Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Donald W. Hayes, D.P.M.
Docket No. A-17-68
Decision No. 2862
March 30, 2018

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Petitioner Donald W. Hayes, D.P.M. (Dr. Hayes) appeals the January 31, 2017 decision of an Administrative Law Judge (ALJ) sustaining on summary judgment the revocation of Petitioner's Medicare enrollment and billing privileges. *Donald W. Hayes, D.P.M.*, DAB CR4782 (2017) (ALJ Decision). The Centers for Medicare & Medicaid Services (CMS) revoked Petitioner's Medicare billing privileges, pursuant to Title 42 of the Code of Federal Regulations (C.F.R.), section 424.535(a)(8), because Petitioner submitted "claims for payment of services that could not have been rendered to specific individuals on the dates of service because those individuals were deceased at the time of service." ALJ Decision at 1. Petitioner did not dispute that he submitted at least 16 claims for Medicare payment for services that Petitioner could not have delivered to the named beneficiaries. For the reasons explained below, we uphold the ALJ Decision.

Applicable legal authorities

The Social Security Act provides for CMS to regulate the enrollment of providers and suppliers in the Medicare program. Social Security Act § 1866(j)(1)(A); 42 U.S.C. § 1395cc(j)(1)(A). The regulations in 42 C.F.R. Part 424, subpart P set out the requirements for establishing and maintaining Medicare billing privileges. In order to receive payment for services furnished to Medicare beneficiaries, a provider or supplier . . . must be "enrolled" in Medicare and maintain active enrollment status.[1] 42 C.F.R. §§ 424.500, 424.505, 424.510, 424.516.

The regulation at 42 C.F.R. § 424.535(a)(8) authorizes CMS to revoke a provider's or supplier's Medicare billing privileges and any corresponding provider or supplier agreement if the provider or supplier abuses its billing privileges by "submit[ting] a claim or claims for services that could not have been furnished to a specific individual on the date of service" because "the beneficiary is deceased."

[1] The term "suppliers" also includes physicians and other non-physician health care practitioners. 42 C.F.R. § 400.202 (stating that, unless the context indicates otherwise, "[s]upplier means a physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare").

The preamble to the final rule publishing this section states, in pertinent part:

> [W]e will not revoke billing privileges under § 424.535(a)(8) unless there are multiple instances, at least three, where abusive billing practices have taken place …. [W]e believe that providers and suppliers are responsible for the claims they submit or the claims submitted on their behalf. We believe that it is essential that providers and suppliers take the necessary steps to ensure they are billing appropriately for services furnished to Medicare beneficiaries.

73 Fed. Reg. 36,448, 36,455 (June 27, 2008).

If CMS revokes a supplier's billing privileges, the supplier is "barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar." 42 C.F.R. § 424.535(c). The re-enrollment bar must last for a minimum of one year but may not exceed three years, "depending upon the severity of the basis for revocation." *Id.* Revocation also results in the termination of the provider's or supplier's agreement with Medicare. *Id*. § 424.535(b).

A supplier whose Medicare enrollment has been revoked may request reconsideration by CMS or its contractor, and then appeal the reconsidered determination in accordance with the procedures at 42 C.F.R. Part 498. 42 C.F.R. §§ 424.545(a), 498.3(b)(17), 498.5(l)(1)-(3), 498.22(a).

Case Background[2]

1. *Notice of Revocation and Petitioner's Response*

Dr. Hayes is a podiatrist in Alabama. ALJ Decision at 2. In a letter dated January 22, 2015, Cahaba GBA, LLC (Cahaba) notified Dr. Hayes that it was revoking his Medicare enrollment and billing privileges and imposing a three-year re-enrollment bar, effective February 22, 2015, pursuant to 42 C.F.R. § 424.535(a)(8), because an audit of his billing practices revealed that he had billed Medicare for services provided to beneficiaries who were deceased on the purported dates of service. ALJ Decision at 2, citing CMS Ex. 1. In its notice letter, Cahaba described Petitioner's abuse of billing privileges, stating in pertinent part:

[2] The background information is drawn, unless otherwise indicated, from the ALJ Decision and the record before the ALJ and is not intended to substitute for her findings.

> Your Medicare privileges are being revoked effective February 22, 2015, for the following reasons:
>
> **42 CFR § 424.535(a)(8) Abuse of Billing Privileges**
>
> Data analysis conducted on claims billed by Dr. Donald Hayes, for dates of service between January 04, 2010 and November 08, 2011, revealed claims for services rendered to beneficiaries who were deceased on the purported date of service. Please see attached claims data.

CMS Ex. 1, at 1 (bold type in the original).

On January 26, 2015, Dr. Hayes timely filed a reconsideration request with Cahaba. CMS Ex. 7, at 3-7. Regarding the allegation of abuse of billing privileges, Dr. Hayes attributed the errant billing of claims cited in the revocation notice to "typographical errors, mishandling, and adverse activity by billing personnel under [his] employ." *Id*. at 3. He proffered payroll documents showing that he had terminated three employees and asked that, in light of this corrective action, "the revocation be reversed immediately." *Id*. In addition, Dr. Hayes contended that the contractor's findings were erroneous, that he was given insufficient notice of revocation because the notice was not served by certified mail, that he had taken other corrective actions, such as replacing his billing software and sending an "amended claim and attached correspondence" to the contractor. *Id*. at 4. Petitioner also raised a due process argument, contending that "it would be contrary to the principles of equality and justice[] to revoke the billing privileges of a physician due to typographical errors[] labeled as 'abuse'" and that errors in Cahaba's "'data analysis' are comparable to the typographical errors" his practice made, "which have all but been eradicated in the past two years." *Id*. at 5. Further, Petitioner argued that revocation of Medicare billing privileges would result in the closing of his practice and financial hardship for "nearly 10 employees and doctors," as well as depriving patients of "necessary continuity of care." *Id*. Petitioner requested a hearing and that revocation be stayed pending exhaustion of his appeal rights. *Id*.

2. *CMS's Reconsidered Determination*

In its May 26, 2015 reconsidered determination, CMS's Center for Program Integrity, Provider Enrollment Oversight Group upheld the contractor's initial determination, and concluded that "the abundance of the errors in billing from January 2010 through November 2011" reflected in the documentation it reviewed was evidence of "abuse of billing, and not a clerical error." CMS Ex. 2, at 2.[3] Petitioner sought ALJ review.

3. *Petitioner's Request for ALJ Hearing*

Petitioner made the following contentions in the memorandum brief (Pet. ALJ Brief)[4] in support of his request for an ALJ hearing: 1) billing errors were clerical mistakes which did not harm the Medicare Trust Fund; 2) his subsequent software policy and procedure changes protect the Medicate Trust Fund from future harm; 3) errors and omissions made by Cahaba and the Medicare Zone Program Integrity Contractor (ZPIC), NCI AdvanceMed, violated statutory requirements; 4) CMS's ruling contravened the "true purpose" of the revocation rule; and 5) CMS's revocation determination deprived Petitioner of due process. Specifically, Petitioner argued that the notice of revocation of his billing privileges was defective because Cahaba sent the notice by regular mail instead of certified mail, as required by the regulation at 42 C.F.R. § 405.874(b)(l),[5] and that his efforts to reach Cahaba to ask about a stay of the revocation and to submit a corrective action plan (CAP) were frustrated because Cahaba's notice did not include a correct telephone number for Cahaba. Pet. ALJ Brief at 7-8. In addition, Petitioner argued that Cahaba erred by attributing to him claims that he did not submit, and which pertained to patients not associated with his practice. *Id*. at 9. Further, Petitioner alleged that NCI AdvanceMed originally misidentified the period of time ("January 4, 2010 to August 28, 2013") for which it performed data analysis of Petitioner's Medicare billing, only to revise the stated period subject to analysis to "January 4, 2010 to November 8, 2011." *Id*. This, Petitioner contended, reflects failure by CMS contractors to use standardized review methodology and to "review the specific details associated with each claim before taking

[3] The reconsidered determination stated that Petitioner's billing indicated a "pattern of fraud." The ALJ rejected this reference to fraud as error, stating that she found no evidence of fraud. However, the ALJ also noted, and we agree, that the number of instances in which Petitioner billed for services allegedly provided to deceased beneficiaries far exceeds the minimum number of claims that the drafters of the regulations explained would support a finding that a "pattern of improper billing" had occurred. ALJ Decision at 9 n.9, citing 73 Fed. Reg. at 36,455.

[4] Petitioner submitted to the ALJ a 19-page memorandum and 53 pages of attachments. The memorandum is not paginated, and we identify the pages of the memorandum by sequential order from one to 19.

[5] The regulation, redesignated by Federal Register notice published at 77 Fed. Reg. 29,016, 29,029 (May 16, 2012) as 42 C.F.R. § 405.800(b)(1), states: (b) *Revocation of Medicare billing privileges*—(1) *Notice of revocation.* If CMS or a CMS contractor revokes a provider's or supplier's Medicare billing privileges, CMS or a CMS contractor notifies the supplier by certified mail. The notice must include the following: (i) The reason for the revocation in sufficient detail for the provider or supplier to understand the nature of its deficiencies. (ii) The right to appeal in accordance with part 498 of this chapter. (iii) The address to which the written appeal must be mailed.

any revocation action." *Id*. at 10 (quoting the preamble to the final rule promulgating the regulation at 42 C.F.R. § 424.535(a)(8), published at 73 Fed. Reg. 36,448, 36,455 (June 27, 2008)). Petitioner also alleged that the reconsidered determination was not conducted by an independent reviewer, and that section 424.535(a)(8) is not intended to be used for "isolated occurrences or accidental billing errors." *Id*. at 10-12. Petitioner asked to cross-examine CMS's witnesses.

CMS moved for summary judgment, arguing that the material facts in this case – that 13 beneficiaries were deceased on the dates of service for which Petitioner had billed Medicare during the period the ZPIC analyzed – were not in dispute. CMS Motion for Summary Judgment at 5. Therefore, CMS argued, CMS properly revoked Petitioner's Medicare enrollment and billing privileges. *Id.* CMS argued that Petitioner's "accidental billing" defense already had been rejected by the Board in *Howard B. Reife,* DAB No. 2527 (2013), and that CMS need not prove that Petitioner intended to defraud Medicare, citing *Louis J. Gaefke, D.P.M.*, DAB No. CR2785 at 3-8 (2013).[6] *Id*. at 6. CMS also argued that the evidence in the administrative record shows that CMS provided an independent review at the reconsideration level in accordance with 42 C.F.R. § 405.803(b) (providing in relevant part that reconsideration of a determination to revoke a supplier's billing privileges is handled by a CMS Regional Office or a contractor hearing officer not involved in the initial determination). *Id.* at 8. CMS further asserted that the question of whether a reconsideration review was conducted in accordance with section 405.803(b) was not an appealable issue properly before the ALJ. *Id.*, citing 42 C.F.R. § 498.3(b) (setting out initial determinations that are subject to appeal under Part 498 regulations). Moreover, CMS argued that since the ALJ conducts review *de novo*, whether CMS complied with section 405.803(b) was irrelevant. *Id*. CMS also argued that Petitioner received "adequate notice" of CMS's revocation action and a reasonable opportunity to respond at the ALJ hearing level, which ensured that Petitioner was afforded due process. *Id.* citing *Green Hills Enterprises, LLC,* No. 2199, at 9 (2008).

Petitioner also filed a Cross Motion for Summary Judgment and Memorandum in Opposition to CMS's Summary Judgment Motion (Pet. Cr. Mot.). Petitioner argued that, without CMS Exhibits 4, 8 and 9[7] (which Petitioner had moved to exclude from the record), CMS did not have an evidentiary basis to support summary judgment. Pet. Cr.

[6] In its summary judgment motion, CMS cites the ALJ decision in *Gaefke*, rather than the Board's decision, DAB No. 2554 (2013). However, the Board affirmed that ALJ decision on the same grounds, and, in this instance, the distinction makes no difference in our analysis.

[7] CMS Exhibit 4 is identified as a set of screen shots from the Medicare Part B Multi-Carrier System pertaining to the claims at issue. CMS Exhibit 8 is the declaration of a Cahaba "Provider Enrollment Operations Manager" authenticating CMS Exhibit 3 (identified on CMS's exhibit list as "Screen Shots from the Health Insurance Master Record for each of deceased beneficiaries"). CMS Exhibit 9 is the declaration of a Cahaba "Support Services Unit Manager" authenticating CMS Exhibit 4. *See* ALJ Decision at 3.

Mot. at 1. Petitioner contended that the regulation at 42 C.F.R. § 424.535(a)(8) permits "only CMS, and not a Medicare contractor" to make the revocation determination. *Id*. at 2, citing *D&G Holdings, LLC d/b/a Doctors Lab*, DAB CR3120, at 18 (2014).[8] Petitioner also challenged the methodology and conclusions reached by the ZPIC, NCI AdvanceMed, arguing that due to "the multiple and persistent instances of inconsistencies in proffered 'evidence' in this matter, it is more than likely that the technology or procedures used to determine the alleged group of infractions is faulty on its face." *Id*. at 4. Petitioner also argued that CMS failed to meet its burden of proof because its notice to Petitioner was inadequate, and that CMS failed to make a prima facie showing of wrongdoing, and failed to demonstrate a "pattern of abusive billing." *Id*. at 4-6. Petitioner contended that the initial determination issued by a contractor was "improper" and inadequate in that it did not "cite to specific beneficiaries, specific claims, or specific dates that support a conclusion that Petitioner abused its billing privileges." *Id.* at 7. Petitioner also said that the reconsidered determination "d[id] nothing to clarify which claims are at issue or what evidence supports the alleged abuse of billing privileges by Petitioner." *Id*.

ALJ Decision

The ALJ granted CMS's motion for summary judgment after admitting Petitioner's Exhibits 1-25, as well as CMS's Exhibits 1-10 into the administrative record (over Petitioner's objection to the admission of CMS Exhibits 4, 8 and 9). ALJ Decision at 2-3. The ALJ found that summary judgment was appropriate because "[t]here [wa]s no genuine dispute as to any material fact in this case." *Id*. at 5. The ALJ reasoned that Petitioner had admitted that he, through his employees, had submitted Medicare claims for services purportedly rendered to beneficiaries who were deceased, and found immaterial Petitioner's explanations of human error and faulty billing technology for the claims at issue. *Id*. Thus, the ALJ found, it was undisputed that Petitioner had submitted claims for services he could not have furnished, satisfying the regulatory criteria for revocation of his Medicare billing privileges. *Id*. at 5-6. The ALJ accepted as true (although immaterial to the outcome) that Petitioner did not intend to defraud the Medicare program and did not consider evidence CMS submitted relating to beneficiaries P.T. and C.C. *Id*. at 6.

[8] ALJ decisions have no precedential weight and so are relevant only to the extent their reasoning is on point and persuasive. Here, Petitioner relies on dicta in which the ALJ noted that CMS's "action" (meaning the revocation) was "inconsistent with its clearly articulated policy" when the contractor (rather than CMS) issued "the initial and reconsideration determinations in this case." *D&G Holdings* at 18 n.12. This was not a legal conclusion on which the ALJ Decision turned. Moreover, we do not find it on point or persuasive here because CMS issued the reconsidered determination in this appeal.

The ALJ concluded that CMS was authorized to revoke Petitioner's Medicare billing privileges under 42 C.F.R. § 424.535(a)(8) for abuse of billing privileges. ALJ Decision at 8. In addition, the ALJ concluded that revocation here was valid notwithstanding that a contractor, rather than CMS, issued the *initial* determination and, in any case, here, CMS issued the reconsidered determination. *Id.* at 12, citing *John M. Shimko, D.P.M.*, DAB No. 2698, at 11 (2016) and *John P. McDonough, III, Ph.D., et al.*, DAB No. 2728, at 7 (2016) (italics added). The ALJ further found that Petitioner had not been deprived of due process because he was given notice of all of the claims at issue, was afforded the opportunity to present evidence and to respond to CMS's allegations, and was not prejudiced by the allegedly defective notice. *Id*. at 12-13. The ALJ overruled Petitioner's objection to the admission of CMS Exhibits 4, 8 and 9, citing the "broad discretion with regard to receiving evidence" afforded her by 42 C.F.R. § 498.61.[9] *Id*. at 3. She reasoned that Petitioner's only stated basis for objecting to the exhibits was that they were not timely submitted according to the Pre-Hearing Order then in effect, and Petitioner had more than a month to review and object to the evidence in his own pre-hearing submission. *Id*. Further, she reasoned, Petitioner did not request additional time to respond or seek leave to submit additional evidence. *Id*. She rejected Petitioner's argument based on the rationale of the *D&G Holdings* decision, "principally because here Petitioner has admitted that he submitted claims for beneficiaries who were deceased on the claimed dates of service." *Id*. at 7, citing CMS Exs. 6, 7; P. Exs. 3, 6.

Petitioner's timely Request for Review (RR) followed. Petitioner's arguments may be summarized this way: The ALJ erred in deciding this case on summary judgment because there is indeed a dispute on what Petitioner says is *the* material factual question: the "true purpose" of and "true motive" behind revocation. Petitioner appears to believe that he was specifically targeted for revocation. RR (unpaginated) at 3 (stating that other providers were "discovered to have billed inappropriately, with no adverse results" and that he was "singled out" for revocation). The ALJ erred, Petitioner also argued, when she concluded that Petitioner had not been denied due process. *Id*. We find no merit in these arguments and we affirm the ALJ Decision upholding the revocation determination. Below we discuss our reasoning.

Standard of Review

Whether summary judgment is appropriate is a legal issue that we address de novo. *Mission Hosp. Reg'l Med. Ctr.*, DAB No. 2459, at 5 (2012), *aff'd, Mission Hosp. Reg'l Med. Ctr. v. Sebelius,* No. SACV 12-01171 AG (MLGx), 2013 WL 7219511 (C.D. Cal. 2013), *aff'd sub nom. Mission Hosp. Reg'l Med. Ctr. v. Burwell*, 819 F.3d 1112 (9th Cir. 2016); *1866ICPayday.com, L.L.C.*, DAB No. 2289, at 2 (2009), citing *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986).

[9] Section 498.61, captioned "Evidence," states: **"**Evidence may be received at the hearing even though inadmissible under the rules of evidence applicable to court procedure. The ALJ rules on the admissibility of evidence."

Summary judgment is appropriate if there is no genuine dispute of fact material to the result and the moving party is entitled to judgment as a matter of law. *Everett Rehab. & Med. Ctr.*, DAB No. 1628, at 3 (1997), citing *Travers v. Shalala*, 20 F.3d 993, 998 (9th Cir. 1994). The Board construes the facts in the light most favorable to the appellant and gives it the benefit of all reasonable inferences. *See Livingston Care Ctr.*, DAB No. 1871, at 5 (2003), *aff'd, Livingston Care Ctr. v. U.S. Dep't of Health & Human Servs.*, 388 F.3d 168, 172-73 (6th Cir. 2004).

Our standard of review on a disputed issue of law is whether the ALJ decision is erroneous. *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare and Medicaid Programs*, http://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/enrollment/index.html.

Analysis

The administrative record supports the ALJ's entry of summary judgment for CMS because it is undisputed that Petitioner submitted 16 claims for podiatric services which could not have been delivered because the 11 named beneficiaries were deceased on the dates of service. In affirming the ALJ we first address the ALJ's Decision granting summary judgment in favor of CMS. Next we address Petitioner's contention that he was denied due process.

1. *Summary judgment was appropriate in this case.*

The evidence in the administrative record supports summary judgment because there is no genuine dispute of material fact. *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 3 (2010), *aff'd, Senior Rehab. & Skilled Nursing Ctr. v. Health & Human Servs.*, 405 F. App'x 820 (5th Cir. 2010). The regulation at 42 C.F.R. § 424.535(a)(8) authorizes revocation for submitting "a claim or claims" that could not have been furnished on the dates of service. CMS policy is not "to revoke billing privileges under § 424.535(a)(8) unless there are multiple instances, at least three, where abusive billing practices have taken place." *See* 73 Fed. Reg. 36,448, 36,455. Here, uncontroverted evidence in the administrative record shows that Petitioner submitted 16 such claims. *See* CMS Exs. 3, 6 and 7. The ALJ found that Petitioner conceded the fact that he billed or caused his employees to bill for podiatric services which could not have been furnished on the purported dates because the named Medicare beneficiaries were deceased. ALJ Decision at 5.

CMS's prima facie showing of abusive billing is no less compelling in the face of Petitioner's claim that his billing errors lacked fraudulent or dishonest intent, and that they were in fact accidentally made. Even if true (which, like the ALJ, we accept), the lack of dishonest intent is irrelevant. In several recent cases, the Board has rejected the notion that CMS must show fraudulent or dishonest intent or that a pattern of billing errors was not accidental. *See Shimko* at 5-6; *McDonough* at 7 citing *Gaefke* at 7; *Access Foot Care, Inc. & Robert Metnick, D.P.M.*, DAB No. 2752, at 10 (2016); *Patrick Brueggeman, D.P.M.*, DAB No. 2725, at 8 (2016) (quoting *Gaefke* at 9-10 and *Reife* at 6). Further, Petitioner has submitted nothing evincing a genuine dispute of material fact over whether Petitioner submitted claims to Medicare for services which could not have been furnished.[10]

Moreover, we find immaterial Petitioner's claim that something other than the 16 errant claims was "the true purpose of revocation." RR at 2. Petitioner contends that NCI AdvanceMed's audit of his Medicare billing practices was unwarranted and produced erroneous results. *Id*. However, Congress, through the Social Security Act, established the Medicare Integrity Program to authorize just the kind of audit to which Petitioner was subjected. Section 1893 of the Act, 42 U.S.C. § 1395ddd, provides, in pertinent part:

> **Medicare Integrity Program**
>
> **(a) Establishment of Program**
> There is hereby established the Medicare Integrity Program (in this section referred to as the ''Program'') under which the Secretary shall promote the integrity of the Medicare program by entering into contracts in accordance with this section with eligible entities, or otherwise, to carry out the activities described in subsection (b) of this section.
>
> **(b) Activities described**
> The activities described in this subsection are as follows:
> (1) Review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under this subchapter (including skilled nursing facilities and home health agencies), including medical and utilization review and fraud review (employing similar standards, processes, and technologies used by private health plans, including equipment and software technologies which surpass the capability of the equipment and technologies used in the review of claims under this subchapter as of August 21, 1996).
> (2) Audit of cost reports.

[10] We note that during earlier stages of review Petitioner offered evidence in an effort to refute some of NCI AdvanceMed's and CMS's allegations of abusive billing. ALJ Decision at 6 n.6. NCI AdvanceMed's initial notice to Petitioner, dated June 12, 2014, alleged Petitioner had submitted 29 claims for services on 21 dates to 19 beneficiaries who were deceased. *See* CMS Exs. 5, 6.

> (3) Determinations as to whether payment should not be, or should not have been, made under this subchapter by reason of section 1395y(b) of this title, and recovery of payments that should not have been made.

To the extent that NCI AdvanceMed's audit might have been inaccurate in some respects, Petitioner nevertheless had an opportunity to dispute the audit. He also availed himself of the opportunity to challenge the initial and reconsidered determinations.[11] Petitioner has not shown that CMS arrived at an erroneous conclusion that he engaged in abusive billing practices. In any event, any inaccurate conclusions NCI AdvanceMed might have reached about some of the claims attributed to Petitioner do not constitute a basis to disregard the 16 claims Petitioner does not dispute he submitted and which CMS determined were indicative of a pattern of abusive billing. The only issue before the ALJ and the Board is whether CMS had established a "legal basis for its actions." *Letantia Bussell, M.D.*, DAB No. 2196, at 13 (2008). Thus, even assuming that CMS's stated basis was not the only basis for revocation, Petitioner has not, through evidence supporting this particular argument, articulated a genuine dispute of *material* fact over whether CMS had a legal basis for revocation.

Further, Petitioner contends that CMS failed to timely respond to his Freedom of Information Act (FOIA) request for documents and, consequently, the ALJ did not have the benefit of review of the evidence he would have offered to the ALJ had he obtained it prior to issuance of the ALJ Decision. Petitioner argues that proceeding with decision on summary judgment was inappropriate where the ALJ had not considered such documents, which Petitioner says prove CMS's actual reason for terminating his Medicare billing privileges. RR at 2. In his Request for Review, Petitioner states:

> []CMS held these documents and did not release them until a month after the ALJ rendered a decision in this matter. (See, Exhibit B: CMS FOIA Release Letter.) Unfortunately, no records were included with the release letter, and therefore, after several phone calls to CMS, the documents relating to his revocation were not actually received by Petitioner until March 24, 2017, not coincidentally, approaching the deadline for this very review request. It is Petitioner's belief that Summary Judgment was not appropriate in this matter, as the ALJ knew of the pending FOIA request, and nevertheless, ruled that there were no "genuine issues of material fact" that would warrant a hearing on the matter.

[11] In his Request for Review, Petitioner states: "After Petitioner pointed out the multitude of errors in this audit, [T.F.] launched an ersatz investigation into his practice and history and submitted unsubstantiated and damning evidence to CMS in an unwarranted and inappropriate manner, in order to gain retribution for Petitioner's rightful, if disrespectful, response to the contractor's errors." RR at 2-3.

Id. These arguments are meritless. First, the FOIA documents were not made part of the administrative record before the ALJ (because, as stated above, Petitioner did not receive them in time to proffer them to the ALJ for consideration). Petitioner errs to the extent he suggests that the ALJ erred in proceeding to decision on summary judgment based on the evidentiary record that was before her, thereby depriving him of a full opportunity to present his case on appeal to the ALJ. "The appeals process under [42 C.F.R.] Part 498 is unrelated to the FOIA process which neither the ALJ nor the Board have authority to enforce." *Ridgeview Hospital*, Ruling 2015-1 (Jan. 12, 2015) on Motion for Reconsideration of DAB No. 2593, at 5; *see also Experts Are Us, Inc.*, DAB No. 2322, at 5, 11 (2010) (on Experts' complaint that CMS failed to respond to its FOIA requests, stating that the ALJ had no authority to enforce FOIA) (remanded on other grounds). Nonetheless, Petitioner made no request to reopen the ALJ decision so he could ask the ALJ to admit the lately acquired records and argue their meaning.[12] On appeal to the Board, Petitioner could have but did not request the Board remand the matter to the ALJ for consideration of new evidence. *See* 42 C.F.R. § 498.88(a). Rather, Petitioner simply appended to his Request for Review three documents apparently related to records he obtained via FOIA request (Petitioner's Exhibits A, B and C). However, in provider/supplier enrollment appeals, such as this, the Board may not admit evidence into the record in addition to the evidence introduced at the ALJ hearing or in addition to the documents considered by the ALJ if the hearing was waived. *See Guidelines;* 42 C.F.R. § 498.86(a). Therefore, we cannot admit into the administrative record Petitioner's Exhibits A, B and C.[13] Moreover, even if we had the authority to admit Petitioner's new evidence, he has failed to show how or why this new evidence creates a dispute of fact over whether Petitioner submitted for payment the 16 errant claims CMS cited as the basis for revocation.

Petitioner also contends that CMS has not revoked the billing privileges of other providers and suppliers who were also found to have "billed inappropriately," and, he argues, "[t]herefore, there must have been another reason that Petitioner was the only provider of this group to lose his privileges." RR at 3.

Petitioner focuses on what CMS or its contractor purportedly did or did not do about *other* providers or suppliers who Petitioner says billed inappropriately. The central factual issue that was before the ALJ in this case is whether there is evidence of *Petitioner's* errant billing – submittal of claims for Medicare payment for services that could not have been provided as claimed because the beneficiaries to whom those

[12] The process for reopening and revision of an ALJ decision is governed by, in pertinent part, sections 498.100 through 498.103 of the Subpart F regulations. We offer no opinion about whether an ALJ would or should have granted a request to reopen or, if so, revised the ALJ Decision now under review.

[13] However, this does not necessarily preclude the possibility that the Board could remand a future appeal to an ALJ where the appellant has shown that previously unavailable evidence affects the undisputed facts of a case. The appellant in this case has made no such showing.

services purportedly were provided were deceased on the dates of service. Petitioner did not and does not dispute this central fact. It is this central fact that establishes a basis for revoking Petitioner's billing privileges. Once CMS has determined that a supplier's claim submissions satisfy the criteria for abusive billing, as it has determined here, the decision to proceed with revocation is solely CMS's to make. On appeal, ALJs and the Board may review whether CMS had a legal basis to revoke a supplier's Medicare billing privileges, but may not look behind CMS's discretion to proceed with revocation. *See Bussell* at 13, quoting *Michael J. Rosen, M.D.*, DAB No. 2096, at 14 (2007). Accordingly, we find that summary judgment was appropriate in this case.

2. *Petitioner has not shown that he was denied due process.*

As noted above, the ALJ concluded that Petitioner was afforded due process because he was given notice of all of the claims at issue and an opportunity to present evidence and to respond to CMS's allegations. ALJ Decision at 12, 13. The ALJ noted that Petitioner has not shown "any actual prejudice in his ability to defend his case before [her]." *Id.* at 13.

Petitioner complains that CMS failed to notify him of revocation by certified mail. Petitioner also contends that NCI AdvanceMed performed a flawed audit and sent Petitioner the error-filled results. RR at 1-2. Petitioner pointed out errors in the audit and, consequently, Petitioner alleges, an NCI AdvanceMed employee, T.F., retaliated against him. *Id*. at 2-3. Petitioner contends that the evidence used to support revocation of his Medicare billing privileges thus consisted of unreliable data analysis, and was "unsubstantiated, unduly prejudicial, and inappropriately considered[.]" *Id.* at 3. Petitioner objects to the results of CMS's data and analysis, alleging that Cahaba ignored and omitted relevant information from its audit (the information Petitioner later obtained by FOIA request). *See id*. at 3-5.

Petitioner further contends that Cahaba furnished information, to which Petitioner had not been privy, to the CMS officer responsible for reviewing Petitioner's reconsideration request.[14] *Id*. at 5. Petitioner argues that this violated his right to due process, and that the violation was not and could not be cured by the reconsidered determination. *Id*.

However, Petitioner fails to establish that CMS relied on anything other than the information made part of the record for the initial determination when reaching its reconsidered determination. In its reconsidered determination dated May 26, 2015, CMS described the documentation submitted and what it reviewed as follows:

[14] Petitioner contends that CMS relied on his former billing agent, J.H., as a witness, and that J.H. was a party to a legal action against Petitioner and had other alleged negative information in J.H.'s background. RR at 4. Petitioner also contends he did not know that CMS had relied on J.H.'s evidence against him to reach the determination to revoke his billing privileges. *Id*. at 4-5.

> SUBMITTED DOCUMENTATION:
>
> - Donald Hayes Reconsideration dated January 26, 2015
> - Cahaba revocation letter date January 22, 2015
> - Exhibit 1: Samples of beneficiary listing
> - Exhibit 2: Copy of medical documentation
>
> CASE ANALYSIS:
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> All of the documentation in the file for Dr. Donald Hayes has been reviewed and the decision has been made in accordance with Medicare guidelines, as outlined in 42 CFR §424.535. After reviewing and taking into consideration the reconsideration submitted on behalf of Dr. Hayes, CMS maintains an unfavorable decision. [. . .] Due to the abundance of billing errors in billing from January 2010 through November 2011, CMS views this as abuse of billing not a clerical error.

CMS Ex. 2, at 1-2 (unpaginated).

Even if CMS considered extraneous information in reaching its reconsidered determination, Petitioner admitted to the facts that form the stated basis for CMS's revocation determination.[15] As discussed above, Petitioner has not shown that the information Petitioner obtained via FOIA request raises a genuine dispute of material fact here. Petitioner has not explained how consideration of those excluded records would obviate or nullify Petitioner's admission that he had submitted claims for services allegedly furnished to Medicare beneficiaries who were deceased on the dates of service. Petitioner does not argue that any evidence, whether excluded or made part of the administrative record, proves that he did not submit those claims CMS found abusive.

Nothing in the regulations authorizes the ALJ to reverse a revocation to sanction CMS for alleged due process violations where CMS had a basis for the revocation under section 424.535(a). *See Gaefke* at 11 n.10. CMS had a legitimate basis to revoke Petitioner's Medicare billing privileges based on the audit results, irrespective of whether a contractor's employee acted vindictively or Petitioner's former billing employee attempted to retaliate against him as part of an unrelated dispute. Each, even if true, is irrelevant in view of the evidence of abusive billing upon which CMS based its revocation determination.

[15] As the ALJ noted, "all of the claims and beneficiaries that are at issue in the present proceedings were identified in the June 12, 2014 letter." ALJ Decision at 13. Therefore, Petitioner was fully informed about the specific claims underlying CMS's revocation determination and the evidence CMS had considered to reach its determination.

The Board has also held that no violation of due process occurs where deficient notice results in no prejudice. *Dinesh Patel, M.D.*, DAB No. 2551, at 8 (2013) (finding that there was no prejudice resulting from alleged inadequate notice where Petitioner did not "claim that the alleged notice deficiency impaired his ability to defend himself before either the ALJ or the Board"). Here, Petitioner received notice sufficient for him to respond to CMS's revocation notice. As the ALJ reasoned, Petitioner was able to persuade CMS to revise its findings, correct its own errors, and reduce the overall number of billing claims by Petitioner that CMS found abusive. *See* ALJ Decision at 13. We agree with the ALJ that Petitioner has not shown any prejudice as a result of allegedly deficient notice.

Lastly, as noted earlier, before the Board, Petitioner alleges that the ALJ denied him due process by reaching a decision upholding CMS's revocation determination before CMS complied with Petitioner's FOIA request. This, Petitioner contends, denied him the opportunity to submit records to the ALJ showing bias or prejudice against him by CMS personnel and others. We have already addressed this contention to some extent, above. Although Petitioner attempts to frame his argument as one about the denial of due process, the argument is, in essence, a request for equitable relief. In his Request for Review, Petitioner states:

> Petitioner never really had the chance to address the allegations against him in their entirety, as he never had any knowledge of the other information upon which CMS relied, both in the initial revocation, and in Reconsideration. Indeed, Petitioner had no knowledge and no opportunity to address the allegations against him until a few days ago.
>
> CMS, in knowingly withholding this information from both Petitioner and the ALJ, denied Petitioner due process protections under the law **throughout every stage of this matter.** In the interest of time and out of respect for this Board, Petitioner will not reiterate legal arguments made below with regard to Due Process. However, Petitioner would like this honorable Board to know that to date, Dr. Hayes has had to sell his house, his car, and his business, and has also suffered a major heart attack, followed by two surgeries as a result of these actions. It is unimaginable, that a man who has dedicated his life to helping other would lose his business, his home and his health at the hand or a personal vendetta.

RR at 5-6 (bold type in the original). He concluded his argument with a request for relief as follows:

> Petitioner asks that in the interest of the newly discovered prejudicial and unethical actions of CMS and its contractors, and the resultant and repeated denial of due process protections, this Board reverse the decision of the ALJ below and reinstate the billing privileges of Dr. Donald Hayes. It is the belief of Petitioner that the loss or his livelihood and nearly his life is payment enough for any billing infraction that may have occurred.

Id. at 6. Having thus described a process as unfair because he was unable to furnish the trier of fact with all of the information he wished to present, and, because of the effects on his medical practice and personal life resulting from CMS's revocation determination and the ALJ decision sustaining it, Petitioner now asks the Board to balance the equities involved in his favor.

The Board has consistently held that neither it nor an ALJ has the authority to restore a supplier's billing privileges on equitable grounds. *Brueggeman* 15-16 (and cases cited therein). In *Brueggeman*, where a podiatrist billed CMS for services purportedly furnished to beneficiaries who were deceased on the dates of service, we concluded that, under section 424.535 of the provider and supplier enrollment regulations (42 C.F.R. Part 424, subpart P), once CMS has shown that one of the regulatory bases for revocation exists, the ALJ and the Board may not refuse to apply the regulation and must uphold the revocation. *Id.* at 15. Therefore, this argument is unavailing.

Conclusion

For the reasons set out above, the Board affirms the ALJ Decision upholding the revocation of Petitioner's Medicare enrollment and billing privileges for a period of three years.

/s/
Constance B. Tobias

/s/
Susan S. Yim

/s/
Christopher S. Randolph
Presiding Board Member