Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Advanced Ambulatory, Inc.,	)	
	)	Date: November 29, 2007
Petitioner,	)	
	)	Docket No. C-06-62
- v. -	)	Decision No. CR1701
	)	
Centers for Medicare &	)	
Medicaid Services.	)	
	)	

DECISION

I affirm the determination of the Medicare Part B Hearing Officer (Hearing Officer) to uphold the denial by the Medicare Part B Carrier, TrailBlazer Health Enterprises, LLC (the Carrier), of Advance Ambulatory's (Petitioner) application for enrollment as a Medicare provider. I find that the Hearing Officer correctly determined that Petitioner does not meet the regulatory requirements for obtaining a Medicare Provider Identification Number (PIN or enrollment number).

I. APPLICABLE AUTHORITY

Title XVIII of the Social Security Act (Act) established the Medicare program, a federally funded health insurance program that provides payment for covered services furnished to aged and certain disabled individuals. Act, section 1801-1896. Section 1831 of the Act establishes the supplementary medical insurance benefits program for the aged and disabled known as Medicare Part B.

Section 1866(j) of the Act, as amended by section 936 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, authorized the Secretary of Health and Human Services (Secretary) to establish a process for the enrollment in the Medicare program of providers of services and suppliers. Section 1866(j)(2) of the Act gives providers and suppliers appeal rights, for certain

determinations involving enrollment, using the procedures that apply under section 1866(h)(1)(A) of the Act. Those procedures are set out at 42 C.F.R. Part 498, *et seq.,* and provide for hearings by Administrative Law Judges (ALJs) and review by the Departmental Appeals Board (Board).

Pursuant to 42 C.F.R. § 410.33(a), an Independent Diagnostic Testing Facility (IDTF) is described as "a fixed location, a mobile entity, or an individual nonphysician practitioner . . . [that is] independent of a physician's office or hospital" where diagnostic procedures are carried out. "Carriers will pay for diagnostic procedures under the physician fee schedule only when performed by a physician, a group practice of physicians, an approved supplier of portable x-ray services, a nurse practitioner, or a clinical nurse specialist when he or she performs a test he or she is authorized by the State to perform." 42 C.F.R. § 410.33(a)(1).

Pursuant to 42 C.F.R. § 410.32(c), portable x-ray services are "furnished in a place of residence used as the patient's home" and are covered if furnished under the supervision of a physician and are limited to certain types of skeletal films, chest or abdominal films, and diagnostic mammograms if the portable x-ray supplier meets the certification requirements.

Pursuant to 42 C.F.R. § 410.34, Medicare Part B pays for diagnostic mammography services if they meet the required conditions of coverage.

In provider appeals under 42 C.F.R. Part 498, the Board has determined that CMS must make a *prima facie* case that an entity has failed to comply substantially with federal requirements. *See MediSource Corporation*, DAB No. 2011 (2006). *"Prima facie"* means that the evidence is "[s]ufficient to establish a fact or raise a presumption unless disproved or rebutted." *Black's Law Dictionary* 1228 (8th ed. 2004); *see also Hillman Rehabilitation Center*, DAB No. 1611, at 8 (1997), *aff'd, Hillman Rehabilitation Center v. U.S. Dept. of Health and Human Services*, No. 98-3789 (GEB) (D.N.J. May 13, 1999). To prevail, the entity must overcome CMS's showing by a preponderance of the evidence. *Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004); *Batavia Nursing and Convalescent Inn*, DAB No. 1911 (2004); *Emerald Oaks*, DAB No. 1800 (2001); *Cross Creek Health Care Center*, DAB No. 1665 (1998); *Hillman*, DAB No. 1611 (1997).

II. PROCEDURAL BACKGROUND

Petitioner applied for enrollment as a mobile facility/portable unit supplier and indicated that it believed it would receive reimbursement in conformity with Ambulatory Surgical Center grouper rates. Petitioner attached the Ambulatory Surgical Center (ASC) Current Procedural Terminology codes along with its application. The Hearing Officer concluded

that Petitioner's business of providing Mobile Ambulatory Surgery Units did not qualify for enrollment as an Ambulatory Surgical Center, Independent Diagnostic Testing Facility, or Mobile Facility and, therefore, the request by Petitioner for a Medicare provider number was denied. The Hearing Officer advised Petitioner of its appeal rights and that it could appeal the decision to an ALJ.

By letter dated October 27, 2005 (hearing request), Petitioner, acting *pro se*, filed a timely appeal of the Hearing Officer's decision. In its hearing request, Petitioner challenges the October 21, 2005 decision of the Hearing Officer, arguing that it is qualified to receive a Medicare Part B provider enrollment number.

On January 5, 2006[1], Petitioner submitted a letter, prepared by Rob Pupelis, President of Advanced Ambulatory, to be accepted as its Prehearing Memorandum along with five exhibits (P. Exs.) 1a-5a[2]. On February 2, 2006, CMS submitted Respondent's Prehearing Memorandum along with eight exhibits (CMS Exs.) 1-8. On May 11, 2006, I held a prehearing conference with the parties to discuss the issue in the case and whether the case required an in-person hearing or could be addressed through written submissions. Petitioner retained and was represented by legal counsel at the prehearing conference. Counsel for CMS argued that the matter involved a purely legal issue which could be resolved through briefs. CMS also indicated that it intended to file a Motion for Summary Judgment. Petitioner's counsel maintained that, in order to understand the type of services that were provided by Petitioner, an in-person hearing would be required. Petitioner's counsel requested leave to submit a response to CMS's initial brief. CMS did not oppose and I granted Petitioner's request. I issued a prehearing order providing Petitioner 30 days to file its amended prehearing memorandum. I also instructed Petitioner to make its arguments as to why an in-person hearing was necessary in this case. On June 27, 2006, Petitioner submitted "Advanced Ambulatory, Inc.'s (Advances in Healthcare) Brief in Support of its Appeal" (Petitioner's Brief) along with seven exhibits, P. Exs. 1b-7b. In its brief, Petitioner included a single sentence indicating: "AAI believes that a full explanation of its role in healthcare would be best served through an in person hearing and live testimony." Petitioner's Brief at 9.

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[1] This letter was incorrectly date stamped January 5, 2005.

[2] Before retaining counsel, Petitioner filed five exhibits with its initial Prehearing Memorandum (received January 5, 2006). Petitioner's counsel then filed seven exhibits with his June 27, 2006 submission. To prevent confusion, I have identified the exhibits that were submitted along with Petitioner's initial brief as P. Exs. 1a-5a and the exhibits filed with Petitioner's second brief have been identified as P. Exs. 1b-7b.

On June 26, 2006, CMS submitted "Respondent's Motion for Summary Judgment and Brief in Support Thereof" (CMS's Motion for Summary Judgment). On July 11, 2006, Petitioner submitted its "Response to CMS' Motion for Summary Judgment" (Petitioner's Response). Neither party has objected to the admissibility of any of the exhibits. I therefore admit into evidence CMS Exs. 1-8, and P. Exs. 1a-5a and 1b-7b.

III. ISSUES

The issues in the matter before me are:

1. Whether summary judgment is appropriate in this case; and

2. Whether Petitioner qualifies as a defined Mobile Facility/Portable Unit.

IV. FINDINGS OF FACT AND CONCLUSIONS OF LAW

I make findings of fact and conclusion of (Findings) to support my decision in this case. I set forth each Finding below as a separate heading and I discuss each finding in detail.

A. Summary judgment is appropriate under the circumstances of this case.

I am deciding this case on CMS's Motion for Summary Judgment. An ALJ may decide a case on summary judgment, without an evidentiary hearing, if the case presents no genuine issue of material fact. *Crestview Parke Care Center v. Thompson,* 373 F.3d 743, 750 (6th Cir. 2004); *Livingston Care Center v. U.S. Dep't. of Health & Human Services,* 388 F.3d 168, 172 (6th Cir. 2004). By interpretive rule, this tribunal has established a summary judgment procedure "akin to the summary judgment standard contained in Federal Rule of Civil Procedure 56." *Crestview Parke Care Center*, 373 F.3d at 750. Under that rule, the moving party may show the absence of a genuine factual dispute by presenting evidence so one-sided that it must prevail as a matter of law, or by showing that the non-moving party has presented no evidence "sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial." *Livingston,* 388 F.3d at 173*, citing Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). The nonmoving party must then act affirmatively by tendering evidence of specific facts showing that a dispute exists. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 n.11 (1986). *See also, Vandalia Park,* DAB No. 1939 (2004); *Lebanon Nursing and Rehabilitation Center*, DAB No. 1918 (2004). A mere scintilla of supporting evidence is not sufficient. "If the evidence is merely colorable or is not significantly probative summary judgment may be granted." *Livingston,* 388 F.3d at 173, *quoting Anderson v. Liberty Lobby,* 477 U.S. 242*,* 249-250 (1986). In deciding a

summary judgment motion, an ALJ may not make credibility determinations or weigh conflicting evidence but must instead view the entire record in the light most favorable to the non-moving party, all reasonable inferences drawn from the evidence in that party's favor. *Innsbruck HealthCare Center,* DAB No. 1948 (2004); *Madison Health Care, Inc.,* DAB No. 1927 (2004).

Petitioner notes in its prehearing brief that AAI believes that a full explanation of its role in healthcare would be best served through an in-person hearing and live testimony. Petitioner's Brief at 9. In its Response to CMS's Motion for Summary Judgment, Petitioner maintains that a genuine issue of material fact exists with regard to Petitioner's role as a health care provider, as well as the reasoning for the failure of CMS to recognize Petitioner as a provider under the program. Petitioner's Response at 1. Petitioner's role as a health care provider is clearly set out in Petitioner's prehearing submission as well as in its response to CMS's Motion for Summary Judgment. What services Petitioner provides is not in dispute. Petitioner fails to point to any material factual dispute or misunderstanding on the part of CMS as to what services Petitioner provides or Petitioner's role as a health care provider. Thus, I find there is no factual dispute as to what services Petitioner provides or its role as a health care provider. Petitioner's second argument as to the reasoning for CMS's failure to recognize Petitioner as a provider under the program is a purely legal issue. As the only real issue before me legal in nature, the case is appropriate for summary judgment.

In evaluating the parties' submissions, I find that even if I construe the entire record in the light most favorable to Petitioner, as discussed below, I would find that Petitioner fails to meet the criteria to be considered a mobile facility/portable unit. Moreover, Petitioner has tendered no specific facts to support that a material fact is in dispute, and CMS has made a *prima facie* case that it is otherwise entitled to judgment as a matter of law. *See Carrier Mills Nursing Home*, DAB No. 1883, at 3-4 (2003).

B. Petitioner has not established that it qualifies as a Mobile Facility/Portable Unit

The Medicare Program Integrity Manual, provides that the terms mobile facility/portable unit apply:

> . . . when a service that requires medical equipment is provided in a vehicle, or the equipment for the service is transported to multiple locations within a geographic area. The most common types of mobile facilities/portable units are mobile independent diagnostic testing facilities, portable X-ray units,

> portable mammography units, and mobile clinics. Physical therapists and other medical practitioners (e.g. physicians, nurse practitioners, physician assistants) who perform services at multiple locations (i.e. house calls, assisted living facilities) are not considered to be mobile facilities/portable units.

Medicare Program Integrity Manual, section 1.1.

Petitioner submitted an application for a Medicare enrollment number and designated its specialty as a Portable Unit Supplier. CMS Ex. 2, at 2. The section entitled "comments" (Section E of the application) asked the applicant to explain among other things "the method by which the supplier renders health care services." *Id.* at 3. Petitioner provided the following explanation:

> From its corporate office in Houston, AAI delivers advanced surgical services to Physicians in Houston, San Antonio, Austin, Corpus Christi and surrounding areas. Like a hospital or surgery center, we provide the equipment, instrumentation and supplies, as well as any technical support the doctor needs to perform surgical procedures.
>
> Our portable units enable health care organizations, physicians, and patients to benefit through reduced costs for minimally invasive surgical procedures, increased physician productivity, greater access to advanced technologies and improved patient satisfaction.

Id.

Petitioner explains in its hearing request that their specialty fits CMS's definition for "Mobile Facility/Portable Unit." According to Petitioner, AAI provides:

1. equipment & instrumentation (lasers, endoscopes, surgical generators, etc.)
2. disposables (over 100 various items)
3. tech support (scrub techs and assistants)
4. surgical field (disinfected or sterile)

Petitioner's Brief at 3. Petitioner also sets up the surgical field in order to maintain "the highest standards of sterile surgical requirements." *Id.*

Petitioner contends that the definition of a "mobile facility" does not exclude Petitioner's specialty and that if their specialty is not excluded by CMS's own definition of mobile facility, then their application must be approved. Petitioner's Brief at 5. Petitioner asserts that the services they provide are "compatible" with the examples of common types of mobile facilities listed in the mobile facility definition. Petitioner maintains that "services performed" by the entity is not defined. *Id.* at 6. Petitioner also contends that the exclusions listed in the definition of a "mobile facility" do not apply to it because it does not provide the actual service at the location, it provides "the ability to perform the service under the direct supervision of a physician, similar to that in a surgical hospital or other surgical center." *Id.* at 5.

CMS argues that Petitioner fails to qualify as a defined mobile facility/portable unit because Petitioner does not provide the same or a similar type equipment or service that has been specified in CMS's explanation of the definition of a mobile facility/portable unit. CMS asserts that the common provider types of mobile facilities/portable units, such as IDTFs, portable X-ray units, and portable mammography units have each been designated as a specialty by regulation. (42 C.F.R. §§ 410.33, 410.32(c), 410.34 respectively). CMS's Motion for Summary Judgment at 6. CMS asserts that it is clear from Petitioner's application that it is supplying surgical equipment to a physician's office. Thus, it is clear that Petitioner is not supplying diagnostic, x-ray, mammography or patient transportation services. *Id.* at 7. Petitioner does not meet the criteria to qualify for any one of the provider types that CMS has deemed as a covered provider type, nor are the services provided by Petitioner designated as a specialty by regulation.

CMS also contends that "[Petitioner's] service is provided to the physician and is intended to enhance the physician's office rather than providing a direct to patient service." *Id.* at 9. Moreover, CMS argues that physician services are excluded from the mobile facility/portable unit definition. CMS explains that certain services provided by physicians are not covered as facility services, but are covered primarily by Medicare Part B as reasonable and medically necessary physicians' services. *Id.* at 10.

Petitioner's explanation of the type of equipment and services it provides is not consistent with the definition of what is considered a mobile facility/portable unit. The services that Petitioner provides do not require medical equipment, are not provided in a vehicle and are not even remotely similar to the type of "service that requires medical equipment" that the Medicare Program Integrity Manual specifies. The service Petitioner lists in Petitioner's Brief in Support of its Appeal is essentially "tech support." Petitioner indicates that prior to a physician beginning a procedure, the Petitioner's "technician" sets up the surgical field. Petitioner's Brief at 3. "Tech support" does not require medical equipment and is not provided in a vehicle, it is a service that is provided on-site in a physician's office. Furthermore, tech support is a service that is clearly provided for the physician's benefit and it is only indirectly of benefit to the patient.

The Medicare Program Integrity Manual identifies physical therapists and other medical practitioners (*e.g.*, physicians, nurse practitioners, physician assistants) who perform services at multiple locations (*e.g.*, house calls, assisted living facilities) as individuals that are not considered to be mobile facilities/portable units. Therefore, it would follow that individuals that provide technical support to a physician cannot be considered as a mobile facility/portable unit either. As CMS maintains, citing 42 C.F.R. § 416.61(b), physician services and medical and other health services for which payment can be made under other Medicare provisions are excluded from facility services. The regulations at 42 C.F.R. § 410.20(a) also provide that physicians' services means professional services performed by physicians for a patient, including diagnosis, therapy, surgery, consultation, and home, office, and institutional calls. CMS's Motion for Summary Judgment at 10. The Act and its implementing regulations provide other ways for the individuals and entities that perform medically necessary services to be paid. A particular procedure has been applied to take into account and provide payment for the supplies and equipment necessary for a physician to perform medically necessary services within the physician's office. *See* Act, section 1848. That procedure is physician reimbursement for these supplies and services. It is from the physician's reimbursement that Petitioner should be seeking to be reimbursed for the services it has provided directly to the physician.

The equipment Petitioner lists as being provided are: lasers, endoscopes, surgical generators, and disposables. Petitioner's Brief at 3. This type of medical equipment does not fall within the definition of the term mobile facility/portable unit. As previously noted, examples listed in the Medicare Program Integrity Manual are diagnostic x-ray, mammography, and mobile clinic. Petitioner's medical equipment and medical services do not constitute diagnostic x-ray or mammography equipment, or patient transportation. Nor does the equipment cited by Petitioner qualify as a mobile clinic as Petitioner is not providing medical clinic services to patients. As CMS points out, if the first sentence of the definition of the term mobile facility/portable unit is considered without taking into account the remaining provisions of the definition, then "an entity that transports surgical gloves and a syringe could be classified as a mobile facility/portable unit," because practically any entity transporting any type of medical equipment could be designated as a mobile facility/portable unit. CMS's Motion for Summary Judgment at 6. However, the applicable definition must be read in its entirety and applied to the facts before me.

Applying the definition to the term mobile facility/portable unit as set forth in the Medicare Program Integrity Manual, section 1.1, I must find that the equipment Petitioner provides does not result in services directly provided to the patient or Medicare beneficiary. Rather, Petitioner provides a service to the physician who is treating Medicare beneficiaries. Petitioner provides the convenience of lasers, endoscopes, surgical generators, and disposables to the physician so that he or she can render services in an office setting rather than utilizing a hospital or surgical unit. Petitioner submits a number of affidavits and letters from physicians who have utilized Petitioner's services in

the past. The authors of the letters and affidavits praise the services provided by Petitioner. The fact that Petitioner provides services to physicians that is of value and assistance to them is not in dispute. However, Petitioner's services primarily benefit the medical practitioner in facilitating his or her ability to perform physician services. The services Petitioner provides to the physician do not result in direct rendition of services from Petitioner to a Medicare patient. The affidavits and letters submitted by Petitioner do not contradict this conclusion. Essentially, Petitioner is servicing another provider and not a beneficiary. While the most common types of mobile facilities/portable units provide services directly to the patient, the same cannot be said about the types of medical equipment that Petitioner is using to justify its classification as a mobile facility/portable unit supplier.

Finally, as previously noted, Petitioner anticipated being certified as a mobile facility/portable unit supplier, but apparently sought to be reimbursed under the Ambulatory Surgical Center payment codes. Petitioner undercuts its own position by arguing, on the one hand, that it fits the requirements and should be enrolled as mobile facility provider/portable unit supplier while, on the other hand, it seeks to be reimbursed as an ASC. If Petitioner indeed fits the requirements to be enrolled as a mobile facility/portable unit supplier, it would not require special treatment relative to reimbursement. Petitioner maintains that it did not apply for enrollment as an ASC, and CMS asserts that Petitioner would not qualify to participate as an ASC in the Medicare program under the applicable regulations. CMS's Motion for Summary Judgment at 11.

V. CONCLUSION

Petitioner has failed to establish that it fits within or satisfies the requirements of the definition of the term mobile facility/portable unit supplier. Thus, Petitioner does not qualify for a Medicare Part B provider enrollment number as a mobile facility/portable unit supplier. I therefore affirm the CMS's denial of Petitioner's enrollment application.

/s/
Alfonso J. Montano
Administrative Law Judge