Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

John M. Shimko, D.P.M.
Docket No. A-16-2
Decision No. 2689
April 25, 2016

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

John M. Shimko, D.P.M. (Petitioner) appeals the decision of an Administrative Law Judge (ALJ) affirming the determination of the Centers for Medicare & Medicaid Services (CMS) revoking Petitioner's Medicare enrollment and billing privileges. *John M. Shimko, D.P.M.*, DAB CR4105 (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.

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 enrollment of providers and suppliers. 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]

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

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) and (c). The re-enrollment bar lasts for at least one year but no more than three years. *Id.* at § 424.535(c).

Factual and procedural background[2]

Petitioner, a North Carolina podiatrist, participated as a supplier in the Medicare program. By letter dated September 4, 2014, Palmetto GBA (a CMS Medicare contractor) notified Petitioner that his enrollment was revoked because "data analysis" conducted on claims billed for dates of service between January 1, 2009 and September 13, 2013 "identified 19 claims . . . for services associated with 12 unique deceased beneficiaries, on 18 unique dates of service," including some with dates of death almost 9½ years prior to the date of service. CMS Ex. 1, at 1. The letter imposed a three-year re-enrollment bar. *Id*. at 2. Petitioner had previously been notified by AdvanceMed (a CMS zone program integrity contractor) that it performed the data analysis with the

[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.

results listed above and that its findings might lead to revocation for abuse of billing privileges. CMS Ex. 3. The AdvanceMed letter included a spreadsheet with the relevant beneficiaries' names, dates of birth, and dates of service, as well as the claim numbers. *Id.* at 3.

Petitioner sought reconsideration of the revocation determination, and also submitted a corrective action plan (CAP) to Palmetto. CMS Ex. 2; P. Exs. 6-7. Petitioner asserted that he had provided services to beneficiaries on the dates of service at issue and had merely erred by submitting claims with the wrong beneficiary name in each case. *Id*. The reconsideration decision issued on November 25, 2014 concluded that Petitioner had "provided no new evidence to disprove the errors resulting in over 19 claims for deceased beneficiaries to Medicare over a 3 year period . . . ." CMS Ex. 1, at 3. It also rejected the proposed CAP, which set out explanations for why the errors were not deliberate, on the ground that the provider remains responsible "to ensure compliance is maintained concerning patient care and signed documentation." *Id*.

Petitioner then requested ALJ review. The parties filed cross-motions for summary judgment. CMS dropped two claims as to one named beneficiary but contended that it was uncontested that Petitioner had submitted numerous claims for services to deceased beneficiaries. CMS Motion for Summary Judgment (MSJ) at 4 n.2. CMS argued that Petitioner's claim that he accidentally submitted claims for deceased beneficiaries because their names were similar to those of living beneficiaries to whom services were provided was insufficient as a matter of law as a defense to revocation under 42 C.F.R. § 424.535(a)(8). *Id*. at 6-7.

Petitioner disputed that CMS's evidence established a prima facie case of abuse of billing privileges. Petitioner's Prehearing Brief, Response to CMS's MSJ, and Cross-MSJ (P. MSJ) at 2-3, 8-14. Petitioner also alleged that CMS and its contractor had provided inadequate information at the reconsideration stage and had shifted its allegations at the ALJ level, and had otherwise denied him due process. P. MSJ at 3, 18-20. Further, Petitioner asserted he was entitled to summary judgment because, if anything, his low error rate showed a pattern of proper billing. *Id*. at 14-17. Petitioner expressly stated, however, that, if summary judgment were not granted in his favor, he sought an evidentiary hearing and sought to cross-examine the contractor employee whose testimony CMS proffered. *Id*. at 1 n.1; CMS Witness List at 1; P. Witness List at 2.

The ALJ granted summary judgment in favor of CMS. ALJ Decision at 1-2. The ALJ stated that he drew all inferences in Petitioner's favor and accepted as true (for purposes of summary judgment) that Petitioner did not intend to defraud Medicare and submitted the admittedly improper claims as a result of clerical errors. *Id.* at 6. Nevertheless, he 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 6-10. The ALJ

explained that the regulation did not require proof of intent to defraud. *Id*. at 8, citing *Louis J. Gaefke, D.P.M.*, DAB No. 2554, at 7 (2013). The ALJ further reasoned that, while the preamble language suggested that CMS would not revoke absent some pattern of improper billing of the kind addressed in the regulation, nothing in the preamble suggested that CMS must show a particular error rate. *Id*. at 8-9, citing *Howard B. Reife, D.P.M.*, DAB No. 2527, at 7 (2013) and 73 Fed. Reg. at 36,455. He found 17 instances of billing for services to deceased beneficiaries sufficient to demonstrate a pattern of improper billing. *Id*. at 9. Finally, the ALJ rejected Petitioner's argument that he could not be revoked because he did provide services on the relevant dates to living beneficiaries, albeit not those for whom he submitted the claims. *Id*. He concluded that the regulation authorizes revocation 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* and *Realhab, Inc.*, DAB No. 2542 (2013).

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

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) (internal citations omitted).

Analysis

1. *Preliminary matter*

In his request for review (RR), Petitioner made a general request for oral argument "for a full discussion of the issues . . . ." RR at 1. In acknowledging the request for review, the Board instructed that "Petitioner should, no later than the time for submission of the reply brief, state the purpose of the oral argument and the issues Petitioner intends to address in oral argument." Acknowledgment letter at 2.

Petitioner submitted his reply brief on December 11, 2015. Petitioner 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, as the Board had instructed. In the conclusion of his reply brief, Petitioner requests that the case be remanded to the ALJ for a hearing but does not reiterate any request for oral argument.

We therefore conclude that Petitioner abandoned the request for oral argument, and none has been scheduled. We proceed to decision on the record before us.

2. Petitioner has not demonstrated the existence of a material dispute of fact.

Petitioner argues that the ALJ erred in concluding that whether his improper billing resulted from intentional fraud or accidental errors was immaterial and hence did not involve a dispute of material fact. RR at 7-9, 12-13. In support of this argument, Petitioner relies on two 2014 ALJ decisions. RR at 6-8, citing *Jaimy H. Bensimon, M.D., P.A.*, DAB CR3236, at 10 (2014); *D & G Holdings, LLC d/b/a Doctors Lab*, DAB CR3120, at 18 (2014). ALJ decisions have no precedential weight and so are useful only to the extent their reasoning is on point and persuasive. In *Bensimon*, the physician's claims were questioned as impossible on the grounds that the total number of patients seen in a day exceeded the hours in the day if the physician spent the average time of a physician visit with each patient. DAB CR3236, at 6, 7-8. The physician submitted evidence that he spent (for various reasons) much less than the average time with each patient. *Id*. at 8-10. The ALJ concluded that this evidence credibly established that the billing was **not** improper and revocation was not authorized. *Id*. at 14. By contrast, Petitioner does not dispute that the claims he submitted were improper or proffer evidence that the identified beneficiaries were treated. Thus, the ALJ's analysis in *Bensimon* offers no support for the proposition that CMS had to prove intentional fraud. The thrust of the *D & G Holdings* opinion relates to the ALJ's assessment that CMS did not provide adequate notice of which claims were the basis of the revocation and reconsideration decisions. DAB CR3120, at 10-17. In addressing the merits, the ALJ in *D & G Holdings* stated that CMS must show in its prima facie case that more than one claim was submitted that could not have been provided as billed, but nowhere suggested that CMS must show intent or prove the errors were not inadvertent. *Id*. at 17-22. The ALJ then concluded that CMS had not provided sufficient evidence to show that the regulation was violated. *Id*. at 22. We thus find nothing in either cited ALJ decision to support Petitioner's position.

More importantly, as the ALJ in this case recognized, the Board has already rejected, in similar cases, 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. In *Reife*, a podiatrist had also 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. DAB No. 2527, at 2-5. The Board quoted

with approval the ALJ's statement 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.'" *Id*. at 5. The Board concluded that 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.'" *Id*. Furthermore, the Board noted that the "preamble language similarly does not state that CMS must establish, as a prerequisite to revocation, that a supplier who submits such claims intended to defraud Medicare." *Id*.

Gaefke also involved a podiatrist whose enrollment was revoked under section 424.535(a)(8) as a result of submitting multiple claims for services that could not have been provided as claimed because the identified beneficiaries were either dead or amputees (for whom debridement of six or more toes was claimed). DAB No. 2554, at 2-3. The supplier asserted that "the admittedly incorrect claims were only errors" mostly committed by its billing agent, with no evidence of fraud or abuse. *Id*. at 5. The Board reiterated that –

> The regulation, and the preamble when read in the context of the regulation, do not support Petitioner's argument that the revocation was unauthorized because his improper claims resulted from inadvertent errors. The plain language of the regulation contains no requirement that CMS establish that the supplier acted with fraudulent or dishonest intent. The regulatory language also does not provide any exception for inadvertent or accidental billing errors.

Id. at 7.

Petitioner fails to address these binding precedents directly, even though they were cited by the ALJ. Instead, Petitioner misreads the *Gaefke* decision to suggest that the Board there held that a pattern of improper billing may be found "[o]nly where a Petitioner's evidence and testimony does 'not establish how the errors occurred, nor demonstrate that the errors did not result from multiple instances of negligence or reckless disregard.'" RR at 13, quoting in part from *Gaefke* at 9. The Board made no such holding in *Gaefke*. Instead, the Board observed that the Petitioner there had **not even** provided credible evidence about the way in which many of the errors occurred. The Board further noted, as it did in *Reife*, that repeatedly making similar errors makes it less plausible to call them merely accidental and "'establishes a pattern of improper billing that suggests a lack of attention to detail, considering that [the billing agent] could have differentiated the patients through their birthdates or Medicare numbers.'" DAB No. 2554, at 9, quoting *Reife* at 6. Nothing in the Board's discussion in *Gaefke* suggests that a pattern of billing abuse may **only** be found when evidence of how the errors occurred is lacking or that proof of reckless disregard is a prerequisite for CMS to act under section 424.535(a)(8).

In any case, we also agree with the ALJ that Petitioner's explanations about the causes of his erroneous billing in themselves present "troubling" questions given the expectation that Petitioner should know who he is treating. ALJ Decision at 10. Petitioner points to his primary practice in nursing homes where, he states, confusion arises from "frequent room or location changes of patients, and often the [impaired] mental health and communication abilities of the population." RR at 3. Surely, repeatedly mistaking the identity of the individual being treated and failing to confirm identifiers (such as full name, Medicare number or date of birth) does raise questions of lack of attention and a pattern of unreliable or abusive billing.

As the Board has previously explained, moreover, abuse of billing privileges does **not** necessarily imply fraud but rather encompasses other forms of misuse of the privilege of submitting Medicare claims. Thus, the Board has rejected the premise that the use of "abuse" in the title of the subsection somehow requires a higher level of intent:

> While Petitioner argues that a definition of "abuse" contained in the Merriam-Webster Dictionary is "a corrupt practice or custom," RR at 15, we note that another dictionary meaning of abuse is simply "wrong or improper use; misuse: the abuse of privileges." (Dictionary.com). Thus, the apparently negligent submission of 35 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 8-9.

Petitioner suggests that reading the regulatory preamble (as it says CMS has here) to mean that any three errors, however widely spaced and however unintentional ("a 'three strikes and you're out' policy"), to demonstrate a pattern of abusive billing is overbroad. RR at 13. CMS's position on section 424.535(a)(8) is not as broad as Petitioner portrays it, however. The improper claims to which that subsection applies are not **all** erroneous claims but 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. Many other errors may occur in billing that do not meet the terms of this provision, but CMS could reasonably choose, as it has in this regulation, to take action where a supplier presents such egregiously inaccurate information on multiple occasions about such core information as who treated whom and when.

3. Petitioner has not shown that CMS lacked sufficient evidence even to establish a prima facie case.

Petitioner offers two reasons that CMS did not establish even a prima facie case that revocation was authorized under section 424.535(a)(8), which Petitioner viewed as a prerequisite to concluding that CMS was entitled to judgment as a matter of law in the absence of a dispute of material fact. RR at 9.[3] First, he argues that CMS's evidence that the beneficiaries were deceased is not "admissible," or at least, not "conclusive." *Id*. Second, he argues that CMS failed to prove "impossibility of service" which he calls a "critical element" of the regulatory standard. *Id*. Neither reason has merit.

As to the first reason, the ALJ expressly rejected this attempt "to create a dispute of fact by disputing CMS's evidence that the beneficiaries identified in the 17 claims were in fact deceased at the time of service, although Petitioner offers no evidence demonstrating the contrary to be true." ALJ Decision at 7. As the ALJ noted, CMS did not merely present a list of beneficiaries and dates of death but "instead provided unrefuted evidence from a CMS database [compiled from records of the Social Security Administration] showing the dates of death for the 11 Medicare beneficiaries identified in the 17 claims at issue." *Id*. at 7-8. Indeed, Petitioner's entire defense rests not on any dispute that the beneficiaries were deceased at the dates of service, but rather on the claim that other beneficiaries (with similar names) were served on those dates and the claims erroneously substituted the dead beneficiaries' names. For purposes of summary judgment, the ALJ accepted this claim as true, as do we. Petitioner does not explain why the CMS database entries were not admissible as business records and does not establish that they were somehow inconclusive in the absence of any conflicting evidence. We thus agree with the ALJ that Petitioner has not established any dispute of fact as to the named beneficiaries' deaths.

As to the second reason, Petitioner points to evidence that he treated patients with names similar to those for which he submitted claims and argues that CMS failed to show that it was impossible for the services to have been provided. RR at 9-12. Petitioner reasoned that, because CMS could not prove that the services were not furnished to a beneficiary in each instance, CMS failed to prove the "impossibility" element of its prima facie case. *Id*. at 12. The ALJ correctly explained that the regulation does not require that no service at all could have been provided but rather that "CMS show impossibility of service to a specific individual identified in the claim submitted . . . ." ALJ Decision at 7 n.4. The ALJ's explanation is consistent with Board precedent. In a case involving physical

[3] Petitioner frames this argument in terms of a failure by CMS to present a prima facie case, but also references whether CMS demonstrated that no material facts were disputed, as required to support summary judgment in its favor. RR at 8-13. The latter is the applicable question on appeal for summary judgment (and also this inquiry favors Petitioner) and is therefore the focus of our analysis.

therapists billing for more hours of one-on-one service to beneficiaries than could possibly have been provided during the hours available, the petitioners argued that interpreting the regulation to cover their situation would be "overbroad" and "would make all innocent coding errors a basis for revocation because, although a Medicare service was provided to a specific beneficiary on a specific day, the claimed Medicare service was not provided." *Realhab, Inc.*, DAB No. 2542, at 15 (2013) (record citation omitted). The Board concluded that, while it was difficult to know which of the multiple beneficiaries billed for the dates of service involved received fewer minutes of therapy than claimed, the regulatory language was broad enough to encompass the improper billing proven in the case. *Id*. at 15-17. The Board found it insufficient to prevent revocation to show that some service was provided although not the service claimed:

> CMS revoked Realhab's billing privileges because Realhab billed for multiple services that Realhab could not have possibly furnished as claimed. Limiting the term "abuse of billing" in the context of revocation to situations in which **no** services could possibly have been furnished, as Realhab suggests (RR at 2), would not adequately protect the integrity of the Medicare program. Claiming for higher paid services than could possibly have been furnished as claimed, as Realhab did, has a detrimental effect on program finances and integrity just as if no services at all had been furnished. Mere denial of individual claims simply would not be as effective a means for protecting Medicare funds.

Id. at 18 (emphasis in original). The Board reiterated this point in *Gaefke* citing with approval an ALJ's rejection of the position that revocation is not authorized "if the supplier in fact delivered the claimed services to a different individual" instead of to the specific individual for which the claim was filed. DAB No. 2554, at 8 n.7.

We conclude that, even accepting for these purposes that Petitioner provided services to beneficiaries other than the ones for whom he billed and that the submission of claims for services to beneficiaries who could not have been treated was not intentional, Petitioner has not shown that a genuine dispute exists as to any material fact required to authorize CMS's revocation determination in this matter.

In this regard, we also note that Petitioner's comments about his purportedly low error rate also fail to demonstrate a genuine dispute of material fact. He estimates that he submitted claims for 80,000 transactions over the relevant period and calculates that his error rate for the 17 transactions at issue would be only .02 per cent. RR at 3. First, this "error rate" claim is based on the unsupported assumption that all of Petitioner's other claims were free from error. But he has not shown that all of his claims were reviewed for all forms of error; all we know is that, in at least 17 instances, he submitted bills for

services that could not have been provided as claimed. Second, as the Board has previously explained, 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). DAB No. 2527, at 7.

4. Petitioner has not shown that he was denied due process.

Petitioner argues that he was denied due process because the contractor that issued the reconsideration decision delayed providing some of the underlying detailed information about the claims at issue until after the deadline for him to respond to the revocation determination. RR at 13. Further, he alleges that some details were different in the CMS MSJ than in an earlier CMS chart, such as newly included middle initials and two dates of service. RR at 14 (record citations omitted). According to Petitioner, these changes amount to CMS improperly raising new issues that were not included at the reconsideration stage. *Id*. He contends that the delays and changes in the information provided prejudiced him because he depends heavily on his Medicare billing privileges for his nursing home-based practice. *Id*.

The ALJ rejected both the factual and legal foundation of Petitioner's due process contentions. The ALJ pointed out that the program integrity contractor notified Petitioner eight months before the revocation determination of 19 improper claims for 12 separate beneficiaries. ALJ Decision at 11, citing CMS Ex. 3, at 3. Petitioner thus had ample time to investigate the underlying claims. The ALJ noted that, even were there delays in providing Petitioner with specific details, Petitioner had ample opportunity to respond during the proceeding before the ALJ. *Id*., citing *Gaefke* at 10-11. The situation in *Gaefke* involved outright refusals by the contractor to provide any factual information about the claims underlying the revocation determination until after the original date for requesting reconsideration had passed, and, while the supplier was permitted to seek reconsideration after receiving the information, the time to do so was very short. DAB No. 2554, at 3. The Board nevertheless concluded that the ALJ had effectively cured any potential due process violations because the ALJ there, as here, accepted the petitioner's factual assertions as true for purposes of summary judgment. *Id*. at 11.

It is true the submission of new documentary information by providers or suppliers at the ALJ level is limited in revocation cases. 42 C.F.R. § 498.56(e). This limitation may be overcome by a good cause showing. *Id*. Petitioner, however, like the petitioner in *Gaefke*, offers no claim that, after obtaining all the details relating to CMS's case, he possessed any additional documentation that he was unable to present at reconsideration. DAB No. 2554, at 11. Furthermore, in the present case, we would find sufficient evidence to support revocation based on abuse of billing privileges even without regard to the claims in which details were added by CMS at the ALJ level. We conclude that Petitioner had full notice and opportunity to present his case before the ALJ and was afforded appropriate due process.

We therefore agree with the ALJ that Petitioner showed no "actual prejudice in his ability to defend his case." ALJ Decision at 11. While we do not question that the loss of his Medicare enrollment has significant financial and professional implications for Petitioner's practice, those consequences result from his repeated submission of improper claims. They do not represent prejudice resulting from any denial of due process in his appeal.

5. *Petitioner is not entitled to raise a new argument that he could have presented to the ALJ but did not.*

Finally, Petitioner raises an argument that his revocation is not valid because CMS permitted its contractor to issue the revocation notice. RR at 4-5. This contention is based on Petitioner's interpretation of language in the preamble to the rule adopting section 424.535(a)(8) stating that "CMS, not a Medicare contractor, will make the determination for revocation" under this subsection. 73 Fed. Reg. at 36,455.

To begin with, Petitioner has proffered no reason that he could not have presented this argument to the ALJ, so we view the claim as untimely raised. *See* Guidelines ("The Board will not consider issues not raised in the request for review, nor issues which could have been presented to the ALJ but were not."). In any case, Petitioner's interpretation of the statement as meaning that "only CMS – not its contractors – would perform these revocations" is inconsistent with the surrounding context in the preamble discussion about how revocations actions would be performed:

> **We will direct contractors to use this basis of revocation** after identifying providers or suppliers that have these billing issues. . . .
>
> In making a revocation determination under § 424.535(a)(8), **we will make the revocation determination based upon information presented by a Medicare contractor**, a CMS Regional Office, or one of our Program Integrity field offices. . . .
>
> *Comment:* Several commenters believed that contractors would be issuing revocations based upon the submission of claims for services that could not be delivered.
>
> *Response:* As stated above, **we will instruct Medicare contractors to issue a revocation** under § 424.535(a)(8).

73 Fed. Reg. at 36,455 (emphases added). The discussion thus contemplates consultation by contractors with CMS and direction by CMS to contractors but clearly states that contractors will issue revocations using this basis.

Conclusion

For the reasons set out above, we affirm the ALJ Decision.

/s/
Constance B. Tobias

/s/
Susan S. Yim

/s/
Leslie A. Sussan
Presiding Board Member