**Department of Health and Human Services**

**DEPARTMENTAL APPEALS BOARD**

**Civil Remedies Division**

Luis E. Zepeda, M.D.,
(NPI: 1215032602),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-17

Decision No. CR2895

Date: August 19, 2013

## DECISION

Petitioner, Luis E. Zepeda, M.D., requested a hearing to challenge the revocation of his Medicare billing privileges by Trailblazer Health Enterprises, LLC (Trailblazer), an administrative contractor for the Centers for Medicare & Medicaid Services (CMS). In its initial and reconsidered determinations, Trailblazer asserted that Petitioner referred patients to Thomas M. Heric, M.D., a physician who remains excluded from participating in Medicare, Medicaid, and all other federal health care programs under section 1128 of the Social Security Act (Act). Trailblazer alleged that Petitioner submitted claims to Medicare seeking payment for services by Dr. Heric and, in response to pre-payment review inquiries, submitted nerve conduction studies by Dr. Heric as support for the submitted claims. According to Trailblazer, and now CMS on appeal, the referral of Medicare beneficiaries to Dr. Heric and subsequent billing for those services authorized CMS to revoke Petitioner's Medicare billing privileges. Petitioner has maintained at all levels of appeal that he has no knowledge of Dr. Heric, that he referred no patients to him, and that he did not submit any claims based on the services he performed. Petitioner also claims that he left the medical practice where the referrals to Dr. Heric originated before those referrals were actually made. Petitioner alleges that an unknown individual or individuals used his billing privileges without his knowledge or authority.

For the reasons explained below, I find and conclude that CMS was ultimately authorized to revoke Petitioner's Medicare billing privileges. CMS, however, did not have authority to revoke Petitioner's billing privileges based on his alleged referral of patients to Dr. Heric and subsequent submission of related claims. Rather, the authority for CMS to revoke Petitioner's billing privileges comes from Petitioner's own defense to the original allegations against him, specifically, his assertion that he left his practice before the referrals to Dr. Heric had been made. Petitioner, however, never notified CMS of this change in his practice location. Accordingly, the regulations authorize CMS to revoke Petitioner's billing privileges.[1]

## I. Case Background and Procedural History

By letter dated June 20, 2012, Trailblazer notified Petitioner that it had revoked his billing privileges effective June 15, 2012.[2] CMS Exhibit (Ex.) 26, at 1. Trailblazer stated:

> The Medicare provider[[3]] Luis E. Zepeda submitted claims that contained billed services performed by a physician on the Office of Inspector General (OIG) exclusion list. Additionally, Thomas M. Heric, M.D., did not have

[1] CMS revoked Petitioner's billing privileges effective June 15, 2012, and imposed a one-year re-enrollment bar. The effective date here must be modified to July 20, 2012, based on the modified basis for revocation. Nevertheless, as of the date of this decision, the re-enrollment bar against Petitioner has expired, and, once he has exhausted the appeal process, he may submit a new enrollment application to attempt to re-enroll in the Medicare program. 42 C.F.R. § 424.535(d).

[2] It is unclear how Trailblazer determined the effective date of Petitioner's revocation. Retroactive revocation is only applicable in certain circumstances, one of which includes the proffered basis for revocation here, a provider's or supplier's exclusion from federal health care programs. *See* 42 C.F.R. § 424.535(a)(2), (g). However, the regulation states that a revocation based on the exclusion of a provider or supplier is retroactive to the date of that exclusion, which in this case was October 19, 2006, not June 15, 2012. *Id.* § 424.535(g). Perhaps the discrepancy in establishing an effective date for this case should have signaled to Trailblazer that something was amiss in its overall analysis. In any event, as discussed later in this decision, the effective date for revoking Petitioner's billing privileges must be modified to reflect the modified basis for revocation.

[3] Dr. Zepeda was actually a "supplier" in the Medicare program. A "supplier" is "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.

> (or ever possess) a license to practice medicine in the State of Texas. According to the medical records, the billed services, diagnostic tests by Thomas M. Heric, M.D., were performed in Texas.

CMS Ex. 26, at 1. The notice then quoted the language of 42 C.F.R. § 424.535(a)(2), which authorizes CMS to revoke a provider's or supplier's billing privileges if the provider or supplier, "or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier" is excluded from Medicare, Medicaid, and all other federal health care programs. Trailblazer also established a one year bar on Petitioner's re-enrollment in the Medicare program. CMS Ex. 26, at 1.

Petitioner requested reconsideration. CMS Ex. 27. Petitioner stated that he "has never employed, contracted with, or delegated any authority to [Dr. Heric]. Dr. Zepeda does not know this person and has never had any contact with him whatsoever . . . . Dr. Zepeda appears to be a victim in this matter, along with the Medicare system." CMS Ex. 27, at 1. Petitioner submitted an affidavit that also asserted his lack of knowledge or association with Dr. Heric. CMS Ex. 27, at 3. The affidavit stated that if any claims for services performed by Dr. Heric were submitted to Medicare under Petitioner's Provider Transaction Access Number (PTAN) or National Provider Identifier (NPI), "it was without [his] knowledge or authority." CMS Ex. 27, at 3. On September 20, 2012, Trailblazer issued a reconsidered determination that upheld the revocation of Petitioner's billing privileges. CMS Ex. 28. The reconsidered determination echoed the basis for revocation stated in the initial determination notice:

> As a part of the pre-payment medical review program, Dr. Zepeda submitted medical records that corresponded with Medicare claims filed. Multiple of the submitted medical records contained diagnostic tests signed by Thomas M. Heric, M.D., Ph.D. Per the Department of Health and Human Services Office of Inspector General (OIG), Dr. Heric is on the List of Excluded Individuals. As such, Trailblazer . . . revoked Dr. Zepeda's Medicare [PTANs] in accordance with 42 [C.F.R.] § 424.535(a)(5) . . . .[4]

CMS Ex. 28, at 1. The Trailblazer hearing officer dismissed Petitioner's affidavit, saying that "the medical records [Dr. Zepeda] submitted in conjunction with the pre-payment medical review program were signed by Dr. Heric and indicate that the two did indeed have some type of working relationship." CMS Ex. 28, at 1.

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[4] The reconsidered determination subsequently quoted the language in 42 C.F.R. § 424.535(a)(*2*), not subsection (a)(*5*). The cite to 42 C.F.R. § 424.535(a)(5) appears to be a typographical error. Aside from this apparently erroneous cite, CMS has not relied on subsection (a)(5) as a basis for revoking Petitioner's billing privileges. Subsection (a)(5) addresses an on-site review, which is not applicable in this case.

On October 2, 2012, Petitioner timely submitted a request for hearing (RFH) to challenge the revocation of his billing privileges. Petitioner reasserted that he had no knowledge of Dr. Heric and did not refer patients to him, and also that he had "not had the opportunity to review the information that was allegedly submitted by Dr. Zepeda and on which the revocation is based." RFH at 1. CMS subsequently moved for summary judgment (CMS Mot. for Summ. J.) and submitted 30 proposed exhibits (CMS Exs. 1-30). Petitioner opposed CMS's motion (P. Opp. to Mot. for Summ. J.) and cross-moved for summary judgment. In his opposition Petitioner stated, among other things, that he "resigned from the Westpark [C]linic on December 22, 2010 and . . . saw no patients and rendered no services at the Westpark [C]linic after his resignation." P. Opp. to Mot. for Summ. J. at 2. Petitioner also submitted three proposed exhibits (P. Exs. 1-3). CMS opposed summary judgment in favor of Petitioner, and submitted three additional exhibits (CMS Exs. 31-33) in support of its opposition. On January 11, 2013, I denied both motions for summary judgment and ordered that the parties develop the record for a hearing. The parties each submitted pre-hearing briefs (CMS Pre-Hrg. Br. and P. Pre-Hrg. Br.).

On Monday, May 6, 2013, I convened a hearing by video teleconference, with the parties and witnesses located in Dallas, Texas. In addition to the 33 exhibits originally submitted with its motion for summary judgment and opposition to Petitioner's motion for summary judgment, CMS sought to add three more exhibits (CMS Exs. 34-36). Petitioner objected to the admission of CMS Exs. 34-36 because CMS had only disclosed the proposed exhibits on Friday, May 3, 2013, well after the time for exchanging final exhibit lists had passed. CMS responded that the three exhibits were in response to arguments Petitioner raised in his prehearing brief. I overruled Petitioner's objection, and admitted CMS Exs. 1-36 into the record. Petitioner withdrew the exhibits submitted with his motion for summary judgment, instead offering two additional exhibits (P. Exs. 4 and 5) that he submitted as part of his prehearing exchange. CMS had no objection, so I admitted P. Exs. 4 and 5into the record. Each party called one witness at the hearing: CMS offered the testimony of Ms. Leslie O'Neal, a medical review manager at Health Integrity, a zone program integrity contractor for CMS; Petitioner offered his own testimony. A copy of the transcript of the hearing (Tr.) has been admitted into the record without substantive change. Each party has submitted post-hearing briefs (CMS Post Br. and P. Post Br.).

Petitioner renewed his objection to CMS Exs. 34-36 in his post-hearing brief and established that CMS had ample time to submit these exhibits before the business day prior to the hearing. *See* P. Post Br. at 6-10. While Petitioner's arguments raise significant concerns about CMS's delay in proffering these exhibits, I decline Petitioner's invitation to reverse my earlier ruling. The delay in providing these exhibits ultimately does not prejudice Petitioner because he has had an opportunity to address them in post-hearing briefing and, as explained below, CMS Exs. 34-36 ultimately do not support the revocation of Petitioner's billing privileges.

## II. Issues

This case presents the following issues:

1. Whether 42 C.F.R. § 424.535(a)(2) authorizes CMS to revoke Petitioner's billing privileges based on the referral of patients to Thomas M. Heric, M.D., and subsequent billing for those services; and

2. Whether 42 C.F.R. § 424.535(a)(9) authorizes CMS to revoke Petitioner's billing privileges based on Petitioner's failure to notify CMS of a change in his practice location within 30 days of the change occurring.

## III. Analysis

### A. Applicable Law

The Act authorizes the Secretary of Health and Human Services (Secretary) to establish by regulation procedures for enrolling providers and suppliers in the Medicare program. Act § 1866(j)(1)(A), 42 U.S.C. § 1395cc(j)(1)(A). The Secretary has promulgated enrollment regulations at 42 C.F.R. §§ 424.500 – 424.570. The regulations authorize CMS to revoke the Medicare billing privileges of an enrolled provider or supplier if CMS determines that certain circumstances exist. *See generally* 42 C.F.R. § 424.535(a). Relevant here, CMS may revoke a provider's or supplier's Medicare billing privileges if:

> The provider or supplier, or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the provider or supplier is —
>
> (i) Excluded from the Medicare, Medicaid, and any other Federal health care program, as defined in § 1001.2 of this chapter, in accordance with section 1128, 1128A, 1156, 1842, 1862, 1867 or 1892 of the Act.
>
> (ii) . . . .

*Id.* § 424.535(a)(2).

The regulations also authorize CMS to revoke a provider's or supplier's Medicare billing privileges if the provider or supplier "did not comply with the reporting requirements specified in § 424.516(d)(1)(ii) and (iii) of this subpart." *Id.* § 424.535(a)(9). The reporting requirements referenced in this section state:

> Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations must report the following reportable events to their Medicare contractor within the specified timeframes:
>
> (1) Within 30 days—
>
> (i) . . .
>
> (ii) Any adverse legal action; or
>
> (iii) A change in practice location.

42 C.F.R. § 424.516(d)(1).

When CMS revokes a provider's or supplier's billing privileges, the regulations require that any provider agreement in effect at the time of revocation be terminated. 42 C.F.R. § 424.535(b). In addition, after revocation, CMS must impose a bar on re-enrollment for a minimum of one year, but no more than three years. *Id.* § 424.535(c). Revocation is effective "30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier . . . ." *Id.* § 424.535(g). Certain exceptions permit retroactive revocation if it is, among other things, "based on Federal exclusion or debarment . . . ." *Id.* In such a case, the revocation is "effective with the date of exclusion or debarment . . . ." *Id.*

### B. Findings of Fact and Conclusions of Law

I make seven findings of fact and conclusions of law (FFCL) to support my decision. Each FFCL is set out below in bold and italics, followed by an analysis for each.

1. ***CMS does not have the authority to revoke Petitioner's billing privileges pursuant to 42 C.F.R. § 424.535(a)(2) based on his referral of Medicare beneficiaries to a physician excluded from participating in all federal health care programs pursuant to section 1128 of the Act.***

The parties do not dispute that beginning October 19, 2006, the Inspector General for the Department of Health and Human Services excluded Dr. Heric from participating in Medicare, Medicaid, and all other federal health care programs pursuant to section 1128 of the Act. *See generally* CMS Exs. 25-27. As stated, the regulations authorize CMS to revoke a supplier's Medicare billing privileges if one of the supplier's managerial staff members, *i.e.*, its "owner, managing employee, authorized or delegated official, medical director, [or] supervising physician," has been excluded from participating in federal health care programs pursuant to section 1128 of the Act. 42 C.F.R. § 424.535(a)(2)(i). The parties agree that this provision is not directly applicable here because Dr. Heric

never had a managerial role in Petitioner's practice. *See* CMS Post Br. at 4-5; P. Post Br. at 4. But the regulations also authorize revocation if "other health care personnel of the provider or supplier" have been excluded. 42 C.F.R. § 424.535(a)(2)(i). Accordingly, whether CMS has the authority to revoke Petitioner's Medicare billing privileges under section 424.535(a)(2) depends upon whether Dr. Heric, an excluded practitioner, is "other health care personnel" of Petitioner's practice.

Trailblazer implied in its initial and reconsidered determinations, and now CMS expressly argues on appeal, that Dr. Heric is "other health care personnel" of Petitioner because nerve conduction study reports signed by Dr. Heric contain Petitioner's name in the letterhead and state that Dr. Zepeda referred the Medicare beneficiary to Dr. Heric. CMS Post Br. at 4-5; *see, e.g.*, CMS Ex. 1, at 61. CMS relies on language in a similarly worded regulation — the regulation authorizing CMS to deny enrollment applications — and argues that "other health care personnel" does not require that the excluded individual be in a supervisory role. CMS Post Br. at 5. CMS posits that section 424.535(a)(2), like section 424.530(a)(2), applies to "nurses and dialysis technicians, as well as any personnel furnishing reimbursable services." CMS Post Br. at 5 (citing 42 C.F.R. §§ 414.310, 424.530). CMS also argues that allowing referrals to excluded physicians is tantamount to employing them in non-managerial roles and could result in an "end-run around the prohibition of payments to excluded individuals." CMS Post Br. at 5.

Not surprisingly, Petitioner disagrees. He relies on the principle of *ejusdem generis*,[5] arguing that the broad phrase "other health care personnel" must be read to mean something similar to the specific list of managerial positions that precede it. P. Post Br. at 3-5. According to Petitioner, Dr. Heric was not in a managerial role in Petitioner's practice and is therefore not an excluded individual contemplated in section 424.535(a)(2) with reference to Petitioner. P. Post Br. at 4

The preamble to the final rule establishing section 424.535(a)(2) shows the phrase "other health care personnel" in section 424.535(a)(2) does not apply only to individuals in a managerial role of a supplier's practice. However, the phrase was not intended to reach the referral-based relationship between practitioners such as Petitioner and Dr. Heric. The preamble to section 424.535(a)(2) states that CMS will have the authority to revoke a provider's or supplier's billing privileges if:

> The provider or supplier, any owner, managing employee, authorized or delegated official, supervising physician or other health care personnel *who must be reported on the CMS 855 (for example, ambulance crew member)*

[5] *Ejusdem generis* refers to a "canon of construction that when a general word or phrase follows a list of specifics, the general word or phrase will be interpreted to include only items of the same type as those listed." Black's Law Dictionary 556 (8th ed. 2004).

> *of the provider or supplier*, in accordance with section 1862(e)(1) and (2) of the Act, becomes excluded from the Medicare, Medicaid or other Federal health care programs . . . .

71 Fed. Reg. 20,754, at 20,761 (Apr. 21, 2006) (emphasis added). Thus, while not stated in the final regulatory language, the preamble establishes that the regulatory drafters intended to limit the phrase "other health care personnel" to individuals "who must be reported on the CMS 855 . . . of the provider or supplier." *Id.* The "CMS 855" is the Medicare enrollment application that providers and suppliers must submit in order to receive and maintain billing privileges. 42 C.F.R. § 424.510; 71 Fed. Reg. at 20,767. Accordingly, whether an excluded practitioner is "other health care personnel" of a provider or supplier for purposes of section 424.535(a)(2) depends upon whether the excluded practitioner was required to be reported on the enrollment application of the provider or supplier subject to revocation.

As a sole practitioner, Petitioner had to submit a CMS-855I to enroll in the Medicare program as a supplier. *See* CMS Ex. 31. Section 3 of that application form requires the enrolling supplier to list any "final adverse action" against the enrollee "under any current or former name or business identity." CMS Ex. 31, at 5. In the preamble that proposed the CMS 855I, the drafters stated that Section 3 applies to "any adverse legal actions that have been imposed or levied against *this supplier*, identified in Section 2B." 68 Fed. Reg. 22,064, at 22,150 (Apr. 25, 2003) (emphasis added). Sections 5 and 6 of the enrollment application require the reporting of persons or entities with an ownership interest or managerial control over the supplier, as well as any adverse actions against those individuals or entities. *Id.* at 22,164. Other non-managerial employees that must be reported include physician's assistants and, in the case of an ambulance service supplier, its ambulance crew members. *See, e.g.*, *id.* at 22,182 (requiring the identity of ambulance crew members to establish the "qualification of crew"). However, nothing in the preamble, the regulations, or in the CMS 855I that Petitioner submitted required that physicians or other practitioners to whom a supplier may eventually refer patients, or from whom a supplier may request medical services, be reported on the enrollment application.

Based on the record here, it is apparent that Dr. Heric was not required to be reported on Petitioner's enrollment application. CMS has not shown that Dr. Heric worked for Petitioner directly, or that there was a partnership or other relationship between the physicians that needed to be reported on Petitioner's enrollment application. The record shows that Petitioner, or someone in his office, ordered nerve conduction studies from Dr. Heric. *See generally* CMS Exs. 1-24. That evidence, however, does not support a finding that Petitioner employed or contracted with Dr. Heric, that Dr. Heric was a manager of Petitioner's practice, or that Petitioner in any way oversaw the care that

Dr. Heric provided.[6] The mere presence of "some type of working relationship," as Trailblazer found in its reconsidered determination, *see* CMS Ex. 26, is not enough to establish that Petitioner was obliged to report Dr. Heric on his enrollment application. Moreover, while CMS touched on the correct analysis in its brief, it never explained where Petitioner needed to report Dr. Heric on his enrollment application, and thus did not satisfy the critical element for identifying "other health care personnel." *See* CMS Post Br. at 5.

The record before me demonstrates that any relationship between Petitioner and Dr. Heric was not subject to reporting on Petitioner's Medicare enrollment application. Accordingly, Dr. Heric was not "other health care personnel" of Petitioner, and the regulations do not authorize CMS to revoke Petitioner's Medicare billing privileges based solely upon Petitioner referring patients to Dr. Heric for nerve conduction studies. Without Dr. Heric occupying one of the positions specified in 42 C.F.R. § 424.535(a)(2), CMS cannot revoke Petitioner's billing privileges pursuant to that provision.

### *2. CMS has not established that it had the authority to revoke Petitioner's billing privileges pursuant to 42 C.F.R. § 424.535(a)(2) based on his submission of claims for payment for services provided by an excluded physician.*

CMS argues here that Petitioner submitted claims for payment for the nerve conduction studies that Dr. Heric performed.[7] *See* CMS Exs. 34-35. Section 1862(e)(1) of the Act prohibits payments for services provided by individuals excluded from participating in Medicare, Medicaid, and all other federal health care programs. Act § 1862(e)(1). There

[6] Referring patients to another physician may be some evidence of an agreement between physicians (which may implicate section 1128B(b)(1) of the Act), but the mere presence of referrals, when taken alone, is not enough to establish with any degree of certainty that any contractual relationship exists. Moreover, even if CMS had shown a contractual relationship existed here, it is questionable whether under those circumstances it would have the authority to revoke Petitioner's billing privileges pursuant to 42 C.F.R. § 424.535(a)(2), or whether the appropriate enforcement authority lies with the Inspector General to impose a civil money penalty or take other action pursuant to section 1128A of the Act.

[7] I do not find that CMS Exs. 1-24 show that Petitioner billed for any services performed by Dr. Heric. The documents bearing Dr. Heric's signature were submitted to CMS in response to Trailblazer's pre-payment review inquiry, and could have reasonably been used as supporting documentation for other claims.

can be little doubt that regardless of who actually submitted the claims in CMS Exs. 34 and 35 — whether Petitioner or some unknown fraudster — the Act strictly prohibits payment of those claims. *Id.*

However, neither the Act nor the implementing regulations authorize CMS to revoke billing privileges based on the submission of claims for services performed by an excluded practitioner. In the preamble to the final rule, the drafters stated that, based on its "general authorities" and the restriction of payments to excluded individuals in section 1862(e) of the Act, CMS may deny or revoke enrollment of a provider or supplier that "arranges or contracts with (by employment or otherwise), any individual or entity that the provider or supplier knows or should know is excluded . . . ." 71 Fed. Reg. at 20,760. But the statutory and regulatory language control, and are not as broad as the preamble. The applicable language limits the scope of what it means to "arrange or contract with" an excluded individual (as that phrase is used in the preamble) to either employment in a capacity that requires an excluded individual be reported on an enrollment application (42 C.F.R. § 424.535(a)(2)(i); 71 Fed. Reg. at 20761), or to provide care "at the medical direction or on the prescription of a physician" that has been excluded (Act § 1862(e)(1)(B)). Neither situation applies here. Petitioner did not need to report Dr. Heric on his enrollment application, and Dr. Heric performed nerve conduction studies, as distinct from ordering them. *See, e.g.*, CMS Ex. 1, at 61. Additionally, despite the preamble's assertion to the contrary, there is no "general authority" for CMS to revoke billing privileges for reasons other than those stated in 42 C.F.R. § 424.535. The submission of a claim for services provided by an excluded physician is not a stated basis for revocation in section 424.535(a)(2) or any other subsection. Therefore, even if Petitioner submitted the claims in CMS Exs. 34 and 35, CMS was not authorized to revoke Petitioner's Medicare billing privileges pursuant to 42 C.F.R. § 424.535(a)(2).

The appropriate remedy appears to be the denial of payment for the submitted claims and, if more egregious billing issues are found, possible exclusion from Medicare, Medicaid, and all other federal health care programs. *See* Act § 1128(b)(7); 42 C.F.R. § 1001.901(a). But the exclusion authority under section 1128 is delegated to the Inspector General, not CMS. *See* 42 C.F.R. § 1001.1(a). CMS cannot arrogate the Inspector General's enforcement authority and revoke billing privileges for the submission of claims for services by an excluded practitioner when the only authorized remedy for such conduct is, under appropriate circumstances, exclusion.

### *3. Petitioner moved practice locations sometime between December 2010 and November 2011.*

Petitioner testified at hearing that he moved practice locations on December 22, 2010. Tr. 66. He testified that on that date he faxed the office manager at Westpark Clinic a letter "saying that our relationship is terminated . . . ." Tr. 66; P. Ex. 4. According to Petitioner, he intended to close the clinic he was operating, Westpark Clinic, effective the

day he faxed the letter terminating his participation with the clinic. Tr. 67. In September 2011, he intended to reopen a medical practice at the same location as Westpark Clinic, but, in November 2011, he accepted an offer with another Houston-based family practice group. Tr. 70.

During cross-examination, counsel for CMS elicited testimony from Petitioner that called into question the veracity of his claim that he moved practice locations on December 22, 2010. Ultimately, however, whether Petitioner left on precisely December 22, 2010, before most of the claims utilizing the services of Dr. Heric were submitted to Medicare, is not consequential to the outcome here. Certainly, whether he left on that date could factor into whether someone perpetrated fraud, or whether Petitioner knowingly submitted claims for payment using the services of an excluded practitioner. But the evidence before me is not sufficient to make a finding as to the exact date Petitioner changed practice locations, and, because of the serious ramifications such a finding could have on possible future action against Petitioner, including potential exclusion pursuant to section 1128(b)(7) of the Act, I decline to make such a finding where it is not necessary and the evidence is in equipoise. There is uncontroverted testimony from Petitioner that he began practicing at Houston Family Physicians Group in November 2011, which I accept as being the latest possible time he moved practice locations from the Westpark Clinic. Tr. 70. Therefore, finding that Petitioner left Westpark Clinic within a range of time between December 20, 2010 and November 30, 2011, is sufficient for purposes of my decision based on the circumstances of the case and applicable regulations.

#### *4. Petitioner did not notify CMS of his change in practice location within 30 days of the change occurring.*

On cross-examination, Petitioner acknowledged that he did not notify CMS of the change in his practice location in or around December 2010.[8] Tr. 98; *see also* P. Br. at 13 (acknowledging that Petitioner "failed to notify CMS of the change of his practice at the Westpark Clinic"). By regulation, Petitioner had to notify CMS or one of its contractors within 30 days of changing practice locations. 42 C.F.R. § 424.516(d)(1)(iii). Based

[8] CMS counsel also elicited testimony from Petitioner that shows he allowed other practitioners to bill for services under his billing number, even though he was only enrolled in Medicare as a sole practitioner. Tr. 103. However, CMS has not alleged that Petitioner was subject to revocation under 42 C.F.R. § 424.535(a)(7) (which authorizes revocation where a provider or supplier knowingly sells or allows another individual or entity to use its billing number, unless as part of a valid reassignment of benefits or a change of ownership), likely because there would not have been enough time for adequate notice and an opportunity to defend that basis for revocation. Even so, the testimony highlights that Petitioner was careless in his enrollment as a supplier in the Medicare program and cavalier towards the access he held to the Medicare Trust Fund.

upon Petitioner's timeline for leaving the Westpark Clinic, he had to notify CMS or one of its contractors of the change in practice location no later than January 21, 2011 (30 days from December 22, 2010). Accepting the notion that Petitioner left the Westpark Clinic much later, in November 2011, when he joined Houston Family Physicians Group, he had to notify CMS of the change in practice location no later than December 30, 2011 (30 days from November 30, 2011). Petitioner never did so. Moreover, the record before me contains no evidence whatsoever that Petitioner *ever* attempted to notify CMS once he had changed practice locations.

### *5. CMS is authorized to revoke Petitioner's billing privileges pursuant to 42 C.F.R. § 424.535(a)(9).*

The regulations authorize CMS to revoke a supplier's billing privileges if the supplier "did not comply with the reporting requirements specified in § 424.516(d)(1)(ii) and (iii) of this subpart." 42 C.F.R. § 424.535(a)(9). Relevant here, section 424.516(d)(1)(iii) requires that physicians such as Petitioner report a "change in practice location" within 30 days of the change occurring. 42 C.F.R. § 424.516(d)(1)(iii). As established above, Petitioner never reported the change in his practice location, and certainly did not do so within the regulatory deadline for reporting such a change. Accordingly, section 424.535(a)(9) authorizes CMS to revoke Petitioner's Medicare billing privileges.

Petitioner states that Trailblazer requested documentation from him for pre-payment review after he left the Westpark Clinic on December 22, 2010, but before the 30-day deadline for reporting that change. He argues that a "timely notice by January 21, 2011 would not have circumvented Trailblazer's requests for medical records [on January 3 and 11, 2011]. There is no evidence in the record showing that either Trailblazer or CMS ever tried to contact Petitioner after Trailblazer received the medical records on February 7, 2011." P. Post Br. at 14. Petitioner's argument seems to confuse several issues but overlooks the most important one: he never notified CMS of the change in his practice location as the regulations require him to do. Moreover, Trailblazer and CMS need not contact a supplier to determine its correct address when sending notices. The regulations place the burden of notifying CMS of any changes in practice location squarely on the supplier that is changing locations without regard to whether CMS actively needs the new address to send a notice or not. 42 C.F.R. § 424.516(d)(1)(iii).

Finally, Petitioner argues that "the failure to timely notify of the change at the Westpark Clinic should not constitute a violation warranting the revocation of all of Petitioner's Medicare privileges." P. Post Br. at 14. However, whether Petitioner's noncompliance with the regulatory requirements *should* or *should not* warrant such a result is not at issue here. This is not a forum for policy debate or pleas for equitable relief. Petitioner's failure to notify CMS of the change in his Westpark Clinic practice location *does* constitute a violation of the applicable Medicare enrollment regulation that warrants the revocation of his Medicare billing privileges. 42 C.F.R. § 424.535(a)(9). There is no

basis or authority to limit the revocation of billing privileges to particular practice locations merely because that is where a violation occurred. Rather, the regulations authorizing revocation speak to "billing privileges" as a whole, without limitation on its scope. 42 C.F.R. § 424.535(a) (lead-in language). Revocation also results in termination of a provider or supplier agreement with Medicare, which further supports my view that revocation is not the piecemeal remedy that Petitioner suggests. *See id.* § 424.535(b).

### *6. The effective date for revocation of Petitioner's billing privileges must be modified to July 20, 2012.*

As noted above, it is unclear whyTrailblazer revoked Petitioner's billing privileges five days retroactive from the date of the revocation notice dated June 20, 2012. *See* n.2, *supra*; CMS Ex. 26. The regulations require that, unless certain exceptions apply, a revocation becomes effective 30 days after the notice of revocation is sent to the affected provider or supplier. 42 C.F.R. § 424.535(g). The original basis for revocation here was premised on the conclusion that Dr. Heric, an excluded practitioner, was "other health care personnel" of Petitioner. Under such circumstances, the date of revocation would be effective to the date of exclusion, which in this case would have been October 19, 2006. *Id.* But, as previously explained, the regulations do not authorize CMS to revoke Petitioner's billing privileges based upon the exclusion of Dr. Heric, so the revocation of his billing privileges cannot be retroactive.

The modified basis for revocation here does not carry an exception as to when it becomes effective. *Id.* Therefore, the effective date for the revocation of Petitioner's billing privileges pursuant to 42 C.F.R. § 424.535(a)(9) must be July 20, 2012, 30 days after Trailblazer sent the notice of revocation. *Id.*; CMS Ex. 26.

### *7. Petitioner has had notice and opportunity to defend the amended basis for revocation.*

In his opposition to CMS's motion for summary judgment, Petitioner stated for the first time that he had moved practice locations on December 22, 2010. P. Opp. to Mot. for Summ. J. at 2-3. After I denied summary judgment, CMS submitted a prehearing brief that added Petitioner's change of practice location and failure to notify CMS of that change as a separate basis for revoking his billing privileges. CMS Pre-Hrg. Br. at 6. Since that time, Petitioner has had an opportunity to address this issue in his prehearing brief, at the in-person hearing, and in his post-hearing brief. Petitioner has done so on all three occasions. P. Pre-Hrg. Br. at 5-6; Tr. at 66, 98; P. Post Br. at 13-14.

In addressing due process concerns that may accompany modified or new bases for an agency determination, the Departmental Appeals Board has stated that "a federal agency may clarify its reasons for a challenged determination, or assert new reasons for that determination, during the [administrative law judge] proceeding as long as the non-

federal party has adequate notice of the reasons and a reasonable opportunity to respond during that proceeding." *Fady Fayed, M.D.*, DAB No. 2266, at 10-11 (2009) (citing *Green Hill Enterprises, LLC*, DAB No. 2199, at 8 (2008)). Here, Petitioner had notice of the modified basis for revocation during the prehearing stage and had three separate opportunities to respond to that basis during these proceedings. Additionally, Petitioner raised the issue himself, and cannot now claim that CMS is prevented from using his intended shield as a sword against him. *See* P. Opp. to Mot. for Summ. J. at 2 (and attached affidavit). Therefore, I find that there has been no due process violation in this case.

## IV. Conclusion

For all of the foregoing reasons, I find that CMS was not authorized to revoke Petitioner's billing privileges based upon his referral of patients to a physician who has been excluded from participating in Medicare, Medicaid, and all other federal health care programs. However, I find that CMS was authorized to revoke Petitioner's billing privileges because he did not notify CMS of the change in his practice location as required by regulation. In light of the modified basis for revocation, the date of revocation must be modified to July 20, 2012. Accordingly, I AFFIRM and MODIFY the determination to revoke Petitioner's billing privileges, effective July 20, 2012.

/s/
Richard J. Smith
Administrative Law Judge