Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Shona Alexander, NP,
(NPI: 1750416061 / PTAN: 202I506554),
Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-16-406

Decision No. CR4675

Date: August 8, 2016

DECISION

The effective date of Medicare enrollment and billing privileges of Petitioner Shona Alexander, NP, is February 27, 2015, with retrospective billing privileges beginning January 28, 2015.

I. Background and Procedural History

Cahaba Government Benefits Administrators, LLC (Cahaba), a Medicare administrative contractor (MAC), notified Petitioner's employer, Life Line Community Healthcare (Life Line), by letter dated May 5, 2015, that her Medicare enrollment application had been approved with a period for retrospective billing beginning January 28, 2015. Centers for Medicare & Medicaid Services (CMS) Exhibit (Ex.) 1 at 15-17. On May 5, 2015, Petitioner requested reconsideration of the initial determination and requested that the "effective date" be changed to January 22, 2015, the date Petitioner first began providing services to Medicare beneficiaries at Life Line. CMS Ex. 1 at 4. Cahaba notified Life Line by letter dated March 2, 2016, that Petitioner's request for reconsideration was denied. CMS Ex. 1 at 1-3. The reconsidered determination states that Petitioner's enrollment applications were received on February 27, 2015. CMS Ex. 1 at 2. The reconsidered determination further explains that pursuant to 42 C.F.R. §§ 424.520(d), and 424.521(a)(1), the effective date of enrollment and billing privileges would be February

27, 2015, the date the applications were received by Cahaba, and the first day authorized for retrospective billing would be January 28, 2015. CMS Ex. 1 at 1-2.

Petitioner requested a hearing before an administrative law judge (ALJ) on March 7, 2016. The case was assigned to me on March 24, 2016, for hearing and decision, and an Acknowledgment and Prehearing Order (Prehearing Order) was issued at my direction.

CMS filed a motion for summary judgment and CMS Ex. 1 on April 25, 2016. Also on April 25, 2016, Petitioner filed two documents, which appear in the Departmental Appeals Board Electronic Filing System (DAB E-File) as Item #8 and Item #9. The documents are not marked as required by the Civil Remedies Division Procedures (CRDP) § 14. However, there is little risk for confusion in referring to the documents so they were not rejected or returned for correction. I treat the document appearing as Item #7 as if marked Petitioner's exhibit (P. Ex.) 1 and the document appearing as Item #8 as if marked P. Ex. 2. On June 10, 2016, CMS waived filing a reply brief.

Petitioner has not objected to my consideration of CMS Ex. 1 and it is admitted as evidence. CMS did not object to my consideration of P. Exs. 1 and 2 and they are admitted as evidence.

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.[1] Act §§ 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395(u)(h)(1)).

---

[1] 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.

Administration of the Part B program is through contractors such as Cahaba. 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.

Petitioner, a nurse practitioner, is a nonphysician practitioner. 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 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 or not summary judgment is appropriate; and
>
> Whether the effective date of Petitioner's Medicare enrollment and billing privileges is February 27, 2015.

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. 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 March 24, 2016, 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 February 27, 2015, the date of filing of a Medicare enrollment application that Cahaba 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 her effective date of enrollment, i.e., beginning on January 28, 2015.

a. Facts

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

Petitioner, a nurse practitioner, asserts that she began providing services for Life Line on January 22, 2015. RFH at 1-2; P. Exs. 1-2. The documents Petitioner submitted show that she provided services at Life Line as early as January 22, 2015. P. Ex. 1-2. Petitioner does not dispute that her Forms CMS- 855I (Medicare enrollment application) and CMS-855R (reassignment of Medicare claims) were received by Cahaba on February 27, 2015. In fact, Petitioner concedes in her request for hearing that Cahaba did not receive her enrollment application until February 27, 2015. RFH at 1.

b. Analysis

Petitioner requests that her effective date of enrollment be changed so that she can retrospectively bill beginning on January 22, 2015, the date she first provided service at Life Line. RFH at 2. Petitioner argues that Life Line "was in the beginning stages of working with the MACS", and that affected the timely submission of all of the necessary paperwork. RFH at 1. Petitioner's exhibits show that she provided services on January 22, 2015. P. Exs. 1-2. Petitioner argues that the facts that she began providing services on January 22, 2015, and that there was only a slight delay in filing her enrollment application, warrants a change in her effective date of enrollment and her retrospective billing date from January 28, 2015 to January 22, 2015. RFH at 1-2.

There is no dispute that Petitioner filed her Medicare enrollment and reassignment applications and that they were received by Cahaba on February 27, 2015, and subsequently approved. 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. 42 C.F.R. § 424.520(d). An enrolled physician or 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. 42 C.F.R. § 424.521.

Although Petitioner began providing services on January 22, 2015, 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(a)(1). There is no dispute that Petitioner's Forms CMS-855I and CMS-855R were not received by Cahaba until February 27, 2015. Petitioner provides no evidence showing that she was actively enrolled in Medicare prior to February 27, 2015. Petitioner also offers no evidence, such as a certified mail receipt or record of electronic filing that shows a date of filing earlier than the date of receipt by Cahaba. The regulation is clear that the effective date of enrollment is the date of the filing of the application which was subsequently approved. 42 C.F.R. § 424.520(d). Petitioner's enrollment application that was processed to approval was received by Cahaba on February 27, 2016 and the date of receipt is treated as the date of filing. Absent evidence of an earlier filing date, February 27, 2016, is the earliest effective date of Petitioner's enrollment. Retrospective billing privileges extend 30 days prior to the effective date of enrollment, that is, January 28, 2015, in this case. 42 C.F.R. § 424.521(a)(1).

Petitioner's arguments may be construed as request 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 her 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.").

Accordingly, I conclude that, pursuant to 42 C.F.R. § 424.520(d), Petitioner's effective date of Medicare enrollment and billing privileges is February 27, 2015. Pursuant to 42 C.F.R. § 424.521(a)(1), Petitioner may retrospectively bill beginning January 28, 2015.

III. Conclusion

For the foregoing reasons, I conclude that the effective date of Petitioner's Medicare enrollment and billing privileges was February 27, 2015, with a 30-day period for retrospective billing beginning on January 28, 2015.

/s/
Keith W. Sickendick
Administrative Law Judge