Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Douglas Bradley, M.D.
Docket No. A-15-64
Decision No. 2663
October 27, 2015

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Douglas Bradley, M.D. (Petitioner) appeals the February 26, 2015 decision of the Administrative Law Judge (ALJ). The ALJ sustained a determination by the Centers for Medicare & Medicaid Services (CMS) to revoke Petitioner's Medicare billing privileges. *Douglas Bradley, M.D.*, DAB CR3670 (2015) (ALJ Decision). We affirm the ALJ Decision because it is supported by substantial evidence and free of legal error.

Legal Background

Section 424.535(a) of title 42 of the Code of Federal Regulations authorizes CMS to revoke the Medicare billing privileges of a physician (or other Medicare "supplier") for any of the "reasons" specified in paragraphs one through 14 of that section. A supplier whose Medicare billing privileges are revoked under section 424.535(a) is "barred from participating in Medicare from the date of the revocation until the end of the re-enrollment bar." 42 C.F.R. § 424.535(c). "The re-enrollment bar lasts a minimum of 1 year, but not greater than 3 years, depending on the severity of the basis for revocation." *Id.*

Paragraph 12 of section 424.535(a) provides that CMS may revoke a supplier's Medicare billing privileges if "*Medicaid* billing privileges are terminated or revoked by a State Medicaid Agency." 42 C.F.R. § 424.535(a)(12)(i) (italics added). Paragraph 12 further states that "Medicare may not terminate unless and until a provider or supplier has exhausted all applicable appeal rights." *Id.* § 424.535(a)(12)(ii).

In promulgating section 424.535(a)(12), CMS explained that it is intended to work "in tandem" with section 6501 of the Patient Protection and Affordable Care Act (ACA) and the Medicaid regulations which implement section 6501. *See* 76 Fed. Reg. 5862, 5946 (Feb. 2, 2011). ACA § 6501 requires a state Medicaid program to "terminate" the Medicaid participation of any individual or entity whose participation in Medicare or

another state's Medicaid program has been "terminated." Pub. L. 111-148, § 6501, 124 Stat. 776. CMS has construed that provision as applicable to individuals or entities whose program participation has been terminated "for cause" – that is, for reasons that pose a "risk of fraud, waste, . . . abuse," and other harm to the Medicare and Medicaid programs and to those programs' beneficiaries. 76 Fed. Reg. at 5943; *see also* 42 C.F.R. § 455.101(stating, in the definition of "termination," that "[t]he requirement for [Medicaid] termination applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include, but is not limited to . . . (i) [f]raud; (ii) [i]ntegrity; or (iii) [q]uality").

Case Background

The following facts, as recounted by the ALJ, are undisputed.

Petitioner is an orthopedic surgeon who, when the actions at issue in this case occurred, was licensed to practice medicine in New Jersey, Pennsylvania, and New York. ALJ Decision at 1.

In January 2011, the New Jersey Attorney General filed a complaint against Petitioner with the New Jersey State Board of Medical Examiners (NJBME), charging him with six counts of professional misconduct, which we will describe in more detail later. *Id.* The disciplinary matter was resolved on December 27, 2011 when NJBME and Petitioner entered into a Final Consent Order and Settlement Agreement. *Id.* In that agreement Petitioner neither admitted nor denied the charges against him but nonetheless agreed to, among other things, the imposition of a civil penalty and costs totaling $48,455, three years of probation, and various conditions on his medical practice. *Id.* at 2.

In 2012, the New York Board of Professional Medical Conduct charged that Petitioner had violated New York Education Law § 6530 by (1) having been found guilty by another state's professional disciplinary body (namely, the NJBME) of improper professional practice or professional misconduct that, had it occurred in New York, would have constituted professional misconduct under New York law and (2) having been disciplined by NJBME for that professional misconduct.[1] *Id.* To resolve the New York charges, Petitioner signed a Consent Agreement in which he: (1) stated that he did not contest the charges that "some of the conduct resulting in the New Jersey disciplinary action would constitute misconduct under the laws of New York State"; and (2) agreed to the imposition of certain sanctions, including "censure and reprimand" and the payment of a $2,000 fine. *Id.* (*quoting* CMS Ex. 6, at 6).

[1] Pennsylvania's Board of Medicine also charged Petitioner with professional misconduct after learning of New Jersey's disciplinary action. ALJ Decision at 2. However, the outcome of Pennsylvania's disciplinary action is not a basis for the challenged revocation.

In a letter dated July 26, 2013, the New York Office of the Medicaid Inspector General (NYOMIG) notified Petitioner that, based on his violation of New York Education Law § 6530, he was being excluded from participation in New York State's Medicaid program.[2] *Id.* at 3, 5 (*citing* CMS Ex. 6, at 12). The letter states that, after Petitioner's exclusion became effective on July 31, 2013, he would no longer be permitted to bill New York's Medicaid program for services or provide services related to medical care that would be billed to Medicaid. *Id.* The July 26, 2013 letter further states that Petitioner could appeal the exclusion by submitting – within 30 days – written argument and documentation to NYOMIG's General Counsel but only with respect to the certain issues, including "whether the [exclusion] determination was based upon a mistake of fact" and "whether the sanction imposed was reasonable." *Id.* at 5, 11; *see also* CMS Ex. 6, at 12-13.

In a letter dated April 8, 2014, Novitas Solutions, Inc. (Novitas), a Medicare Administrative Contractor acting on behalf of CMS, notified Petitioner that his Medicare billing privileges had been revoked effective August 1, 2013 and that he was barred from re-enrolling in Medicare for three years. ALJ Decision at 1, 3; CMS Ex. 1. The April 8, 2014 notice cites two paragraphs of section 424.535(a) as the legal grounds for the revocation: paragraph two, which is not at issue in this appeal[3]; and paragraph 12. ALJ Decision at 3.

In response to the revocation notice, Petitioner filed a request for reconsideration, but a Novitas hearing officer upheld the initial determination. ALJ Decision at 3. Petitioner then requested an administrative law judge hearing to challenge the revocation. *Id.* As instructed by the ALJ, Petitioner and CMS exchanged documentary evidence and written direct testimony. *Id.* at 4. Finding that "neither party [had] requested to cross-examine a

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[2] NYOMIG's notice states that the exclusion was imposed in accordance with section 515.7(e) of title 18 of the New York Codes, Rules and Regulations. Section 515.7(e) states:

> Upon receiving notice that a person has been found to have violated a State or Federal statute or regulation pursuant to a final decision or determination of an agency having the power to conduct the proceeding and after an adjudicatory proceeding has been conducted, in which no appeal is pending, or after resolution of the proceeding by stipulation or agreement, and where the violation resulting in the final decision or determination would constitute an act described as professional misconduct or unprofessional conduct by the rules or regulations of the State Commissioner of Education or the State Board of Regents, or an unacceptable practice under this Part, or a violation of article 33 of the Public Health Law, the department may immediately sanction the person and any affiliate.

18 N.Y. Comp. Codes, R. & Regs. § 515.7(e).

[3] CMS did not appeal the ALJ's refusal to sustain Petitioner's revocation under 42 C.F.R. § 424.535(a)(2), and so we decline to review or disturb that holding.

witness," the ALJ proceeded to "issue a decision based on the written record." ALJ Decision at 4.

Stating that the issue before him was "[w]hether CMS had a legitimate basis for revoking Medicare billing privileges" under 42 C.F.R. § 424.535(a), the ALJ held that the revocation of Petitioner's Medicare billing privileges could not be affirmed on the basis of paragraph two of section 424.535(a). *See* ALJ Decision at 5-7. The ALJ further held, however, that CMS had lawfully revoked Petitioner's Medicare billing privileges under paragraph 12, which, as noted, authorizes CMS to revoke a supplier's Medicare billing privileges if "Medicaid billing privileges [have been] terminated or revoked by a State Medicaid Agency." *Id.* at 7-12. In support of that holding, the ALJ found that: (1) NYOMIG was a "State Medicaid Agency"; (2) NYOMIG's "exclusion" of Petitioner from New York's Medicaid program was "equivalent" to a "termination" of his Medicaid billing privileges; (3) Petitioner did not appeal his exclusion within the 30-day period permitted by New York Medicaid regulations; and (4) his appeal of a decision to deny his request to be removed from a Medicaid "exclusion list" was "not an appeal related to the decision to exclude him from the New York Medicaid program." *Id.* at 7, 8, 11, 12. In addition, the ALJ rejected or refused to entertain various other arguments that, according to Petitioner, justify reversal of the revocation determination. *Id.* at 12-13. Finally, the ALJ held that he lacked "jurisdiction" to consider Petitioner's contention that the three-year re-enrollment bar imposed by CMS was "arbitrary and capricious." *Id.* at 13.

Petitioner then filed this appeal,[4] contending that the revocation of his Medicare billing privileges under section 424.535(a)(12) is unlawful and restating most of the arguments he presented to the ALJ.

Standard of Review

The Board's standard of review on a disputed factual issue is whether the ALJ decision is supported by substantial evidence in the record as a whole. *See Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program* ("*Guidelines"*), available at http://www.hhs.gov/dab/divisions/appellate/guidelines/prosupenrolmen.html. The standard of review on a disputed issue of law is whether the ALJ decision is erroneous. *Id.*

[4] In his reply brief, Petitioner requested oral argument. We have determined that the issues have been adequately presented by the parties in their written materials and that oral argument would not help our decision-making. We therefore deny the request for oral argument. *West Texas LTC Partners, Inc.*, DAB No. 2652, at 2 n.1 (2015) (denying oral argument on the ground that it would not "help [the Board's] decision making").

Substantial evidence means "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales*, 402 U.S. 389, 401 (1971), *quoting Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938). Under the substantial evidence standard, the Board does not re-weigh the evidence or overturn an ALJ's "choice between two fairly conflicting views" of the evidence; instead, the Board determines whether the contested finding could have been made by a reasonable fact-finder "tak[ing] into account whatever in the record fairly detracts from [the] weight" of the evidence that the ALJ relied upon. *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 488 (1951); *see also Allentown Mack Sales & Service, Inc. v. NLRB*, 522 U.S. 359, 377 (1998); *Golden Living Ctr. – Frankfort*, DAB No. 2296, at 9-10 (2009), *aff'd*, *Golden Living Ctr. – Frankfort v. Sec'y of Health & Human Servs.*, 656 F.3d 421 (6th Cir. 2011).

Discussion

Petitioner makes six general contentions in this appeal. First, Petitioner contends that this case should be remanded to the ALJ because the ALJ did not grant his request to cross-examine CMS's witnesses. Appeal of Petitioner Douglas Bradley, M.D. (P. Br.) at 24. Second, he contends that there is "no basis to revoke" his Medicare billing privileges under 42 C.F.R. § 424.535(a)(12). *Id.* at 4-9. Third, emphasizing that CMS's regulations permit but do not require CMS to revoke a supplier's Medicare billing privileges in certain circumstances, Petitioner contends that the ALJ should have considered whether the decision to revoke those privileges was a reasonable exercise of that discretionary authority. *Id.* at 9-14. Fourth, Petitioner contends that the revocation must be reversed because Novitas, CMS's contractor, lacked the legal authority to issue the initial revocation determination. *Id.* at 14-16. Fifth, Petitioner contends that the ALJ should have entertained his argument that NYOMIG's decision to exclude him from New York's Medicaid program was substantively and procedurally flawed. *Id.* at 16-24. Finally, Petitioner contends that the imposition of a three-year re-enrollment bar is "arbitrary, capricious, an abuse of discretion, unsupported by the evidence or law and should have been reviewed by the ALJ." *Id.* at 9, 11, 12-13, 14.

We address each of these contentions in turn.

A. *The ALJ's failure to provide for cross-examination was harmless error.*

Petitioner asserts that this matter "should be reversed and remanded for a full hearing" because he was not given an opportunity to cross-examine CMS's witnesses. P. Br. at 24. In his February 26, 2015 decision, the ALJ found that "neither party [had] requested

to cross-examine a witness." ALJ Decision at 5. That finding was erroneous because, on page three of his January 5, 2015 pre-hearing brief, Petitioner "request[ed] the opportunity to cross-examine all witnesses named by CMS."[5]

In reviewing alleged procedural errors, the Board has consistently applied a harmless error standard. *See, e.g., Carrington Place of Muscatine*, DAB No. 2321, at 22-23 (2010) (*citing* Board decisions and rejecting a claim that the ALJ improperly restricted cross-examination); *Cmty. Nursing Home*, DAB No. 1807 (2002) (finding that a refusal to admit evidence was harmless error).

The ALJ's erroneous finding that neither party had requested cross-examination was harmless because, as discussed below, we can and do affirm the ALJ Decision based on the law and evidence that does not include the testimony of CMS's witnesses. Moreover, although Petitioner states that CMS "relies on" declarations of its witnesses (Reply Br. at 15), he does not indicate precisely how or why his inability to cross-examine those witnesses possibly affected the outcome. Petitioner proffered nothing to suggest that he sought to adduce from CMS's witnesses any specific evidence that would support his case. Since we conclude below that the outcome is the same as a matter of law even without relying upon their declarations, it follows that Petitioner was not prejudiced by losing the opportunity to test their credibility through cross-examination. We therefore conclude that the ALJ's error was harmless in this case.

B. *The ALJ correctly concluded that the elements necessary for revocation under 42 C.F.R. § 424.535(a)(12) were satisfied.*

As the ALJ stated, and the Board has consistently held, the review of a revocation determination in this administrative appeals process is limited to deciding whether the regulatory "elements required for revocation were present." *Letantia Bussell, M.D.*, DAB No. 2196, at 13 (2008). If those elements were present – that is, if the record substantiates one or more of the grounds for revocation in paragraphs one through 14 of section 424.535(a) – then the revocation must be sustained. *Id.*; *see also John Hartman, D.O.*, DAB No. 2564, at 6 (2014) (holding that "[t]he Board reviews only whether the regulatory elements necessary for CMS to exercise its revocation authority were satisfied"); *Stanley Beekman, D.P.M.*, DAB No. 2650, at 10 (2015) (stating that an administrative law judge and the Board must sustain a revocation "[i]f the record establishes that the regulatory elements are satisfied").

[5] CMS proffered the declarations of three witnesses. CMS Exs. 6, 7, and 11.

There are two regulatory elements that must be satisfied to sustain Petitioner's revocation under section 424.535(a)(12). First, a State Medicaid Agency must have "terminated or revoked" his Medicaid billing privileges for cause. 42 C.F.R. § 424.535(a)(12)(i). Second, Petitioner must have exhausted "applicable appeal rights." *Id.* § 424.535(a)(12)(ii). We consider these elements separately.

1. The ALJ properly found that NYOMIG terminated or revoked Petitioner's Medicaid billing privileges effective July 31, 2013.

The ALJ found that when NYOMIG (a State Medicaid Agency[6]) imposed its Medicaid "exclusion" on Petitioner, it "terminated" his Medicaid billing privileges within the meaning of section 424.535(a)(12)(i). In making that finding, the ALJ reasoned that because CMS intended section 424.535(a)(12) to promote "coordination" between Medicaid and Medicare to minimize the risks of fraud, waste, and abuse to those programs, and because "states may use various terms in their statutes and regulations to indicate that an individual has been prohibited from billing a state's Medicaid program," it was necessary and appropriate to look beyond the "specific name" of the adverse action taken by NYOMIG in order to decide whether Petitioner's Medicaid billing privileges have been "terminated or revoked." ALJ Decision at 8-9. Using that analytical approach, the ALJ found that Petitioner's exclusion was equivalent to a termination of Medicaid billing privileges because the exclusion has "essentially the same effect" (or produces the same "fundamental result") as a termination. *Id.* at 9-10.

The ALJ's legal analysis is sound. Focusing on the *nature and effect*, rather than the label, of the State Medicaid Agency's action is consistent with – and likely necessary to achieve – section 424.535(a)(12)'s purpose, which is to coordinate the effort of federally-financed healthcare programs to protect their fiscal integrity and beneficiaries. The nature of an exclusion (under New York law) and the nature of a for-cause termination are the same: in both instances, an individual or entity is denied the opportunity to participate in, and be paid by, Medicaid for reasons of fraud, abuse, or other misconduct that poses a risk to that program. *See* 18 N.Y. Comp. Codes, R. & Regs. §§ 515.3 (authorizing various sanctions, including "exclusion," on a person determined to have engaged in an "unacceptable practice") and 515.2 (defining "unacceptable practices" to

[6] The ALJ found (ALJ Decision at 8), and Petitioner does not dispute, that NYOMIG is a "State Medicaid Agency" for purposes of applying section 424.535(a)(12).

include various types of misconduct). Furthermore, as the ALJ observed, an exclusion has "essentially the same effect" as a "termination" of billing privileges – namely, a prospective prohibition on billing the Medicaid program for covered services.[7] That is plainly apparent from the text of NYOMIG's July 26, 2013 exclusion decision. That decision advised Petitioner that, beginning on the exclusion's effective date, "no Medicaid payments" could be made to him (or on his behalf) "for medical care, services or supplies furnished" and that he could not "be involved in any activity . . . *relating to claiming* or receiving *payment* for medical care, services or supplies." CMS Ex. 12, at 6 (italics added). Likewise, the state regulation to which that particular statement cites – section 515.5(c) of title 18 of the New York Codes, Rules and Regulations – explicitly equates "exclusion" with a prohibition on Medicaid claiming (or billing) by stating that *"[a] person who is excluded from the [New York Medicaid] program cannot be involved in any activity* relating to furnishing medical care, services or supplies to recipients of medical assistance for which claims are submitted to the program, or *relating to claiming or receiving payment for medical care, services or supplies* during the period [of exclusion]" (italics added).

Petitioner contends that his Medicaid billing privileges could not have been "terminated" within the meaning of section 424.535(a)(12)(i) because he "was never enrolled in, participated in or received reimbursements from NYS Medicaid." P. Br. at 4, 6. Petitioner submits that a "dictionary definition" of the word "terminate" assumes the "preexistence of a benefit or privilege[.]" P. Br. at 6.

In support of his allegation that he was "never enrolled" in Medicaid, Petitioner proffered a declaration which states that "I never submitted an application for enrollment, or otherwise enrolled, in the New York State Medicaid Program" and that "I never participated in" or "received reimbursement from" that program for services rendered. P. Ex. 2, at 1. Petitioner also submitted a December 16, 2014 letter (P. Ex. 3) in which CMS – in response to his written request for "a copy of any application by Dr. Bradley

[7] Petitioner asserts that New York's Medicaid regulations "differentiate" between a "termination" of a "provider" (an individual or entity enrolled in the Medicaid program) under section 504.7(b) of title 18 of the New York Codes, Rules, and Regulations and an "exclusion" under the provisions of part 515 of that title. Reply Br. at 4-5. However, section 504.7(b)'s text confirms that Medicaid terminations and Medicaid exclusions under New York law have the same essential purpose and effect – namely, they prospectively bar the Medicaid participation of certain individuals or entities for cause; indeed, section 504.7(b) expressly states that the basis for a termination under that section is one that also supports an exclusion under Part 515. See N.Y. Comp. Codes, R. & Regs. §§ 504.7(b) (providing that the Medicaid "participation" of a provider may be terminated if the State Medicaid Agency has found the provider to have "engaged in an unacceptable practice as set forth in Part 515 of this Title"), 504.1(d)(16) (defining "provider" as "any person who has enrolled" in Medicaid and "participation" in part as the "ability and authority . . . to receive payment from the medical assistance program for . . . care, services or supplies"), and 515.3 (authorizing sanctions, including "exclusion," against persons found to have engaged in unacceptable practices").

for enrollment in New York's Medicaid program" (P. Ex. 10) – states that "there is no enrollment application for Dr. Bradley's enrollment in the New York Medicaid program." Petitioner claims that under New York law, he could not have participated, or been approved to participate, in the Medicaid program without first having submitted an enrollment application. P. Br. at 5 (*citing* 18 N.Y. Comp. Codes, R. & Regs. § 504.2(b)).

CMS presented evidence on this issue that includes the declaration of a NYOMIG employee who stated that she was authorized to access an electronic database called eMedNY, which records and tracks the processing of provider enrollment. CMS Ex. 6, ¶¶ 6-7. The employee further stated that her search of eMedNY revealed a record indicating that Petitioner "was enrolled as a provider in the New York State Medicaid program since February 24, 2004 to provide services as part of Hudson Health Plan, a managed care provider for the New York Medicaid program, until [he] was excluded from the . . . program . . . ." *Id.*, ¶ 7. In addition, the NYOMIG employee stated that her search results appear on the "screen shot[s]" attached to her declaration. *Id.* (referring to pages 15-17 of Exhibit 6).

After considering this evidence, the ALJ made a finding that Petitioner was enrolled in New York Medicaid program when NYOMIG excluded him in July 2013. ALJ Decision at 10-11. However, the ALJ indicated that he also thought it was unnecessary to make that finding given his earlier conclusion that Petitioner's exclusion was "equivalent" to a termination of his Medicaid billing privileges. *Id.* at 11 (stating that he made a finding concerning Petitioner's enrollment status "[t]o the extent that [it] is necessary to uphold the revocation"). We agree that the ALJ's factual finding was unnecessary and do not rely on it. Because the nature and effect of an exclusion under New York law is the same as a for-cause termination of Medicaid billing privileges, and because an exclusion may be applied against any "person" (whether or not the person is currently enrolled as a provider in Medicaid),[8] Petitioner's enrollment status on the date of his exclusion is immaterial to deciding whether CMS properly revoked his Medicare billing privileges under section 424.535(a)(12).[9]

[8] *See* 18 N.Y. Comp. Codes, R. & Regs. §§ 515.1(a)(1) (stating that sections 515.2 through 515.10 "set[ ] forth the requirements and procedures for . . . sanctioning *persons*" under the New York Medicaid program (italics added)), 515.1(b)(10) (defining "[s]anction" to mean "any final administrative action taken by the [State Medicaid Agency] under [Part 515] which limits a person's participation in the medical assistance program"), and 515.3(a) (indicating that the "sanctions" which may be applied against a "person" who has engaged in an "unacceptable practice" include "exclusion from the program for a reasonable time"); *Matter of Tobon v. Bane*, 192 A.D.2d 851, 853 (N.Y. App. Div. 1993) (rejecting the proposition that an exclusion may be imposed only on a person who is enrolled as a "provider" in New York's Medicaid program).

[9] Also immaterial in light of our legal conclusion is the ALJ's reliance on the declaration of the NYOMIG employee who testified concerning Petitioner's enrollment status but who was not subjected to cross-examination.

Even if the enrollment issue were material, and without relying on the relevant CMS witness testimony, we would find no basis for rejecting the ALJ's finding that Petitioner "was enrolled in the New York Medicaid program prior to being excluded from it." We note that Petitioner does not deny an affiliation with Hudson Health Care or refute the possibility that he became enrolled in Medicaid as part of that organization's managed care network. Petitioner makes two points, neither of which detracts from the ALJ's finding. First, citing CMS's December 16, 2014 letter, Petitioner asserts that "CMS has conceded that [he] did not submit a NYS Medicaid application." P. Br. at 5. CMS did not concede that Petitioner had not "submitted" a Medicaid enrollment application; the fairest reading of that ambiguous letter is that CMS was unable to *locate* a copy of an application for Petitioner. Second, Petitioner asserts that the eMedNY screenshots produced by CMS are "indecipherable and inconclusive." P. Br. at 5. However, Petitioner does not discuss the documents' content or tell us why he thinks they are indecipherable and inconclusive. He also does not dispute that the screenshots are what they appear to be – records obtained from a New York State database that tracks the enrollment of Medicaid-participating providers. At a minimum, the screenshots on their face confirm Petitioner's association with Hudson Health Care, a Medicaid managed care plan. In addition, the third screenshot appears to show, in the "enrollment status" section, a Medicaid enrollment "begin date" of February 24, 2004 for Petitioner as well as an enrollment "end date" of July 31, 2013 (the effective date of his exclusion). CMS Ex. 6, at 17.

For the reasons just stated, we affirm the ALJ's conclusion that Petitioner's Medicaid billing privileges were terminated or revoked within the meaning of 42 C.F.R. § 424.535(a)(12)(i).

2. Substantial evidence supports the ALJ's finding that Petitioner exhausted all applicable appeal rights.

We next consider the ALJ's finding that Petitioner has "exhausted all applicable appeal rights" within the meaning of 42 C.F.R. § 424.535(a)(12)(ii). The law which authorized his exclusion (termination) from New York's Medicaid program is section 515.7(e) of title 18 of the New York Codes, Rules and Regulations. *See* CMS Ex. 6, at 12. Section 515.7(e) provides, in relevant part, that the State Medicaid Agency may impose an "immediate *sanction*" on a person when it receives notice that the person has been found (upon agency adjudication or by "stipulation or agreement") to have engaged in "professional misconduct" or "unprofessional conduct." 18 N.Y. Comp. Codes, R. & Regs. § 515.7(e) (italics added). The term "sanction" includes "exclusion from the [Medicaid] program for a reasonable time." *Id.* § 515.3(a)(1).

The appeal rights of a "person sanctioned" under section 515.7 are found in paragraph (g) of that section. Paragraph (g)(1) states:

> A person sanctioned under this section is not entitled to an administrative hearing, but may, within 30 days of the date of the notice, submit written arguments and documentation on the following issues:
>
> (i) whether the determination was based upon a mistake of fact;
>
> (ii) whether any crime charged in an indictment, or any conviction of a crime, resulted from furnishing or billing for medical care, services or supplies; and
>
> (iii) whether the sanction imposed was reasonable.

18 N.Y. Comp. Codes, R. & Regs. § 515.7(g)(1).

In his January 2015 prehearing brief to the ALJ, Petitioner argued that he had not exhausted all applicable appeal rights, pointing to correspondence which shows that, on August 18, 2014, he asked NYOMIG to remove his name from the New York State Medicaid exclusion list – a list of individuals or entities excluded from participating in New York's Medicaid program under section 515.7(e) – while also stating that he did not wish to enroll in Medicaid. P. Ex. 4. Notwithstanding his desire not to enroll in Medicaid, NYOMIG treated Petitioner's removal request as an application for enrollment or reinstatement (rather than as a challenge to the legality of the exclusion) and, on October 22, 2014, denied the request. *Id.* Dissatisfied with that denial, Petitioner asked NYOMIG for "reconsideration." P. Ex. 6. According to Petitioner's prehearing brief, the reconsideration request was still pending in January 2015 (a month before the ALJ issued his decision).[10]

The ALJ concluded that Petitioner had exhausted all applicable appeal rights because he did not appeal his exclusion in accordance with section 515.7(g)(1) and because his request to remove his name from New York State's Medicaid exclusion list "is not an appeal related to the decision to exclude him from the New York Medicaid program." ALJ Decision at 11-12. That conclusion is legally sound and supported by the record. Petitioner has never alleged, much less demonstrated, that he exercised his appeal rights under section 515.7(g)(1), which are the appeal rights applicable to his exclusion under

[10] *See* Prehearing Brief and Brief in Opposition to CMS's Motion for Summary Judgment (Jan. 5, 2015) at 16-18.

section 515.7(e). Moreover, nothing in the record suggests that the validity of the exclusion would be affected by a favorable decision on his request to be removed from the exclusion list. Indeed, Petitioner's August 18, 2014 removal request did not challenge the merits of the exclusion.[11] In addition, Petitioner does not argue here that New York law required NYOMIG to treat the removal request as anything but an application for enrollment or reinstatement in the Medicaid program.

We also reject Petitioner's suggestion that if he were to prevail in his appeal of NYOMIG's denial of his request to remove his Medicaid exclusion from the New York Medicaid exclusion list, CMS's revocation of his Medicare billing privileges would be invalid because CMS would be required to accept the removal as a correction of a "deficient compliance requirement" under section 424.535(a)(1). Petitioner offers no explanation why CMS would be required to accept as a corrective action under section 424.535(a)(1) a state's decision on a pending appeal (to remove Petitioner from a list of excluded persons) that we have already concluded is irrelevant to CMS's authority to revoke his Medicare billing privileges. Nor has he explained how an opportunity to correct would have any meaning in the situation of a revocation based on a Medicaid termination for cause. *See* 73 Fed. Reg. 69,726, 69,864-65 (Nov. 19, 2008) (noting that similar grounds for Medicare revocation – including revocations based on felony convictions, license suspension or revocation, or federal exclusion or debarment – do not "lend themselves to a corrective action plan"). Finally, Petitioner has not explained why the opportunity to correct mentioned in section 424.535(a)(1) would even apply to a revocation of billing privileges which, like his, was based on section 424.535(a)(12), which contains no mention of such an opportunity. *See A to Z DME, LLC*, DAB No. 2303 at 9 (2010) (suggesting, at the very least, that the opportunity to correct applied only to section 424.535(a)(1) revocations because "[s]ections 424.535(a)(2) through (a)(8) [the only other bases for revocation provided under section 424.535 when that case was decided] make no mention of the opportunity for corrective action discussed in section 424.535(a)(1)"); 79 Fed. Reg. 72,500, 72,523 (Dec. 5, 2014) (amending 42 C.F.R. § 424.535(a)(1) and revising 42 C.F.R. § 405.809 to clarify that "in cases where § 424.535(a)(1) is one of several reasons for a particular revocation, the provider [or supplier] would be able to submit a CAP with respect to the § 424.535(a)(1) revocation reason").

[11] Petitioner's August 18, 2014 removal request recited the history of his disciplinary actions in New Jersey and New York, stated that he had "fully complied" with conditions imposed by those states as a result of those actions, notified NYOMIG that the New York State Department of Health had recently released him from "probation," and made representations and commitments regarding his ownership of stock in healthcare companies. P. Ex. 4.

For all these reasons, we affirm the ALJ's conclusion that Petitioner exhausted "applicable appeal rights" within the meaning of 42 C.F.R. § 424.535(a)(12)(ii).

C. *The ALJ properly refused to review the revocation determination for abuse of discretion.*

In the proceeding below, Petitioner argued that CMS (or its agent, Novitas) had discretion under the regulations to refrain from revoking his Medicare billing privileges and that CMS abused its discretion when it chose to proceed with the revocation.[12] The ALJ correctly refused to entertain Petitioner's abuse-of-discretion argument. While it is true that CMS's revocation authority is discretionary, the Board has consistently held that review of a revocation determination by an administrative law judge or the Board is limited to deciding whether CMS had a "legal basis" for that action. *Letantia Bussell* at 10. Hence, if CMS establishes that the regulatory elements necessary for revocation are satisfied, as they are here, then the revocation must be sustained, and neither the administrative law judge nor the Board may "substitute its discretion for that of CMS in determining whether revocation is appropriate under all the circumstances."[13] *Abdul Razzaque Ahmed, M.D.*, DAB No. 2261, at 19 (2008), *aff'd, Ahmed v. Sebelius*, 710 F. Supp.2d 167 (D. Mass. 2010).

Petitioner asserts that CMS (through Novitas) provided no evidence that it "reviewed – let alone considered – the facts of his case." P. Br. at 11. Petitioner's assertion is based on the premise that CMS and its contractors are required to explain the reasons they choose to exercise discretion in favor of a determination adverse to a provider or supplier. However, in *Brian Ellefsen, D.O.*, the Board rejected that premise, expressly rejecting Dr. Ellefsen's argument that CMS was required to "explain the reasoning behind" a discretionary decision to deny his Medicare enrollment application. DAB No. 2626, at 4, 9. In doing so, the Board noted that the regulations in 42 C.F.R. Part 498 that govern the administrative appeal process require that the appealable (reconsidered) determination identify only the legal reasons or "authority" which enabled CMS to exercise its discretion. *Id.* at 9. The Board also found no regulation requiring CMS to "explain the reasons for exercising its discretion." *Id.* The reasoning in *Ellefsen* applies equally to this case because the review of a revocation determination and the review of an enrollment denial are governed by the same administrative appeals process.

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[12] *See* Prehearing Brief and Brief in Opposition to CMS's Motion for Summary Judgment of Petitioner Douglas Bradley, M.D. (Jan. 5, 2015) at 22.

[13] Petitioner asserts that an administrative law judge possesses authority to make a "de novo" revocation determination. P. Br. at 14. Petitioner confuses the concept of "de novo" review, which is a *standard of review* permitting a reviewing tribunal to make an independent determination regarding issues before it (without deference to a prior determination), *see United States v. First City Nat. Bank of Houston*, 386 U.S. 361, 368 (1967), with the question of whether an issue is reviewable at all. *Bussell, Ahmed,* and other Board decisions hold that the reasonableness of CMS's exercise of discretion is not a reviewable issue under any standard of review.

Moreover, in *Ellefsen*, the Board discussed the well-established presumption of regularity that attaches to actions of government agencies and their agents. *U.S. Postal Service v. Gregory*, 534 U.S. 1, 10 (2001). The presumption permits a reviewing court or other tribunal to presume that government officials have "properly discharged their official duties" absent "clear evidence to the contrary." *United States v. Chemical Foundation, Inc.*, 272 U.S. 1, 14-15 (1926). Petitioner has not identified any evidence, much less clear evidence, that we are not entitled to rely here on the presumption that CMS reviewed the facts of his case and exercised its discretion in revoking his Medicare billing privileges.[14]

D. *The ALJ correctly rejected Petitioner's arguments regarding Novitas's authority to issue the revocation.*

Petitioner contends that the revocation must be vacated because Novitas, a Medicare Administrative Contractor, was not authorized to make the discretionary decision to revoke his Medicare billing privileges. P. Br. at 14-16. Petitioner asserts that section 424.535(a) authorizes "CMS" to revoke Medicare billing privileges without expressly extending that discretionary authority to Medicare program contractors. *Id.* at 15, 16.

In the first place, the premise of Petitioner's argument – that Novitas independently exercised the discretion conferred by section 424.535(a) – ignores the ALJ's unchallenged finding that Novitas issued the initial revocation determination "at CMS's direction." ALJ Decision at 13 (*quoting* the reconsidered determination in CMS Exhibit 5). But even absent evidence of specific direction by CMS, the revocation would be lawful, as the ALJ correctly held. The Board has, on two previous occasions, considered but rejected arguments that CMS contractors lack the authority to make determinations concerning a provider's or supplier's enrollment in the Medicare program. In *Fady Fayad, M.D.*, DAB No. 2266 (2009), *aff'd*, *Fady Fayad v. Sebelius*, 803 F. Supp. 2d 699 (E.D. Mich. 2011), the Board held that sections 1842 and 1874A of the Medicare statute, 42 U.S.C. §§ 1395u and 1395kk-1, authorize CMS to delegate to its Medicare Administrative Contractors the authority to make revocation determinations under section 424.535(a). DAB No. 2266, at 17-20. A contractor's exercise of discretion is also lawful, said the Board in *Fayad*, "because [the Department of Health & Human Services] has, in effect, retained final authority over contractor-issued revocation determinations by

[14] In *Ellefsen*, the Board found that certain language in the contractor's notice letters cited by Dr. Ellefsen made it unclear whether CMS actually recognized that it had discretion and thus remanded the case to the ALJ to address and seek clarification on that issue. Unlike Dr. Ellefsen, Petitioner here has not cited any language in the contractor letters that might indicate that CMS (through its contractor) did not recognize that it had discretion. Instead, Petitioner relies only on his perception that the notice letters did not explain why CMS exercised its discretion as it did.

subjecting them to review, when challenged, by departmental ALJs and the Board." *Id.* at 19. More recently, in *Brian K. Ellefsen, D.O.*, the Board used the same reasoning to reject a physician's contention that only CMS – and not its contractor – had the authority to deny his application for Medicare enrollment under 42 C.F.R. § 424.530(a). DAB No. 2626, at 5-6.

Petitioner has given us no reason to question the reasoning in *Fayad* and *Ellefsen* – reasoning that was expressly affirmed by the United States District Court in *Fady Fayad v. Sebelius*, 803 F. Supp.2d 699 (E.D. Mich. 2011). Petitioner asserts that the court's decision "does not support the authority of CMS to sub-delegate discretionary revocation decisions to private contractors." P. Br. at 16. We disagree: the court expressly rejected the plaintiff's contention that Medicare's contractor in that case lacked a valid delegation of authority from CMS or the Secretary of Health & Human Services, holding that "Plaintiff's assertions that [the contractor] lacked authority to make the initial [revocation] determination is contrary to" sections 1842 and 1874A of the Medicare statute. 803 F. Supp.2d at 704-05.

E. *The ALJ properly refused to entertain Petitioner's claim that NYOMIG's decision to exclude him from New York's Medicaid program was substantively and procedurally flawed.*

Petitioner contends that NYOMIG's decision to exclude him from the New York Medicaid program was substantively and procedurally flawed. P. Br. at 16-18. Petitioner suggests that an administrative law judge or the Board should review the exclusion's merits because New York law "fails to provide the procedural safeguards[, such as a pre- or post-deprivation administrative hearing,] guaranteed to all Medicare participants under the Social Security Act and Medicare regulations." P. Br. at 22-24.

The ALJ refused to entertain this argument, saying:

> A revocation under section 424.535(a)(12) is derivative to the action of a state Medicaid agency. The terms of that regulation do not authorize me to review the merits or procedures involved in the exclusion decision. If Petitioner wanted to challenge the exclusion, Petitioner ought to have followed the appeal procedures in New York State's regulations and, if necessary, sought judicial relief.

ALJ Decision at 13.

We agree with the ALJ. Section 424.535(a)(12) does not require a finding by CMS that a State Medicaid Agency's action was substantively correct under state law or consonant with due process. The regulation simply states that CMS "may revoke" if the supplier's Medicaid billing privileges "are terminated or revoked" and the supplier's appeal rights

under state law have been exhausted. 42 C.F.R. § 424.535(a)(12)(i). Hence, in reviewing the legality of a revocation under section 424.535(a)(12), an administrative law judge is authorized to decide only whether (1) a supplier's Medicaid billing privileges have been terminated or revoked by a State Medicaid Agency and (2) that action has become unappealable, or otherwise final, under state law. Moreover, the regulations governing this proceeding authorize hearing and appeal rights only with respect to specific *federal agency* determinations. *See* 42 C.F.R. §§ 498.3, 498.5. Nothing in those regulations, or in the Medicare statute, even remotely suggests that they were intended provide a forum to collaterally challenge adverse decisions by federal or state courts or non-federal regulatory bodies. *Cf. Mark Koch, D.O.*, DAB No. 2610, at 3-4 (2014) (holding that allegations questioning the validity of the federal conviction upon which the supplier's revocation was based were immaterial because the revocation was "based on *the fact*" of the conviction and because there was no evidence that the conviction had been vacated or overturned (italics in original)). If anything, the requirement in section 424.535(a)(12)(ii) that CMS refrain from revoking Medicare billing privileges until after appeal rights with respect to the adverse Medicaid determination have been exhausted indicates that CMS intended to rely upon state appeal processes, rather than on the federal administrative appeals process in 42 C.F.R. Part 498, to ensure the reliability of adverse Medicaid determinations.

F. *Petitioner has not provided any arguments supporting his contention that the ALJ erred in concluding that he had no jurisdiction to consider Petitioner's argument concerning the re-enrollment bar.*

In his pre-hearing brief to the ALJ, Petitioner contended that the "imposition of the maximum three year re-enrollment bar was arbitrary, capricious, an abuse of discretion, and unsupported by substantial evidence or law," implying but not specifically arguing that the re-enrollment bar should be reduced.[15] (As noted earlier, section 424.535(c) requires a "minimum" re-enrollment bar of one year.)

The ALJ acknowledged Petitioner's contention concerning the re-enrollment bar but stated that he lacked "jurisdiction" to consider it. ALJ Decision at 13. In doing so, the ALJ cited two Civil Remedies Division decisions in which an administrative law judge held that a provider's or supplier's right to a hearing in a revocation case "is limited to challenging whether CMS had authority to revoke . . . enrollment . . . in the Medicare program" and did not extend to "challenging CMS's judgment as to the duration of the revocation, where it falls clearly within the regulation." *Emmanuel Brown, M.D. and Simeon K. Obeng, M.D.*, DAB CR2145, at 10 (2010); *see also Ravindra Patel, M.D.*, DAB CR2171, at 7 n.5 (2010).

[15] *See* Prehearing Brief and Brief in Opposition to CMS's Motion for Summary Judgment (Jan. 5, 2015) at 22.

In his appeal briefs, Petitioner restates his contention that the three-year re-enrollment bar is "arbitrary and capricious" and an "abuse of discretion," suggesting that the conduct supporting his exclusion from the New York Medicaid program was not severe or extensive. P. Br. at 11, 12-13. However, Petitioner fails to address the ALJ's jurisdictional holding. While Petitioner states that his argument about the re-enrollment bar "should have been reviewed" by the ALJ, *id.* at 9, 13, he presents no argument demonstrating that the ALJ's holding that he had no jurisdiction constitutes an error of law.[16] We therefore do not review the ALJ's holding on this legal issue.

In any event, Petitioner's characterization of the relevant conduct is, to put it charitably, incomplete. While properly conceding that CMS's revocation authority exists to protect the Medicare program and its beneficiaries from fraud, abuse, and professional incompetence and misconduct,[17] Petitioner describes his conduct as a mere "oversight" that did "not create a risk of fraud, waste, or abuse." *Id.* at 13. He asserts that "the only finding of misconduct against [him] concerned his *insufficient monitoring* unrelated to his orthopedic surgery practice, a finding that both New Jersey and New York licensing authorities deemed an inadequate ground for suspending or revoking [his] medical licenses." *Id.* (italics added). However, the charges issued by the New Jersey and New York medical boards – charges for which he consented to be disciplined in both states – were far more extensive and included: "unlawful referral" of patients to a company, Neurophysiological Monitoring LLC (NPM), in which he held a substantial ownership interest; "extended failure to provide a physician to perform real-time monitoring for procedures performed by technicians"; "misrepresentation of technicians' credentials"; "misrepresentation" in obtaining a hospital contract for NPM; "allowing deception to insurance carriers" regarding the ownership of NPM; "preparation of inadequate IOM [intraoperative monitoring] reports"; and "billing for medically unnecessary and fraudulently billed IOM services." CMS Ex. 6, at 10; *see also* P. Ex. 1, at 3-12. This misconduct plainly creates a risk of fraud, waste, or abuse to the Medicare program. Petitioner has alleged no other circumstances demonstrating that a three-year re-enrollment bar is excessive.

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[16] For example, Petitioner does not address whether or how the regulations in 42 C.F.R. Part 498 – which list the types of CMS determinations that are subject to appeal in this administrative appeals process but do not expressly mention the length of a re-enrollment bar – authorize Board review. *See* 42 C.F.R. § 498.3(a), (b).

[17] *See* Final Rule, Dept. of Health & Human Servs., *Medicare Program; Requirements for Providers and Suppliers to Establish and Maintain Medicare Enrollment*, 71 Fed. Reg. 20,754, 20,773-20,774 (April 21, 2006) (noting that the chief aim of the regulations governing Medicare enrollment is to prevent "unqualified, fraudulent, or excluded providers and suppliers from providing items and services to Medicare beneficiaries or billing the Medicare program or its beneficiaries"); *Fayad*, DAB No. 2266, at 19 (stating that "[r]evocation helps ensure access to high quality medical care by removing from the program practitioners and entities that pose a risk to its fiscal integrity and the well-being of program beneficiaries").

Conclusion

Under 42 C.F.R. § 424.535(a)(12), CMS was authorized to revoke Petitioner's Medicare billing privileges if (1) his Medicaid billing privileges were terminated or revoked and (2) he exhausted his appeal rights with respect to the termination. The ALJ's conclusion that those regulatory elements were satisfied in this case is supported by substantial evidence and free of legal error. We therefore affirm the ALJ's decision.

/s/
Leslie A. Sussan

/s/
Susan S. Yim

/s/
Sheila Ann Hegy
Presiding Board Member