Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Care Pro Home Health, Inc.
Docket No. A-16-23
Decision No. 2723
July 21, 2016

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Care Pro Home Health, Inc. (Petitioner), a Texas home health agency, has appealed the October 15, 2015 decision by an administrative law judge (ALJ), *Care Pro Home Health, Inc.*, DAB CR4321 (2015) (ALJ Decision). In that decision, the ALJ held that the Centers for Medicare & Medicaid Services (CMS) had lawfully revoked Petitioner's enrollment in the Medicare program on the ground that Petitioner "was not operational at the practice location on file with CMS and its administrative contractor[.]" ALJ Decision at 1. For the reasons discussed below, we affirm the ALJ Decision.

Legal Background

In order to enroll and maintain enrollment in Medicare, a home health agency or other "provider" must comply with Medicare program requirements, including the "enrollment requirements" in 42 C.F.R. Part 424, subpart P (sections 424.500-.575). *See* 42 C.F.R. § 424.516(a). The enrollment requirements obligate a provider to submit – and keep current – a CMS-approved "enrollment application"[1] that identifies, among other things, the provider's "practice location." *Id.* §§ 424.502 (definition of "enroll/enrollment"), 424.510(a)(1), 424.510(d), 424.515, 424.516(b)-(e). Another enrollment requirement states that a provider must be "*operational* to furnish Medicare covered items or services." *Id.* §§ 424.510(d)(6), 424.515(a) (italics added). "Operational" means that "the provider or supplier has a qualified physical practice location, is open to the public for the purpose of providing health care related services, is prepared to submit valid Medicare claims, and is properly staffed, equipped, and stocked . . . to furnish these items or services." *Id.* § 424.502.

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[1] The term "enrollment application" is defined in the regulations to mean the "CMS-approved paper enrollment application" (the CMS-855) or "an electronic Medicare enrollment process approved by OMB [the Office of Management and Budget]." 42 C.F.R. § 424.502.

In addition to specifying Medicare's enrollment requirements, the regulations in 42 C.F.R. Part 424, subpart P authorize CMS to take various actions to ensure compliance with those requirements. For example, CMS has the right to perform an "onsite review" or inspection of a provider in order "to verify that the enrollment information submitted to CMS or its agents is accurate and to determine compliance with Medicare enrollment requirements." *Id.* § 424.517(a); *see also id.* §§ 424.510(d)(8), 424.515(c). In addition, CMS may revoke a provider's Medicare enrollment for any of the "reasons" specified in paragraphs one through 14 of section 424.535(a). Of relevance here is paragraph five, which permits revocation if, "[u]pon onsite review or other reliable evidence, CMS determines that the provider or supplier is . . . [n]o longer operational to furnish Medicare-covered items or services." *Id.* § 424.535(a)(5)(i).

Case Background

There is no dispute about the following facts: on July 16, 2014, Palmetto Government Benefit Administrators (Palmetto), a Medicare Administrative Contractor, performed a "site verification survey" of Petitioner at the following address: 205 Oleander Drive, Desoto, Texas. CMS Ex. 2, at 1; P. Ex. 1, ¶ 10. When Palmetto's surveyor arrived at this address, a private residence, the residence's "owner" informed the surveyor that Petitioner was no longer operating there and that Petitioner's new address was 2700 Pleasant Run Road, Suite 380, in Lancaster, Texas. CMS Ex. 2, at 1.

On November 4, 2014, Palmetto notified Petitioner, by letter, that its Medicare enrollment as a home health agency had been revoked under section 424.535(a)(5) because it was no longer "operational" at the Desoto, Texas address.[2] CMS Ex. 3.

On November 11, 2014, Petitioner appealed the revocation determination by filing a request for reconsideration with CMS. *See* CMS Ex. 1, at 6. That request stated (in part):

> . . . [W]e regret to realize that we failed to notify CMS of our change of address ***when we moved to a medical office building in city of Lancaster on Nov[ember] 4, 2013.*** The new facility address is 2700 W. Pleasant Run Road, Suite 380, Lancaster, TX 75146. Phone, fax, and email address remain same . . . . We are open 9AM to 5PM Monday to Friday. Phones are answered 24/7.

[2] Palmetto advised Petitioner that the revocation was effective on July 16, 2014, the date of the site verification survey. CMS Ex. 3, at 1.

> Before the move, Care Pro Home Health Inc. had notified [the] [Texas] Department of Aging and Disability (DADS) 30 days in advance of the intended move by completing [the] required form. We are sorry that we forgot to notify Palmetto GBA/CMS of the change in facility address.
>
> We have taken corrective action by instituting measures to ensure that future address changes are communicated to Palmetto GBA/CMS promptly.
>
> Please reconsider the Medicare privileges revocation decision. We have rectified the oversight by completing a 855A enrollment application online.

Id. (italics and emphasis added).

On December 19, 2014, CMS denied Petitioner's reconsideration request and upheld the revocation, citing section 424.535(a)(5) as the "Revocation Reason." CMS Ex. 1, at 1.

Petitioner then filed a request for hearing with the ALJ. In response, CMS submitted a prehearing brief in which it argued that it had "a basis for the revocation of [Petitioner's] billing privileges when it determined [that Petitioner] was no longer operating at the practice location, 205 Oleander Dr., Desoto, Texas, provided to Medicare on its enrollment application." April 8, 2015 CMS Prehearing Br. at 4. In support of that argument, CMS proffered the declaration of Tanesha M. Norman, Palmetto's Manager of Provider Enrollment. *See* CMS Ex. 4. Ms. Norman stated that Palmetto "is responsible for enrolling [Texas] home health agencies into the Medicare program and for updating changes in enrollment data when a change of information is submitted by a home health agency." *Id.*, ¶ 4. Ms. Norman further stated that "[o]n July 16, 2014," the date of Palmetto's site verification survey, "the enrollment information on file with Palmetto, and therefore, Medicare, for [Petitioner] reported a practice location of 205 Oleander Dr., Desoto, Texas 75115" and that "[t]his was [Petitioner's] practice location identified on its initial enrollment application." *Id.*, ¶ 8. In addition, Ms. Norman stated that "between August 26, 2010 and November 17, 2014, Palmetto did not receive a Form 855A or an update via PECOS [the Provider Enrollment, Chain and Ownership System] from [Petitioner] indicating a change in it practice location."[3] *Id.*, ¶ 10.

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[3] PECOS is a web-based electronic enrollment process established under OMB System of Records Number (SORN) 09-70-0532. 66 Fed. Reg. 51961 - 51966 (October 11, 2001); *see also*, 71 Fed. Reg. 60536 – 60540 (October 13, 2006); Privacy Act Issuances, Office of the Federal Register, 09-70-0532, available at http://www.ofr.gov/(S(ykgiyoo3jf5wcg1gif4mou3k))/Privacy/2009/hhs.aspx (last visited June 27, 2016). A provider or supplier may apply via PECOS to enroll in Medicare or make changes to its enrollment information. CMS Ex. 4, ¶ 6.

After CMS submitted its opening brief and evidence, Petitioner moved for summary judgment, asserting that it had been continuously "operational" since 2008 at either its former (Desoto, Texas) or current (Lancaster, Texas) address; that "the government's own records reflect [its] ongoing business" at its current (Lancaster) practice location; and that Palmetto performed the site verification survey at the "wrong" (Desoto) address. P. Ex. 1, ¶¶ 3, 6, 10 (affidavit of Petitioner's owner); May 8, 2015 Motion and Notice of Motion for Summary Judgment at 1-2.

The administrative law judge to whom the case had initially been assigned denied the summary judgment motion. ALJ Decision at 3 n.2. Petitioner then waived its opportunity for an in-person hearing, and the ALJ proceeded (after further briefing by the parties) to issue a decision based on the parties' declarations, documentary evidence, and legal argument. *Id.* at 3.

Accepting CMS's framing of the decisive legal issue, the ALJ held that the revocation's validity turned on whether Petitioner was "operational at the practice location on file with CMS" on July 16, 2014, the date of the site verification survey. *See* ALJ Decision at 4; *see also id.* at 8 (stating that "the issue before me is not whether the Texas [Department of Aging and Disability Services] was notified of the relocation, or even whether Petitioner timely notified CMS of its change in address, but rather, whether the office location on file with Medicare was operational at the time of the July 16, 2014 on-site review"). The ALJ found that "205 Oleander Drive, Desoto, Texas . . . was the address Petitioner had on file with CMS" on July 16, 2014. *Id.* at 10. She further found that it was "undisputed" that Petitioner was not operational at the Desoto address on that date. *Id.* Based on these findings, the ALJ concluded that "CMS had a legal basis to revoke Petitioner's billing privileges pursuant to 42 C.F.R. § 424.535(a)(5)(i)." *Id.*

Petitioner then timely filed a request for review of the ALJ Decision. Petitioner urges us to set aside the revocation because it was "operational at all times relevant to the revocation action" and because Palmetto "performed an on-site review at an address [205 Oleander Drive in Desoto, Texas] known to be incorrect and outdated." Pet.'s Request for Review (RR) at 7, 8.

Standard of Review

The Board's standard of review for disputed issues of law is whether the ALJ's decision is erroneous. The standard of review for disputed issues of fact 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.

Discussion

1. *The ALJ correctly held that CMS had lawfully revoked Petitioner's Medicare enrollment under 42 C.F.R. § 424.535(a)(5)(i).*

In reviewing a revocation determination, an ALJ or the Board is limited to deciding whether CMS had a valid "legal basis" for that action. *Letantia Bussell, M.D.*, DAB No. 2196, at 12-13 (2008); *Abdul Razzaque Ahmed, M.D.*, DAB No. 2261, at 17, 19 (2009), *aff'd, Ahmed v. Sebelius*, 710 F. Supp.2d 167 (D. Mass. 2010). The initial and reconsidered determinations identify 42 C.F.R. § 424.535(a)(5)(i) as CMS's legal basis for the challenged revocation. The ALJ concluded that CMS had lawfully revoked Petitioner's Medicare enrollment under that regulation because Petitioner was not operational at 205 Oleander Drive in Desoto, Texas on July 16, 2014.

In this appeal, Petitioner does not, of course, deny that it was non-operational in Desoto, Texas on July 16, 2014. Nor does Petitioner contest the ALJ's finding that the Medicare application on file with CMS on July 16, 2014 identified Petitioner's practice location as 205 Oleander Drive in Desoto. Petitioner nonetheless contends that the ALJ should have deemed it operational (within the meaning of section 424.535(a)(5)(i)) because it was open for business on July 16, 2014 in Lancaster, Texas. The ALJ considered but rejected that contention, holding that Petitioner's operational status in Lancaster was legally irrelevant:

> Even if Petitioner was open and staffed at its Lancaster, Texas, location on July 16, 2014, the regulatory definition of the term "operational" refers to the "qualified physical practice location" of a provider. 42 C.F.R. § 424.502. The Medicare enrollment application directs that a provider report all practice locations and states that "the 'primary practice location' must be associated with the [National Provider Identifier] that the provider intends to use to bill for Medicare services" (see form CMS-855A), and a provider must provide "[c]omplete, accurate and truthful responses to all information requested within each section [of the enrollment application] as applicable to the provider or supplier type." 42 C.F.R. § 424.510(d)(2)(ii). CMS may perform on-site inspections to verify that the enrollment information submitted by a provider is accurate and to determine compliance with Medicare requirements. 42 C.F.R. § 424.517(a). This means that CMS will inspect the "qualified physical practice location" that has been provided by the provider and is currently on file with CMS. *See, e.g.*, *JIB Enterprises, LLC*, DAB CR3010 at 9 (2013). . . .

ALJ Decision at 9-10.

We find no legal error in this reasoning. The regulations state that a provider may be subject to revocation based on the results of an "onsite review." 42 C.F.R. § 424.517(a). A primary purpose of the onsite review is to verify that the "enrollment information submitted to CMS" is "accurate."[4] *Id.* The enrollment information submitted to CMS includes the address of a provider's physical practice location – that is, the place where the provider is supposed to be "operational to furnish Medicare covered items or services." *Id.* § 424.510(d)(2)(ii). In this case, the "enrollment information submitted to CMS" as of July 16, 2014 indicated that Petitioner was operating from a practice location in Desoto, Texas. Palmetto's onsite review found that information to be inaccurate: Petitioner was "no longer operational" in Desoto on July 16, 2014, contrary to the "enrollment information submitted to CMS" as of that date. Section 424.535(a)(5)(i) expressly authorized CMS to revoke Petitioner's enrollment based on that onsite-review finding, because the regulation states that a provider's enrollment may be revoked when CMS determines "[u]pon on-site review" that the provider is no longer operational. Furthermore, the compliance actions taken by Palmetto and CMS did not deprive Petitioner of any opportunity afforded by the regulations to notify the Medicare program of its change in practice location.[5] For these reasons, we agree with the ALJ that CMS lawfully revoked Petitioner's Medicare enrollment based on its non-operational status in Desoto, Texas on July 16, 2014. *See also Viora Home Health, Inc.*, DAB No. 2690, at 13 (2016) (holding that CMS had a basis to revoke a home health agency's Medicare enrollment "because its *practice location of record* was . . . not operational *upon onsite review*" (italics added)).

2. *Petitioner's allegations of factual or legal error do not undermine the ALJ's ultimate legal conclusion.*

Petitioner alleges numerous factual and legal "errors" by the ALJ. *See* RR at 3-8. In general, these allegations are unsubstantiated, irrelevant, or unsupported by legal argument. For example, Petitioner suggests that the ALJ erred in failing to find that Palmetto knew about its Lancaster practice location *prior to* the site verification survey. *See* RR at 6 (stating that the ALJ "erred in not finding that CMS's contractor verified and

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[4] CMS has said in Medicare rulemakings that the "primary purpose of an unannounced and unscheduled site visit is to ensure that a provider or supplier is operational *at the practice location found on the Medicare enrollment application*." 76 Fed. Reg. 5862, 5870 (Feb. 2, 2011) (italics added).

[5] A provider or supplier may change its practice location without first notifying CMS or obtaining its approval in advance for the change. However, the provider or supplier must notify Medicare of the change within 90 days after its occurrence. 42 C.F.R. § 424.516(e)(2). Petitioner admitted to the ALJ that it did not update its Medicare enrollment information to reflect its current (Lancaster, Texas) practice location until November 18, 2014, more than one year after it moved to that location. May 14, 2015 Amended Brief of Petitioner (to the ALJ) at 4.

knew of Petitioner's new practice location prior to initiating the on-site survey"). However, there is no evidence in the record that Palmetto became aware of Petitioner's change in practice location earlier than July 16, 2014.[6] *Id.* Nor has Petitioner explained how or why such awareness, assuming it existed, should affect our decision here.

Petitioner also contends that when Palmetto learned on July 16, 2014 that the enrollment information concerning its practice location was not "current," Palmetto or CMS should have requested "clarifying information." *See* RR at 6, 8. In support of that contention, Petitioner cites section 15.5.4(A) of the Medicare Program Integrity Manual (PIM), which in relevant part states:

> The contractor shall verify that the practice locations listed on the [Medicare enrollment application] actually exist. If a particular location cannot at first be verified, the contractor shall request clarifying information; for instance, the contractor can request that the applicant furnish letterhead showing the appropriate address.

P. Ex. 11, at 12-13. Petitioner asserts that "[n]one of these procedures were followed by CMS and its contractor in this instance . . . ." Reply Br. at 4. "Had CMS and its contractor followed proper procedure for provider address verification," says Petitioner, "[it] would not have lost its Medicare billing privilege and provider agreement." *Id.*

There are three problems with this line of argument. First, the PIM instructions cited by Petitioner are not regulations with the force of law and thus do not bind administrative law judges or the Board. *Marcia M. Snodgrass, APRN*, DAB No. 2646, at 9 n.10, 14-15 (2015) (holding that a CMS manual provision was not a binding legal requirement); *BGI Retirement, LLC,* DAB No. 2620, at 10 (2015) (stating that "CMS manuals, instructions, or policy 'guidance' do not have the force of law").

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[6] A declaration by the owner and chief financial officer of Petitioner was admitted as Petitioner's Exhibit 1. The declarant reported that Petitioner had relocated to its new location in Lancaster, Texas, on October 25, 2013. P. Ex. 1, ¶ 5. The declarant further indicated that "[a]bout 30 days prior to moving, on September 23, 2013, [Petitioner] sent the required change-of-address notice to the state home health licensing agency, the Texas Department of Aging and Disability Services ('DADS')." *Id.* In addition, the declarant asserted that "[b]ecause [Petitioner] gave proper notice of relocation [to DADS], Care Pro's correct address and operational status [in Lancaster, Texas] were reflected in the government's survey and certification records maintained by the United States Department of Health and Human Services ('HHS'), such as [the] Automated Survey Processing Environment or 'ASPEN,' as well as DADS' internal and public records." *Id.*, ¶ 7. Petitioner's appeal briefs do not cite these statements to support its allegation that Palmetto became aware of Petitioner's relocation to Lancaster prior to July 16, 2014 (or to support any other claim of factual error by the ALJ). In addition, there is no documentary evidence in the record which substantiates the declarant's assertion that Petitioner's relocation from Desoto to Lancaster was reflected in HHS's "survey and certification records" prior to July 16, 2014.

Second, the cited PIM instructions do not interpret, or purport to interpret, any statute or regulation applicable to determining the legality of the revocation. They merely specify various procedures for contractors to follow in verifying the accuracy of a provider's enrollment information. The purpose of our review is to determine whether the evidence in the record before us substantiates CMS's authority to take the proposed action, not to evaluate compliance by CMS contractors with their procedural instructions. Thus, the outcome of this case turns on whether the condition for revocation specified in section 424.535(a)(5)(i) was satisfied – being non-operational at the practice location shown in Petitioner's enrollment records – not on whether Palmetto followed CMS's instructions about how to verify a provider's compliance with Medicare requirements.

Third, even if those instructions were legally relevant, it is at best unclear that Palmetto failed to follow them. Section 15.5.4(A) calls on a contractor to seek "clarifying" information – by, for example, asking the provider to "furnish letterhead" – if it is unable to "verify" the "exist[ence]" of a practice location specified in the provider's enrollment application. These instructions, particularly the suggestion to obtain paper-verification ("letterhead"), implies that section 15.5.4(A) is intended to cover the situation in which a contractor is unable to confirm the **physical existence** of a practice location, as distinct from being unable to verify, through onsite review, that a provider meets all the requirements for being "operational" at some location. In this case, Palmetto did not need clarifying information because it was able to confirm the existence of the practice-location address on file with CMS as of July 16, 2014. Petitioner's position is that section 15.5.4(A) required Palmetto to take some further action upon learning, *during the onsite review*, that Petitioner had moved. However, section 15.5.4(A) does not say what a contractor should do in these circumstances. Indeed, the provision says nothing about changes in practice location or about a contractor's obligation to verify or follow-up on information acquired during an onsite review.

Extending its argument that CMS or Palmetto did not follow its established investigative procedures, Petitioner submits:

> Not only did CMS not contact Petitioner or extend to the provider an opportunity to update information with Palmetto prior to the on-site visit, it *knew* of the provider's newly licensed, correct practice location *at the time of the on-site review*. CMS's own evidence, the Site Verification Survey Form, establishes that CMS was informed of Petitioner's newly licensed practice location before the on-site visit.

Reply Br. at 4 (italics in original, underscoring added). This passage mischaracterizes the record. Palmetto's Site Verification Survey Form (CMS Ex. 2) does not, contrary to Petitioner's assertion, indicate that Palmetto or CMS "was informed of Petitioner's newly licensed practice location before the on-site visit." Reply Br. at 4. Rather, as Petitioner admitted in a prehearing brief,[7] the form indicates that Palmetto learned about the new location *during* the onsite visit based on information supplied by the owner of the residence at 205 Oleander Drive.

The just-quoted passage is misleading in another respect. It erroneously implies that Palmetto's surveyor *commenced* the onsite review *after* receiving the information about Petitioner's relocation from the owner of 205 Oleander Drive. The onsite review began when the surveyor arrived at that address. There is no evidence that CMS or Palmetto learned about Petitioner's relocation prior to that moment.

We reject Petitioner's suggestion that CMS should have given it an opportunity to update its enrollment information in lieu of revoking its enrollment. We are aware of no statute or regulation that required CMS to do so in these circumstances.[8] As noted earlier (*see* footnote 5), section 424.516(e)(2) provided Petitioner an opportunity to update its enrollment and (possibly) avoid the adverse outcome it now faces. That regulation allowed Petitioner 90 days from November 4, 2013, the date it moved from Desoto to Lancaster, to notify Medicare of the relocation. That 90-day notification period expired more than five months *before* Palmetto performed the site verification survey. That circumstance distinguishes this case from *Adora Healthcare Services, Inc.*, DAB No. 2714 (2016). Like this case, *Adora* involved a section 424.535(a)(5)(i) revocation stemming from an onsite review that had been conducted at a home health agency's (HHA's) former practice location. An administrative law judge reversed the revocation. In upholding the reversal, the Board held that CMS's determination to revoke was "premature" because the HHA's "90-day window for notifying CMS" of its change in practice location "had not closed at the time of the inspection on which CMS based its determination." DAB No. 2714, at 7. The Board expressly noted that its holding did not

[7] In Petitioner's May 14, 2015 amended brief to the ALJ, Petitioner asserted, in paragraph six of the section titled "Statement of Undisputed Facts," that: "The Site Verification Survey Form indicated in the additional comments section that CMS was informed *at the time of the visit* the provider had relocated to its newly licensed practice location" (italics added).

[8] CMS itself may have discretion to consider unique or mitigating circumstances in deciding whether, or how, to exercise its revocation authority. However, the Board has made clear that its role (and the role of administrative law judges) is limited to deciding whether CMS has a permissible "legal basis" for revocation. *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." *Douglas Bradley, M.D.*, DAB No. 2663, at 13 (2015) (internal quotation marks omitted).

preclude a section 424.535(a)(5)(i) revocation based on the onsite review of a former practice location that occurs – as it did in this case – after the expiration of the 90-day notification period. *Id.* at 6.

Petitioner's other allegations of error (apart from its contention that the ALJ improperly excluded evidence from the record, a topic we take up in next section) merit only brief discussion. Petitioner asserts that "[t]he ALJ erred in concluding that the 'regulatory definition of the term 'operational' refers to the 'qualified physical practice location' of a provider." RR at 7. We see no error here because the term "operational" is expressly defined in the regulations to mean that the "provider or supplier has a qualified physical practice location." 42 C.F.R. § 424.502.

Petitioner asserts that "[t]he ALJ erred in citing *JIB Enterprises, L.L.C.*, DAB CR3010 at 9 (2013) to support the conclusion that the [term] 'qualified physical practice location' exclusively means information on file with CMS's contractor." RR at 8. The ALJ cited *JIB Enterprises* to support the proposition that an onsite review is performed to "inspect the 'qualified practice location' that has been provided by the provider and is currently on file with CMS." ALJ Decision at 9-10. That proposition is legally and factually correct, with or without the citation to *JIB Enterprises*, for the reasons discussed at the beginning of this section. In any case, as another ALJ decision, *JIB Enterprises* is not binding precedent and may be relied upon only to the extent that its reasoning is persuasive. *Singing River Rehab. & Nursing Ctr.*, DAB No. 2232, at 11 n.7 (2009).

Petitioner also contends that the ALJ "erred by not addressing the retroactive application of CMS's sanction [.]" RR at 7. Petitioner offers no argument that explains this claim of error. If Petitioner is objecting to the revocation's effective date, which predates the issuance of CMS's initial determination, that objection is legally unfounded. When CMS revokes a provider's enrollment on the ground that it is "no longer operational," the regulations require CMS to make the revocation effective on "the date that CMS or its contractor determined that the provider or supplier was no longer operational." 42 C.F.R. § 424.535(g).

Petitioner argues that its right to due process was violated. RR at 7. The apparent basis for this claim is Petitioner's allegation that CMS had "improperly changed or concealed its theory" for the revocation at the ALJ level and thereby "deprived [it] of a reasonable opportunity to challenge the revocation." RR at 3 (item 7), 6. The record, however, shows that CMS did not change or "conceal" its legal theory. To the contrary, CMS consistently argued throughout the ALJ proceeding that the revocation should be upheld under section 424.535(a)(5)(i). *See* CMS's April 8, 2015 Prehearing Br. at 1, 3, 5; CMS's Aug. 8, 2015 Opening Br. at 1, 5-6. Moreover, CMS expressly advised Petitioner during the ALJ proceeding that it was not seeking to justify the revocation on any other legal ground. May 26, 2015 Reply to Pet.'s Br. at 5-6.

Petitioner contends that the ALJ should have discussed the two-year re-enrollment bar imposed by CMS as a result of the revocation. RR at 8. Nothing required her to do so. Because Petitioner's enrollment was validly revoked, CMS was required to bar Petitioner from seeking re-enrollment in the Medicare program for a "minimum" period of one year. 42 C.F.R. § 424.535(c)(1). The regulations permit CMS to increase the mandatory one-year bar up to three years "depending on the severity of the basis for revocation." *Id*. However, the merits of a decision to impose a re-enrollment bar exceeding the one-year mandatory minimum are not subject to review by an ALJ (or by the Board). *Vijendra Dave, M.D.*, DAB No. 2672, at 9, 11 (2016) (holding that the authority of an ALJ or the Board in a revocation appeal "does not extend to reviewing the length of the reenrollment bar imposed by CMS").

Finally, Petitioner asserts that the ALJ "erred in concluding that *Gibraltar Healthcare Services, L.L.C.,* DAB CR3422 (2014), was factually dissimilar and not relevant to Petitioner's appeal." RR at 8. Because Petitioner does not tell us why it thinks the ALJ was wrong to distinguish *Gibraltar,* which in any case was a non-precedential ALJ decision, we do not discuss the point further.

In sum, based on the evidence of record, we conclude that the ALJ committed no error of law or fact in concluding that Petitioner's Medicare's enrollment was subject to revocation under 42 C.F.R. § 424.535(a)(5)(i).

3. *The ALJ's evidentiary rulings were not erroneous or an abuse of discretion.*

Petitioner contends that the ALJ erroneously excluded five exhibits that Petitioner had not submitted to CMS at or before the reconsideration level. RR at 3-5. The excluded exhibits are identified as Petitioner's Exhibits 2, 5, 7, 8, and 10.

In enrollment revocation cases, an ALJ must exclude "new documentary evidence" – that is, documentary evidence that a provider did not previously submit to CMS at the reconsideration stage (or earlier) – unless the ALJ determines that "the provider or supplier has good cause for submitting the evidence for the first time at the ALJ level." 42 C.F.R. § 498.56(e)(1).

Petitioner offered the disputed evidence in conjunction with its motion for summary judgment. In that motion, Petitioner claimed that CMS had "recently" begun to rely upon section 424.516(e), which imposes certain reporting requirements on Medicare enrollees, as a supplemental or alternative legal basis for the revocation. *See* Pet.'s May 8, 2015 Motion and Notice of Motion for Summary Judgment at 3. Petitioner advised the ALJ that it was offering the new documentary evidence to demonstrate its compliance with section 424.516(e) and undercut CMS's reliance on that provision. *Id.* at 3-4. Petitioner

further asserted that "good cause" existed to admit the evidence "because the bases for CMS's revocation after reconsideration have evolved and changed." *Id.* at 4. In addition, Petitioner alleged that the evidence "was not available" when it filed its reconsideration request. *Id.* at 3.

CMS formally objected to the admission of the new documentary evidence, asserting that Petitioner had not shown good cause for submitting that evidence for the first time at the ALJ level. *See* May 26, 2015 CMS Objections to Petitioner's Exhibits. CMS also urged the ALJ to exclude the proffered exhibits as irrelevant. *Id.*

The ALJ rejected Petitioner's good-cause claim, noting that section 424.535(a)(5) – not section 424.516(e) – was the only legal basis for revocation cited in the initial and reconsidered determinations and that she was precluded in any event from considering any legal basis for revocation other than the one specified in the reconsidered determination. ALJ Decision at 6-7. The ALJ also observed that four of the five exhibits in question (namely, Petitioner's Exhibits 5, 7, 8, and 10) appeared to be irrelevant. *Id.* at 7 n.8. "[E]ven if I could accept these exhibits and admit them as evidence," she said, Petitioner has not shown how they would support its appeal." *Id.* at 7.

In its request for review, Petitioner reasserts the good-cause claim stated in its motion for summary judgment, with respect to Exhibit 2, "to complete the record of submitted documents to DADS by the provider." *See* RR at 3. The ALJ properly rejected that claim, however, because its factual premise is illusory: in defending the revocation at the ALJ level, CMS *never* sought to rely upon Petitioner's noncompliance with the reporting requirements in section 424.516(e) as a legal basis for revocation. Petitioner does not point to any evidence of record showing otherwise.[9]

In its Motion for Summary Judgment, Petitioner argued that the fact that Exhibit 5 did not exist at the time of the reconsideration request was good cause for admission into the record. Petitioner's Motion for Summary Judgment at 3, ¶ 6. It is undisputed that Petitioner's Exhibit 5 (dated February 6, 2015) did not exist when Petitioner submitted its reconsideration request (November 11, 2014). The unavailability of the document establishes good cause for the ALJ to have admitted it into the record.

However, in this appeal, rather than argue good cause for the admission of Petitioner's Exhibit 5 based on its prior unavailability, Petitioner asserts the exhibit's relevance, arguing that it shows that Petitioner was "operational" at its new location. Petitioner stated:

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[9] The ALJ also correctly stated that her review was limited to deciding whether CMS had substantiated the legal ground for revocation specified in the December 19, 2014 reconsidered determination. *Precision Prosthetic, Inc.*, DAB No. 2597, at 11 (2014) (explaining that 42 C.F.R. § 498.5(l) "limits ALJs to considering the basis or bases for denial or revocation of enrollment and billing privileges set forth in the . . . reconsidered determination").

> The ALJ also erred in weighing the relevance of the exhibit. Petitioner presented exhibit 5 for admission into the record to show that CMS assessed the overpayment for services *after* the relocation authorized by DADS and delivered while operating from its newly licensed, qualified practice location. Additionally, the exhibit established that CMS issued the notice of overpayment to Petitioner months after imposing the sanction. The demand for refund from CMS shows that the provider was, in fact, operational, at the time of the on-site visit and thereafter and both CMS and its contractor knew of Petitioner's operational status. Good cause existed for the filing of the evidence at the ALJ level and the ALJ's decision to exclude the evidence was error.

Id. at 4 (emphasis in the original).

These statements about the relevance of Exhibit 5 amount to an argument that Petitioner should have been deemed "operational" because it was still in business at its new location in Lancaster, Texas. As discussed, the ALJ correctly rejected that argument, finding it legally irrelevant and reiterating that she was bound to review only the issue CMS identified in its revocation notice – revocation under section 424.535(a)(5) (because Petitioner was no longer operational at the Desoto, Texas address). *See* ALJ Decision at 6-7. Hence, although the ALJ erred in denying admission of Petitioner's Exhibit 5 due, in part, to lack of good cause for late introduction of the exhibit into the record, the error was harmless because the ALJ also correctly denied its admission due to lack of relevance. We agree with the ALJ that Petitioner's Exhibit 5 is irrelevant to the question before the ALJ and hold that the ALJ was correct to reject the exhibit for that reason.

In asserting that the ALJ had good cause to admit Exhibits 7, 8, and 10, Petitioner asserts that it offered those exhibits for varying purposes *other than* to counter CMS's supposed reliance on section 424.516(e). In particular, Petitioner asserts that it offered:

- Exhibit 7 – a January 30, 2015 letter authored by DADS (with the addressee's name and address blocked out) – "to show that DADS obtained authorization from CMS *prior to* approving the provider's relocation request, which placed CMS and Palmetto on notice of Petitioner's new location prior to the date of the on-site visit";

- Exhibit 8 – a March 21, 2013 letter authored by Palmetto (with the addressee's name and address apparently blocked out) – "to show that Palmetto's own practice and policy is to first request that a provider update information when it learns the practice location reflected in the on-file enrollment application is not current"; and

- Exhibit 10 – a March 3, 2015 letter from Petitioner's lawyer to a CMS Deputy Regional Commissioner – "to show that CMS was informed that the provider was actively treating Medicare beneficiaries and submitting claims for payment to Palmetto subsequent to the on-site visit."

RR at 3-5 (italics in original).

The key problem with these assertions is that they do not constitute "cause" (much less good cause) for submitting the exhibits for the first time at the ALJ level; in other words, they do not explain or excuse Petitioner's failure to submit them at the reconsideration stage (or earlier). A second problem is that Petitioner did not tell the ALJ that it was offering the exhibits for these additional purposes. We cannot find that the ALJ should have found good cause based on reasons she was never asked to consider.

Petitioner did not press in this appeal the point it alleged in its summary judgment motion that good cause existed to admit Exhibits 5, 7, and 10 because those exhibits were "not available" when Petitioner sought reconsideration.[10] Moreover, we observe that, in at least two instances, the exhibits do not show what Petitioner says they show. Petitioner indicates that Exhibit 7 shows that the DADS got authorization from CMS prior to approving the relocation request and thus that CMS and Palmetto knew of the new location prior to the on-site visit. RR at 4. We see nothing in Exhibit 7, however, which indicates when – or even if – CMS received notice of the relocation as a result of Petitioner's contact with the DADS. Petitioner also asserts that Exhibit 8 reveals a "practice and policy" by Palmetto to request that a provider update its enrollment information upon finding that the practice location on file is not current (rather than to proceed to revocation). RR at 4. We discern no "policy" of any kind in the letter, which merely asks the addressee (whose name and address is blocked out) to update its "contact information" because an overpayment letter had been "returned to our office as undeliverable mail." The letter does not reflect any awareness by Palmetto that the addressee had moved its physical practice location.

In addition, what Exhibit 5 shows is not relevant to the question before the ALJ. Exhibit 5 shows the consequences of the revocation action in the form of CMS's assessment of an overpayment against Care Pro; it also shows that Care Pro continued to bill for services after moving to its new location. Neither is relevant to the question whether, at the time of the site visit on July 16, 2014, Care Pro was in an operational status at its qualified physical practice location, 205 Oleander Drive, DeSoto, Texas, as required under the regulations.

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[10] Petitioner also does not challenge the ALJ's finding that Exhibit 2 consists of documents that are already part of the record (in virtually identical form) or were available to Petitioner when it filed its request for reconsideration. *See* ALJ Decision at 5-6.

In short, Petitioner has not alleged a sufficient reason to overturn the ALJ's finding that good cause was lacking to admit its new documentary evidence. We therefore sustain her decision to exclude that evidence. Even if we found that good cause existed to admit Exhibits 5, 7, and 10 (because their creation post-dated issuance of the reconsidered determination), we would still not overturn their exclusion because it is clear that those exhibits are, as the ALJ observed, irrelevant and therefore inadmissible on that alternative ground. *Cf.* 42 C.F.R. § 498.60(b) (stating an administrative law judge "receives in evidence . . . documents that are *relevant and material*"); *Sandra E. Johnson*, *CRNA*, DAB No. 2708, at 11 (2016) (upholding an exclusion of documents in part because the petitioner did not show that she was "prejudice[d]" thereby). As discussed, the ALJ properly decided the appeal by answering two questions: (1) on the date of the onsite review, what did the enrollment information on record with the Medicare program show as the address of Petitioner's practice location? and (2) was Petitioner operational at that address on the date on the onsite review? Nothing in the excluded exhibits would have changed the ALJ's answers to those questions or provided some other factual basis to overturn the revocation.

Conclusion

Because the ALJ's factual findings are supported by substantial evidence and her legal conclusions are not erroneous, we affirm her decision that CMS had a valid legal basis to revoke Petitioner's Medicare enrollment effective July 16, 2014.

/s/
Sheila Ann Hegy

/s/
Leslie A. Sussan

/s/
Christopher S. Randolph
Presiding Board Member