Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Mark Rausch, M.D.,

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-533

Decision No. CR2926

Date: September 18, 2013

DECISION

Physician Services Nationwide, appearing here on behalf of Petitioner Mark Rausch, M.D., appeals the effective date assigned to Petitioner's enrollment as a Medicare provider with Emergency Physicians Care Center, PLLC. For the reasons explained below, I grant the Centers for Medicare & Medicaid Services' (CMS's) Motion for Summary Judgment and uphold the January 18, 2013 effective date.

I. Background

On March 6, 2013, Petitioner filed a hearing request challenging the effective date determination made by Palmetto GBA (Palmetto), a Medicare contractor. In accordance with my Acknowledgment and Initial Docketing Order dated March 20, 2013, CMS and Petitioner filed Reports of Readiness. I convened a teleconference in this matter on June 12, 2013, and issued an Amended Order. Subsequently, CMS submitted a Motion for Summary Judgment and a brief in support of its motion (CMS Br.), along with five exhibits identified as CMS Exs. 1-5. Petitioner filed a brief in opposition to the CMS

Motion for Summary Judgment (P. Br.), and attached several documents, which I have identified as P. Ex. 1. Neither party chose to file an Answer Brief. On August 15, 2013, I issued an Order Closing Record in this matter.

In the absence of objection, I admit CMS Exs. 1-5 and P. Ex. 1 into the record.

II. Applicable Law

The Social Security Act (Act) authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations governing the enrollment process for providers and suppliers. Act §§ 1102, 1866(j) (42 U.S.C. §§ 1302, 1395cc(j)). Under the Secretary's regulations, a provider or supplier that seeks billing privileges under Medicare must "submit enrollment information on the applicable enrollment application. Once the provider or supplier successfully completes the enrollment process . . . CMS enrolls the provider or supplier into the Medicare program." 42 C.F.R. § 424.510(a).

Also, a "provider or supplier must submit a complete enrollment application and supporting documentation to the designated Medicare fee-for-service contractor," and the application must include "complete . . . responses to all information requested within each section as applicable to the provider or supplier type." 42 C.F.R. § 424.510(d)(1)-(2).

The effective date of enrollment for physicians and nonphysician practitioners is set as follows:

> The effective date for billing privileges for physicians, 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.

42 C.F.R. § 424.520(d).

III. Issue

The issue in this case is whether CMS's contractor and CMS properly determined Petitioner's effective date of Medicare enrollment.

IV. Analysis

My findings of fact and conclusions of law are set forth in italics and bold in the discussion captions of this decision.

1. This case is appropriate for summary judgment.

CMS argues that it is entitled to summary disposition in the nature of summary judgment. 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 Rehabilitation & Skilled Nursing Center, DAB No. 2300, at 3 (2010) (citations omitted).

The Board has further explained that 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 Village at Notre Dame, Inc.*, DAB No. 2291, at 5 (2009).

I have accepted all of Petitioner's factual assertions as true and drawn all reasonable inferences in Petitioner's favor. Therefore, I accept Petitioner's claim that Petitioner mailed a Medicare enrollment application around November 1, 2012. Hearing Request (HR); P. Br. at 1. I further accept Petitioner's concession that this application was not received and "never scanned into the system for review" by Palmetto. P. Br. at 1. Finally, I accept Petitioner's assertion that a new Medicare enrollment application was submitted in January of 2013, after Petitioner spoke with a Palmetto representative and learned the application sent around November 1, 2012 had not been processed. HR; P. Br. at 1. For the purposes of summary judgment, I accept Petitioner's description of these events as true. However, this depiction does not support a favorable outcome for Petitioner. Petitioner has not disputed any fact material to my resolution of the case. Accordingly, I agree with CMS that summary judgment is appropriate.

2. CMS correctly determined the effective date of Petitioner's Medicare enrollment.

Petitioner is a physician employed by Emergency Physicians Immediate Care (the group practice) located in Midlothian, Virginia. CMS Ex. 3; P. Br. at 1. On or about November 1, 2012, Petitioner contends that he and several other physicians signed Medicare enrollment applications and applications to assign Medicare payments (Forms CMS 855R and CMS 855I) for participation as group practice members, and began seeing Medicare beneficiaries. HR; P. Br. at 1. Petitioner claims that his enrollment application was submitted on November 1, 2012 to Palmetto, along with the applications of the other group practice members. P. Br. at 1. Petitioner did not send this Medicare enrollment application by certified or registered mail and cannot provide proof showing that Petitioner mailed a completed, approvable enrollment application to Palmetto on November 1, 2012. Also, a cover letter to Medicare dated September 6, 2012, submitting three other group practice members' Medicare enrollment applications referenced in Petitioner's brief, does not mention or include Petitioner's Medicare enrollment application. CMS Ex. 1.

Subsequently, Petitioner called Palmetto to verify that Petitioner's application had been received. P. Br. at 1. A Palmetto representative informed Petitioner that the enrollment application "was not scanned into the system and therefore, resubmit." P. Br. at 1. Petitioner began preparing another application for submission following this conversation. P. Br. at 1. On January 18, 2013, Palmetto received an application to assign Petitioner's Medicare payments and Petitioner was given a retrospective billing date of December 19, 2012.[1] CMS Exs. 2, 5.

The determination of the effective date of Medicare enrollment is governed by 42 C.F.R. § 424.520. Section 424.520(d) provides that the effective date for enrollment for physicians, among others, 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." 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." 73 Fed. Reg. 69,725, 69,769 (Nov. 19, 2008). It is well settled that the date of filing is the date the Medicare contractor receives an approvable application. *Caroline Lott Douglas, PA*, DAB CR2406 (2011); *Rizwan Sadiq, M.D.*, DAB CR2401 (2011); *Jennifer Tarr, M.D.*, DAB CR2299 (2010); *Roland J. Pua, M.D.*, DAB CR2163 (2010); *Michael Majette, D.C.*, DAB CR2142 (2010).

[1] Petitioner's effective date of Medicare enrollment is January 18, 2013, the date Petitioner's enrollment application was received by Palmetto. However, Palmetto granted Petitioner authorization to file claims for services retrospective to December 19, 2012. CMS Br. at 1-2; 42 C.F.R. § 424.521(a)(1).

Petitioner requests that I hold the date that he asserts he first submitted an application to be controlling, even though there is no evidence that this application was received or processed by Palmetto. Petitioner wishes to have his billing privileges adjusted to the date that Petitioner alleges he initially sent an application, but Petitioner has pointed to no authority that would allow this departure from settled principles. Petitioner presents no evidence that would support his assertion that he mailed an application on November 1, 2012. Moreover, the regulations are clear that an application must be *received* and *subsequently approved* by a Medicare contractor before an effective date can be established. It is undisputed that the contractor did not receive an application it was able to process to approval from Petitioner until January 18, 2013. Therefore, the correct effective date of Petitioner's enrollment remains January 18, 2013. 42 C.F.R. § 424.520(d).

Petitioner's argument is essentially that the effective date should be adjusted because the CMS contractor mishandled the application Petitioner sent in November of 2012. As blunt as this assertion is, Petitioner can point to no evidence in support of it, and in the absence of any such evidence I cannot accept it as proven. Even if the assertion were proven, however, this is not a basis to adjust Petitioner's enrollment date. Petitioner's argument amounts to a claim of equitable estoppel. It is well-established by federal case law, and in Board precedent, that: (1) estoppel cannot be the basis to require payment of funds from the federal government; (2) estoppel can lie against the government, if at all, only on a showing of affirmative misconduct, such as fraud; and (3) I am not authorized to order payment contrary to law based on equitable grounds. *See, e.g., Oklahoma Heart Hospital*, 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); *Office of Personnel Management v. Richmond*, 496 U.S. 414 (1990); *Heckler v. Community Health Services of Crawford County, Inc.*, 467 U.S. 51 (1984). Petitioner alleges no affirmative misconduct against the government, and it is simply the case that the regulations governing this situation were promulgated with the understanding that these stricter requirements for enrolling and maintaining enrollment would have possible effects on providers and suppliers. Yet, the stricter Medicare enrollment requirements — such as those that guide this decision — were understood as a necessary means to further program integrity. *See* 73 Fed. Reg. 69,725, 69,768 (November 19, 2008).

V. Conclusion

For the reasons explained above, and based on the undisputed fact that Palmetto did not receive an enrollment application it was able to process to approval from Petitioner until January 18, 2013, I conclude that Petitioner's effective date of enrollment was correctly determined to be January 18, 2013.

/s/
Richard J. Smith
Administrative Law Judge