Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Patrick Brueggeman, D.P.M.
(NPI: 1376669150),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-1904

Decision No. CR4422

Date: November 12, 2015

DECISION

A Medicare administrative contractor, First Coast Service Options, Inc. (First Coast), revoked the Medicare enrollment and billing privileges of Patrick Brueggeman, D.P.M. (Petitioner), effective December 7, 2014, pursuant to 42 C.F.R. § 424.535(a)(8).[1] In a reconsidered determination, the Centers for Medicare & Medicaid Services (CMS) upheld the revocation of Petitioner's enrollment and billing privileges because CMS determined that Petitioner submitted claims for payment of services that could not have been provided to the individuals identified in the claim considering those individuals were deceased on the date of service. Petitioner requested a hearing before an administrative law judge. CMS now moves for summary judgment, which Petitioner opposes.

For the reasons set forth below, I find that the undisputed material facts establish a legal basis for CMS to revoke Petitioner's Medicare enrollment and billing privileges because

[1] CMS substantially amended 42 C.F.R. § 424.535(a)(8), effective February 3, 2015. *See* 79 Fed. Reg. 72,500 (Dec. 5, 2014). Although I discuss below the recently amended version of the regulation, in this decision I apply the version of the regulation that was in effect at the time the Medicare contractor revoked Petitioner's billing privileges.

Petitioner submitted multiple claims for payment that identified Medicare beneficiaries who were deceased on the alleged date of service. CMS is therefore entitled to judgment affirming the revocation of Petitioner's Medicare enrollment and billing privileges.

I. Case Background and Procedural History

Petitioner is a podiatrist in Florida. He participated in the Medicare program as a "supplier" of services.[2] By letter dated November 7, 2014, First Coast notified Petitioner that it was revoking Petitioner's Medicare enrollment and billing privileges effective December 7, 2014, pursuant to 42 C.F.R. § 424.535(a)(8) and (g), because review of Petitioner's Medicare claims identified many claims where Petitioner billed for services provided to 16 different beneficiaries who were deceased at the alleged time of service. CMS Exhibit (Ex.) 3 at 1. First Coast also imposed a three-year bar on Petitioner's re-enrollment in the Medicare program. CMS Ex. 3 at 2.

On December 4, 2014, Petitioner submitted a request for reconsideration as well as a corrective action plan (CAP). CMS Ex. 5; CMS Ex. 6. Petitioner acknowledged in both his request for reconsideration and his CAP that he had submitted Medicare claims that identified deceased beneficiaries, but he explained at length that the claims in question were unintentional billing errors and that he actually provided services to individuals with names similar to the deceased individuals identified on the claims. CMS Ex. 5 at 2-6; CMS Ex. 6 at 2-6. On March 26, 2015, CMS rejected Petitioner's CAP and issued a reconsidered determination that upheld the revocation. CMS Ex. 7. When addressing Petitioner's claim that the improper claims were accidental and that he did not receive reimbursement for them, CMS wrote:

> This revocation is based on claims data dating back to January 1, 2012. Claims were submitted for those beneficiaries and were denied. The denial of these claims would have systematically provided information sufficient for [Petitioner] to realize his error(s) and put into place changes that would prevent future noncompliance . . . . Due to the abundance of errors in billing from January 2012 through August 2014, after being aware of this problem when the claims were originally denied, CMS views this as abuse of billing, and not a clerical error or oversight.

CMS Ex. 7 at 2; Petitioner Exhibit (P. Ex.) 4 at 2.

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[2] A "supplier" is defined as "a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under [Title XVIII of the Social Security Act]." 42 U.S.C. § 1395x(d); *see also* 42 C.F.R. § 400.202.

By letter dated April 1, 2015, Petitioner requested a hearing before an administrative law judge to challenge the reconsidered determination. This case was assigned to me. On April 2, 2015, I issued an Acknowledgment and Pre-Hearing Order (Pre-Hearing Order), which established general procedures for record development in this case and permitted the parties to file for summary judgment, if appropriate. *See* Pre-Hearing Order ¶ 4. CMS timely filed a motion for summary judgment with a supporting brief (CMS Br.) along with nine proposed exhibits (CMS Exs. 1-9). Petitioner filed an opposition to CMS's motion for summary judgment with a supporting brief (P. Br.) and 30 proposed exhibits (P. Exs. 1-30). In his opposition, Petitioner objected to the admission of certain parts of CMS Ex. 9, which I discuss below. CMS did not object to Petitioner's proposed exhibits.

II. Statutory and Regulatory Framework

The Social Security Act authorizes the Secretary of Health and Human Services (Secretary) to establish by regulation procedures for enrolling providers and suppliers in the Medicare program. 42 U.S.C. § 1395cc(j)(1)(A). The Secretary has promulgated enrollment regulations for providers and suppliers in 42 C.F.R. Part 424, Subpart P. *See* 42 C.F.R. §§ 424.500 – 424.545 (2014). The regulations provide CMS with the authority to revoke the billing privileges of an enrolled provider or supplier if CMS determines that certain circumstances exist. *Id.* § 424.535(a). Relevant to this case, CMS may revoke a provider's or supplier's billing privileges if:

> 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 beneficiary is deceased, the directing physician or beneficiary is not in the State or country when services were furnished, or when the equipment necessary for testing is not present where the testing is said to have occurred.

Id. § 424.535(a)(8); *see also* 73 Fed. Reg. 36,448 at 36,455 (June 27, 2008) ("We will direct contractors to use this basis of revocation after identifying providers or suppliers that have these billing issues. We have found numerous examples of situations where a physician claims to have furnished a service to a beneficiary more than a month after their recorded death, or when the provider or supplier was out of State when the supposed services had been furnished."). The regulatory drafters explained in the preamble to section 424.535(a)(8):

> This revocation authority is not intended to be used for isolated occurrences or accidental billing errors. Rather, this basis for revocation is directed at providers and suppliers who are engaging in a pattern of improper billing . . . . Accordingly, [CMS] will not revoke billing privileges under [section]

> 424.535(a)(8) unless there are multiple instances, at least three, where abusive billing practices have taken place.

73 Fed. Reg. at 36,455.

When CMS revokes a provider's or supplier's billing privileges, any provider agreement in effect at the time of revocation is terminated. 42 C.F.R. § 424.535(b). In addition, after revocation CMS must impose a bar on re-enrollment for a minimum of one year, but no more than three years. *Id.* § 424.535(c). Once the re-enrollment bar has expired, the supplier must submit a new enrollment application to re-enroll in the Medicare program. *Id.* § 424.535(d).

A provider or supplier may request reconsideration of the initial determination to revoke his or her billing privileges. 42 C.F.R. §§ 498.5(*l*)(1), 498.22(a). If dissatisfied with the reconsidered determination, the supplier may request a hearing before an administrative law judge. *Id.* § 498.5(*l*)(2).

III. Evidentiary Ruling

Petitioner objects to the admission of certain parts of CMS Ex. 9 because it contains "irrelevant information not attributable to Petitioner, such as services not provided or ordered by Petitioner, including therapy services." P. Br. at 15. CMS Ex. 9 contains screenshot printouts of various beneficiaries from the Medicare "Common Working File." *See* CMS Ex. 2 at ¶ 5 (affidavit from a First Coast employee explaining how he obtained the information presented in CMS Ex. 9). The information includes the beneficiary's name, gender, address, date of birth, date of death, and other coded information that appears to be, at least in part, the Medicare claims history for the beneficiary. *See, e.g.*, CMS Ex. 9 at 1. The contractor collected this demographic information in the exhibit from a Social Security Administration database. *See* CMS Ex. 2 at ¶ 5.

The regulations grant an administrative law judge broad discretion regarding receiving evidence, even if that evidence is generally inadmissible under the Federal Rules of Evidence. 42 C.F.R. § 498.61. As a general matter, evidence must be relevant and reliable. Here, portions of CMS Ex. 9, including the beneficiary's name, gender, date of birth, date of death are relevant, and Petitioner did not object to them. CMS has not demonstrated how certain information in CMS Ex. 9 relates to Petitioner or is relevant to my consideration. That information includes coded material, which appears to be general claims-related information. Therefore, I do not consider those parts of CMS Ex. 9 for this decision. However, because the dates that the beneficiaries were born and died are very relevant to this case, I overrule Petitioner's objection and admit CMS Ex. 9, the reliability of which Petitioner did not challenge.

In the absence of further objections, I receive CMS Exs. 1-9, as well as P. Exs. 1-30 into the record for consideration.

IV. Discussion

A. Issues

This case presents two issues:

1. whether CMS is entitled to summary judgment; and

2. whether CMS was authorized to revoke Petitioner's Medicare billing privileges pursuant to 42 C.F.R. § 424.535(a)(8).

B. Conclusions of Law and Analysis

1. Summary judgment is appropriate.

Summary judgment is appropriate if "the record shows that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law." *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 3 (2010) (citations omitted). The moving party must show that there are no genuine issues of material fact requiring an evidentiary hearing and that it is entitled to judgment as a matter of law. *Id.* If the moving party meets its initial burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial . . . .'" *Matsushita Elec. Industrial Co. v. Zenith Radio*, 475 U.S. 574, 587 (1986). "To 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 — a fact that, if proven, would affect the outcome of the case under governing law." *Senior Rehab.*, DAB No. 2300, at 3. To determine whether there are genuine issues of material fact for hearing, an administrative law judge must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. *Id.*

There is no genuine dispute of any material fact in this case. CMS presented evidence showing that Petitioner submitted claims for services that could not have been provided to a specific individual on the date of service because the individual identified in the claim was deceased at the alleged time of service. *See generally* CMS Ex. 8; CMS Ex. 9; *see also* CMS Ex. 2 at ¶¶ 5-6. Petitioner does not dispute that he submitted claims that identified individuals who were deceased at the alleged time of service, but he argues that the claims at issue were "submitted in good-faith as a result of an inadvertent clerical billing error," and that Petitioner did not receive any Medicare payments for the improper claims. P. Ex. 22 at ¶ 15; P. Br. at 5-6, 11. Petitioner also explains that he provided

services to individuals with similar names to the deceased individuals identified in the claims he submitted. P. Ex. 22 at ¶¶ 18-64. However, the general nature of the billing errors — that is, whether they were accidental or not — is not material to the outcome of the case. The plain language of the regulation applicable in this case does not necessarily require a "pattern of improper billing," which derives solely from the preamble, nor does it expressly exclude clerical billing errors as a basis for revocation. *See* 42 C.F.R. § 424.535(a)(8). Any evidence or factual inferences that may be drawn showing that the claims Petitioner submitted were clerical errors or accidental in nature do not impact the result here. In addition, whether Petitioner provided services to individuals other than those named in the claims he submitted is not material to the outcome of the case, which focuses on the claims that Petitioner actually submitted to Medicare. Thus, a fact or inference that shows Petitioner provided services to an individual with a name similar to one actually identified in the claim does not impact the result. This case turns on a matter of law, and is therefore appropriate for summary judgment.

For purposes of summary judgment, I draw all inferences in favor of Petitioner. Even though not material to the outcome, I accept as true that Petitioner did not intend to defraud Medicare and that the improper claims submitted were the result of clerical errors.

2. The undisputed facts show that Petitioner submitted Medicare claims for services that could not have been furnished to specific individuals on the dates of services.

In support of its motion for summary judgment, CMS presented the results of an investigation that show Petitioner submitted Medicare claims for services that could not have been provided to the beneficiaries identified in the claims because the beneficiaries were deceased on the dates of the claimed services. CMS Ex. 8; CMS Ex. 9; CMS Ex. 2 at ¶¶ 5-6. Petitioner does not dispute that he submitted the claims in question or that they identified individuals who were actually deceased at the time of service. Petitioner argues that the billing errors were the result of the billing system Petitioner's office used, and the services described in the claims were rendered to living beneficiaries with names similar to those of the deceased Medicare beneficiaries identified in the claims. P. Br. at 5-6. With regard to the claims at issue, Petitioner qualifies them as billing mistakes, inadvertent, and not rising to a level of abuse or a pattern of improper claims. P. Br. at 5-6, 11; P. Ex. 22 at ¶¶ 15-16.

The evidence shows that Petitioner submitted 31 claims for services that Petitioner performed after the beneficiary identified on the claim had died. *See* CMS Ex. 4 (providing summary chart of information contained in CMS Ex. 8 and CMS Ex. 9). For example, CMS has presented evidence showing that a beneficiary with the initials "J.A." was born on August 6, 1928, and died on January 24, 2011. CMS Ex. 9 at 3. The last four characters of J.A.'s Health Insurance Claim Number (HICN) were 745A. CMS

Ex. 9 at 3. Petitioner submitted 12 Medicare claims for services rendered to J.A. *See* CMS Ex. 4; CMS Ex. 8 at 1-24. Six of these claims were in 2012, three were in 2013, and three were in 2014, all of which occurred after J.A. had died. As noted, Petitioner argues that he provided care to living Medicare beneficiaries with the same or similar names to the deceased beneficiaries identified on the submitted claims. Indeed, Petitioner demonstrated that he previously provided services to an individual with the same name as J.A., but who was born in 1953 and had HICN ending 454A. CMS Ex. 6 at 3; P. Ex. 22 at ¶¶ 24-26. Yet it is undisputed that Petitioner submitted 12 claims as though he had performed those services on J.A. born in 1928, who was deceased at that time.

In another example, a Medicare beneficiary with the initials "R.K." was born February 18, 1926, and died on September 28, 2011. CMS Ex. 9 at 6. The last four characters in R.K.'s HICN were 505A. CMS Ex. 9 at 6. Petitioner submitted a Medicare claim for services allegedly rendered to R.K. on October 5, 2012 (CMS Ex. 8 at 37-38), which occurred over one year after R.K. had died. Petitioner's records show that he provided service to an individual with nearly the reverse interchanged names of R.K., but a different gender, with a different date of birth, and a HICN ending 776A, all of which distinguished the living beneficiary from R.K. *See* CMS Ex. 6 at 3; P. Ex. 22 at ¶¶ 33-35. However, Petitioner ultimately identified R.K. on the Medicare claim that he submitted. CMS Ex. 8 at 37. The treatment records that Petitioner provided in this case support his claim that at some point in the Medicare claims process, he confused the deceased beneficiaries, who were former patient of his, with the beneficiaries actually receiving treatment. *See* CMS Ex. 6 at 4; P. Ex. 22 at ¶¶ 15. Petitioner explained that some of the misidentifications resulted from his treatment of many living beneficiaries in the same skilled nursing facility where the deceased beneficiaries once resided. *See, e.g.*, P. Ex. 22 at ¶ 7-9, 22, 25, 28, 31, 37, 40, 46, 49, 55.

Ultimately, Petitioner's evidence does not create a genuine dispute about whether he submitted the claims at issue to Medicare, or about whether those claims identified deceased beneficiaries as receiving treatment. Regardless of whether Petitioner provided the claimed services to living beneficiaries — which I accept as true for purposes of summary judgment — the claims he submitted to Medicare actually identified *deceased* Medicare beneficiaries, which is a trigger for CMS's revocation authority under section 424.535(a)(8). Petitioner has not come forward with evidence to refute CMS's evidence that shows he submitted claims for services that could not have been provided to a specific beneficiary because that beneficiary was dead.

3. CMS was authorized to revoke Petitioner's Medicare billing privileges pursuant to 42 C.F.R. § 424.535(a)(8).

Once CMS had determined that Petitioner submitted a claim or claims that could not have been furnished to specific individuals on the dates of service, it was then authorized to revoke Petitioner's Medicare billing privileges. 42 C.F.R. § 424.535(a)(8). Here, there

are 31 instances where Petitioner submitted a claim for a service that could not have been furnished to a specific individual on the date of service because the specific individual identified was deceased at that time. *See* CMS Ex. 4. Petitioner has offered statistical estimates of his overall Medicare claims, arguing that the instances of improper billing that lead to his revocation are a fraction of a percent of his total claims, which shows that he was not defrauding Medicare or otherwise motivated by improper pecuniary gain.[3] P. Br. at 2-3, 9. Petitioner repeatedly argues that the billing errors were "inadvertent." *See* P. Br. at 9-10; P. Ex. 22 at ¶ 15.

The operative language of the revocation provision applicable in this case does not require that CMS demonstrate Petitioner intended to defraud Medicare before it may revoke Petitioner's billing privileges. *See* 42 C.F.R. § 424.535(a)(8). It merely requires the existence of improper claims. *Id.*; *see also Louis J. Gaefke, D.P.M.*, DAB No. 2554, at 7 (2013) ("The plain language of the regulation contains no requirement that CMS establish that the supplier acted with fraudulent or dishonest intent."). In addition, the regulation does not suggest that a certain minimum percentage of improper claims compared to the supplier's overall claims is acceptable before CMS may revoke a supplier's Medicare billing privileges. 42 C.F.R. § 424.535(a)(8); *see also Howard B. Reife, D.P.M.*, DAB No. 2527, at 7 (2013) ("There is also no requirement in the regulation (or the preamble) establishing a minimum claims error rate . . . that must be exceeded before CMS may revoke billing privileges."). Therefore, Petitioner's claims that he did not act fraudulently by submitting his improper claims and that his error rate was extremely low are not sufficient to negate CMS's authority to revoke Petitioner's billing privileges pursuant to 42 C.F.R. § 424.535(a)(8).

The drafters of the regulation suggest that CMS must demonstrate that Petitioner's billing practices showed a pattern of improper billing, that is, a pattern of making claims that could not have been furnished to specific individuals on the dates of service. *Id.*; *see* 73 Fed. Reg. at 36,455 ("[T]his basis for revocation is directed at providers and suppliers who are engaging in a pattern of improper billing."). As explained above, CMS demonstrated in 31 instances that Petitioner engaged in such a "pattern of improper billing" for services that could not have been furnished to specific individuals on the dates of service. According to the regulatory drafters, a "pattern of improper billing" occurs when there are three or more instances of improper billing, which is undisputedly the case with Petitioner. 73 Fed. Reg. at 36,455. Despite Petitioner's extrapolation of his improper billing over several years, neither the regulation nor the preamble allow repeated improper billing over an extended period, so long as it is sufficiently spread out

[3] Petitioner argues that the improper claims at issue in this case represent 0.0024% of his total Medicare claims during the period the improper claims cover. P. Br. at 2-3; P. Ex. 22 at ¶ 16. There is no documentary evidence in the record to support that specific percentage; however, I will accept that percentage as true for purposes of summary judgment.

over that period. The regulation simply requires "a claim or claims" that are improper before revocation is authorized, and the preamble explains that a "pattern of improper billing" occurs after three or more improper claims without reference to any timeframe of how soon after one another those improper claims must occur. As I noted in *Howard B. Reife, D.P.M.*, DAB CR2728, at 6 (2013), "[r]epeatedly making [the] same errors [in the Medicare claims at issue] reduces their credibility as 'accidental' and establishes a pattern of improper billing that suggests a lack of attention to detail considering Petitioner could have differentiated the patients through their birthdates or Medicare numbers." CMS did point out in its reconsidered determination that many of the improper claims were denied, yet Petitioner has not offered any explanation about why the denied claims did not provide a clear warning that he was submitting claims that identified deceased beneficiaries. *See* CMS Ex. 7 at 2. He continued to make improper claims, which further demonstrates the "pattern of improper billing" that supports revocation. Petitioner's repeated errors in this case are sufficient to establish a "pattern of improper billing" under the standard stated in the preamble. Petitioner's attempt to show that his improper claims were a *de minimus* amount of his overall proper claims submissions is not material. *See Reife*, DAB No. 2527, at 7.

Moreover, Petitioner's argument that he provided the services claimed, albeit to living beneficiaries with names similar to those deceased beneficiaries identified in the claims at issue, does not undermine CMS's legal authority to revoke Petitioner's billing privileges. As another administrative law judge explained in a similar case addressing a similar argument:

> Petitioner's argument overlooks that the regulation authorizing revocation requires that the improper claim be for services that Petitioner could not have provided to "a *specific* individual," not just "an individual." 42 C.F.R. § 424.535(a)(8) (emphasis added). Contrary to Petitioner's argument, the regulation requires specificity with reference to whom the services were allegedly provided, not a generic identification of any individual. The specific individual identified in a claim must be the specific individual who received the services claimed, otherwise the claim is for services that could not have been provided to "a specific individual," and revocation is permissible. *Id.*

Louis J. Gaefke, D.P.M., DAB CR2785, at 9 (2013), *aff'd*, DAB No. 2554, at 8 n.7. The Board has also concluded that the revocation authority in section 424.535(a)(8) hinges on the appropriate identification of a beneficiary in Medicare claims:

> While section 424.535(a)(8) provides that "abuse of billing privileges" involves submitting a claim or claims "that could not have been furnished to a specific individual on the date of service," the purpose of the phrase "to a specific individual" is to cover situations where a practitioner was

> available and had the necessary equipment to furnish a service, but could not have furnished the service to the *identified beneficiary* given that beneficiary's status or location.

Realhab, Inc., DAB No. 2542, at 16 (2013) (emphasis added). Thus, for the same reasons as stated in *Gaefke* and *Realhab*, I also reject Petitioner's argument that providing services to a living beneficiary not identified in the Medicare claims at issue absolves him from the revocation of his Medicare billing privileges for submitting Medicare claims that identified beneficiaries who were deceased at the time of service.

Finally, Petitioner's reliance on the recent amendments to section 424.535(a)(8) is incorrect. The amended section now states in its entirety:

> (8) *Abuse of billing privileges*. Abuse of billing privileges includes either of the following:
>
> > (i) The provider or supplier submits a claim or claims for services that could not have been furnished to a specific individual on the date of service. These instances include but are not limited to the following situations:
> >
> > > (A) Where the beneficiary is deceased.
> > >
> > > (B) The directing physician or beneficiary is not in the state or country when services were furnished.
> > >
> > > (C) When the equipment necessary for testing is not present where the testing is said to have occurred.
> >
> > (ii) CMS determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements. In making this determination, CMS considers, as appropriate or applicable, the following:
> >
> > > (A) The percentage of submitted claims that were denied.
> > >
> > > (B) The reason(s) for the claim denials.
> > >
> > > (C) Whether the provider or supplier has any history of final adverse actions (as that term is defined under § 424.502) and the nature of any such actions.

> (D) The length of time over which the pattern has continued.
>
> (E) How long the provider or supplier has been enrolled in Medicare.
>
> (F) Any other information regarding the provider or supplier's specific circumstances that CMS deems relevant to its determination as to whether the provider or supplier has or has not engaged in the pattern or practice described in this paragraph.

42 C.F.R. § 424.535(a)(8) (effective Feb. 3, 2015). Petitioner argues that the factors in subsection 424.535(a)(8)(ii) should inform my analysis in this case because CMS's underlying basis for revoking Petitioner's Medicare enrollment was actually that Petitioner's improper claims simply failed to meet Medicare requirements. *See* P. Br. at 8.

Petitioner overlooks that subsection 424.535(a)(8)(i) is unchanged from the regulatory language that was in effect at the time CMS revoked Petitioner's enrollment. That language authorizes CMS to revoke enrollment based on a provider or supplier's submission of "a claim or claims for services that could not have been furnished to a specific individual on the date of service." 42 C.F.R. § 424.535(a)(8)(i). It is undisputed that Petitioner submitted claims for services that could not have been furnished to a specific individual on the date of service because that individual was dead. *See* 42 C.F.R. § 424.535(a)(8)(i)(A). CMS has not argued that Petitioner's claims simply did not follow Medicare requirements. Nor has Petitioner explained why subsection 424.535(a)(8)(i) would not apply to his case, and there is no apparent reason why it would not. Therefore, I do not find Petitioner's argument persuasive.

4. The duration of Petitioner's re-enrollment bar is not subject to review.

A re-enrollment bar after a revocation is a minimum of one year and a maximum of three years. 42 C.F.R. § 424.535(c). Petitioner argues that the three year re-enrollment bar that CMS imposed in this case is "clearly excessive" when considering the amount and nature of erroneous claims that Petitioner submitted. P. Br. at 13; *see* CMS Ex. 3 at 2.

Petitioner has not argued that the length of a re-enrollment bar is part of an "initial determination," which the regulations limit, in relevant part, to a determination to revoke a provider or supplier's Medicare enrollment in accordance with section 424.535. 42 C.F.R. § 498.3(b)(17). A re-enrollment bar is automatic after an initial determination to revoke enrollment, which suggests that the re-enrollment bar is not part of the "initial

determination" to revoke, but a derivative consequence of that initial determination. *See* 42 C.F.R. § 424.535(c). Consistent with other administrative law judges, I have previously determined that the duration of a re-enrollment bar is not an appealable initial determination, and thus an administrative law judge does not have the authority to consider it. *See, e.g.*, *Hatem M. Dajani, M.D.*, DAB CR3612, at 13-14 (2015); *see also Gaefke*, DAB CR2785, at 3 n.3; *Criskel Home Health, Inc.*, DAB CR3417, at 12 n.6 (2014). When faced with a similar argument as the one Petitioner makes here, the Board did not accept that the duration of a re-enrollment bar was not subject to review, but it did not reject that conclusion either. *See John Hartman, D.O.*, DAB No. 2564, at 6 (2014) ("We need not address the reviewability of the enrollment bar here because we would in any case find the length of the bar to be reasonable."). I will not reconsider the longstanding conclusion especially in light of Petitioner's failure to explain why the duration of a re-enrollment bar is part of an "initial determination" that would be subject to review. The "initial determination" relevant to this case consists of the determination to revoke in accordance with section 424.535, not whether CMS imposed an appropriate re-enrollment bar as a result of the revocation. Accordingly, my authority is limited to determining whether CMS had a basis to revoke Petitioner's enrollment and billing privileges. *See* 42 C.F.R. §§ 424.535(c), 498.3(b)(17); *David Tolliver, M.D.*, DAB CR2281, at 12-13 (2010).

V. Conclusion

For the reasons explained above, I grant summary judgment in favor of CMS. There is no genuine dispute of material facts, and CMS is entitled to judgment affirming its revocation of Petitioner's Medicare billing privileges effective December 7, 2014, with a three year re-enrollment bar.

/s/
Joseph Grow
Administrative Law Judge