Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Chaturbhai B. Patel, M.D.,
(NPI: 1558379750 \ PTANs: 0493271, H149330, H149331),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-16-847

Decision No. CR4792

Date: February 15, 2017

DECISION

The Medicare enrollment and billing privileges of Petitioner, Chaturbhai B. Patel, M.D., are revoked pursuant to 42 C.F.R. § 424.535(a)(9) for failure to report to CMS or its contractor a change in practice location within 30 days as required by 42 C.F.R. § 424.516(d)(1)(iii).[1] Revocation is effective April 9, 2016, 30 days after the March 10, 2016 notice to Petitioner that his enrollment and billing privileges were revoked. 42 C.F.R. § 424.535(g). Petitioner is subject to a two-year bar to re-enrollment running from the effective date of the revocation of his Medicare enrollment and billing privileges.

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[1] Citations are to the 2015 revision of the Code of Federal Regulations (C.F.R.), unless otherwise stated.

I. Background and Procedural History

CGS Administrators, LLC (CGS), a Medicare administrative contractor, notified Petitioner by letter dated March 10, 2016, that his Medicare billing privileges were revoked 30 days from the date of the letter. CGS cited 42 C.F.R. § 424.535(a)(9) as authority for the revocation and alleged that Petitioner failed to notify the Centers for Medicare & Medicaid Services (CMS) of a change in practice location as required by 42 C.F.R. § 424.516. CGS also advised Petitioner that he was subject to a two-year bar to re-enrollment. CMS Exhibit (Ex.) 1.

Petitioner requested reconsideration by letters dated April 15 and 18, 2016. CMS Exs. 2, 3. A CGS hearing officer issued a reconsidered determination on May 27, 2016. The hearing officer determined that revocation was appropriate pursuant to 42 C.F.R § 424.535(a)(9) because Petitioner failed to report that he closed his practice location within 90 days as required by 42 C.F.R. § 424.516(d)(2). CMS advised Petitioner by letter dated July 26, 2016, that CMS had reopened and revised the May 27, 2016 reconsidered determination. CMS concluded that Petitioner had failed to report a change of practice location within 30 days as required by 42 C.F.R. § 424.516(d)(1)(iii) and that that was a basis for revocation pursuant to 42 C.F.R. § 424.535(a)(9). CMS Ex. 5.

Petitioner filed a request for hearing before an administrative law judge (ALJ) on June 13, 2016 (RFH). The request for hearing was docketed as C-16-654 and assigned to me on June 30, 2016. An Acknowledgment and Prehearing Order (Prehearing Order) was also issued on June 30, 2016. Petitioner filed additional requests for hearing on August 16 and 17, 2016, seeking review of the CMS revised reconsidered determination. Those requests for hearing were docketed together as C-16-847 and assigned to me on September 2, 2016. On September 2, 2016, I consolidated the requests for hearing under docket number C-16-847.

CMS filed a motion for summary judgment and prehearing brief (CMS Br.) with CMS Exs. 1 through 7 on October 3, 2016.[2] On November 1, 2016, Petitioner filed a

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[2] CMS styled its filing as its "Pre-hearing Brief and Motion for Summary Disposition." Summary disposition is a broad and non-specific phrase that could refer to any disposition such as dismissal, remand, or any other means for disposing of a case without a hearing and/or decision on the merits. Summary disposition is not a term of art and there are no rules or procedures specific to summary disposition. I treat the CMS motion as a motion for summary judgment as provided for by Prehearing Order, para. II.D & G.; the Civil Remedies Division Procedures § 19; Fed. R. Civ. Pro. 56; and various decisions of the Departmental Appeals Board (Board) cited in this decision. Petitioner's opposition *(Footnote continued next page.)*

prehearing brief (P. Br.), cross-motion for summary judgment, and his opposition to CMS's motion for summary judgment, with no exhibits. On November 16, 2016, CMS filed a reply brief (CMS Reply). On November 23, 2016, Petitioner filed a sur-reply (P. Reply). Petitioner has not objected to my consideration of CMS Exs. 1 through 7 and all are admitted as evidence.

II. Discussion

A. Applicable Law

Section 1831 of the Social Security Act (the Act) (42 U.S.C. § 1395j) establishes the supplementary medical insurance benefits program for the aged and disabled known as Medicare Part B. Administration of the Part B program is through contractors, such as CGS. Act § 1842(a) (42 U.S.C. § 1395u(a)). Payment under the program for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of services and suppliers. Act §§ 1835(a) (42 U.S.C. § 1395n(a)), 1842(h)(1) (42 U.S.C. § 1395u(h)(1)). Petitioner, a physician, is a supplier.

The Act requires the Secretary of Health and Human Services (Secretary) to issue regulations that establish a process for enrolling providers and suppliers in Medicare, including the requirement to provide the right to a hearing and judicial review of certain enrollment determinations, such as revocation of enrollment and billing privileges. Act § 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to 42 C.F.R. § 424.505, suppliers such as Petitioner must be enrolled in the Medicare program and be issued a billing number to have billing privileges and to be eligible to receive payment for services rendered to a Medicare-eligible beneficiary.

Suppliers must submit complete, accurate, and truthful responses to all information requested in the enrollment application. 42 C.F.R. § 424.510(d)(2). Pursuant to 42 C.F.R. §§ 424.502 and 424.510(d)(3), a supplier's application to enroll in Medicare must be signed by an authorized official, that is, one with authority to bind the provider or supplier both legally and financially. The regulation provides that the signature attests to the accuracy of information provided in the application. The signature also attests to the fact that the provider or supplier is aware of and abides by all applicable statutes,

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(Footnote continued.)

and cross-motion to the CMS motion reflect that Petitioner also treated the motion to be for summary judgment with no confusion as to the nature of the CMS motion or the rules to be applied.

regulations, and program instructions. 42 C.F.R. § 424.510(d)(3). Suppliers must meet basic requirements depending on their type of service. 42 C.F.R. §§ 424.505, 424.516, 424.517. Suppliers are subject to additional requirements to maintain active enrollment status, including reporting requirements. 42 C.F.R. § 424.516(b) – (e). Physicians, such as Petitioner, are required to report within 30 days a change in ownership, any adverse legal action, or a change in practice location. 42 C.F.R. § 424.516(d). Reporting must be accomplished using the enrollment application (CMS-855) appropriate to the type of supplier or provider. 42 C.F.R. §§ 424.510, 424.515.

The Secretary has delegated the authority to revoke enrollment and billing privileges to CMS. 42 C.F.R. § 424.535. CMS or its Medicare contractor may revoke an enrolled supplier's Medicare enrollment and billing privileges and supplier agreement for any of the reasons listed in 42 C.F.R. § 424.535. Pursuant to 42 C.F.R. § 424.535(a)(9), CMS may revoke Medicare enrollment and billing privileges when a provider or supplier fails to comply with the reporting requirements in 42 C.F.R. § 424.516(d)(1)(iii), which requires that physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations report a change in practice location within 30 days. 42 C.F.R. § 424.516(d)(1)(iii).

If CMS revokes a supplier's Medicare billing privileges, the revocation becomes effective 30 days after CMS or one of its contractors mails the revocation notice to the supplier, subject to some exceptions not applicable in this case. 42 C.F.R. § 424.535(g). After a supplier's Medicare enrollment and billing privileges are revoked, the supplier is barred from re-enrolling in the Medicare program for one to three years. 42 C.F.R. § 424.535(c).

A supplier whose enrollment and billing privileges have been revoked may request reconsideration and review as provided by 42 C.F.R. pt. 498. A supplier submits a written request for reconsideration to CMS or its contractor. 42 C.F.R. § 498.22(a). CMS or its contractor must give notice of its reconsidered determination to the supplier, giving the reasons for its determination and specifying the conditions or requirements the supplier failed to meet, and advising the supplier of its right to an ALJ hearing. 42 C.F.R. § 498.25. If the decision on reconsideration is unfavorable to the supplier, the supplier has the right to request a hearing by an ALJ and further review by the Board. Act § 1866(j)(8) (42 U.S.C. § 1395cc(j)(8)); 42 C.F.R. §§ 424.545, 498.3(b)(17), 498.5(l)(2). CMS is also granted the right to request ALJ review of a reconsidered determination with which it is dissatisfied. 42 C.F.R. § 498.5(l)(2). A hearing on the record, also known as an oral hearing, is required under the Act. *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743, 748-51 (6th Cir. 2004). The supplier bears the burden to demonstrate that it meets enrollment requirements with documents and records. 42 C.F.R. § 424.545(c).

B. Issues

The issues in this case are:

> Whether or not summary judgment is appropriate; and
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> Whether there is a basis for revocation of Petitioner's Medicare enrollment and billing privileges.

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

My conclusions of law are set forth in bold followed by my findings of fact and analysis.

1. Summary judgment is appropriate.

Both parties have requested summary judgment. A supplier whose enrollment has been revoked has a right to a hearing and judicial review, and a hearing on the record is required under the Act. Act §§ 205(b), 1866 (h)(1), (j); 42 C.F.R. §§ 498.3(b)(1), (5), (6), (8), (15), (17), 498.5; *Crestview*, 373 F.3d at 748-51. A party may waive appearance at an oral hearing but must do so affirmatively in writing. 42 C.F.R. § 498.66. In this case, Petitioner has not waived the right to oral hearing or otherwise consented to a decision based only upon the documentary evidence or pleadings. Accordingly, disposition on the written record alone is not permissible, unless the motions for summary judgment have merit.

Summary judgment is not automatic upon request but is limited to certain specific conditions. The Secretary's regulations that establish the procedure to be followed in adjudicating Petitioner's case are at 42 C.F.R. pt. 498. The regulations do not establish a summary judgment procedure or recognize such a procedure. However, the Board has long accepted that summary judgment is an acceptable procedural device in cases adjudicated pursuant to 42 C.F.R. pt. 498. *See, e.g.*, *Illinois Knights Templar Home*, DAB No. 2274 at 3-4 (2009); *Garden City Med. Clinic*, DAB No. 1763 (2001); *Everett Rehab. & Med. Ctr*., DAB No. 1628 at 3 (1997). The Board also has recognized that the Federal Rules of Civil Procedure do not apply in administrative adjudications such as this, but the Board has accepted that Federal Rule of Civil Procedure 56 and related cases provide useful guidance for determining whether summary judgment is appropriate. Furthermore, a summary judgment procedure was adopted as a matter of judicial economy within my authority to regulate the course of proceedings and made available to the parties in the litigation of this case by my Prehearing Order, para. II.D. & G. The parties were given notice by the Prehearing Order that summary judgment is an available procedural device and that the law as it has developed related to Federal Rule of Civil Procedure 56 will be applied. The parties were advised that a fact alleged and not specifically denied, may be accepted as true for purposes of ruling upon a motion for

summary judgment. The parties were also advised that on summary judgment evidence is considered admissible and true unless a specific objection is made. Prehearing Order ¶ II.D. & G.

Summary judgment is appropriate when there is no genuine dispute as to any issue of material fact for adjudication and/or the moving party is entitled to judgment as a matter of law. In determining whether there are genuine issues of material fact for trial, the judge must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. The party requesting summary judgment bears the burden of showing that there are no genuine issues of material fact for trial and/or that it is entitled to judgment as a matter of law. Generally, the non-movant may not defeat an adequately supported summary judgment motion by relying upon denials in its pleadings or briefs but must furnish evidence of a dispute concerning a material fact, i.e., a fact that would affect the outcome of the case if proven. *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 at 3 (2010) (and cases cited therein); *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986).

The standard for deciding a case on summary judgment and an ALJ's decision-making in deciding a summary judgment motion differs from resolving a case after a hearing. On summary judgment, the ALJ does not make credibility determinations, weigh the evidence, or decide which inferences to draw from the evidence, as would be done when finding facts after a hearing on the record. Rather, on summary judgment the ALJ construes the evidence in a light most favorable to the non-movant and avoids deciding which version of the facts is more likely true. *Holy Cross Vill. at Notre Dame, Inc.*, DAB No. 2291 at 5 (2009). The Board also has recognized that on summary judgment it is appropriate for the ALJ to consider whether a rational trier of fact could find that the party's evidence would be sufficient to meet that party's evidentiary burden. *Dumas Nursing & Rehab., L.P.*, DAB No. 2347 at 5 (2010). The Secretary has not provided for the allocation of the burden of persuasion or the quantum of evidence in 42 C.F.R. pt. 498. However, the Board has provided some persuasive analysis regarding the allocation of the burden of persuasion in cases subject to 42 C.F.R. pt. 498. *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 Fed. App'x 181 (6th Cir. 2005).

Petitioner does not dispute that he stopped seeing patients at 458 Glessner Avenue, Mansfield, Ohio 44903 (Glessner Avenue location) in May 2010. Petitioner does not dispute that he did not notify CMS or its contractor within 30 days of that change. P. Br. at 1. Whether closing a practice location is a change that is required to be reported under 42 C.F.R. § 424.516(d)(1)(iii) is a question of law, not a question of fact. I conclude that Petitioner has not identified a genuine dispute of material fact that makes a trial necessary in this case.

There is no genuine dispute as to any material fact in this case and summary judgment in favor of CMS is appropriate. The issues in this case that require resolution are issues of law related to the interpretation and application of the regulations that govern enrollment and billing privileges in the Medicare program to the undisputed facts of this case. The undisputed facts show that there is a basis for the revocation of Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(9).

2. Closing a physician practice location is a change that must be reported under 42 C.F.R. § 424.516(d)(1)(iii).

3. Petitioner failed to report to CMS or its contractor a change in practice location within 30 days in violation of 42 C.F.R. § 424.516(d)(1)(iii).

4. Petitioner's violation of 42 C.F.R. § 424.516(d)(1)(iii) is a basis for revocation of Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(9).

5. Revocation is effective April 9, 2016, 30 days after the March 10, 2016 notice to Petitioner that his enrollment and billing privileges were revoked. 42 C.F.R. § 424.535(g).

a. Facts

The material facts are not disputed and any inferences are drawn in Petitioner's favor on summary judgment.

Petitioner does not dispute that he was enrolled in the Medicare program as a physician or that his Medicare enrollment record listed the Glessner Avenue location as his practice location.[3] CMS Ex. 1. Petitioner also does not dispute that on January 20, 2016, an inspector for CGS visited the Glessner Avenue location to conduct a site visit. The inspector found a "for sale" sign at the location. CMS Exs. 1; 6 at 1. The inspector's photographs documenting the site visit show a for-sale sign and Petitioner's business sign lying on the ground near the facility. CMS Ex. 6 at 1. Petitioner concedes that after May 2010 he saw no patients at the Glessner Avenue location. Petitioner further concedes that he has been working as a hospitalist since before May 2010 when he stopped seeing patients at the Glessner Avenue location. CMS Exs. 2, 3; P. Br.; P. Reply. In his April

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[3] The parties were advised by the Prehearing Order, para. II.G. that a fact alleged and not specifically denied may be accepted as true for purposes of summary judgment.

15 and April 18, 2016 requests for reconsideration, Petitioner concedes that he closed his Glessner Avenue location in May 2010. CMS Exs. 2, 3; P. Br. at 2. Petitioner also admits that he did not notify CMS that he closed the Glessner Avenue location. CMS Ex. 3; P. Br. at 4.

b. Analysis

Petitioner does not dispute that he had a practice at the Glessner Avenue location that he closed in May 2010 without notifying CMS or CGS. Petitioner does not dispute that he failed to report that he closed the Glessner Avenue location within 30 days of closing it. CMS Ex. 3 at 1; P. Br. at 2. Pursuant to 42 C.F.R. § 424.516(d)(1)(iii) (2009), Petitioner was required to report to CMS any change in practice location within 30 days.

In his request for hearing filed on June 13, 2016, Petitioner argued that a violation of 42 C.F.R. § 424.516(d)(2), the basis for revocation alleged in the original reconsidered determination, is not a basis for revocation pursuant to 42 C.F.R. § 424.535(a)(9). Petitioner is correct that revocation pursuant to 42 C.F.R. § 424.535(a)(9) is limited to failure to comply with 42 C.F.R. § 424.516(d)(1)(ii) and (iii). Revocation for violation of 42 C.F.R. § 424.516(d)(2) would be pursuant to 42 C.F.R. § 424.535(a)(5)(ii), which is not cited in the reconsidered or revised reconsidered determination or argued by CMS before me. Petitioner also argues that CMS had no authority to issue the revised reconsidered determination, which changed the basis for revocation pursuant to 42 C.F.R. § 424.535(a)(9), to correctly cite a violation of 42 C.F.R. § 424.516(d)(1)(iii). Petitioner does not revisit this argument in his briefs. Abandoning the argument was well-advised as CMS clearly had authority to reopen and revise the reconsidered determination pursuant to 42 C.F.R. §§ 498.30-.32, and that authority was unaffected by the filing of the request for hearing.

Petitioner argues in his requests for hearing filed on August 16 and 17, 2016, that he never actually closed his Glessner Avenue practice location. The assertion that Petitioner never actually closed his Glessner Avenue location is inconsistent with Petitioner's admissions in his April 15 and 18, 2016 reconsideration requests that he closed his private practice at the Glessner Avenue location in May 2010. CMS Exs. 2, 3. The assertion that he did not close the Glessner Avenue location is also inconsistent with the assertion in his briefs that he decided to no longer see patients at that location. P. Br. at 1; P. Reply at 1. Petitioner argues that when he closed his Glessner Avenue practice location, he did not actually change his practice location. He argues that he simply ceased providing services at that location. Petitioner argues that, under the circumstances, no notification to CMS was required. Petitioner argues that he continued to own the building and that CMS failed to present evidence that he sold the building. Petitioner argues that CMS failed to show that he opened another medical practice following the closing of his Glessner Avenue practice location. P. Br.; P. Reply. Petitioner cites no legal authority to support his interpretation of the regulation.

I conclude that Petitioner's arguments are without merit. There is no dispute that Petitioner was enrolled in Medicare with a practice location at the Glessner Avenue address. In May 2010, he closed that location. After Petitioner closed the Glessner Avenue location, his patients could no longer see him at that location, a change from the enrollment information on file with CMS and CGS. After closing his Glessner Avenue location, Petitioner concedes that he continued to practice medicine as a hospitalist. CMS Exs. 2, 3. The plain language of 42 C.F.R. § 424.516(d) supports a conclusion that closing the Glessner Avenue location constituted a "change in practice location" that Petitioner was obligated to timely report to CMS under 42 C.F.R. § 424.516(d)(1)(iii).

However, even if I accepted Petitioner's argument that closing the practice location is not the same as changing the practice location, closing the location was clearly a change in enrollment information that Petitioner failed to report within 90 days as required by 42 C.F.R. § 424.516(d)(2), and the failure to satisfy that Medicare enrollment requirement would be a basis for revocation pursuant to 42 C.F.R. § 424.535(a)(5)(ii). Thus, had CMS decided to pursue it, another basis for revocation existed as a result of Petitioner's failure to report his change in practice location.

I conclude that Petitioner failed to report within 30 days that he closed his Glessner Avenue location, and that the closure of a practice location is the same as a change of practice location within the meaning of 42 C.F.R. § 424.516(d)(1)(iii). I further conclude that Petitioner's violation of 42 C.F.R. § 424.516(d)(1)(iii) is a basis for revocation pursuant to 42 C.F.R. § 424.535(a)(9).

My authority is limited to determining whether there is a legal basis for revocation of Petitioner's Medicare enrollment and billing privileges. I have no authority to review the exercise of discretion by CMS or its contractor to revoke once I have found that there is a basis for revocation. *Abdul Razzaque Ahmed, M.D.*, DAB No. 2261 at 19 (2009), *aff'd*, *Ahmed v. Sebelius*, 710 F. Supp. 2d 167 (D. Mass. 2010).

Petitioner argues that if a basis exists for the revocation of his Medicare billing privileges, the duration of his Medicare re-enrollment bar should be less than two years. When a supplier's Medicare enrollment and billing privileges are revoked, the supplier is barred from re-enrolling in the Medicare program for one to three years. 42 C.F.R. § 424.535(c). There is no statutory or regulatory language establishing a right to review of the duration of the re-enrollment bar CMS imposes. Act § 1866(j)(8) (42 U.S.C. § 1395cc(j)(8)); 42 C.F.R. §§ 424.535(c), 424.545; 498.3(b), 498.5. The Board has held that the duration of a revoked supplier's re-enrollment bar is not an appealable initial determination listed in 42 C.F.R. § 498.3(b) and is not subject to ALJ review. *Vijendra Dave*, DAB No. 2672 at 10-11 (2016).

To the extent that Petitioner's arguments may be construed as a request for equitable relief, I have no authority to grant such relief. *US Ultrasound*, DAB No. 2302 at 8 (2010)

I am also required to follow the Act and regulations and have no authority to declare statutes or regulations invalid. *1866ICPayday.com, L.L.C.*, DAB No. 2289 at 14 (2009).

III. Conclusion

For the foregoing reasons, Petitioner's Medicare enrollment and billing privileges are revoked pursuant to 42 C.F.R. § 424.535(a)(9), based on a violation of 42 C.F.R. § 424.516(d)(1)(iii). The effective date of revocation is April 9, 2016. Petitioner is subject to a two-year bar to re-enrollment commencing on the effective date of the revocation.

/s/
Keith W. Sickendick
Administrative Law Judge