Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Kelvin D. Gipson, DPM
(NPI: 1013022698; PTAN: CZ576A),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-4203

Decision No. CR4550

Date: March 21, 2016

DECISION

The Medicare enrollment and billing privileges of Petitioner, Kelvin D. Gipson, DPM, are revoked pursuant to 42 C.F.R. § 424.535(a)(8)(i),[1] effective May 24, 2015.

I. Background

First Coast Service Options, Inc. (FCSO), a Centers for Medicare & Medicaid Services (CMS) Medicare contractor, notified Petitioner by letter dated April 24, 2015, that his Medicare billing number and billing privileges were revoked effective May 23, 2015. FCSO cited 42 C.F.R. § 424.535(a)(8) as the basis for the revocation. FCSO also notified Petitioner that he was subject to a three-year bar to re-enrollment pursuant to 42 C.F.R. § 424.535(c). CMS Exhibit (Ex.) 1 at 8-14. Petitioner requested reconsideration on June 19, 2015. CMS Ex. 3. On July 7, 2015, CMS upheld the revocation on reconsideration. CMS Ex. 1 at 1-4.

---

[1] Citations are to the 2015 revision of the Code of Federal Regulations (C.F.R.), unless otherwise stated.

Petitioner filed a request for hearing (RFH) before an administrative law judge (ALJ) on September 3, 2015. On October 2, 2015, the case was assigned to me for hearing and decision and I issued an Acknowledgement and Prehearing Order (Prehearing Order).

On November 2, 2015, CMS filed a motion for summary judgment (CMS Br.) with CMS Exs. 1 and 2. On November 4, 2015, CMS filed CMS Ex. 3. On December 4, 2015, Petitioner filed an opposition to CMS's motion and a cross-motion for summary judgment (P. Br.). On December 21, 2015, CMS filed its reply (CMS Reply). On December 22, 2015, Petitioner filed an objection to the CMS reply brief, specifically to references to CMS Ex. 2 contained in the CMS reply brief.

Petitioner did not object to my consideration of CMS Exs. 1 and 3 and they are admitted. On November 12, 2015, Petitioner filed an objection to my consideration of CMS Ex. 2. Petitioner objects on grounds that CMS Ex. 2 contains new and prejudicial information that CMS had not previously provided to Petitioner. Petitioner argues that CMS Ex. 2 contains information beyond the scope of the basis for revocation cited by CMS. CMS Ex. 2 appears on its face to be the report and recommendation to revoke Petitioner's Medicare enrollment and billing privileges. The document appears to have been prepared by Investigator Brenda Turner, SafeGuard Services LLC, the Zone Program Integrity Contractor (ZPIC). The document is unsigned and unsworn. CMS Ex. 2 at 1. However, Petitioner does not dispute the relevance or authenticity of this document only that it contains information in addition to the allegations in the FCSO notice of initial determination and the CMS reconsidered determination. CMS Ex. 2 appears to have been part of the administrative record or "file" considered by CMS on reconsideration. CMS Ex. 1 at 1. CMS Ex. 2 is admitted. However, I do not consider any allegations in CMS Ex. 2 of possible noncompliance or dereliction other than allegations specifically cited by CMS in the reconsidered determination as a basis for revocation.

II. Discussion

A. Applicable Law

Section 1831 of the Social Security Act (the Act) (42 U.S.C. § 1395j) establishes the supplementary medical insurance benefits program for the aged and disabled known as Medicare Part B. Administration of the Part B program is through contractors, such as FCSO. Act § 1842(a) (42 U.S.C. § 1395u(a)). Payment under the program for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of

services and suppliers.[2] Act §§ 1835(a) (42 U.S.C. § 1395n(a)), 1842(h)(1) (42 U.S.C. § 1395u(h)(1)). Petitioner, a podiatric physician, is a supplier.

The Act requires the Secretary of Health and Human Services (Secretary) to issue regulations that establish a process for the enrollment in Medicare of providers and suppliers, including the right to a hearing and judicial review of certain enrollment determinations, such as revocation of enrollment and billing privileges. Act § 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to 42 C.F.R. § 424.505, suppliers such as Petitioner must be enrolled in the Medicare program and be issued a billing number to have billing privileges and to be eligible to receive payment for services rendered to a Medicare-eligible beneficiary.

The Secretary has delegated the authority to revoke enrollment and billing privileges to CMS. 42 C.F.R. § 424.535. CMS or its Medicare contractor may revoke an enrolled supplier's Medicare enrollment and billing privileges and supplier agreement for any of the reasons listed in 42 C.F.R. § 424.535. If CMS revokes a supplier's Medicare billing privileges, the revocation becomes effective 30 days after CMS or one of its contractors mails the revocation notice to the supplier, subject to some exceptions not applicable in this case. After a supplier's Medicare enrollment and billing privileges are revoked, the supplier is barred from reenrolling in the Medicare program for a minimum of one year, but no more than three years. 42 C.F.R. § 424.535(c).

A supplier whose enrollment and billing privileges have been revoked may request reconsideration and review as provided by 42 C.F.R. pt. 498. 42 C.F.R. § 424.545(a). A supplier submits a written request for reconsideration to CMS or its contractor. 42 C.F.R. § 498.22(a). CMS or its contractor must give notice of its reconsidered determination to the supplier, giving the reasons for its determination and specifying the conditions or requirements the supplier failed to meet, and the right to an ALJ hearing. 42 C.F.R. § 498.25. If the decision on reconsideration is unfavorable to the supplier, the supplier has the right to request a hearing by an ALJ and further review by the Departmental

---

[2] A "supplier" furnishes services under Medicare and includes physicians or other practitioners and facilities that are not included within the definition of the phrase "provider of services." Act § 1861(d) (42 U.S.C. § 1395x(d)). A "provider of services," commonly shortened to "provider," includes hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, hospice programs, and a fund as described in sections 1814(g) (42 U.S.C. § 1395f(g)) and 1835(e) (42 U.S.C. § 1395n(e)) of the Act. Act § 1861(u) (42 U.S.C. § 1395x(u)). The distinction between providers and suppliers is important because they are treated differently under the Act for some purposes.

Appeals Board (the Board). Act § 1866(j)(8) (42 U.S.C. § 1395cc(j)(8)); 42 C.F.R. §§ 424.545, 498.3(b)(17), 498.5. A hearing on the record, also known as an oral hearing, is required under the Act unless waived. *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743, 748-51 (6th Cir. 2004). The supplier bears the burden to demonstrate that it meets enrollment requirements with documents and records. 42 C.F.R. § 424.545(c).

B. Issues

Whether summary judgment is appropriate;

Whether there was a basis for the revocation of Petitioner's billing privileges and enrollment in Medicare.

C. Findings of Fact, Conclusions of Law, and Analysis

My conclusions of law are set forth in bold followed by my findings of fact and analysis. The findings of fact are based on the documents admitted as exhibits.

1. Summary judgment is appropriate.

The parties each requested summary judgment. As noted above, a supplier whose enrollment has been revoked has a right to a hearing and judicial review, and a hearing on the record is required under the Act. Act §§ 205(b), 1866 (h)(1), (j); 42 C.F.R. §§ 498.3(b)(1), (5), (6), (8), (15), (17), 498.5; *Crestview*, 373 F.3d at 748-51. A party may waive appearance at an oral hearing but must do so affirmatively in writing. 42 C.F.R. § 498.66. In this case, Petitioner has not waived the right to oral hearing or otherwise consented to a decision based only upon the documentary evidence or pleadings. Accordingly, disposition on the written record alone is not permissible, unless summary judgment is appropriate.

Summary judgment is not automatic upon request but is limited to certain specific conditions. The Secretary's regulations at 42 C.F.R. pt. 498 that establish the procedures to be followed in adjudicating Petitioner's case do not establish a summary judgment procedure or recognize such a procedure. However, the Board has long accepted that summary judgment is an acceptable procedural device in cases adjudicated pursuant to 42 C.F.R. pt. 498. *See, e.g.*, *Ill. Knights Templar Home*, DAB No. 2274 at 3-4 (2009); *Garden City Med. Clinic*, DAB No. 1763 (2001); *Everett Rehab. & Med. Ctr.*, DAB No. 1628 at 3 (1997). The Board also has recognized that the Federal Rules of Civil Procedure do not apply in administrative adjudications such as this, but the Board has accepted that Fed. R. Civ. Pro. 56 and related cases provide useful guidance for determining whether summary judgment is appropriate. Furthermore, a summary judgment procedure was adopted as a matter of judicial economy within my authority to regulate the course of proceedings and made available to the parties in the litigation of

this case by my Prehearing Order. The parties were given notice by the Prehearing Order that summary judgment is an available procedural device and that the law as it has developed related to Fed. R. Civ. Pro. 56 will be applied.

Summary judgment is appropriate when there is no genuine dispute as to any issue of material fact for adjudication and/or the moving party is entitled to judgment as a matter of law. In determining whether there are genuine issues of material fact for trial, the reviewer must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. The party requesting summary judgment bears the burden of showing that there are no genuine issues of material fact for trial and/or that it is entitled to judgment as a matter of law. Generally, the non-movant may not defeat an adequately supported summary judgment motion by relying upon the denials in its pleadings or briefs but must furnish evidence of a dispute concerning a material fact, i.e., a fact that would affect the outcome of the case if proven. *Mission Hosp. Reg'l Med. Ctr.*, DAB No. 2459 at 4 (2012) (and cases cited therein); *Experts Are Us, Inc.*, DAB No. 2452 at 4 (2012) (and cases cited therein); *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 at 3 (2010) (and cases cited therein); *see also Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986).

The standard for deciding a case on summary judgment and an ALJ's decision-making in deciding a summary judgment motion differ from that used in resolving a case after a hearing. On summary judgment, the ALJ does not make credibility determinations, weigh the evidence, or decide which inferences to draw from the evidence, as would be done when finding facts after a hearing on the record. Rather, on summary judgment, the ALJ construes the evidence in a light most favorable to the non-movant and avoids deciding which version of the facts is more likely true. *Holy Cross Vill. at Notre Dame, Inc.*, DAB No. 2291 at 5 (2009). The Board also has recognized that on summary judgment it is appropriate for the ALJ to consider whether a rational trier of fact could find that the party's evidence would be sufficient to meet that party's evidentiary burden. *Dumas Nursing & Rehab., L.P.*, DAB No. 2347 at 5 (2010). The Secretary has not provided in 42 C.F.R. pt. 498 for the allocation of the burden of persuasion or the quantum of evidence required to satisfy the burden of persuasion. However, the Board has provided some persuasive analysis regarding the allocation of the burden of persuasion in cases subject to 42 C.F.R. pt. 498. *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd*, *Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 Fed. App'x 181 (6th Cir. 2005).

Viewing the evidence before me in a light most favorable to Petitioner and drawing all inferences in Petitioner's favor, I conclude that there are no genuine disputes as to any material facts pertinent to revocation under 42 C.F.R. § 424.535(a)(8)(i) that require a hearing in this case. The issues in this case raised by Petitioner related to revocation under 42 C.F.R. § 424.535(a)(8)(i) must be resolved against him as a matter of law.

The undisputed evidence shows that there is a basis for revocation of Petitioner's Medicare enrollment and billing privileges. Accordingly, summary judgment is appropriate.

> **2. Billing privileges are abused, within the meaning of 42 C.F.R. § 424.535(a)(8)(i), when three or more claims are submitted to Medicare for services that could not have been furnished to the specific individuals identified in the claims on the dates the services were claimed to be delivered.**
>
> **3. Petitioner submitted 28 claims for payment to Medicare; the claims were false because they were for services not delivered to the 25 dead beneficiaries listed on the claims; and the filing of the claims constituted an abuse of billing privileges under 42 C.F.R. § 424.535(a)(8)(i).**
>
> **4. It is no defense to a revocation action for abuse of billing privileges under 42 C.F.R. § 424.535(a)(8) that the false claims were due to inadvertent or unintentional errors of Petitioner's agents or employees or others.**
>
> **5. There is a basis for revocation of Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(8)(i).**
>
> **6. The effective date of revocation in this case was May 24, 2015, 30 days after the date of the notice of initial determination to revoke. 42 C.F.R. § 424.535(g).**
>
> **7. I have no authority to review the imposition or duration of a bar to re-enrollment. 42 C.F.R. §§ 424.545, 498.5(*l*)(1)-(2).**

The notice of initial determination in this case was issued on April 24, 2015, and the reconsidered determination was issued on July 7, 2015. Therefore, 42 C.F.R. § 424.535(a)(8) as amended effective February 3, 2015, applies in this case. On December 5, 2014, 42 C.F.R. § 424.535(a)(8) was amended to re-number 42 C.F.R. § 424.535(a)(8) as § 424.535(a)(8)(i) and add 42 C.F.R. § 424.535(a)(8)(ii). The change was effective February 3, 2015. 79 Fed. Reg. 72,500, 72,513-521 (Dec. 5, 2014).

The revision effective February 3, 2015 provides:

> (8) *Abuse of billing privileges.* Abuse of billing privileges includes either of the following:

> (i) The provider or supplier submits a claim or claims for services that could not have been furnished to a specific individual on the date of service. These instances include but are not limited to the following situations:
>
> (A) Where the beneficiary is deceased.
>
> (B) The directing physician or beneficiary is not in the state or country when services were furnished.
>
> (C) When the equipment necessary for testing is not present where the testing is said to have occurred.
>
> (ii) CMS determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements. In making this determination, CMS considers, as appropriate or applicable, the following:
>
> (A) The percentage of submitted claims that were denied.
>
> (B) The reason(s) for the claim denials.
>
> (C) Whether the provider or supplier has any history of final adverse actions (as that term is defined under § 424.502) and the nature of any such actions.
>
> (D) The length of time over which the pattern has continued.
>
> (E) How long the provider or supplier has been enrolled in Medicare.
>
> (F) Any other information regarding the provider or supplier's specific circumstances that CMS deems relevant to its determination as to whether the provider or supplier has or has not engaged in the pattern or practice described in this paragraph.

42 C.F.R. § 424.535(a)(8) (italics in original). I conclude that the basis for revocation in this case is that currently described by 42 C.F.R. § 424.535(a)(8)(i), and that is the basis for revocation that is subject to my review.

The regulation provides Petitioner notice that billing privileges and Medicare enrollment may be revoked for an abuse of billing privileges. 5 U.S.C. §§ 551(4), 552(a)(1). The elements of the CMS prima facie case for revocation based on the language of 42 C.F.R. § 424.535(a)(8)(i) are: (1) the provider or supplier submits one or more claims for services; and (2) the services for which a claim or claims were submitted could not have been delivered to the specific Medicare beneficiary on the date the service was claimed to have been delivered to him or her. *Realhab, Inc.*, DAB No. 2542 at 16-17 (2013). Although the plain language of the regulation seems clear enough at first blush, there have been several Board decisions that discussed the legislative history of the regulations for clarification of what was intended to be a sufficient basis for revocation. *Proteam Healthcare, Inc.*, DAB No. 2658 (2015); *Ronald J. Grason, M.D.*, DAB No. 2592 at 8 (2014); *Realhab, Inc.*, DAB No. 2542 at 16; *Howard B. Reife, D.P.M.*, DAB No. 2527 at 1-2 (2013). CMS, the proponent of the regulation, explained in comments to the final rulemaking in 2008:

> 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 services to a beneficiary who could not have received the service which was billed*.** This revocation authority is not intended to be used for isolated occurrences or accidental billing errors. Rather, this basis for revocation is directed at providers and suppliers who are engaging in a pattern of improper billing . . . . We believe that it is both appropriate and necessary that we have the ability to revoke billing privileges when services could not have been furnished by a provider or supplier. We recognize the impact that this revocation has, and a revocation will not be issued unless sufficient evidence demonstrates abusive billing patterns. **Accordingly, we will not revoke billing privileges under § 424.535(a)(8) *unless there are multiple instances, at least three*, where abusive billing practices have taken place** . . . . **In conclusion, *we believe that providers and suppliers are responsible for the claims they submit or the claims submitted on their behalf*. We believe it is essential**

> **that providers and suppliers take the necessary steps to ensure they are billing appropriately for services furnished to Medicare beneficiaries.**

73 Fed. Reg. 36,448, 36,455 (June 27, 2008) (emphases added). Based on this regulatory history, I conclude that CMS must also show as part of its prima facie case that there were more than one and at least three claims for services that could not have been delivered to the Medicare beneficiary named in the claims. I note that the drafters of the regulation also state that only CMS and not a Medicare contractor will make the determination to revoke pursuant to 42 C.F.R. § 424.535(a)(8). 73 Fed. Reg. at 36,455; 79 Fed. Reg. at 72,513-521. The Board's decision in *Proteam Healthcare, Inc.*, DAB No. 2658, is consistent with my interpretation and application and I reject Petitioner's argument for a different interpretation of *Proteam*. P. Br. at 17-21.

a. Undisputed Facts

Petitioner argues summary judgment for CMS is not appropriate. Petitioner agrees, however, that the facts are "largely undisputed." P. Br. at 1.

FCSO notified Petitioner on April 24, 2015, that his enrollment and billing privileges were revoked effective May 23, 2015. The notice alleged abuse of billing privileges and that revocation was pursuant to 42 C.F.R. § 424.535(a)(8). CMS Ex. 1 at 8-9. Attached to the FCSO notice was a list of 28 claims for 25 beneficiaries, with claims dated as early as February 2012 through December 2014. CMS Ex. 1 at 10; CMS Ex. 3 at 15. The parties were cautioned by the Prehearing Order that on summary judgment a fact alleged and not specifically denied may be accepted as true for purposes of a motion or cross-motion for summary judgment. Prehearing Order ¶ II.G. Petitioner does not deny that he or someone on his behalf filed the 28 claims alleged by FCSO. Petitioner does not deny that each of the 25 beneficiaries associated with each of the 28 claims was deceased and did not receive the service for which the claim was filed. P. Br. at 4. He specifically concedes that "each of the alleged billing errors . . . occurred." P. Br. at 5.
Petitioner requested reconsideration on June 19, 2015. CMS Ex. 3. Petitioner argued that there were erroneous claims based on erroneous patient identification by the nursing home or care facility where Petitioner delivered services. CMS Ex. 3 at 2. Petitioner stated that he did not intentionally submit claims to Medicare for services to deceased beneficiaries. Petitioner further stated that he did provide a service to a Medicare beneficiary for each claim alleged by FCSO, just not the deceased beneficiary listed on the claim. CMS Ex. 3 at 2. Petitioner explained that for 22 of the 25 beneficiaries identified by FCSO a misidentification had occurred and Petitioner submitted records and his affidavit to support the explanation. Petitioner had no records for 3 of the 25. CMS Ex. 3 at 2-6, 9-11, 16-77. I accept for purposes of summary judgment Petitioner's explanation as true. Specifically, Petitioner submitted 28 claims for services for the 25 beneficiaries on the FCSO list (CMS Ex. 3 at 15); the 25 listed beneficiaries were

deceased at the time services were claimed to have been delivered; services were actually delivered to other Medicare-eligible beneficiaries (even though there is no evidence that such services were reasonable and necessary for the beneficiaries); and the 25 deceased beneficiaries listed on the 28 claims were identified erroneously by the nursing home or facility as the beneficiaries receiving Petitioner's services. I further accept as true that Petitioner had no intent to abuse his billing privileges or defraud Medicare. I accept as true for purposes of summary judgment that Petitioner received no payment from Medicare for any of the claims alleged by FCSO. CMS Ex. 3 at 9-11; P. Br. at 4-6.

Petitioner asserts the same facts before me relying upon the evidence submitted on reconsideration. CMS Ex. 3. Petitioner does not offer additional documents for my consideration. Petitioner's list of witnesses for hearing includes Petitioner, who would testify consistent with the submissions on reconsideration, which I accept as true. Petitioner also lists an expert witness who would testify that Petitioner's billing records meet or exceed the industry standard for accuracy; any errors in billing are consistent with accidental billing errors; any errors are within the normal and expected error rate; and that, in his opinion, Petitioner did not engage in abusive or fraudulent billing. Petitioner's List of Proposed Witnesses and Expert Witness Disclosure. I accept that the witnesses Petitioner lists would testify consistent with the descriptions provided. I accept as true for purposes of summary judgment Petitioner's statements in his affidavit as summarized in the witness list. I accept the expert's opinions, to the extent relevant. However, I do not accept the expert's opinion on the legal issue of whether or not Petitioner abused his billing privilege within the meaning of 42 C.F.R. § 424.535(a)(8)(i), as that issue is solely for me to decide in this proceeding.

b. Analysis

I conclude that the undisputed facts are sufficient to establish a prima facie case of abuse of billing privileges under 42 C.F.R. § 424.535(a)(8)(i). The elements of the CMS prima facie case for revocation based on the language of 42 C.F.R. § 424.535(a)(8)(i) are: (1) the undisputed facts are that Petitioner submitted 28 claims for services provided to 25 beneficiaries; and (2) the services for which the 28 claims were submitted could not have been delivered to the 25 Medicare beneficiaries on the date the service was claimed to have been delivered because the 25 beneficiaries were dead when the services were claimed to have been delivered. *Realhab, Inc.*, DAB No. 2542 at 16-17. There is no requirement under the regulatory language for CMS to establish that Petitioner had any intent to defraud or engage in abusive billing. Furthermore, whether or not claims were paid is not relevant to whether there was a basis for revocation under 42 C.F.R. § 424.535(a)(8). The issue is whether or not Petitioner submitted claims for services that could not have been furnished to a specific individual on the claimed date of service. 42 C.F.R. § 424.535(a)(8)(i). The fact that a false claim is not paid is not a defense as it is the act of submitting more than three claims that triggers a possible revocation under 42 C.F.R. § 424.535(a)(8)(i).

I conclude that the undisputed facts establish that Petitioner filed claims for services provided to specific Medicare beneficiaries for dates of service after the dates of death of those beneficiaries. Therefore, CMS has made a prima facie showing. The issue is whether or not Petitioner has presented sufficient evidence to rebut the prima facie showing or to establish an affirmative defense.

The gist of Petitioner's defense is that misidentifications by nursing homes and other facilities caused the erroneous claims and those billing errors are not an abuse of billing privileges and should be excused. Petitioner also asserts that he has developed procedures to avoid similar errors in the future. Petitioner argues that the errors were accidental or unintentional and committed by the facilities where he delivered services and, therefore, do not constitute an abuse of billing privileges. P. Br. at 8-9; 15-17; CMS Ex. 3 at 10-11. Petitioner's defenses are not persuasive.

Petitioner identifies the following issues as being presented by this case:

> Whether the law requires perfection in Medicare billing and coding and allows CMS to adopt a zero-tolerance policy that penalizes unintentional billing errors;
>
> Whether CMS has exceeded its authority to revoke Medicare enrollment and billing privileges for billing errors;
>
> Whether, in this case, the billing errors amount to an abuse of billing privileges; and
>
> Whether CMS contractors have authority to revoke a provider's billing privileges under 42 C.F.R. § 424.535(a)(8).

P. Br. at 2.

The first issue raised by Petitioner is whether the law requires perfection in Medicare billing and coding and allows CMS to adopt a zero-tolerance policy that penalizes unintentional billing errors. P. Br. at 8-10. Whether or not CMS adopts a zero-tolerance policy is just that, a policy issue. As already discussed, 42 C.F.R. § 424.535(a)(8)(i) and its regulatory history gives suppliers notice that CMS may revoke an enrolled supplier's Medicare enrollment and billing privileges if the supplier submits three or more claims for services; and the services for which a claim or claims were submitted could not have been delivered to a Medicare beneficiary on the date the service was claimed to have been delivered. I would not characterize the impact of the regulation and CMS policy as a "zero-tolerance" policy because a single claim is insufficient and CMS has retained discretion to decide whether or not to revoke in individual cases even if more than three false claims are submitted. However, if as a matter of policy, CMS chooses to apply the

regulation strictly, it appears to be within CMS's discretion under the regulation to do so. My jurisdiction is limited to determining whether, consistent with the Act and regulations CMS has a basis to revoke Medicare enrollment and billing privileges. I have no authority to review the exercise of discretion by CMS to revoke where there is a basis for revocation. *Abdul Razzaque Ahmed, M.D.*, DAB No. 2261 at 19 (2009).

The second and third issues raised by Petitioner are addressed together, as CMS only has authority to revoke under 42 C.F.R. § 424.535(a)(8) if Petitioner's claims amount to an abuse of billing privileges. The second issue raised by Petitioner is whether CMS has exceeded its authority to revoke his Medicare enrollment and billing privileges for billing errors. P. Br. at 10-12. The third issue raised by Petitioner is whether the billing errors amount to an abuse of billing privileges. P. Br. at 12-17. Petitioner concedes that the 28 claims for 25 beneficiaries identified by FCSO were false or in error because he did not deliver services to the 25 deceased beneficiaries identified in those claims. Petitioner argues, however, that CMS has not presented evidence of a single abusive billing practice and that the evidence shows only isolated occurrences of accidental billing errors. P. Br. at 3. The gist of Petitioner's argument is that he delivered services to 25 individuals for which he submitted 28 claims to Medicare. But it was the long-term care facilities that gave him bad information about the identity of the individuals to whom he provided services and it was the correct information that was included in the 28 claims. Petitioner rationalizes that there are 28 simple billing errors, for which he should not be held responsible, because they do not amount to an abuse of billing privileges. The Board has upheld determinations that abuse in the context of 42 C.F.R. § 424.535(a)(8) occurs when a provider bills Medicare for services that could not have been provided to the Medicare beneficiary to whom the claim is related. *Realhab, Inc.*, DAB No. 2542 at 15. The Board has commented that a common definition of abuse is misuse, wrong, or improper use, and that the negligent submission of multiple erroneous claims for services that could not have been delivered to beneficiaries, amounts to abuse. *Louis J. Gaefke, D.P.M.*, DAB No. 2554 at 9 (2013); *Howard B. Reife, D.P.M.*, DAB No. 2527 at 6. CMS is not required to show that Petitioner intended to defraud Medicare before it revokes his enrollment and billing privileges. The regulation only requires the existence of claims for services that could not have been delivered. 42 C.F.R. § 424.535(a)(8); *Louis J. Gaefke, D.P.M.*, DAB No. 2554 at 7 ("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."). Petitioner's argument that he should not be held responsible for innocent clerical errors of the long-term facilities that misidentified the patients in this case is also without merit. P. Br. at 21-22. Petitioner is ultimately responsible as a matter of law for ensuring that his claims for Medicare reimbursement were accurate and for any errors in those claims. *Louis J. Gaefke, D.P.M.*, DAB No. 2554 at 5-6 (citing 73 Fed. Reg. at 36,455). Petitioner cannot avoid responsibility for his claims by the simple expedient of shifting responsibility and liability to the long-term care facilities where he delivered services. Petitioner filed 28 claims for services to 25 former Medicare

beneficiaries who were dead at the time the claimed services were supposed to be delivered. Petitioner or his billing agent filed the claims. Petitioner, as the enrolled supplier, is responsible to ensure that he is in compliance with Medicare requirements. 42 C.F.R. §§ 424.510(d)(3); 424.516. As the drafters of 42 C.F.R. § 424.535(a)(8) stated:

> In conclusion, we believe that providers and suppliers are responsible for the claims they submit or the claims submitted on their behalf. We believe 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.

The last question raised by Petitioner is readily answered. CMS has made clear in the regulatory history already cited, that CMS exercises the authority to revoke under 42 C.F.R. § 424.535(a)(8) not its contractor. No provision of the Act or the regulations requires that CMS make the decision to revoke for abuse of billing privileges under 42 C.F.R. § 424.535(a)(8). Rather, CMS stated as part of the regulatory history for 42 C.F.R. § 424.535(a)(8) that CMS would make the determination to revoke for abuse of billing privileges rather than relying upon its contractors for that determination. At most, the statement in the regulatory history is evidence of a CMS policy not a statement of law. CMS did not violate its policy in this case. Pursuant to 42 C.F.R. § 498.5(*l*)(1) a supplier dissatisfied with an initial determination to revoke its Medicare enrollment is entitled to request reconsideration. If a supplier is dissatisfied with the reconsidered determination that upholds revocation, the supplier has the right to request a hearing before an ALJ. 42 C.F.R. § 498.5(*l*)(2). Therefore, it is the reconsidered determination that is before me for hearing and decision. In this case the reconsidered determination reflects on its face that it was made by the CMS Provider Enrollment Oversight Group not FCSO. CMS Ex. 1 at 1-4. Accordingly, I conclude that CMS complied with its policy to make the revocation determination rather than have FCSO make that decision. Even if the fact that FCSO made the initial determination was considered a violation of the CMS policy, that policy was clearly remedied by the reconsidered determination made by CMS. Accordingly, I conclude that CMS exercised the authority to revoke Petitioner's enrollment and billing privileges in this case.

I conclude that there is a basis to revoke Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(8)(i).

Petitioner argues in his request for hearing that CMS arbitrarily chose an effective date of revocation. I agree that the effective date stated in the initial determination is in error. The regulation provides that when CMS revokes a supplier's Medicare billing privileges, the revocation becomes effective 30 days after CMS or one of its contractors mails the revocation notice to the supplier, subject to some exceptions not applicable in this case.

42 C.F.R. § 424.535(g). In this case, the notice of the initial determination revoking Petitioner's Medicare enrollment and billing privileges was dated April 24, 2015. Therefore, the effective date of revocation was May 24, 2015, not May 23, 2015, as stated in the FCSO notice of initial determination. CMS Ex. 1 at 8. Contrary to Petitioner's argument which is unsupported by any citation of authority, I conclude that this simple one-day error does not invalidate the revocation.

Petitioner argues in his request for hearing that a three-year bar to re-enrollment is disproportionate. Under the regulations, the re-enrollment bar after a revocation is a minimum of one year and a maximum of three years. 42 C.F.R. § 424.535(c). There is no statutory or regulatory language establishing a right to review of the duration of the re-enrollment bar CMS imposes. Act § 1866(j)(8); 42 C.F.R. §§ 424.535(c); 424.545; 498.3(b); and 498.5. The Board has held that the duration of a revoked supplier's re-enrollment bar is not an appealable initial determination listed in 42 C.F.R. § 498.3(b), and thus, is not subject to ALJ review. *Vijendra Dave*, DAB No. 2672 at 11 (2016).

To the extent Petitioner's arguments may be construed as a request for equitable relief, I have no authority to grant equitable relief. *US Ultrasound*, DAB No. 2302 at 8 (2010) ("[n]either the ALJ nor the Board is authorized to provide equitable relief by reimbursing or enrolling a supplier who does not meet statutory or regulatory requirements."). I am also required to follow the Act and regulations and have no authority to declare statutes or regulations invalid. *1866ICPayday.com, L.L.C.*, DAB No. 2289 at 14 (2009) ("[a]n ALJ is bound by applicable laws and regulations and may not invalidate either a law or regulation on any ground.").

III. Conclusion

For the foregoing reasons, the Medicare enrollment and billing privileges of Petitioner are revoked pursuant to 42 C.F.R. § 424.535(a)(8)(i), effective May 24, 2015.

/s/
Keith W. Sickendick
Administrative Law Judge