Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Shrikant Tamhane,
(PTAN: CP342Z, NPI: 1497868251),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-17-542

Decision No. CR4959

Date: October 26, 2017

DECISION

Petitioner, Shrikant Tamhane, is a physician who participated as a supplier in the Medicare program until the Centers for Medicare & Medicaid Services (CMS) revoked his Medicare supplier number and billing privileges and established a three-year re-enrollment bar based on noncompliance with 42 C.F.R. § 424.535(a)(8)(i) because he repeatedly billed Medicare for services rendered to Medicare beneficiaries who were deceased at the time of service. Petitioner appeals the revocation of his Medicare supplier number. For the reasons detailed below, I find that Petitioner was not compliant with Medicare requirements and that CMS properly revoked his supplier number.

I. Background

Petitioner is a family practice physician. *See* CMS Exhibit (Ex.) 1 at 2. Petitioner contends that he "is a sole practitioner whose practice focuses on providing medical services to elderly patients in skilled nursing facilities and other subacute Hospital care facilities in Southern California." Petitioner's Brief (P. Br.) at 6.

In a letter dated October 20, 2016, CMS's Provider Enrollment and Oversight Group notified Petitioner that his Medicare supplier number would be revoked for a period of at least three years, effective November 19, 2016. CMS Ex. 4 at 2-3. CMS stated that the basis for revocation was noncompliance with 42 C.F.R. § 424.535(a)(8)(i) (Abuse of Billing Privileges). CMS Ex. 4 at 2. The letter informed Petitioner that he must request reconsideration of that determination within 60 calendar days of the postmark date of the letter, and that the reconsideration request "must state the issues or findings of fact with which you disagree and the reasons for disagreement." CMS Ex. 4 at 2. The letter further instructed that "if you have additional information that you would like a hearing officer to consider during the reconsideration or, if necessary, an administrative law judge to consider during a hearing, you must submit that information with your request for reconsideration" and that this is "your only opportunity to submit information during the administrative appeals process . . . unless an administrative law judge specifically allows you to do so under 42 CFR §498.56(e)." CMS Ex. 4 at 2. In its determination, CMS explained the following, in pertinent part:

> Data analysis conducted on claims billed by Shrikant Tamhane, for dates of service between February 1, 2011 and August 1, 2016, revealed that Shrikant Tamhane billed two hundred eight (208) claims for services provided to ninety-six (96) unique Medicare beneficiaries who were deceased on the purported date of service.

CMS Ex. 4 at 2. CMS appended a 27-page enclosure that identified claims in which Petitioner requested Medicare reimbursement for services rendered to deceased beneficiaries.[1] CMS Ex. 4 at 4-30 ("Enclosure A," which is a spreadsheet listing claim control numbers, along with the corresponding names of deceased beneficiaries, dates of service, and dates of death).

Petitioner submitted a request for reconsideration on November 14, 2016, in which he stated the following, in pertinent part:

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[1] Petitioner acknowledged that "[o]f the claims listed on CMS Exhibit 4, 98% represent hospital or skilled nursing home facility patient care and treatment." P. Br. at 6.

> We [r]eceived your letter dated October 20, 2016 along with the list of billings for deceased patient post date of death. It is a shock to me that this has been going on past 5 years. Medicare has been denying these claims but I was not informed by the billing service about this. Had they told me about this immediately we could have corrected the communication problem that we have now identified between the provider and the billing service. This was an innocent oversight in communication and not any intentional abuse of the billing process. Communication set up to bill patients was our mistake and I wish somebody had informed me about it when Medicare first started denying these claims so we could have corrected it many years ago. We have now realized that that the feedback from the hospital or nursing facility about the actual date of death is not available to the billing service immediately. Hence you have identified several [b]illings post the date of death. This was a[n] innocent oversight and not any intentional over billing.

CMS Ex. 6 at 1. In requesting reconsideration, Petitioner did not dispute CMS's determination that it received 208 claims for reimbursement for services provided to 96 deceased beneficiaries.

A month later, on December 14, 2016, an attorney submitted a letter on behalf of Petitioner, which stated, in part:

> Dr. Tamhane was unaware of what the billing service was submitting to CMS, including the dates of service being claimed, and on what patient. Dr. Tamhane, in all good faith, believed the practices of the billing service to be honest and forthright.
>
> All denials of the claims went directly to the billing service and not to Dr. Tamhane. All communications subsequent to the denials, were handled by the billing service. Dr. Tamhane relied on this billing service to be detailed, thorough, and honest. There was no act of Dr. Tamhane that can be deemed to be an abuse of billing privileges, as provided for at 42 CFR Section 424.535(a)(8)(i).

CMS Ex. 7 at 1. Nearly a month later, on January 12, 2017, and well beyond 60 days following the October 20, 2016 determination, another attorney from a different law firm requested additional information and an opportunity to "amend his request for reconsideration and/or to provide a Corrective Action Plan" after he received that information. CMS Ex. 8. Neither the December 14, 2016 letter nor the January 12, 2017 letter disputed CMS's determination that it had received 208 claims for reimbursement for services rendered to deceased Medicare beneficiaries.

On February 8, 2017, CMS issued a reconsidered determination upholding the revocation of Petitioner's Medicare enrollment and billing privileges because Petitioner "billed 208 claims for items/services for 96 deceased beneficiaries between February 1, 2011 and August 1, 2016." CMS Ex. 9 at 4. CMS explained that a "provider's failure to oversee the claims that the billing company submitted to Medicare for services that could not have been delivered to beneficiaries amounts to abuse." CMS Ex. 9 at 3. Further, CMS explained that "it is the responsibility of the provider to oversee the claims billed on his behalf in order to ensure that the claims billed are correct." CMS Ex. 9 at 3. CMS determined there was "no error made in the determination of a revocation." CMS Ex. 9 at 4.

Petitioner timely filed a request for a hearing before an administrative law judge (ALJ) on April 7, 2017. The Civil Remedies Division assigned the case to me, and I issued an Acknowledgement and Pre-Hearing Order (Order) on April 17, 2017. CMS submitted a brief and motion for summary judgment (CMS Br.), along with nine proposed exhibits. Petitioner submitted a brief and cross-motion for summary judgment, and nine proposed exhibits.[2] CMS thereafter submitted evidentiary objections and a response to Petitioner's motion for summary judgment.

In my April 17, 2017 Order, I explained that "[a] party must exchange as a proposed exhibit the complete, written direct testimony of any proposed witness." Order, § 8. I further explained that a party has the right to cross-examine any witness for whom direct testimony has been offered. Order, § 9.

Petitioner submitted the unsigned written direct testimony of Dona Hall[3] (P. Ex. 8) and Demosthenes A. Halcoussis, Ph.D. (P. Ex. 9). CMS has not requested an opportunity to cross-examine either of these witnesses. Therefore, a live hearing for the purpose of cross-examination of witnesses is unnecessary.[4]

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[2] Petitioner, through counsel, marked his nine exhibits as P. Exs. A, B, C, D, E, F, G, H, and I, and did not identify each of its exhibits with a "separate unique, and whole identifying number" as directed by my Pre-Hearing Order. Order, § 5(c). In lieu of rejecting Petitioner's exhibits, I have re-designated Petitioner's exhibits as P. Exs. 1-9.

[3] In my Order, I directed that written direct testimony "must be submitted in the form of an affidavit made under oath or as a written declaration that the witness signs under penalty of perjury for false testimony." Order, § 5(c).

[4] As an in-person hearing to cross-examine witnesses is not required, it is unnecessary to further address the parties' motions for summary judgment.

CMS has objected to various proposed exhibits submitted by Petitioner, namely P. Exs. 1, 4, 5, 8, and 9. Petitioner submitted P. Exs. 1, 4, and 5 in support of its arguments, and while those arguments are not persuasive, I nonetheless admit these publicly available documents that could have been introduced in Petitioner's briefing through reference to the websites where they were obtained rather than as submitted exhibits. *See https://oig.hhs.gov/oei/reports/oei-04-12-00130.asp* (P. Ex.1)*; https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/fraud_and_abuse.pdf* (P. Ex. 4)*; https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Downloads/2015-Medicare-and-Medicaid-Fraud-and-Abuse-Prevention-Workbook-Oct.pdf* (P. Ex. 5) (all sites last visited October 17, 2017). Likewise, while the testimony of Petitioner's two witnesses is not particularly probative with respect to the issue I must decide, CMS has presented no valid reason for me to deny giving Petitioner an opportunity to submit written direct testimony as permitted by my April 17, 2017 Order. I point out that "ALJs of the Departmental Appeals Board are not bound by the Federal Rules of Evidence, though they may 'apply [them] where appropriate, for example, to exclude unreliable evidence.'" *Realhab, Inc.,* DAB No. 2542 at 4 (2013); *see* 42 C.F.R. § 498.61; Civil Remedies Division Procedures, § 20. Pursuant to 42 C.F.R. § 498.61, "[e]vidence may be received at the hearing even though inadmissible under the rules of evidence applicable to court procedure." Section 498.61 further states that "[t]he ALJ rules on the admissibility of evidence." While I see limited probative and evidentiary value of Petitioner's submissions, I will admit all submitted exhibits. I therefore admit CMS Exs. 1-9 and P. Exs. 1-9.

II. Discussion

A. Issue

Whether CMS has the authority to revoke Petitioner's billing privileges pursuant to 42 C.F.R. § 424.535(a)(8).[5]

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

The Social Security Act (Act) authorizes the Secretary of Health and Human Services (Secretary) to establish by regulation procedures for enrolling providers and suppliers in the Medicare program. 42 U.S.C. § 1395cc(j)(1)(A). The Secretary thereby has promulgated enrollment regulations. *See* 42 C.F.R. § 424.500 *et seq*. These regulations give CMS the authority to revoke the billing privileges of an enrolled supplier if CMS determines that certain circumstances exist. 42 C.F.R. § 424.535(a). Relevant to this

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[5] Petitioner's briefing does not raise any disagreement with the effective date of revocation.

case, CMS may revoke a provider's or supplier's billing privileges under the following circumstance:

> (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.

42 C.F.R. § 424.535(a)(8)(i). In addition to revocation, CMS must impose a bar on re-enrollment for a minimum of one year, but no more than three years. 42 C.F.R. § 424.535(c). CMS imposed a three-year re-enrollment bar. CMS Ex. 14 at 3.

1. Petitioner does not dispute CMS's allegation that he submitted 208 claims for services that could not have been provided to 96 beneficiaries on the specific dates of service because those 96 beneficiaries were deceased on the purported dates of service.

CMS determined that Petitioner submitted 208 claims for services rendered to 96 deceased beneficiaries, and Petitioner has not presented evidence or argument that CMS was incorrect in its determination. To the contrary, Petitioner appears to believe that submitting only 208 improper claims over the span of approximately five years is a laudable achievement. *See* P. Br. at 24 (discussing that "out of 120,000 Medicare claims in the review period, CMS identified *only* 208 claims with this problem," which amounts to "only one claim [in] every 576 claims or *only* about 3 claims per month on average during the Review Period.") (emphasis added). CMS points out that "Petitioner does not dispute that he submitted Medicare claims for at least 96 deceased beneficiaries in at least 208 instances," and it is "undisputed that these beneficiaries were already deceased at the time Petitioner claimed to have provided services to them." CMS Br. at 6.

Although Petitioner repeatedly asserts that his billing company is solely responsible for the billing errors, he presents no probative evidence that his billing company "made data entry errors by entering the billing data into the wrong patient's account or by typing the wrong date of service." P. Br. at 6. Therefore, I do not accept Petitioner's bare assertion that he had no fault in the 208 erroneous claims for services rendered to deceased beneficiaries. In fact, it is implausible that on more than 200 occasions the billing company, on its own initiative, would submit claims for Medicare reimbursement for the

practice's deceased patients, and it appears to be just as plausible, in the absence of any evidence showing otherwise, that the billing company submitted those claims based on the direction it received from Petitioner. Further, and most significantly, Petitioner has not argued, with any cogent support, that he is not responsible for any errors committed by the entity he directed to perform his billing.[6] *See Louis J. Gaefke, D.P.M.,* DAB No. 2554 at 6 (2013) (stating that "a Medicare supplier is ultimately responsible for the accuracy of its claims for Medicare reimbursement" and "Petitioner's efforts to assign blame for the improper billing to his billing agent or his assistant do not relieve him of his responsibility for the improper claims or bar CMS from revoking his billing privileges."). Aside from the efforts of Petitioner and his witnesses (who were not personally involved in his own billing operations or the submission of the claims at issue) to cast blame elsewhere, Petitioner has not succeeded in passing the blame for the billing errors to anyone but himself.[7]

A billing company does not submit claims for reimbursement to Medicare out of thin air. Rather, a billing company acts as an agent for a provider or supplier, meaning that it submits claims for reimbursement at the direction of the provider or supplier. Petitioner has not submitted any evidence that his billing company acted without authority by submitting false claims on more than 200 occasions or that it made "data entry errors." CMS presented a list of 208 claims involving 96 deceased beneficiaries, and Petitioner has not refuted any of those 208 instances of erroneous billing; to the contrary, Petitioner boasts an "extremely low" error rate. CMS Ex. 4; P. Br. at 9. As Petitioner does not dispute that services could not have been rendered on any of the 208 occasions, I need not disturb CMS's determination that Petitioner erroneously submitted 208 claims for services rendered to 96 deceased beneficiaries. *See* CMS Exs. 4, 5.

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[6] I note that Petitioner previously explained that he was unaware that Medicare had denied payment of all 208 claims based on the that the beneficiary was deceased. Even assuming this dubious allegation is true for purposes of this discussion, that means that Petitioner had such little oversight over his billing practices that he was unaware that he had not been paid thousands of dollars in reimbursements.

[7] The unsigned written direct testimony of Dona Hall, who Petitioner regards as having provided an "expert opinion," does not provide any specific facts or circumstances that led Ms. Hall to conclude that the billing company committed more than 200 billing errors. P. Ex. 8; *see* P. Br. at 4. Ms. Hall references P. Ex. G (which I re-designated as P. Ex. 7) as support for her determination that the billing company is responsible for the errors. However, nothing on the face of P. Ex. 7 indicates that the billing company is independently responsible for billing for services purportedly provided to deceased beneficiaries, as P. Ex. 7 does not include the information that Petitioner provided to the billing company. I add that Ms. Hall stated, without any reference to supporting evidence, that "it would have been impossible for [Petitioner] to have identified all billing errors prior to their submission to Medicare." P. Ex. 8 at 5.

2. CMS has a sufficient basis to revoke Petitioner's Medicare billing privileges pursuant to 42 C.F.R. § 424.535(a)(8).

CMS is authorized to revoke a supplier's Medicare billing privileges if that supplier "submits a claim or claims for services that could not have been furnished to a specific individual on the date of service." 42 C.F.R. § 424.535(a)(8)(i). The facts of this case show that Petitioner submitted 208 claims for services that could not have been furnished to the specific individual on the date of service. CMS Exs. 4, 5. Specifically, Petitioner repeatedly billed for services provided to beneficiaries who were already deceased, and the regulation authorizes CMS to revoke Petitioner's Medicare billing privileges.

The text of section 424.535(a)(8) does not contain the word "abuse," and neither "abuse" nor "abusive billing practices" is a required element, in itself, for CMS to revoke billing privileges pursuant to 42 C.F.R. § 424.535(a)(8)(i). *See Louis J. Gaefke, D.P.M.*, DAB No. 2554 at 8 ("Given the absence from the regulation of any requirement to show fraudulent intent, or exceptions for inadvertent error, the preamble cannot be read in a manner that would effectively bar CMS from taking action against providers or suppliers who submit multiple improper claims, even where the claims were the result of negligence or reckless indifference by the provider or supplier.").

Petitioner argues that CMS's policy that it will not revoke billing privileges unless there are three or more instances of improper billing is invalid and does not comply with the Administrative Procedure Act. P. Br. at 18-19; *see* 5 U.S.C. § 553. First, I point out that this case does not involve a mere three improper claims that triggers consideration of 42 C.F.R. § 424.535(a)(8)(i), but rather, involves *hundreds* of improperly billed claims over a period of more than five years. CMS Exs. 4, 5. Petitioner, in making this argument, contends that the preamble of the rulemaking for 42 C.F.R. § 424.535(a)(8) imposed a "<u>strict</u> rule of <u>automatic</u> revocation if 'three or more' incorrect billings to deceased patients occur." P. Br. at 18 (emphasis in original) (quoting 73 Fed. Reg. at 36,455). However, Petitioner fails to realize the minimum number addressed in the preamble supports the intent to not target "isolated occurrences or isolated billing errors." *See Access Foot Care, Inc., & Robert Metnick, D.P.M*, DAB No. 2752 at 9 (2016) ("The preamble to the Final Rule does provide guidance as to what may show a pattern of abusive billings by stating CMS will *not* revoke Medicare billing privileges for improper billing *unless* the improper billing consists of 'multiple instances' of abusive billing.") (*see* P. Ex. 3); *see also John P. McDonough III, Ph.D., Geriatric Psychological Specialists, and GPS II, LLC,* DAB No. 2728 at 8 (2016) ("We conclude that the plain language of the regulation sufficed to notify Petitioners that the submission of a claim for services that could not have been provided to the specific individual identified in the claim on the date of services was an abuse of billing privileges that could lead to revocation, and the preamble provided notice that the submission of at least three such claims would not be viewed as merely accidental."). The language of the regulation shows that it targets more egregious incidents in which "[t]he 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" and gives examples such as the beneficiary being deceased on the date of service, the directing physician or beneficiary not having been present in the state or country when services were furnished, or the equipment necessary for testing not having been present where the testing is said to have occurred. 42 C.F.R. § 424.535(a)(8)(i). These situations involve essentially logistical impossibilities, and the statements in the preamble at most articulate CMS's enforcement policy and do not create extra-regulatory essential elements that must be proven to uphold a revocation action based on section 424.535(a)(8).[8] Petitioner fails to recognize that the text from the preamble is *more permissive* than the plain language of the regulation, which authorizes CMS to revoke a supplier's billing privileges after that supplier submits "*a claim* or claims" for services that could not have been provided. 42 C.F.R. § 424.535(a)(8)(i) (emphasis added). Based on the face of the regulation, a single claim can trigger CMS's authority to revoke a supplier's billing privileges. Yet, the preamble more permissively 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. at 36,455. Thus, Petitioner has not shown that the preamble to the rulemaking creates any ambiguity in the regulation or denies him rights afforded under the regulation. Petitioner erroneously billed for not just three, but for 208 claims for services provided to deceased beneficiaries; even under the most lenient reading of 42 C.F.R. § 424.535(a)(8), Petitioner's actions were egregious and do not amount to "sporadic" or "isolated" mistakes.[9] *See* P. Br. at 19, 24.

Petitioner argues that during the period of time at issue, he averaged only three billing errors per month in which he billed Medicare for treating deceased beneficiaries and a "percentage of claims denied due to post-death date of service error was .173%." P. Br. at 21, 24. Petitioner argues that this error rate is "extremely low." P. Br. at 9. Aside from the fact Petitioner's statement is nothing short of preposterous, Petitioner fails to recognize that the applicable regulatory section, 42 C.F.R. § 424.535(a)(8)(i), is not triggered based on a threshold *percentage* of abusive billing. *Patrick Brueggeman, D.P.M.*, DAB No. 2725 at 12 (2016), and cases cited therein. Rather, noncompliance

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[8] Petitioner cites no authority authorizing an ALJ to invalidate a regulation. I am bound by all applicable regulations and "may not invalidate either a law or regulation on any ground."). *See, e.g., 1866ICPayday.com, L.L.C.*, DAB No. 2289 at 14 (2009).

[9] Petitioner's "expert opinion" by Demosthenes A. Halcoussis is not persuasive. Mr. Halcoussis provides no foundation for his determination that the 208 erroneous claims were the result of "billing errors." Absent any evidence from Petitioner that the 208 claims were the result of "billing error," it is just as possible that each erroneous claim was intentionally submitted as a deliberate effort to abuse the Medicare program, and therefore, was not submitted in error. For purposes of section 424.535(a)(8), I need not determine whether the latter applies in the instance case.

exists when a "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." 42 C.F.R. § 424.535(a)(8)(i). While the plain language of the regulation allows for a finding of abuse of billing privileges based on a single instance, CMS has explained that it will exercise its revocation authority only when there are "multiple instances, at least three, where abusive billing practices have taken place." 73 Fed. Reg. at 36,455; *see John P. McDonough III, Ph.D., et al,* DAB No. 2728 at 8. There are certainly multiple instances of abusive billing, under the regulatory definition, present here; specifically, there are 208 instances of abusive billing involving services purportedly provided to deceased beneficiaries.

Further, Petitioner's reliance on its "extremely low" error rate and its self-calculated .173% "percentage of claims denied due to post-death date of service error" is misplaced. P. Br. at 9, 21; *See Patrick Brueggeman, D.P.M.*, DAB No. 2725 at 11-12 (discussing that neither the regulation nor the preamble suggest any requirement for a minimum claims error rate). After all, Petitioner is a physician, one would expect that he would only treat living beneficiaries; therefore, it is logical to expect that of the 120,000 claims he reports he submitted, all of those beneficiaries would have been alive at the time of treatment and there should never be an instance in which he billed for providing services to a deceased patient.[10] As CMS correctly states, "[t]he basis for revocation is the submission of the improper claims themselves, not the error rate calculation or the dollar amount of any overpayment later determined by CMS." CMS Br. at 8.

Petitioner also argues that he did not receive payment for these claims. P. Br. at 2. However, revocation pursuant to section 424.535(a)(8)(i) is based on abusive billing, and a supplier's return of improperly received reimbursement or that the Medicare contractor caught the error prior to issuing payment is irrelevant.

Petitioner also argues that the Inspector General (IG) of HHS "recommended that CMS take 'appropriate action' when providers and suppliers have 'high numbers' of paid and/or unpaid Part B claims with dates of service after beneficiaries' deaths" and that Petitioner "does not meet the benchmark of having a 'high number' of claims billed for services with dates after date of death." P. Br. at 7, citing P. Ex. 1 (Medicare Payments Made on Behalf of Deceased Beneficiaries in 2011, OEI-04-12-00130, October 2013). Petitioner points to no authority that a recommendation by the IG in a study or audit report has the force of law, and therefore I reject this unsupported argument.

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[10] None of the 208 claims were for services rendered on the same date as the death of the beneficiary (i.e., the beneficiary expired on the same date that he or she received treatment). CMS Ex. 4.

3. The effective date of the revocation of Petitioner's billing privileges is November 19, 2016.

The revocation of Medicare billing privileges is effective 30 days after CMS or its contractor issues the notice of revocation, unless certain exceptions apply. 42 C.F.R. § 424.535(g). The effective date of Petitioner's revocation is November 19, 2016.

4. The three year length of the reenrollment bar is not reviewable.

The Departmental Appeals Board (DAB) has explained that "CMS's determination regarding the duration of the re-enrollment bar is not reviewable." *Vijendra Dave, M.D.*, DAB No. 2672 at 11 (2016). The DAB explained that "the only CMS actions subject to appeal under Part 498 are the types of initial determinations specified in section 498.3(b)." *Id.* The DAB further explained that "[t]he determinations specified in section 498.3(b) do not, under any reasonable interpretation of the regulation's text, include CMS decisions regarding the severity of the basis for revocation or the duration of a revoked supplier's re-enrollment bar." *Id.* The DAB discussed that a review of the rulemaking history showed that CMS did not intend to "permit administrative appeals of the length of a re-enrollment bar." *Id.* I have no authority to review this issue and I do not disturb the three-year reenrollment bar. Petitioner requests that I remand this matter "with a directive that [CMS] exercise its discretion in regard to the length of the revocation . . . ." P. Br. at 23. That is unnecessary; Petitioner's conduct was egregious, in that he billed Medicare more than 200 times for rendering services to deceased beneficiaries over a period of more than five years. A three-year ban to reenrollment is entirely appropriate.

III. Conclusion

I affirm CMS's revocation of Petitioner's Medicare billing privileges, effective November 19, 2016.

/s/
Leslie C. Rogall
Administrative Law Judge