Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Patrick Brueggeman, D.P.M.
Docket No. A-16-32
Decision No. 2725
July 26, 2016

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Patrick Brueggeman, D.P.M. (Petitioner) appeals the decision of an Administrative Law Judge (ALJ) granting summary judgment and affirming the determination of the Centers for Medicare & Medicaid Services (CMS) revoking Petitioner's Medicare enrollment and billing privileges for a period of three years. *Patrick Brueggeman, D.P.M.*, DAB CR4422 (2015) (ALJ Decision). The revocation arose from a determination by a Medicare contractor (upheld on reconsideration) that Petitioner claimed Medicare payments for podiatry services that could not have been provided to specific individuals on the claimed dates of service because they were deceased.

As explained below, we find no error in the ALJ Decision and consequently uphold the revocation.

Applicable legal authorities

The Social Security Act provides for CMS to regulate the enrollment of providers and suppliers in the Medicare program. Social Security 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. Among the applicable provisions, section 424.535(a) provides reasons for which enrollment may be revoked, including the following:

> (8) *Abuse of billing privileges.* 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.[1]

The preamble to the final rule provides the following guidance regarding its intended uses:

> 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. . . . We believe that it is both appropriate and necessary that we have the ability to revoke billing privileges when services could not have been furnished by a provider or supplier. We recognize the impact that this revocation has, and a revocation will not be issued unless sufficient evidence demonstrates abusive billing patterns. Accordingly, we 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. . . . In conclusion, we 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. 36,448, 36,455 (June 27, 2008).

The regulations provide that the effect of revocation is to terminate any provider agreement and to bar the provider or supplier "from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar." 42 C.F.R. § 424.535(b), (c). The re-enrollment bar lasts for at least one year but no more than three years. *Id.* at § 424.535(c).

A provider or supplier whose Medicare enrollment has been revoked may request reconsideration by CMS or its contractor, and then appeal the reconsideration decision, to an ALJ and then to the Board, in accordance with the procedures at 42 C.F.R. Part 498. 42 C.F.R. §§ 424.545(a), 498.3(b)(17), 498.5(l)(1)-(3), 498.22(a).

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[1] As the ALJ noted, this subsection was substantially revised effective February 3, 2015 (79 Fed. Reg. 72,500, 72,532 (Dec. 5, 2014) (ALJ Decision at 1 n.1), but we too apply the regulation as in effect at the time of the revocation.

Factual and procedural background[2]

Petitioner, a Florida podiatrist, participated as a supplier in the Medicare program. By letter dated November 7, 2014, First Coast Service Options, Inc. (First Coast), a CMS Medicare contractor, notified Petitioner that his enrollment was revoked because a "data analysis" of his Medicare claims "for dates of service between January 1, 2012 and August 31, 2014" showed that Petitioner billed for services provided to 16 different beneficiaries who were deceased at the alleged time of service. CMS Exhibit (Ex.) 3, at 1. The revocation notice included a spreadsheet showing 33 claims for services provided to 16 beneficiaries after their dates of death. *Id*. at 3. First Coast imposed a three-year re-enrollment bar. *Id*. at 2.

Petitioner sought reconsideration of the revocation determination, and also submitted a corrective action plan (CAP) to First Coast. CMS Exs. 5, 6. Petitioner stated that he "provides services to many patients who have the same or very similar names, which on occasion causes unintended data entry errors resulting in errant but good faith billing issues." CMS Exs. 5, at 3; 6, at 3.

The reconsideration decision issued on March 26, 2015 upheld the revocation. CMS Ex. 7. In its reconsideration decision, First Coast noted Petitioner's arguments that he "did 'not knowingly or intentionally bill for services provided to deceased beneficiaries . . . did not receive any reimbursement for these services'" and had "'taken concrete steps to ensure that appropriate safeguards are in place to ensure that such errors do not occur.'" *Id*. at 1-2. First Coast also noted, however, that the revocation was based on data of denied claims dating back to January 1, 2012, which had provided Petitioner "information sufficient for [Petitioner] to realize his error(s) and put into place changes that would prevent future noncompliance." *Id*. at 2. First Coast viewed "the abundance of the errors in billing from January 2012 through August 2014, after being aware of this problem when the claims were originally denied" as "abuse of billing, and not a clerical error or oversight." *Id.* First Coast also rejected the proposed CAP.

The ALJ proceedings and ALJ Decision

Petitioner requested an ALJ hearing. CMS filed nine proposed exhibits and Petitioner filed 30 proposed exhibits to which CMS did not object. Petitioner objected to portions of CMS's Exhibit 9, which included beneficiary and claim information, on the grounds of relevance. The ALJ found that portions of the exhibit to which Petitioner did not object were relevant to the case and agreed that other portions consisting of "coded material,

[2] Factual information in this section is drawn from the ALJ Decision and undisputed facts in the record before the ALJ and is not intended to add to or modify the ALJ's findings.

which appears to be general claims-related information" were not relevant. ALJ Decision at 4. The ALJ overruled Petitioner's objection and admitted the exhibit but stated that he did not consider those parts of the exhibit that were not relevant and to which Petitioner objected. *Id*.

CMS moved for summary judgment and Petitioner opposed CMS's motion. *Id*. at 3. Before the ALJ, Petitioner did not dispute submitting 31 claims for services to deceased beneficiaries during the period January 2012 through August 2014.[3] Petitioner's Opposition to CMS Motion for Summary Judgment & Pre-Hearing Brief (P. Br.) at 9. Petitioner argued that those claims "represent a tiny fraction (***.0024%***)" of his Medicare billing during that time and "were submitted in good-faith as a result of an inadvertent clerical billing error" related to the "vast majority" of the deceased beneficiaries having "the same or highly similar name[s]" as living beneficiaries he treated. *Id*. at 2-3, 5, 12 (Petitioner's emphasis). Petitioner argued that section 424.535(a)(8), titled "abuse of billing privileges," did not cover his conduct because CMS stated in the preamble that this section "is not intended to be used for isolated occurrences or accidental billing errors" and is "directed at providers and suppliers who are engaging in a pattern of improper billing," whereas his "submission of 31 claims, which were the result of inadvertent clerical billing errors, out of 13,595 over the course of two years and eight months, was clearly accidental and cannot fairly be considered a pattern of improper billing" and was "not indicative of abusive billing practices." *Id*. at 6-7, 15, citing 73 Fed. Reg. 36,455.

The ALJ granted summary judgment in favor of CMS. ALJ Decision at 5-12. The ALJ stated that for the purposes of summary judgment he drew "all inferences in favor of Petitioner." *Id*. at 6. The ALJ concluded that no material facts were in dispute and CMS had, as a matter of law, sufficient grounds to revoke Petitioner's Medicare enrollment. *Id*. at 6-11. The ALJ found that "Petitioner does not dispute that he submitted claims that identified individuals who were deceased at the alleged time of service" and did not dispute that he "submitted the claims in question or that they identified individuals who were actually deceased at the time of service." *Id*. at 5, 6. The ALJ further found that "[t]he undisputed facts show that Petitioner submitted Medicare claims for services that could not have been furnished to specific individuals on the dates of services" and that it was undisputed that "the claims [Petitioner] submitted to Medicare actually identified *deceased* Medicare beneficiaries" which, the ALJ concluded, "is a trigger for CMS's revocation authority under section 424.535(a)(8)." *Id*. at 6, 7.

[3] Petitioner's request for an ALJ hearing stated that the actual number of claims relating to deceased beneficiaries was 31, not the 33 shown in the revocation notice spreadsheet, which contained two duplicate claims. CMS agreed that "two of the claims on the spreadsheet provided with the revocation letter were duplicates of other claims" and submitted a corrected spreadsheet as its Exhibit 4. CMS Motion for Summary Judgment & Pre-hearing Br. at 4 n.1.

The ALJ reviewed the undisputed evidence and found it showed that "Petitioner submitted 31 claims for services that Petitioner performed after the beneficiary identified on the claim had died." *Id*. at 6. As examples, the ALJ discussed the evidence concerning two beneficiaries who were deceased at the time of the services Petitioner claimed and found it "undisputed that Petitioner submitted 12 claims as though he had performed those services" and that the evidence showed that Petitioner "ultimately identified [the other beneficiary] on the Medicare claim that he submitted." *Id*. at 7.

The ALJ "accept[ed] as true" for purposes of summary judgment "that Petitioner did not intend to defraud Medicare," submitted the improper claims as a "result of clerical errors" and "provided the claimed services to living beneficiaries[.]" *Id*. In discussing the two examples of beneficiaries who were deceased at the time of the services Petitioner claimed, the ALJ found that "Petitioner demonstrated that he previously provided services to an individual with the same name" but a different birth year and "HICN ending" as one of the beneficiaries, and to an individual "with nearly the reverse interchanged names" of the other beneficiary "but a different gender, with a different date of birth, and a [different] HICN ending . . . all of which distinguished the living beneficiary . . . ." *Id.*

The ALJ found these facts and Petitioner's assertions about lack of intent to defraud and the causes of the claims "not material to the outcome" of the appeal because, as he explained, the regulation "does not require that CMS demonstrate Petitioner intended to defraud Medicare before it may revoke Petitioner's billing privileges" but "merely requires the existence of improper claims." *Id*. at 6, 8, citing *Louis J. Gaefke, D.P.M.*, DAB No. 2554, at 7 (2013). The ALJ cited CMS's preamble language (quoted above) that "a 'pattern of improper billing' occurs when there are three or more instances of improper billing, which," he concluded, "is undisputedly the case with Petitioner." *Id*. at 8, citing 73 Fed. Reg. at 36,455. The ALJ also concluded that the low error rate Petitioner said the improper claims represented (which the ALJ accepted as true for purposes of summary judgment) did not render the revocation authority inapplicable because nothing in the preamble suggested that CMS must show a particular error rate to revoke. *Id*. citing *Howard B. Reife, D.P.M.*, DAB No. 2527, at 7 (2013).

The ALJ also "reject[ed] 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." *Id*. at 10. He concluded that the regulation, which authorizes revocation for claiming services that could not have been furnished to "a specific individual," applies when a supplier bills for services that could not have been provided to the identified beneficiary (even if they may have been provided to some beneficiary). *Id*. at 9-10, citing *Gaefke D.P.M*, DAB CR2785, at 9 (2013), *aff'd* DAB No. 2554; and *Realhab, Inc.*, DAB No. 2542, at 16 (2013).

Based on these findings and conclusions, the ALJ concluded that CMS was authorized to revoke Petitioner's enrollment.[4] This appeal ensued.[5]

Standard of review

The ALJ's grant of summary judgment is a legal issue that we address de novo. *Lebanon Nursing & Rehab. Ctr.*, DAB No. 1918, at 4 (2004); *see Guidelines — Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program*, http://www.hhs.gov/dab/divisions/appellate/guidelines/prosupenrolmen.html (Guidelines) (standard of review on disputed conclusion of law is whether ALJ decision is erroneous). Summary judgment is appropriate if there are no genuine disputes of fact material to the result. In reviewing whether there is a genuine dispute of material fact, we view proffered evidence in the light most favorable to the non-moving party. *Grace Living Ctr. – Northwest OKC*, DAB No. 2633, at 6 (2015), citing *Elant at Fishkill*, DAB No. 2468, at 5-6 (2012) (citations omitted).

Petitioner's arguments

Petitioner does not allege any disputes of material fact or argue that summary judgment was inappropriate. Instead, Petitioner reiterates his arguments to the ALJ, who he says "erred as a matter of law in his interpretation of 42 C.F.R. § 424.535(a)(8)" by rejecting those arguments and concluding that the regulation covered Petitioner's conduct. P. Request for Review (RR) at 2-3, 7.

[4] The ALJ also rejected Petitioner's argument that his case did not meet factors to be considered in determining to revoke that are found in the amendments to section 424.535(a)(8) that became effective after CMS took the revocation here. *Id*. at 10-11. The ALJ noted that those amendments, which added a new subsection (a)(8(ii) authorizing revocation for "a pattern or practice of submitting claims that fail to meet Medicare requirements" and containing the factors Petitioner cited, did not alter the regulatory provision under which CMS revoked Petitioner's billing privileges. *Id*. That provision is now in subsection (a)(8)(i) and "is unchanged from the regulatory language that was in effect at the time CMS revoked Petitioner's enrollment." *Id*. Petitioner did not challenge this conclusion by the ALJ or repeat his argument regarding the criteria in new subsection (a)(8)(ii). The Board in another case pointed out that "[t]he amendments are immaterial because they took effect in 2015 after Petitioner's revocation" and because they "do not change the regulatory language that is the basis for the revocation in this case." *Mohammad Nawaz, M.D., & Mohammad Zaim, M.D., PA*, DAB No. 2687, at 7 (2016).

[5] Petitioner in his appeal made a general request "to present oral argument" to the Board. RR at 1, 12. The Board in acknowledging the appeal told Petitioner to "state the purpose of the oral argument" by "[n]o later than the time" for submitting his reply to CMS's response to the appeal. Acknowledgment letter at 2. Petitioner filed his reply brief on February 9, 2016 but did not, either in that brief or in any submission prior to that date, offer an explanation of the purpose or scope of the requested oral argument. The Board thus by letter dated February 25, 2016 denied the request for oral argument.

Petitioner, as below, argues that the 31 claims he filed for services to 16 deceased beneficiaries "were accidental" and resulted from "isolated mistakes and inadvertent clerical errors" and that he "did not intend to defraud Medicare." RR at 2-3. He attributes the filing of the improper claims to difficulties in using billing software (he "is not technologically savvy") and distractions caused by his wife's illness during 2012 and 2013, and calls the failure to grant relief based on those circumstances the application of a strict liability standard. *Id*. at 4 n. 1, 9.

Petitioner also argues that "the conduct occurred over a lengthy period of time and represents a very small fraction of Appellant's total claims for that time period." RR at 7. He again states that these "inadvertent" and "accidental" claims represented a "tiny faction" of the total number of beneficiaries Petitioner treated and claims he submitted, with the 16 beneficiaries "representing .0024% of the claims" billed and "31 claims out of 13,595" over "a lengthy period of time" of approximately two years and eight months. RR at 1, 2, 5-7. He argues that he thus "did not engage in a pattern of abusive claims as defined in 42 C.F.R. § 424.535(a)(8)" or under the preamble language stating that revocation "is to be used to punish providers and suppliers 'who are engaging in a pattern of improper billing[]'" and "is ***not*** intended to be used for isolated occurrences or accidental billing errors.'" RR at 6, citing 73 Fed. Reg. 36,455 (Petitioner's emphasis). He argues that the revocation "does not follow with the purpose and intent of the regulation, namely to protect the Medicare trust fund from bad actors." RR at 5.

Petitioner argues that the ALJ erred by discounting the preamble statement that section 424.535(a)(8) "'is ***not*** intended to be used for isolated occurrences or accidental billing errors'" in favor of the preamble language that a "'pattern of improper billing' occurs after three or more improper claims," because the ALJ failed to consider that Petitioner's conduct "occurred over a lengthy period of time . . . ." RR at 4, citing 73 Fed. Reg. 36,455 (Petitioner's emphasis); 7, quoting ALJ Decision at 9. He argues that the ALJ thus erred by "fail[ing] to recognize that isolated mistakes and inadvertent clerical errors do occur, which must be considered when such drastic consequences are possible," for failing "to properly apply [section 424.535(a)(8)] given the fact that the inadvertent billing errors were so few in light of the considerable time at issue" and for having "imposed" a "standard [that] is unreachable given today's practice environment, including the use of electronic medical records and billing software, which are inherently prone to occasional good-faith errors." RR at 3, 7. He also argues that he has been unreasonably punished and denied due process.

Analysis

1. Petitioner's argument that his filing of claims for services to deceased persons was accidental or inadvertent does not show any error in the ALJ Decision.

    a. The ALJ did not err in concluding that Petitioner's intent in filing improper claims was irrelevant under the regulation.

The ALJ accepted for purposes of summary judgment "that Petitioner did not intend to defraud Medicare and that the improper claims submitted were the result of clerical errors" but found this "not material" to the case. ALJ Decision at 6. The ALJ found Petitioner's intent not material because, as the ALJ reasoned, "[t]he plain language of the regulation contains no requirement that CMS establish that the supplier acted with fraudulent or dishonest intent." *Id*. at 8, quoting *Gaefke* at 7.

The ALJ's reasoning is consistent with similar cases where the Board "has already rejected . . . the idea that a supplier's intent in submitting improper claims of the kind described in section 424.535(a)(8) is relevant in a revocation case based on that subsection." *John M. Shimko, D.P.M.*, DAB No. 2689, at 5-6 (2016), citing *Reife* and *Gaefke*. *Gaefke*, which the ALJ quoted, involved a podiatrist whose enrollment was revoked under section 424.535(a)(8) for submitting multiple claims for services to beneficiaries who were either deceased or had only one foot (and for whom Petitioner claimed services performed on more than five toes). The petitioner there argued principally that the claims resulted from clerical errors by his billing agent and that petitioner had provided services to living patients with the same or similar names as the deceased beneficiaries. *Gaefke* at 3. The Board concluded that the regulation's plain language does not require CMS to establish fraudulent or dishonest intent to revoke a supplier's billing privileges and that "[t]he regulatory language also does not provide any exception for inadvertent or accidental billing errors." *Id*. at 7. Thus, as in *Gaefke*, Petitioner's submission "of multiple claims for services that could not have been provided as claimed falls squarely within the conduct the regulation prohibits." *Id*. at 8.

In *Reife*, which also involved a podiatrist who submitted multiple claims for treatment of deceased beneficiaries (and to both feet of amputees), which he attributed largely to accidental billing errors by his billing service, the Board quoted with approval the ALJ's observation (which the ALJ also made here) that "the 'operative language' of the regulation 'does not require that CMS demonstrate that Petitioner intended to defraud Medicare before it may revoke Petitioner's billing privileges.'" *Reife* at 5; *see also* ALJ Decision at 8. As the Board concluded in *Reife*, the regulation "simply authorizes revocation where the supplier submits 'a claim or claims for services that could not have

been furnished to a specific individual on the date of service,' including, as is particularly applicable here, 'where the beneficiary is deceased.'" *Reife* at 5. This is clear from the language of the regulation, which includes no requirement to show the intent to defraud Medicare.

Petitioner fails to address these binding precedents directly, even though they were cited by the ALJ. Thus, Petitioner's position, which the ALJ accepted for purposes of summary judgment, that filing of 31 claims for services to 16 beneficiaries who were deceased at the time of service was inadvertent and did not result from any intent to defraud Medicare is irrelevant under the regulation and provides no basis to reverse the ALJ Decision.

b. The ALJ did not err in concluding that Petitioner's intent in filing improper claims was also irrelevant under the preamble language on which he relies.

Petitioner relies on preamble language quoted earlier, stating that the revocation authority at section 424.535(a)(8) is directed at "providers and suppliers 'who are engaging in a pattern of improper billing' [and] 'is ***not*** intended to be used for isolated occurrences or accidental billing errors.'" RR at 6, citing 73 Fed. Reg. at 36,455 (Petitioner's emphasis). Petitioner argues that this language shows "an intent to carve-out an exception for those providers who inadvertently and accidentally but in good faith submitted isolated numbers of improper claims, but who otherwise did not have questionable motives or billing practices." RR at 5.

Petitioner also argues that dictionary definitions of "pattern" and "abuse" show that he did not engage in a "pattern of improper billing" or "'abusive' billing practices." RR at 3, 7. He cites a definition of "pattern" as "the regular and repeated way in which something happens or is done" or "something that happens in a regular and repeated way" and argues that his "inadvertent submission of 31 claims out of 13,595" was not a "pattern" of improper billing as used in the preamble because it was "clearly not the result of a regular and repeated way or action." RR at 7, citing "Merriam-Webster." Petitioner also cites a medical dictionary definition of "abuse" as "[m]isuse or wrongful use, especially excessive use, of anything" and "[i]njurious, harmful, or offensive treatment, as in child abuse, or sexual abuse." RR at 3, citing Stedman's Medical Dictionary. He argues that he did not engage in "abuse of billing privileges" as used in the title of the regulation or in "'abusive' billing practices," the term used in the preamble, because he "did not misuse, wrongfully use, or excessively use anything; he did not injure anyone or anything; he did not cause any harm to anyone or anything; and he did not engage in any offensive treatment" and provided the claimed services, albeit to different individuals than the deceased beneficiaries identified on the claims. *Id*.

These arguments demonstrate no error in the ALJ Decision. First, the definitions of "pattern" and "abuse" Petitioner advances are preempted by CMS's explanation of those terms in the preamble. There, CMS stated an intent to overlook "isolated occurrences or accidental billing errors" in favor of cases that presented "a pattern of improper billing," notwithstanding that the regulation covers submission of "***a claim***" or claims for services that could not have been furnished to a specific individual on the date of service. 73 Fed. Reg. at 36,455; 42 C.F.R. § 424.535(a)(8) (emphasis added). CMS however limited that intent by making clear that a "pattern of improper billing" triggering revocation is shown by submission of three or more improper claims for services that could not have been delivered as claimed. *See* ALJ Decision at 8, citing 73 Fed. Reg. at 36,455 ("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."). These clear statements by CMS control over the definitions Petitioner advances. As in *Gaefke*, "the subject claims here, by their sheer number, fall within the preamble language, in which the Secretary stated a policy of not initiating revocation based on accidental claims but also warned that the submission of three or more improper claims would not be considered accidental." DAB No. 2554, at 8.

In addition, the Board has previously rejected reliance on a dictionary definition of "abuse" as showing that the title of section 424.535(a)(8) (abuse of billing privileges) imposes an intent requirement. The petitioner in *Gaefke* cited "a definition of 'abuse' [as] 'a corrupt practice or custom'" and argued that the accidental submission of 35 claims for services to 16 beneficiaries was not "abuse" of billing privileges authorizing revocation. *Gaefke* at 8. The Board there noted that "that another dictionary meaning of abuse is simply 'wrong or improper use; misuse: the abuse of privileges,'" meaning that the petitioner's claims for services that could not have been delivered as claimed "constituted an abuse of Petitioner's billing privileges covered by the regulation as well as by the preamble and the regulatory title when read in the context of the entire regulation." *Id*. at 8-9, citing Dictionary.com. As the Board observed in *Shimko*, the *Gaefke* decision "rejected the premise that the use of 'abuse' in the title of the subsection [424.535(a)(8), abuse of billing privileges] somehow requires a higher level of intent[.]" *Shimko* at 7, citing *Gaefke* at 8-9. We find no reason why this conclusion in *Gaefke* about the wording of the title of the regulation does not apply equally to the use of "abusive billing practices" in the preamble.

Similarly, as in *Gaefke*, applying the medical dictionary definition of abuse Petitioner advances (misuse or wrongful use; injurious, harmful, or offensive treatment) would not bar the revocation. Nothing in that definition turns on the intent of the actor, and CMS could very reasonably view the ongoing filing of multiple claims for services to deceased beneficiaries as "Misuse or wrongful use" of, or "injurious" or "harmful" to, the integrity of the Medicare Trust Fund that CMS is charged with protecting.

Thus, as the Board held in *Reife* and *Gaefke*, "[n]othing in either the preamble language or the regulation requires CMS to establish that the improper claims were not accidental" or "that a supplier's explanation for the improper claims (i.e., similarities among patient names or between the incorrect procedure code used in the claims and the correct code that would have yielded lower reimbursement) was the result of a carefully concocted story or scheme to cover improper behavior by a supplier acting to defraud Medicare." *Gaefke* at 9-10, quoting *Reife* at 6. As the Board noted in *Reife*, the "preamble language . . . does not state that CMS must establish, as a prerequisite to revocation, that a supplier who submits such claims intended to defraud Medicare." DAB No. 2527, at 5. As the Board stated in *Gaefke*, "the apparently negligent submission of [31] claims for services to 16 beneficiaries that could not have been delivered as claimed constituted an abuse of Petitioner's billing privileges covered by the regulation as well as by the preamble and the regulatory title when read in the context of the entire regulation." DAB No. 2554, at 9.

In sum, the plain language of the regulation put Petitioner on notice that the submission of a claim for services that could not have been provided to the specific individual identified in the claim on the date of services was an abuse of billing privileges supporting revocation, and the preamble notified him that even the accidental submission of at least three such claims would subject him to revocation.

2. Petitioner's arguments about the frequency of the improper claims and the duration of his conduct are not relevant and show no error in the ALJ Decision.

Petitioner argues revocation was not warranted because his claims for services to deceased persons represented only "a tiny fraction of [his] claims" or ".0024% of the total claims he billed" during the relevant timeframe. RR at 2; P. Reply at 1. Petitioner also argues that, absent "guidance [in the preamble] regarding the period of time over which these alleged abusive billings practices must occur in order for a pattern to be established," the ALJ erred by "impos[ing] – or more accurately, refus[ing] to impose" a standard regarding duration by failing to consider that "the conduct occurred over a lengthy period of time and represents a very small fraction of Appellant's total claims for that time period." RR at 7.

As we recognized in *Shimko* and *Reife*, however, "neither the regulation nor its preamble suggest any requirement for CMS to find 'a minimum claims error rate or dollar amount' before revoking billing privileges under section 424.535(a)(8)." *Shimko* at 10, quoting *Reife* at 7, *see also Gaefke* at 10 ("there is no requirement in the regulation (or the preamble) establishing a minimum claims error rate or dollar amount that must be exceeded before CMS may revoke billing privileges"). The ALJ cited *Reife* in concluding that "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." ALJ Decision at 8, citing *Reife* at 7. Petitioner has shown no error in that conclusion by the ALJ. Additionally, as the Board noted in *Shimko*, the claimed error rate in that case (0.02% based on "17 transactions at issue" out of "80,000 transactions over the relevant period") was "based on the unsupported assumption that all of Petitioner's other claims were free from error" even though the petitioner "has not shown that all of his claims were reviewed for all forms of error . . . ." *Shimko* at 9. Here, as in *Shimko*, "all we know is that, in at least 1[6] instances [Petitioner] submitted bills for services that could not have been provided as claimed." *Id*. at 9-10; *see also Gaefke* at 10 ("the record does not indicate that the review scrutinized all of the claims Petitioner submitted during that time period, or that [the CMS contractor's] identification of the improper claims constitutes a determination of the propriety of all of Petitioner's remaining claims"). Thus, Petitioner's arguments about the error rate his improper claims represented provide no basis for reversing the ALJ Decision.

Similarly, the absence from the preamble (or the regulation) of any direction to consider the length of the period during which conduct covered by the regulation occurred supports the ALJ's determination not to consider duration as a factor and does not constitute error as Petitioner argues. RR at 7. The ALJ concluded that "[d]espite 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 over that period." ALJ Decision at 8-9. Petitioner cites nothing in the regulation or in the preamble that would excuse the filing of three or more improper claims covered by the regulation based on the length of the period during which those claims were filed.

The ALJ's analysis, moreover, implicitly considered the time period over which Petitioner filed the 31 improper claims and indicated that it does not weigh in Petitioner's favor. The ALJ noted that 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." ALJ Decision at 9, citing CMS Ex. 7, at 2. Instead, as the ALJ observed, Petitioner "continued to make improper claims, which further demonstrates the 'pattern of improper billing' that supports revocation." *Id*. As the ALJ noted, quoting his reasoning in the *Reife* decision that the Board sustained, "[r]epeatedly making [the] same errors 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." *Id*.

Petitioner calls the reasoning from the reconsideration determination the ALJ adopted "utterly incorrect" because he says he "did timely identify several of the inadvertent clerical errors and did take measures to correct them (as well as prevent them from occurring again in the future)" and "[a]fter receiving the denials, [Petitioner] submitted corrected claims reflecting the living beneficiary for whom services were provided." RR at 8.

Petitioner's response misses the point. Filing corrected claims addressed only the submission of individual improper claims after they had been flagged by First Coast. It did not remedy whatever problems, inadvertent or not, led to Petitioner, over a period of more than two years, improperly claiming reimbursement for services to deceased persons in the first place, as is shown by the fact that Petitioner continued to submit such claims notwithstanding whatever corrective measures Petitioner says he took (but did not identify to the Board). Petitioner had ample opportunities during that time to identify and remedy, prior to the revocation action, the clerical or software problems Petitioner states caused the filing of the 31 claims for services to deceased beneficiaries. His failure to do so resulted in the repeated submission of claims for reimbursement for services to deceased individuals that constituted a pattern of improper claims and thus an abuse of billing privileges under the regulation and preamble. Petitioner has not explained why the length of the period during which he filed the 31 claims for services to deceased individuals (two years and eight months) should insulate him from revocation, when Petitioner failed during that time to correct whatever issues led to his repeated filing of claims for services to deceased beneficiaries.

3. Petitioner's other arguments provide no basis to reverse the revocation, and the Board is not authorized to provide equitable relief.

Petitioner argues that the circumstances he says resulted in his inadvertent filing of the improper claims show that revocation is not warranted and has an unduly harsh effect. Petitioner attributes the filing of the improper claims to "a combination of Petitioner's use of CMS-approved software for electronic health records and billing (that auto-populated certain patient information), and Petitioner's patient roster, which included several patients with the same or similar name as other patients," and to distractions caused by his wife's illness during 2012 and 2013. RR at 4 n.1; P. Reply at 2. Petitioner calls the revocation "an absolutist and strict liability approach [that] is fundamentally unfair and legally improper." RR at 4. He calls the three-year revocation "absurd in light of [his] flawless history with the Medicare program," a "death sentence to [his] practice and reputation, and a case of CMS "twisting the knife . . . ." P. Reply at 3-4. He argues that the ALJ denied his appeal "without any substantive analysis and without a hearing on the merits" and that he "has not been afforded meaningful due process and an opportunity to be heard, and he has instead been subjected to a rigidly legalistic process that has

utterly failed to take into consideration the totality of the circumstances surrounding the propriety of his revocation." *Id*. at 2. He also alleges that CMS has in at least one other case accepted that billing errors were inadvertent and chosen not to proceed with revocation. RR at 10-11.

We do not agree that Petitioner has been denied due process because we find that he has been afforded all of the hearing rights provided by the applicable regulations. Although asserting he was denied a hearing, Petitioner has not specifically argued that summary judgment was not appropriate or alleged the existence of any disputed material facts that would have rendered summary judgment improper or required an evidentiary hearing to resolve. Indeed, Petitioner has noted that the ALJ accepted, for purposes of summary judgment, that Petitioner provided the claimed services to living beneficiaries, that the claims at issue were filed as the result of inadvertent clerical errors and that Petitioner did not intend to defraud Medicare. RR at 2, 4, 7; *see* ALJ Decision at 6, 7 (ALJ "draw[s] all inferences in favor of Petitioner" and accept[s] as true that Petitioner did not intend to defraud Medicare and that the improper claims submitted were the result of clerical errors" and "provided the claimed services to living beneficiaries"). The Board has repeatedly acknowledged that summary judgment is appropriate when the record shows there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. *Grace Living Ctr. – Northwest OKC* at 6, citing *Elant at Fishkill*; *1866ICPayday.com, L.L.C.*, DAB No. 2289, at 2 (2009), citing *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986).

Even accepting Petitioner's assertion that CMS in at least one other case determined not to proceed with revocation because the billing errors were inadvertent or accidental does not provide a basis for reviewing CMS's exercise of its discretion in determining to impose revocation here.[6] As the Board has recognized, in *Gaefke*, "[n]othing in the regulations authorizes 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)." *Gaefke* at 11 n.10; *see also Mission Home Health, et al*., DAB No. 2310, at 8-9 (2011) (facility's "argument that its constitutional rights were violated . . . provides no basis to reverse a denial of enrollment that is fully supported by the applicable laws and regulations").

[6] Petitioner quotes three sentences from what he identifies as a recent CMS determination, but provides no citation or source of the quoted language and did not offer the CMS determination as an exhibit. RR at 10-11.

Petitioner also argues that "[t]he regulation **as written** and interpreted in this case significantly overreaches by failing to distinguish between billing errors that were intentional and billing errors that were accidental." RR at 2 (emphasis added). To the extent this statement attacks the validity of the regulation, the Board has no authority to consider it, as ALJs and the Board are bound by the regulations. *E.g. Fady Fayad, M.D.*, DAB No. 2266, at 14 (2009), *aff'd*, *Fayad v. Sebelius*, 803 F. Supp. 2d 699 (E.D. Mich. 2011).

While Petitioner complains about the effect on him of the three-year revocation, he does not argue that the ALJ erred in concluding that "[t]he duration of Petitioner's re-enrollment bar is not subject to review." ALJ Decision at 11. We note, in any event, that the Board has recently held "that CMS's determination of the length of the reenrollment bar [under section 424.535(c)] is not subject to review." *Mohammad Nawaz, M.D., & Mohammad Zaim, M.D., PA* at 15, citing *Vijendra Dave, M.D.*, DAB No. 2672, at 10-11 (2016). This holding is based on the fact that the duration of a revocation is not among the "initial determinations" identified in 42 C.F.R. Part 498 that are subject to ALJ and Board review. The Board "has emphasized that with respect to appeals under Part 498, ALJs and the Board may only review issues specifically identified as appealable administrative actions (i.e., 'initial determinations') in section 498.3" which "[o]n its face . . . does not describe any matter related to a post-revocation re-enrollment bar." *Id*.; *see also* 42 C.F.R. § 498.3(b)(17) (initial determinations include "[w]hether to deny or revoke a provider or supplier's Medicare enrollment in accordance with § 424.530 or § 424.535").

Finally, Petitioner's arguments about the severity of the revocation and the inadvertent nature of his conduct are essentially a request for equitable relief, which the ALJs and the Board are not empowered to grant. The Board has consistently held that neither it nor an ALJ has the authority to restore a supplier's billing privileges on equitable grounds. *Neb Grp. of Ariz. LLC*, DAB No. 2573, at 6 (2014), citing *Complete Home Care, Inc.*, DAB No. 2525, at 7 (2013), citing *Letantia Bussell, M.D.*, DAB No. 2196, at 12-13 (2008) (explaining that ALJs and the Board are authorized to review only whether CMS has a legal basis to revoke a provider or supplier's billing privileges).

Section 424.535 of the provider and supplier enrollment regulations (42 C.F.R. Part 424, subpart P) specifies the reasons for which CMS may legally revoke a provider or supplier's billing privileges. So long as CMS has shown that one of the regulatory bases for enrollment exists, the Board may not refuse to apply the regulation and must uphold the revocation. *E.g. Stanley Beekman, D.P.M.*, DAB No. 2650, at 10 (2015) (stating that an administrative law judge and the Board must sustain a revocation "[i]f the record establishes that the regulatory elements are satisfied"); *Letantia Bussell, M.D.* at 13 (stating that the only issue before an ALJ and the Board in enrollment cases is whether

CMS has established a "legal basis for its actions"); *see also id.* at 13 (explaining that "the right to review of CMS's determination by an ALJ serves to determine whether CMS had the authority to revoke [a petitioner's] Medicare billing privileges, not to substitute the ALJ's discretion about whether to revoke").

Conclusion

For the reasons set out above, the Board affirms the ALJ Decision upholding the revocation of Petitioner's Medicare enrollment and billing privileges for a period of three years.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Christopher S. Randolph
Presiding Board Member