Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Arriva Medical, LLC
Docket No. A-17-82
Decision No. 2934
March 28, 2019

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Petitioner Arriva Medical, LLC (Arriva) appeals the April 25, 2017 decision of an Administrative Law Judge (ALJ) sustaining the revocation of Arriva's Medicare billing privileges. *Arriva Medical, LLC*, DAB CR4834 (2017) (ALJ Decision). The Centers for Medicare & Medicaid Services (CMS) revoked Arriva's Medicare enrollment and billing privileges pursuant to Title 42 of the Code of Federal Regulations (C.F.R.), section 424.535(a)(8)(i), because Arriva, a supplier of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) to Medicare beneficiaries, submitted claims for items that could not have been provided to the beneficiaries on dates of service between April 15, 2011, and April 25, 2016, because they were deceased. In addition, CMS imposed a bar of three years on Arriva's eligibility to re-enroll in the Medicare program. The ALJ determined that CMS lawfully revoked Arriva's billing privileges under 42 C.F.R. § 424.535(a)(8)(i) and granted summary judgment for CMS.

For the reasons explained below, we affirm the ALJ Decision.

Applicable Legal Authorities

The Social Security Act (the Act) provides for CMS to regulate the enrollment of providers and suppliers in the Medicare program. Act § 1866(j)(1)(A); 42 U.S.C. § 1395cc(j)(1)(A).

The term "supplier" means, unless the context otherwise requires, a physician or other practitioner, a facility, *or other entity* (other than a provider of services) *that furnishes items or services* under the Act. Act § 1861(d). A DMEPOS supplier is an entity or individual that sells or rents DMEPOS items covered under Part B of Title XVIII of the Act to Medicare beneficiaries and which meets the applicable standards. *See* 42 C.F.R. § 424.57.

The regulations in 42 C.F.R. Part 424, subpart P set out the requirements for establishing and maintaining Medicare billing privileges. In order to receive payment for items or services furnished to Medicare beneficiaries, a provider or supplier must be "enrolled" in Medicare and maintain active enrollment status. 42 C.F.R. §§ 424.500, 424.505, 424.510, 424.516. The regulation at 42 C.F.R. § 424.535(a) states that CMS may revoke a provider's or supplier's Medicare billing privileges and any corresponding provider or supplier agreement for various reasons. Among those reasons, relevant here, section 424.535(a)(8)(i)[1] states in part:

> (8) *Abuse of billing privileges.* Abuse of billing privileges includes . . . :
> (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.

The preamble to the final rule publishing the original version of this subsection states that CMS "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." 73 Fed. Reg. 36,448, 36,455 (June 27, 2008).

If CMS revokes a supplier's billing privileges, as it has done in this case, the supplier is "barred from participating in the Medicare program from the date of the revocation until the end of the re-enrollment bar." 42 C.F.R. § 424.535(c).[2] The re-enrollment bar must last for a minimum of one year but may not exceed three years, "depending upon the severity of the basis for revocation." *Id.* Revocation also results in the termination of the provider's or supplier's agreement with Medicare. *Id*. § 424.535(b).

A supplier, such as Arriva, whose Medicare enrollment has been revoked may request reconsideration by CMS or its contractor, and then appeal the reconsideration decision in accordance with the procedures at 42 C.F.R. Part 498. 42 C.F.R. §§ 424.545(a), 498.3(b)(17), 498.5(l)(1)-(3), 498.22(a), 498.24; 498.40, 498.80.

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[1] This subsection was revised and renumbered effective February 3, 2015 (79 Fed. Reg. 72,500, 72,532 (Dec. 5, 2014)), though no substantive changes were made to the content of the regulation. We cite to, and apply, the version of section 424.535 that was in effect on October 5, 2016, the date that CMS's contractor issued the initial revocation determination. *John P. McDonough III, Ph.D., et al.*, DAB No. 2728, at 2 n.1 (2016). Accordingly, we apply the revised regulation, which is still in effect, to all of the claims cited in the revocation notice. The text of the revised regulation is available at http://www.ecfr.gov/cgi-bin/text-idx?node=se42.3.424_1535&rgn=div8.

[2] While we note that CMS has issued a Proposed Rule which would increase the maximum reenrollment bar from 3 years to 10 years (with certain exceptions) (81 Fed. Reg. 10,720, 10,732, 10,746 (Mar. 1, 2016)), the final regulation is not scheduled to be published until no later than March 1, 2020 (84 Fed. Reg. 6740 (Feb. 28, 2019)), and we apply the regulation as in effect at the time of the revocation.

Case Background[3]

Arriva is a supplier of mail-order diabetic testing supplies. ALJ Decision at 2 (citing Petitioner Exhibit (P. Ex.) 3, at 3). In a letter dated October 5, 2016, CMS notified Arriva that it had revoked Arriva's Medicare enrollment and billing privileges under the regulation at 42 C.F.R. § 424.535(a)(8) for abuse of billing privileges. *Id*.; CMS Exhibit (CMS Ex.) 1, at 1. The October 5, 2016 revocation letter stated in pertinent part:

> **42 CFR § 424.535(a)(8)(i) - Abuse of Billing**
>
> Data analysis conducted on claims billed by Arriva Medical, LLC, for dates of service between April 15, 2011 and April 25, 2016, revealed that Arriva Medical, LLC billed for items/services provided to 211 Medicare beneficiaries who, per the Social Security Administration Death Master File, were deceased on each purported date of service. *See Enclosure A for a sample of the claims data.*

Id. CMS also imposed a three year reenrollment bar on Arriva. *Id*. at 2. Attached to the revocation letter was a spreadsheet, identified as "Enclosure A," containing the names, Health Insurance Claim (HIC) numbers (unique identifiers issued to Medicare beneficiaries), dates of service, dates of death, and claim control numbers for 47 beneficiaries, and stating that Arriva provided diabetic testing supplies after the dates of the beneficiaries' death. *See id*. at 3-4.

Arriva submitted a request for reconsideration on October 28, 2016, in which it asserted that in each instance it provided an item to a beneficiary, it "received a valid request for a refill of diabetic testing supplies for a Medicare beneficiary and furnished supplies pursuant to that request." ALJ Decision at 3 (quoting Reconsideration Decision at 5). Arriva stated that it was unaware of the death of numerous beneficiaries due to its limited access to the HIPAA Eligibility Transaction System (HETS), which contains information regarding a beneficiary's status. *Id*. (citing Reconsideration Request at 5-7). Arriva acknowledged, however, that "there are 9 claims in the sample where a Medicare eligibility check run prior to the date a caregiver for the beneficiary ordered supplies returned a status code that the beneficiary was deceased, yet Arriva failed to identify the consumer's fraud and mistakenly continued to process the order." *Id*. at 3-4 (quoting Reconsideration Request at 7 n.4).

[3] The factual findings stated here are taken from the ALJ Decision and the administrative record. We make no new findings of fact, and the facts stated are undisputed unless we indicate otherwise.

CMS denied the request for reconsideration on November 2, 2016, stating in relevant part:

> Arriva admits that there are nine claims in the sample data where it ran a Medicare eligibility check prior to when a beneficiary ordered supplies, and found that the beneficiary was deceased, but still continued to process the order. Arriva admits that there was a delay between when a beneficiary's status changed and when Arriva's internal systems were updated. However, negligent submission of multiple erroneous claims for services that could not have been delivered to beneficiaries amounts to abuse.
>
> Durable medical equipment prosthetics, orthotics, or suppliers must contact the beneficiary or the beneficiary's designee for refills no sooner than 14 calendar days prior to the shipping date. In the sample data, 13 claims were submitted where no contact was made with the beneficiary, within 14 days of the shipment. In all of these instances, the beneficiary was deceased prior to the date of shipment.
>
> For many of the claims included in the sample data, Arriva alleges that the beneficiaries' caregivers contacted Arriva to place an order. CMS does not find these allegations credible, as these conversations allegedly occurred after the beneficiary was deceased.
>
> It is irrelevant that Arriva did not receive a payment from CMS for many of these claims or that it returned payments once it realized that the beneficiary was deceased. CMS has the authority to revoke a supplier in accordance with 42 C.F.R. § 424.535(a)(8)(i) when a supplier submits claims for services that could not have been furnished to a specific individual because the individual is deceased. Therefore, CMS did not err in revoking Arriva's Medicare billing privileges, pursuant to 42 C.F.R. § 424.535(a)(8).

CMS Ex. 2, at 3-4; ALJ Decision at 9-10.

Arriva filed a timely request for ALJ hearing on December 27, 2016. *Id*. at 10. In its Request for Hearing (RFH), Arriva argued that, "[g]iven the totality of the circumstances, CMS misused its discretion in this case and acted unreasonably in determining that Arriva engaged in 'abusive' billing practices that warranted revocation of its Medicare supplier number." RFH at 2. Arriva asserted that, in the case of 21 claims identified by CMS, Arriva checked the eligibility of the beneficiaries through HETS after the dates of death, but the system had not been updated to accurately reflect that the beneficiary had

died. *Id*. at 7. Arriva also asserted that in several claims identified by CMS the beneficiary died after an order for supplies was placed but more than 10 calendar days before the beneficiary was scheduled for a refill of supplies, resulting in Arriva having "no knowledge that these beneficiaries had died in the intervening period." *Id*. at 8. Arriva stated that in "a few cases" its "internal systems" were not updated in a timely manner and it "mistakenly billed for Medicare beneficiaries who Arriva later discovered were deceased on the date of service." *Id*. Arriva stated that, "[i]n all of these cases, Arriva was not paid for the claims, and if payment was rendered, Arriva promptly refunded the payment." *Id*.

Arriva again acknowledged that in nine of the claims at issue, it ran a Medicare eligibility check and found that the beneficiary was deceased, yet still processed and billed for the order–

> Arriva acknowledges that there are 9 claims in the sample where a Medicare eligibility check run prior to the date a caregiver for the beneficiary ordered supplies returned a status code that the beneficiary was deceased, yet Arriva failed to identify the consumer's fraud and mistakenly continued to process the order. These isolated instances, which all occurred prior to February 2015, were the result of internal systems limitations that, for a short period of time during a systems change, relied on Arriva personnel to manually update Arriva's billing systems with Medicare beneficiary status information.

Id. at 8 n.7. Arriva argued that its billing did not establish a pattern of abusive billing because the 211 claims at issue represented only 0.003% error rate of the total claims submitted during the 5-year time period. *Id*. at 9. Arriva also requested an expedited hearing before the ALJ and a stay of revocation pending completion of the appeals process. *Id*. at 11.

On January 11, 2017, Arriva filed a memorandum (Pet. Memo) in support of its request for expedited hearing. CMS filed a response in opposition to Arriva's request for expedited hearing on January 18, 2017.

On January 30, 2017, CMS filed a motion for summary judgment, witness list, exhibit list, and 11 proposed exhibits (CMS Exs. 1-11), including the written declarations for three witnesses. ALJ Decision at 10. In its motion for summary judgment (MSJ), CMS argued that "Petitioner does not dispute that it submitted forty seven (47)" claims for services furnished to deceased beneficiaries, "including nine claims where Petitioner admits it had information that the beneficiaries were deceased before mailing the supplies." MSJ at 1. CMS also stated that all of Arriva's arguments "have been previously rejected by the Board." *Id*. at 2.

On February 24, 2017, Arriva filed a pre-hearing brief, witness list, exhibit list, and eight proposed exhibits (P. Exs. 1-8), including the written declarations of three witnesses. ALJ Decision at 10. In its pre-hearing brief, Arriva argued that if CMS interprets the regulation at 42 C.F.R. § 424.535(a)(8)(i) to mean that "a supplier's submission of three or more claims for beneficiaries deceased on the date of service automatically triggers revocation," such an interpretation would be "facially invalid" and CMS would be acting "outside the scope of its proper regulatory authority" for three reasons: (1) CMS is required to analyze the facts and circumstances of its billing errors to determine if there was an "abuse of billing privileges"; (2) CMS has discretion to impose a less severe remedy and is not required to revoke whenever there are more than three instances of a supplier billing for items provided to deceased beneficiaries; and (3) the regulation is not meant to be applied to mail-order suppliers (like Arriva) as it would apply to providers who furnish services in a face-to-face manner. Pet. Pre-hearing Brief at 6-13. Arriva further argued that, in the alternative, if CMS interprets section 424.535(a)(8)(i) to mean that it has discretion to revoke the billing privileges of a supplier who submits errant claims of the type at issue "regardless of the number of claims submitted," CMS abused its discretion "by ignoring key facts and revoking Arriva's Medicare billing privileges in an arbitrary and capricious manner." *Id*. at 13.

Arriva argued that the ALJ should deny CMS's motion for summary judgment, and identified the following five "disputed issues of material fact":

- Whether CMS officials adopted a strict and improper interpretation of CMS's revocation authority under 42 C.F.R. § 424.535(a)(8)(i), which would render the regulation facially invalid and mean that CMS acted outside the scope of its regulatory authority in revoking Arriva's Medicare billing privileges.

- To what extent CMS officials adequately reviewed the facts and circumstances of each of the 227 claims at issue, including whether the services were properly ordered by Medicare beneficiaries or their caregivers and whether, to the best of Arriva's knowledge, the Medicare beneficiary was eligible to receive services, to make a reasonable determination whether Arriva committed "abuse" of billing privileges or that these were "isolated occurrences" or "accidental billing errors."

- To what extent CMS officials adequately reviewed the facts and circumstances of each of the 227 claims at issue to identify inaccuracies in the CMS data underlying the claims.

- Whether CMS officials adequately considered a number of highly relevant factors in determining whether Arriva committed "abusive" billing, including the accuracy and reliability of Medicare eligibility data, restrictions placed on Arriva's ability to access Medicare eligibility data, the frequency of billing errors in light of Arriva's volume of Medicare claims, and the lack of payment made to Arriva for any of the claims at issue.

- Whether CMS officials improperly used CMS's revocation authority under 42 C.F.R. § 424.535(a)(8)(i) to remove Arriva as a Medicare supplier to reduce the substantial Medicare claims appeal backlog that CMS has been ordered to process in a more timely manner.

Id. at 28-29. Arriva asserted that "[e]ach of the above factual questions is highly pertinent to any decision on the merits in this case." *Id*. at 29.

In its proposed witness list, Arriva indicated that it would request that the ALJ issue a subpoena to compel three CMS officials to testify because, according to Arriva, CMS declined to make those individuals available for testimony. ALJ Decision at 11; Petitioner's Proposed Witness List at 2-4. On March 6, 2017, CMS filed an objection, arguing that "[t]he proposed areas of testimony are not pertinent to the narrow question before this Tribunal: whether CMS was authorized to revoke Arriva's Medicare enrollment based on Arriva's submission of numerous Medicare claims for deceased Medicare beneficiaries." CMS Objection to Petitioner's Proposed Witness List at 1. On March 9, 2017, CMS filed a reply brief, arguing, in part, that the "claims in instances where Arriva was aware the Medicare beneficiary died before the date of service . . . are more than sufficient to support the revocation." CMS Reply at 2 (citing RFH at 8 n.7).

On March 16, 2017, Arriva filed a surreply. Arriva argued that the central issue before the ALJ was "whether CMS has demonstrated a reasonable basis for concluding that Arriva has in fact 'abused' its billing privileges, or whether CMS is unreasonably and arbitrarily seeking to impose the draconian sanction of revoking Arriva's billing privileges based on alleged inadvertent billing errors without any evidence of actual abuse or reasoned explanation why that sanction is justified." Pet. Surreply at 2. Arriva further argued that "CMS has provided no evidence that it meaningfully reviewed the particular circumstances of any of the 227 claims for services to 211 Medicare beneficiaries submitted by Arriva that CMS cited as the purported basis for its revocation decision" and "has not provided Arriva with any meaningful details regarding how its review was conducted, who conducted the review, the methodology used, or why the review was initiated . . . [.]" *Id*. at 6. Arriva reiterated and expanded on many arguments previously made, including that its billing errors were "isolated occurrences" and did not

establish a "pattern of improper billing," that it did not receive payment for any of the improper claims, that its access to the HETS system was restricted, that it took steps to reduce its billing errors after receiving remittance notices issued by CMS, and that CMS revoked its billing privileges in order to eliminate the high volume of Medicare appeals generated by Arriva. *Id*. at 7-14.

On April 4, 2017, Arriva filed a motion for a subpoena to compel the testimony of three CMS officials. ALJ Decision at 12. CMS filed an objection to Arriva's motion on April 10, 2017. *Id.* at 12-13.

The ALJ Decision

The ALJ affirmed the revocation of Petitioner's billing privileges, granting summary judgment in favor of CMS. In reaching her conclusion that summary judgment is appropriate, the ALJ relied on Arriva's admissions "that it had knowingly billed for items provided to deceased beneficiaries" on nine occasions (ALJ Decision at 16 (citing Reconsideration Request at 20-30)), and "that it 'mistakenly continued to process the order for each of the nine instances in which an eligibility check conducted prior to the date of reorder of supplies revealed that the beneficiary was deceased." *Id*. (citing Reconsideration Request at 7 n.4). The ALJ also relied on "the records Petitioner submitted supporting those admissions[.]" *Id*. at 17 (citing Reconsideration Request at 3-9, 20-30; Pet. Ex. 4, at 1048-1051, 1053-1056, 1058-1061, 1063-165, 1097-1100, 1134-1137, 1143-1146, 1148-1151, 1163-1166).

The ALJ found that Arriva "has not presented any evidence to refute that it submitted claims for services that could not have been provided to a specific beneficiary because that beneficiary was deceased." *Id*. at 21. The ALJ considered and rejected the five "disputed issues of material fact" put forth by Arriva (see Pet. Pre-hearing Brief at 28-29), finding that each such issue asserted as one of fact was "actually a question[,]" and stating that even if she "were to answer each one of these questions in Petitioner's favor, it would make no difference to [her] determination of whether any *material facts* are in dispute, and would not erase that *Petitioner* has admitted to billing Medicare on at least nine occasions for providing supplies to beneficiaries it knew were deceased." ALJ Decision at 17 (emphasis in ALJ Decision). The ALJ concluded that summary judgment was warranted after drawing all inferences in favor of Arriva, writing in relevant part:

> For purposes of summary judgment, I have drawn all inferences in favor of Petitioner. For example, I accept, for purposes of summary judgment, that Petitioner contacted "caregivers" who approved the reorder of diabetes supplies for deceased beneficiaries. I also accept, for purposes of summary judgment, that Petitioner has at times had difficulties accessing the HETS system and did not always obtain the current information it was seeking

> regarding the status of beneficiaries. Likewise, I accept, for purposes of summary judgment, that the then-Acting Administrator of CMS may not have been fully informed about Petitioner's case on the two occasions he spoke with a member of Alere's governing board.[4] Even assuming all of these facts in Petitioner's favor, I still conclude that Petitioner shipped and billed Medicare for sending supplies to nine beneficiaries who it knew were deceased at the time of service. While Petitioner has raised *legal* arguments regarding its revocation, it has not identified any disputed material facts that counter its own admissions regarding the nine claims. . . . Petitioner has not disputed the *material facts* at issue, namely, that it provided diabetes supplies to nine beneficiaries it knew were deceased and then billed Medicare those supplies.

Id. at 19-20 (ALJ's emphases).

The ALJ also considered and rejected Arriva's arguments, among others, that it was unable to access timely information from the HETS database; that section 424.535(a)(8) does not apply to a mail-order supplier that has no face-to face contact with beneficiaries; that CMS must prove an "abuse of billing privileges" by showing that Arriva intended to submit improper claims; that Arriva had a miniscule error rate; that Arriva did not receive payment for the claims at issue; and that CMS's true motivation for revoking the billing privileges of Arriva, "by far the largest supplier of home-delivered diabetic testing suppliers in the nation" (Pet. Pre-hearing Br. at 3), was to reduce the Medicare claims appeals backlog. ALJ Decision at 22-26.

On June 7, 2017, Arriva timely appealed the ALJ's decision to the Board. CMS filed a response brief on July 14, 2017, and Arriva filed a Reply brief on July 31, 2017.

Standard of Review

Whether summary judgment is appropriate is a legal issue that we address de novo. *Patrick Brueggeman, D.P.M.*, DAB No. 2725, at 6 (2016); *1866ICPayday.com, L.L.C.*, DAB No. 2289, at 2 (2009), *citing Lebanon Nursing & Rehab. Ctr*., DAB No. 1918 (2004).

Summary judgment is appropriate if there is no genuine dispute of fact material to the result and the moving party is entitled to judgment as a matter of law. *See 1866ICPayday.com* at 2, *citing Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986); *Everett Rehab. & Med. Ctr.*, DAB No. 1628, at 3 (1997), citing *Travers v. Shalala*, 20

[4] The ALJ noted that Alere, Inc. is Arriva's parent company. ALJ Decision at 10.

F.3d 993, 998 (9th Cir. 1994). The Board construes the facts in the light most favorable to the appellant and gives it the benefit of all reasonable inferences. *See Livingston Care Ctr.*, DAB No. 1871, at 5 (2003), *aff'd, Livingston Care Ctr. v. U.S. Dep't of Health & Human Servs.*, 388 F.3d 168, 172-73 (6th Cir. 2004).

To defeat an adequately supported summary judgment motion, the nonmoving 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. *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 3 (2010), *aff'd, Senior Rehab. & Skilled Nursing Ctr. v. Health & Human Servs.*, 405 F. App'x 820 (5th Cir. 2010). A party "must do more than show that there is 'some metaphysical doubt as to the material facts . . . Where the record taken as a whole could not lead a rational trier of fact to find for the nonmoving party, there is no genuine issue for trial."' *Mission Hosp. Reg'l Med. Ctr.*, DAB No. 2459, at 5 (2012) (*quoting Matsushita Elec. Industrial Co. v. Zenith Radio, Ltd., 475 U.S. 574, at 587 (1986)), aff'd, Mission Hosp. Reg'l Med. Ctr. v. Sebelius*, No. SACV 12-01171 AG (MLGx), 2013 WL 7219511 (C.D. Cal. 2013), *aff'd sub nom. Mission Hosp. Reg'l Med. Ctr. v. Burwell*, 819 F.3d 1112 (9th Cir. 2016). In examining the evidence to determine the appropriateness of summary judgment, an ALJ must draw all reasonable inferences in the light most favorable to the non-moving party. *See Brightview Care Ctr.*, DAB No. 2132, at 2, 9 (2007); *but see Cedar Lake Nursing Home*, DAB No. 2344, at 7 (2010); *Brightview* at 10 (entry of summary judgment upheld where inferences and views of nonmoving party are not reasonable). Drawing factual inferences in the light most favorable to the non-moving party does not require that an ALJ accept the non-moving party's legal conclusions. *Cedar Lake Nursing Home* at 7.

Our standard of review on a disputed issue of law is whether the ALJ decision is erroneous. *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare and Medicaid Programs*, http://www.hhs.gov/dab/divisions/appellate/guidelines/prosupenrolmen.html.

Analysis

In its brief in support of its request for review (RR) and reply brief (Reply), Arriva does not dispute the ALJ's central finding on which the ALJ upheld the section 424.535(a)(8)(i) revocation on summary judgment for CMS – that Arriva billed Medicare on nine occasions for supplies furnished after the beneficiaries had died. *See* ALJ Decision at 13, 16, 17, 21-22. Rather, Arriva argues, in chief, that CMS failed to exercise its discretion in a non-arbitrary manner because it ignored several facts which show that Arriva's billing errors did not constitute an "abuse of billing privileges" necessary for revocation under 42 C.F.R. § 424.535(a)(8). We conclude that the administrative record

supports the ALJ's entry of summary judgment for CMS. In affirming the ALJ Decision, we first address the legal basis for revocation and the additional factors that Arriva contends CMS ignored when exercising its discretion to revoke. We next address the ALJ and Board's scope of review in revocation actions. Finally, we discuss the appropriateness of summary judgment.[5]

I. CMS had a valid legal basis to revoke under 42 C.F.R. § 424.535(a)(8)(i) because the undisputed facts show that Arriva billed Medicare for supplies that could not have been provided to nine beneficiaries on the dates of service.

Arriva's billing privileges were revoked pursuant to section 424.535(a)(8), which states in pertinent part:

> (8) *Abuse of billing privileges*. Abuse of billing privileges includes . . .
> (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.

CMS stated in the 2008 preamble to the final rule promulgating the original regulation that it "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." 73 Fed. Reg. at 36,455; *see also Med-Care Diabetic & Medical Supplies, Inc.*, DAB No. 2764, at 17 (2017) ("CMS was clear that the regulation would apply to a pattern of prohibited claims, which consists, at a minimum, of three prohibited claims."). Arriva's repeated submission of claims for items for deceased beneficiaries is a type of abusive practice for which the regulation authorizes CMS to revoke a supplier's billing privileges.

Arriva does not dispute the ALJ's finding as to improper billing on at least nine occasions. Arriva contends, however, that CMS failed to meet the standards of "reasoned decision-making," that is, that CMS failed to articulate a basis for revocation that took into account the full "context and circumstances in which" Arriva's billing errors occurred to determine whether they "qualify as substantial evidence of a pattern of abusive billing practices . . . ." Reply at 9; *see also id*. at 7 (CMS "must provide a

[5] Arriva asked the Board to hold oral argument "to further clarify the complex and serious issues presented by this case for the benefit of the Board's review." RR at 38. In its June 15, 2017 acknowledgment of Arriva's appeal (at 2), the Board noted Arriva's request to present oral argument and stated that "CMS may comment on the request in its response." In its response (at 1-2), CMS maintained that "oral argument is not necessary" in this case. In its reply brief (at 19), Arriva "reaffirm[ed]" its request. Having heard from both parties and having considered whether oral argument would aid our decision-making, we have decided to proceed to decision based on the written submissions.

reasoned explanation why the supplier has engaged in a 'pattern of improper billing' sufficient to qualify as an 'abuse'" and not merely undertake "[a]n inquiry that is based on a rote formula without considering relevant facts or real-world circumstances fails that requirement."). Arriva is essentially arguing that the revocation action should be reversed because CMS failed to take certain "context specific" factors into account and, if CMS had, it would have been unreasonable for CMS to conclude that Arriva's billing errors constitute an "abuse of billing privileges" within the meaning of subsection (a)(8). In support, Arriva quotes CMS's statement in the 2008 preamble that it would "review the specific details associated with each claim before taking any revocation action." 73 Fed. Reg. at 36,455.

Arriva further asserts that its billing errors were "accidental" and "that Arriva did not knowingly intend to bill for ineligible beneficiaries and did not know (or have the ability to know) that the beneficiaries were deceased upon the date of service." RR at 27; *see also* Reconsideration Request at 7 n.4 (The nine claims at issue were "isolated instances" that were "the result of internal systems limitations that, for a short period of time during a systems change, relied on Arriva personnel to manually update Arriva's billing systems with Medicare beneficiary status information."). Arriva invokes CMS's statement in the preamble to the 2008 final rule that revocation under subsection (a)(8) "is not intended to be used for isolated occurrences or accidental billing errors." RR at 15 (quoting 73 Fed. Reg. at 36,455).

The Board has consistently rejected the contention that CMS must show that a supplier intended to submit improper claims in order to revoke under subsection (a)(8). *See, e.g., John M. Shimko, D.P.M.*, DAB No. 2689, at 5-6 (2016) (The Board "has already rejected . . . the idea that a supplier's intent in submitting improper claims of the kind described in section 424.535(a)(8) is relevant in a revocation case based on that subsection.") (and cases cited therein). The Board has found that the plain language of subsection (a)(8) does not require that CMS establish "fraudulent or dishonest intent" and "does not provide any exception for inadvertent or accidental billing errors." *Louis J. Gaefke D.P.M.*, DAB No. 2554, at 7 (2013). Moreover, that Arriva repeatedly billed Medicare for supplies furnished to beneficiaries after a Medicare eligibility check indicated that the beneficiaries were deceased indicates that the billing errors were not merely isolated or accidental occurrences, but rather constituted a pattern of improper billing. *See Shimko* at 6 (quoting *Howard B. Reife, D.P.M.*, DAB No. 2527, at 6 (2013) ("[R]epeatedly making similar errors makes it less plausible to call them merely accidental and establishes a pattern of improper billing that suggests a lack of attention to detail . . . .") (internal quotation marks omitted)).

Arriva contends that CMS failed to take into account that its "error rate" was "approximately 0.003%," based on "227 billing errors identified by CMS out of approximately 5.8 million claims submitted by Arriva over a 5-year period." RR at 23. The Board previously rejected the argument that revocation under subsection (a)(8) is predicated on a minimum error rate. *See Brueggeman* at 11-12 (citing *Shimko* at 10 ("[N]either the regulation nor its preamble suggest[s] any requirement for CMS to find 'a minimum claims error rate or dollar amount before revoking billing privileges under section 424.535(a)(8)."), *Reife* at 7 ("There is . . . no requirement in the regulation (or the preamble) establishing a minimum claims error rate or dollar amount that must be exceeded before CMS may revoke billing privileges."), and *Gaefke* at 10 (same)). Moreover, Arriva's asserted error rate (0.003%) is based on the unsupported assumption that all of Arriva's remaining claims were error-free. The record shows that CMS performed a data analysis of 5.8 million claims submitted by Arriva with dates of service between April 15, 2011, and April 25, 2016, in which the services were rendered at least 15 days after the respective beneficiary's death. CMS Ex. 7, at 1-2. Thus, CMS evidently reviewed only a sample of those 5.8 million claims and, of that sample, CMS identified "227 Medicare claims for [211] unique beneficiaries who were deceased at least 15 days prior to the supplies or equipment being delivered." *Id*. at 3; *see also Shimko* at 9-10 (Dr. Shimko "has not shown that all of his claims were reviewed for all forms of error; all we know is that, in at least 17 instances, he submitted bills for services that could not have been provided as claimed.").

The Board has also rejected the argument that, under subsection (a)(8), CMS cannot treat mail-order suppliers such as Arriva as they treat providers and suppliers who meet patients face-to-face. Arriva contends that CMS intended subsection (a)(8) to apply solely to the latter group and did not even contemplate mail-order suppliers when it promulgated the regulation. RR at 17-19. The Board has considered and rejected a similar argument made by another high-volume, mail-order supplier. *See Med-Care* at 10-12. In *Med-Care*, the Board first looked at the plain language of subsection (a)(8), and found that the regulation "does not distinguish between providers and suppliers" and "makes no distinction between "in-person" suppliers and "mail-order suppliers . . . ." *Id*. at 11. The Board next found that CMS's application of subsection (a)(8) to mail-order DMEPOS suppliers is reasonable and consistent with CMS's prior statements in the preamble to the final rule regarding the intent of the regulation (73 Fed. Reg. at 36,455). *Id*. at 11-12. Arriva cites no authority that compels us to alter our conclusions regarding the application of subsection (a)(8) to mail-order suppliers in *Med-Care*.

Arriva contends that CMS failed to consider that the HETS system reflected incorrect information "in approximately half of the 227 claims cited by CMS," and that CMS limited Arriva's ability to access the HETS system. RR at 20-23; Reply at 16. Arriva also contends that CMS ignored that its billing errors were "authorized by someone whom Arriva had every reason to believe was the patient or an authorized caregiver for

the patient." RR at 26. We reject these arguments because they are based on matters that are immaterial to the dispositive question of legality of revocation under section 424.535(a)(8)(i), such as who "authorized" the order. In upholding the revocation on summary judgment, the ALJ relied solely (and rightly) on claims in which Arriva admitted that it had run a Medicare eligibility check *prior to* furnishing supplies and that the eligibility check indicated that the beneficiaries were deceased. By Arriva's own admission, the nine claims at issue were the result of Arriva's own "internal systems limitations." Reconsideration Request at 7 n.4. Moreover, that the furnished supplies were authorized by a caregiver does not negate the fact that Arriva continued to process the orders and bill Medicare when it had information indicating that the supplies could not be used by the intended recipients.

Arriva contends that CMS ignored its "contractual obligations" with Arriva. RR at 10-11. Arriva states that it was awarded "the DMEPOS Competitive Bidding Program National Mail-Order contract for diabetic testing supplies effective July 1, 2013 through June 30, 2016 and July 1, 2016 through December 31, 2018." *Id*. at 3-4. Arriva argues that because "CMS is a contracting partner with Arriva," it "must fulfill its contractual obligations in good faith." *Id*. at 11 (citing *Precision Pine & Timber, Inc. v. United States*, 596 F.3d 817, 828 (Fed. Cir. 2010)). Arriva attempts to bring into discussion a matter that is immaterial to a determination on the issue of legality of revocation here. The regulation in 42 C.F.R. § 424.535(a)(8)(i) authorizes CMS to revoke the billing privileges of a supplier like Arriva for the submittal of a claim for items that could not have been furnished to the intended user-beneficiary on the date of service because that individual is deceased.

Arriva raises other arguments that we reject as meritless. Arriva contends that CMS ignored that it did not receive payment for items furnished to deceased beneficiaries and, "in the rare event" that Arriva was paid for a claim, it "promptly refunded" the payment to the Medicare program. *Id*. at 30-31. The Board has previously rejected the notion that a supplier must actually receive payment to be subject to revocation under subsection (a)(8). *See Med-Care* at 19 ("[T]he regulation prohibits abusive *billing*, and is not predicated upon the supplier receiving actual payment."). Arriva also argues that CMS ignored the preventative measures Arriva took to prevent future billing errors, and that hundreds of thousands of diabetic beneficiaries would be harmed by revoking its billing privileges. RR at 25; Reply at 13. But we are aware of no authority obligating CMS to consider any preventative measures instituted by a supplier after the billing errors occurred or the number of beneficiaries serviced by a supplier before revoking billing privileges where there is a legal basis for revocation, and Arriva cites no authority on point.

In sum, CMS had a valid legal basis to revoke Arriva's Medicare billing privileges under 42 C.F.R. § 424.535(a)(8)(i).

II. Neither the ALJ nor the Board may look behind CMS's exercise of discretion to revoke Arriva's Medicare billing privileges because its determination to revoke under 42 C.F.R. § 424.535(a)(8)(i) was lawful.

Arriva contends that CMS failed to exercise its discretion to revoke Arriva's Medicare billing privileges in a reasonable, non-arbitrary manner. Arriva argues that the ALJ should have reversed the revocation pursuant to section 706 of the Administrative Procedure Act (APA), which states that a reviewing court must hold unlawful and set aside agency action that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law . . . ." RR at 9-10 (citing 5 U.S.C. § 706(2)); *see also id.* at 10-11 (invoking principles of due process and contracts). Arriva further states that "CMS has taken the position that as long as it has discretionary authority under its regulations to revoke a Medicare participant's billing privileges, it makes no difference whether the agency exercises that discretion reasonably and consistent with the requirements of reasoned decision-making." Reply at 2.

The APA establishes the arbitrary and capricious standard for federal court review of final agency actions. ALJs and the Board, however, are adjudicators in the administrative appeal process governed by 42 C.F.R. Part 498, not in federal courts, and neither CMS's determination to revoke Arriva's billing privileges, nor the ALJ's decision to affirm that determination, is the final agency action. *See* 42 C.F.R. § 498.90 (providing that the Board decision is the final agency action that may be appealed to federal court); *see also Hanover Hill Health Care Ctr.*, DAB No. 2507, at 7 (2013) ("Nothing in the APA . . . applies the 'arbitrary and capricious standard' to Board review of an ALJ decision on behalf of the Secretary . . . ."); *Cal Turner Extended Care Pavilion*, DAB No. 2030, at 7-8 (2006) (drawing a distinction between "the oversight role of a federal court reviewing agency decisions to determine if an adequate basis is articulated and the internal agency appeals process for formulating final agency action").

The Board has held that the review of CMS's exercise of discretion to revoke a supplier's Medicare billing privileges is "limited to deciding whether CMS had a valid legal basis for that action." *Care Pro Home Health, Inc.*, DAB No. 2723, at 5 (2016) (internal quotation mark omitted) (citing *Letantia Bussell, M.D.*, DAB No. 2196, at 12-13 (2008) (ALJ's review of revocation is "limited to whether CMS had established a legal basis for its actions"; once the ALJ found the "elements required for revocation were present" the ALJ "was obliged to uphold the revocation, as are we"). Neither the Board nor the ALJs have the authority to substitute their own discretion for that of CMS. *Abdul Razzaque Ahmed, M.D.*, DAB No. 2261, at 17, 19 (2009) ("[T]he scope of administrative review before the ALJ and the Board is limited to determining whether CMS had a sufficient legal predicate . . . for its revocation determination [and] we may not substitute our discretion for that of CMS in determining whether revocation is appropriate under all the

circumstances."), *aff'd, Ahmed v. Sebelius*, 710 F. Supp. 2d 167 (D. Mass. 2010)). Moreover, neither the Board nor the ALJs have authority to overturn a legally valid agency action on equitable grounds or otherwise grant equitable relief. *See, e.g., Central Kan. Cancer Inst.*, DAB No. 2749, at 10 (2016) (The Board "is bound by the regulations, and may not choose to overturn the agency's lawful use of its regulatory authority based on principles of equity.").

As explained above, the ALJ properly concluded that CMS had a legal basis to revoke Arriva's Medicare billing privileges, and neither the ALJ, nor the Board, may look behind that exercise of discretion.

III. Petitioner's remaining arguments are inapposite and raise no material factual dispute that could defeat summary judgment for CMS on the legality of revocation.

To defeat an adequately supported summary judgment motion, the nonmoving party 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. *Med-Care* at 12 (citing *Senior Rehab. & Skilled Nursing Ctr.* at 3). Arriva argues that there is a genuine dispute of material fact concerning "[w]hether CMS used billing for deceased beneficiaries as a pretext for other, improper motivations in revoking Arriva's Medicare supplier number . . . ." RR at 34-37. Specifically, Arriva argues that there is a dispute as to whether the "true motivations" behind revoking its Medicare billing privileges involved the high volume of Medicare appeals pursued by Arriva. *Id*. at 34. Arriva argues that comments made by the former CMS Acting Administrator and "other key facts . . . strongly suggest that CMS may believe that revoking Arriva's Medicare supplier number will help solve its backlog problem and comply with a judicial mandate to reduce that backlog by at least 25% over each of the next four years." *Id*. at 35. Arriva further argues that the ALJ should have allowed Arriva to develop the record further and question CMS employees "regarding their involvement in Arriva's Medicare revocation." *Id*.

As we have already discussed, when reviewing a revocation action, ALJs (and the Board) are limited to determining whether CMS had a valid legal basis for the revocation. Where, as here, the legal basis exists and CMS decides to proceed with revocation, ALJs may not look behind that exercise of discretion, nor may they substitute their own decision as to whether *they* would have revoked. Thus, for purposes of summary judgment, Arriva's allegations about CMS's motives were immaterial to the ALJ's dispositive finding that Arriva billed Medicare – on at least nine occasions – for supplies that could not have been furnished to the beneficiaries identified because they were deceased on the dates of service.

Moreover, while Arriva contends that the ALJ failed "to view all facts and inferences in the light most favorable to" it (RR at 33), we find no evidence which, when viewed in the light most favorable to Arriva, could alter the outcome on the issue of whether CMS had a legal basis for revoking Arriva's billing privileges. Arriva faults the ALJ for reviewing "only 47 sample claims instead of the entire universe of 227 claims." *Id.* However, a review of all 227 claims was unnecessary insomuch as the ALJ properly concluded that a valid legal basis existed for revocation based on an undisputed fact of nine errant claims. Arriva also argues that the ALJ disregarded several "discrepancies" that Arriva identified in its analysis of the 227 claims that "call into serious question the integrity of the data analysis conducted by CMS" (RR at 32-33), but Arriva presented no evidence that such alleged discrepancies even tainted the nine claims at issue. *See Med-Care* at 14 ("[E]ven if Petitioner could prove that some of the dates of death were calculated incorrectly, it still would not foreclose the conclusion, which we have reached here, that enough of the improper claims in the record were for services to beneficiaries whose dates of death were correct."). After a thorough review of the record, we conclude that the evidence supports the ALJ's findings regarding these nine claims, and that no material facts remain in dispute. Therefore, we conclude that summary judgment was proper.

Conclusion

For the reasons set out above, the Board affirms the ALJ Decision upholding the revocation of Arriva's Medicare enrollment and billing privileges for a period of three years.

/s/
Constance B. Tobias

/s/
Susan S. Yim

/s/
Christopher S. Randolph
Presiding Board Member