Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Jason Deal, D.C.,
(NPI: 1619316817 / PTAN: 118721002),
Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-2333

Decision No. CR4474

Date: December 1, 2015

DECISION

The effective date of Medicare enrollment and billing privileges of Petitioner Jason Deal, D.C., is December 1, 2014, with retrospective billing privileges beginning November 1, 2014.

I. Background and Procedural History

Wisconsin Physicians Service Insurance Corp (WPS), a Medicare contractor, notified Petitioner by letter dated February 7, 2015, that his Medicare enrollment application had been approved with an effective date of December 23, 2014.[1] Centers for Medicare & Medicaid Services (CMS) Exhibit (Ex.) 7. On February 26, 2015, Petitioner requested reconsideration of the initial determination and requested that the "effective date" be changed to December 11, 2013, the date Petitioner first began providing services to

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[1] WPS lists Petitioner's "effective date" as December 23, 2014. CMS Ex. 7 at 1. It is not clear if this is the effective date of enrollment or the first day that retrospective billing was permitted. 42 C.F.R. §§ 424.520(d), 424.521(a)(1). CMS asserts that the date is the effective date of enrollment. CMS Br. at 2 ¶3.

Medicare beneficiaries at LaBounty Family Chiropractic (LaBounty). P. Ex. at 2[2]. WPS notified Petitioner by letters dated March 25[3] and 30, 2015, that on reconsideration his "effective date" was changed to November 1, 2014. CMS Exs. 8, 9; P. Ex. at 3-7. The reconsidered determination states that Petitioner's enrollment applications were received on December 1, 2014, and that WPS granted an effective date of November 1, 2014. P. Ex. at 4. The terminology used by WPS in the reconsidered determination is clearly in error. Pursuant to 42 C.F.R. § 424.520,[4] the effective date of enrollment and billing privileges would be December 1, 2014, the date of filing the applications. Pursuant to 42 C.F.R. § 424.521(a), the first day authorized for retrospective billing would be November 1, 2014.

Petitioner requested a hearing (RFH) before an administrative law judge (ALJ) on April 16, 2015. RFH; CMS Ex. 10. The case was assigned to me on May 15, 2015, for hearing and decision, and an Acknowledgment and Prehearing Order (Prehearing Order) was issued at my direction.

CMS filed a motion for summary judgment, a brief in support of its motion, and CMS Exs. 1 through 10 on June 29, 2015. Petitioner filed his response to the CMS motion for summary judgment on August 26, 2015 (P. Br.). On September 2, 2015, CMS waived filing a reply brief.

Petitioner has not objected to my consideration of CMS Exs. 1 through 10 and they are admitted as evidence. CMS did not object to my consideration of the documents submitted by Petitioner with the request for hearing and they are admitted as Petitioner's exhibit.

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[2] Petitioner failed to file properly marked exhibits as part of the exchange of exhibits required by paragraph II.D.2 of the Acknowledgement and Prehearing Order (Prehearing Order) issued in this case on May 15, 2015. However, Petitioner filed with his request for hearing a packet of documents which I treat as Petitioner's exhibit (P. Ex.).

[3] CMS Ex. 8 is missing the second page of the reconsidered determination dated March 25, 2015. The complete reconsidered determination is at P. Ex. at 3-5. I infer that the letter dated March 30, 2015, was intended to implement the reconsideration determination. CMS Exs. 8, 9; P. Ex. at 3-7. My inference is consistent with the dates on the two letters and the arguments of CMS before me. CMS Br. at 2, ¶ 5.

[4] Citations are to the 2014 revision of the Code of Federal Regulations (C.F.R.), unless specifically stated.

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.[5] 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 such as WPS. Act § 1842(a) (42 U.S.C. § 1395u(a)).

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 a Medicare eligible beneficiary.

The effective date of enrollment in Medicare of a physician, nonphysician practitioner, and physician and nonphysician practitioner organizations is governed by 42 C.F.R. § 424.520(d). The effective date of enrollment for a physician or nonphysician practitioner may only be the later of two dates: the date when the physician 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 physician first began providing services at a new practice location. *Id.* An enrolled physician or

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[5] Petitioner is a "supplier" under the Act and the regulations. 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.

nonphysician practitioner may retrospectively 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 U.S.C. §§ 5121-5206. 42 C.F.R. § 424.521.

The Secretary has issued regulations that establish the right to a hearing and judicial review of certain enrollment determinations. Act § 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to section 1866(h)(1) and (j)(8), a provider or supplier whose enrollment application or renewal application is denied is entitled to an administrative hearing and judicial review. Pursuant to 42 C.F.R. § 424.545(a), a provider or supplier denied enrollment in Medicare or whose Medicare enrollment and billing privileges are revoked has the right to administrative and judicial review in accordance with 42 C.F.R. pt. 498. Appeal and review rights are specified by 42 C.F.R. § 498.5.

B. Issues

The issues in this case are:

> Whether summary judgment is appropriate; and
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> Whether the effective date of Petitioner's Medicare enrollment and billing privileges is December 1, 2014.

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

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

1. Summary judgment is appropriate.

Summary judgment is not automatic upon request but is limited to certain specific conditions. The Secretary's regulations that establish the procedure to be followed in adjudicating Petitioner's case are at 42 C.F.R. pt. 498. 42 C.F.R. § 424.545(a)(1). The regulations do not establish a summary judgment procedure or recognize such a procedure. However, the Departmental Appeals Board (the Board) has long accepted that summary judgment is an acceptable procedural device in cases adjudicated pursuant to 42 C.F.R. pt. 498. *See, e.g., Illinois 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). The Board also has recognized that the Federal Rules of Civil Procedure do not apply in administrative adjudications such as this, but the Board has accepted that Federal Rule of Civil Procedure 56 and related cases provide useful guidance for determining whether summary judgment is appropriate. 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 dated May 15, 2015, paragraph II.G. The parties were given notice by the Prehearing Order that summary judgment is an available procedural device and that the law as it has developed related to Federal Rule of Civil Procedure 56 will be applied. The parties were advised that a fact alleged and not specifically denied, may be accepted as true for purposes of ruling upon a motion for summary judgment. The parties were also advised that on summary judgment evidence is considered admissible and true unless a specific objection is made. Prehearing Order ¶ II.G.

Summary judgment is appropriate when there is no genuine dispute as to any issue of material fact for adjudication and/or the moving party is entitled to judgment as a matter of 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. The party requesting summary judgment bears the burden of showing that there are no genuine issues of material fact for trial and/or that it is entitled to judgment as a matter of law. Generally, the non-movant may not defeat an adequately supported summary judgment motion by relying upon the denials in its pleadings or briefs but must furnish evidence of a dispute concerning a material fact, i.e., a fact that would affect the outcome of the case if proven. *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 at 3 (2010) (and cases cited therein); *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (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 the party's evidence would be sufficient to meet that party's evidentiary burden. *Dumas Nursing & Rehab., L.P.*, DAB No. 2347 at 5 (2010). The Secretary has not provided for the allocation of the burden of persuasion or the quantum of evidence in 42 C.F.R. pt. 498. However, the Board has provided some persuasive analysis regarding the allocation of the burden of persuasion in cases subject to 42 C.F.R. pt. 498. *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 Fed. App'x 181 (6th Cir. 2005).

The material facts in this case are not disputed 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. Accordingly, summary judgment is appropriate.

2. Pursuant to 42 C.F.R. § 424.520(d), Petitioner's effective date of Medicare enrollment was December 1, 2014, the date of filing of a Medicare enrollment application that WPS was able to process 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 his effective date of enrollment, i.e., beginning on November 1, 2014.

a. Facts

The material facts are not disputed and any interferences are drawn in Petitioner's favor on summary judgment.

Petitioner, a chiropractor, began working at LaBounty on December 11, 2013. Petitioner wanted to reassign to LaBounty his Medicare claims for his services he rendered to Medicare-eligible beneficiaries. RFH; CMS Ex. 10.

Petitioner filed several enrollment applications in this case. WPS received a CMS-855I application from Petitioner on January 20, 2014. WPS was not able to develop the application because it was incomplete. On February 25, 2014, WPS requested additional information from Petitioner in order to process the application and advised Petitioner that he needed to submit a CMS-855R application in order to reassign his payments to the group practice. CMS Ex. 1. Petitioner submitted the corrections to the CMS-855I; however, he did not submit the CMS-855R application for reassignment of his benefits. On April 3, 2014, WPS notified Petitioner that his January 2014 application was rejected because Petitioner did not submit the required CMS-855R application and also did not respond to phone calls initiated by WPS staff to discuss his applications. CMS Ex. 2 at 1.

WPS subsequently received a CMS-855I enrollment application and a CMS-855R reassignment application from Petitioner, which were dated November 20, 2014. CMS Ex. 3. On December 16, 2014, WPS notified Petitioner that it received his applications on December 1, 2014. The letter advised Petitioner that additional information was needed for WPS to process the applications and the information needed to be submitted within 30 days of the December 16, 2014 letter. CMS Ex. 4. By letter dated January 19, 2015, WPS notified Petitioner that his December 2014 application was rejected because the group to which he sought to reassign benefits was deactivated, i.e., the group's Medicare enrollment was apparently inactive. CMS Ex. 5 at 1.

Petitioner sent WPS a third set of applications, a CMS-855I and CMS-855R both dated January 21, 2015. WPS received the applications and requested corrections. CMS Ex. 6. On February 7, 2015, WPS notified Petitioner that his Medicare enrollment application was approved with an effective date of December 23, 2014. CMS Ex. 7.

Petitioner requested reconsideration of the effective date, specifically that the date be changed to December 11, 2013, the date he joined the group practice. P. Ex. at 2. On reconsideration WPS changed Petitioner's enrollment date from December 23, 2014 to December 1, 2014, with retrospective billing privileges effective November 1, 2014. The WPS determination was based on the previously rejected enrollment application dated November 20, 2014 and received by WPS on December 1, 2014. P. Ex. at 3-4.

b. Analysis

Petitioner wants LaBounty to be able to bill Medicare for services he provided to Medicare–eligible beneficiaries at the group practice as early as December 11, 2013. Petitioner argues that his office manager assisted him in completing the Medicare enrollment applications, which she submitted. He states that he never heard anything further from the office manager. Petitioner thought he was successfully enrolled and it was not until recently that he realized he was not enrolled. RFH; CMS Ex. 10. Petitioner argues that he did not see the February 25, 2014 WPS letter that requested correction of his January 2014 application or the April 3, 2014 letter that rejected his January 2014 application. Petitioner argues that because he never saw the February 25 and April 3 notices, he never took action to submit the paperwork WPS requested. P. Br.

There is no dispute that Petitioner submitted enrollment and reassignment applications to WPS on January 20, 2014, which were rejected by WPS. Rejection of an application is governed by 42 C.F.R. § 424.525. CMS may reject a Medicare enrollment application if the applicant fails to furnish complete information and supporting information within 30 days from the date the contractor requests it. 42 C.F.R. § 424.525(a)(1). There is no right to administrative or judicial review of the rejection of an application. 42 C.F.R. § 424.525(d). Therefore, Petitioner's January 2014 applications are not subject to my review. Once an application is rejected a new application and all support documentation must be submitted for review and approval. 42 C.F.R. § 424.525(c). When a subsequent application is processed to completion, it is the filing date of that subsequent application that was processed to completion which controls and not the filing date of the earlier application that the contractor was unable to process. *Karthik Ramaswamy, M.D.*, DAB No. 2563 at 6 (2014); 71 Fed. Reg. 20,754, 20,759 (April 21, 2006).

Although the application received by WPS from Petitioner on December 1, 2014 was initially rejected by WPS (CMS Ex. 5), WPS determined on reconsideration that it was appropriate to consider the application received on December 1, 2014. The record shows

that on reconsideration, WPS used the December 1, 2014 enrollment application as a basis to change the effective date of Petitioner's enrollment and billing privileges to December 1, 2014, with a period of retrospective billing beginning November 1, 2014. P. Ex. at 3-5. It is undisputed that Petitioner did not file an earlier application that could have been processed to completion WPS.

The enrollment and reassignment applications were filed by Petitioner on December 1, 2014, after the date he began delivering services at the group practice location. Therefore, under the regulation the earliest possible effective date for Petitioner's enrollment and billing privileges was December 1, 2014, the date the applications were filed. The regulation provides that it is the later of the date of filing a Medicare enrollment application or the date services were first provided that controls. 42 C.F.R. § 424.520(d). Retrospective billing is permitted for 30 days prior to the effective date of enrollment and billing privileges, except in a situation not presented in this case. 42 C.F.R. § 424.521.

Accordingly, I conclude that, pursuant to 42 C.F.R. §§ 424.520(d), Petitioner's effective date of Medicare enrollment and billing privileges is December 1, 2014. Pursuant to 42 C.F.R. § 424.521(a)(1), Petitioner may retrospectively bill beginning November 1, 2014.

Petitioner's pleas may be viewed as requests for equitable relief. However, I do not have the authority to grant equitable relief in the form of an earlier effective date of enrollment. *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 authority by which I may grant him relief from the applicable regulatory requirements. I also 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.").

III. Conclusion

For the foregoing reasons, I conclude that the effective date of Petitioner's Medicare enrollment and billing privileges was December 1, 2014, with a 30-day period for retrospective billing beginning on November 1, 2014.

/s/
Keith W. Sickendick
Administrative Law Judge