**Department of Health and Human Services**

**DEPARTMENTAL APPEALS BOARD**

**Civil Remedies Division**

David W. Laudon, D.C.,
(PTAN: 350003311),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-10-857

Decision No. CR2310

Date: January 13, 2011

# DECISION

Petitioner, David W. Laudon, D.C., a chiropractor, challenges the Centers for Medicare and Medicaid Services' (CMS's) revocation of his Medicare enrollment and billing privileges, effective December 30, 2009. Petitioner and CMS have filed cross motions for summary judgment. I deny both motions. I proceed to decide the case based on the written record before me. I conclude that CMS had the authority to revoke Petitioner's enrollment and billing privileges in the Medicare program for failing to report an adverse legal action under 42 C.F.R. § 424.535(a)(9).

## I. Background

On December 30, 2009, the Minnesota Board of Chiropractic Examiners suspended Petitioner's license to provide chiropractic services in the State of Minnesota due to outstanding child support liability. P. Ex. 5. Petitioner asserts that he or someone on his behalf reported this action to Wisconsin Physicians Service (WPS), the Medicare contractor, on December 31, 2009. Hearing Request (HR). Petitioner submitted with his hearing request a copy of a letter signed by Petitioner, dated December 31, 2009 and

addressed to "insurance companies," with a "cc" to "Medicare." P. Ex. 2, at 1. The letter states that his license was suspended for "unknown duration," an action "[d]ue to American Family's inability to pay Auto Accident Bills."[1] *Id.*

By letter dated March 26, 2010, WPS, the Medicare contractor, notified Petitioner that his Medicare enrollment and billing privileges were revoked effective December 30, 2009, because he had failed to report the suspension of his chiropractic license as an adverse action as required. CMS Ex. 1, at 1.

By letter dated April 12, 2010, Petitioner requested contractor reconsideration. P. Ex. 3. The contractor issued an unfavorable reconsideration decision on July 12, 2010. P. Ex. 7. The contractor hearing officer found that Petitioner had failed to report his license suspension as an adverse action within 30 days as required by 42 C.F.R. § 424.535(a)(9). The hearing officer noted that, along with his reconsideration request, Petitioner included a copy of his "December 31, 2009, letter that was addressed to 'Insurance Companies' as notification of suspension; however, WPS Medicare Provider Enrollment never received the appropriate notification on a CMS-855 application."[2] P. Ex. 7, at 1.

By letter dated July 16, 2010, Petitioner timely requested an Administrative Law Judge (ALJ) hearing pursuant to the instructions in the reconsideration decision. HR. This case was assigned to me for hearing and decision pursuant to 42 C.F.R. § 498.44, which permits designation of a Member of the Departmental Appeals Board (Board) to hear appeals taken under Part 498.

On July 30, 2010, I issued an Acknowledgement and Pre-Hearing Order (PHO) and established a briefing schedule. On August 12, 2010, our office received Petitioner's undated exchange, including a very brief argument titled "Motion for Summary Jud[g]ement" (P. MSJ), proposed exhibits 1-7 (labeled in accordance with my PHO although with an incorrect docket number), and a proposed witness list. Petitioner did not submit written direct testimony of his proposed witnesses as required by my PHO.[3]

---

[1] The letter further states: "Due to the Action of Some insurance companies not to pay (2+ years delinquent) Medical bills Dr. Laudon responsibility to make Child Support payments were not met." P. Ex. 2, at 1.

[2] The CMS-855 application refers to the Office of Management and Budget approved Medicare enrollment application. The approved form for physicians and non-physician practitioners, such as Petitioner, is the CMS-855I. The same CMS-855 form is used for a number of purposes including for notifying the contractor of any changes.

[3] Petitioner mailed a second copy of his exchange which was received by this office on August 17, 2010.

CMS filed its exchange, including a motion for summary judgment and memorandum in support thereof (CMS Br.), proposed exhibits 1-3, and written direct testimony for its one proposed witness. CMS did not submit a formal response to Petitioner's motion for summary judgment but addressed Petitioner's arguments and evidence in its brief. CMS objected to an unexecuted "affidavit" dated December 31, 2009, signed by Amanda Greenwaldt, submitted as part of Petitioner's proposed exhibit 2. CMS Br. at 4. CMS argued that this document should be excluded as new documentary evidence because Petitioner failed to show good cause for his failure to submit it to the hearing officer as required for its admission by 42 C.F.R. § 498.56(e).

On September 2, 2010, Petitioner submitted another document titled "Summary Brief." In this filing, Petitioner argued that CMS did not respond to his August 12, 2010 motion for summary judgment and therefore his motion should be granted. Also with this filing, Petitioner submitted a proposed exhibit 8, and a summary description of an additional proposed witness. Petitioner did not submit sworn written direct testimony for any of his witnesses, contrary to the instructions in my PHO. Neither party requested to cross-examine any of the opposing party's proposed witnesses.

On September 9, 2010, CMS indicated it would not submit a response to Petitioner's September 2, 2010 submission. The staff attorney assigned to this case contacted Petitioner on September 9 and on September 15, 2010, inquiring as to whether Petitioner intended to file any further response to CMS's motion for summary judgment beyond Petitioner's September 2, 2010 submission. Petitioner failed to respond and I therefore issued an Order Closing the Record on September 28, 2010.

## II. Applicable legal authority

The regulations at 42 C.F.R. Part 424, subpart P, set out the requirements for enrollment and reporting of changes to enrollment information. "Providers and suppliers must meet and maintain these enrollment requirements to bill either the Medicare program or its beneficiaries for Medicare covered services or supplies." 42 C.F.R. § 424.500.

Section 424.535 lists the bases on which CMS may revoke a provider's or supplier's Medicare billing privileges and provider or supplier agreement. Subsection 424.535(a)(9) authorizes CMS to revoke billing privileges where a provider or supplier failed to comply with the reporting requirements including the requirement that "[p]hysicians [and] nonphysician practitioners . . . must report . . . to their Medicare contractor . . . [w]ithin 30 days . . . [a]ny adverse legal action." 42 C.F.R. § 424.516(d)(1)(ii). A "[f]inal adverse action" is defined to include "[s]uspension or revocation of a license to provide health care by any State licensing authority." 42 C.F.R. § 424.502.

Providers or suppliers who have had their billing privileges revoked "are barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar," which is "a minimum of 1 year, but not greater than 3 years depending on the severity of the basis for revocation." 42 C.F.R. § 424.535(c).

## III. Issue

The issue in this case is whether CMS properly revoked Petitioner's Medicare enrollment and billing privileges.

## IV. Analysis

My findings of fact and conclusions of law are set out in italics as headings with my supporting rationale in the discussions under each.

### *A. Neither party is entitled to summary judgment.*

Summary judgment is appropriate only when the record shows that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 3 (2010). In determining whether there are genuine issues of material fact for trial, I must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. Thus, my role in deciding a summary judgment motion is different from my role in resolving a case on the merits after the record is fully developed. In the summary judgment phase, I must not assess credibility or evaluate the weight of conflicting evidence. *Holy Cross Vill. at Notre Dame, Inc*, DAB No. 2291, at 5 (2009).

In the present case, both parties moved for summary judgment. I evaluate each motion separately. It is not disputed that, on December 30, 2009, the Minnesota Board of Chiropractic Examiners suspended Petitioner's license to provide chiropractic services in the State of Minnesota due to outstanding child support liability. P. Ex. 5. The regulation at 42 C.F.R. § 424.502 defines a license suspension, such as Petitioner's, as an adverse legal action, and therefore the regulation required Petitioner to report this adverse action within 30 days. 42 C.F.R. § 424.516(d)(1)(ii). Petitioner does not deny that he was required to report the suspension. Petitioner's central argument is that he did timely notify the Medicare contractor of his suspension on December 31, 2009, and that, although he did not submit the notice on the required form, he was never notified of a requirement to use a specific form. HR.

Petitioner's August 12, 2010 exchange accompanied a motion for summary judgment which set out as a statement of fact the following assertion:

> On December 31, 2009 Medicare did receive a letter notifying them of adverse sanctions brought on NPI 1922123868 and MN Chiropractic License Number 4587 of notice of Suspension by Becker County for Failure to make Child Support.

P. MSJ at i.[4] As evidence of this assertion, Petitioner submitted the letter described above, dated December 31, 2009, and showing a "cc" to Medicare. P. Ex. 2, at 1[5]. Along with the letter, Petitioner submitted an unsworn form document entitled "affidavit of service by mail" and signed by Amanda Greenwaldt. *Id*. at 2. Ms. Greenwaldt avers that she mailed a copy of the letter on December 31, 2009 to "Medicare of Minnesota" at "8120 Penn Ave. South, Suite 200, Bloomington MN 55431" from the "Detroit Lakes Federal Post[] Off[ice]." *Id*.

Petitioner's entire argument consists of the following two contentions:

> I. Medicare did indeed receive the December 31st, 2009 letter notifying them of adverse sanctions.
> II. Affidavit of Service signed and mailed by Amanda Greenwaldt, 12-31-2009.

---

[4] Petitioner's motion also set out a second statement of fact relating to his contention that testimony relating to the child support case showed that notice was not sent to the correct address and that, as a result, his suspension was done "falsely and with malice." P. MSJ at i. I find this statement irrelevant to any issue before me. Petitioner identifies no regulatory basis, and I find none, that would allow him to collaterally attack the basis for the qualifying adverse action. The adverse action, in this case the license suspension, in and of itself triggers the requirement to report. Since Petitioner does not deny that the suspension occurred, any defenses he might have had to the imposition of the suspension or to any underlying child support proceeding are not material to the sole issue before me of whether he properly and timely reported the suspension. For the same reason, I find irrelevant and do not discuss further the proposed testimony of three witnesses named in Petitioner's witness list regarding proceedings in state court, as to whom I have already noted that Petitioner failed to provide any written direct testimony in any case.

[5] Petitioner also attached to his initial exchange: his professional firm registration (P. Ex. 1); his reconsideration request to WPS (P. Ex. 3); a copy of his hearing request (P. Ex. 4); orders from the State Board of Chiropractic Examiners suspending and then reinstating his license to practice (P. Exs. 5 and 6); and the reconsideration decision (P. Ex. 7). CMS objects only to the "affidavit" included in Petitioner's Exhibit 2. I discuss this objection later in the decision and admit the remainder of Petitioner's Exhibit 2 and Petitioner's other exhibits without further discussion. Petitioner did not object to any of CMS's exhibits which are therefore also admitted.

P. MSJ at ii. I find that a genuine dispute of fact plainly exists as to Petitioner's claims because CMS denies that WPS ever received the December 31, 2009 letter and provides an affidavit from an employee of WPS that a search of Petitioner's records at WPS and survey of all relevant employees did not reveal any indication that such a letter was ever received. CMS Br. at 8; CMS Ex. 2. This alone requires me to deny Petitioner's motion for summary judgment. I discuss the "affidavit" submitted by Petitioner later in this decision.

CMS also moved for summary judgment. CMS asserted that no genuine issue of fact existed "concerning whether Petitioner mailed the December 31, 2009 letter to WPS," on the grounds that the evidence on that point submitted by Petitioner "is incomplete and unreliable to the point that it cannot be found to raise a material issue of fact." CMS Br. at 8. CMS argues that Petitioner's own statements should be disregarded as "self-interested;" that the letter itself lacked any detail; and that the "affidavit" was produced belatedly, was "murky" in content and lacked indicia of reliability. *Id.* at 8-10. Further, CMS points out that WPS "specifically denied" having any record of receiving the letter. *Id*. at 8.

CMS's arguments go to the weight to be accorded to Petitioner's evidence and the credibility to be given to Petitioner's statements as opposed to those of WPS staff. Such arguments are appropriately considered as part of evaluating the record. At the summary judgment stage, however, my job is not to weigh evidence or assess credibility, but rather to determine whether any reasonable trier of fact could find that Petitioner reported the adverse action, accepting Petitioner's evidence as true and drawing all reasonable inferences in Petitioner's favor. Under that standard, I must conclude that Petitioner has raised a genuine issue of fact as to whether he mailed a report of the adverse action against him to his Medicare contractor.

### *B. I find that Petitioner did not properly report his suspension as required by section 424.516(d) and conclude that CMS was authorized to revoke his enrollment in Medicare*.

#### *1. No further proceedings are required.*

Having concluded that summary judgment is not appropriate in this case, I do not find a need for any further proceedings. My initial order instructed the parties that they must exchange all proposed exhibits, written direct testimony for any proposed witnesses, and briefs addressing all issues of law and fact at the same time as their motions for summary judgment (if any). PHO at 2 (July 30, 2010). Petitioner was instructed that he must affirmatively request in his brief to cross-examine any CMS witness or I would assume that he did not desire to conduct cross-examination. *Id.* at 3. Petitioner did not request to cross-examine CMS's one witness. Neither party's brief or motion for summary

judgment suggested that any further record development would be sought if summary judgment was denied.

Both parties were nevertheless contacted in September 2010 by a staff attorney from my office to determine if they wished to make further submissions. CMS indicated that it would not submit any additional response, and Petitioner failed to indicate any intent to make another submission by the deadline set. The record was therefore closed by my order dated September 28, 2010.

I will therefore proceed to determine the merits of the appeal based on the record developed before me.

***2. I exclude the new evidence proffered by Petitioner.***

CMS argues that the "affidavit" Petitioner submitted as part of Petitioner's proposed exhibit 2 constitutes new evidence under 42 C.F.R. § 498.56(e), that Petitioner has not established that good cause exists, and that the document therefore must be excluded. CMS Br. at 9. The applicable regulation provides as follows:

> (e) *Provider and supplier enrollment appeals: Good cause requirement —*
>
> > (1) *Examination of any new documentary evidence.* After a hearing is requested but before it is held, the ALJ will examine any new documentary evidence submitted to the ALJ by a provider or supplier to determine whether the provider or supplier has good cause for submitting the evidence for the first time at the ALJ level.
> >
> > (2) *Determining if good cause exists. —*
> >
> > > (i) *If good cause exists.* If the ALJ finds that there is good cause for submitting new documentary evidence for the first time at the ALJ level, the ALJ must include evidence and may consider it in reaching a decision.
> > >
> > > (ii) *If good cause does not exist.* If the ALJ determines that there was not good cause for submitting the evidence for the first time at the ALJ level, the ALJ must exclude the evidence from the proceeding and may not consider it in reaching a decision.

42 C.F.R. § 498.56(e). I explained these requirements in my initial order and instructed Petitioner to explain in his brief the good cause justifying later submission of any new evidence. PHO at 3.

Petitioner does not claim that he submitted the Greenwaldt "affidavit of service" to the hearing officer. P. Ex. 2, at 2. The hearing officer's reconsideration decision lists only two documents submitted at that level – the reconsideration request and a copy of a notification letter of suspended licenses (presumably the documents submitted to me as Petitioner's Exhibits 3 and 5). The "affidavit" is dated December 31, 2009, and was therefore presumably in existence during each prior level of appeal. I conclude that the exhibit is new documentary evidence within the meaning of section 498.56(e)(1).

Petitioner has not provided any argument as to why I should find that good cause is established for the submission of this document for the first time at this level of appeal. Nothing on the face of the document suggests a reason why it was not produced before. I therefore find no good cause and must exclude the document from the proceeding as a result.

I note that, even had I accepted the "affidavit" into evidence, I would not have found it reliable proof that Petitioner mailed notice of adverse action to WPS. The "affidavit" describes the mailing as "Letter head attached to Medicare and all insurance Companies Chiropractic Health Consultant * Medicare Letter head Dated 12/31/2009." P. Ex. 2, at 2. Petitioner describes Ms. Greenwaldt in his witness list as "stylist" and describes her as filing "Affidavits of Service to parties." P. Witness List at 2. Petitioner filed no sworn written direct testimony for Ms. Greenwaldt as required by my initial order. PHO at 3. No explanation was offered for the purported creation of this unexecuted document at the same time as the letter purporting to provide notice of Dr. Laudon's suspension to "all insurance companies" and Medicare nor was any explanation offered for the omission of the notarial subscription called for on the form. The "affidavit" provides an address for WPS but does not identify any other insurance company to which the letter was addressed. The appearance raises questions about whether the "affidavit" was created after-the-fact to cure the absence of any evidence that the notice letter was ever mailed to WPS. In the absence of any testimony clarifying the cryptic description of what was mailed or the unclear role of Ms. Greenwaldt, I would not have credited the statement in the "affidavit."

### *3. Petitioner did not demonstrate that he notified Medicare as required.*

As noted, the regulation requires that a supplier, such as Petitioner, notify the Medicare contractor of any adverse legal action. 42 C.F.R. § 424.516(d)(1)(ii). Petitioner does not deny that the suspension was an adverse action that he was required to report. His argument is, instead, that he did provide the required notice. I find three problems with his argument. First, he did not prove that he even mailed to WPS the letter to which he points as notice. Second, he did not prove that mailing notice is sufficient to meet the requirement of reporting without any evidence that it was ever received by WPS. Third, he did not prove that the letter, even if received, would constitute adequate reporting.

On the first point, Petitioner offered no explanation of the circumstances under which the December 31, 2009 letter was supposedly mailed. The vague language of the letter, and the absence of any specific name or address of an addressee, further undercuts any confidence that it was actually sent to the required Medicare contractor. I have already excluded the unexecuted affidavit of service signed by Petitoner's "stylist," and explained why it would not be credible proof of mailing to WPS's address even if it were admissible.

On the second point, I note that the regulations require that a provider or supplier notify the Medicare contractor. Nothing in the regulations suggests that an attempt to provide notice by mailing a letter is enough to meet that requirement. *See* 42 C.F.R. § 424.535(a)(9). Petitioner bears the burden of showing that WPS was actually notified. I note that Petitioner could have used a form of mailing that provided evidence of tracking or receipt, but chose not to. Petitioner has not provided any evidence that the contractor received the December 31, 2009 letter. On the contrary, CMS provided sworn and uncontradicted testimony that the contractor looked for the letter and found no evidence of its receipt. CMS Ex. 2.

Moreover, the timing of the contractor revocation is further evidence that the contractor did not receive the notice Petitioner mailed. If the contractor received the notice in January 2010, I would have expected it to have taken action much sooner to revoke Petitioner's enrollment. As the contractor's reconsideration points out, the loss of the license to provide chiropractic services meant that Petitioner was not in compliance with an enrollment requirement and was subject to revocation on that ground. CMS Ex. 1, at 1. This timing is likewise consistent with the assertion proffered in the CMS affidavit that CMS or their contractor only learned of the suspension through other means. CMS Ex. 2.

On the third point, CMS argues that the December 31, 2009 letter would not suffice because the report must be made on a specific form. CMS Br. at 5-7. CMS has interpreted the regulatory notice requirement in this way in Chapter 10, § 7.1 of the Medicare Program Integrity Manual (MPIM) --

> Unless otherwise specified in this manual, if an enrolled provider is adding, deleting, or changing information under its existing tax identification number, it must report this change using the applicable CMS-855 form. Letterhead is not permitted.
>
> The provider shall furnish the changed data in the applicable section of the form and sign and date the certification statement. In accordance with 42 CFR §424.516(d) and (e), the timeframes for providers to report changes in their CMS-855 information are as follows:

> A. For physicians . . . [t]he following changes must be reported within 30 days:
>
> > A change of ownership
> > A final adverse action
> > A change in practice location . . . .

MPIM Chapter 10, § 7.1. CMS argues that the use of the CMS-855I form is not merely a formality but a necessity for the contractor to obtain all substantive information required to correctly process the information related to the adverse action. CMS Br. at 6.

I note that the preamble to the final regulation highlights the importance of prompt reporting, especially in light of the disincentives inherent in reporting an adverse action that may in itself jeopardize the supplier's ability to continue to receive Medicare payments. Thus, the preamble explains as follows:

> Comment: One commenter stated that "any adverse legal action" is not defined; therefore a 30-day reporting requirement is unreasonable as are the other proposed requirements. The commenter also stated that we should save our severe penalties for proven fraudulent behavior, not minor clerical oversights.
>
> Response: *We disagree with this commenter that failure to report a final adverse action is a minor clerical oversight.* Since reporting a final adverse action may affect a physician or NPP's ability to continue to participate in the Medicare program, we understand why these actions may not be reported to a Medicare contractor; however, we believe that final adverse actions, including State licensing suspensions and revocations, should be reported within 30 days of the reportable event, even if the physician or NPP plans on appealing the final adverse action. By reporting the final adverse action within 30 days, the Medicare program will carefully review any revocation action and exercise its discretion as to whether to impose a revocation and the length of time of the reenrollment bar.

73 Fed. Reg. 69,726, 69,778 (November 19, 2008) (emphasis added).

CMS could reasonably require sufficient information to ensure that it can review and evaluate the adverse action. The CMS-855I form specifically identifies which sections a supplier is required to complete in the event of a final adverse action, including identifying information and professional license information, and the date of the adverse action as well as "the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any." CMS Ex. 3, at 6, 7, 14. Furthermore, the

reporting supplier is directed to attach a copy of the documentation related to the reported final adverse action. *Id*. at 14.

I need not decide whether a full and timely report submitted on a document other than the prescribed CMS-855 form could still result in a revocation for failure to report. As I concluded above, I find no credible evidence that the December 31, 2009 letter was sent to or received by WPS. On its face, the letter provides less than adequate information for a careful review of the adverse action, lacking for example, a clear reason for the suspension, the date the suspension occurred or took effect, or a copy of the suspension action. At a minimum, had WPS ever received this letter it would have, under its own policies, required Petitioner to complete a CMS-855I form containing the missing information required for a full review. CMS Ex. 2, at 2.

## V. Conclusion

For the reasons explained above, I conclude that CMS had authority to revoke Petitioner's Medicare enrollment and billing privileges under 42 C.F.R. § 424.535(a)(9) based on Petitioner's failure to report his adverse action as required.

/s/
Leslie A. Sussan
Board Member