Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Mel Lucas, D.O.
(NPI: 1225022627; PTAN: 000013477),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-16-386

Decision No. CR4889

Date: July 12, 2017

DECISION

The Medicare enrollment and billing privileges of Petitioner, Mel Lucas, D.O., are revoked pursuant to 42 C.F.R. § 424.535(a)(8)(i)[1], effective September 2, 2015.

I. Background

Wisconsin Physicians Service Insurance Corporation (WPS), a Centers for Medicare & Medicaid Services (CMS) Medicare Administrative Contractor (MAC), notified Petitioner by letter dated August 3, 2015, that his Medicare billing number and billing privileges were revoked effective September 2, 2015. WPS cited 42 C.F.R. § 424.535(a)(8) as the basis for the revocation. WPS also notified Petitioner that he was subject to a three-year bar to re-enrollment pursuant to 42 C.F.R. § 424.535(c).[2] CMS

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[1] Citations are to the 2015 revision of the Code of Federal Regulations (C.F.R.), unless otherwise stated.

[2] Petitioner's practice, Patterson Medical Clinic (Patterson), was also notified by WPS by letter dated August 3, 2015, that its enrollment and billing privileges were being
(Footnote continued next page.)

Exhibit (Ex.) 2 at 6-7. Petitioner requested reconsideration on October 1, 2015. CMS Ex. 2 at 1-5. On January 6, 2016, a CMS hearing officer upheld the revocation on reconsideration.[3] CMS Ex. 3.

Petitioner filed a request for hearing before an ALJ on March 9, 2016. On March 16, 2016, the case was assigned to me for hearing and decision and I issued an Acknowledgement and Prehearing Order (Prehearing Order).

On April 15, 2016, CMS filed a motion for summary judgment; a memorandum in support of its motion (CMS Br.); and CMS Exs. 1 through 5. On October 14, 2016, Petitioner filed a response (P. Br.) with no exhibits. On November 17, 2016, CMS filed a waiver of reply. Petitioner has not objected to my consideration of the CMS exhibits and they are admitted.

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. Administration of the Part B program is through contractors, such as WPS. Act § 1842(a) (42 U.S.C. § 1395u(a)). Payment under the program for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of services and suppliers.[4] Act §§ 1835(a) (42 U.S.C. § 1395n(a)), 1842(h)(1) (42 U.S.C. § 1395u(h)(1)). Petitioner, a physician, is a supplier.

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(Footnote Continued.)

revoked pursuant to 42 C.F.R. § 424.535(a)(8), with a three-year re-enrollment bar. CMS Exhibit (Ex.) 1. I have no evidence that a reconsidered determination was issued or a hearing was requested on behalf of Patterson. The fact that CMS offered a copy of the August 3, 2015 notice to Patterson as evidence does not bring Patterson within my jurisdiction absent evidence of an adverse reconsidered determination involving Patterson, as it is an adverse reconsidered determination that triggers an affected party's right to administrative law judge (ALJ) review. 42 C.F.R. § 498.5(*l*)(2).

[3] The letter announcing the reconsidered determination is dated January 6, 2015, which I treat as a scrivener's error based on the fact that the request for reconsideration is dated October 1, 2015. CMS Ex. 3 at 1.

[4] A "supplier" furnishes services under Medicare and includes physicians or other practitioners and facilities that are not included within the definition of the phrase

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The Act requires the Secretary of Health and Human Services (Secretary) to issue regulations that establish a process for the enrollment in Medicare of providers and suppliers, including the right to a hearing and judicial review of certain enrollment determinations, such as revocation of enrollment and billing privileges. Act § 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to 42 C.F.R. § 424.505, suppliers such as Petitioner 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.

The Secretary has delegated the authority to revoke enrollment and billing privileges to CMS. 42 C.F.R. § 424.535. CMS or its Medicare contractor may revoke an enrolled supplier's Medicare enrollment and billing privileges and supplier agreement for any of the reasons listed in 42 C.F.R. § 424.535. If CMS revokes a supplier's Medicare billing privileges, the revocation becomes effective 30 days after CMS or one of its contractors mails the revocation notice to the supplier, subject to some exceptions not applicable in this case. After a supplier's Medicare enrollment and billing privileges are revoked, the supplier is barred from re-enrolling in the Medicare program for a minimum of one year, but no more than three years. 42 C.F.R. § 424.535(c).

A supplier whose enrollment and billing privileges have been revoked may request reconsideration and review as provided by 42 C.F.R. pt. 498. 42 C.F.R. § 424.545(a). A supplier submits a written request for reconsideration to CMS or its contractor. 42 C.F.R. § 498.22(a). CMS or its contractor must give notice of its reconsidered determination to the supplier, giving the reasons for its determination and specifying the conditions or requirements the supplier failed to meet, and the right to an ALJ hearing. 42 C.F.R. § 498.25. If the decision on reconsideration is unfavorable to the supplier, the supplier has the right to request a hearing by an ALJ and further review by the Departmental Appeals Board (the Board). Act § 1866(j)(8) (42 U.S.C. § 1395cc(j)(8)); 42 C.F.R. §§ 424.545, 498.3(b)(17), 498.5. A hearing on the record, also known as an oral hearing, is required under the Act unless waived. CMS is also granted the right to request ALJ review of a reconsidered determination with which it is dissatisfied. 42 C.F.R.

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(Footnote Continued.)

"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) (42 U.S.C. § 1395f(g)) and 1835(e) (42 U.S.C. § 1395n(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.

§ 498.5(*l*)(2). *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743, 748-51 (6th Cir. 2004). The supplier bears the burden to demonstrate that it meets enrollment requirements with documents and records. 42 C.F.R. § 424.545(c).

B. Issues

Whether summary judgment is appropriate;

Whether there was a basis for the revocation of Petitioner's billing privileges and enrollment in Medicare.

C. Findings of Fact, Conclusions of Law, and Analysis

My conclusions of law are set forth in bold followed by the undisputed facts and analysis.

1. Summary judgment is appropriate.

CMS filed a motion for summary judgment. As noted above, a supplier whose enrollment has been revoked has a right to a hearing and judicial review, and a hearing on the record is required under the Act. Act §§ 205(b), 1866(h)(1), (j); 42 C.F.R. §§ 498.3(b)(5), (6), (8), (15), (17), 498.5; *Crestview*, 373 F.3d at 748-51. A party may waive appearance at an oral hearing but must do so affirmatively in writing. 42 C.F.R. § 498.66. In this case, Petitioner has not waived the right to oral hearing or otherwise consented to a decision based only upon the documentary evidence or pleadings. Accordingly, disposition on the written record alone is not permissible, unless summary judgment is appropriate.

Summary judgment is not automatic upon request but is limited to certain specific conditions. The Secretary's regulations at 42 C.F.R. pt. 498 that establish the procedures to be followed in adjudicating Petitioner's case do not establish a summary judgment procedure or recognize such a procedure. However, 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.*, *Ill. 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 Fed. R. Civ. Pro. 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. 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 Fed. R. Civ. Pro. 56 will be applied. 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 ALJ 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. *Mission Hosp. Reg'l Med. Ctr.*, DAB No. 2459 at 4 (2012) (and cases cited therein); *Experts Are Us, Inc.*, DAB No. 2452 at 4 (2012) (and cases cited therein); *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 at 3 (2010) (and cases cited therein); *see also 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 differ from that used in 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 in 42 C.F.R. pt. 498 for the allocation of the burden of persuasion or the quantum of evidence required to satisfy the burden of persuasion. 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).

Viewing the evidence before me in a light most favorable to Petitioner and drawing all inferences in Petitioner's favor, I conclude that there are no genuine disputes as to any material facts pertinent to revocation under 42 C.F.R. § 424.535(a)(8)(i) that require a hearing in this case. The issues in this case raised by Petitioner related to revocation under 42 C.F.R. § 424.535(a)(8)(i) must be resolved against him as a matter of law.

Petitioner argues that summary judgment is not appropriate because CMS has failed to show it is entitled to judgment as a matter of law. Petitioner's legal theory is that CMS failed to show the material fact that it was Petitioner whose Medicare enrollment and

billing privileges were revoked by WPS rather than Patterson Medical Clinic. P. Br. at 1-3. However, there is no dispute of fact that Petitioner was also notified of the initial determination to revoke (CMS Ex. 2 at 6-7); Petitioner exercised the right to request a reconsidered determination (CMS Ex. 2 at 1-5); and Petitioner has not disputed the assertion of WPS and CMS that Petitioner is the owner of Patterson Medical Clinic (CMS Exs. 1 at 1, 2 at 6). Petitioner has also not specifically disputed the admissibility of CMS Exs. 4 and 5 or the allegations and information contained in those documents. I advised the parties in the Prehearing Order that "a fact alleged and not specifically denied, may be accepted as true for purposes of a motion or cross-motion for summary judgment" and that "[a]ny evidence will be considered admissible and true unless specific objection is made to its admissibility and accuracy." Prehearing Order ¶ II.G. Petitioner also asserts that the claims cited as the basis for abuse of billing privileges are listed in CMS Ex. 5 as claims by Patterson Medical Clinic rather than by Petitioner. P. Br. at 2-4. However, Petitioner fails to recognize that even if the claims were submitted by Patterson Medical Clinic, Petitioner as the undisputed owner of Patterson was responsible for those claims. 42 C.F.R. § 424.510. Furthermore, CMS Ex. 5 clearly lists all claims as being submitted by the entity with national provider identifier (NPI) 1225022627, which, it is undisputed, is Petitioner's NPI. Accordingly, Petitioner's argument that CMS has not proven the claims were submitted by Petitioner fails as a matter of law, for Petitioner was responsible for the claims submitted by Petitioner both as a matter of law and undisputed fact.

The undisputed evidence shows that there is a basis for revocation of Petitioner's Medicare enrollment and billing privileges and CMS is entitled to judgment as a matter of law. Accordingly, summary judgment is appropriate.

> **2. Billing privileges are abused, within the meaning of 42 C.F.R. § 424.535(a)(8)(i), when three or more claims are submitted to Medicare for services that could not have been furnished to the specific individuals identified in the claims on the dates the services were claimed to have been delivered.**
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> **3. Claims for payment were submitted to Medicare between January 16, 2008 and September 9, 2011 by Petitioner or on his behalf as owner of Patterson Medical Clinic; the claims were false because they were for services rendered during periods of time when Petitioner was out of the country; and the filing of the claims constituted an abuse of billing privileges under 42 C.F.R. § 424.535(a)(8)(i).**
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> **4. It is no defense to a revocation action for abuse of billing privileges under 42 C.F.R. § 424.535(a)(8)(i) that the false claims were due to inadvertent or unintentional errors of Petitioner's agents or employees or others.**

5. There is a basis for revocation of Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(8)(i).

6. The effective date of revocation in this case was September 2, 2015, 30 days after the date of the notice of initial determination to revoke. 42 C.F.R. § 424.535(g).

7. I have no authority to review the imposition or duration of a bar to re-enrollment. 42 C.F.R. §§ 424.545, 498.5(*l*)(1)-(2).

The notice of the reconsidered determination in this case was issued on January 6, 2016. CMS Ex. 3. Therefore, 42 C.F.R. § 424.535(a)(8), as amended effective February 3, 2015, applies in this case. On December 5, 2014, 42 C.F.R. § 424.535(a)(8) was amended to re-number 42 C.F.R. § 424.535(a)(8) as 42 C.F.R. § 424.535(a)(8)(i) and to add subsection (8)(ii). The change was effective February 3, 2015. 79 Fed. Reg. 72,500, 72,513-521 (Dec. 5, 2014).

The revision effective February 3, 2015, provides:

> (8) *Abuse of billing privileges.* Abuse of billing privileges includes either of the following:
>
> (i) The provider or supplier submits a claim or claims for services that could not have been furnished to a specific individual on the date of service. These instances include but are not limited to the following situations:
>
> (A) Where the beneficiary is deceased.
>
> (B) The directing physician or beneficiary is not in the state or country when services were furnished.
>
> (C) When the equipment necessary for testing is not present where the testing is said to have occurred.
>
> (ii) CMS determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements. In making this determination, CMS considers, as appropriate or applicable, the following:
>
> (A) The percentage of submitted claims that were denied.

> (B) The reason(s) for the claim denials.
>
> (C) Whether the provider or supplier has any history of final adverse actions (as that term is defined under § 424.502) and the nature of any such actions.
>
> (D) The length of time over which the pattern has continued.
>
> (E) How long the provider or supplier has been enrolled in Medicare.
>
> (F) Any other information regarding the provider or supplier's specific circumstances that CMS deems relevant to its determination as to whether the provider or supplier has or has not engaged in the pattern or practice described in this paragraph.

42 C.F.R. § 424.535(a)(8) (italics in original). I conclude that the basis for revocation in this case is that currently authorized by 42 C.F.R. § 424.535(a)(8)(i), and that is the legal authority for revocation that is subject to my review.

The regulation provides Petitioner notice that billing privileges and Medicare enrollment may be revoked for an abuse of billing privileges. 5 U.S.C. §§ 551(4), 552(a)(1). The elements of the CMS prima facie case for revocation based on the language of 42 C.F.R. § 424.535(a)(8)(i) are: (1) the provider or supplier submitted one or more claims for services; and (2) the services for which a claim or claims were submitted could not have been delivered to the specific Medicare beneficiary on the date the service was claimed to have been delivered to him or her. *Realhab, Inc.*, DAB No. 2542 at 16-17 (2013). Although the plain language of the regulation seems clear enough at first blush, there have been several Board decisions that discussed the legislative history of the regulations for clarification of what was intended to be a sufficient basis for revocation. *Proteam Healthcare, Inc.*, DAB No. 2658 (2015); *Ronald J. Grason, M.D.*, DAB No. 2592 at 8 (2014); *Realhab, Inc.*, DAB No. 2542 at 16; *Howard B. Reife, D.P.M.*, DAB No. 2527 at 1-2 (2013). CMS, the proponent of the regulation, explained in comments to the final rulemaking in 2008:

> CMS, not a Medicare contractor, will make the determination for revocation under the authority at § 424.535(a)(8). We will direct contractors to use this basis of revocation after identifying providers or suppliers that have these billing issues. We have found numerous examples of situations where a physician claims to have furnished a service to a

> beneficiary more than a month after their recorded death, or when the provider or supplier was out of State when the supposed services had been furnished. **In these instances, the provider has billed the Medicare program for services *which were not provided* and has submitted Medicare claims *for services to a beneficiary who could not have received the service which was billed*.** This revocation authority is not intended to be used for isolated occurrences or accidental billing errors. Rather, this basis for revocation is directed at providers and suppliers who are engaging in a pattern of improper billing . . . . We believe that it is both appropriate and necessary that we have the ability to revoke billing privileges when services could not have been furnished by a provider or supplier. We recognize the impact that this revocation has, and a revocation will not be issued unless sufficient evidence demonstrates abusive billing patterns. **Accordingly, we will not revoke billing privileges under § 424.535(a)(8) *unless there are multiple instances, at least three,* where abusive billing practices have taken place** . . . . **In conclusion*, we believe that providers and suppliers are responsible for the claims they submit or the claims submitted on their behalf*. We believe it is essential that providers and suppliers take the necessary steps to ensure they are billing appropriately for services furnished to Medicare beneficiaries.**

73 Fed. Reg. 36,448, 36,455 (June 27, 2008) (emphasis added). Based on this regulatory history, I conclude that CMS must also show as part of its prima facie case that there were more than one and at least three claims for services that could not have been delivered to the Medicare beneficiary named in the claims. I note that the drafters of the regulation also state that only CMS and not a Medicare contractor will make the determination to revoke pursuant to 42 C.F.R. § 424.535(a)(8). 73 Fed. Reg. at 36,455; 79 Fed. Reg. at 72,513-521.

a. Facts

WPS notified Petitioner on August 3, 2015, that his enrollment and billing privileges were revoked effective September 2, 2015. The notice alleged abuse of billing privileges

and that revocation was pursuant to 42 C.F.R. § 424.535(a)(8).[5] CMS Ex. 2 at 6-7. Specifically, the WPS notice alleged that Petitioner billed for services between January 16, 2008 and September 9, 2011, while he was out of the country. CMS Ex. 2 at 6; CMS Ex. 5. The parties were cautioned by the Prehearing Order that on summary judgment a fact alleged and not specifically denied may be accepted as true for purposes of a motion or cross-motion for summary judgment. Prehearing Order ¶ II.G. Petitioner does not deny that he, or Patterson on his behalf, filed the claims listed in CMS Ex. 5 under Petitioner's NPI. Petitioner also does not deny that he was out of the country on the dates listed in CMS Ex. 5 as the dates of service.

Petitioner requested reconsideration on October 1, 2015. CMS Ex. 2. In his request for reconsideration, Petitioner sought "reconsideration of the determination that his conduct is sufficiently severe to warrant a re-enrollment bar for a period of three years" and requested "the re-enrollment bar be reduced from three years to one year." CMS Ex. 2 at 1-2. Petitioner did not deny that the services at issue were billed under his NPI, but argued there were mitigating factors that warranted reduction of the re-enrollment bar. CMS Ex. 2 at 2-5. Petitioner argued the services were provided by either a nurse practitioner or a physician's assistant employed by his office under the supervision of another doctor. CMS Ex. 2 at 2. Petitioner argued that he "reasonably believed" that supervision by another doctor "provided the requisite supervision to properly submit incident to claims for the patient office visits and patient services at issue." CMS Ex. 2 at 2. Petitioner admitted he made billing mistakes, but argued "all charges were for legitimate patient care." CMS Ex. 2 at 4. I accept for purposes of summary judgment Petitioner's explanation as true. I further accept as true Petitioner's assertion that he had no intent to abuse his billing privileges or defraud Medicare.

b. Analysis

I conclude that the facts establish a prima facie case of abuse of billing privileges under 42 C.F.R. § 424.535(a)(8)(i). The elements of the CMS prima facie case for revocation based on the language of 42 C.F.R. § 424.535(a)(8)(i) are met as follows: (1) it is undisputed that claims were submitted using Petitioner's NPI for services between January 16, 2008 and September 9, 2011, which Petitioner admitted in his reconsideration request were delivered by others using his NPI; and (2) the services for which the claims were submitted could not have been delivered to the Medicare beneficiaries by Petitioner on the date the service was claimed to have been delivered because Petitioner was out of the country at the time. The regulation does not require CMS to establish that Petitioner had any intent to defraud or engage in abusive billing.

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[5] The Medicare privileges of Petitioner's clinic, Patterson Medical Center, were also revoked for the same allegations. CMS Ex. 1.

The issue is whether or not Petitioner submitted claims or claims were submitted on his behalf for services that could not have been furnished to a specific individual on the claimed date of service. 42 C.F.R. § 424.535(a)(8)(i).

I conclude that the undisputed facts establish that claims for services to specific Medicare beneficiaries were filed using Petitioner's NPI for dates of service while Petitioner was out of the country. I further conclude that Petitioner could not have furnished the services for which the claims listed on CMS Ex. 5 were filed using his NPI. Petitioner has failed to show a genuine dispute as to any material fact and CMS is entitled to judgment as a matter of law that there is a basis for revocation of Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(8)(i).

Petitioner requested in his request for reconsideration (CMS Ex. 2 at 1-2) that the period of his bar to re-enrollment be reduced. Petitioner specifically noted that his ability to challenge the duration of the bar may be limited on higher review. CMS Ex. 2 at 2. Petitioner alleged specific facts as mitigation for the reconsideration hearing officer to consider. CMS Ex. 2 at 2-5. Petitioner did not renew the request for reduction of the period of the bar to re-enrollment in his request for hearing or brief. When a supplier's Medicare enrollment and billing privileges are revoked, the supplier is barred from re-enrolling in the Medicare program for one to three years. 42 C.F.R. § 424.535(c). There is no statutory or regulatory language establishing a right to review of the duration of the re-enrollment bar CMS imposes. Act § 1866(j)(8) (42 U.S.C. § 1395cc(j)(8)); 42 C.F.R. §§ 424.535(c), 424.545, 498.3(b), 498.5. The Board has held that the duration of a revoked supplier's re-enrollment bar is not an appealable initial determination listed in 42 C.F.R. § 498.3(b) and not subject to ALJ review. *Vijendra Dave*, DAB No. 2672 at 10-11 (2016).

To the extent Petitioner's arguments may be construed as a request for equitable relief, I have no authority to grant equitable relief. *US Ultrasound*, DAB No. 2302 at 8 (2010). I am also required to follow the Act and regulations and have no authority to declare statutes or regulations invalid. *1866ICPayday.com, L.L.C.*, DAB No. 2289 at 14 (2009).

III. Conclusion

For the foregoing reasons, the Medicare enrollment and billing privileges of Petitioner are revoked pursuant to 42 C.F.R. § 424.535(a)(8)(i), effective September 2, 2015.

/s/
Keith W. Sickendick
Administrative Law Judge