Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Vijendra Dave, M.D.
Docket No. A-15-88
Decision No. 2672
January 15, 2016

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Vijendra Dave, M.D. (Petitioner) appeals the May 20, 2015 Administrative Law Judge (ALJ) decision, *Vijendra Dave, M.D.*, DAB CR3871 (2015). In that decision, the ALJ sustained a determination by the Centers for Medicare & Medicaid Services (CMS) to revoke Petitioner's Medicare enrollment due to the suspension of his medical license. The ALJ also held that the revocation became effective on May 30, 2014, the date on which Petitioner's license was suspended. In addition, the ALJ refused to entertain Petitioner's request to reduce the three-year re-enrollment bar imposed by CMS as a consequence of the revocation.

For the reasons discussed below, we affirm the ALJ's decision in its entirety.

A. Legal Background

The relevant regulations governing Medicare enrollment are found in 42 C.F.R. Part 424, subpart P (sections 424.500 through 424.570). Section 424.535(a) authorizes CMS to revoke the Medicare enrollment of a physician or other "supplier" for any of the "reasons" specified in paragraphs one through 14 of that section. 42 C.F.R. § 424.535(a). The enumerated reasons for revocation include noncompliance with Medicare "enrollment requirements." *Id.* § 424.535(a)(1). One requirement for maintaining enrollment in Medicare is compliance with state licensure requirements relevant to the "type of services" for which the supplier bills the program. *Id.* § 424.516(a)(2).

The effective date of a revocation is determined in accordance with section 424.535(g). That regulation states, in relevant part, that "[w]hen a revocation is based on . . . a license suspension . . ., the revocation is effective with the date of . . . license suspension . . . ." 42 C.F.R. § 424.535(g).

Section 424.535(c) states "[if] a . . . supplier has [his] billing privileges revoked, [he] [is] barred from participating in Medicare from the date of the revocation until the end of the re-enrollment bar." *Id.* § 424.535(c). 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).

B. Case Background

On May 30, 2014, the Kansas State Board of Healing Arts issued an emergency order that suspended Petitioner's medical license.[1] CMS Ex. 3 ("Ex Parte Emergency Order of Suspension"). The "notice of rights" attached to the emergency order states that the order was effective "when rendered." *Id.* at 7.

About one month later, in a letter dated June 27, 2014, a CMS contractor notified Petitioner that his Medicare enrollment had been revoked due to the suspension of his Kansas medical license. CMS Ex. 1. The June 27 letter cited section 424.535(a)(1) as the legal basis for revocation.[2] The June 27 letter further advised Petitioner that the revocation of his Medicare enrollment was effective May 30, 2014. *Id.* In addition, the June 27 letter notified Petitioner that he was barred from re-enrolling in Medicare for three years. *Id.* at 2. Finally, the letter advised Petitioner that pursuant to 42 C.F.R. § 424.565, CMS was "assessing an overpayment" against him "for all claims paid to [him] for services that were provided to Medicare beneficiaries on and after May 30, 2014." *Id.*

Petitioner filed a request for reconsideration with the CMS contractor, contending (among other things) that: (1) the revocation should be overturned because the Kansas medical board suspended his license without first giving him an opportunity for a hearing to challenge the grounds for the suspension; (2) a three-year Medicare re-enrollment bar is excessive and contrary to instructions in CMS's Medicare Program Integrity Manual; and (3) the decision to impose the maximum re-enrollment bar was "based on the incorrect factual assumption" that he billed Medicare for services that he furnished after his medical license was suspended. CMS Ex. 6.

[1] The Kansas medical board's emergency order states that Petitioner's license was suspended "on a temporary basis pending an evidentiary hearing to determine if there is adequate cause for the suspension to remain in effect during the proceedings on the underlying Petition" for disciplinary action against Petitioner. CMS Ex. 3, at 5. Petitioner does not allege that the medical board lifted the suspension at any point after May 30, 2014.

[2] The June 27 revocation notice also cites 42 C.F.R. § 410.20(b), which states that Medicare will pay for physician services only if they are furnished by physicians who are licensed to practice medicine in the state where they perform them. CMS Ex. 1, at 1.

Petitioner's reconsideration request was denied by a Medicare hearing officer, who stated that CMS's contractor had "correctly revoked [Petitioner's] Medicare billing number and issued the appropriate re-enrollment bar of three years." CMS Ex. 8, at 1.

Petitioner then requested a hearing before the ALJ, restating most of the arguments he had presented to the Medicare hearing officer. *Compare* CMS Ex. 6 and Pet.'s Dec. 2, 2014 Request for Hearing (RH). In support of his contention that the duration of the re-enrollment bar was based on an "incorrect factual assumption" regarding the propriety of his post-May 30, 2014 billing activity, Petitioner alleged that the Kansas medical board emailed him an electronic copy of the emergency suspension order during the mid-afternoon of May 30, 2014 and that any Medicare claims he submitted after that date were for services he provided prior to the email's transmission. RH at 2. He asserted that the last services he provided ended earlier in the afternoon before he received the emailed order. *Id.* Petitioner maintained that his Medicare claims for those services were "permissible" and did "not constitute overpayments as suggested in the Revocation Letter." *Id.*

CMS responded to the hearing request with a motion for summary judgment. In addition to arguing that the license suspension adequately justified the revocation of Petitioner's Medicare enrollment, CMS contended that it had properly imposed a three-year re-enrollment bar, consistent with instructions in its Medicare Program Integrity Manual (MPIM). CMS's Prehearing Br. and Motion for Summary Judgment (MSJ) at 4, 5. CMS asserted that the MPIM "requires a three-year reenrollment bar if a practitioner's medical license is revoked or suspended and the practitioner continues to bill Medicare after the revocation/suspension."[3] *Id.* at 5. To establish that Petitioner "continue[d] to bill

[3] Petitioner asserts, and CMS does not dispute, that when his medical license was suspended, section 15.27.2.E of the MPIM stated:

> Unless stated otherwise in this section, the re-enrollment bar is a minimum of 1 year but not greater than 3 years, depending on the severity of the basis for revocation. The contractor shall establish the re-enrollment bar in accordance with the following:
>
> 1 year (AR 73) – License revocation/suspension that a deactivated provider (i.e., is enrolled, but is not actively billing) failed to timely report to CMS.
>
> 2 years (AR 74) – The provider is no longer operational.
>
> 3 years (AR 81) – Medical license revocation/suspension and the practitioner continued to bill Medicare after the license revocation/suspension; felony conviction and the practitioner continued to bill Medicare after the date of the conviction; falsification of information. *See* RR at 28-29.

These provisions have since been deleted from the MPIM. *See* CMS Pub. 100-08, § 15.27, available at https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms019033.html (last visited Jan. 7, 2016).

Medicare" after the license suspension, CMS proffered what appear to be Medicare database records showing that, on June 3, 2014 (four days after the issuance of the emergency order but more than three weeks before CMS revoked his Medicare enrollment), Petitioner billed Medicare for services that he had provided to two patients (with initials ML and TM) on May 30, 2014. CMS Ex. 9. CMS acknowledged Petitioner's allegation that he had provided those services before receiving the medical board's suspension order but stated that "[b]ecause CMS has no way to verify such assertions, it uses the date of [license] suspension as the cutoff for billing." MSJ at 5.

In his response to CMS's MSJ, Petitioner did not dispute that CMS had sufficient grounds to revoke his Medicare enrollment. *See* March 10, 2015 Answer Br. and Resp. to MSJ. Instead he focused on the revocation's effective date and the duration of the re-enrollment bar. *Id.* at 6-15. Regarding those two issues, Petitioner submitted evidence (including three affidavits, one of them his own) that the Kansas medical board transmitted the emergency suspension order to him via email sent at 3:13 p.m. (Central Standard Time) on May 30, 2014; that he saw patients ML and TM between 10:20 a.m. and 1:50 p.m. on that day; and that he was subjectively unaware of the suspension order until after 6:00 p.m. on May 30th when he returned home and accessed his email account.[4] P. Ex. 3, ¶¶ 3-4, 6; *see also* P. Exs. 4-5.

In light of these circumstances, Petitioner asserted that CMS should have treated the medical board's suspension order as having been issued on May 31, 2014 (after "close of business hours" on May 30, 2014), thereby making the revocation of his Medicare enrollment effective on May 31, 2014. Answer Br. and Resp. to MSJ at 6-9. Petitioner alternatively suggested that May 31, 2014 was the appropriate effective date because that was the first day on which he was no longer "operational" as a Medicare supplier. *Id.* at 7-8, 12-13. Petitioner further contended that the three-year re-enrollment bar was "excessive" and "contrary to regulation," and that the Medicare claims he submitted on behalf of ML and TM were for services that he provided while actively licensed and thus should not have been used to justify the imposition of the maximum re-enrollment bar. *Id.* at 7, 9-11, 14. Petitioner suggested that the bar should instead be one year "because "[a]part from his failure to maintain Medicare enrollment due to license suspension, [his] only violation in the instant proceeding was his failure to timely report" his license

[4] Petitioner's copy of the Kansas medical board's May 30, 2014 email has a 2:13 p.m. time stamp. P. Ex. 2. However, Petitioner asserts in his affidavit that his "e-mail time clock on May 30, 2014 . . . [was] set at Daylight Savings Time and so the correct time for the receipt of the e-mail from the [Kansas medical board] . . . in [his] e-mail account was at 3:13 PM (Central Standard Time)." P. Ex. 3, ¶ 4. For discussion purposes, we assume that the email was sent at 3:13 p.m. CST.

suspension to CMS. Id. at 5. (CMS did not charge Petitioner with failing to report the license suspension given that it issued the initial revocation determination before the applicable 30-day reporting period elapsed.[5])

CMS did not proffer any witness testimony and expressed no desire to cross-examine Petitioner's proposed witness. For that reason, the ALJ indicated that he was deciding the case based "on the written record." DAB CR3871, at 2. The ALJ then held that CMS had properly revoked Petitioner's Medicare enrollment and correctly identified May 30, 2014 as the revocation's effective date. *Id.* at 3. In addition, the ALJ declined to review (on the merits) Petitioner's objection to the duration of the re-enrollment bar, stating that "CMS's selection of a re-enrollment bar is not a determination subject to ALJ review because it is not a reviewable initial determination under 42 C.F.R. § 498.3(b)(17), which only enumerates the revocation action." *Id.* at 4.

Petitioner timely appealed the ALJ's decision.

C. Discussion

As a preliminary matter, we clarify the nature of the ALJ's decision and identify our standard of review. Throughout his appeal brief, Petitioner asserts that the ALJ improperly granted summary judgment to CMS. However, the ALJ did not resolve the parties' dispute under a summary judgment standard. Although his decision does not state explicitly how he disposed of CMS's summary judgment motion, it appears that the ALJ effectively denied the motion when he closed the record (observing that CMS did not intend to cross-examine Petitioner's proposed witnesses), proceeded to decide the matter based on the "written record," and issued a decision indicating that that he was making "findings of fact" (rather than ruling on the existence or non-existence of genuine disputes of material fact).[6] Petitioner asserts that the ALJ committed a "prejudicial error

[5] Title 42 C.F.R. § 424.516(d)(1) requires a Medicare-enrolled physician to report any "adverse legal action" to CMS within 30 days of that action. In this case, the adverse legal action (license suspension) occurred on May 30, 2014; CMS's contractor issued the initial revocation determination on June 27, 2014.

[6] Summary judgment may be granted when the record shows that there are no genuine disputes of material fact and the moving party is entitled to judgment as a matter of law. *1866ICPayday.com, L.L.C.*, DAB No. 2289, at 2 (2009). In deciding whether facts material to the outcome are in dispute, the adjudicator must view the proffered evidence in the light most favorable to the non-moving party. *Id.* at 3. When summary judgment is not granted and the case is decided on the record (written or otherwise), the ALJ must weigh any conflicting evidence (rather than view it in the light most favorable to the non-moving party) and make findings of fact based on a preponderance-of-the-evidence standard. *Lyle Kai, R.Ph.*, DAB No. 1979, at 4 (2005), *aff'd*, *Kai v. Leavitt*, Civ. No. 05-00514-BMK (D. Haw. July 17, 2006) (unpublished).

of procedure" by failing to "to state on the record the reasons for" denying summary judgment.[7] RR at 12, 13. However, Petitioner does not specify how the omission prejudiced him, and we can discern no harm. Furthermore, Petitioner does not contend in this appeal that additional evidentiary proceedings were necessary for the ALJ to resolve the dispute fairly. Accordingly, we review the ALJ's decision using the appellate review standard applicable to decisions that are issued after a full opportunity for a hearing. *See Marcus Singel, D.P.M.*, DAB No. 2609, at 5-6 (2014) (holding that the administrative law judge properly decided the case on the "written record," rather than based on a summary judgment standard, when "neither [party] filed proposed written direct testimony, and both parties expressly stated that they did not intend to call any witnesses"); *Centro Radiologico Rolon, Inc.*, DAB No. 2579, at 4 (2014) (finding that the administrative law judge "effectively denied CMS's summary judgment motion by proceeding to decide the case on the written record due to [the supplier's] failure to timely comply with his pre-hearing order"). Under that standard, the Board reviews a disputed finding of fact to determine whether it is supported by substantial evidence on the record as a whole. *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. The Board's standard of review concerning a disputed conclusion of law is whether the conclusion is erroneous. *Id.*

1. *Petitioner does not dispute that CMS had legally sufficient grounds to revoke his Medicare enrollment.*

In rendering his decision, the ALJ first considered whether CMS had legally sufficient grounds to revoke Petitioner's Medicare enrollment. The ALJ resolved that issue in CMS's favor. He held that "[b]ecause [Petitioner's] license was suspended, CMS properly revoked [his] enrollment and billing privileges" under 42 C.F.R. § 424.535(a)(1). DAB CR3871, at 3. Petitioner does not challenge that holding in this appeal. We therefore summarily affirm it.

2. *The ALJ correctly concluded that the revocation's effective date is May 30, 2014.*

Petitioner's appeal focuses on two issues other than the legal basis for revocation – namely, the revocation's effective date (the issue we address in this section) and the duration of the re-enrollment bar. Restating the argument he made at the reconsideration

[7] Had the ALJ granted summary judgment, we might well have found that appropriate in any event because Petitioner identified no genuine disputes of material fact. According to Petitioner, the "central genuine disputed issue of material fact" was whether his medical license "was in suspended status during business hours on May 30, 2014." RR at 13. As our discussion in section C.2 makes clear, the parties' evidence uniformly shows that Petitioner's medical license was placed in suspended status on May 30, 2014.

and hearing levels, Petitioner contends that the effective date of the revocation should be May 31, 2014 – not May 30, 2014 – given the timing of, and other circumstances surrounding, his receipt of the Kansas medical board's suspension order. *See* Request for Review of ALJ Decision (RR) at 8-12, 16-17. As the ALJ did, we reject that argument because accepting it would violate the applicable regulation.

The applicable regulation, section 424.535(g), states when a revocation is based on a "license suspension," the revocation is "effective with the *date of . . . license suspension*" (italics added).[8] The ALJ found that the date of license suspension was May 30, 2014. DAB CR3871, at 3-4. That finding is supported by substantial and uncontradicted evidence. The Kansas medical board's emergency suspension order, signed by the board's Presiding Officer, is dated May 30, 2014. CMS Ex. 3, at 1, 5. The order on its face states that it was effective "when rendered." *Id.* at 7; *see also* Kan. Stat. Ann. § 77-536(d) (providing that a state agency's emergency order is "effective when rendered"). And the record confirms that the medical board "rendered" – that is, formally issued and delivered[9] – the suspension order during "normal business hours" (which Petitioner says are 9:00 a.m. to 6:00 p.m.) on May 30, 2014. CMS Ex. 3, at 1 (indicating, above the caption, that the order was "Filed" by the medical board on May 30, 2014); CMS Ex. 2, at 2 (chronological listing, on the medical board's website, of official "actions" affecting Petitioner's license, including the emergency suspension dated May 30, 2014); P. Ex. 2 (copy of May 30, 2014 email transmitting the emergency order to Petitioner during the mid-afternoon on that day); CMS Ex. 3, at 8 ("certificate of service" stating that the medical board served the suspension order by United States mail on May 30, 2014); RR at 12 (asserting that "normal business hours" are 9:00 a.m. to 6:00 p.m.). Petitioner vaguely suggests that Kansas law made the suspension of his medical license effective "only after the close of normal business hours" on May 30, 2014, but he cites no state law, regulation, or judicial decision to support that proposition. *See* RR at 9-11, 19. Because the record unequivocally shows that the date of Petitioner's license suspension was May 30, 2014, section 424.535(g) plainly required CMS to make the revocation effective on that date.

[8] Petitioner's appeal brief (at page 7) identifies two factual errors in the ALJ's decision, neither of which is material to the outcome. First, the ALJ misstated the date of the initial determination as June 24, 2014. DAB CR3871, at 2. The correct date is June 27, 2015. CMS Ex. 1. Second, the ALJ mistakenly identified Petitioner's Exhibits 4 and 5 as affidavits of two different individuals when it fact both were made by a single person (Petitioner's office manager).

[9] *See* Black's Law Dictionary (10th ed. 2014) (indicating that the primary definition of the term "render" is "[t]o transmit or deliver" and that secondary definition is to "deliver formally" as in to "render a judgment").

Implicitly conceding the weakness of his argument on this issue, Petitioner asks us to designate May 31, 2014 as the revocation's effective date based on a "grant of exception under its own authority[.]" RR at 12; *see also id.* at 23 (asking "this appellate tribunal to grant exception to the limiting language in [section] 424.535(g) under its own authority"). The Board cannot grant that request. It is bound by applicable statutes and regulations and has no authority to make exceptions to their applicability. *DMS Imaging, Inc.*, DAB No. 2313, at 11 (2010).

Petitioner also suggests, in passing, that the effective date should be May 31, 2014 because that was date he was no longer "operational" as a Medicare supplier. RR at 29-30. However, the effective-date regulation permits that result only if Petitioner's revocation was based on a determination by CMS or its contractor that he was no longer operational. 42 C.F.R. § 424.535(g) (providing that the revocation is effective "with . . . the date that *CMS or its contractor determined* that the . . . supplier was no longer operational" (italics added); *id.* § 424.535(a)(5)(i) (authorizing CMS to revoke a supplier's enrollment if the supplier is found, upon on-site review, to be "[n]o longer operational to furnish Medicare-covered items or services"). CMS did not make a determination about Petitioner's operational status or revoke his enrollment on that basis. Consequently, Petitioner's operational status is irrelevant in determining the revocation's effective date.[10]

3. *The ALJ and the Board lack authority to review CMS's assessment of the severity of the basis for revocation or its consequent judgment concerning the appropriate duration of the re-enrollment bar.*

Because his Medicare enrollment was validly revoked, Petitioner is barred from seeking re-enrollment for a "minimum" period of one year. 42 C.F.R. § 424.535(c)(1). Section 424.535(c)(1) permits CMS to increase the re-enrollment bar up to three years "depending on the severity of the basis for revocation." *Id.* CMS exercised that authority in this case, imposing a three-year bar on Petitioner wholly or partly because Petitioner

[10] In an appeal challenging a Medicare enrollment revocation, the Board is limited to reviewing the basis for revocation articulated in the unfavorable reconsidered determination issued by CMS or its contractor. *Keller Orthotics, Inc.*, DAB No. 2588, at 7 (2014); *Precision Prosthetic, Inc.*, DAB No. 2597, at 11 (2014) (explaining that 42 C.F.R. § 498.5(l) "limits ALJs to considering the basis or bases for denial or revocation of enrollment and billing privileges set forth in the . . . reconsidered determination"). In this case, the CMS contractor, upon reconsideration, upheld the revocation based solely on the fact that Petitioner's medical license had been suspended. Hence, further review by the ALJ and the Board is limited to deciding whether that stated basis for revocation is factually substantiated and legally sufficient; our decision regarding the revocation's legality may not rest upon any alternative ground, such as Petitioner's operational status. *Keller Orthotics* at 7 (holding that "[b]ecause the reconsideration decision made no finding that [the supplier] was not operational, the ALJ erred in determining [that] there was a basis to revoke on the alternative ground that it was not operational"); *see also Orthopaedic Surgery Associates*, DAB No. 2594, at 7 (2014) (holding that that the "ALJ erred in reaching a revocation ground" that was not found in the reconsidered determination).

continued to bill Medicare after his medical license was suspended. *See* Response Br. at 4 (stating that its program manual "require[d] a three-year re-enrollment bar if a practitioner's medical license is . . . suspended and the practitioner continues to bill Medicare after the . . . suspension"). Petitioner asserts (as he did below) that a three-year bar is "excessive and contrary to regulation." RR at 21. He contends that his post-May 30, 2014 Medicare claims were proper because they sought payment for services that he furnished while still "actively licensed" (that is, prior to the Kansas medical board's electronic transmission of the emergency suspension order). *See* RR at 14, 17-19, 21-22, 24-26. For that and other reasons, Petitioner asks the Board to reduce, or to direct CMS to reduce, the re-enrollment bar from three years to one year. RR at 24, 29.

Whatever merit there may be in Petitioner's argument that his post-suspension billing activity was not improper,[11] and thus did not exacerbate the "severity of the basis for revocation," we find those issues not relevant here because we agree with the ALJ that CMS's decision to impose a three-year re-enrollment bar is not subject to review in this proceeding. The Board has not previously taken a definitive position on the question of whether the length of a re-enrollment bar is within our authority to review, because we found it unnecessary to do so to resolve prior cases in which the issue arose. *See, e.g.*, *Keller Orthotics*, DAB No. 2588, at 7-8 (2014); *John Hartman, D.O.*, DAB No. 2564, at 6 (2014). We now conclude, for the reasons explained below, that our authority in a revocation case does not extend to reviewing the length of the reenrollment bar imposed by CMS.

[11] According to evidence submitted by CMS, Petitioner's post-suspension Medicare claims were filed on June 3, 2014, a few days after his license was suspended and more than three weeks before Petitioner received notice that his Medicare enrollment had been revoked. *See* CMS Ex. 9, at 1, 3 (showing a claim "receipt date" of June 3, 2014). CMS's evidence also shows that the claims were filed for services provided to Medicare beneficiaries with the initials ML and TM. *Id.* As noted earlier (in section B), Petitioner proffered evidence that he provided those services prior to the moment that the Kansas medical board notified him of its suspension order. In addition, when CMS issued the revocation determination, section 424.535(h) stated that a supplier had "60 calendar days" from the "effective date of revocation" to submit "all claims for items and services furnished." 42 C.F.R. § 424.535(h) (Oct. 1, 2013). In promulgating that regulation, CMS noted that the Medicare program "[h]istorically" has "allowed providers and suppliers whose Medicare billing numbers have been revoked to continue billing services furnished prior to revocation" and that CMS was implementing a change requiring a provider or supplier to "submit all outstanding claims not previously submitted within 60 calendar days [instead of 27 months] of the revocation['s] effective date." 73 Fed. Reg. 69,726, 69,782 (Nov. 19, 2008). In light of these factual and legal circumstances, it is unclear whether Petitioner acted improperly in attempting to bill Medicare for the services he provided to patients ML and TM. We need make no finding on that issue in this decision because its resolution cannot change the outcome on the issues within our authority to review. For the same reason, as explained later, we do not reach Petitioner's arguments (RR at 9) about whether his claims constituted overpayments since that question is not properly within our authority to resolve.

This proceeding was initiated under, and is governed by, the regulations in 42 C.F.R. Part 498. *See* CMS Ex. 8, at 2-3 (notifying Petitioner of his right to appeal the reconsidered determination under 42 C.F.R. Part 498 by filing a request for hearing with the Departmental Appeals Board's Civil Remedies Division); Pet.'s Dec. 2, 2014 Request for Hearing (filed with the Civil Remedies Division). The Part 498 regulations set forth the rights of physicians and other suppliers to appeal certain CMS actions that adversely affect their participation in the Medicare program. *See* 42 C.F.R. §§ 498.1, 498.5. In particular, suppliers have the right to appeal "initial determinations" by CMS "with respect to the matters specified in paragraph (b)" of section 498.3. *Id.* § 498.3(a)(1). An initial determination with respect to one of the matters specified in section 498.3(b) may be appealed by a supplier in accordance with the procedures in subparts B-E of Part 498, which provide for a hearing before an administrative law judge and Board review of the hearing decision. *See id.* §§ 498.3(b)(17), 498.5(l)(1), 498.22(a), 498.40(a), 498.80.

Among the "matters" listed in section 498.3(b) is "*[w]hether to . . . revoke* a . . . provider's or supplier's Medicare enrollment in accordance with . . . [42 C.F.R.] § 424.535." *Id.* § 498.3(17) (italics added). Hence, a determination to revoke a supplier's enrollment under section 424.535(a) may be appealed by a supplier in accordance with Part 498's procedures. There is, however, no such right to appeal a decision by CMS concerning the duration of a post-revocation re-enrollment bar because that decision is nowhere mentioned in section 498.3(b)'s list of appealable initial determinations. An appealable determination to revoke a supplier's enrollment, and a decision about how long the revoked supplier must wait before being allowed to apply for reentry to the program, are factually distinct matters governed by different legal requirements. The decision to revoke must be based on one or more of the "reasons," or bases, for revocation specified in section 424.535(a). On the other hand, a determination to impose a re-enrollment bar in excess of the one-year minimum is based on the criterion in section 424.535(c) – namely, the "severity" of the basis for revocation. 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 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.

Moreover, relevant rulemaking history reveals no intent by CMS to permit administrative appeals of the length of a re-enrollment bar. Paragraph 17 of section 498.3(b), which makes a revocation determination subject to administrative appeal, was promulgated in 2006, prior to CMS's proposal and promulgation of the regulation (section 424.535(c)) mandating the imposition of a re-enrollment bar.[12] When CMS promulgated section 424.535(c) in 2008, it did not amend section 498.3(b) to include the re-enrollment bar in the list of "matters" about which CMS makes initial determinations. 73 Fed. Reg. at 36,462. Nor did CMS state or imply in its rulemaking that section 498.3(b)(17) could or should be interpreted to encompass a decision about the appropriate length of a re-enrollment bar. To the contrary, CMS expressed the view that suppliers could *not* appeal the duration of the re-enrollment bar. *Id.* at 36,454 (". . . [W]hile we believe that providers and suppliers can appeal the revocation determination, we do not believe that providers and suppliers can appeal the duration of the re-enrollment bar for Medicare billing privilege.").

In sum, the only CMS actions subject to appeal under Part 498 are the types of initial determinations specified in section 498.3(b). The determinations specified in section 498.3(b) do not, under any reasonable interpretation of that 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. For these reasons, we affirm the ALJ's refusal to review Petitioner's contention that his three-year re-enrollment bar was excessive and contrary to section 424.535(c).

Because CMS's determination regarding the duration of the re-enrollment bar is not reviewable, we have no power to grant Petitioner's request (stated in various ways throughout his appeal brief) to "remand" the case to the CMS contractor's Medicare hearing officer and to instruct that official to reduce the duration of the re-enrollment bar. Petitioner suggests that 42 C.F.R. § 498.56(d) authorized the ALJ to remand the case for that purpose and that the ALJ abused his discretion in not doing so. RR at 14-16, 25-26. That suggestion is meritless. That regulation authorizes an administrative law judge to remand a case to CMS "for *consideration* of a *new issue* and, if appropriate, *a determination*" on the issue. 42 C.F.R. § 498.56(d). The authority in section 498.56(d) applies only to issues subject to review by an ALJ. As we have concluded, the length of a reenrollment bar is not an issue reviewable by an ALJ. In any event, the duration of the re-enrollment bar was not a "new issue." Indeed, as the record shows, the Medicare

[12] *See* Final Rule, 71 Fed. Reg. 20,754, 20,781 (April 21, 2006) (adding section 498.3(b)(17) to specify that the "revocation of a provider or supplier's Medicare enrollment" is a matter about which CMS makes appealable determinations); 71 Fed. Reg. 37,504, 37,505 (June 30, 2006) (further amending section 498.3(b)(17) to its current form); 72 Fed. Reg. 9479, 9485 (March 2, 2007) (proposing section 424.535(c)); 73 Fed. Reg. 36,448, 36,461 (June 27, 2008) (promulgating section 424.535(c)).

hearing officer considered and rejected Petitioner's argument, later presented to the ALJ, concerning the duration of the re-enrollment bar, finding that the three-year bar was "appropriate." CMS Ex. 8, at 1. The ALJ was correct to deny Petitioner's request for remand. Because the Board also lacks the authority to review the length of the re-enrollment bar, we also deny Petitioner's request.

4. CMS's overpayment determination is not reviewable in this proceeding.

Petitioner asks the Board to overturn CMS's overpayment determination concerning the Medicare claims he filed for services he allegedly furnished to patients ML and TM on May 30, 2014. RR at 14, 22 30 (asserting, at page 22, that his services to those beneficiaries "occurred in a proper manner while he was actively licensed"). However, the Board has no authority to review that determination. As discussed earlier, this proceeding is governed by the regulations in 42 C.F.R. Part 498, which permit a Medicare supplier to appeal only certain types of CMS "initial determinations," as specified in section 498.3(b). Those appealable initial determinations do not include an adverse Medicare coverage or payment determination. *Ronald J. Grason, M.D.*, DAB No. 2592, at 8 (2014) (holding that initial determinations that may be appealed under the Part 498 regulations "do not include CMS denials of individual Medicare payment claims"); *Bionicare Medical Technologies, Inc.*, DAB No. 2338, at 3 (2010) (stating that a supplier must use the Medicare claims appeal process to appeal a determination concerning the merits of a Medicare coverage or payment claim). In a Part 498 appeal that flows from a revocation determination, as this one does, our authority is limited to deciding "whether the regulatory elements necessary for CMS to exercise its revocation authority were satisfied." *John Hartman, D.O.* at 5-6; *see also Stanley Beekman, D.P.M.*, DAB No. 2650, at 10 (2015) (Part 498 review of a revocation is limited to deciding whether "a legal basis" existed for that action).

Medicare coverage and payment determinations may be appealed under a separate multi-step administrative appeal process which includes review by administrative law judges in the Office of Medicare Hearing and Appeals and then, if appropriate, by the Departmental Appeals Board's Medicare Appeals Council. *See* 42 C.F.R. Part 405, subpart I (setting out an administrative appeal process relating to initial determinations regarding claims for benefits under Medicare Parts A and B, including determinations that an overpayment of benefits was made). Petitioner must use that appeal process to seek relief from CMS's overpayment determination.

Conclusion

For the reasons stated above, we affirm the ALJ's decision to sustain the revocation of Petitioner's Medicare enrollment effective May 30, 2014.

/s/
Sheila Ann Hegy

/s/
Christopher S. Randolph

/s/
Leslie A. Sussan
Presiding Board Member