Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Blossomwood Medical, P.C. and
Vytautas Pukis, M.D.,
Docket Nos. A-18-81 and A-18-82
Decision No. 2914
December 7, 2018

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Appellants Vytautas Pukis, M.D. and Blossomwood Medical, P.C. (collectively, Blossomwood) appeal the April 12, 2018 decision of an Administrative Law Judge (ALJ) upholding the revocation of their Medicare enrollment and billing privileges by the Centers for Medicare & Medicaid Services (CMS).[1] *Blossomwood Medical, P.C., et al.*, DAB CR5068 (2018) (ALJ Decision). The ALJ granted summary judgment in favor of CMS in both cases because the revocations were based on identical facts and the two Appellants were affiliated. He concluded that CMS was authorized to revoke Blossomwood because he found it undisputed that Blossomwood billed Medicare 115 claims for services allegedly provided during a three-year period to 108 beneficiaries by Dr. Pukis at times when he was not in the United States. These facts, the ALJ concluded, established that Blossomwood abused its billing privileges as defined by regulation. The ALJ rejected Blossomwood's assertions that the claims were inadvertently submitted, or, in the case of home health certifications, were proper in that the services could legitimately have been provided during Dr. Pukis' absences.

We uphold the ALJ Decision sustaining CMS's revocations of both Appellants. For the reasons explained below, we conclude that the undisputed facts support CMS's determination of abuse of billing privileges, even without considering the contested home health certification claims.

Applicable legal authorities

The Social Security Act (Act) provides for CMS to regulate the enrollment of providers and suppliers in the Medicare program. Act § 1866(j)(1)(A), 42 U.S.C. § 1395cc(j)(1)(A). The implementing regulations appear in 42 C.F.R. Part 424,

[1] At Appellants' request, the Board has consolidated the appeals and now issues a single decision.

subpart P. Section 424.535 lays out the reasons for which CMS may revoke billing privileges and participation by a currently-enrolled Medicare supplier.[2] One reason is "[a]buse of billing privileges," which is defined to include situations in which the supplier "submits a claim or claims for services that **could not have been furnished** to a specific individual on the date of service," specifically including when the "**directing physician** . . . **is not in the state or country** when services were furnished." 42 C.F.R. § 424.535(a)(8)(i) (emphasis added).[3]

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

A supplier whose Medicare enrollment has been revoked may request reconsideration. *Id.*, §§ 498.3(b)(17), 498.22(a). If the reconsideration determination is unfavorable, the supplier may appeal the reconsideration decision to an ALJ and then to the Board, pursuant to 42 C.F.R. Part 498. *Id.* §§ 424.545(a), 498.5(l)(1)-(2).

Case Background

By letters dated June 14, 2017, CMS notified both Appellants that their billing privileges would be revoked. CMS Ex. 2.[4] Both letters contained the same explanation:

> Data analysis conducted on claims billed by Blossomwood Medical, PC, listing Vytautas Pukis, M.D. as the rendering provider, for dates of service between June 17, 2013, and June 20, 2016, revealed one hundred fifteen (115) claims submitted for services rendered to one hundred eight (108) beneficiaries by Dr. Pukis for periods of time when he was out of the country. Vytautas Pukis, M.D. attested he ". . . was not present in the United States of America from . . . June 15, 2013 until June 24, 2013", "from September 26, 2014 until September 29, 2014", "from June 12, 2015 until June 17, 2015", "from September 21, 2015 until September 26, 2015" and "from June 8, 2016 until June 19, 2016". Vytautas Pukis, M.D. reassigns his Medicare benefits to Blossomwood Medical, PC, and is listed as the 5% or more owner on its Medicare 855 enrollment record. . . .

[2] Both Appellants (a physician and his affiliated professional corporation) are "suppliers" as that term is used in the Medicare program. 42 C.F.R. § 498.2.

[3] The conduct cited in the revocation action occurred between June 2013 and June 2016. This subsection was substantially revised effective February 3, 2015. 79 Fed. Reg. 72,500, 72,532 (Dec. 5, 2014). We apply the regulation as in effect at the time of the notice of revocation (June 14, 2017).

[4] For this citation, and all subsequent citations to exhibits before the ALJ, we refer to the Blossomwood case file. Analogous documents appear in Dr. Pukis' case file before the ALJ but with different exhibit numbers.

Id. at 1. Blossomwood timely sought reconsideration, submitting multiple documents, including a chart of its explanations of the contested claims (identified as Exhibit B to the reconsideration request). P. Ex. 2. On October 17, 2018, CMS issued its reconsideration determinations upholding the revocations on the same basis. CMS Ex. 1. Blossomwood then sought an ALJ hearing.

The ALJ granted summary judgment to CMS after concluding that no material facts were in dispute. ALJ Decision at 2. He rejected Blossomwood's arguments that CMS was precluded from revoking them because the errors were "inadvertent" and did not establish a "pattern of improper billing." ALJ Decision at 3 (citing 73 Fed. Reg. 36,448, 36,455 (June 27, 2008)). The ALJ concluded that, even if Blossomwood could show inadvertent error, CMS was authorized to revoke where more than three claims were submitted in which the services could not possibly have been provided as claimed. *Id*. at 4. Moreover, the ALJ noted that Blossomwood proffered only conclusory assertions that particular claims resulted from inadvertence or error and did not actually offer any evidence that these particular claims were, for example, caused by incompatible electronic billing systems, as alleged. *Id*. Finally, he ruled that Blossomwood's contentions that the claims at issue represented a small percentage of its Medicare claims and that revocation would adversely affect beneficiaries' access to care were not within the scope of his review. *Id*. at 5.

Standard of review

Whether summary judgment is appropriate is a legal issue that we address de novo. *Patrick Brueggeman, D.P.M.*, DAB No. 2725, at 6 (2016); *1866ICPayday.com, L.L.C.*, DAB No. 2289, at 2 (2009) (citing *Lebanon Nursing & Rehab. Ctr*., DAB No. 1918 (2004)); *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare and Medicaid Programs*, http://www.hhs.gov/dab/divisions/appellate/guidelines/prosupenrolmen.html.

Summary judgment is appropriate if there is no genuine dispute of fact material to the result and the moving party is entitled to judgment as a matter of law. *See 1866ICPayday.com* at 2 (citing *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986)); *Everett Rehab. & Med. Ctr*., DAB No. 1628, at 3 (1997) (citing *Travers v. Shalala*, 20 F.3d 993, 998 (9th Cir. 1994)). The Board construes the facts in the light most favorable to the non-moving party and gives it the benefit of all reasonable inferences. *See Livingston Care Ctr*., DAB No. 1871, at 5 (2003), *aff'd, Livingston Care Ctr. v. U.S. Dep't of Health & Human Servs*., 388 F.3d 168, 172-73 (6th Cir. 2004). To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a

material fact – a fact that, if proven, would affect the outcome of the case under governing law. *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 3 (2010), *aff'd, Senior Rehab. & Skilled Nursing Ctr. v. Health & Human Servs*., 405 F. App'x 820 (5th Cir. 2010).

Analysis

On appeal, Blossomwood divides the claims CMS cited as abusive into three categories, i.e., those allegedly caused by (1) incompatibility between Blossomwood's electronic health record and electronic billing systems; (2) "inadvertent charting and billing errors by formerly employed" certified registered nurse practitioners (CRNPs); and (3) certifications by Dr. Pukis of the need for home health services for patients who were released from hospital while the doctor was out of the country. Request for Review (RR) at 2. Below, we first address Blossomwood's explanations for the three categories of false claims and then review Blossomwood's other general arguments for reversing the revocation.

A. *Blossomwood's assertions about the causes of the claims at issue do not refute the evidence that multiple claims were submitted for services that could not have been furnished as billed.*

Blossomwood argues that CMS should not have considered as a basis for revocation categories of false claims which Blossomwood attributes to inadvertent errors. RR at 3. Blossomwood relies as authority for this argument on selected language from the preamble to the regulation to show that CMS did not intend to use revocation under the regulation "for isolated occurrences or accidental billing errors," but rather intended to target suppliers "engaging in a pattern of improper billing." *Id*. (quoting 73 Fed. Reg. at 36,455 (June 27, 2008)) (Blossomwood's emphasis and internal quotation marks omitted). According to Blossomwood, the first two categories of claims were "accidental billing errors" that should not have triggered revocation in the absence of any evidence of fraudulent intent. *Id*.

Blossomwood asserts that it notified CMS in its reconsideration request that it had identified "numerous errors in communication between Blossomwood's EHR charting and billing systems, Praxis and CollaborateMD, respectively, where the bill submitted to Medicare for services performed by a CRNP was inadvertently submitted under Dr. Pukis' provider number" as a "result of technical miscommunications between the Praxis and CollaborateMD systems." RR at 4. According to Blossomwood, until receiving the revocation notice, it was "not aware that issues relating to the compatibility of Blossomwood's EHR and billing systems still occurred." *Id*. To dispute the ALJ's

finding that it failed to proffer evidence tying the claims to the alleged incompatibility issues, Blossomwood points to a June 30, 2017 letter from its IT provider reporting that these issues "were occurring intermittently, throughout the time period the erroneous claims were submitted." *Id.*; P. Ex. 2, Ex. C.

The June 30, 2017 letter fails to undermine the ALJ's point, which was that even were it relevant that the claims were inadvertently false – which it is not – Blossomwood proffered no evidence that these particular claims resulted from charting-and-billing-system incompatibilities. P. Ex. 2, Ex. C at 1. The letter does assert that Blossomwood experienced many repeated frustrations with its Praxis software since 2011, including, among other issues, "[p]roblems with Praxis/Collaborate not working together." *Id*. It does not, however, assert that any of these problems with systems working together actually caused these improper claims to be submitted. As the ALJ noted, the only information presented about this connection was in attachments to the reconsideration request consisting of a chart listing claims and making generic conclusory statements about the category of error in which each allegedly fell. ALJ Decision at 4; P. Ex. 2, Ex. B.

What the letter **does** tend to undermine are two of Blossomwood's own contentions. First, if Praxis was causing multiple problems since 2011 to the point that the IT provider advised by 2017 that it would not troubleshoot the software further without input from Praxis, as the letter indicates (P. Ex. 2, Ex. C at 2), it is hard to reconcile that with Blossomwood's position that it was unaware that problems were "still occurring" throughout the relevant years until it received the revocation notice. Second, the IT provider states that, while "many of the continuing factors to these issues may be out of your control," no other practices among those the IT provider serviced have had such serious problems for such an extended period and that "most . . . would have already made a change rather than continue." *Id.* at 1. Hence, Blossomwood's own evidence suggests that, if indeed compatibility problems in its software systems caused some of the false claims, Blossomwood had at least some control over the causes and also could have taken steps to change the systems rather than allowing the problems to continue for so long.

In any case, the ALJ correctly found that inadvertence is not a defense when many claims are submitted that could not have been provided as claimed. ALJ Decision at 4. Blossomwood's reliance on the preamble language it selectively quotes (RR at 3) to excuse multiple submissions of false claims ignores further discussion on the same page of what CMS meant by isolated or accidental errors:

> CMS, not a Medicare contractor, will make the determination for revocation under the authority at § 424.535(a)(8). We will direct contractors to use this basis of revocation after identifying providers or suppliers that have these billing issues. We have found numerous examples

> of situations where a physician claims to have furnished a service to a beneficiary more than a month after their recorded death, or when the provider or supplier was out of State when the supposed services had been furnished. In these instances, the provider has billed the Medicare program for services which were not provided and has submitted Medicare claims for service to a beneficiary who could not have received the service which was billed. . . .
>
> . . . 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. at 36,455.[5] In context, CMS indicated here that, rather than having its contractors strictly enforce the revocation provision whenever a claim was filed for services that could not have been provided as presented, it would exercise its own discretion in deciding whether to revoke and would limit revocation to situations where at least three "impossible"[6] claims have been submitted. CMS also indicated, however, that the primary responsibility to prevent the submission of such claims rests with the supplier.

This understanding of CMS's intent has been the basis for many prior Board decisions. For example, the Board upheld an ALJ's conclusion in granting summary judgment in another case involving multiple impossible claims, holding that whether "improper billing resulted from intentional fraud or accidental errors was immaterial and hence did

[5] We note that the revisions to the regulation in 2014 added an additional subsection (424.535(a)(8)(ii)) that expanded the basis for revocation for abuse of billing beyond submission of claims that "could not" have been provided to authorize revoking suppliers with a pattern or practice of submitting claims that do not meet Medicare requirements. 79 Fed. Reg. at 72,532. The previous regulatory language was retained as 424.535(a)(8)(i) without change. Therefore, the preamble discussion of that language when it was adopted remains relevant in interpreting its meaning.

[6] We use "impossible" as shorthand to refer to claims that "could not have been furnished to a specific individual on the date of service" for reasons described in section 424.535(a)(8)(i). *See, e.g., John M. Shimko, D.P.M.*, DAB No. 2689, at 7 (2016).

not involve a dispute of material fact." *John M. Shimko, D.P.M.*, DAB No. 2689, at 5 (2016) (claims for podiatric services provided after date of death). Similarly, in a case involving a podiatrist's claims for "impossible" services to amputees and decedents, the Board held 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.

Louis J. Gaefke, D.P.M., DAB No. 2554, at 7 (2013).

We also reject as irrelevant, as did the ALJ (ALJ Decision at 3-4), Blossomwood's assertions that its actions were not "egregious," "improper," or "abusive" in submitting these claims and that it did not have "any intent to defraud" Medicare. RR at 4-5. As the Board has explained, the reference in this regulatory provision to "abuse of billing privileges does **not** necessarily imply fraud but rather encompasses other forms of misuse of the privilege of submitting Medicare claims." *Shimko* at 7 (emphasis in original); *see also Howard B. Reife, D.P.M.*, DAB No. 2527, at 5 (2013) (quoting with approval the conclusion of the ALJ in that case 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'"). The Board also pointed out in *Shimko* that, while "abuse" may indeed sometimes refer to corrupt practice, the word is also defined to encompass less egregious behavior, such as "wrong or improper use; misuse: the abuse of privileges." *Shimko* at 7 (quoting an example from *dictionary.com*) (internal quotation marks omitted).

The same principles govern Blossomwood's contentions about claims submitted under Dr. Pukis' name for CRNP services provided in his absence. Blossomwood offers the following description of this category:

> When Dr. Pukis was out of the country, Dr. Pukis' CRNPs continued to see and treat his patients under the supervision of covering physicians. In Dr. Pukis' absence, covering physicians and CRNPs were instructed to bill and, to Appellants' knowledge, did bill under their own provider numbers. CRNPs are instructed not to bill under Dr. Pukis' profile if he is not personally providing services to a patient. In the claims identified by CMS

> in the Revocation Notice, the identified CRNPs continued to chart services she provided under Dr. Pukis profile, despite being instructed to use her own profile. Neither Appellant had any knowledge that the CRNPs were billing for their services under Dr. Pukis' profile until it investigated the claims listed in the Revocation Notice.

RR at 5. The Board has previously held that claiming services provided by CRNPs while a physician is out of the country using the billing number of the physician constitutes abusive billing under section 424.535(a)(8)(i). *Zille Shah, M.D., et al.*, DAB No. 2688 (2016). While Blossomwood claims to have been unaware of the billing practices of its CRNPs and to have instructed them to do otherwise, Blossomwood fails to recognize its own responsibility to control and monitor the use of its billing number to ensure that only proper claims are submitted, especially given that it failed to detect the repeated misuse over multiple years.

Blossomwood makes somewhat different arguments as to the claims involving home health certification. First, Blossomwood asserts that these claims were not improper at all, because regulatory provisions at 42 C.F.R. § 424.22 allow the physician to certify the need for home health before or as soon as possible after the services begin, and the certification could properly be signed later so long as the claims were not submitted until after the certification was signed. RR at 6-7 (also citing CMS Pub. 100-04, Ch. 4, § 30.1 (Rev. 101 (Change Request 9748), Sept. 16, 2016) https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c04.pdf). Second, Blossomwood argues that the ALJ held the claims improper despite CMS acknowledging in the reconsideration determination that the "home health related claims were likely billed appropriately." *Id*. at 7. The patients at issue were released from the hospital into home health care while Dr. Pukis was out of the country (CMS Ex. 1, at 5), but Blossomwood asserts that Dr. Pukis could properly certify the need after his return. RR at 7.[7] The reconsideration determination says the following about this category:

> Blossomwood states that 42 C.F.R. § 424.22(a)(2) allows the certification of need for home health services to be obtained at the time the plan of care is established or as soon thereafter as possible, and that in compliance with the regulation, Dr. Pukis signed and dated the home health certifications referenced in the claims analysis upon his return to the country. As true as that may be, Blossomwood still had an obligation to ensure that the claims submitted are submitted accurately and correctly.

CMS Ex. 1, at 6. We do not find here a clear statement of whether or why CMS concluded that the home health claims were incorrect or inaccurate as submitted.

[7] The ALJ's discussion of this category appears to misconstrue the issue as involving whether the physician provided required supervision of home health care. *See* ALJ Decision at 5.

We need not resolve this aspect of the dispute, however, because a review of the chart Blossomwood submitted with its request for reconsideration indicates that it identified fewer than 15 claims that allegedly fell in this category (out of 115 total claims). P. Ex. 2, Ex. B. The undisputed facts relating to the first two categories of claims support the ALJ's conclusion that, as a matter of law, CMS had the authority to revoke Blossomwood's billing privileges.

B. *Blossomwood's general arguments provide no basis to reverse the ALJ Decision.*

1. The ALJ did not err in deciding the matter on summary judgment.

Blossomwood argues that it was improper for the ALJ to decide the case on summary judgment without holding a hearing. According to Blossomwood, a genuine dispute of material fact exists about whether it "engaged in a pattern of abusive billing," which the ALJ dismissed without "substantial evidence" or "proper analysis." Blossomwood Reply Br. at 2.

The Board has discussed the application of the summary judgment standard in a case involving impossible claims for durable medical equipment items shipped to beneficiaries who were deceased. The supplier there challenged summary judgment on the grounds that it had not conceded that it erroneously submitted 78 such claims. *Med-Care Diabetic & Med. Supplies, Inc*., DAB No. 2764, at 1-17 (2017). The Board rejected that challenge because Med-Care failed to rebut the evidence that multiple claims were submitted for deceased beneficiaries. The Board explained that "CMS need only provide evidence of three or more instances of billing by Med-Care for items furnished to deceased beneficiaries to be entitled to summary judgment. By contrast, Med-Care must furnish evidence disputing the existence of a pattern of abusive billing in order to overcome summary judgment." *Id*. at 17.

As we concluded above, Blossomwood offered no evidence disputing the submission of more than 100 claims (even omitting the home health certifications) that could not have been provided as claimed because Dr. Pukis was out of the country, i.e., impossible claims, in a span of about three years. Such repeated false billing, even in the absence of intent, amply supports CMS's authority to impose revocation based on a pattern of impossible, and therefore abusive, billing.

Moreover, for a factual dispute to preclude summary judgment, it must be material. For that reason, we also reject Blossomwood's argument that summary judgment was inappropriate because the ALJ did not resolve its allegations and associated evidentiary presentations about the potential impact of Blossomwood's revocation on beneficiaries'

access to care in its area. *See* RR at 7-8. As we explain further in the next section, arguments going to the equity or advisability of CMS's decision to revoke are not within the scope of the ALJ's review authority. Therefore, disputes about facts relating only to such issues are not material.

2. The ALJ correctly understood his review to be limited to whether CMS was authorized to revoke based on the regulatory provision cited and not to extend to whether CMS should have exercised its discretion to take that action.

Blossomwood raises several issues which it suggests that the ALJ was obliged to reach beyond the question of whether it indeed submitted multiple impossible claims. For example, Blossomwood points to what it considers mitigating factors and states that the ALJ "failed to properly rebuke CMS's disregard of the mitigating circumstances that Appellants took reasonable steps to ensure that claims submitted to Medicare were and will be properly billed in the future, and that the claims were only a small fraction of the overall claims submitted by Appellants." RR at 6. It contends that the disputed claims represent an error rate of less than 0.29%, "representing an amount in controversy of $4,183.19, which has been voluntarily repaid," making it "inequitable" to revoke on this basis. *Id.* at 5.

The text of section 424.535(a)(8)(i) does not provide for "mitigating factors" of any kind in determining whether revocation is authorized. While CMS may consider many facts and circumstances in deciding whether to permit its contractor to revoke a supplier's billing privileges in a particular case, it is well-established that the role of the ALJ, and of the Board in turn, is to ensure that CMS has acted within its authority. The Board recently reiterated this:

> Section 424.535 of the subpart P regulations specifies the reasons for which CMS may legally revoke a provider or supplier's billing privileges. So long as CMS has shown that one of the regulatory bases [for revocation] exists, the Board may not refuse to apply the regulation and must uphold the revocation. *Patrick Brueggeman, D.P.M.*, DAB No. 2725, at 15 (2016), and the cases cited therein. Therefore, we cannot consider as part of this appeal whether and to what extent CMS weighed offense severity, mitigating circumstances and other such factors when it determined to revoke Petitioners' billing privileges.

Wassim Younes, M.D., et al., DAB No. 2861, at 7 (2018).

As far as "error rate," section 424.535(a)(8)(i) does not include any requirement for a particular frequency of abusive claims. *John P. McDonough III, Ph.D., et al.*, DAB No. 2728, at 8 (2016) (recognizing that "the Board has made clear that section 424.535(a)(8) [prior to the addition of subsection (a)(8)(ii)] does not require CMS to establish an error rate or percentage of improper claims").[8] Whether CMS's determination here is somehow "inequitable" is not a matter subject to our review as we do not have authority to grant equitable relief from lawful application of the governing regulations. *Brueggeman* at 15 ("The Board has consistently held that neither it nor an ALJ has the authority to restore a supplier's billing privileges on equitable grounds." (citations omitted)).

Blossomwood's contentions about its efforts to ensure future compliance and the potential impact of the loss of its services on beneficiaries' access to care similarly amount to an invitation for us to grant equitable relief from revocation. As to the access argument, it would also ask us to second-guess CMS's discretionary decision given that, as the ALJ noted, CMS expressly rejected this claim. ALJ Decision at 5 n.2.

Finally, Blossomwood asks us to reduce the three-year reenrollment bar which CMS imposed pursuant to 42 C.F.R. § 424.535(c). The length of the reenrollment bar imposed by CMS is not one of the initial determinations identified in section 42 C.F.R. § 498.3 for which ALJ and Board review is available, unlike CMS's decision to revoke a supplier's enrollment for which review is provided by section 498.3(b)(17). Therefore, the Board has repeatedly held that we cannot alter the length of a reenrollment bar. *See, e.g., Mohammad Nawaz, M.D., et al.*, DAB No. 2687, at 15 (2016) (citing *Vijendra Dave, M.D.*, DAB No. 2672, at 10-11 (2016)).

[8] By contrast, section 424.535(a)(8)(ii), added in 2014, does identify "percentage of submitted claims that were denied" as one of the factors CMS is to consider in determining whether a supplier "has a pattern or practice of submitting claims that fail to meet Medicare requirements." That subsection, however, deals with the submission of any claims not properly payable, whereas (a)(8)(i) is limited to impossible claims, which by their nature should be far less likely to occur.

Conclusion

We affirm the ALJ Decision upholding the revocation of Appellants' Medicare enrollment and billing privileges.

/s/
Christopher S. Randolph

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member