Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Pierre-Richard Edouard, M.D.,

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-3375

Decision No. CR4558

Date: March 24, 2016

DECISION

The Centers for Medicare & Medicaid Services (CMS), through an administrative contractor, revoked the Medicare enrollment and billing privileges of Pierre-Richard Edouard, M.D. (Dr. Edouard or Petitioner) because he failed to provide documentation, based on a CMS request, related to numerous Medicare claims involving home health services that Dr. Edouard ordered or certified. Petitioner requested a hearing to dispute the revocation. CMS subsequently moved for summary judgment. Because there is no dispute that Petitioner failed to provide five of the requested documents, I grant CMS's motion for summary judgment and affirm the revocation of Petitioner's Medicare enrollment and billing privileges for a period of one year.

I. Background and Procedural History

Dr. Edouard is a physician licensed to practice medicine in the state of Florida and, therefore, a supplier for purposes of the Medicare program. *See* 42 U.S.C. § 1395x(d); 42 C.F.R. §§ 400.202 (definition of *Supplier*), 410.20(b)(1); CMS Exhibit (Ex.) 23 at 8. In a January 30, 2015 initial determination, CMS's administrative contractor revoked Petitioner's Medicare billing privileges, effective March 1, 2015, for the following reason:

> **42 CFR § 424.535(a)(10) Failure to Document or Provide CMS Access to Documentation**
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> On October 15, 2014, Safeguard Services, LLC (SGS) requested 40 medical records for 40 beneficiaries for whom Pierre-Richard Edouard had ordered and certified [home health] services. On November 18, 2014, SGS received partial medical records from Pierre-Richard Edouard and his attorney . . . in which two of the requested beneficiaries['] medical records were not submitted and 22 of the beneficiaries' records were incomplete. Pierre-Richard Edouard failed to submit any written and electronic documents relating to written orders and certifications and request for home health services, specifically the plan of care, face-to-face forms, verbal orders and prescriptions for two of the beneficiaries requested.

CMS Ex. 1 at 3 (emphasis in original). CMS's administrative contractor barred Petitioner from re-enrolling in the Medicare program for one year. *Id*. at 4.

Petitioner timely requested reconsideration of the revocation determination. CMS Ex. 1 at 1; CMS Ex. 23. On May 13, 2015, the CMS administrative contractor upheld its initial determination. Petitioner (P.) Ex. H.

Petitioner timely requested a hearing. On August 7, 2015, I issued an Acknowledgment and Pre-Hearing Order (Order) establishing deadlines for the submission of pre-hearing exchanges. In accordance with the Order, CMS filed its pre-hearing exchange, which included a motion for summary judgment and brief, and 23 exhibits (CMS Exs. 1-23). Petitioner filed an initial brief and opposition to summary judgment (P. Br.), and nine exhibits (P Exs. A-I). CMS then filed a reply brief (CMS Reply Br.).

II. Issues

This case presents three issues:

1. Whether CMS is entitled to summary judgment;

2. Whether CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(10); and

3. Whether Petitioner was prejudiced by CMS's failure to comply with his discovery requests.

III. Jurisdiction

I have jurisdiction to hear and decide this case. *See* 42 C.F.R. §§ 498.3(b)(17), 498.5(*l*)(2); *see also* 42 U.S.C. § 1395cc(j)(8).

IV. Findings of Fact, Conclusions of Law, and Analysis[1]

The Social Security Act authorizes the Secretary of Health and Human Services (Secretary) to establish regulations governing the enrolling of providers and suppliers in the Medicare program. 42 U.S.C. § 1395cc(j)(1)(A). The Secretary promulgated enrollment regulations in 42 C.F.R. part 424, subpart P. *See* 42 C.F.R. §§ 424.500-.570. The regulations provide CMS with the authority to revoke the billing privileges of an enrolled provider or supplier if CMS determines that a provider or supplier violated a provision in 20 C.F.R. § 424.535(a).

A provider or supplier may request reconsideration of an initial determination to revoke his or her billing privileges. 42 C.F.R. §§ 498.5(*l*)(1), 498.22(a). If dissatisfied with the reconsidered determination, the provider or supplier may request a hearing before an Administrative Law Judge (ALJ). *Id.* § 498.5(*l*)(2). When appropriate, ALJs may decide a case arising under 42 C.F.R. part 498 by summary judgment. *Livingston Care Ctr. v. U.S. Dep't of Health & Human Servs.*, 388 F.3d 168, 172 (6th Cir. 2004) (citing *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743 (6th Cir. 2004)). "Matters presented to the ALJ for summary judgment will follow Rule 56 of the Federal Rules of Civil Procedure and federal case law . . . ." Civil Remedies Division Procedures § 19(a). As stated by the United States Supreme Court:

> Rule 56(c) of the Federal Rules of Civil Procedure provides that summary judgment 'shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.' By its very terms, this standard provides that the mere existence of *some* alleged factual dispute between the parties will not defeat an otherwise properly supported motion for summary judgment; the requirement is that there be no *genuine* issue of *material* fact."

Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 247-48 (1986) (emphasis in original).

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[1] My findings of fact and conclusions of law are set forth in italics and bold font.

To determine whether there are genuine issues of material fact for an in-person hearing, the ALJ must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor.

1. Summary judgment is appropriate.

Petitioner disputes some of CMS's assertions that the requested documents were not provided and Petitioner disputes whether he was required to provide some of the requested documents. P. Ex. I. However, it is undisputed that some of the requested documents were not provided, and that Petitioner was required to provide those documents. Petitioner's undisputed failure to provide some of the requested documents provides a basis for summary judgment because Petitioner's arguments related to them are legal in nature.

As summarized above, a CMS contractor requested the medical documentation for 40 beneficiaries. In its initial determination, the CMS contractor stated that Petitioner did not provide any medical documentation for two beneficiaries and that Petitioner provided incomplete medical documentation for 22 beneficiaries. CMS Ex. 1 at 3. Now, in its motion for summary judgment, CMS asserts that Petitioner's billing privileges were properly revoked based on a shortened list of beneficiaries for whom CMS asserts that Petitioner did not provide all of the requested documentation. CMS submitted a chart that specifies the documents Petitioner failed to provide related to 18 beneficiaries. CMS Br. at 10-11 (Appendix). Further, for purposes of summary judgment, CMS accepted that Petitioner did not treat the two beneficiaries for whom Petitioner provided no documentation. *See* CMS Reply Br. at 2 n.1.

In his reconsideration request, Petitioner asserted that he was not provided a definite statement of the requested documents that CMS's contractor determined were missing. Instead, Petitioner argues that the CMS contractor instructed Petitioner "to go on a fishing expedition to 'look through the 40 charts' it requested to self-determine whatever concluded deficient practices exist . . . ." CMS Ex. 23 at 5. Petitioner also asserted that the CMS contractor did not comply with Petitioner's requests for more information regarding the missing documents on which the CMS contractor based the revocation. CMS Ex. 23 at 9-10. In his hearing request, Petitioner stated that he would submit recently obtained evidence "confirming that it did submit the requested patient information . . . ." Hearing Request at 3. In his pre-hearing exchange Petitioner responded to CMS's chart that specified the documents Petitioner allegedly failed to provide to the CMS contractor for 18 beneficiaries. P. Ex. I. However, Petitioner did not submit additional substantive evidence related to the 18 beneficiaries identified by CMS and failed to account for all of the missing documents identified by CMS in its chart. Therefore, I conclude that Petitioner does not dispute that it failed to submit to the CMS contractor all unaccounted for documentation identified by CMS in the appendix to its brief in this case.

For purposes of summary judgment, I draw all reasonable inferences in favor of Dr. Edouard. I accept as true that at the lower levels of appeal, the CMS contractor did not provide a statement of all of the specific documents missing from Petitioner's submission to CMS, despite his requests for such a statement. P. Br. at 13-14. I also accept as true that Petitioner instructed his prior attorney to comply with the CMS contractor's requests, and that Petitioner provided access to all documentation in his possession. P. Br. at 8, 14. I further accept as true that throughout this process Petitioner attempted to provide CMS with all requested documentation. CMS Br. at 13.

2. CMS was authorized to revoke Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(10) because Petitioner did not dispute that he failed to maintain and/or provide CMS with copies of two plans of care and three verbal orders for beneficiaries who were certified by Petitioner as needing home health services.

In April 2014, an investigator with a CMS contractor interviewed Dr. Edouard regarding patients for whom Dr. Edouard had ordered durable medical equipment and home health services. CMS Ex. 2; P. Ex. B. On October 15, 2014, the CMS contractor requested by letter "any and all documentation that supports the billed services" for 40 beneficiaries for whom Petitioner had ordered/certified home health services. CMS Ex. 3. The letter provided a list of the beneficiaries in question as well as a non-exhaustive list of the types of documents that Petitioner was required to provide for each of the beneficiaries, including "Plans of Care" and "Verbal Orders." CMS Ex. 3 at 1, 4.

On November 17, 2014, Petitioner's attorney submitted documents in response to CMS's request, noting that two of the named beneficiaries neither appeared in Petitioner's electronic medical records nor in Petitioner's stored patient charts. CMS Ex. 4 at 1. Nevertheless, Petitioner submitted over 2,000 pages of documents to the CMS contractor related to 38 beneficiaries. CMS Exs. 4-22. The CMS contractor determined that Petitioner did not submit all of the documents requested for all of the beneficiaries in question and revoked Petitioner's enrollment and billing privileges. CMS Ex. 1 at 1.

CMS may revoke a provider's or supplier's billing privileges if:

> (i) The provider or supplier did not comply with the documentation or CMS access requirements specified in § 424.516(f) of this subpart.
> (ii) A provider or supplier that meets the revocation criteria specified in paragraph (a)(10)(i) of this section, is subject to revocation for a period of not more than 1 year for each act of noncompliance.

42 C.F.R. § 424.535(a)(10); *see also* 42 U.S.C. § 1395u(h)(9). Of importance in this case, 42 C.F.R. § 424.516(f)(2) states:

> (i) A physician who orders/certifies home health services and the physician or, when permitted, other eligible professional who orders items of DMEPOS or clinical laboratory or imaging services is required to –
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> (A) Maintain documentation (as described in paragraph(f)(2)(ii) of this section) for 7 years from the date of the service; and
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> (B) **Upon request of CMS or a Medicare contractor, to provide access to that documentation** (as described in paragraph (f)(2)(ii) of this section).
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> (ii) **The documentation includes written and electronic documents** (including the NPI of the physician who ordered/certified the home health services and the NPI of the physician or, when permitted, other eligible professional who ordered the items of DMEPOS or the clinical laboratory or imaging services) **relating to written orders or certifications** or requests for payments for items of DMEPOS and clinical laboratory, imaging, and **home health services**.

42 C.F.R. § 424.516(f)(2) (emphasis added).

Even if I accept every dispute that Petitioner raised in his pre-hearing exchange with regard to the specific list of documents that CMS alleges that Petitioner failed to provide (*compare* CMS Br. at 10-11 *with* P. Ex. I), Petitioner still did not dispute that he failed to provide two plans of care and documentation of three verbal orders for home health services. The following is the list of undisputed documents that Petitioner failed to provide to CMS:

1. Beneficiary A.C.: Petitioner did not provide a verbal order for the February 19, 2013 plan of care. *See* CMS Br. at 10; P. Ex. I at 1.

2. Beneficiary I.R.: Petitioner did not provide a plan of care for April 11, 2013. *See* CMS Br. at 10; P. Ex. I at 2.

3. Beneficiary A.R.: Petitioner did not provide a verbal order for October 7, 2011. *See* CMS Br. at 10; P. Ex. I at 2.

4. Beneficiary G.S.: Petitioner did not provide either a plan of care or a verbal order for August 15, 2012. *See* CMS Br. at 11; P. Ex. I at 3 (acknowledging the plan of care may have been lost during transition to electronic medical records).

I agree with the conclusion in *Carlos E. Fossi, M.D.*, DAB CR3294, at 11 (2014), that the statutory requirement under 42 U.S.C. § 1395x(m), i.e., that home health services be provided in accordance with a plan of care, means "that a plan of care is related to an order for home health services, and is a document that must be maintained by a physician certifying or recertifying home health services and made accessible to CMS upon request." *See also* 42 C.F.R. § 424.22(a)(1)(iii). By extension, I also conclude that when a physician does not initially sign a plan of care, a record of a physician's verbal order for the home health services, as required by 42 C.F.R. § 409.43, must also be maintained and made accessible to CMS on request.

When CMS's contractor determined that Dr. Eduoard failed to provide all of the requested documentation, including the above-referenced plans of care and records of verbal orders, it was then authorized to revoke Dr. Eduoard's Medicare enrollment and billing privileges. 42 C.F.R. § 424.535(a)(10). Here, there is no dispute that Petitioner did not provide these five requested documents to CMS. CMS Br. 10-11; P Ex. I. Further, Dr. Edouard did not assert that he was not required to provide these five requested documents. Therefore, CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(10).

3. Petitioner did not avail himself of the opportunity to file a corrective action plan (CAP) with the CMS contractor, and Petitioner received sufficient notice of the factual basis for revocation to defend himself during this de novo proceeding.

Petitioner argues that the CMS contractor failed to provide specific information concerning the factual basis for the revocation, which impeded his ability to create a CAP and defend himself against revocation. For the reasons stated below, I reject Petitioner's argument.

The January 30, 2015 initial determination provided Petitioner with notice that he had 30 days to file a CAP with the CMS contractor. CMS Ex. 1 at 3. It appears that Petitioner unsuccessfully attempted to obtain information from the CMS contractor following the initial determination to revoke Petitioner's Medicare enrollment and billing privileges. P. Ex. D; P. Ex. E; P. Ex. G at 3. Petitioner argues that the lack of responses from the CMS contractor to his discovery requests resulted in Petitioner being unable to file a CAP.

As an initial matter, supplier revocation appeals from the reconsidered determination stage through Departmental Appeals Board review are governed by the procedures set forth in 42 C.F.R. part 498 (42 C.F.R. §§ 405.803(a), 424.545(a), 498.5(*l*)). Those regulations "do not expressly provide for the use of . . . pre-hearing discovery tools available under the Federal Rules of Civil Procedure." *Oaks of Mid City Nursing and Rehab. Ctr*., DAB No. 2375, at 32 (2011). Therefore, CMS was under no obligation to respond to Petitioner's discovery demands.

Although Petitioner did not obtain additional information from the CMS contractor concerning the factual basis for the revocation, Petitioner failed to file a timely CAP based on the information provided to Petitioner with the initial determination. Therefore, Petitioner lost the opportunity to file a CAP. In any event, review of a CAP is not within an ALJ's jurisdiction. *See* 42 C.F.R. § 405.809 (2014); *DMS Imaging, Inc.*, DAB No. 2313, at 5 (2010).

Petitioner also argues that the CMS contractor's alleged failure to provide sufficient notice regarding the basis for revocation prevented Petitioner from setting forth an effective defense. However, Petitioner conceded that, in the present proceeding, CMS's appendix to its pre-hearing brief "lists alleged deficient findings with particularity. It is exactly what Undersigned requested multiple times." P. Br. at 14. As explained in the following quote, CMS's use of its brief (CMS Br. at 10-11) to clarify its exact factual position as to Petitioner's alleged violation is sufficient to provide Petitioner with notice of the basis for CMS's revocation.

> As we outlined in the Case Background section, CMS explained and clarified the factual and legal bases for the revocation in briefs supporting its motion for summary disposition. The Board has held that a federal agency may clarify its reasons for a challenged determination, or assert new reasons for that determination, during the ALJ proceeding as long as the non-federal party has adequate notice of the reasons and a reasonable opportunity to respond during that proceeding.
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> . . .
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> To the extent that Petitioner is claiming that the revocation should be overturned because he lacked sufficient notice of the basis of CMS's revocation determination at the reconsideration stage . . . we stress that Petitioner subsequently received a de novo hearing before the ALJ concerning the validity of the revocation determination. In general, the ALJ proceeding is not an appellate or quasi-

> appellate review of the adequacy of the federal agency's decision-making or review process. Rather, the ALJ hearing under 42 C.F.R. Part 498 is a de novo proceeding in which the ALJ determines the legality of the challenged determination based on the evidence presented in that proceeding.

Fady Fayad, M.D., DAB No. 2266, at 10-11 (2009) (citations omitted). I conclude that CMS's pre-hearing brief provided Petitioner with sufficient notice of the documents Petitioner failed to provide to CMS, which formed the basis of the revocation. Further, Petitioner had plenty of time to respond to the additional information provided in CMS's brief, filed on September 11, 2015, because Petitioner ultimately filed his pre-hearing brief more than three and a half months later on December 31, 2015, and his proposed exhibits nearly four months later on January 4, 2016. Therefore, Petitioner received a full opportunity to defend himself in this proceeding.

V. Conclusion

For the reasons explained above, I grant summary judgment in favor of CMS. Consequently, I affirm CMS's determination to revoke Petitioner's Medicare enrollment and billing privileges effective March 1, 2015.

/s/
Scott Anderson
Administrative Law Judge