Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Sheetal Kumar, M.D., P.A.
Docket No. A-19-9
Decision No. 2965
August 20, 2019

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Petitioner Sheetal Kumar, M.D., P.A. appeals the August 21, 2018 decision of an Administrative Law Judge (ALJ) sustaining the revocation of Petitioner's Medicare enrollment and billing privileges by the Centers for Medicare & Medicaid Services (CMS). *Sheetal Kumar, M.D., P.A.*, DAB CR5168 (2018) (ALJ Decision). CMS revoked Petitioner's Medicare billing privileges, pursuant to 42 C.F.R. § 424.535(a)(8)(i), because Petitioner submitted or caused to be submitted Medicare reimbursement claims for services that could not have been furnished on the claimed service dates. The ALJ granted summary judgment in favor of CMS, finding it undisputed that Petitioner filed 12 reimbursement claims for services allegedly provided to 10 Medicare beneficiaries on dates when Petitioner's owner (Dr. Kumar) was out of the country. ALJ Decision at 3 (citing CMS Ex. 8, at 4; CMS Ex. 9, at 4). For the reasons explained below, we uphold the ALJ Decision.

Applicable legal authorities

The Social Security Act (Act) authorizes CMS to regulate the enrollment of providers and suppliers in the Medicare program. Act § 1866(j)(1)(A), 42 U.S.C.§ 1395cc(j)(1)(A). The implementing regulations appear in 42 C.F.R. Part 424, subpart P. The purpose of the enrollment provisions in subpart P is to protect the best interests of Medicare beneficiaries and trust funds. *See* 71 Fed. Reg. 20,754, 20,773-74 (Apr. 21, 2006).

Section 424.535(a) lays out multiple reasons for which CMS may revoke a supplier's Medicare enrollment and billing privileges. 42 C.F.R. § 424.535(a).[1] CMS has authority to revoke a supplier's billing privileges for "[a]buse of billing privileges" if the supplier "submits a claim or claims for services that could not have been furnished to a specific

[1] Petitioner, a physician and her affiliated professional association, is a "Supplier" as that term is used in the Medicare program. 42 C.F.R. §§ 00.202, 498.2.

individual on the date of service," specifically including when "[t]he directing physician . . . is not in the state or country when services were furnished." *Id.* § 424.535(a)(8)(i)(B); 73 Fed. Reg. 36,448, 36,455 (June 27, 2008).

The preamble to the final rule publishing this section states, in pertinent part:

> [W]e will not revoke billing privileges under § 424.535(a)(8) unless there are multiple instances, at least three, where abusive billing practices have taken place . . . . [W]e believe that providers and suppliers are responsible for the claims they submit or the claims submitted on their behalf. We believe that it is essential that providers and suppliers take the necessary steps to ensure they are billing appropriately for services furnished to Medicare beneficiaries.

73 Fed. Reg. at 36,455.

Revocation effectively terminates a supplier's agreement with Medicare. After CMS or its contractor revokes a supplier's billing privileges, the supplier may not participate in Medicare from the effective date of the revocation until the end of the re-enrollment bar. 42 C.F.R. § 424.535(b), (c). The revocation regulation requires CMS to impose a re-enrollment bar for a "minimum of [one] year, but not greater than [three] years depending on the severity of the basis for revocation." *Id.* § 424.535(c)(1).

A supplier whose Medicare enrollment has been revoked may request reconsideration by CMS or its contractor. *See id.* §§ 424.545(a), 498.3(b)(17), 498.5(l). If dissatisfied with the reconsidered determination, the supplier may appeal that determination to an ALJ and then to the Board, pursuant to 42 C.F.R. Part 498. *Id.* §§ 424.545(a), 498.3(b)(17), 498.22(a), 498.40, 498.5(l).

Factual and procedural background[2]

CMS provided notice, by letter dated October 25, 2017, that it had revoked Petitioner's Medicare enrollment and billing privileges effective November 24, 2017, with a three-year reenrollment bar. CMS Ex. 10, at 1-2. The letter explained the reason for the revocation:

[2] The background information is drawn from the ALJ Decision and the record before the ALJ and is not intended to substitute for his findings.

> **42 CFR §424.535(a)(8)(i) – Abuse of Billing Privileges**
>
> Data analysis conducted on claims billed by Sheetal Kumar, M.D. P.A. for dates of service between August 2, 2016 and March 16, 2017, revealed twelve (12) claims for services purportedly rendered to multiple beneficiaries by Dr. Sheetal Kumar during periods of time when Dr. Sheetal Kumar was out of the country. . . .
>
> U.S. Department of Homeland Security documentation and information obtained by the Department of Health and Human Services Office of Inspector General indicate that Dr. Kumar was out of the country during . . . March 13, 2017 through March 19, 2017 . . . [and] July 30, 2016 through August 9, 2016 . . .

Id. at 1 (citation omitted) (bold type in the original).

Petitioner timely sought reconsideration. CMS Ex. 11, at 1. In the reconsideration request, Petitioner contended that the allegation of abuse of billing privileges was incorrect, as the identified claims underlying CMS's decision to revoke "represent an error rate of less than a fraction of one percent (1%)" and the payments for the twelve claims had already been recouped. *Id.* at 2. Petitioner further contended that revocation was an atypically harsh punishment for violating the Medicare "incident to" policy requiring direct supervision by a physician or other qualifying professional. *Id.* at 1-2. Petitioner argued that it did not act deliberately or for financial gain, that the services rendered on the dates of Dr. Kumar's absence were medically necessary, and that the services helped, rather than harmed, the beneficiaries. *Id.* at 2. In addition, Petitioner questioned the validity of the revocation determination itself based on the length of employment of the CMS employee who issued the initial revocation decision. *Id.* at 2-3.

On March 26, 2018, CMS issued an unfavorable reconsidered determination. CMS Ex. 1. The reconsidered determination concluded that Petitioner's submission of multiple claims that could not have been furnished because Dr. Kumar was out of the country on the purported dates of service amounted to an abuse of billing privileges and warranted revocation under 42 C.F.R. § 424.535(a)(8)(i). *Id.* at 4. Petitioner then sought an ALJ hearing. Request for Hearing.

CMS moved for summary judgment, arguing that the material facts in this case – that Dr. Kumar filed 12 Medicare claims for services provided while she was out of the country – are not in dispute. CMS Motion for Summary Judgment at 4-5. CMS further contended that the same arguments made by Petitioner here have been rejected by the Board in prior cases and are, in any event, immaterial to the outcome of the case. *Id.* at 6. Petitioner

opposed CMS's motion for summary judgment, asserting that the services in question were actually furnished by personnel in its office (even though Dr. Kumar admittedly was not present to supervise). Petitioner's Pre-Hearing Brief and Opposition to CMS's Motion for Summary Judgment (Pet. Pre-Hearing Br.) at 2. Petitioner argued that this assertion raised a genuine dispute of material fact "because CMS may not allege abusive billing if services were rendered." *Id*. at 3. Petitioner denied that CMS has authority to revoke based solely on a supplier's failure to provide direct supervision of "incident to" services – as Petitioner portrayed the services rendered in Dr. Kumar's absence. *Id*. at 4-5.

ALJ Decision

The ALJ granted summary judgment to CMS, concluding that there was no genuine dispute of the material facts that Dr. Kumar was out of the country on the dates in question and that claims were filed on her behalf for services that she did not provide. ALJ Decision at 1-3. He rejected Petitioner's position that the revocation was invalid because the services were in fact provided, even if not properly supervised:

> Petitioner's argument . . . mischaracterizes CMS's grounds for revocation. . . . The regulatory authority . . . in this case springs directly from the fact that the services could not have been provided *as claimed*. It is irrelevant that the services might otherwise be legitimate services or that they are deficient only due to a lack of requisite supervision.

Id. at 3 (emphasis added) (citing *Louis J. Gaefke, D.P.M.*, DAB No. 2554, at 3, 6-7 (2013), *appeal dismissed*, *Gaefke v. Sebelius*, 2:14-cv-02085 (D. Kan. Aug. 8, 2014)).

The ALJ also found Petitioner's contention that its reimbursement claims were mere clerical errors to be without merit. *Id*. at 4. The ALJ explained:

> There is no regulatory exception for inadvertent or clerical errors once a supplier crosses the threshold of submitting three or more claims that it could not have provided. . . . Nothing in the regulation requires CMS to demonstrate malign intent on the part of a supplier who claims reimbursement for three or more services that it could not have provided.

Id. (citing *Gaefke* at 6-7).

The ALJ declined to address the equitable arguments raised by Petitioner, ruling that Petitioner's arguments regarding the reasonableness of the length of the re-enrollment bar and any improprieties in the revocation process were outside the scope of his authority. *Id*. (citing 42 C.F.R. §§ 498.3(b), 498.5(e), and *Richard Weinberger, M.D. and Barbara Vizy, M.D.*, DAB No. 2823, at 18 (2017)). The ALJ explained that his authority was

limited to the issue of whether CMS's determination was supported by applicable regulatory language based on the material facts (which were not disputed), and did not extend to an independent review of whether Petitioner abused its billing privilege outside of applying the regulatory standards. *Id.*

Standard of review

Whether summary judgment is appropriate is a legal issue that we address de novo. *Patrick Brueggeman, D.P.M.*, DAB No. 2725, at 6 (2016) (citing *Lebanon Nursing & Rehab. Ctr.*, DAB No. 1918 (2004)); *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program*, https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/enrollment/index.html (last visited Aug. 15, 2019).

Summary judgment is appropriate if there is no genuine dispute of fact material to the result and the moving party is entitled to judgment as a matter of law. *See 1866ICPayday.com, L.L.C.*, DAB No. 2289, at 2 (2009) (citing *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986)). In evaluating a motion for summary judgment, the Board construes the facts in the light most favorable to the non-moving party and gives it the benefit of all reasonable inferences. *See Livingston Care Ctr.*, DAB No. 1871, at 5 (2003), *aff'd*, *Livingston Care Ctr. v. U.S. Dep't of Health & Human Servs.*, 388 F.3d 168, 172-73 (6th Cir. 2004).

"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. & Skilled Nursing Ctr.*, DAB No. 2300, at 3 (2010) (citing *Matsushita Elec. Indus. Co. v. Zenith Radio*, 475 U.S. 578, 586 n.11 (1986); *Celotex*, 477 U.S. at 322), *aff'd*, *Senior Rehab. & Skilled Nursing Ctr. v. Health & Human Servs.*, 405 F. App'x 820 (5th Cir. 2010).

Analysis

Below, we first address Petitioner's argument that the services billed were furnished as "incident to" a physician service, even if lacking required supervision, which does not justify revocation under 42 C.F.R. § 424.535(a)(8)(i). Next, we reject the assertion that revocation is inappropriate because the specified beneficiaries received services on the dates at issue. We then explain why the grant of summary judgment was proper, contrary to Petitioner's contentions that genuine disputes of material fact existed, that Petitioner never explicitly conceded that Dr. Kumar was out of the country, and that the ALJ did not provide an independent review. Finally, we uphold the ALJ's conclusion that he lacked authority to alter the length of the revocation bar or grant equitable relief.

1. *The ALJ correctly found that the basis for Petitioner's revocation was claiming payment for services when the directing physician was out of the country, not merely providing inadequate supervision for services provided by others.*

Section 424.535(a)(8)(i), on its face, authorized CMS to revoke Petitioner's billing privileges for submitting claims to Medicare representing that Dr. Kumar furnished services to beneficiaries when Dr. Kumar was not in the country on the specified dates. The plain language of the regulation defines services that could not have been provided as claimed to include those for services provided when "[t]he directing physician or beneficiary is not in the state or country when services were furnished." 42 C.F.R. § 424.535(a)(8)(i)(B). The claims at issue indicate that Dr. Kumar was the directing physician; Dr. Kumar was out of the country on the dates Petitioner listed Dr. Kumar as providing services. *See* CMS Exs. 7-9. Petitioner submitted 12 such claims, well above the three-instance threshold CMS set for revoking under section 424.535(a)(8)(i). *Med-Care Diabetic & Med. Supplies, Inc.*, DAB No. 2764, at 17 (2017), *appeal dismissed*, *Med-Care Diabetic & Med. Supplies, Inc. v. Price*, 9:17-cv-80578 (S.D. Fla. Nov. 7, 2017); *see also John M. Shimko, D.P.M.*, DAB No. 2689, at 9-10 (2016). Petitioner nevertheless attempts to carve out an exception to justify the claims as for actual services provided to specified beneficiaries by non-physicians in Petitioner's offices under the rubric of the "incident to" billing provision. We find no such exception.

Thus, Petitioner argued to the ALJ that the services provided on the dates Dr. Kumar was out of the country qualify as "incident to" services because "[e]ven if [Dr. Kumar] were physically present at the clinic during [the] dates of service, the services denoted on [the] claims would have been furnished by Petitioner's non-physician clinicians in the same manner."[3] Pet. Pre-Hearing Br. at 3. On appeal, Petitioner reiterates its contention that the fact that "services were in fact furnished to specific individuals on specific dates of service . . . [although physician] supervision was absent" "should have precluded revocation." Request for Review (RR) at 3. Petitioner contends that section 424.535(a)(8)(i) does not authorize revocation for lack of adequate supervision and the only flaw in the claims at issue, according to Petitioner, was that the non-physician clinicians who provided the services lacked direct supervision by Dr. Kumar (or another physician) as required by 42 C.F.R. § 410.26(b)(5). Pet. Pre-Hearing Br. at 4; RR at 3.

Petitioner's arguments misconstrue the meaning and requirements for billing "incident to" services. The regulations provide for some supplemental services to be billed by a physician although provided by other clinicians under the physician's supervision when those services are "incident to" the physician's own treatment. Section 410.26(b)(2) states that Medicare "pays for services and supplies incident to the service of a physician

[3] We will discuss later Petitioner's assertion that it did not "concede" that Dr. Kumar was absent from the country on the relevant dates.

. . . [which] must be an integral, though incidental, part of the service of a physician . . . in the course of diagnosis or treatment of an injury or illness." "Incident to" services, by definition, cannot be furnished or billed independently of the primary services of a physician. Petitioner has not established that this requirement for a physician's primary services could be have been met when Dr. Kumar was out of the country. In addition, as Petitioner recognizes, "incident to" services (with exceptions not relevant here) require direct supervision by the billing physician. 42 C.F.R. § 410.26(b)(5). CMS reasonably concluded that the services here could not have been provided on the dates claimed to the specified beneficiaries because Dr. Kumar could not have met these basic conditions to provide "incident to" services.

It is unavailing for Petitioner to assert that the services would have been furnished in the same manner had Dr. Kumar been present in the office. Even if true, the quality of the services rendered does not bear on the fact that the services do not meet the regulatory definition of "incident to" services, and were not claimable by Petitioner as services rendered by Dr. Kumar. The truth of how the services might have differed had they actually been rendered incident to Petitioner's primary service and directly supervised is, in any case, unknowable. We agree with the ALJ in rejecting Petitioner's contention that it was revoked merely for "technical non-compliance with the 'incident-to' policy" due to inadequate supervision (Pet. Pre-Hearing Br. at 3). ALJ Decision at 3.

Moreover, even had a substitute physician provided direct supervision of the services (as Petitioner now suggests it could have arranged while offering no evidence it actually did so (Reply at 2)), Petitioner still could not possibly have provided or billed for the services under the regulations. While section 410.26(b)(5) provides that "the physician . . . supervising the auxiliary personnel need not be the same physician . . . who is treating the patient more broadly," the regulation expressly states that "*only the supervising physician* . . . may bill Medicare for incident to services." (Emphasis added.) Petitioner could have had a substitute physician supervise the services, but then only that substitute physician, not Dr. Kumar, could have billed Medicare for the "incident to" services, under 42 C.F.R. § 410.26(b)(5).

In short, the basis for revocation was filing claims for services that could not have been provided as claimed, not failing to provide required supervision for "incident to" services.

2. *The ALJ correctly rejected Petitioner's argument that CMS was precluded from revoking Petitioner's billing privileges because services were in fact furnished on the dates at issue.*

The ALJ did not err in rejecting the argument that CMS had no basis to revoke under section 424.535(a)(8)(i) because "the services actually were furnished" on the claimed dates of service. Reply at 1; *see also* Pet. Pre-Hearing Br. at 3. We agree with the ALJ

that Petitioner's interpretation of section 424.535(a)(8)(i) is misguided. It is immaterial to CMS's authority to revoke under section 424.535(a)(8)(i) that any services were provided on the relevant dates.

The Board has previously held that the revocation authority in section 424.535(a)(8)(i) applies to "claims for services that could not have been provided *as claimed*, that is to say that are 'impossible' in that the identified beneficiary could not have been treated by the identified provider/supplier on the specific date given." *Shimko* at 7 (emphasis added, bold type omitted); *Realhab, Inc.*, DAB No. 2542, at 18 (2013); *Gaefke* at 8 n.7. The dispositive factor in deciding whether CMS had a valid basis to revoke Petitioner's billing privileges is not that "services actually were furnished," but rather that Petitioner claimed Dr. Kumar furnished those services, when it was not possible for Dr. Kumar to have done so because she was out of the country. *See Shimko* at 9 ("[I]t [is] insufficient to prevent revocation to show that some service was provided although not the service claimed.").

It is equally irrelevant if, as Petitioner argued (*see, e.g.,* Pet. Pre-Hearing Br. at 3), no beneficiaries were harmed by the services provided and that the services were arguably medically necessary. Revocation of enrollment is a remedy intended to protect the integrity of the Medicare program and trust funds, as well as the beneficiaries served. *Neil Niren, M.D. and Neil Niren, M.D, P.C.*, DAB No. 2856, at 10 (2018). In specifying that a supplier is subject to revocation for claiming to have provided services while out of the country, section 424.535(a)(8)(i)(B) prevents physicians from attempting to practice remote medicine and bill Medicare—and, by extension, federal taxpayers—for services that he or she did not, in fact, provide. Regardless of whether any beneficiaries were harmed, claiming payment for services that one could not have provided as claimed undermines the integrity of the Medicare program.

Likewise, Petitioner's intent in submitting these 12 claims has no bearing on CMS's basis to revoke. The Board has repeatedly rejected the contention that a supplier who has submitted claims for services that could not have been furnished to a specific individual on the date of service under section 424.535(a)(8) must also be proven to have done so intentionally. *See Gaefke* at 7 (holding that the regulation's plain language does not require CMS to establish fraudulent or dishonest intent and provides no exception for inadvertent or accidental billing errors); *see also Brueggeman* at 10; *Shimko* at 5-6; *Howard B. Reife, D.P.M.*, DAB No. 2527, at 5-6 (2013).

As the ALJ held, the revocation did not rely on the specified beneficiaries receiving no services or inadequate services but rather on Petitioner not providing the services as they were claimed and billed because services could not have been provided as claimed with Dr. Kumar outside the country.

3. *Summary judgment was appropriate because the ALJ correctly determined that there was no genuine dispute of material fact.*

Petitioner contends the ALJ erred in granting summary judgment to CMS on the grounds that: (1) Petitioner's assertion that services were actually furnished to beneficiaries at least created a genuine dispute of material fact; (2) Petitioner never conceded that Dr. Kumar was out of the country on the dates at issue but merely made references to her "lack of physical presence in the office"; and (3) the ALJ abused his discretion by not making an independent assessment of whether Petitioner "abused" its billing privileges and by declining to hold a hearing.

As explained above, CMS revoked Petitioner's enrollment and billing privileges under section 424.535(a)(8)(i) on the ground that Petitioner submitted 12 Medicare reimbursement claims which represented that Dr. Kumar had furnished services at its location in the United States, on dates that Dr. Kumar was out of the country and therefore could not have possibly provided the services as claimed. Accordingly, the facts material to the ALJ's decision, and to our de novo review, are: (1) whether Petitioner submitted the claims for services listing Dr. Kumar as the directing physician providing the services; and (2) if so, whether Dr. Kumar was out of the country on the dates of service appearing on the claims.

The evidence produced by CMS, unless contradicted, clearly demonstrates both facts. That evidence includes: (1) the 12 claims for services billed by Dr. Kumar from July 30, 2016 through August 9, 2016 and from March 13, 2017 through March 19, 2017 (CMS Exs. 8-9); and (2) documentation by the Department of Homeland Security (DHS) establishing that Dr. Kumar was out of the country on these dates (CMS Ex. 7). Petitioner proffered no evidence raising a genuine dispute of these facts, as is required for a non-moving party to defeat summary judgment.

As discussed earlier, the fact that services may have been provided to beneficiaries on the claimed dates of service is not material to the issue of whether CMS had a valid basis to revoke Petitioner's billing privileges. CMS is authorized to revoke when the services, whether actually furnished or not, could not possibly have been provided *as claimed*. *See Shimko* at 9. We note that Petitioner did not produce any evidence that the claimed

services were in fact furnished on the specified dates.[4] Even if Petitioner had produced evidence to corroborate its assertion that the claimed services were furnished (by someone other than Dr. Kumar), this fact would not be material. Thus, the ALJ did not err in ruling that Petitioner's assertion that services were actually provided on the dates at issue did not raise a genuine issue of material fact.

Petitioner acknowledged that Dr. Kumar did not provide direct supervision for the services and recognized that direct supervision would require physical presence in the office. Pet. Pre-Hearing Br. at 2-4. Petitioner did not affirmatively state where Dr. Kumar was on the dates at issue, but nowhere disputed before the ALJ that Dr. Kumar was out of the country, much less offered any evidence tending to contradict the DHS records submitted by CMS. On appeal, Petitioner argues that the admission that Dr. Kumar was not physically present does not constitute concession that she was out of the country because "lack of physical presence in the clinic does not always and only mean lack of physical presence in the state or country." RR at 1. The fact that Petitioner asserts it never conceded that Dr. Kumar was out of the country on these dates is not sufficient to defeat summary judgment. Failing to concede a material fact does not equate to disputing it. Petitioner still has not denied that Dr. Kumar was out of the country and still does not point to any evidence tending to undercut CMS's proof on this point. Therefore, Petitioner raised no dispute of material fact as to Dr. Kumar's absence.

Petitioner contends that the ALJ failed to exercise his discretion because his decision stated that he did not "have the authority to decide whether Petitioner 'abused' its billing privileges in some manner not directly addressed by regulatory language." RR at 2 (quoting ALJ Decision at 4). Petitioner points to a prior decision by a different ALJ as demonstrating independent exercise of discretion in issuing a favorable decision "based solely on circumstantial evidence," even though the nurse practitioner who was subject to revocation conceded she did not have a master's degree in nursing. *Id*. (citing *Therese R. Grenchik, FNP*, DAB CR5157 (2018)).

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[4] Petitioner requested oral argument before the Board and explained that the purpose would be to respond to questions and to "proffer facts, including protected health information, related to each claim to dispute the assertion by CMS in compliance with the Health Insurance Portability and Accountability Act without redactions." Reply at 2. The time to have proffered evidence on any factual matter was at the time of reconsideration. Even before the ALJ, new evidence is admissible in supplier enrollment cases only upon a showing of good cause for producing it for the first time at that level. 42 C.F.R. § 498.56(e); *see also Sandra E. Johnson, CRNA*, DAB No. 2708, at 9-11 (2016). The Board lacks authority to admit new evidence in such cases. 42 C.F.R. § 498.86(a). As far as any specific information about individual claims, as stated in the text, it would not be material to the outcome here even had Petitioner established that the services were needed and provided. For these reasons, the Board declined to conduct oral argument in this matter.

Petitioner misunderstands what the ALJs did in this case and in the cited case. In the present case, the ALJ was explaining that his review of whether Petitioner's actions constituted an abuse of billing privileges is constrained by the regulatory definition. In other words, where the regulation has clearly delineated the exact scenario of Petitioner's case as confirmed by the undisputed material facts, the ALJ does not have discretion to ignore or reject the regulatory language defining it as an abuse of billing privileges. *See Meadowmere Emergency Physicians, PLLC*, DAB No. 2881, at 8-9 (2018) (explaining that ALJs and the Board may not substitute their discretion for that of CMS in determining whether revocation is appropriate under all the circumstances, but may only decide the issue of whether CMS has shown a legal basis for the revocation).

Grenchik was not a revocation case. Rather, it was a denial-of-enrollment case, in which the issue was whether the appellant qualified to be "grandfathered" as a nurse practitioner under a regulation not requiring the master's degree for those with Medicare billing privileges prior to 2001. DAB CR5157, at 1, 9-10. The ALJ there concluded that the preponderance of the evidence (both testimonial and documentary) supported a conclusion that the appellant had been enrolled in Medicare as a nurse practitioner since before 2001. *Grenchik* at 11. In short, *Grenchik* entailed entirely different issues of fact and law from that of Petitioner. Nothing in that case supports the idea that an ALJ has discretion to disregard a binding regulation or may redefine the terms of a regulation. In any event, ALJ decisions are not precedential and "are useful only to the extent their reasoning is on point and persuasive." *Shimko* at 5.

Where a party proffers no evidence of any disputed fact that, if proven, would affect the outcome of the case under governing law, an ALJ does not abuse discretion by resolving the matter without a hearing. *See, e.g.,* S*enior Rehab.* at 5-7. Therefore, the ALJ did not err in deciding this case on summary judgment for CMS.

4. *The ALJ did not abuse his discretion in declining to review the length of the re-enrollment bar imposed on Petitioner.*

The ALJ correctly concluded that, since the length of a re-enrollment bar "is not an initial determination that gives rise to hearing rights," it was not in his authority to change the length of Petitioner's three-year enrollment bar. ALJ Decision at 4. The Board has repeatedly made clear that its review, and that of the ALJ, is limited to reviewing the reconsideration of the revocation to determine if CMS had authority to revoke under the applicable law and regulations based on the facts of record. *See, e.g., Angela R. Styles, MD*, DAB No. 2882, at 10-11, 11 n.2 (2018).

Petitioner is correct, of course, in stating that an ALJ's authority to reverse a revocation logically includes the potential to remove the related re-enrollment bar. RR at 2. It does not follow from this effect that an ALJ who upholds a revocation as authorized by law may also review the length of the re-enrollment bar. The only CMS actions subject to

appeal are the types of initial determinations specified in section 498.3(b). *Vijendra Dave, M.D.*, DAB No. 2672, at 9-11 (2016) (duration of a re-enrollment bar is not a specified "initial determination"). The Board has held that "[a]lthough the re-enrollment bar is a direct and legally mandated consequence of an appealable revocation determination, nothing in Part 498 authorizes the Board to review the length of the bar despite that relationship between a revocation and a reenrollment bar." *Id.* at 10; *see also* 73 Fed. Reg. at 36,454 (CMS stating ". . . while we believe that providers and suppliers can appeal the revocation determination, we do not believe that providers and suppliers can appeal the duration of the re-enrollment bar for Medicare billing privilege"). Thus, where a revocation is upheld—as in Petitioner's case—the ALJ and the Board do not have the authority to change the length of the re-enrollment bar set by CMS.

Since the ALJ concluded that CMS had a valid basis for revoking Petitioner's billing privileges, the ALJ did not err or abuse his discretion in ruling that he did not have the authority to change the length of Petitioner's three-year re-enrollment bar.

Conclusion

For the reasons stated above, we affirm the ALJ Decision.

/s/
Christopher S. Randolph

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member