Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Mohammad Nawaz, M.D., and Mohammad Zaim, M.D., PA
Docket No. A-16-12
Decision No. 2687
April 19, 2016

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Petitioner Mohammad Nawaz, M.D., and Mohammad Zaim, M.D., PA, (Petitioner)[1] appeals an Administrative Law Judge (ALJ) decision upholding on summary judgment the Centers for Medicare & Medicaid Services' (CMS) determination to revoke Petitioner's Medicare enrollment and billing privileges under 42 C.F.R. § 424.535(a)(8). *Mohammad Nawaz, M.D. and Mohammad Zaim, M.D., PA*, DAB CR4244 (September 22, 2015) (ALJ Decision). The ALJ concluded that the revocation was authorized under that regulation because Petitioner submitted or caused to be submitted claims for Medicare reimbursement for services he could not have provided on the claimed service dates. For the reasons stated below, we affirm the ALJ Decision.

Background[2]

The legal basis for the revocation

CMS, through Novitas Solutions (Novitas), a CMS Medicare contractor, revoked Petitioner's Medicare enrollment and billing privileges based on 42 C.F.R. § 424.535(a)(8), which authorizes CMS to revoke where it finds an abuse of Medicare billing privileges. As of October 30, 2014 (the date of Petitioner's revocation), the regulation provided as follows:

[1] The ALJ explained that the two names in the case identify one individual who enrolled in Medicare as an individual physician and as a professional association. The ALJ referred to the individual as Petitioner and "him," and we do the same. *See* ALJ Decision at 1 n.1.

[2] Unless otherwise indicated, the facts stated in this section reflect the findings in the ALJ Decision and/or undisputed facts of record.

> *Abuse of billing privileges*. 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 situations where . . . the directing physician or beneficiary is not in the State or country when services were furnished . . . .

42 C.F.R. § 424.535(a)(8). On its face, the language "claim or claims" would authorize revocation for abuse of billing privileges based on the filing of a single claim **for** services that could not have been provided on the claimed date of service. However, the regulation's preamble indicates that CMS has chosen not to revoke unless at least three such claims are submitted. 73 Fed. Reg. 36,448, 36,455 (June 27, 2008). Providers and suppliers whose enrollment and billing privileges are revoked are subject to a re-enrollment bar of from one to three years. 42 C.F.R. § 424.535(c).

The revocation history

Petitioner, a cardiologist, participated as a supplier in the Medicare program.[3] On September 25, 2014, Novitas issued an initial determination revoking Petitioner's Medicare enrollment and billing privileges under 42 C.F.R. § 424.535(a)(8) for abuse of billing privileges. CMS Ex. 6. The initial determination letter stated that Medicare claims data and Department of Homeland Security records revealed that Petitioner "submitted in excess of one hundred Medicare claims during documented periods of travel outside of the United States." *Id*. at 1. The documented periods of travel outside the United States listed in the letter were June 18-June 20, 2011; September 27-October 2, 2011; May 2-4, 2012; and May 20-June 4, 2013. *Id*. The initial determination letter notified Petitioner of his rights to file a corrective action plan and to seek reconsideration of the initial determination, and further stated, "You may submit additional information with the reconsideration that you believe may have a bearing on the decision." *Id*. at 2. Finally, the letter told Petitioner that Novitas was establishing a three-year reenrollment bar. *Id*.

On October 20, 2014, Petitioner submitted a corrective action plan to Novitas. CMS Ex. 5. On November 7, 2014, Novitas rejected the plan, on the ground that the plan "gives an explanation of the circumstances, but does not negate the fact that claims were submitted for services that could not have been furnished by you on the date(s) of service reported." *Id*. at 1. In a letter dated November 18, 2014, Petitioner sought reconsideration of the initial determination. CMS Ex. 4, at 4-5. Petitioner admitted he had "submitted Medicare claims for periods that I was outside the United States" but "disagree[d] that this was done intentionally and abusively." *Id*. at 4. Petitioner further stated that the

[3] The regulations define "supplier" to mean "a physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare." 42 C.F.R. § 400.202.

services for which he billed "were performed by nurse practitioners rather than myself" and that "[a]t the time these claims were submitted, I was unaware that services for a nurse practitioner could not be billed under my NPI [national provider identifier] number unless I was physically present with them at all times." *Id*.

On March 9, 2015, Novitas denied Petitioner's request for reconsideration, stating that the lack of awareness stated by Petitioner in his reconsideration request "does not correct the deficient compliance cited in the revocation and the excess of one hundred Medicare claims submitted during his documented travel outside the United States." CMS Ex. 1, at 2. Petitioner then filed the hearing request that led to the ALJ decision.

Principal ALJ findings

The ALJ found that the undisputed facts established that Petitioner was out of the country from June 18-June 20, 2011; September 27-October 2, 2011; May 2-4, 2012; and May 20-June 4, 2013. ALJ Decision at 4. The ALJ also found that Petitioner submitted to Medicare claims for reimbursement for services allegedly provided by him on those dates. *Id*., citing CMS Ex. 1, at 1-3; CMS Ex. 7, at 6-109. The ALJ noted that while Petitioner questioned whether the total number of improper claims was as high as CMS alleged (more than 100 in total), Petitioner "does not deny that he submitted some unspecified number of claims for services that he could not have provided on the claimed service dates." *Id*. at 5. The ALJ said that the three-claim threshold the preamble stated was not a legal requirement but that, in any event, "there is no doubt that [Petitioner] submitted or caused to be submitted more than three [improper claims]." *Id*. The ALJ concluded that while Petitioner made a number of arguments "intended to deflect blame for the false claims that he submitted or caused to be submitted . . . what Petitioner *does not deny* . . . is that he was out of the country for periods of time and that he submitted or caused to be submitted claims for services that he allegedly provided on dates when he was not in the United States. That concession is all that CMS needs in order to authorize revocation of Petitioner's participation." *Id*. (emphasis in original). Finally, the ALJ rejected the "basic misconception that underlies Petitioner's arguments . . . that there must be proof of culpability to justify revocation pursuant to 42 C.F.R. § 424.535(a)(8)." *Id*. citing *Louis J. Gaefke, D.P.M*., DAB No. 2554, at 5-6 (2013).[4]

[4] In *Gaefke*, the Board found no error in the ALJ's rejection of the supplier's argument that "the title of the regulation, 'Abuse of billing privileges,' . . . means that there must be a level of intent that is not stated in the regulation itself . . . ." DAB No. 2554, at 8. The Board relied on "[t]he plain language of the regulation [which] contains no requirement that CMS establish that the supplier acted with fraudulent or dishonest intent." *Id*. at 7. "The regulatory language," the Board continued, "also does not provide any exception for inadvertent or accidental billing errors." *Id*. As in *Gaefke*, we find no error in the ALJ's rejection of Petitioner's argument that proof of culpability is required to revoke under section 424.535(a)(8).

Standard of Review

We review the ALJ's grant of summary judgment de novo, construing the facts in the light most favorable to Petitioner and giving him 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). Summary judgment is appropriate when there is no genuine dispute about a fact or facts material to the outcome of the case and the moving party is entitled to judgment as a matter of law. *Id.*; *Celotex Corp. v Catrett*, 477 U.S. 317, 322-25 (1986). The party moving for summary judgment (here, CMS) has the initial burden of demonstrating that there is no genuine issue of material fact for trial and that it is entitled to judgment as a matter of law. *Celotex*, 477 U.S. at 323. If the moving party carries that burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial.'" *Matsushita Elec. Industrial Co., LTD. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986) (quoting Rule 56(e) of the Federal Rules of Civil Procedure).[5] Our standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. *See Guidelines — Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program*, http://www.hhs.gov/dab/divisions/appellate/guidelines/prosupenrolmen.html.

Discussion

A. The ALJ applied the correct legal standards.

Petitioner argues that the ALJ did not apply the correct legal standards when he concluded that CMS was authorized to revoke Petitioner's enrollment and billing privileges under section 424.535(a)(8). Request for Review (RR) at 4-8. We conclude for the reasons stated below that the ALJ applied the correct legal standards and properly concluded that the revocation was lawful.

1. Summary judgment was appropriate since there was no dispute about the material facts.

Petitioner first alleges that "CMS failed to meet its burden to obtain summary judgment." RR at 4. We disagree and conclude that the ALJ properly granted summary judgment to CMS. As stated above, summary judgment is proper when there is no genuine dispute about any fact material to the outcome of the case. CMS revoked Petitioner's enrollment

[5] Effective December 1, 2010, Rule 56 of the Federal Rules of Civil Procedure was "revised to improve the procedures for presenting and deciding summary-judgment motions and to make the procedures more consistent with those already used in many courts." Committee Notes on Rules - 2010 Amendment, available at http://www.law.cornell.edu/rules/frcp/rule_56. The revisions alter the language of the rule, but the "standard for granting summary judgment remains unchanged." *Id.* Although the Federal Rules do not directly apply, the Board may use them as guidance.

and billing privileges under section 424.535(a)(8) because CMS concluded he had abused those billing privileges by filing multiple claims for services that he could not have furnished to specific individuals on the dates claimed because he was out of the country. Accordingly, the facts material to the ALJ's decision, and to our de novo review, are 1) whether Petitioner was out of the country on the dates alleged and 2) whether he billed Medicare for services he claimed to have provided to specific individuals on those dates.

As indicated above, under the summary judgment standard, CMS had the initial burden to come forward with evidence on these facts. CMS clearly met that burden. CMS submitted evidence, including Department of Homeland Security records, showing that Petitioner was out of the country from June 18-20, 2011; September 27-October 2, 2011; May 2-4, 2012; and May 20-June 4, 2013. CMS Ex. 6, at 1; CMS Ex. 7, at 105-09. CMS also submitted Medicare billing records showing that Petitioner submitted more than 100 claims for services he claimed to have provided to Medicare patients on the dates he was out of the country. CMS Ex. 6, at 1; CMS Ex. 7, at 8-104. The ALJ cited this evidence and further found that Petitioner did not deny that he was out of the country on the dates in question or that he submitted multiple claims for services ostensibly provided by him on those dates. ALJ Decision at 4 (citations omitted).

Petitioner's request for review does not directly challenge the ALJ's findings regarding these undisputed facts. Moreover, the record before the ALJ (which is the record for our review) shows that Petitioner actually admitted to the facts on which CMS based the revocation and on which CMS's motion for summary judgment relied. As indicated above, Petitioner stated in his request for reconsideration, "Your [Novitas's] letter states that I submitted Medicare claims for periods that I was outside the United States. <u>While I admit that this, in fact happened</u>, I disagree that this was done intentionally and abusively." CMS Ex. 4, at 4 (emphasis added). At most, as the ALJ noted, Petitioner questioned whether the total number of improper claims he submitted was as high as CMS alleged. However, as the ALJ also noted, he "does not deny that he submitted some unspecified number of claims for services that he could not have provided on the claimed service dates." ALJ Decision at 5.

On appeal, as below, Petitioner does not identify any particular Medicare claim that he disputes. Also, while disputing the total number, Petitioner does not provide evidence of how many claims he alleges were not submitted as CMS charged, and certainly does not allege that they were fewer than the three instances of improper billing posited as a threshold in the preamble. Petitioner makes only vague, unexplained and unsupported assertions such as that "[o]f the dates given by Kirk [the Office of the Inspector General (OIG) investigator who reviewed and reported on the claims data] an entire month has been without question proven incorrect by Petitioner's evidence." RR at 10. Unsupported assertions are not enough to defeat a motion for summary judgment. *See e.g. 1866ICPayday.com, L.L.C.*, DAB No. 2289, at 11 (2009) (upholding summary judgment where nonmoving party had failed to produce documentary evidence to support

allegations); *Livingston Care Center*, DAB No. 1871, at 5 (stating that "[t]o defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact . . . ." citing *Matsushita*, 475 U.S. at 586, n.11; *Celotex*, 477 U.S. at 322). Moreover, Petitioner's documented absences from the country included four different periods of time, two of which involved two months. Accordingly, even assuming CMS's data for one month was incorrect, its data for the remaining periods of time remains an undisputed basis for the revocation.

Petitioner also does not challenge the ALJ's specific finding that "whether Petitioner submitted at least 100 false claims or somewhat fewer than that number, there is no doubt that he submitted or caused to be submitted more than three of them." We thus do not find it necessary to address Petitioner's argument that CMS must always provide more than three claims that meet the description in the regulation, since the number of improperly billed claims submitted by Petitioner clearly met or exceeded that threshold.

Petitioner argues that the evidence presented by CMS, including the declaration by the OIG inspector, is unreliable hearsay, but Petitioner is not specific and does not explain this assertion. The ALJ noted a similar lack of explanation or specificity when he overruled Petitioner's argument that CMS's evidence should not be admitted because, according to Petitioner, the Medicare claims records were "'incomprehensible' or not credible and reliable" and the OIG investigator's declaration was "not credible." ALJ Decision at 2. The ALJ stated,

> I need not address that argument [about the investigator's affidavit] in order to issue summary judgment favorable to CMS because CMS does not rely on anything in the affidavit to establish facts that are in dispute. As I have explained, Petitioner admits that he was out of the country during periods of time when he claimed reimbursement for services that he ostensibly provided to Medicare beneficiaries. Additionally the claims are not incomprehensible. I note, additionally, that Petitioner does not deny filing, or causing to be filed, any of the claims that are identified in the exhibit. Petitioner has not explained its credibility and reliability objections and I overrule them for that reason.

Id. For all of the reasons stated above, we reject Petitioner's arguments that the ALJ erred by relying on CMS's evidence in support of summary judgment.[6] In summary, we conclude that the ALJ did not err in deciding this case on summary judgment given the absence of any dispute of material fact.[7]

2. The ALJ correctly did not require CMS to show a pattern of intentionally abusive billing.

Petitioner argues that the ALJ should have required CMS to establish a pattern of abuse and intent. He contends, furthermore, that CMS could not have done so because "[i]n this case, the billing errors were not intentional and could not fairly be said to constitute a pattern of abuse." *Id*. at 5. We find no support for this argument.

Petitioner relies on amendments to section 424.535(a)(8) that **added** to the existing grounds for revocation based on abusive billing a new basis addressing a pattern or practice of submitting claims that fail to meet Medicare requirements. *See* 79 Fed. Reg.72,500 (Dec. 5, 2014) (effective Feb. 3, 2015).[8] The amendments are immaterial because they took effect in 2015 after Petitioner's revocation. They also are immaterial because, as the ALJ noted, they "do not change the regulatory language that is the basis for the revocation in this case." ALJ Decision at 3, n.3. Petitioner's revocation for abuse of billing privileges here was not based on the provision of section 424.535(a)(8) addressing a pattern or practice of submitting claims that do not meet Medicare requirements (which did not exist at the time) but, rather, based on submitting claims for services that could not have been furnished to a specific individual on the dates of the claims.

Petitioner also relies on *Velocity Healthcare Servs., LLC*, DAB CR3849 (2015) and faults the ALJ for not commenting on that decision. The ALJ committed no error in not addressing *Velocity*. In the first place, ALJ decisions do not bind other ALJs or the Board. *E.g*. *Britthaven of Chapel Hill*, DAB No. 2284, at 9-10 (2009). In addition, the case is wholly inapposite. *Velocity*, unlike the case here, involved a revocation under

[6] Petitioner makes the same assertions about the alleged unreliability of CMS's evidence in its argument that "The [ALJ] Decision is Unsupported By Substantial Evidence." RR at 9-10. These arguments are equally baseless there, indeed, more so since "substantial evidence" is not the standard of review that applies to the Board's review of a decision made on summary judgment.

[7] In light of this conclusion, we must summarily reject Petitioner's argument that he "was denied a hearing and right to cross examine." RR at 11. Petitioner had no right to an evidentiary hearing since the ALJ properly concluded that there were no disputes about material facts needing resolution in such a hearing.

[8] The amendments redesignated the existing basis of revocation for abusive billing (the basis at issue here) as section 424.535(a)(8)(i) and designated the new basis as section 424.535(a)(8)(ii). *Id*. at 72,532. We note that the amended regulation still does not contain a requirement that abusive billing be intentional.

section 424.535(a)(8)(ii) for a pattern or practice of submitting claims that did not comply with Medicare requirements, the revocation basis added by the 2015 amendments discussed above. The ALJ in *Velocity* reversed the revocation because it occurred before the amendments authorizing revocation on that basis took effect. Contrary to Petitioner's contention, the decision did not hold that CMS may not revoke based on a supplier's submission of claims that it could not have furnished on the date in question if the services were actually furnished by someone. That was not a holding or even an issue in *Velocity*. There was no dispute that Velocity (an ambulance company) actually furnished the services for which it claimed reimbursement. CMS revoked not because the supplier billed for services that it had not provided, but because the documentation for the claims did not support a finding that they were medically necessary, a Medicare requirement.

3. The ALJ correctly rejected Petitioner's argument that the claims submitted were lawful because they were for services provided by a nurse practitioner that were "incident to" his services.

Petitioner argues that he relied on CMS's "incident to" billing policies which, he contended, permitted him to claim Medicare reimbursement for the services provided to his patients by a nurse practitioner while Petitioner was out of the country. Petitioner asserts that the ALJ erroneously rejected that argument when he raised it below. We conclude that the ALJ did not err in concluding that the "incident to" rule did not permit Petitioner to bill for the services furnished by the nurse practitioner during Petitioner's absence.

The regulations allow a physician, in certain circumstances, to bill for Medicare Part B services provided to their patients by auxiliary personnel (another physician or other practitioner) that are "incident to" the billing physician's services. *See* 42 C.F.R. § 410.26(b) ("Medicare Part B pays for services and supplies incident to the service of a physician (or other practitioner)"). However, the regulations contain a number of requirements that must be met in order for the physician to bill for "incident to" services.

One of these requirements is that the "incident to" services provided by auxiliary personnel must be provided under the direct supervision of the billing physician. At the time the services were furnished, the regulatory section stating this requirement, section 410.26(b)(5), provided as follows:

> Services and supplies must be furnished under the direct supervision of the physician (or other practitioner). The physician (or other practitioner) directly supervising the auxiliary personnel need not be the same physician (or other practitioner) upon whose professional service the incident to service is based.

42 C.F.R. § 410.26(b)(5).[9] The regulations further stated (and still state) that "*[d]irect supervision* means the level of supervision by the physician (or other practitioner) of auxiliary personnel as defined in § 410.32(b)(3)(ii)," 42 C.F.R. § 410.26(a)(2), and section 410.32(b)(3)(ii) defines "direct supervision" as follows:

> *Direct supervision* in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

42 C.F.R. § 410.32(b)(3)(ii).

The ALJ concluded that the services furnished by the nurse practitioner did not qualify as "incident to" services because Petitioner was unavailable to provide the nurse practitioner with the direct supervision required by section 410.26(b)(5). ALJ Decision at 4-5. The ALJ cited a CMS Medicare Learning Network notice that articulated the definition of "direct supervision" that appears in section 410.32(b)(3)(ii) quoted above. *Id*. The ALJ concluded that because the rule required the supervising physician to be present in the office suite, "Petitioner could not have met the 'incident to' billing requirements if he/she was out of the country at the time the services were furnished." *Id*.

Although he has admitted he was out of the country when the nurse practitioner furnished the services, Petitioner nonetheless challenges the ALJ's conclusion. Petitioner asserts that the last sentence of section 410.32(b)(3)(ii) – stating that the supervising physician need not be present in the room where the "incident to" procedure is performed – supports his argument that he could bill for the nurse practitioner's services even though he was out of the country. This argument ignores the critical first sentence of the regulation on which the ALJ relied, that "the physician must be present in the office suite

[9] The version of the regulation Petitioner quotes in his Reply contains amended language that took effect January 1, 2016, well after the services here were provided, and, thus, does not apply. 80 Fed. Reg. 70,886, 71,372 (Nov. 16, 2015). We also note that the last sentence of the version Petitioner quotes states, "However, only the supervising physician (or other practitioner) may bill Medicare for incident to services." Reply at 5. Petitioner's counsel stated during oral argument that this supported Dr. Nawaz's position that he could bill for the services provided by the nurse practitioner even though Dr. Nawaz was out of the country and could not provide direct supervision of the nurse practitioner. We disagree. As stated by a Board member at that time, the language "seems to say quite clearly that only the physician providing the supervision may bill, whether or not that's the physician treating the patient more broadly." Tr. at 37. Moreover, as we discuss later, the record does not establish that any physician or practitioner supervised the nurse practitioner as she furnished the services in question.

and immediately available to furnish assistance and direction throughout the performance of the procedure." 42 C.F.R. § 410.32(b)(3)(ii). Clearly, Petitioner could not have been present in the office suite[10] on the dates the services here were provided since he was not even in the country.

In his Reply, Petitioner argues for the first time that the definition of "direct supervision" must be read together with the part of section 410.26(b)(5) providing that "[t]he physician (or other practitioner) directly supervising the auxiliary personnel need not be the same physician (or other practitioner) upon whose professional service the incident to service is based." Reply at 5. Petitioner argues –

> To read these two Regulations together in a manner which purports to require the "direct supervision" and personal presence of **only** the billing provider is fundamentally wrong. 42 C.F.R. §426.10 [*sic*] expressly recognizes and permits, under subsections (a)(1), (a)(2), (b), and (b)(5), supervision by the physician ***or other practitioner***.[11]

Id. (emphasis in original). Petitioner also states in his Reply, "The evidence presented in this case by Petitioner demonstrated that with respect to the billings in question where he was out of the country, there nevertheless was proper coverage and supervision by another practitioner in compliance with the law." [12] *Id*. at 6, citing Petitioner's Amended Response to Respondent's Motion for Summary Judgment, Ex. 14, Nawaz Affidavit.[13]

It is not entirely clear whether Petitioner is arguing that the nurse practitioner (i.e., a non-physician "other practitioner") was providing the required supervision or whether he is suggesting that some physician other than himself supervised the nurse practitioner furnishing the services. To the extent he is arguing the former, it is insupportable on its

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[10] As we discuss later, it appears that many of the services were not even furnished in an office setting but, rather, were services furnished to patients in hospitals and skilled nursing facilities and, thus, could not qualify as "incident to" services for that reason as well.

[11] Petitioner cited 42 C.F.R. § 426.10 but was clearly referring to section 410.26.

[12] We see no evidence in the record that Petitioner argued before the ALJ or even in his Request for Review that the alleged covering physicians provided direct supervision to the nurse practitioner as she furnished the services for which Petitioner billed Medicare, and when questioned about this by a Board Member during oral argument, Petitioner's counsel was unable to cite such evidence. Tr. at 21. Petitioner is not permitted to raise on appeal an issue he could have raised but did not raise before the ALJ or in his Request for Review. *Guidelines, supra*, Completion of the Review Process (a). (We note that comments by co-counsel on page 39 of the transcript responding to this Board Member question address another Petitioner in a companion case, not Dr. Nawaz, and the briefs cited by counsel, in any event, merely asserted that covering physicians were available, not that they supervised the nurse practitioner.)

[13] The record before the ALJ contains two Petitioner Exhibits 14, both affidavits of Petitioner. The second affidavit is described as "Petitioner's Amended Exhibit 14" on "Amended Petitioner's Exhibit and Witness List." The relevant language in the paragraph of the affidavit cited by Petitioner is the same in both affidavits.

face because under section 410.26(b)(5), the nurse practitioner who furnished the services would be the auxiliary personnel and could not supervise herself. *See* 42 C.F.R. § 410.26(a)(1) (defining "auxiliary personnel" as meaning "any individual who is acting under the supervision of a physician (or other practitioner) . . . ."). To the extent Petitioner is arguing the latter, the affidavit he cites does not support this assertion. Petitioner's affidavit states only that Petitioner had "2 cardiologists covering for him," while he was out of the country, not that the cardiologists supervised (even generally, much less directly) the nurse practitioner each time she furnished the services for which Petitioner improperly billed Medicare.

Statements in Petitioner's Motion for Summary Judgment also undercut any inference that the covering cardiologists supervised the nurse practitioner while she furnished the services to Petitioner's patients, who, Petitioner says, resided in nursing homes. Most significantly, after discussing his assertion that he had two cardiologists covering for him as necessary, Petitioner stated: "However, CMS has no evidence to suggest that this necessity arose on the dates in question." Petitioner's Motion for Summary Judgment at 11. Thus, the implication is that no evidence shows that the covering cardiologists were present in person in the location (i.e., the office suite) to provide direct supervision. In addition, Petitioner asserts that: "No other cardiologists are willing or able, with heart failure certification, to tend to Medicare beneficiaries in nursing homes and/or rehab to improve quality of care and reduce the need for readmission." *Id*. at 4. This statement raises questions about the likelihood that the covering cardiologists were present in the nursing homes during the nurse practitioner's service delivery.

Another requirement for "incident to" services is that the "[s]ervices and supplies must be furnished in a noninstitutional setting to noninstitutional patients." 42 C.F.R. § 410.26(b)(1). A "*[n]oninstitutional setting*" means all settings other than a hospital or skilled nursing facility." 42 C.F.R. § 410.26(a)(5). While the ALJ based his rejection of Petitioner's "incident to" argument, as discussed above, on Petitioner's not meeting the requirements of section 410.26(b)(5), section 410.26(b)(1) raises further questions about how the services which Petitioner asserted throughout were provided in nursing homes, rather than in an office setting, could be determined to have been properly billed as "incident to" services. Petitioner failed to explain before us how these services could meet the requirement of a noninstitutional setting. The billing data of record confirms that many of the claims submitted to Medicare were for services to patients in hospitals and skilled nursing facilities, institutional patients and settings. CMS Ex. 7, at 95. In addition, in his affidavit, Petitioner denied that his nurse practitioners were seeing patients in hospital or office settings but admitted they were seeing patients "in the nursing facilities and long term facilities." P. Ex. 14, ¶ 3. Long term care facilities include skilled nursing facilities. 42 C.F.R. § 488.301; *see also* 42 U.S.C. § 1395i-3(a) (defining "skilled nursing facility as "an institution (or a distinct part of any institution) which . . . (1) is primarily engaged in providing to residents— (A) skilled nursing care and related services for residents who require medical or nursing care . . . ."). Finally, in

response to questions at oral argument regarding the record references to the type of facility in which the nurse practitioner's services were provided, Petitioner's counsel admitted that the services were provided to residents in nursing facilities that had skilled care components. Tr. at 21-25. Nursing facilities whose services include skilled care services are institutional settings for purposes of section 410.26(b)(1). Thus, by Petitioner's own admission, at least some of the services furnished by the nurse practitioner, and for which Petitioner was found to have improperly billed, were services to patients in institutional settings and, for that reason as well, would not qualify as "incident to" services regardless of whether the direct supervision requirement was met.[14]

B. Petitioner's other arguments have no merit.

1. *The ALJ committed no abuse of discretion or error in his handling of Petitioner's evidentiary submissions.*

Petitioner argues that the ALJ abused his discretion in failing to find good cause for Petitioner to supplement during the ALJ proceeding the evidence it presented to Novitas with its reconsideration request.[15] RR at 8-9. Petitioner also argues that the ALJ erred in excluding Petitioner Exhibits 7 and 8 "because both exhibits are testimonial in nature and relevant to the case." RR at 11. There is no merit to either argument.

The ALJ excluded Petitioner Exhibits 7 through10c and 15 through 18 on the ground Petitioner had not submitted these exhibits with his request for reconsideration and had not shown good cause for submitting them for the first time at the ALJ level. ALJ Decision at 2-3. The ALJ relied on 42 C.F.R. § 498.56(e)(1) which provides that in provider and supplier appeals "the ALJ will examine any new documentary evidence submitted to the ALJ by a provider or supplier to determine whether the provider or supplier has good cause for submitting the evidence for the first time at the ALJ level" and that "[i]f the ALJ determines that there was not good cause for submitting the evidence for the first time at the ALJ level, the ALJ must exclude the evidence from the proceeding and may not consider it in reaching a decision." The ALJ found that Petitioner had not shown "good cause." *Id*.

[14] The fact that the ALJ did not address section 410.26(b)(1) does not preclude also relying on the latter for our decision since Petitioner himself raised section 410.26 as a defense to the revocation and, in addressing that defense, we must correctly apply the "incident to" regulation as a whole. In any event, as discussed below, we also agree with the ALJ's reason for rejecting this defense.

[15] In a footnote in his Reply, Petitioner moves alternatively for admission of all evidence excluded by the ALJ. Reply at 15 n.2. While Petitioner claims all of the evidence is "'relevant and material' to the issues herein," he makes no argument to support that assertion. Having found no error in the ALJ's handling of Petitioner's submissions, we have no basis for granting this motion and deny it.

Petitioner argued below, and reiterates here, that the initial determination letter notifying him of his right to seek reconsideration of the initial revocation determination and to submit exhibits supporting his reconsideration request was ambiguous because it stated only that Petitioner "may" submit new evidence and did not specifically inform him that any evidence not submitted at that time might not be admissible in an ALJ appeal. ALJ Decision at 3; RR at 13-14. Petitioner argues that this alleged ambiguity and inadequate information was a violation of due process as well as a basis for the ALJ to find good cause. RR at 13-14. Petitioner also argues that he "was not aware of the necessity for submission of medical records because during the operative time period, Petitioner had not yet received a copy of the Kirk report" and did not have "knowledge that none of his medical records were analyzed until the document exchange and the response to public records [FOIA] request was received."[16] *Id*. at 9.

We find no abuse of discretion or error of law in the ALJ's decision to exclude the documentary evidence for failure to show "good cause" why that evidence was being submitted for the first time in the ALJ proceeding. Section 498.56(e)(1), as the ALJ noted, "is unambiguous." Without a specific showing of "good cause," required by that regulation, the ALJ was required to exclude the evidence. The ALJ, as he indicated, had no discretion to decline to follow that mandate even if use of the word "may" in the notice of Petitioner's right to seek reconsideration may have been "in some respects ambiguous" with respect to the submission of additional evidence. ALJ Decision at 3. The regulation itself provided adequate notice of the requirement to provide all documents on reconsideration, and Petitioner has not explained why he could not have complied, especially since Petitioner was represented by counsel, who, as the ALJ noted, was "charged with the responsibility of reading and understanding governing regulations [and] . . . should have known what her responsibilities were" under section 498.56(e)(1). *Id*.

The ALJ Decision does not specifically discuss Petitioner's assertion that good cause also existed because he "was not aware of the necessity for submission of medical records" until after he received the Kirk report.[17] RR at 9. However, the ALJ concluded that "none of the exhibits that Petitioner offers – including those that I exclude – establishes facts that contradict the undisputed facts upon which I base this decision." ALJ Decision at 3. Accordingly, it is clear that the ALJ viewed the exhibits, even had they been admissible, as irrelevant or immaterial or both. We agree with the ALJ.

[16] The record does not contain information about a FOIA request, and Petitioner does not explain this assertion.

[17] Petitioner made this argument below in Petitioner's Reply to CMS' Response to Petitioner's Challenge to Evidence and Witnesses and Objection to Petitioner's New Evidence at 5.

Petitioner suggests on appeal that the relevance is that the exhibits show "his ongoing involvement with patient care and initial comprehensive work ups – facts which apparently are not in dispute given CMS Response to Petitioner's Motion for Summary Judgment and lack of evidence regarding same." RR at 9 (citations omitted). However, Petitioner's initial or ongoing involvement with his patients is not relevant because he admitted that whatever involvement he had did not include being present, or even in the country, when the services at issue were furnished.

We also find no merit to Petitioner's assertion that the ALJ erred in not admitting Petitioner Exhibits 7 and 8. Petitioner says these exhibits were testimonial in nature and cites *Modesto Radiology Imaging, Inc*., DAB CR3483, at 2 (2014) as holding that "[t]estimonial evidence is not subject to 42 C.F.R. § 405.1028, and, as such, must only be relevant to be admitted." RR at 10. As we stated earlier, ALJ decisions do not bind other ALJs or the Board. Moreover, *Modesto* did not discuss the regulation Petitioner cites, which applies to Medicare Part B appeals, not to ALJ review of revocations under Part 498. The decision does not support Petitioner for another reason. The ALJ in *Modesto* admitted an affidavit by the supplier's (an IDTF) coding specialist, finding that it was testimony and not documentary evidence. The ALJ cited *Arkady B. Stern, M.D.*, DAB No. 2329, at 4 n.4 (2010) in which the Board observed that "[t]estimonial evidence that is submitted in written form in lieu of live in-person testimony is not 'documentary evidence' within the meaning of 42 C.F.R. § 498.56(e)." However, Petitioner here did not identify either Petitioner Exhibit 7 or Petitioner Exhibit 8 as testimonial evidence being "submitted in written form in lieu of live in-person testimony." Indeed, on his witness list, Petitioner expressly stated, "At this time, Petitioner anticipates introducing no[] statements in lieu of testimony." Petitioner's Exhibit and Witness List at (unnumbered) 7. In addition, whether testimonial in nature or not (and on their face they do not appear to be), neither the text messages in Petitioner Exhibit 7 nor the letters of recommendation from other practitioners and patients in Petitioner Exhibit 8, have any relevance to our decision which is based on the undisputed material facts, including Petitioner's own admissions, that Petitioner billed Medicare for services furnished to patients while he was out of the country.

In sum, we find no abuse of discretion or error in the ALJ's handling of Petitioner's evidentiary submissions.

2. Petitioner's constitutional challenges cannot be resolved in this forum, and the Board is not authorized to provide equitable relief.

Petitioner makes a number of arguments alleging abridgment of his constitutional rights: 1) that the revocation of his Medicare billing privileges was an unconstitutional abridgment of valuable property (RR at 16-17); 2) that the ALJ's refusal to review Novitas's rejection of Petitioner's corrective action plan was a denial of due process (RR at 15-16); 3) that initiating revocation proceedings while a criminal prosecution was

pending denied him due process and "could violate the Fifth Amendment" (RR at 14-15); and, 4) that the "severity" of the revocation (the length of the enrollment bar) was disproportionate to the wrongful act he committed (RR 17-18). The Board may not resolve any of these issues.

ALJs and the Board are bound by the regulations and may not declare them unconstitutional or decline to follow them on that basis. *E.g. Fady Fayad, M.D.*, DAB No. 2266, at 14 (2009), *aff'd, Fayad v. Sebelius*, 803 F. Supp. 2d 699 (E.D. Mich. 2011). Section 424.535 of the provider and supplier enrollment regulations (42 C.F.R. Part 424, subpart P) specifies the reasons for which CMS may legally revoke a provider or supplier's billing privileges. So long as an ALJ (and the Board) finds that CMS has shown that one of the regulatory bases for enrollment exists, the Board may not refuse to apply the regulation and must uphold the revocation. *E.g. Stanley Beekman, D.P.M.*, DAB No. 2650, at 10 (2015) (stating that an administrative law judge and the Board must sustain a revocation "[i]f the record establishes that the regulatory elements are satisfied"); *Letantia Bussell, M.D.*, DAB No. 2196, at 13 (2008) (stating that the only issue before an ALJ and the Board in enrollment cases is whether CMS has established a "legal basis for its actions"); *see also id*. at 13 (explaining that "the right to review of CMS' determination by an ALJ serves to determine whether CMS had the authority to revoke [a Petitioner's] Medicare billing privileges, not to substitute the ALJ's discretion about whether to revoke").

Moreover, the Board has emphasized that with respect to appeals under Part 498, ALJs and the Board may only review issues specifically identified as appealable administrative actions (i.e., "initial determinations") in section 498.3(b). *E.g. Vijendra Dave, M.D.*, DAB No. 2672, at 10-11 (2016). Thus, the Board has held that CMS's rejection of a corrective action plan is not subject to review because section 498.3(b) does not identify it as an appealable issue. *DMS Imaging, Inc.*, DAB No. 2313, at 5-6 (2010); *Conchita Jackson, M.D.*, DAB No. 2495, at 6 (2013). For the same reason, the Board held in *Vijendra Dave* that CMS's determination of the length of the reenrollment bar under section 498.535(c) is not subject to review. DAB No. 2672, at 10-11.[18] The Board explained:

> Although the re-enrollment bar is a direct and legally mandated consequence of an appealable revocation determination, nothing in Part 498 authorizes the Board to review the length of the bar despite that relationship between a revocation and a reenrollment bar. Given section 498.3(b)'s precise and exclusive enumeration of appealable determinations, we cannot

[18] Section 424.535(c) states "[if] a . . . supplier has [his] billing privileges revoked, [he] [is] barred from participating in the Medicare program from the date of the revocation until the end of the re-enrollment bar." That provision further states that the re-enrollment bar "lasts a minimum of 1 year, but not greater than 3 years, depending on the severity of the basis for revocation." *Id.* § 424.535(c)(1).

> find a CMS action to be appealable under Part 498 unless section 498.3(b) describes the subject matter of that action. *See North Ridge Care Ctr.*, DAB No. 1857, at 8 (2002) (stating that "[b]y its very terms, Part 498 provides appeal rights *only for these listed actions*" (italics added)). On its face, section 498.3(b) does not describe any matter related to a post-revocation re-enrollment bar.

Id. at 10.

Petitioner argued in his briefs and at oral argument that the three-year reenrollment bar is too severe, has caused financial hardship to Petitioner and should be reduced. RR at 17; Reply at 16; Tr. at 27-28. However, as the decisions cited above indicate, the Board is not authorized to reduce the term of the bar. Furthermore, the Board has consistently held that it has no authority to provide equitable relief. *E.g*. *Arkansas Dep't of Human Servs*., DAB No. 2664, at 4 (2015) (citations omitted).

Conclusion

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

/s/
Christopher S. Randolph

/s/
Leslie A. Sussan

/s/
Sheila Ann Hegy
Presiding Board Member