disaster which precluded her Medicare enrollment prior to providing services. Instead, Petitioner waited to advance this argument and submit new evidence until after receiving the CMS pre-hearing exchange and Motion for Summary Judgment. Petitioner argues that she was unaware of the "undisclosed . . . loophole, to account for a 90-day retrospective billing period." P. Response at 11.

While the Board has never precisely defined the term "good cause," it is clear to me that Petitioner has not shown good cause for submitting evidence relating to a Presidentially-declared disaster for the first time in response to the CMS Motion for Summary Judgment. Petitioner claims that she was not informed of the need to argue that she qualified for 90 days of retrospective Medicare billing due to a Presidentially-declared disaster by employees of CMS or its contractors; otherwise, she would have raised this argument previously. P. Reply at 7. Petitioner also argues that she did not notice "the 90-day reference" in her reconsideration decision and "took great care to keep the letters succinct and limited to one page, in the hopes it would actually be read by someone." P. Reply at 8. Petitioner contends that she left out certain details, such as a national disaster declared in Oregon, because these details "didn't seem as important for me to mention at the time" and instead focused on explaining other personal circumstances which prevented her submitting an enrollment application prior to June 7, 2011.

I conclude that Petitioner's arguments do not demonstrate good cause for her submission of new evidence at this late date because circumstances beyond her control did not prevent her from advancing it at her reconsideration review. Thus, even if I were to assume for purposes of summary judgment that a Presidentially-declared disaster prevented Petitioner from submitting her enrollment application prior to June 7, 2011, it is undisputed that she did not present this evidence or advance these arguments at the reconsideration level, or even in her request for hearing. Therefore, I am now in effect precluded from considering those arguments.

IV. Conclusion

After reviewing the evidence in the light most favorable to Petitioner, I conclude there is no genuine issue of material fact at issue here. I therefore grant summary judgment in

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[3] Petitioner's claims to the exception relate to a one-day Presidentially-declared disaster in select Oregon counties after the ill-fated events of the tsunami that struck Japan in March 2011.

favor of CMS because Petitioner submitted an application, which was subsequently approved by the contractor, on June 7, 2011 and find CMS's determination of Petitioner's effective date of Medicare enrollment was consistent with regulatory requirements. I have no authority to order CMS to make payment for claims prior to May 9, 2011 that were provided outside of the applicable 30-day retrospective billing period provided by regulation.

/s/
Joseph Grow
Administrative Law Judge