Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Horace Bledsoe, M.D. and Bledsoe Family Medicine
Docket Nos. A-16-93 & A-16-94
Decision No. 2753
December 15, 2016

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

In separate written determinations, the Centers for Medicare & Medicaid Services (CMS) revoked the Medicare enrollment and billing privileges of Horace Bledsoe, M.D. and Bledsoe Family Medicine (Dr. Bledsoe's limited liability company, of which he was apparently the sole owner). The basis for these revocation determinations was CMS's finding that Dr. Bledsoe had been convicted in 2009 of a federal felony crime involving a controlled substance.

Dr. Bledsoe and Bledsoe Family Medicine appealed the revocation determinations by filing requests for an administrative law judge hearing. Their hearing requests were docketed separately by the Civil Remedies Division (CRD) as case numbers C-15-2325 (Horace Bledsoe, M.D.) and C-15-2324 (Bledsoe Family Medicine) and assigned to the same administrative law judge (ALJ). In each case, the ALJ issued a decision granting summary judgment to CMS and sustained the revocation. *See Horace Bledsoe, M.D.*, DAB CR4563 (March 30, 2016), Dkt. No. C-15-2325; and *Bledsoe Family Medicine*, DAB CR4564 (March 30, 2016), Dkt. No. C-15-2324.

Dr. Bledsoe and Bledsoe Family Medicine then filed requests for review, which the Board docketed as appeal numbers A-16-93 and A-16-94. Because the requests for review were filed by the same lawyer, are substantively identical (the same document was filed in both appeals), and seek review of ALJ decisions that are based on the same facts and similar records, the Board, at the appellants' request, consolidated the appeals for purposes of briefing and decision.

As explained below, we find no error by the ALJ in granting summary judgment to CMS. Consequently, we sustain CMS's determination to revoke the Medicare enrollment and billing privileges of Horace Bledsoe, M.D. and Bledsoe Family Medicine. Except where

necessary for factual clarity, we hereafter refer to both appellants as "Petitioner," there being no distinction between Dr. Bledsoe and Bledsoe Family Medicine that is material to our decision to affirm the ALJ Decisions being challenged in this consolidated appeal.[1]

Legal Background

A "supplier" of Medicare services –a term which includes a physician or a physician practice – must be enrolled in the Medicare program in order to receive payment for items and services covered by Medicare.[2] 42 C.F.R. § 424.505. "Enrollment" is the process that CMS uses to: (1) identify a prospective supplier; (2) validate the supplier's eligibility to provide items or services to Medicare beneficiaries; (3) identify and confirm a supplier's owners and "practice location"; and (4) grant the supplier "Medicare billing privileges." *Id.* § 424.502.

Supplier enrollment is governed by regulations in 42 C.F.R. §§ 424.500-.575. Those regulations authorize CMS to revoke a supplier's Medicare enrollment and billing privileges for any of the "reasons" specified in paragraphs (1) through (14) of section 424.535(a). Relevant here, paragraph (3) permits CMS to revoke a supplier's enrollment and billing privileges if the supplier, or any "owner" of the supplier, was convicted, "within the 10 years preceding enrollment or revalidation of enrollment," of a "Federal or State felony offense that CMS has determined to be detrimental to the best interests of the [Medicare] program and its beneficiaries." 42 C.F.R. § 424.535(a)(3) (Oct. 1, 2014).[3] Offenses that CMS has determined to be detrimental to the best interests of Medicare are enumerated in section 424.535(a)(3)(i) and include, as relevant here, "[a]ny felonies that would result in mandatory exclusion under section 1128(a) of the [Social Security] Act." *Id.* § 424.535(a)(3)(i)(D); *see also Dinesh Patel, M.D.*, DAB No. 2551, at 4-5 (2013). Offenses that would result in mandatory exclusion under section 1128(a) include felonies "relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance." 42 U.S.C. § 1320a-7(a)(4).

[1] Where we use the pronouns "he," "him," or "his" rather than "Petitioner," those references also should be understood to mean both Dr. Bledsoe and Bledsoe Family Medicine, unless the context indicates otherwise.

[2] The term "supplier" is defined in Medicare's regulations 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 (defining terms as used in the Medicare program).

[3] We cite to, and apply, the version of section 424.535 that was in effect on January 22, 2015, the date that CMS's contractor issued the initial revocation determinations. *John P. McDonough III, Ph.D., et al.*, DAB No. 2728, at 2 n.1 (2016).

For purposes of section 424.535(a)(3), the term "*[o]wner* means any individual or entity that has any partnership interest in, or that has 5 percent or more direct or indirect ownership of the provider or supplier as defined in sections 1124 and 1124A(A) of the [Social Security] Act." 42 C.F.R. § 424.502.

A supplier whose enrollment and billing privileges have been revoked under section 424.535 is "barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar." *Id.* § 424.535(c).

Case Background

It is undisputed that on December 17, 2009, a federal district court convicted Dr. Bledsoe (based on a guilty plea entered on October 15, 2009) of a single count of "acquir[ing] and obtain[ing] possession of Testosterone, a Schedule III controlled substance, by misrepresentation, fraud, deception, and subterfuge" in violation of 21 U.S.C. § 843(a)(3). CMS Ex. 4, at 1, 5 (Dkt. Nos. C-15-2325 and C-15-2324).

It also is undisputed that on January 22, 2015, Palmetto GBA (Palmetto), a CMS Medicare Administrative Contractor, notified both Dr. Bledsoe and Bledsoe Family Medicine that their Medicare enrollment and billing privileges were being revoked under 42 C.F.R. § 424.535(a)(3) based on Dr. Bledsoe's 2009 conviction and the fact that Dr. Bledsoe was identified in Medicare's records as a "5% or more owner" of Bledsoe Family Medicine. CMS Ex. 2 (Dkt. No. C-15-2325); CMS Ex. 2 (Dkt. No. C-15-2324). The revocation notice states that the revocation became effective on October 15, 2009 and that Palmetto had established a three-year re-enrollment bar.[4] *Id.*

Dr. Bledsoe and his company requested reconsideration of Palmetto's revocation determinations, but CMS sustained both determinations, again citing section 424.535(a)(3) as the legal basis for its actions. *See* CMS Ex. 3 (Dkt. No. C-15-2325); CMS Ex. 3 (Dkt. No. C-15-2324); CMS Ex. 1 (Dkt. No. C-15-2325); CMS Ex. 1 (Dkt. No. C-15-2324).

[4] Although Petitioner argues that Palmetto "actually revoked [its] enrollment and billing privileges . . . as early as March 1, 2010," an argument we discuss later, Petitioner agrees that the January 22, 2015 revocation notices are facts of record. Request for Review of ALJ Decisions Nos. CR4564 & CR4563 (RR) at 16.

Dr. Bledsoe and Bledsoe Family Medicine then filed essentially identical requests for an administrative law judge hearing. The hearing requests asserted that:

- Petitioner had disclosed the 2009 felony conviction in one or more Medicare applications filed with Palmetto in early 2010, the purpose of those applications being to notify the Medicare program that Dr. Bledsoe had established a physician practice (Bledsoe Family Medicine) that he intended to operate as a limited liability company;

- On July 22, 2010, Palmetto approved one of Petitioner's 2010 applications despite its knowledge of Dr. Bledsoe's conviction;

- Petitioner relied in "good faith" on that approval to claim Medicare payments for services provided to program beneficiaries.

See April 30, 2015 Request for Hearing (Dkt. Nos. C-15-2325 & C-15-2324) at 2. The hearing requests further asserted that it was inequitable for CMS to issue revocations "retroactively" in these circumstances, noting that, as a result of the January 2015 revocation determinations, CMS was trying to recoup $500,000 in Medicare payments received in the years following Dr. Bledsoe's conviction. *Id.*

CMS responded to the hearing requests with motions for summary judgment. CMS argued that it had lawfully revoked the Medicare enrollment and billing privileges of Dr. Bledsoe and Bledsoe Family Medicine under section 424.535(a)(3) because: (1) Dr. Bledsoe's 2009 felony was one that CMS has determined to be detrimental to the best interests of Medicare and its beneficiaries; (2) his conviction for that offense occurred within 10 years preceding enrollment or revalidation of enrollment; and (3) Dr. Bledsoe owned Bledsoe Family Medicine. *See* CMS's June 19, 2015 Motion for Summary Judgment in Dkt. Nos. C-15-2325 (at 4-7) and C-15-2324 (at 4-7).

In response to the allegations concerning Petitioner's 2010 Medicare applications, CMS submitted copies of two applications – forms CMS-855B and CMS-855R, both signed by Dr. Bledsoe on January 10, 2010 – that Palmetto received on or about February 17, 2010. CMS Ex. 5 (Dkt. No. C-15-2325); CMS Ex. 5-6 (Dkt. No. C-15-2324).[5] Dr. Bledsoe did not report his conviction in the section of the 855B designated for reporting adverse legal actions. CMS Ex. 5, at 5-6 (Dkt. Nos. 2324, 2325). However, CMS does not dispute that a January 27, 2010 letter written by Dr. Bledsoe's attorney disclosing the fact and

[5] The 855B reported a change in practice location. CMS Ex. 5, at 7 (both docket numbers). The 855R sought to reassign benefits from Dr. Bledsoe to Bledsoe Family Medicine. CMS Ex. 6, at 7-12. The 855R appears only in the record for Docket No. C-15-2324, but there is no dispute in either case that Petitioner filed an 855R with Palmetto.

nature of the conviction was attached to the 855R. (CMS's revocation action was based only on Dr. Bledsoe's conviction, not on failure to report the conviction.) CMS Response at 2; *see also* CMS Ex. 6, at 16-18 (Dkt. No. C-15-2324). CMS also submitted a copy of a form CMS-855I application for a change of practice location for Bledsoe Family Medicine that was signed by Dr. Bledsoe on October 1, 2010. CMS Ex. 7 (Dkt. No. C-15-2324); CMS Ex. 6 (Dkt. No. C-15-2325). This 855I did not contain information reporting Dr. Bledsoe's conviction. There is no dispute that Petitioner filed the 855B, 855R and 855I submitted by CMS or about their content.

Prior to responding to CMS's summary judgment motion, Petitioner filed a "Motion for Production of Documents Pursuant to 42 C.F.R. § 405.1307" (Motion to Compel), asking for CMS to produce a copy of a CMS-855I application that he claimed to have filed "on or about March 2010" together with "all enclosures, attachments or addendum[.]" Motion to Compel at 5.[6] Petitioner alleged that he had disclosed the 2009 conviction in an addendum to that filing and that CMS had failed to produce that document voluntarily upon request. *Id.* at 4-5; Ex. 1 to Motion to Compel.

The ALJ denied the Motion to Compel, finding that the "only avenue by which I may compel the production of documents is by issuing a subpoena for them" in accordance with 42 C.F.R. § 498.58. Aug. 6, 2015 Ruling Denying Petitioner's Motion to Compel Production, Dkt. Nos. C-15-2325 & C-15-2524. Petitioner accordingly requested issuance of a subpoena directing CMS or Palmetto to produce "all forms 855 with addendum filed by petitioner or others acting on his behalf between January 1, 2010 and July 22, 2010 and all other documents upon which CMS relied in granting re-enrollment to Petitioner effective July 22, 2010." Aug. 11, 2015 Request for Subpoena Pursuant to 42 C.F.R. § 498.58, Dkt. Nos. C-15-2325 & C-15-2324 (Subpoena Request). Petitioner asserted that the documents sought – including the "missing 855I" – would show that Palmetto had "actual notice" of his 2009 conviction when it approved the application on July 22, 2010. *Id.* at 4, 6. Petitioner further argued that the Medicare program's alleged awareness of his conviction in 2010 supports a claim that CMS acted in "an arbitrary, unreasonable or capricious manner" when it revoked his enrollment and billing privileges five years later (in 2015) and thereby exposed him to significant overpayment liability. *Id.* at 6-7, 8-9.

[6] The motion was filed in each case below on July 10, 2015. Petitioner's statements about when it filed an earlier 855I are inconsistent. *See e.g.*, RR at 8 (stating "February 2010"); *compare* Motion to Compel at 3, 4 (stating "March 2010"). A CMS letter dated July 1, 2010 refers to forms 855B, 855R and 855I "that we originally received . . . on February 16, 2010." Ex. 7 to July 29, 2015 Reply to Response to Pet.'s Motion for Production of Documents (Dkt. Nos. C-15-2524 and C-15-2525). This letter, which CMS has not disputed, indicates that Petitioner filed a CMS 855I in February 2010. Accordingly, for summary judgment purposes we accept as true that Petitioner submitted an 855I in February 2010 as well as the one filed on October 1, 2010. As we discuss later, however, this is not a material fact.

In his subpoena request, Petitioner acknowledged that administrative law judges and the Board "do not have jurisdiction in matters of equity." Subpoena Request at 4. However, Petitioner asserted that "fair and equitable administrative due process dictates that the record before the Agency be complete so that a reviewing Federal Court can determine if the actions of CMS violated administrative due process or [were] . . . arbitrary, unreasonable or capricious[.]" *Id.* at 4-5. Petitioner attached to the subpoena request an affidavit from his office manager, who stated she had filed Medicare applications on behalf of Petitioner in "February/March 2010"; that all of the applications she allegedly filed included a copy of January 27, 2010 letter written by Petitioner's attorney; but that she could not find copies of those applications because her office had been broken into and "completely ransacked." Ex. 7 to Request for Subpoena.

The ALJ denied Petitioner's subpoena request based on the following reasoning:

> I may issue a subpoena for the production of documents or testimony at the request of a party or *sua sponte*, but only if I conclude that a subpoena is "reasonably necessary for the full presentation of a case." 42 C.F.R. § 498.58(a). Here, I find that Petitioners have not shown that the documents requested are reasonably necessary for the presentation of their cases. . . . When a provider or supplier whose billing privileges are revoked by CMS challenges the determination by requesting a hearing, what may be challenged is whether a regulatory basis exists to revoke the provider or supplier's billing privileges. However, I may not consider whether CMS properly exercised its discretion to invoke its authority in an individual case. . . .
>
> Petitioners' request that CMS produce "all other documents upon which CMS relied in granting enrollment to Petitioners effective July 22, 2010," [also] does not meet the requirements of 42 C.F.R. § 498.58(c). Petitioners have not identified the other documents to be produced as required by section 498.58(a)(1). Petitioners have also not explained how the facts they seek to establish cannot be established without the issuance of subpoenas, as required by section 498.58(a)(3).

Sept. 24, 2015 Ruling Denying Petitioners' Requests for Issuance of Subpoenas Duces Tecum, Dkt. Nos. C-15-2324 and C-15-2325 (Sept. 24, 2015 Ruling).

Petitioner then filed a response to CMS's summary judgment motion, arguing, based on a comment by a Palmetto employee ("Provider excluded as per CMS for 3-year period begin[n]ing 10/15/2009"), that Palmetto actually revoked Petitioner's enrollment and billing privileges "as of March 1, 2010" but nonetheless allowed him to continue billing

Medicare when on July 22, 2010, it approved one of his 2010 applications effective January 18, 2010.[7] Oct. 8, 2015 Response to Motion for Summary Judgment and Pet.'s Pre-Hearing Exchange, Dkt. Nos. C-15-2324 and C-15-2325, at 6 (*citing* CMS Ex. 6, at 24); *see also* CMS Ex. 3, at 4-5 (Dkt. No. C-15-2324) (July 22, 2010 letter). Petitioner also reiterated the arbitrary and capricious and due process arguments asserted in its subpoena request and argued that CMS's actions in 2010 equitably estopped CMS from later revoking his Medicare enrollment and billing privileges based on the 2009 conviction. *Id.* at 6, 7-8.

The ALJ's Decision

The ALJ held that Petitioner's felony conviction – the occurrence, date, and nature of which are not in dispute – "falls squarely within the scope of [a mandatory] exclusion" under section 1128(a)(4) of the Social Security Act and is therefore a felony offense that CMS has determined to be detrimental to the best interests of the Medicare program and its beneficiaries. DAB CR4563, at 4-5; DAB CR4564, at 5. The ALJ also held that Dr. Bledsoe's conviction occurred within the ten-year period specified in 42 C.F.R. § 424.535(a)(3). DAB CR4563, at 4; DAB CR4564, at 4. Based on those holdings and Dr. Bledsoe's undisputed ownership of Bledsoe Family Medicine, the ALJ concluded that the prerequisites for revocation under section 424.535(a)(3) were met with respect to both Dr. Bledsoe and Bledsoe Family Medicine.[8] DAB CR4563, at 4-5, 7; DAB CR4564, at 5-6.

While acknowledging Petitioner's abuse-of-discretion, constitutional, and equitable claims, the ALJ held that they created no genuine disputes of material fact – or grounds for vacating or reversing the revocation – because he was legally bound to sustain the revocation as long as the undisputed facts established a basis to revoke Petitioner's enrollment and billing privileges under section 424.535(a)(3). DAB CR4563, at 6-7; DAB CR4564, at 6-7.

[7] The comment Petitioner cites appears in an exhibit that CMS's Exhibit List describes as "CMS-855R January 2010" and that contains some documents related to that application but also includes a March 1, 2010 letter to Petitioner from Palmetto stating that Palmetto had received Petitioner's "applications for enrollment," that the 855B and 855R applications were being closed because "[o]nly the 855I application is needed," and that additional information was needed to complete the application. CMS Ex. 6, at 1-2 (Dkt. No. C-15-2324). The context and meaning of the comment cited by Petitioner is not clear, and there is no revocation notice letter in the record other than the January 22, 2015 notice letter appealed in this proceeding. Accordingly, Petitioner has not raised a genuine dispute about the date of CMS's revocation action.

[8] The ALJ did not address Petitioner's contention that there is dispute of material fact concerning the date of the initial revocation determination.

Having concluded that Petitioner had identified no genuine dispute of material fact, and that the prerequisites for revocation under section 424.535(a)(3) were satisfied, the ALJ granted summary judgment to CMS and sustained its determination to revoke the Medicare enrollment and billing privileges of Dr. Bledsoe and Bledsoe Family Medicine, effective on the date of Dr. Bledsoe's conviction. DAB CR4563, at 3, 5, 7; DAB CR4564, at 3, 5-7.

Standard of Review

The ALJ's grant of summary judgment is a legal issue that we address de novo. *Patrick Brueggeman, D.P.M.*, DAB No. 2725, at 6 (2016). Summary judgment is appropriate if there is no genuine dispute as to any material fact and the moving party is entitled to judgment as a matter of law. *Id.* "The applicable substantive law will identify which facts are material, and only disputes over facts that might affect the outcome of the [case] under the governing law will properly preclude the entry of summary judgment." *Southpark Meadows Nursing & Rehab. Ctr.*, DAB No. 2703, at 5 (2016) (internal quotation marks and brackets omitted).

Discussion

1. *The challenged revocations were lawful under 42 C.F.R. § 424.535(a)(3), and the ALJ properly granted summary judgment to CMS.*

Section 424.535(a) specifies the bases upon which CMS may lawfully revoke a supplier's Medicare enrollment and billing privileges. In appeals challenging Medicare enrollment revocations, the Board has consistently held that administrative law judges and the Board are authorized to review only whether CMS has established a legal basis for revocation under section 424.535(a). *See, e.g., Letantia Bussell, M.D.*, DAB No. 2196, at 12-13 (2008); *Lorrie Laurel, P.T.*, DAB No. 2524, at 7-8 (2013). In other words, although "CMS itself may have discretion to consider unique or mitigating circumstances in deciding whether, or how, to exercise its revocation authority," *Care Pro Home Health, Inc.*, DAB No. 2723, at 9 n.8 (2016), Board and ALJ review of a revocation determination is confined to deciding whether CMS has established the existence of one or more of the permissible grounds for revocation (such a qualifying felony conviction) specified in paragraphs (1) through (14) of section 424.535(a).

Section 424.535(a)(3) authorizes CMS to revoke a supplier's Medicare enrollment and billing privileges if the following conditions are met: (1) the supplier, or the supplier's "owner," was convicted of a felony offense; (2) the conviction occurred "within the 10 years preceding enrollment or revalidation of enrollment"; and (3) the conviction was for an offense that CMS has determined to be detrimental to the best interests of the Medicare program and its beneficiaries. *See Dinesh Patel, M.D.* at 5 (discussing section 424.535(a)(3)).

It is important to note that the Medicare statute and regulations do not require CMS to take action within a specified time frame after discovering information about a Medicare enrollee's conviction. CMS may revoke at any time based on a conviction if the regulatory elements in section 424.535(a)(3) are satisfied. The only legally mandated time limit is the requirement in section 424.535(a)(3) that *the conviction* occur within 10 years preceding enrollment or revalidation of enrollment. Also absent from the statute and regulations is any limitation on CMS's authority to issue a revocation based on prior action or inaction by the Medicare program with respect to the supplier's enrollment status. *Cf. Central Kansas Cancer Institute*, DAB No. 2749, at 10 (2016) (finding that section 424.535(a) authorized CMS to exercise its revocation authority under section 424.535(a)(3) "regardless of any prior decision by itself or its contractor not to exercise it").

The ALJ concluded that undisputed facts about the timing and nature of Dr. Bledsoe's 2009 federal felony conviction demonstrate that section 424.535(a)(3)'s prerequisites were satisfied, both with respect to Dr. Bledsoe and Bledsoe Family Medicine. Petitioner takes no issue with that legal conclusion or its factual underpinnings. More specifically, Petitioner does not dispute that Dr. Bledsoe was convicted of a felony offense that CMS has determined to be detrimental to Medicare and its beneficiaries,[9] or that the conviction occurred within 10 years preceding enrollment or revalidation of enrollment, or that Dr. Bledsoe was the "owner" of Bledsoe Family Medicine within the meaning of section 424.535(a)(3).

As noted, Petitioner argues that a dispute of material fact exists concerning the date of CMS's revocation determination, with Petitioner taking the position that the revocation occurred as early as March 1, 2010, relying on a written comment by a Palmetto employee. As we indicated earlier, supra n. 7, the context and meaning of the comment is not clear, and there is no revocation notice letter in the record other than the January 22, 2015 notice letter appealed in this proceeding. Accordingly, we conclude that Petitioner has not raised a genuine dispute about the date of CMS's revocation action.[10]

[9] The ALJ held that CMS had "already determined that Petitioner's offense is detrimental to the Medicare program and its beneficiaries because it is type of offense that is subject to a mandatory exclusion under section 1128(a)(4) of the Social Security Act, 42 U.S.C. § 1320a-7(a)(4)." DAB CR4563, at 5; DAB CR4564, at 5. Petitioner takes no issue with that reasoning, which is consistent with prior Board holdings. *See Dinesh Patel, M.D.* at 11 (holding that "the Secretary [of Health & Human Services], by regulation, has determined that crimes that would result in a mandatory exclusion . . . are the type of felony offenses that are detrimental to the best interests of the Medicare program and its beneficiaries").

[10] We also note that Petitioner does not explain 1) why if Palmetto actually revoked its enrollment and billing privileges on March 1, 2010, Petitioner has not submitted a copy of a revocation notice letter; 2) why Petitioner would not have filed for reconsideration of that alleged revocation; or 3) why Petitioner would have continued billing Medicare after receiving notice of the alleged revocation action. Although the record shows that Palmetto approved one of Petitioner's enrollment applications on July 22, 2010, with an effective date of January 18, 2010, Petitioner would not have known of the retroactive billing date until it received the July 22, 2010 notice.

But even assuming the notice date of the revocation was March 1, 2010, as Petitioner alleges, that would not be material. Given our limited scope of review, a fact is material only if it might alter our conclusion, which is based on undisputed facts, that CMS had a basis for its January 22, 2015 revocation action under section 424.535(a)(3). We conclude that the alleged factual dispute is not material and note that Petitioner itself does not argue that the alleged factual dispute is material to our conclusion. To the contrary, Petitioner disclaims any materiality by stating that "[a] finding of fact by the ALJ on the notice date of the revocation was not a judgment on whether CMS had sufficient legal basis to revoke Dr. Bledsoe's billing privileges . . . ."[11] Request for Review of ALJ Decisions Nos. CR4564 & CR4563 (RR) at 17.

In short, Petitioner has made no meaningful attempt to challenge the ALJ's conclusion that CMS had a regulatory basis to revoke in these circumstances. We therefore affirm that conclusion without further discussion. *Cf. Vijendra Dave, M.D.*, DAB No. 2672, at 6 (2016) ("summarily" affirming the ALJ's holding, on summary judgment, that CMS had legally sufficiently grounds to revoke because the supplier failed to challenge the holding on appeal); *Centro Radiologico Rolon, Inc.*, DAB No. 2579, at 7 (2014) (summarily affirming an uncontested conclusion by the ALJ that the regulatory elements necessary for revocation were satisfied).

2. *The Board has no authority to consider Petitioner's abuse-of-discretion, constitutional, and equitable claims.*

We decline to consider Petitioner's argument – the details of which are set out above – that CMS acted unreasonably or arbitrarily and abused its discretion in exercising its revocation authority in his case.[12] As we just explained, the Board and administrative law judges have no authority to review CMS's exercise of discretion to revoke in these circumstances. If the "regulatory elements [in section 424.535] necessary for CMS to exercise its revocation authority [are] satisfied," as they are in this case, then "we "must sustain the revocation" and "may not substitute our discretion for that of CMS in

[11] Petitioner does not assert that the alleged factual dispute is material to any other issue within the scope of our review.

[12] Petitioner alleges a denial of "administrative due process," *see* RR at 7, 11, 19, but does not claim that it lacked adequate notice of, or an opportunity to be heard about, the issues resolved by the ALJ. Instead, it appears that Petitioner's use of the term "administrative due process" is simply another way of characterizing its claim that CMS's actions are arbitrary, unreasonable, and an abuse of discretion given its particular circumstances. *See* RR at 11 (asserting that CMS "denied administrative due process by acting in an arbitrary, unreasonable, and capricious manner in the enforcement of the Medicare law and regulations"); RR at 19 (asserting that the "facts are ripe for a finding by the Federal Court that CMS's conduct violated administrative due process and imposed an unconscionable and unequitable burden on the Petitioners").

determining whether revocation is appropriate under all the circumstances." *John Hartman, D.O.*, DAB No. 2564, at 6 (2014); *see also Patrick Brueggeman, D.P.M.* at 15 (holding that the Board must uphold a revocation "[s]o long as CMS has shown that one of the regulatory bases for enrollment exists"); *Stanley Beekman, D.P.M.*, DAB No. 2650, at 10 (2015) (stating that "if the record establishes that the regulatory elements [for revocation] are satisfied, . . . the Board must sustain the revocation" (internal quotation marks omitted)).

Petitioner contends that the revocation has deprived it of property "without notice and . . . an opportunity to be heard" (RR at 23) in violation of Fifth Amendment to the Constitution. Petitioner, however, did receive notice and an opportunity to be heard under the applicable administrative appeal regulations and did not point to any failure by CMS or the ALJ to comply with the procedures specified in those regulations. *See Patrick Brueggeman, D.P.M.* at 13-14 (disagreeing with a due process claim because the supplier "ha[d] been afforded all of the hearing rights provided by the applicable regulations"). Indeed, the record in these cases shows that Petitioner has taken full advantage of the opportunity to be heard provided by those regulations. But even if this were not the case, the Board, once again, may not reverse a revocation authorized by the regulations based on arguments of constitutional invalidity. Nor may the Board do so based on alleged harsh economic consequences to the entity whose enrollment and billing privileges are revoked.[13] *See e.g. Mohammad Nawaz, M.D., et al.*, DAB No. 2687, at 14-15 (2016) (declining to address various constitutional arguments, including a claim that the challenged enrollment revocation "was an unconstitutional abridgement of valuable property"); *see also Ronald J. Grason, M.D.*, DAB No. 2592, at 7 (2014) (quoting a prior Board holding that the applicable regulations do not "authorize[ ] the ALJ to reverse a revocation to sanction CMS for alleged due process violations where CMS had a basis for the revocation under section 424.535(a)" (internal quotation marks omitted)), *aff'd, Grason v. Burwell*, ___ F. App'x ___, 2016 WL 4533407 (Aug. 30, 2016).

Finally, we decline to rule on Petitioner's equitable estoppel claim. "The Board, as stated earlier, is bound by the regulations, and may not [as Petitioner concedes[14]] choose to overturn the agency's lawful use of its regulatory authority based on principles of equity." *Central Kansas Cancer Institute* at 10.

---

[13] To the extent that Petitioner may be subject to overpayment recovery determinations as a result of the revocation, those 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. *Vijendra Dave, M.D.* at 12.

[14] Petitioner states that he is "mindful that the ALJ and the DAB do not have jurisdiction in matters of equity," RR at 7, and that he is asserting his estoppel and other claims to preserve them for judicial review, RR at 18.

3. *The ALJ properly denied Petitioner's subpoena request.*

We next consider the ALJ's denial of Petitioner's request for a subpoena. The governing regulation, 42 C.F.R. § 498.58, states that an ALJ "may issue subpoenas if they are reasonably necessary for the full presentation of a case." 42 C.F.R. § 498.58(a). The regulation also requires the party requesting the subpoena to "[i]dentify the . . . documents to be produced," *id.* § 498.58(c)(1), and to "[s]pecify the pertinent facts the party expects to establish by the . . . documents" sought and to "indicate why those facts could not be established without use of a subpoena," *id.* § 498.58(c)(3).

The ALJ found that the requested subpoena was not reasonably necessary for the full presentation of Petitioner's case because it sought information to support abuse-of-discretion and other claims that he (the ALJ) had no authority to consider in deciding the case. Sept. 24, 2015 Ruling at 1-2. The ALJ also found that Petitioner had not explained how the facts that he sought to establish with the subpoena request could not be established without issuing a subpoena. *Id.* at 2. In addition, the ALJ found that Petitioner did not satisfy the requirement (in section 498.58(c)(1)) that a subpoena request "[i]dentify the . . . documents to be produced." *Id.*

Petitioner expresses no specific disagreement with the ruling's factual findings or legal reasoning. *See* RR at 2-3, 3-15. Petitioner notably admits that his proposed subpoena sought documents to support claims, or raise issues (or "matters of equity"), that are outside the scope of the ALJ's review or otherwise irrelevant to deciding whether CMS had established a regulatory basis for revocation. RR at 7, 18. More specifically, Petitioner states that the sought-after material is "relevant and material to the issue of whether CMS denied administrative due process by acting in an arbitrary, unreasonable, and capricious manner in the enforcement of the Medicare law and regulations" and is also needed "to establish that CMS shortened the debarment period and that Petitioner will not, therefore, owe CMS over $300,000" in overpayments. RR at 11. Petitioner simultaneously concedes that CMS "had the authority to revoke [his] billing privileges." RR at 12.

In addition, Petitioner does not argue that the ALJ's ruling is based on a misreading or misapplication of 42 C.F.R. § 498.58, nor do we find any such error. The ruling's key finding is that the subpoena did not seek documents for the purpose of developing a case on the controlling legal issue – that being whether CMS had a basis to revoke under section 424.535. That finding comports with the requirement, in section 498.58(c)(3), that the party requesting a subpoena show that it is necessary to establish a "pertinent" fact. The finding is also consistent with prior Board decisions that have sustained the denial of subpoenas for documents that are irrelevant or immaterial to the administrative law judge's decision-making. *See, e.g., Ridgeview Hospital*, DAB No. 2593, at 16 (2014) (upholding the denial of a subpoena "[i]n light of [the Board's] determination that the

documentation sought . . . did not relate to a material disputed issue"); *Oaks of Mid City Nursing & Rehab. Ctr.*, DAB No. 2375, at 34 (2011) (upholding the denial of a subpoena for testimony because its proponent failed to show that the testimony was necessary for the full presentation of its case "on the issues properly before the ALJ").

While admitting that the subpoena sought material on "'issues of equity' [that] are not within the jurisdiction of the ALJ or the DAB," Petitioner asserts that "Federal Courts are not barred from ruling on issues relating to Constitutional violations and matters of equity." RR at 18. Petitioner further asserts that he has a "right" to a "complete" administrative record on those issues so that he may present them on judicial review of the Secretary's final decision on the revocation, and that the ALJ's denial of the subpoena request infringed that right. RR at 7, 13 (asserting that "fair and equitable administrative due process dictates that the record before the Agency be complete so that a reviewing Federal Court can determine if the actions of CMS violated administrative due process or if CMS acted in an arbitrary, unreasonable, or capricious manner in enforcing the law and regulations"). However, Petitioner does not identify the statute or regulation establishing his claimed right to a "complete" administrative record. Nor does he cite any Board decision suggesting that this administrative appeal process may be used as a forum for developing a record on issues that are irrelevant or immaterial to Board or ALJ decision-making. Petitioner's subpoena request, in the final analysis, sought a document (a 2010 Medicare application) that could have no effect on the ALJ's decision or ours.

In short, we sustain the ruling denying Petitioner's subpoena request because Petitioner has not demonstrated that the ruling is erroneous under 42 C.F.R. § 498.58. Even if we had found that the ALJ erred, the error would be harmless and thus not require us to reverse the ALJ's decision or remand the case for further proceedings. *Douglas Bradley, M.D.*, DAB No. 2663, at 6 (2015) (holding that the Board has consistently applied a harmless error standard in reviewing alleged procedural errors). The alleged error is harmless because the document(s) sought by Petitioner would not alter our dispositive legal conclusion, which is that CMS lawfully revoked Petitioner's Medicare enrollment under 42 C.F.R. § 424.535(a)(3). It is also harmless because if a court on appeal found that the record should include the documents requested, it could presumably either order those documents to be produced in the court proceeding or remand to the ALJ with instructions to subpoena them.

4. *Petitioner has not shown that oral argument is necessary to reach a sound decision in this appeal.*

Petitioner requested oral argument in its reply brief. The Board's appellate review guidelines instruct a party to "state the purpose" of any request for oral argument. *See Guidelines – Appellate Review of Decisions Affecting a Provider's or Supplier's*

Enrollment in the Medicare Program, "Development of the Record on Appeal, ¶ (g).[15] Petitioner did not give any reason for requesting oral argument, and such argument is not necessary for us to reach a sound decision. We therefore deny Petitioner's request.

5. *We exclude from the record of this decision the claims lists submitted with Petitioner's request for review and reply brief.*

Along with its requests for review in these consolidated appeals, Petitioner attached a list of Medicare claims for which an "overpayment" had been identified. The information on that list included beneficiaries' full names, Health Insurance Claim Numbers, dates of service, Medicare overpayment amounts, and other personally identifying information. Petitioner asked the Medicare Appeals Council (MAC), a separate tribunal that hears appeals of Medicare coverage and payment determinations, to "accept" the list in order to establish the "amount in controversy" in appeals that Petitioner has filed (or will file) with the MAC to contest overpayment recoveries that were triggered by the revocation determinations at issue here.

In its May 27, 2016 letter acknowledging the receipt of Petitioner's appeals, the Board advised the parties that the "issue before the Board is CMS's revocation of Petitioners' Medicare enrollment" and that issues of "Medicare coverage, reimbursement, and recoupment of overpayment assessments are not matters before the Board" and will not be addressed. The Board further advised:

> If . . . Petitioners' position is that the list of beneficiaries is relevant to the matter that is before the Board (revocation) and [Petitioners] wish to have the list be made part of the record in this consolidated case, they should file a redacted list that conceals personal identifying information (identify each beneficiary using his or her initials; provide only the last four digits and letter of the HICN, e.g., 1234A).

With its reply brief, Petitioner submitted a copy of the claims list with personally identifying information redacted and asserted that the list is relevant to the "issues of equity" that he wishes to preserve for judicial review. Reply Br. at 1-2.

In order to protect the privacy of the Medicare beneficiaries whose information is on the unredacted list, we exclude that list from the administrative record. While the redacted list remains in the administrative record, it is irrelevant to our decision because it relates to matters – alleged Medicare payment issues – that are not within our jurisdiction. We also note that while the redacted claims list remains part of the administrative record in

[15] The Guidelines are available at http://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/index.html.

the sense that the list has been filed in this proceeding , that list must be excluded from the decisional record, even if relevant – which it is not. This is because 42 C.F.R. § 498.86(a) bars the Board from deciding a supplier enrollment appeal "based on evidence not provided at the reconsideration or ALJ hearing level." *Sandra E. Johnson, CRNA*, DAB No. 2708, at 10 (2016); *see also* 42 C.F.R. § 498.86(a) (permitting the Board to admit "relevant and material evidence" not provided at the ALJ hearing level "[e]xcept for provider or supplier enrollment appeals").

Conclusion

For the reasons stated above, we affirm the ALJ's March 30, 2016 decisions (DAB CR4563 and DAB CR4564) sustaining the determinations by CMS to revoke the Medicare enrollment and billing privileges of Horace Bledsoe, M.D. and Bledsoe Family Medicine.

/s/
Leslie A. Sussan

/s/
Susan S. Yim

/s/
Sheila Ann Hegy
Presiding Board Member