Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Robert S. Macinga, CRNA and,
Donna E. Ward, CRNA,

Petitioners,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-12-259

Decision No. CR2562

Date: July 2, 2012

DECISION

Petitioners, Robert S. Macinga and Donna E. Ward, appeal two reconsideration decisions issued on December 19, 2011. I grant summary judgment and sustain the determinations of the Centers for Medicare and Medicaid Services (CMS) finding that the undisputed evidence establishes that CMS properly enrolled Petitioners in the Medicare program effective October 18, 2011.

I. Background and Procedural History

Petitioners are Certified Registered Nurse Anesthetists (CRNAs), and both challenge the effective date that they received for Medicare billing privileges as Medicare suppliers for the group East Liverpool Anesthesia Associates, LLC (East Liverpool). To obtain direct billing privileges from Medicare for care provided to beneficiaries while working for East Liverpool, Petitioners completed reassignment enrollment applications, CMS Forms 855-R, and requested an effective date of August 1, 2011. CMS Exhibit (Ex.) 1, at 5-6 and CMS Ex. 2, at 5-6. East Liverpool mailed the applications for both Petitioners on October 12, 2011. CMS Ex. 7, at 2 and CMS Ex. 8, at 2. CGS Administrators, LLC (CGS), a CMS contractor, received the enrollment applications for both Petitioners on

October 18, 2011 and acknowledged receipt by letter dated October 24, 2011. CMS Exs. 3 and 4. CGS then notified East Liverpool that it had approved Petitioners' Medicare enrollment applications effective October 18, 2011, with a retrospective billing date of September 19, 2011 (which CGS mischaracterized as an "effective date"). CMS Exs. 5 and 6.

East Liverpool requested reconsideration of the initial decisions on behalf of both Petitioners and requested Petitioners be given the earlier effective enrollment date of August 1, 2011. CMS Exs. 7 and 8. On December 19, 2011, a contractor hearing officer issued two reconsideration decisions denying Petitioners' requests for earlier effective dates of enrollment. CMS Exs. 10 and 11.

Petitioners 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 January 10, 2012, CMS filed a Motion for Summary Disposition and Pre-hearing Brief (CMS Br.), accompanied by thirteen exhibits (CMS Exs. 1-13), on February 13, 2012. Petitioners did not respond to the CMS Motion for Summary Disposition, and I subsequently issued an Order to Show Cause on April 3, 2012. On April 9, 2012, Petitioners responded to my Order to Show Cause (P. Response) by letter and explained that "[t]he Petitioners do not dispute the facts set forth by CMS and ask that the case be decided upon the written record of all documents previously submitted . . . we thought the case had already been decided in CMS favor. Not being lawyers we did not understand a response was required." P. Response. In the absence of objection, I admit CMS Exs. 1-13 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 §§ 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395u(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 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 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 signed enrollment application and supporting documentation. 42 C.F.R. § 424.510(d)(1); 73 Fed. Reg. 69,725, 69,769 (Nov. 19, 2008).

Additionally, an enrolled supplier may bill 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(a). Retrospective billing for up to 90 days prior to the effective date of enrollment is permitted only in the case of a Presidentially-declared disaster, pursuant to 42 C.F.R. § 424.521. Here, Petitioners "do not dispute the facts set forth by CMS and ask that the case be decided upon the written record of all documents previously submitted." P. Response.

III. Analysis

A. Issue

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

B. Applicable Standard For 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 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. Finding of Fact and Conclusion of Law

1) The undisputed evidence shows CMS's contractor and CMS properly determined Petitioners' effective date of Medicare enrollment and Petitioners' retrospective billing date for Medicare privileges.

The relevant facts are not disputed, and I draw all reasonable inferences in favor of Petitioners. Petitioners began providing services to Medicare patients on behalf of East Liverpool in August of 2011. HR. Petitioners subsequently submitted their Medicare reassignment enrollment applications to CGS. CMS Exs. 1 and 2. CGS received Petitioners' Medicare enrollment applications on October 18, 2011. CMS Br.; CMS Exs. 3 and 4. On October 27, 2011, CGS approved Petitioners' enrollment applications with an effective date of October 18, 2011 and retrospective billing privileges commencing on September 19, 2011. CMS Exs. 5 and 6.

Petitioners do not deny that CMS received their enrollment applications on October 18, 2011. However, Petitioners argue that their effective date should be August 1, 2011 because "while the group was setting up Robert S. Macinga has 1 case for date of service 8/17/11 and Donna E. Ward had 4 cases for date of service 8/24/11. At the time they were used the group application had not been completed." HR. The Hearing Request further states that East Liverpool "was given a great deal of incorrect information regarding [the] application including the fact that [it] should not send [the] 855R applications until [the] group application was completed . . . [East Liverpool] did not receive [the] group enrollment approval until 10/10/2011, so [it] did not send these 2 CRNA applications until then and CMS states they did not receive it until 10/18/2011." The Hearing Request further states that "approvals for these 2 CRNAs missed the only 2 dates they actually worked for the group" and contends that "due to the incorrect information . . . received . . . we should [not] be penalized with an effective date that is after the date of service these 2 members worked for us." HR. Petitioners subsequently stated that although East Liverpool "was given incorrect information from CMS provider enrollment, we have no proof of the conversation that took place . . . ." P. Response.

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 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.

(Emphasis added).

The regulation is clear that 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). Thus, CMS properly determined that Petitioners' effective date was the date Petitioners originally filed their applications, October 18, 2011. Because it is undisputed that the contractor received Petitioners' enrollment applications on October 18, 2011, which is after the date Petitioners began providing services, the regulation dictates that this is the effective date of Petitioners' enrollment, and I have no discretion to ignore regulations and determine an earlier effective date.

Despite not meeting the legal requirements, Petitioners made various arguments for equitable relief at the reconsideration level and during this appeal pertaining to delays during the enrollment process, inaccurate information conveyed by CMS and its contractors, the fact that Petitioners will be financially penalized despite their diligence in supplying the required information "as quickly as possible," and that Petitioners provide services in an area which has a high percentage of Medicare patients. P. Response; HR. I am not without sympathy for Petitioners' predicament. Petitioners did not argue, however, that they filed complete applications 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 CGS or CMS to provide an exemption to Petitioners under the regulations set forth at 42 C.F.R. §§ 424.520(d) and 424.521(a), which are binding on me. I cannot alter or deviate from the regulations' explicit limitation on Petitioners' ability to bill for services up to 30 days prior to the date CGS received Petitioners' complete applications. *See Kate E. Paylo*, DAB CR2232, at 14-15 (2010). I have no authority to extend the retrospective billing period for Petitioners in this circumstance or ignore the clear requirements of the regulations governing their enrollment in Medicare. *Id*. Even accepting all of Petitioners' assertions as true, Petitioners' equitable arguments give me no ground to grant Petitioners 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.").

Additionally, Petitioners' claims regarding misleading advice given to them by CMS employees and contractors may also be construed to be an equitable estoppel argument. Even assuming Petitioner accurately described what transpired during Petitioners' conversations with representatives of CMS regarding provider enrollment, Petitioners do not allege any affirmative misconduct, and I am unable to grant the relief that Petitioners request. 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 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). CMS has already provided Petitioners with the maximum amount of retrospective billing permitted under the applicable regulations by granting a 30-day retrospective billing date of September 19, 2011.

I conclude that Petitioners' effective date of Medicare enrollment was October 18, 2011, the undisputed date on which Petitioners submitted enrollment applications that could be processed to approval. CMS also properly authorized Petitioners to directly bill Medicare for services provided to Medicare beneficiaries on behalf of East Liverpool up to 30 days prior to their effective date of enrollment, *i.e.*, September 19, 2011. Accordingly, I grant summary judgment in favor of CMS.

/s/
Joseph Grow
Administrative Law Judge