Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Jason R. Bailey, M.D., P.A.
Docket No. A-17-74
Decision No. 2855
March 5, 2018

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Jason R. Bailey, M.D., P.A. (Petitioner) appeals the February 17, 2017 decision of an administrative law judge (ALJ), *Jason R. Bailey, M.D., P.A.,* DAB CR4793 (ALJ Decision). The ALJ Decision sustained on summary judgment a determination by the Centers for Medicare & Medicaid Services (CMS) to revoke Petitioner's Medicare enrollment and billing privileges under 42 C.F.R. § 424.535(a)(5) and (a)(9). The Board affirms the ALJ Decision.

Legal Background

To receive payment under Medicare, a physician or other "supplier" of Medicare services must be enrolled in the program. 42 C.F.R. § 424.505.[1] Enrollment confers on a supplier "billing privileges," i.e., the right to claim and receive Medicare payment for health care services provided to program beneficiaries. *Id.* §§ 424.502 (defining "Enroll/enrollment"), 424.505.

Supplier enrollment is governed by the regulations in 42 C.F.R. Part 424, subpart P, which authorize CMS to perform on-site inspections of a supplier to verify that the enrollment information submitted to CMS or its agents is accurate and to determine compliance with Medicare enrollment requirements. *Id.* §§ 424.510(d)(8), 424.517(a).

CMS may revoke a supplier's Medicare billing privileges for any of the "reasons" stated in subsection 424.535(a). Relevant here, subsection 424.535(a)(5) authorizes revocation where, "[u]pon on-site review or other reliable evidence, CMS determines that the . . . supplier is . . . [n]o longer operational to furnish Medicare-covered items or services." The term "operational" means that the supplier "has a qualified physical practice location, is open to the public for the purpose of providing health care related services, is

[1] The term "supplier" refers to "a physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare." 42 C.F.R. § 400.202.

prepared to submit valid Medicare claims, and is properly staffed, equipped, and stocked (as applicable, based on the type of facility or organization, . . . supplier specialty, or the services or items being rendered), to furnish these items or services." *Id.* § 424.502. CMS also may revoke a supplier's billing privileges if the supplier "did not comply with the reporting requirements specified in [42 C.F.R.] § 424.516(d)(1)(ii) and (iii)[.]"[2] *Id.* § 424.535(a)(9).

Revocation effectively terminates any provider agreement and bars the supplier from participating in Medicare from the effective date of the revocation until the end of the re-enrollment bar. *Id.* § 424.535(b), (c). The re-enrollment bar lasts between one year and three years, depending on the severity of the basis for revocation. *Id.* § 424.535(c). Revocation takes effect 30 days after CMS or its contractor mails the notice of determination to revoke with certain exceptions, one of which is where the basis for revocation is that the supplier was not operational, in which case revocation takes effect on the date that CMS or its contractor determined that the supplier was no longer operational. *Id.* § 424.535(g).

A supplier may seek reconsideration of an initial determination to revoke. *Id.* §§ 498.3(b)(17), 498.5(*l*)(1), 498.22(a). If dissatisfied with the reconsidered determination, the supplier may request a hearing before an ALJ. *Id.* §§ 498.5(*l*)(2), 498.40.

Case Background[3]

Dr. Bailey, a Texas physician, specializes in plastic and reconstructive surgery. P. Ex. 6, at 1, 3; P. Ex. 13, at 1. In 2011 and 2012, Dr. Bailey's practice, Petitioner Jason R. Bailey, M.D., P.A., was located at 3100 Timmons Lane, Suite 445, Houston, Texas 77027 (Timmons Lane). P. Ex. 13, at 1-2; P. Ex. 3, at 1. On August 25, 2011, Dr. Bailey entered into an agreement with First Call Business Solutions, a billing services company. P. Ex. 4. In or around January 2012, First Call Business Solutions completed and submitted Form CMS-855I (Medicare enrollment application form for physicians and non-physician practitioners) to report Petitioner's billing information, correspondence and special payments addresses, and practice location as 21175 Tomball Parkway, Suite

[2] As relevant here, physicians and physician practitioner organizations "must" report "[a] change in practice location" "to their Medicare contractor" "[w]ithin 30 days." 42 C.F.R. § 424.516(d)(1)(iii).

[3] The background information is drawn from the ALJ Decision and the record before the ALJ and is not intended to substitute for her findings.

173, Houston, Texas 77070 (Tomball Parkway). CMS Ex. 1, at 22, 24-26, 28; P. Ex. 13, at 2; P. Ex. 16, at 2, 9, 11, 14.[4] Within the "practice location" section of the form, the box for "CHANGE" is checked and "12/01/2011" is entered for the date of change of the practice location; below that information is the Tomball Parkway address. CMS Ex. 1, at 24; P. Ex. 16, at 9.

In October 2014, Dr. Bailey signed a lease for office space at 12121 Richmond Avenue, Suite 104, Houston, Texas 77082 (Richmond Avenue). P. Ex. 11, at 75-101. In or around November 2014, he moved his practice from Timmons Lane to Richmond Avenue. P. Ex. 13, at 2. On or about November 18, 2014, MedEnEx, LLC, a credentialing company retained by Dr. Bailey, submitted a Form CMS-855I to update the practice's correspondence and special payments addresses. P. Ex. 13, at 3; P. Ex. 18, at 3, 4, 18, 26. As the ALJ noted, the November 2014 form did not report a change to the practice location. ALJ Decision at 2, citing P. Ex. 18, at 16 (the section of the form for reporting a change in practice location is not completed).

On November 6, 2015, Dr. Bailey's staff updated the practice location (Richmond Avenue) and correspondence addresses (a post office box number) in the National Plan and Provider Enumeration System (NPPES)[5] database. P. Ex. 13, at 3; P. Ex. 10, at 1.

On January 11, 2016, an inspector for Novitas Solutions, Inc. (Novitas) visited Tomball Parkway. CMS Ex. 2 (Site Verification Survey Form). The inspector reported that Tomball Parkway was the site of a "commercial receiving agency (UPS Store)." *Id.* at 1 (boxes for "N" for "No" are marked for "Is the provider/supplier open for business[?]";

[4] As the ALJ noted, each party submitted to the ALJ a copy of the enrollment application form purported to have been submitted to Novitas Solutions, Inc. (Novitas), CMS's Medicare Administrative Contractor, on or around January 17, 2012 (CMS Ex. 1; P. Ex. 16). However, the copy CMS submitted, in contrast to the copy Petitioner submitted, did not include section 2.B of the form; included two copies of section 2.D of the form; and included two certification pages, one that Dr. Bailey signed on July 19, 2011 and the other on January 17, 2012. ALJ Decision at 2 n.1, citing CMS Ex. 1, at 4-7, 28, and 29; P. Ex. 16, at 19 (certification statement signed on January 17, 2012). Petitioner does not dispute that the form was submitted to Novitas on or around January 17, 2012.

[5] NPPES is a web-based system through which a health care provider applies for assignment of a National Provider Identifier (NPI), a ten-digit number used to identify a health care provider or health plan. https://nppes.cms.hhs.gov; Medicare Program Integrity Manual (MPIM), CMS Pub. 100-08, Ch. 15 ("Medicare Enrollment"), § 15.3 ("National Provider Identifier"). CMS maintains the NPPES NPI Registry, accessible at https://npiregistry.cms.hhs.gov. The NPI system was established to implement the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which mandated the adoption of a standard, unique health identifier for health care providers that meets HIPAA's definition of a "covered entity." *See* HIPAA Administrative Simplification: Standard Unique Health Identifier for Health Care Providers; Final Rule, 69 Fed. Reg. 3434 (Jan. 23, 2004); 45 C.F.R. §§ 162.406-162.410.

"Does the facility appear to have employees/staff present?"; "Does there appear to be signs of customer activity present during the survey?"; and "Does the facility appear[] to be operational[?]").[6]

By initial determination dated April 19, 2016, Novitas revoked Petitioner's enrollment and billing privileges effective January 11, 2016. CMS Ex. 3, at 1. Novitas cited two bases for revocation: (1) 42 C.F.R. § 424.535(a)(5), based on a failed inspection at Tomball Parkway, Petitioner's practice location on file, which was "non-operational" on January 11, 2016; and (2) 42 C.F.R. § 424.535(a)(9), for failure to report a change in practice location as required by 42 C.F.R. § 424.516. *Id.* Novitas informed Petitioner that it was barred from re-enrolling in Medicare for two years. *Id.* at 2.

By reconsidered determination dated July 18, 2016, Novitas affirmed its initial determination. CMS Ex. 5. Novitas restated the two bases for revocation (subsections 424.535(a)(5) and 424.535(a)(9)), *id.* at 1, and added:

> [Petitioner's] enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS)[7] reflects a practice location of [Tomball Parkway]. On January 11, 2016, there was a site visit performed at [Tomball Parkway] which confirmed that you are non-operational.
>
> The reconsideration request indicates due to a series of clerical errors by the supplier's third party billing agency and administrative staff, the Tomball [Parkway] address was erroneously provided to Medicare as a practice location. The supplier never practiced at this location. The Tomball [Parkway] address was a post office box and should only have been used for correspondence. The supplier's staff was unaware of the error. The

[6] The inspector's report includes the following comment: "An employee [of the UPS Store] stated that box 175 was closed approximately two months ago and no one has been in to pick up correspondence that had accumulated prior to the date the box was closed." CMS Ex. 2, at 1 (emphasis added). Also included is a close-up photograph of a grid of mailboxes with mailbox 175 appearing in the center of the photograph. *Id.* at 2. It is possible that the inspector mistakenly believed that mailbox 175 (rather than mailbox 173) was associated with Petitioner and asked a store employee about the renter of mailbox 175, or that the information the store employee gave the inspector pertained to Petitioner but the inspector mistakenly referred to mailbox 175 in his report and photographed mailbox 175. In any case, despite the apparent error, the first page of the inspector's report correctly reflects "STE 173." *Id.* at 1. It is undisputed that on the inspection date, 21175 Tomball Parkway housed a UPS Store. *Id.* (photograph of the front entrance, bearing "21175" and "The UPS Store Print & Business Services").

[7] PECOS stands for "Provider Enrollment, Chain and Ownership System." PECOS is a web-based system for enrolling providers and suppliers into the Medicare program.

> reconsideration [request] goes on to say the supplier does not deny the inadvertent failure to update the Medicare enrollment, but asserts that the supplier has been operational and furnishing Medicare covered items and services at the Richmond [Avenue] address.
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> * * *
>
> [Petitioner] did not notify Medicare [of] the change of practice location per the requirements for enrolling and maintaining active enrollment status in the Medicare program under 42 CFR §424.516. A CMS-855B enrollment application was not submitted to . . . Novitas . . . to notify [it] of any changes of the practice location until the reconsideration request was received.
>
> DECISION:
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> [Petitioner] does not dispute the practice location of [Tomball Parkway] on the PECOS file is non-operational since this address should have been used for correspondence only. Therefore, the reconsideration is denied and the revocation is upheld.

Id. at 2.

ALJ Proceedings and Decision

Petitioner requested a hearing before an ALJ. CMS moved for summary judgment, asserting that there is no dispute that: (1) Tomball Parkway, Petitioner's practice location on file, was not operational during an inspection attempted on January 11, 2016; and (2) Petitioner failed to update its enrollment record to report a change in practice location. CMS's motion for summary judgment and pre-hearing brief (CMS's MSJ), at 8-10. Accordingly, CMS asserted, it lawfully revoked Petitioner's enrollment and billing privileges under subsections 424.535(a)(5) and (a)(9). *Id.* at 12.

Petitioner opposed CMS's motion and asked to cross-examine "CMS officials regarding their utilization of the NPPES database to maintain provider enrollment." Petitioner's pre-hearing brief in support of "Motion for Reversal of Revocation" (P. Br.) at 10. The ALJ noted that, pursuant to her Acknowledgment and Pre-Hearing Order, ¶ 10, "[a]n in-person hearing to cross-examine witnesses will be necessary only if a party files admissible, written direct testimony, and the opposing party asks to cross-examine." CMS, the ALJ noted, did not offer the written direct testimony of any witness. ALJ

Decision at 4. The ALJ also noted that CMS had asked to cross-examine Dr. Bailey, who submitted his sworn declaration (P. Ex. 13). *Id.* However, the ALJ determined that an in-person hearing to cross-examine Dr. Bailey was not necessary because she was granting CMS's motion for summary judgment.[8] *Id.*

Before the ALJ, Petitioner's position, in sum, was this: Beginning in 2011, Petitioner was located at Timmons Lane. In or around November 2014, Dr. Bailey moved his practice from Timmons Lane to Richmond Avenue, where the practice was operational on January 11, 2016 and remains operational. In 2012, First Call Business Solutions erroneously reported Tomball Parkway as the practice location when at that time Timmons Lane was the practice location. Dr. Bailey relied on First Call Business Solutions to properly complete Form CMS-855I and believed that Tomball Parkway was reported only as a correspondence address. He reviewed only the certification form accompanying Form CMS-855I prepared by First Call Business Solutions and signed that form. He was unaware that Tomball Parkway was incorrectly reported as a practice location, and learned about the error in 2016, after the inspection. Upon relocation to Richmond Avenue in late 2014, MedEnEx, LLC, the credentialing company, failed to report the relocation. However, on November 6, 2015, before the inspection, Dr. Bailey's staff updated the NPPES database to report Richmond Avenue as the practice location. P. Ex. 13; P. Br. at 2, 4-5, 6, 10.

The ALJ first determined that the undisputed evidence established a basis for revocation under subsection 424.535(a)(5). ALJ Decision at 5. The ALJ found that, on or about January 17, 2012, Dr. Bailey signed a Form CMS-855I that identified Tomball Parkway as the practice location, thereby certifying the contents of that form as accurate. *Id.* at 5-6. The ALJ also found that, on January 11, 2016, an inspector for a CMS contractor visited Tomball Parkway, and found there a UPS Store, rather than a medical office. *Id.* at 6. The ALJ also accepted Dr. Bailey's representation that he never practiced medicine at Tomball Parkway and that his practice at Richmond Avenue was operational on January 11, 2016. *Id.* at 6 and 7. The ALJ nevertheless found that whether Petitioner was operational at Richmond Avenue on January 11, 2016 was immaterial since there was no dispute that on that date Petitioner was not operational at Tomball Parkway, the practice location identified on the Form CMS-855I submitted to Novitas in 2012. *Id.* at 7, quoting 76 Fed. Reg. 5862, 5870 (February 2, 2011) ("[T]he 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*.") (ALJ's emphasis); *id.* at 8 (noting that Tomball Parkway was the "only practice address Dr. Bailey had on file with Novitas . . . [on] January 11, 2016").

[8] Neither party raises any argument concerning the ALJ's determination not to hold an in-person hearing.

The ALJ also accepted that, on November 6, 2015, Dr. Bailey (or his staff) updated the NPPES database to show Richmond Avenue as the practice location, but stated:

> The fact that Petitioner may have updated the NPPES database with the Richmond Avenue address d[id] not relieve him of the duty to update his enrollment information, via PECOS [which the ALJ noted Dr. Bailey admitted he had not done, *id.*, citing P. Br. at 6] or paper submission. Moreover, Petitioner's contention that I should impute constructive knowledge of his change of practice location to CMS because he updated the NPPES database ignores the reality of how the Medicare program is administered. As a Medicare supplier, Petitioner is undoubtedly aware that CMS does not directly administer the Medicare program, but relies on a host of contract entities to do so. Novitas . . . is responsible for supplier enrollment in [Texas]. By contrast, CMS has contracted with a different entity, Cognosante, LLC, to serve as the NPI Enumerator, operating NPPES . . . . I am not persuaded that notice to one CMS contractor for one purpose constitutes notice to all CMS contractors for all purposes.
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> The essence of Petitioner's argument is that, if CMS or Novitas had pursued additional avenues of inquiry, i.e. by accessing the NPPES database, such inquiry may have revealed the actual physical location of Dr. Bailey's practice. While I am required to decide whether CMS had a legal basis to revoke Dr. Bailey's enrollment, I am not required to assess whether CMS could have made additional efforts to identify his practice location, and Petitioner has not cited any authority showing CMS had such an obligation . . . . Moreover, given the vast scope of the data collection and analysis required to enroll and revalidate Medicare providers and suppliers, it is not unreasonable for CMS and its contractors to place the burden on the provider or supplier to report accurately its practice location or locations when completing an application for enrollment or revalidation purposes.

Id. at 7-8.

The ALJ determined that even assuming CMS lacked a basis to revoke Petitioner's enrollment and billing privileges under subsection 424.535(a)(5), CMS had another basis to revoke under subsection 424.535(a)(9) because the undisputed evidence established that Petitioner failed to report a change of practice location within 30 days as required by subsection 424.516(d)(1)(iii). *Id.* at 8-10. The ALJ stated that, even were she to assume that updating the NPPES database comports with subsection 424.516(d)(1)(iii), the earliest date of compliance with that regulation would be November 6, 2015, the date on which Petitioner updated the NPPES database. *Id.* at 9 & 9 n.5. However, the ALJ

noted, "[b]y November 6, 2015, approximately one year had passed since Dr. Bailey moved his practice location to the Richmond Avenue address. Therefore, he did not report a change in his practice location within 30 days as he was required to do." *Id.* at 9. The ALJ noted, moreover, Dr. Bailey's concession that neither he nor his billing agents timely updated PECOS to reflect Richmond Avenue as the practice location (*id.*, citing P. Br. at 6) and that MedEnEx did not update the practice location information when it submitted a Form CMS-855I in November 2014 (*id.*, citing P. Br. at 5).

Lastly, in response to Dr. Bailey's argument that if the revocation is upheld CMS would recoup payments made for medically necessary services provided to Medicare beneficiaries (P. Br. at 6), the ALJ stated that the "argument is, at root, an equitable one in that [Dr. Bailey] argues that it would be unjust for him to have to repay CMS for services he provided in good faith." *Id.* at 10. The ALJ then determined that she was without authority to consider a request for equitable relief inasmuch as the right to have an ALJ review CMS's determination to revoke entailed only the right to have the ALJ decide whether CMS had a legal basis to revoke, and not to have the ALJ look behind CMS's exercise of discretion to revoke. *Id.*, citing *Letantia Bussell, M.D.*, DAB No. 2196 (2008) and *Abdul Razzaque Ahmed, M.D.*, DAB No. 2261 (2009), *aff'd, Ahmed v. Sebelius*, 710 F. Supp. 2d 167 (D. Mass. 2010).

Standard of Review

We review the ALJ's grant of summary judgment de novo, construing the facts in the light most favorable to Petitioner and giving Petitioner the benefit of all reasonable inferences. *See Livingston Care Ctr.*, DAB No. 1871, at 5 (2003), *aff'd, Livingston Care Ctr. v. U.S. Dep't of Health & Human Servs.*, 388 F.3d 168, 172-73 (6th Cir. 2004). Summary judgment is appropriate when there is no genuine dispute about a fact or facts material to the outcome of the case and the moving party is entitled to judgment as a matter of law. *Id.*; *Celotex Corp. v Catrett*, 477 U.S. 317, 322-25 (1986). The party moving for summary judgment has the initial burden to demonstrate that there is no genuine issue of material fact for trial and that it is entitled to judgment as a matter of law. *Celotex*, 477 U.S. at 323. If the moving party carries that burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial.'" *Matsushita Elec. Indus. Co., Ltd. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986) (quoting Rule 56(e) of the Federal Rules of Civil Procedure) (italics omitted). The Board's standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. *See Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program*, http://www.hhs.gov/dab/divisions/appellate/guidelines/prosupenrolmen.html.

Discussion

We conclude for the reasons stated below that the ALJ properly ruled on summary judgment that CMS had legal bases for revocation under both subsections 424.535(a)(5) and 424.535(a)(9).

A. *CMS lawfully revoked Petitioner's enrollment and billing privileges under 42 C.F.R. § 424.535(a)(5) because the undisputed evidence establishes that, on January 11, 2016, Petitioner was not operational at Tomball Parkway, the practice location on file with Novitas.*

1. Petitioner does not dispute that it was not operating at Tomball Parkway, its practice location of record with Novitas, on the date of Novitas' inspection.

In or around January 2012, First Call Business Solutions reported Tomball Parkway as Petitioner's practice location. CMS Ex. 1; P. Ex. 16; P. Ex. 13, at 2. Dr. Bailey does not dispute that First Call is a company that he had retained to perform billing services for his practice, or that the company's staff were acting for him and his practice when they prepared and submitted Form CMS-855I to Novitas reporting Tomball Parkway as the practice location. In fact, Dr. Bailey wrote, "On August 25, 2011, I entered into a Billing Services Agreement with [T.S.], doing business as First Call Business Solutions, to perform billing services for my practice." P. Ex. 13, at 2. Dr. Bailey also wrote that, in January 2012, "[T.S.] prepared a CMS 8[5]5-I form that . . . requested that my correspondence address b[e] changed to [Tomball Parkway] . . . . I was not aware the CMS 8[5]5-I form also requested that my physical practice location be changed to [Tomball Parkway] . . . ." *Id.* However, as Petitioner also does not dispute, Tomball Parkway was not its practice location on January 11, 2016, the date of Novitas' inspection at that location.[9] Thus, Petitioner has effectively conceded that it "was no longer operational to furnish Medicare-covered items or services" at Tomball Parkway on the inspection date. Instead, Petitioner argues that CMS's determination that it was non-operational is invalid because it was operating its practice at Richmond Avenue on that date. For the reasons discussed below, we reject that argument.

[9] Indeed, as the contractor's reconsidered determination shows, Tomball Parkway was never Petitioner's practice location but, instead, its UPS Store mailbox address. ALJ Decision at 3.

2. The fact that Petitioner was operating a practice at Richmond Avenue on the inspection date does not invalidate CMS's determination that it was no longer operational.

    a. For purposes of revoking a physician's or physician practitioner organization's billing privileges under subsection 424.535(a)(5), the "practice location" is the location reported to the physician's or physician practitioner organization's Medicare contractor (here Novitas), not a location reported to the NPPES contractor.

CMS may revoke a supplier's billing privileges where, "[u]pon on-site review or other reliable evidence," it determines that the supplier is "[n]o longer operational to furnish Medicare-covered items or services." 42 C.F.R. § 424.535(a)(5)(i). To be "operational," the supplier must have a "qualified physical practice location" and meet certain other requirements. *Id.* § 424.502. CMS may conduct on-site inspections to verify that the enrollment information submitted by a supplier – which would include the practice location information reported in the enrollment application – is accurate and that the supplier meets applicable enrollment requirements. *See id.* §§ 424.510(d)(1), 424.517(a).

The regulations governing the enrollment of providers and suppliers in 42 C.F.R. Part 424, subpart P also require providers and suppliers to update enrollment information, for example, by reporting a change in practice location. 42 C.F.R. § 424.516(d), (e). As applicable here, physicians and physician practitioner organizations like Dr. Bailey and Jason R. Bailey, M.D., P.A. "must" report "[a] change in practice location" "to their Medicare contractor" "within 30 days" *Id.* § 424.516(d)(1)(iii) (emphasis added). The words "their Medicare contractor," within the context of Part 424, subpart P regulations, plainly mean that physicians and physician practitioner organizations must notify the CMS contractor designated to handle their Medicare enrollment.

Petitioner relocated its practice from Timmons Lane to Richmond Avenue in or around November 2014. P. Ex. 13, at 2. Petitioner contends that, by updating the NPPES database on November 6, 2015 to show Richmond Avenue as the practice location, Petitioner notified "CMS" of relocation and thus established Richmond Avenue as the practice location on file before the inspection on January 11, 2016. Petitioner's brief in support of request for Board review (P. Br. to the Board) at 2-3; P. Ex. 10, at 1. According to Petitioner, the "NPPES is a valid medium of notifying CMS of any changes in a [supplier's] Medicare enrollment." P. Br. to the Board at 4. Petitioner moreover asserts that, where, as here, the supplier notifies "CMS" of a change in practice location, CMS is responsible for communicating that information to its contractor(s) and, therefore, here, CMS should have had Novitas send an inspector to Richmond Avenue

rather than to an "outdated" address at Tomball Parkway (the UPS Store). Had the inspector visited Richmond Avenue on January 11, 2016, Petitioner says, the inspector would have found it fully operational. *Id.* at 3; Petitioner's reply brief (P. Reply) at 3 ("Whether CMS actually communicated its actual knowledge to its group of contractors is beyond the control of the providers who utilize an appropriate means of notification.").

However, subsection 424.516(d)(1)(iii), which applies here, specifies *to whom* such a report must be made – to the physician's or physician practitioner organization's "Medicare contractor." It does not state that a change in practice location may be reported to a CMS contractor or any CMS contractor. As noted earlier, the NPPES database of NPIs was established to comply with certain HIPAA provisions. Obtaining and disclosing an NPI, and updating an enrollment record that does not include the NPI with the NPI, are parts of the enrollment process. *See* CMS Ex. 1, at 3 (Form CMS-855I's section headed "BILLING NUMBER INFORMATION" states, "As a Medicare healthcare supplier, you must obtain an NPI prior to enrolling in Medicare or before submitting a change to your existing Medicare enrollment information. Applying for the NPI is a process separate from Medicare enrollment."); 42 C.F.R. § 424.506(b) (a provider or supplier eligible for an NPI must report the NPI in the enrollment application or, if the provider or supplier was in the Medicare program before obtaining an NPI and the NPI is not in the provider's or supplier's Medicare enrollment record, the enrollment record must be updated with the NPI). Thus, obtaining and maintaining an NPI through the NPI enumeration system is a process separate and distinct from applying to the Medicare contractor (in this case Novitas), which is responsible for enrolling providers and suppliers in the Medicare program, or updating enrollment information already on file with that Medicare contractor. That the enrollment application form instructs applicants to report the NPI, which must be obtained through a process separate and distinct from Medicare enrollment, lends further support to the ALJ's conclusion (ALJ Decision at 8) that sending updated practice location information to the NPI enumeration system is not equivalent to, or a substitute for, reporting that NPI-holder's practice location information to the holder's "Medicare contractor" as expressly required by subsection 424.516(d)(1)(iii).

It is undisputed that Novitas is CMS's Medicare Administrative Contractor designated to handle Part B enrollment matters in Texas (ALJ Decision at 8), where Dr. Bailey practices medicine and his physical practice location was (and still is) sited. There is no evidence or an assertion that the NPPES contractor that maintained the NPPES database Petitioner updated on November 6, 2015 (P. Ex. 10, at 1) acted as Petitioner's "Medicare contractor" overseeing Medicare enrollment in Texas at any time relevant to this case. More to the point, there is no dispute that Petitioner did not actually notify *Novitas* that Richmond Avenue was the practice location at any time between the date of relocation to

Richmond Avenue (in or around November 2014) and January 11, 2016, the inspection date. Rather, by Petitioner's own admission, Petitioner only reported the relocation to the NPPES contractor. Thus, Petitioner did not comply with subsection 424.516(d)(1)(iii)'s requirement to notify its "Medicare contractor" of the change in practice location.[10]

Not only did Petitioner fail to report the relocation to Novitas as it was required to do, Petitioner nowhere asserts, or shows, that Novitas actually was aware of the relocation before the inspection date. Moreover, the proposition that reporting to a CMS contractor could impute notice to CMS, which is then responsible for ensuring that all of its contractors are made aware of the report – a proposition for which Petitioner cites no authority on point – evades the plain regulatory mandate that a supplier such as Petitioner here must report a change in practice location to its Medicare contractor. We also observe that, while Petitioner repeatedly avers that it has proven that it reported the relocation to "CMS" since "CMS" confirmed that report, on November 6, 2015 (e.g., P. Reply at 3, 5), nowhere in the two November 6, 2015 contractor letters Petitioner relies on as proof of notice of relocation indicates any confirmation by *CMS* (or Novitas) of a report of relocation. Those letters are from the NPPES contractor, and they specifically refer to a "request" made concerning Petitioner's *NPI* and to *NPPES* information about Petitioner. P. Exs. 9 and 10. (The second letter refers to Timmons Lane as the "old" practice location, and Richmond Avenue as the "new" practice location. P. Ex. 10, at 1.).

b. Petitioner impermissibly makes new arguments on appeal, including arguments based on decisions by an ALJ and the Board that in any event are inapposite; none defeats summary judgment for CMS.

Petitioner also raises several new arguments that it did not raise below. A party appearing before the Board is not permitted to raise on appeal issues that could have been raised before the ALJ but were not. *See Russell L. Reitz, M.D.*, DAB No. 2748, at 8 (2016)*; see also* the Board's *Guidelines* (included with the ALJ Decision), "Completion of the Review Process," ¶ (a) (the Board "will not consider issues . . . which could have been presented to the ALJ but were not"); *ACT for Health, Inc.*, DAB No. 1972, at 5 (2005) (*Guidelines*' bar on raising issues not presented to the ALJ "mirrors the rule applied in federal appellate courts, which generally refuse to consider issues or arguments raised for the first time on appeal"). Since Petitioner did not raise the arguments below and has not shown that it could not have done so, the arguments are not properly before us. *Reitz* at 8. But even were we to consider the new arguments despite the unexplained failure to raise them earlier, as we explain below, the arguments are inapposite. Importantly, none raises a dispute of material fact that could defeat summary judgment for CMS.

[10] Petitioner nowhere disputed that in 2012, a Form CMS-855I was submitted on its behalf to Novitas, which indicates awareness of the need to report practice location information to the Medicare contractor.

Petitioner belatedly complains that CMS denied it the opportunity to challenge "irregularities" in the inspection report (CMS Ex. 2) before CMS made its "final" decision to revoke because CMS did not provide the report before the ALJ proceedings. P. Br. to the Board at 6. Petitioner also questions the validity of the inspection and the report of the inspection, asserting that: (1) the inspection report does not include Petitioner's telephone number; (2) there is no indication that the inspector attempted to call Petitioner to verify whether the telephone number is operational and connects to the practice location on file in accordance with the Medicare Provider Integrity Manual (MPIM), Chapter 15, § 15.5.4.A; (3) the photographs included in the inspection report are not date- or time-stamped in accordance with the MPIM, Chapter 15, § 15.20.1.C; and (4) the inspection report does not include a declaration signed by the inspector, in accordance with the MPIM, Chapter 15, § 15.20.1.D. According to Petitioner, without a report of a valid inspection and inspection report, the record lacks evidentiary support for revocation. P. Br. to the Board at 2, 5-7; P. Reply at 7 ("purported on-site inspection is fatally flawed").

But Petitioner cites no authority for the proposition that the alleged "irregularities" concerning the inspection report invalidate the inspection, or in support of its argument that it was entitled to receive the inspection report before the reconsidered determination was rendered. During the ALJ proceedings, Petitioner was provided a copy of the report and an opportunity to raise any dispute concerning its contents, but did not do so. Moreover, none of the alleged "irregularities" raises a genuine dispute of material fact. Petitioner does not dispute that it was not operational at Tomball Parkway, the practice location on file with Novitas, on January 11, 2016. Petitioner also fails to explain how an attempt to call Petitioner on the inspection date, if made, could have made any difference in outcome here, where the physical practice location on file was a UPS Store and was not an "operational" medical practice.

Petitioner also asserts that: (1) as long as a provider or supplier effectuates actual notice of a change in practice location, it may use "any" reporting "method" (meaning that Petitioner's actual notice to the NPPES contractor was legally sufficient); and (2) CMS is responsible for staying abreast of reported changes in enrollment information and disseminating such information to its contractor community and thus the ALJ erred to the extent she put the burden on Petitioner to prove it reported the relocation unless it used either PECOS or the paper form. Petitioner relies on *Viora Home Health, Inc.*, DAB No. 2690 (2016) and *Adora Healthcare Services, Inc.*, DAB CR4229 (2015), respectively, as authorities for these arguments. P. Br. to the Board at 3-4; P. Reply at 4-6.

Petitioner ignores the central point – the regulations hold the provider or supplier responsible for reporting, and updating, enrollment information; they do not impose on CMS or its contractors a duty to make additional inquiries to verify that information. As we have said elsewhere, Petitioner did not comply with the regulation that required it, a physician practitioner organization, to report its relocation to its Medicare contractor.

Moreover, the Board's decision in *Viora* is simply inapposite here. The central issue in *Viora* was whether, as a factual matter, Viora, a home health agency, proved that it had actually effectuated the notice of relocation to a new practice location that Viora claimed it sent to its Medicare contractor before the date of the failed site inspection. Viora, unlike Petitioner, did not dispute to whom it was required to report the relocation in order to comply with the applicable reporting requirement, which in that case was 42 C.F.R. § 424.516(e)(2). There was no legal issue in *Viora* as to whom notice of a change in practice location was required to be submitted.

Adora, DAB CR4229, a decision by an ALJ which the Board reviewed on appeal,[11] is also inapposite. *Adora*, unlike the present case, involved a situation where the time during which the home health agency had to report its relocation had not expired when an inspector visited the location on record with the Medicare contractor. For this reason, *Adora* is factually distinguishable from Petitioner's case. But, more importantly, neither the ALJ's decision, nor the Board's decision, nor the Board's subsequent ruling denying reconsideration, suggested, much less stated, that the "burden is with the CMS to prove that the provider did not provide a change of address" (P. Reply at 5)[12] for purposes of revocation for not being operational at the practice location on file at the time of the inspection.

Lastly, quoting Federal Register preamble language from a 2011 final rule in which CMS discussed database checks that Medicare contractors perform to verify the eligibility of providers and suppliers as part of the enrollment process (e.g., checking the NPPES database to verify a health care provider's NPI; checking the state licensing board to verify whether a professional is licensed to furnish medical services), Petitioner asserts that CMS has "admitted" that it "at least has the ability to transfer information from

[11] An ALJ's decision is not precedential and does not bind other ALJs or the Board. *Melissa Michelle Phalora*, DAB No. 2772, at 14 (2017) (and cases cited therein). By decision issued on June 20, 2016, eight months before the date the ALJ issued her decision in Petitioner's case, the Board reviewed DAB CR4229, upholding the ALJ's decision to reverse the revocation but for different reasons. *Adora Healthcare Services, Inc.*, DAB No. 2714 (2016). The Board later denied reconsideration of DAB No. 2714. *Adora Healthcare Services, Inc.*, DAB Ruling 2017-4 (May 18, 2017).

[12] To the extent the Board discussed burden of proof, the Board stated only that, once CMS makes its prima facie case that the cited basis for revocation exists (here, CMS made its prima facie case as to two bases), the provider or supplier must rebut that basis by a preponderance of the evidence. DAB No. 2714, at 4-5.

NPPES to PECOS." P. Br. to Board at 5; P. Reply at 6, quoting 76 Fed. Reg. 5862, 5866 (Feb. 2, 2011) ("[W]e have deactivated the NPIs of more than 11,500 individuals who were previously assigned a type 1 (individual) NPI. We automatically transfer this information from NPPES to [PECOS] . . . ."). That CMS is able to access various databases, including the NPPES database, to verify the eligibility of providers and suppliers participating in or seeking to participate in the program and, as part of that verification process, previously deactivated the NPIs of certain providers and suppliers who presumably were determined less than fully eligible to participate in Medicare and transferred information about the deactivation to PECOS, does not lend Petitioner support here. Petitioner neither shows, nor asserts, that CMS or its Medicare contractors routinely check (much less that they are required to check) all NPPES database updates, or that all such updates are automatically transferred to PECOS, regardless of the active or inactive status of an NPI.

B. *CMS alternatively had a legal basis to revoke Petitioner's enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(9).*

In provider/supplier revocation cases, ALJs and the Board are limited to determining whether CMS had a basis to revoke the provider's or supplier's Medicare enrollment and billing privileges. *See Bussell* at 13 (stating that the only issue before an ALJ and the Board in enrollment cases is whether CMS has established a "legal basis for its actions"); *accord Stanley Beekman, D.P.M.*, DAB No. 2650, at 10 (2015) (an ALJ and the Board are required to uphold a revocation if the record establishes that the regulatory elements for revocation are satisfied); *Fady Fayad, M.D.*, DAB No. 2266, at 16 (2009) (if CMS establishes a qualifying felony conviction as the basis for revocation, the Board must uphold revocation without regard to factors, such as the scope or seriousness of the supplier's criminal conduct, that CMS might reasonably have weighed in determining whether to revoke), *aff'd, Fayad v. Sebelius*, 803 F. Supp. 2d 699 (E.D. Mich. 2011); *Ahmed*, DAB No. 2261, at 19 (CMS is "legally entitled to revoke a supplier's billing privileges" where the elements of subsection 424.535(a)(3) are met). Concluding that CMS had <u>one</u> of the bases for revocation enumerated in the regulations is all that is necessary to uphold revocation. *Donna Maneice, M.D.*, DAB No. 2826, at 8 (2017) ("CMS needs to establish only one ground for revocation"). Since the ALJ upheld the revocation under subsection 424.535(a)(5), and we have affirmed the ALJ, the revocation would stand, regardless of whether CMS had an alternative basis to revoke under subsection 424.535(a)(9). Nonetheless, we agree with the ALJ that the revocation was also lawful under subsection 424.535(a)(9).

1. The undisputed evidence establishes that Petitioner did not timely report a change in practice location as required by 42 C.F.R. § 424.516(d)(1)(iii).

Subsection 424.535(a)(9) authorizes CMS to revoke a supplier's Medicare billing privileges if the supplier fails to comply with the reporting requirements in subsections 424.516(d)(1)(ii) and (iii). As applicable here, physicians and physician practitioner organizations "must" report "[a] change in practice location" "to their Medicare contractor" "[w]ithin 30 days." 42 C.F.R. § 424.516(d)(1)(iii).

Dr. Bailey's own declaration establishes that in late 2014, Petitioner moved its practice location from Timmons Lane to Richmond Avenue, where Dr. Bailey's medical practice continues. Dr. Bailey's declaration also establishes that on November 6, 2015, Petitioner updated the NPPES database to show Richmond Avenue as its practice location. P. Ex. 13, at 2 ("[i]n or around November 2014, I moved my practice from the Timmons Lane location to . . . Richmond Avenue") and 3 ("[o]n November 6, 2015, my office staff accessed the NPPES database . . . to update my practice location and correspondence address" and "I continued to practice medicine and see patients at [Richmond Avenue]"). As we have already concluded, Petitioner's updating its practice location information in the NPPES database was not a substitute for the regulatory requirement that it notify the Medicare Part B contractor of that change in location.

But even assuming notification to the NPPES contractor was legally sufficient, nowhere in the record is there any indication that Petitioner or anyone acting for Dr. Bailey or Petitioner reported the relocation to Richmond Avenue *before* November 6, 2015. Therefore, as the ALJ correctly found, based on the record, November 6, 2015 is the earliest date of notice of relocation from Timmons Lane to Richmond Avenue. Accordingly, the notice of the change in practice location was unquestionably noncompliant with subsection 424.516(d)(1)(iii), which requires that such notice "must" be given "within 30 days." Even if we had concluded, which we did not, that Petitioner had actually notified its Medicare contractor of the relocation, it is undisputed that the report was made well beyond the 30-day period. Therefore, CMS had a basis to find a violation of subsection 424.516(d)(1)(iii) on which it could also find, and did find, a basis for revocation under subsection 424.535(a)(9).

2. Petitioner's new arguments about revocation under subsection 424.535(a)(9) raise no material factual dispute that could defeat summary judgment for CMS.

Petitioner raises two new arguments concerning revocation under subsection 424.535(a)(9) that it could have raised, but failed to raise, before the ALJ and thus are not properly before us. As we explain below, even were to we consider them despite the unexplained failure to raise them earlier, they do not raise a material factual dispute.

First, Petitioner asserts that CMS did not have a legal basis to revoke under subsection 424.535(a)(9) because Petitioner was denied an opportunity to correct the reporting deficiency to which it was entitled. P. Br. to the Board at 6. Under section 424.535 as revised effective February 3, 2015 (79 Fed. Reg. 72,500, 72,532 (Dec. 5, 2014)) and in effect in April 2016, when Novitas issued its initial determination to revoke Petitioner's enrollment and billing privileges, the sole basis among the bases for revocation enumerated in section 424.535 for which an opportunity to correct is available is that in subsection (a)(1), which states:

> *Noncompliance.* The provider or supplier is determined to not be in compliance with the enrollment requirements described in this subpart P or in the enrollment application applicable for its provider or supplier type, and has not submitted a plan of corrective action as outlined in part 488 of this chapter. The provider or supplier may also be determined not to be in compliance if it has failed to pay any user fees as assessed under part 488 of this chapter.

42 C.F.R. § 424.535(a)(1).[13] Because Petitioner's billing privileges were not revoked under subsection 424.535(a)(1), Petitioner was not wrongfully denied the opportunity to correct that is afforded under that regulation. More to the point, CMS has established two lawful bases for revocation – 42 C.F.R. § 424.535(a)(5) and (a)(9) – either of which supports revocation, and neither of which contemplates an opportunity to correct.

Second, Petitioner complains that "CMS deliberately chose to go to the *wrong* address *after* confirming to the Petitioner that his address was updated" and "ignored its *actual* knowledge of Petitioner's updated address." P. Reply at 9 (Petitioner's emphasis). In Petitioner's view, CMS's determination to revoke under subsection 424.535(a)(9) despite such actual notice "rises to the level of 'affirmative misconduct,' which forecloses any basis CMS may have in revoking the Petitioner's billing privileges" and is an "abuse of power." *Id.* at 9-10. According to Petitioner, CMS's action here would discourage suppliers from addressing even "innocent oversights" out of fear of reprisal. *Id.* at 10. Petitioner also states that subsection 424.535(a)'s use of the word "may" indicates that CMS has an "option to revoke or not" for noncompliance with subsection 424.535(a)'s bases for revocation, suggesting that CMS somehow overstepped its authority or overreached in proceeding with revocation here. *Id.* at 8.

[13] Consistent with the regulation, Novitas stated in its reconsidered determination that a "corrective action plan (CAP) can only be submitted for revocation reason 42 CFR §424.535(a)(1)" and that the initial determination "only offered [Petitioner] reconsideration appeal rights" and not also an opportunity to correct since it revoked Petitioner's billing privileges under subsections 424.535(a)(5) and (a)(9). CMS Ex. 5, at 2.

CMS's determination to revoke in this case was a lawful exercise of authority conferred to CMS by regulation. As a supplier participating in the Medicare program, Petitioner is bound to follow all applicable requirements for enrolling in, and maintaining enrollment in, the program, which include the regulatory mandate to timely report a change in practice location to its Medicare contractor. Petitioner has not complied with that mandate. Accordingly, CMS had a legal basis to revoke under subsection 424.535(a)(9) in addition to subsection 424.535(a)(5). The Board has held that the determination whether to revoke is a discretionary determination for CMS, and, if (as here) CMS chooses to proceed with revocation, on appeal, the inquiry for the ALJ and the Board is whether CMS had a lawful basis to revoke. *See Kimberly Shipper, P.A.*, DAB No. 2804, at 9 (2017), citing *Beekman* at 10 and *Bussell* at 13. Two bases for revocation are established here.

C. *The effective date of revocation is January 11, 2016.*

In its brief to the Board, under a subsection headed "Effective Date of the Revocation," Petitioner asserts that, since Novitas failed to issue its initial determination to revoke within seven days after the inspection date (January 11, 2016), CMS "should be estopped from seeking recoupment for any payments made to Petitioner for dates of service after January 18, 2016." P. Br. to the Board at 7-8; CMS Ex. 3 (initial determination dated April 19, 2016). As support, Petitioner relies on the following MPIM language:

> If a provider or supplier is determined not to be operational or not to be in compliance with the regulatory requirements for its provider/supplier type, the contractor shall revoke the Medicare billing privileges of the provider or supplier – unless the provider or supplier has submitted a change that notified the contractor of a change in practice location. *Within 7 calendar days of CMS or the Medicare contractor determining that the provider or supplier is not operational, the Medicare contractor shall update PECOS or the applicable claims processing system (if the provider does not have an enrollment record in PECOS) to revoke billing [sic] Medicare billing privileges and issue a revocation notice to the provider or supplier.* The Medicare contractor shall afford the provider or supplier applicable appeal rights in the revocation notification letter.

P. Br. to the Board at 7, quoting MPIM, Ch. 15, § 15.20.1.E (emphasis added).[14]

[14] Chapter 15 of the MPIM from which Petitioner quotes sets out CMS's instructions and guidance for its Medicare fee-for-service contractors to follow for establishing and maintaining provider and supplier enrollment in Medicare. *See* MPIM, Ch. 15, § 15.1.

The effective date of revocation is determined by regulation. "Revocation becomes effective 30 days after CMS or the CMS contractor mails notice of its determination to the . . . supplier, except" under certain circumstances, one of them being where "the practice location is determined by CMS or its contractor not to be operational," in which case revocation takes effect "the date that CMS or its contractor determined that the . . . supplier was no longer operational." 42 C.F.R. § 424.535(g). The initial determination here correctly assigned an effective date of revocation of January 11, 2016 based on the date of the failed inspection that determined that Petitioner was not operational at its practice location on file. CMS Ex. 3, at 1.

Despite Petitioner's attempt to frame its argument as one about the effective date of revocation, Petitioner does not now raise (and has not previously raised) any specific argument about the effective date of revocation, which is determined by operation of subsection 424.535(g).[15] Petitioner instead makes a different argument, seeking to minimize the financial consequences of revocation, based on a misreading of sub-regulatory guidance in the MPIM that could not supplant the regulation governing the determination of the effective date of revocation even if the MPIM actually stated what Petitioner asserts it does. The quoted MPIM language does not address recovery of an overpayment from a supplier whose billing privileges have been revoked, let alone the effective date of revocation that is and must be determined by regulation.

We also observe that the italicized sentence in the MPIM language Petitioner quotes can be read as meaning only (contrary to Petitioner's reading) that, within seven days of determining that a provider or supplier is not operational, CMS or the contractor is to update PECOS or the applicable claims processing system to revoke the billing privileges, not that within seven days of determining the provider or supplier is not operational, CMS or the contractor must <u>also</u> issue a revocation letter to the revoked provider or supplier. In any case, the MPIM does not have the authority of regulations[16] and, therefore, does not limit the revocation authority accorded CMS by the regulations, which contain no limitation as to the timing of a revocation pursuant to subsections 424.535(a)(5) or 424.535(a)(9). Nor does the language of the MPIM itself state that if

[15] The ALJ Decision did not discuss the effective date of revocation, presumably because Petitioner did not raise this issue before the ALJ. In any case, in appeals of revocation actions, the Board may consider the question of effective date to determine whether CMS has correctly assigned the effective date in accordance with the regulations based on the cited basis for revocation. *See, e.g., Vijendra Dave, M.D.*, DAB No. 2672, at 6-8 (2016); *Keller Orthotics, Inc.*, DAB No. 2588, at 8-9 (2014); *Norpro Orthotics & Prosthetics, Inc.*, DAB No. 2577, at 7-8 (2014).

[16] The Board has stated that, unlike the Medicare statute and regulations, CMS's manual instructions to contractors do not have the force and effect of law and are not binding on the Board. *See, e.g., Tri-Valley Family Medicine, Inc.*, DAB No. 2358, at 9 (2010) and *Fayad*, DAB No. 2266, at 10 n.6.

CMS or the contractor does not issue a revocation notice within seven days after the date of the inspection that resulted in a determination that the supplier was not operational, CMS cannot or may not recoup any overpayment for paid claims for dates of service beyond day seven from the inspection date.

Finally, to the extent Petitioner's request that CMS's recovery of any overpayment be prohibited for dates of service after January 18, 2016 may be viewed as a request for equitable relief, the Board does not have authority to sit in equity. *See Patrick Brueggeman, D.P.M.*, DAB No. 2725, at 15 (2016) (and cases cited therein). And, in any case, the relief Petitioner seeks concerns matters over which the Board does not have jurisdiction. *See Horace Bledsoe, M.D. and Bledsoe Family Medicine*, DAB No. 2753, at 11 n.13, 14 (2016) (Medicare coverage, payment, and recovery of overpayments are not matters properly before the Board; to the extent a supplier may be subject to recovery of overpayment as a result of revocation, overpayment determinations may be appealed to the administrative law judges of the Office of Medicare Hearings and Appeals and then to the Departmental Appeals Board's Medicare Appeals Council, pursuant to the regulations in 42 C.F.R. Part 405, subpart I). As we stated elsewhere, our task here is to determine whether or not CMS has established a legal basis to revoke. We have concluded CMS had two bases to revoke. We therefore must uphold the revocation.

Conclusion

The Board affirms the ALJ Decision.

/s/
Sheila Ann Hegy

/s/
Constance B. Tobias

/s/
Susan S. Yim
Presiding Board Member