Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Precision Prosthetic, Inc.
Docket No. A-14-80
Decision No. 2597
September 29, 2014

REMAND OF ADMINISTRATIVE LAW JUDGE DECISION

Precision Prosthetic, Inc. (Precision), a supplier of durable medical equipment prosthetics, orthotics and supplies (DMEPOS supplier), appeals the April 2, 2014 decision of an administrative law judge (ALJ) affirming on the written record the August 28, 2013 determination of the Centers for Medicare & Medicaid Services (CMS) to retroactively deny Precision's April 10, 2006 application to re-enroll in the Medicare program. *Precision Prosthetic, Inc.*, DAB CR3187 (2014)(ALJ Decision). The ALJ concluded that although the CMS contractor, National Supplier Clearinghouse (NSC), had approved Precision's application on September 5, 2006, CMS was authorized to deny the application retroactively based upon felony convictions entered against Precision's owner on April 5, 2005, convictions NSC did not know about when it approved Precision's application. Precision argues on appeal that the regulations relied upon by the ALJ – 42 C.F.R. § 424.530(a)(1) and 42 C.F.R. § 424.530(a)(3)(i)(B) – did not authorize retroactive denial of its re-enrollment application. CMS disagrees and also argues that the enrollment regulations as a whole (and the statute they implement) allow retroactive denials in a circumstance where CMS learns of felony convictions that occurred within ten years before a previously accepted enrollment application because the regulations do not contain any express constraints as to the timing of denials of enrollment and because retroactive denials in this circumstance are consistent with the protective purposes of the statute and regulations.

We do not reach the issue of whether the regulations relied on by the ALJ or any other legal authority permitted CMS to retroactively deny Precision's re-enrollment application because we have concluded we must reverse on procedural grounds and remand to correct error that prejudiced both parties.[1] The error was the ALJ's remand of Precision's

[1] For the same reason, we do not reach CMS's argument that the Board should not reach the legal arguments made by Precision here because Precision did not present those arguments to the ALJ. CMS's Response to Appellant's Request for Review at unnumbered pages 3-4.

original request for a hearing on CMS's determination to revoke Precision's Medicare enrollment and billing privileges retroactive to the date of the owner's felony convictions with instructions to CMS "to consider whether NSC had intended [instead] to deny Petitioner's enrollment retroactively." ALJ Decision at 2; *see also* June 11, 2012 Amended Order of Remand, Docket No. C-13-195 (Remand Order)(stating additional instructions) at 3-4.[2] Rather than remanding, the ALJ should have decided the revocation case before him even if he had concluded (as concerns expressed in his Remand Order and the ALJ Decision suggest) that while he was inclined to uphold the revocation, he was legally compelled to change the effective date of the revocation. The ALJ cited 42 C.F.R. § 498.56(d) as authority for the remand, but section 498.56, including paragraph (d), addresses the ALJ's authority to hear "new issues" in the context of the administrative action before the ALJ. The question of whether CMS should have made a determination denying enrollment retroactively rather than revoking enrollment retroactively does not involve a new issue in the case before the ALJ but, rather, a wholly different administrative action. In addition, even with respect to new issues, the regulations authorizing ALJs to hear new issues contain an exception for provider and supplier enrollment appeals that the ALJ Decision does not indicate was considered. 42 C.F.R. § 498.56(a)(2).

The ALJ compounded the remand error by including in the Remand Order instructions that clearly influenced CMS to abandon its revocation determination and issue a new determination to, instead, deny Precision's 2006 application retroactively. For reasons explained below, we conclude that this resulted in prejudice to both parties.
In order to correct this error, and restore the case to its original posture, we have concluded we must remand this appeal to the ALJ for the ALJ to remand the matter once again to CMS to reinstate its determination to revoke Precision's enrollment and billing privileges, assuming CMS chooses to continue an unfavorable administrative action against Precision's enrollment based on its owner's felony convictions. We set forth further remand instructions at the conclusion of this decision.

[2] Because we remand, we do not decide whether the ALJ properly construed the language "at any time" in section 424.530(a)(1) as applying to section 424.530(a)(3) to give CMS the option of retroactively denying a DMEPOS supplier's previously granted enrollment in Medicare. We do note certain concerns about the analysis in the ALJ Decision. The analysis includes no discussion of whether section 424.530(a)(3) may be read as stating an independent basis for denying an application rather than an enrollment "requirement" within the meaning of section 424.530(a)(1), as the ALJ's analysis concludes. Nor does the analysis reflect consideration of whether the phrase "requirements described in this section . . ." in section 424.530(a)(1) might refer to the special payment rules for DMEPOS suppliers set out in section 424.57(c) and, if so, how this affects the analysis. We also note that while the analysis cites the Board decision in *US Ultrasound*, DAB No. 2302 (2010), it does not mention that that case, unlike the case being analyzed by the ALJ here, involved a denial under section 424.530(a) for failure to meet the requirements applicable to IDTF suppliers, not for conviction of a felony under section 424.530(a)(3). *See* ALJ Decision at 9.

Legal Background

The Medicare program provides health insurance benefits to persons 65 years and older and to certain disabled persons. Social Security Act (Act) § 1811.[3] CMS, a component of the Department of Health and Human Services (HHS), administers Medicare. Private insurance companies contracting with CMS (CMS contractors) process claims for Medicare coverage and perform other program functions. *See* Act § 1842. In order to receive Medicare payment for services furnished to program beneficiaries, a medical provider or supplier must be "enrolled" in Medicare.[4] 42 C.F.R. § 424.505. The regulations contain special payment rules for DMEPOS suppliers. 42 C.F.R. § 424.57. DMEPOS "stands for durable medical equipment, prosthetics, orthotics and supplies," 42 C.F.R. § 424.57(a), and a DMEPOS supplier is "an entity or individual . . . which sells or rents Part B covered items to Medicare beneficiaries and which meets the standards in paragraphs (c) and (d) of [section 424.57]." *Id.*

A key purpose of Medicare enrollment is to ensure that providers and suppliers comply with requirements for program participation and payment. 42 C.F.R. §§ 424.520(a) (stating that CMS enrolls a provider or supplier when it is found to meet Medicare program requirements), 424.502 (defining "enrollment" as a process that includes "[v]alidation of the provider's or supplier's eligibility to provide items or services to Medicare beneficiaries"). In April 2006, responding to concern about unqualified or fraudulent providers and suppliers participating in Medicare, CMS published a final rule establishing standard Medicare enrollment requirements and procedures.[5] Final Rule, Medicare Program Requirements for Providers and Suppliers to Establish and Maintain

[3] The current version of the Social Security Act can be found at www.ssa.gov/OP_Home/ssact/comp-ssa.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section.

[4] "Providers" are hospitals, nursing facilities, or other medical institutions. 42 C.F.R. § 400.202. "Suppliers" include physicians and other non-physician health care practitioners. *Id.* (stating that, unless the context indicates otherwise, "[s]upplier means a physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare").

[5] In 2003, Congress directed the Secretary of HHS to "establish by regulation a process for the enrollment of providers of services and suppliers" and also establish "procedures under which there are deadlines for actions on applications for enrollment[.]" Act § 1866(j)(1)(A)-(B); Pub. L. No. 108-173, § 936, 117 Stat. 2066, 2411-12 (2003).

Medicare Enrollment, 71 Fed. Reg. 20,754 (Apr. 21, 2006) (Final Rule).[6] These requirements and procedures are codified in 42 C.F.R. Part 424, subpart P, and are referred to here as the subpart P regulations. The effective date of the Final Rule was June 20, 2006. *Id.*

The subpart P regulations state that a provider or supplier "must be enrolled in the Medicare program" in order to receive Medicare "billing privileges" (i.e., the privilege to bill Medicare for covered services furnished to Medicare beneficiaries). 42 C.F.R. § 424.505. The terms "enroll" and "enrollment" are defined to mean: the process that Medicare uses to establish eligibility to submit claims for Medicare covered services and supplies. The process includes —

(1) Identification of a provider or supplier;

(2) Validation of the provider's or supplier's eligibility to provide items or services to Medicare beneficiaries;

(3) Identification and confirmation of the provider or supplier's practice location(s) and owner(s); and

(4) Granting the provider or supplier Medicare billing privileges.

42 C.F.R. § 425.502.

Section 424.510 sets out requirements for enrolling in the Medicare program, one of which is the submission of verifiable "enrollment information on the applicable enrollment application." 42 C.F.R. § 424.510(a), (d)(4). Since at least the mid-1990s, the "applicable enrollment application" has been the CMS-855.[7] To maintain Medicare billing privileges, providers and suppliers must resubmit and recertify the accuracy of enrollment information periodically; for DMEPOS suppliers, this is every three years after the billing privileges are first granted. 42 C.F.R. § 424.515; 42 C.F.R.

[6] To a substantial degree, the new regulations consolidate and codify existing enrollment policies, practices, and requirements. The Final Rule states that it "consolidates current regulations found throughout the Code of Federal Regulations and more clearly defines what Medicare expects from providers and suppliers furnishing items or rendering services to the Medicare beneficiaries." 71 Fed. Reg. at 20,773.

[7] *See* 61 Fed. Reg. 37,278 (July 17, 1996); 64 Fed. Reg. 3637, 3643 (Jan. 25, 1999).

§ 424.57(e) (Code of Federal Regulations Oct. 1, 2012 revision).[8] DMEPOS suppliers submitting an enrollment application for the first time, or revalidating their enrollment, must meet the special standards set forth at 42 C.F.R. § 424.57. Revalidation includes completing a new application. 42 C.F.R. § 424.57(e).

CMS is authorized to deny enrollment in the Medicare program to a provider or supplier for reasons specified in the regulations, including certain felony convictions of the provider or supplier, or any owner thereof, occurring within 10 years preceding enrollment or revalidation of enrollment. 42 C.F.R. § 424.530.

> **§ 424.530 Denial of enrollment in the Medicare program.**
>
> (a) *Reasons for denial*. CMS may deny a provider's or supplier's enrollment in the Medicare program for the following reasons:
>
> (3) *Felonies.* If within the 10 years preceding enrollment or revalidation of enrollment, the provider, supplier, or any owner of the provider or supplier, was convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. CMS considers the severity of the underlying offense.
>
> (i) Offenses include —
>
> * * *
>
> (B) Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

(Emphasis and italics in original.)

Section 424.535, using substantially identical language, authorizes revocation of billing privileges for this reason. Section 424.535 provides in relevant part:

[8] An editorial note states, in relevant part, that amendments to section 424.57 published at 74 Fed. Reg. 198, (Jan. 2, 2009) included redesignation of paragraph (e) as paragraph (f), but that the amendments could not be incorporated in the Code of Federal Regulations due to inaccurate amendatory instructions. We refer here to paragraph (e) for the revalidation provision.

> **§ 424.535 Revocation of enrollment and billing privileges in the Medicare program**
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> *Reasons for revocation*. CMS may revoke a currently enrolled provider or supplier's billing privileges and any corresponding provider agreement or supplier agreement for the following reasons:
>
> * * *
>
> (3) *Felonies*. The provider, supplier, or any owner of the provider or supplier, within the 10 years preceding enrollment or revalidation of enrollment, was convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries.
>
> Offenses include —
>
> * * *
>
> (B) Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

(Emphasis and italics in original.)

In the preamble to the Final Rule, CMS summarized the protective purposes of the enrollment requirements:

> The primary goal of this final rule, through standard enrollment requirements and periodic revalidation of the enrollment information, is to allow us to collect and maintain (keep current) a unique and equal data set on all current and future providers and suppliers that are or will bill the Medicare program for items or services rendered to our beneficiaries. By achieving this goal, we will be better positioned to combat and reduce the number of fraudulent and abusive providers and suppliers in the Medicare program, thereby protecting the Trust Funds and the Medicare beneficiaries.

71 Fed. Reg. at 20,774.

Although the authority to deny enrollment in Medicare and to revoke enrollment and billing privileges based on felony convictions has remained substantially unchanged since implementation of the Final Rule in 2006, the regulation governing the effective date for

revocations based on felony convictions was amended in 2009. 73 Fed. Reg. 69,940 (Nov. 19, 2008). Under the 2006 Final Rule, the effective date of either a denial of enrollment (addressed in section 424.530(e), which covered all denials), or a revocation of enrollment or billing privileges based on a felony conviction (addressed in section 424.535(f), which then covered all revocations), was "within 30 days of the initial . . . notification." 71 Fed. Reg. at 20,779; 71 Fed. Reg. at 20,780. The 2009 amendments to section 424.535 added paragraph (g) which retained the 30-day rule previously in paragraph (f) except for revocations based on felony convictions and some other bases not relevant here. For revocations based on felony convictions, under the 2009 amendments, the revocation "is effective with the date of . . . felony conviction . . . ." 73 Fed. Reg. at 69,865 (Nov. 19, 2008). The effective date for a denial of enrollment, which is still addressed in section 424.530(e), remains unchanged since 2006.

Case Background[9]

1. *Precision's re-enrollment, the revocation determination and the hearing request.*

On April 10, 2006, Precision, a company in El Paso, Texas, that sells DMEPOS products, submitted to NSC an application to re-enroll in the Medicare program. ALJ Decision at 1-2. John K. Lee was listed as owner in the application. ALJ Decision at 6. On September 5, 2006, after further development of the application and an on-site inspection, NSC notified Precision that its application had been accepted and that it was re-enrolled effective December 17, 2002. *Id*. at 2. On October 10, 2012, NSC notified Precision that it was revoking Precision's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(3)(i)(B) and (D), and that the revocation was effective retroactive to April 5, 2005.[10] *Id*. NSC cited the April 5, 2005 felony convictions of Precision's owner, John K. Lee, for mail fraud and worker's compensation fraud, as the basis for the

[9] The factual information in this section, unless otherwise indicated, is drawn from undisputed findings of fact in the ALJ Decision and undisputed facts in the record and is presented to provide a context for the discussion of the issues raised on appeal. Nothing in this section is intended to replace, modify, or supplement the ALJ's findings of fact.

[10] Paragraph (D) of section 424.535(a)(3)(i) defines as a category of felony offense providing a basis for revocation "[a]ny felonies that would result in mandatory exclusion under section 1128(a) of the Act." The felonies listed under that statute include those "relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct" when committed "in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program . . . operated by or financed in whole or in part by any Federal, State, or local government agency."

revocation. *Id*. NSC also stated in the notice that it was imposing a three-year bar on re-enrollment pursuant to 42 C.F.R. § 424.535(c). *Id*. Petitioner requested reconsideration by an NSC hearing officer, and on November 26, 2012, the hearing officer issued a reconsidered decision upholding the revocation.[11] *Id*. Petitioner then requested a hearing before an ALJ of the Civil Remedies Division (CRD) of the Departmental Appeals Board (DAB), and the request was docketed as Docket Number C-13-195. *Id*.

2. T*he ALJ remand*.

After the parties filed their prehearing submissions, the ALJ "determined that NSC had not considered in its initial or reconsidered determination whether it could revoke Petitioner's enrollment retroactively to April 5, 2005, since the regulation authorizing retroactive revocation, 42 C.F.R. § 424.535(g), became effective on January 1, 2009. *See* 73 Fed. Reg. 69,726, 69,940-41 (Nov. 19, 2008)." *Id*. The ALJ remanded the case to CMS with instructions, including "to consider that issue or, in the alternative, to consider whether NSC had intended to deny Petitioner's enrollment retroactively." *Id*. Citing 42 C.F.R. § 498.56(d) and retaining jurisdiction, the ALJ directed CMS to give Precision an opportunity to respond to whatever course of action CMS decided to take on remand, to issue a determination by a date certain and to return the case to him for further proceedings. *Id*.

[11] The date for the reconsideration notice stated in the ALJ Decision is "November 16, 2012," but the actual date on the notice is "November 26, 2012." *See* CMS Ex. 4. The ALJ correctly noted in his Remand Order that the record contains no complete version of the reconsideration decision; CMS exhibit 4 contains only the first page and Precision submitted with its hearing request what appear to be two additional pages. *See* Remand Order at 2, n.1. The parties do not dispute either the ALJ's finding that the reconsideration determination was unfavorable to Precision or that it was based on John K. Lee's felony convictions. The pages of the reconsideration decision in the record show a discussion of the convictions followed by this statement: "[T]his hearing officer has found that the NSC was appropriate in their revocation of the supplier's billing privileges based upon the information on the record at the time and the appropriateness within." *See* electronic Docket No. C-13-195, Item 1 (request for Hearing Supporting Documents). Thus, the record, albeit incomplete, supports a finding of an unfavorable reconsideration determination that upheld the revocation of Precision's enrollment and billing privileges based on owner John K. Lee's felony convictions.

3. *Administrative action on remand*.

On remand, CMS proposed a new determination, changing its administrative action based on John K. Lee's felony convictions from a revocation of Precision's billing privileges retroactive to the date of the convictions (April 5, 2005) to a retroactive denial of Precision's April 10, 2006 re-enrollment application.[12] *Id*. at 3. CMS solicited comments from Precision, and one Katherine Lee responded on August 21, 2013. *Id*. Ms. Lee "described the 'process of submitting the April 2006 revalidation application, taking over [Petitioner] from [John K. Lee] and another past owner due to [John K. Lee's] military service and federal prison sentence, and submitting the 2012 revalidation application.'" *Id*., quoting CMS Ex. 11, at 2. On August 28, 2013, CMS issued its "Determination Pursuant to ALJ Anderson's June 11, 2013 Amended Order of Remand." *Id*. CMS denied Precision's [April 2006] re-enrollment application. *Id*. CMS also filed its new determination with the ALJ, who re-docketed the case under Docket Number C-13-1256. *Id*.

4. Proceedings before the ALJ on appeal of the new CMS determination.

Precision filed a timely appeal. *Id*. CMS filed a motion for summary judgment and eleven proposed exhibits, and Precision filed a Motion to Dismiss and eight proposed exhibits. The ALJ concluded that Precision's motion to dismiss was actually a response opposing a decision favorable to CMS and arguing that the denial of its re-enrollment application was wrong. *Id*. Both parties objected to various proposed exhibits. *Id*. Ruling on those objections, the ALJ admitted all of CMS's proposed exhibits and all but one of Precisions's proposed exhibits. *Id*. After noting that neither party had submitted written direct testimony for any witnesses as directed by his Pre-hearing Order, thus eliminating any need for a hearing to cross-examine witnesses, the ALJ issued the decision on the record affirming the retroactive denial of Precision's re-enrollment application now being appealed to the Board. *Id*.

[12] The ALJ Decision does not discuss whether the new determination notice stated an effective date for the denial, but we see no such date in CMS Ex. 11, the document the ALJ correctly cited as containing CMS's August 28, 2013 determination. CMS asserted in its summary judgment brief before the ALJ that the denial was retroactive to the date of Precision's convictions, but the ALJ Decision did not decide the effective date issue.

Standard of Review

The standard of review on a disputed factual issue is whether the ALJ decision is supported by substantial evidence in the record as a whole. The standard of review on a disputed issue of law is whether the ALJ decision is erroneous. *See Guidelines -- Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program* (Guidelines), http://www.hhs.gov/dab/divisions/ appellate/guidelines/prosupenrolmen.html. The Board's Guidelines state that "[t]he bases for modifying, reversing, or remanding an ALJ decision include the following: . . . a prejudicial error of procedure . . . was committed." *Guidelines*; *see also Blossom South Nursing and Rehabilitation Center*, DAB No. 2578, at 6 (2014)(citing the Guidelines and stating that the standard of review for allegations of procedural error is "whether the ALJ committed an error of procedure that resulted in prejudice (including an abuse of discretion under the law or applicable regulations)."

Analysis

A. The regulations did not authorize the ALJ to remand for CMS to determine whether to take an administrative action other than the one at issue in the case before the ALJ.

As indicated above, the ALJ Decision before us states that the ALJ remanded the enrollment revocation hearing request before him, docketed under Docket Number C-13-195, for CMS "to consider whether NSC had intended [instead] to deny Petitioner's enrollment retroactively." ALJ Decision at 2. The ALJ's Remand Order provides more details about the remand. After discussing amendments to the regulations since 2006 with respect to the effective date of revocations based on felony convictions, the ALJ stated –

> I do not find that the application of the rule that providers or suppliers may be revoked based on the conviction of a felony in the last ten years is an improper retroactive application of the regulations promulgated in 2006. *Robert F. Tzeng, M.D.*, DAB No. 2169, at 12-14 (2008). However, my concern is how to reconcile the effective date provisions given that Petitioner was convicted in 2005.
>
> * * *
>
> I have decided to remand this case for CMS to consider, in light of the law expressed above, whether CMS needs to impose a new effective date for the revocation.

> On remand, CMS must also consider whether, given the law stated above, it meant to retroactively deny Petitioner's application revalidation in 2006 rather than revoke billing privileges. *See Arizona Medical Boutique, LLC*, DAB CR2674, at 7 (2012).

Remand Order at 3.

Appeal rights in provider and supplier enrollment cases, and ALJ review authority in those cases, are governed by 42 C.F.R. § 498.5(l)("[a]ppeal rights related to provider enrollment"). Under section 498.5(l)(2), an "existing supplier dissatisfied with a reconsidered determination [related to enrollment] is entitled to a hearing before an ALJ." Based on the regulation's limitation of appeal rights to reconsidered determinations, the Board has held repeatedly that section 498.5(l) limits ALJs to considering the basis or bases for denial or revocation of enrollment and billing privileges set forth in the CMS contractor's reconsidered determination. *E.g*. *Ortho Rehab Design Prosthetics and Orthotics*, DAB No. 2591 at 9 (2014); *Better Health Ambulance*, DAB No. 2475, at 4 (2012). In this case, there is no dispute that the original reconsidered determination, which was before the ALJ in Docket Number C-13-195, was a determination to revoke Precision's enrollment and billing privileges based on the 2005 felony convictions of John K. Lee, who owned Precision at the time of the revocation action. Thus, the authority of the ALJ extended only to considering and determining whether the revocation was authorized under 42 C.F.R. § 424.435(a)(3) and, if so, whether at the time CMS took the revocation action, it was authorized to make the date of John K. Lee's felony convictions the effective date for the revocation. The Board concludes that the ALJ lacked authority for the remand and should have decided the case before him. Accordingly, the remand was error.

Although the ALJ cited section 598.56(d) as authority for the remand, that regulation does not provide such authority. Section 498.56 describes when an ALJ can provide a "[h]earing on new issues" and, in pertinent part, provides as follows:

> *(a) Basic rules*. (1) Within the time limits specified in paragraph (b) of this section, the ALJ may, at the request of either party, or on his or her own motion, provide a hearing on new issues that impinge on the rights of the affected party.
>
> (2) Except for provider or supplier enrollment appeals which are addressed in § 498.56(e), the ALJ may consider new issues even if CMS . . . has not made initial or reconsidered determinations on them, and even if they arose after the request for hearing was filed or after the prehearing conference.

> * * *
>
> (d) *Remand to CMS* . . . . At the request of either party, or on his or her own motion, in lieu of a hearing under paragraph (c) of this section, the ALJ may remand the case to CMS . . . for consideration of the new issue and, if appropriate, a determination. If necessary, the ALJ may direct CMS . . . to return the case to the ALJ for further proceedings.
> (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.

(Italics in original.)

We do not decide here the precise meaning of the language in section 498.56(a)(2) "[e]xcept in provider or supplier enrollment appeals which are addressed in § 498.56(e)" as it affects an ALJ's authority to hear new issues in provider and supplier enrollment cases.[13] We need not do so because section 498.56 in its entirety, including paragraph (a)(2), plainly restricts any authority the regulation may grant ALJs to the hearing of "new issues" in pending appeals. (Emphasis added.) The question of whether CMS would have been authorized to deny Precision's enrollment application rather than revoke Precision's enrollment and billing privileges was not a "new issue" in the case before the ALJ but, rather, an entirely different administrative action under different authority. As indicated above, the administrative action before the ALJ was a revocation pursuant to CMS's authority under section 424.535, whereas the administrative action the ALJ instructed CMS to consider was one pursuant to CMS's authority under section 424.530. Regardless of whether the exception in section 498.56(a)(2) precludes an ALJ's considering "new issues" in a provider or supplier appeal under any circumstances, an ALJ clearly may not rely on any part of section 498.56 to employ a procedure (in this case remand), that, intended or not, suggests that CMS change the administrative action being appealed to an entirely new and different administrative action.

[13] Section 498.56(e), to which section 498.56(a)(2) refers, does not address whether the ALJ may hear "new issues" in provider and supplier enrollment cases but, rather, addresses the circumstances under which an ALJ can consider documentary evidence not submitted to the CMS contractor in provider and supplier enrollment cases. Presumably, then, any newly presented documentary evidence admitted under section 498.56(e) would relate to issues already before the ALJ.

A. *The remand and instructions prejudiced both parties.*

As stated above, where the issue on review involves possible procedural error, the Board's inquiry is 1) whether that error occurred and, assuming a conclusion it did, 2) whether the error caused prejudice. We have concluded that the ALJ committed error here when he remanded with instructions that generated, whether intended or not, a wholly new and different administrative action under separate legal authority that the ALJ then proceeded to hear and decide. That error could be viewed as either simple legal error, the application of authority in section 498.56 where it does not apply, or, alternatively, as procedural error because a remand was involved. Taking the former view, no further inquiry on our part would be required. However, in light of the ambiguity on this point and in the interest of addressing more specifically our concern about the remand instructions, we find it prudent to take the next step and address why we find that the remand prejudiced the parties.

The instructions in the Remand Order prejudiced the parties because they clearly influenced CMS to abandon its revocation determination and issue a new determination to deny Precision's 2006 application retroactively. We recognize that the remand instructions did not expressly direct CMS to change its administrative action from a revocation of enrollment and billing privileges to a denial of enrollment. CMS could have followed the first option in the instructions "to consider, in light of the law expressed above, whether CMS needs to impose a new effective date for the revocation." Remand Order at 3. However, the instructions did not end there but went on to instruct CMS as follows: "CMS must also consider whether, given the law stated above, it meant to retroactively deny Petitioner's application revalidation in 2006 rather than revoke billing privileges." *Id.* (Emphasis added.) Directly after that instruction, the ALJ Decision cited another ALJ's holding in the *Arizona Medical Boutique. LLC* case, based on essentially the same analysis employed by the ALJ here, that CMS was authorized to retroactively deny a re-enrollment application.[14] *Id*. The mandatory instruction

[14] As the Board has often stated, ALJ Decisions do not bind either other ALJs or the Board. *E.g*. *Mark B. Kabins*, DAB No. 2410 (2011); *Maysville Nursing and Rehabilitation Facility*, DAB No. 2317 (2010). We also note that although the ALJ in *Arizona Medical Boutique, LLC,* found that considerations of due process did not preclude CMS's changing a revocation to a denial during the proceedings before him, the ALJ mistakenly cited *Green Hills Enterprises, LLC,* DAB No. 2199 (2008) as support for that proposition. In *Green Hills Enterprises, LLC,* the Board did reject a provider's argument that its due process rights were violated by the ALJ's having considered what the provider asserted were new reasons for the denial of its enrollment as a community mental health center. However, *Green Hills Enterprises, LLC,* did not involve a change from a denial to a revocation (or any other change to an entirely different administrative action). For that reason, among others, the decision does not support the proposition for which the ALJ cited it.

to CMS ("must also consider"), taken together with the case citation could well be read by CMS as, at the very least, strongly suggesting that it should change the administrative action to one of denying Precision's re-enrollment application and that the ALJ would be inclined to uphold such a change. Indeed, language in CMS's new determination notice on remand shows that this language did influence CMS to make the new determination to deny Precision's re-enrollment action retroactively. After quoting the language from the second instruction in the Remand Order, CMS stated, "Based on our review of the full record in this proceeding and the decision in *Arizona Medical Boutique*, DAB CR2674 (2012), we retroactively deny Precision's enrollment application pursuant to 42 C.F.R. § 424.530(a)(1), (a)(3)(i)(B), and (a)(4)." August 28, 2013 Determination Pursuant to ALJ Anderson's June 11, 2013 Amended Order of Remand, at 1. This change by CMS at least arguably affected Precision's rights adversely by facilitating the ALJ's ultimate decision to affirm CMS's unfavorable determination. Although the ALJ suggested in the remand order that he would have affirmed CMS's authority to revoke retroactively (although he was concerned about whether there was authority to make the revocation retroactive to the date of the felony convictions), that does not necessarily mean that would have been the ALJ's actual ultimate decision. Similarly, the instructions arguably deprived CMS of a favorable ALJ Decision on the merits of the revocation even if the ALJ had concluded that he must change the effective date of the revocation. At the very least, the remand and the instructions prejudiced the parties by causing confusion and increasing the administrative and hearing process burdens for the parties.

Conclusion

For the reasons stated above, we reverse the ALJ on procedural grounds for prejudicial legal error and remand for further proceedings consistent with this decision. The ALJ shall remand the case once again to CMS to reinstate its determination to revoke Precision's enrollment and billing privileges, assuming CMS chooses to continue with an unfavorable administrative action against Precision's enrollment based on its owner's felony convictions. The ALJ should instruct the parties that if CMS issues a new determination to revoke Precisions' enrollment and billing privileges, Precision should file a new hearing request within the time limits specified in CMS's notice of that determination, and the ALJ should assign a new docket number to that request. The ALJ shall then decide that case, applying his usual hearing procedures. The ALJ Decision should decide both whether to affirm the revocation and the legally authorized effective date for that revocation.

/s/
Constance B. Tobias

/s/
Leslie A. Sussan

/s/
Sheila Ann Hegy
Presiding Board Member