Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Donald W. Hayes, D.P.M.
(NPI: 1093754566/PTAN: 051503512),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-3351

Decision No. CR4782

Date: January 31, 2017

DECISION

Donald W. Hayes, D.P.M. (Petitioner or Dr. Hayes), challenges the Centers for Medicare & Medicaid Services' (CMS's) reconsidered determination upholding the revocation by Cahaba GBA, LLC (Cahaba), a CMS administrative contractor, of Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(8).[1] CMS agreed with the contractor's determination that Petitioner, a podiatrist, 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. Both parties now move for summary judgment.

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[1] CMS substantially amended 42 C.F.R. § 424.535(a)(8), effective February 3, 2015. *See* 79 Fed. Reg. 72,500 (Dec. 5, 2014). The amendment did not change the substance of the basis for revocation at issue in the present case. Nevertheless, for purposes of this decision, I apply the version of the regulation in effect on January 22, 2015, the date Cahaba revoked Petitioner's billing privileges (i.e. the version published in the 2014 edition of the Code of Federal Regulations).

For the reasons set forth below, I find that there is no genuine dispute of any material fact and that CMS is entitled to judgment affirming the revocation of Petitioner's Medicare enrollment and billing privileges. Accordingly, I deny Petitioner's motion for summary judgment and grant summary judgment in favor of CMS.

I. Case Background and Procedural History

Petitioner is a podiatrist in Alabama. As a podiatrist, Petitioner participated in the Medicare program as a "supplier" of services.[2] By letter dated January 22, 2015, Cahaba notified Petitioner that it was revoking Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(8) because "data analysis" revealed that Petitioner billed Medicare for services provided to beneficiaries who were deceased on the purported dates of service. CMS Exhibit (Ex.) 1. Cahaba's notice letter stated that it was revoking Petitioner's billing privileges effective February 22, 2015. Cahaba also imposed a three-year bar on Petitioner's re-enrollment in the Medicare program.

On January 26, 2015, Petitioner submitted a request for reconsideration as well as a corrective action plan (CAP) to Cahaba. *See* CMS Ex. 7 at 3-5. In that document, Petitioner acknowledged that he had submitted Medicare claims for services purportedly rendered to deceased beneficiaries, but he explained that such errors were the result of human error and faulty billing software. *Id.* Petitioner additionally explained that he had taken a number of corrective actions, such as: sending written requests to Cahaba to withdraw the incorrect claims; replacing the billing software that was in use at the time; and removing certain billing personnel. *Id.* By letter dated May 26, 2015, a representative of CMS's Provider Enrollment Oversight Group issued a reconsidered determination upholding the revocation. CMS Ex. 2. The reconsidered determination stated, "Due to the abundance of the errors from January 2010 through November 2011, CMS views this as abuse of billing, and not a clerical error." CMS Ex. 2 at 2.

By letter dated July 2, 2015, Petitioner requested a hearing before an administrative law judge to challenge the reconsidered determination. In support of his hearing request, Petitioner submitted a Memorandum in Support of Request for Reversal of Medicare Billing Privileges (P. Mem.) and sixteen proposed exhibits (P. Exs. 1-16).[3] The case was originally assigned to Administrative Law Judge Carolyn Cozad Hughes. On July 21, 2015, Judge Hughes issued an Acknowledgment and Pre-Hearing Order (Pre-Hearing

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[2] 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.

[3] P. Ex. 6 was inadvertently omitted when DAB staff uploaded Petitioner's hearing request and supporting documents to the DAB E-File system. Although I note that the content of P. Ex. 6 largely duplicates CMS Ex. 7, I have directed that P. Ex. 6 be added to the E-File record of this case, so that the record is complete.

Order), which permitted the parties to move for summary judgment, if appropriate. *See* Pre-Hearing Order ¶ 4. CMS filed a motion for summary judgment with a supporting brief, but subsequently filed an amended brief. Citations in this decision are to the amended brief (CMS Br.). With its brief, CMS submitted nine proposed exhibits (CMS Exs. 1-9). Petitioner filed an opposition to CMS's motion for summary judgment as well as his own motion for summary judgment with supporting brief (P. Br.). Petitioner submitted two additional proposed exhibits with his brief (P. Exs. 17, 18). Petitioner also objected (P. Obj.) to the admission of CMS Exs. 4, 8, and 9. I discuss Petitioner's objection below. CMS filed a reply brief (CMS Reply) and opposed summary judgment in favor of Petitioner. On September 16, 2016, this case was reassigned to me. I issued an order to develop the record, dated October 13, 2016. The parties filed responses (P. Supp.; CMS Supp.). With his supplemental response, Petitioner offered seven additional proposed exhibits (P. Exs. 19-25). With its supplemental response, CMS offered one additional proposed exhibit (CMS Ex. 10).

II. Evidentiary Rulings

Petitioner objects to the admission of CMS Exs. 4, 8, and 9. P. Obj. at 1. Petitioner argues that the exhibits were not submitted timely in accordance with Judge Hughes' Pre-Hearing Order and that their admission would be "patently unfair" to Petitioner. P. Obj. at 2.

CMS Ex. 4 is identified as screen shots from the Medicare Part B Multi-Carrier System pertaining to the claims at issue. CMS Ex. 8 is the declaration of a Cahaba "Provider Enrollment Operations Manager" authenticating CMS Ex. 3 (which was submitted timely). CMS Ex. 9 is the declaration of a Cahaba "Support Services Unit Manager" authenticating CMS Ex. 4.

Petitioner's objection is overruled. The regulations grant an ALJ broad discretion with regard to receiving evidence. 42 C.F.R. § 498.61. CMS submitted the exhibits seven days after the deadline set in Judge Hughes' Pre-Hearing Order. However, even at the time the exhibits were submitted, Petitioner still had nearly a month before his pre-hearing submissions were due within which to review and respond to this evidence. Petitioner did not ask Judge Hughes to grant him additional time to respond to the exhibits or to allow him to offer additional documentary evidence in response. Therefore, I find no unfairness to Petitioner in admitting this evidence.

In the absence of any further objections, I receive CMS Exs. 1-10 and P. Exs. 1-25 into the record for consideration.

III. Statutory and Regulatory Framework

The Social Security Act authorizes the Secretary of Health and Human Services (Secretary) to establish by regulation procedures for enrolling providers and suppliers in the Medicare program. 42 U.S.C. § 1395cc(j)(1)(A). The Secretary has promulgated enrollment regulations for providers and suppliers in 42 C.F.R. Part 424, Subpart P. *See* 42 C.F.R. §§ 424.500 – 424.545 (2014). The regulations authorize CMS to revoke the billing privileges of an enrolled provider or supplier if CMS determines that certain circumstances exist. 42 C.F.R. § 424.535(a). Relevant to this case, CMS may revoke a provider's or supplier's billing privileges if—

> The provider or supplier submits a claim or claims for services that could not have been furnished to a specific individual on the date of service. These instances include but are not limited to situations where the beneficiary is deceased, the directing physician or beneficiary is not in the State or country when services were furnished, or when the equipment necessary for testing is not present where the testing is said to have occurred.

42 C.F.R. § 424.535(a)(8); *see also* 73 Fed. Reg. 36,448 at 36,455 (June 27, 2008) ("We will direct contractors to use this basis of revocation after identifying providers or suppliers that have these billing issues. We have found numerous examples of situations where a physician claims to have furnished a service to a beneficiary more than a month after their recorded death, or when the provider or supplier was out of State when the supposed services had been furnished."). The regulatory drafters explained in the preamble to section 424.535(a)(8):

> This revocation authority is not intended to be used for isolated occurrences or accidental billing errors. Rather, this basis for revocation is directed at providers and suppliers who are engaging in a pattern of improper billing . . . . Accordingly, [CMS] will not revoke billing privileges under [section] 424.535(a)(8) unless there are multiple instances, at least three, where abusive billing practices have taken place.

73 Fed. Reg. at 36,455.

When CMS revokes a provider's or supplier's billing privileges, any provider agreement in effect at the time of revocation is 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. 42 C.F.R. § 424.535(c). Once the re-enrollment bar has expired, the supplier must submit a new enrollment application to re-enroll in the Medicare program. 42 C.F.R. § 424.535(d).

A provider or supplier may request reconsideration of the initial determination to revoke his or her billing privileges. 42 C.F.R. §§ 498.5(*l*)(1), 498.22(a). If dissatisfied with the reconsidered determination, the supplier may request a hearing before an ALJ. 42 C.F.R. § 498.5(*l*)(2).

IV. Discussion

A. Issues

This case presents two issues:

1. Whether either party is entitled to summary judgment; and

2. Whether CMS was authorized to revoke Petitioner's Medicare billing privileges pursuant to 42 C.F.R. § 424.535(a)(8).

B. Conclusions of Law and Analysis

1. Summary judgment is appropriate.

Summary judgment is appropriate if "the record shows that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law." *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 at 3 (2010) (citations omitted). The moving party must show that there are no genuine issues of material fact requiring an evidentiary hearing and that it is entitled to judgment as a matter of law. *Id.* If the moving party meets its initial burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial . . . .'" *Matsushita Elec. Industrial Co. v. Zenith Radio*, 475 U.S. 574, 587 (1986). "To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact — a fact that, if proven, would affect the outcome of the case under governing law." *Senior Rehab.*, DAB No. 2300 at 3. To determine whether there are genuine issues of material fact for hearing, an ALJ must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. *Id.*

There is no genuine dispute as to any material fact in this case. CMS's evidence shows that Petitioner submitted claims for services that could not have been provided to specific individuals on the dates of service. Petitioner does not dispute that he or a member of his staff submitted these claims, but he argues that the claims at issue identified deceased beneficiaries because of "human error" and "clerical billing errors" (e.g., staff entered incorrect account numbers or patient names in Petitioner's billing software). *See* P. Mem. at 2-3. However, the nature of the billing errors—that is, whether they were accidental or not—is not material to the outcome of the case. The plain language of the

applicable regulation requires only that the supplier "submits a claim or claims" that could not have been furnished as claimed. *See* 42 C.F.R. § 424.535(a)(8). Thus, under the regulation, submitting even a single improper claim could be a basis to revoke a supplier's billing privileges.[4] Any evidence or factual inferences that may be drawn showing that the claims submitted by Petitioner or his billing staff were clerical errors or accidental do not alter the plain language of the regulation and do not impact the result here. Petitioner has not submitted any evidence that detracts from CMS's evidence. This case turns on a matter of law, and is therefore appropriate for summary judgment.

For purposes of summary judgment, I draw all inferences in favor of Petitioner. Even though not material to the outcome, I accept as true that Petitioner did not intend to defraud Medicare and that the improper claims resulted from problems with Petitioner's billing software or errors made by Petitioner's employees who prepared and submitted the claims. I further accept as true that another podiatrist, and not Petitioner, submitted the Medicare claim for services purportedly rendered to Beneficiary P.T.[5] and that Beneficiary C.C. was not treated at Petitioner's practice.[6]

2. The undisputed facts show that Petitioner submitted Medicare claims for services that could not have been furnished to specific individuals on the dates of service.

In support of its motion for summary judgment, CMS presented evidence showing that Petitioner submitted Medicare claims for services that could not have been provided to the beneficiaries identified in the claims because the beneficiaries were deceased on the dates of the claimed services. CMS Exs. 3, 4, 5. Petitioner has never disputed that he (or employees on behalf of his practice) submitted at least some of the claims in question. Instead, Petitioner argues that because some of the claims upon which CMS relied were cited in error (a fact I accept as true for purposes of summary judgment), I should disregard all evidence from the investigation. P. Br. at 3-4. Petitioner argues, therefore, that CMS failed to meet its burden to establish a prima facie case of wrongdoing by Petitioner. Petitioner additionally stresses that he never intended to defraud Medicare; that he never received payment from Medicare for the improper claims; and that, upon

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[4] CMS's policy statement that it does not intend to invoke its revocation authority where improper claims represent "isolated" or "accidental" errors, but only where such errors constitute a "pattern of improper billing," appears only in the preamble, and not in the regulation itself. *See* 73 Fed. Reg. at 36,455.

[5] I refer to patients/beneficiaries by their initials for privacy reasons.

[6] I note that at one point Petitioner agreed that his office had submitted an improper claim for Beneficiary C.C. *See* CMS Ex. 6 at 2. However, for purposes of this decision, I accept that Petitioner has withdrawn his admission regarding this beneficiary.

discovering the improper claims, he took a number of steps to ensure that his practice would not submit such improper claims in the future. None of Petitioner's arguments demonstrate that he did not submit improper claims as alleged by CMS.

CMS presented evidence that Petitioner or an employee of Petitioner's practice submitted at least sixteen claims for services that Petitioner allegedly performed after the beneficiary identified on the claim had died.[7] For example, CMS presented evidence that Beneficiary E.G. was born July 15, 1909, and died September 3, 2005. CMS Ex. 3 at 2. Petitioner submitted a Medicare claim for services allegedly rendered to E.G. on June 30, 2010, after the date of death. CMS Ex. 4 at 2. The following table summarizes the evidence CMS presented to establish that Petitioner filed improper claims.

Initials	HICN (last 4)	Date of Death	Date of Service	Claim Number
J.A.	4276A	01/05/2006	03/31/2010	2210263683870
J.A.	4276A	01/05/2006	03/31/2010	2210098343860
J.D.	5605A	04/09/2011	06/27/2011	2211188893870
J.D.	5605A	04/09/2011	06/27/2011	2811188545540
S.D.	3451D	09/19/2010	11/30/2010	2210340326140
M.D.	7210D	03/01/2005	06/24/2010	2210182326160
M.D.	7210D	03/01/2005	06/24/2010	2210182326170
S.E.	2643A	03/26/2011	03/28/2011	2211096676750
E.G.	0901A	09/03/2005	06/30/2010	2210193295280
W.G.	9562A	01/16/2011	02/21/2011	2211055162940
W.G.	9562A	01/16/2011	07/11/2011	2211228329450
N.S.	5343A	03/28/2006	04/04/2011	2211097406610
H.S.	7331A	12/29/2009	01/04/2010	2210036006550
G.U.	3395T	06/05/2009	05/03/2010	2210263649680
G.U.	3395T	06/05/2009	05/03/2010	2210133438750
C.W.	7067D	08/08/2005	06/24/2010	2210182326220

CMS's evidence is found in CMS Exs. 3 and 4. *See also* CMS Br. Att. A.

Petitioner cites an administrative law judge's decision in *D&G Holdings*, DAB CR3120 (2014) in support of his argument that CMS's evidence fails to establish a prima facie case of wrongdoing because CMS has not offered copies of actual claims or death certificates. *See* P. Br. at 2, 5. However, I do not find the rationale of the *D&G Holdings* decision persuasive in the present case, principally because here Petitioner has admitted that he submitted claims for beneficiaries who were deceased on the claimed dates of service. *See* CMS Exs. 6, 7; P. Exs. 3, 6. Moreover, although Petitioner objected to

[7] Sixteen claims for eleven beneficiaries remain after the claims for Beneficiaries P.T. and C.C. are excluded from consideration.

CMS Ex. 4 (screen shots of Petitioner's submitted claims) on the grounds of untimeliness, he did not contend that the documents were inauthentic or that the information in the documents was untrue. P. Obj. As noted above, I have overruled Petitioner's objection. Finally, it is well-settled that administrative law judge decisions are not precedential.[8] *See, e.g., Alexander C. Gatzimos, M.D.*, DAB No 2730 at 16 (2016).

Contrary to Petitioner's argument, the evidence CMS has presented is sufficient to establish a prima facie case that the beneficiaries identified in the claims at issue were, in fact, deceased at the time of the service. Petitioner has offered no evidence to dispute this, or raise any genuine dispute that the beneficiaries identified in the claims at issue were actually alive at the time of service. To the contrary, Petitioner has at various times acknowledged that the claims were submitted in error. *See* CMS Exs. 6, 7; P. Exs. 3, 6. In light of Petitioner's admissions, I find meritless Petitioner's contention that CMS's allegations are generally unreliable because CMS may have alleged that Petitioner submitted claims relating to two beneficiaries (out of thirteen) who were not his patients. The *undisputed* facts show that Petitioner (or an employee of Petitioner's practice) submitted claims to Medicare for at least sixteen claims for services rendered to eleven beneficiaries who were deceased on the alleged dates of service, which is a basis for CMS's revocation authority under section 424.535(a)(8). As noted above, a mere denial or unsupported disagreement with certain evidence, which is all Petitioner offers in response to CMS's evidence, is not sufficient to prevent summary judgment. *Senior Rehab.*, DAB No. 2300 at 3. Therefore, summary judgment is appropriate. Further, as explained more fully below, Petitioner's arguments that CMS abused its discretion or otherwise denied him due process are not a basis to defeat CMS's motion for summary judgment.

3. CMS was authorized to revoke Petitioner's Medicare billing privileges pursuant to 42 C.F.R. § 424.535(a)(8).

Once CMS determined that Petitioner submitted claims that could not have been furnished to specific individuals on the dates of service, CMS was authorized to revoke Petitioner's Medicare billing privileges. 42 C.F.R. § 424.535(a)(8). Here, I have concluded that the undisputed evidence establishes that, in sixteen instances, Petitioner submitted claims for services that could not have been furnished to eleven specific individuals on the dates of service because the specific individuals identified were deceased at that time. Petitioner argues—and I accept for purposes of this decision—

[8] Indeed, the same administrative law judge who decided *D&G Holdings* has recently granted summary judgment in favor of CMS where a supplier did not dispute that it submitted more than three Medicare claims that could not have been provided to the identified beneficiaries because the identified beneficiaries were deceased on the purported dates of service. *Kelvin D. Gipson, DPM*, DAB CR4550 (2016).

(1) that he never intended to defraud Medicare; (2) that he never received payment from Medicare for the improper claims; and (3) that, upon discovering the improper claims, he took a number of steps to ensure that his practice would not submit such improper claims in the future. These arguments fail for two reasons. First, the regulations do not require CMS to demonstrate that Petitioner intended to defraud Medicare (or even that Petitioner was overpaid) before it may revoke Petitioner's billing privileges. Second, any actions Petitioner has taken to ensure that he does not submit improper claims in the future are irrelevant to the present proceedings because they relate either to Petitioner's state of mind or to his proposed CAP.

As to the first point, the applicable regulation does not require CMS to demonstrate that Petitioner intended to defraud Medicare or that he received payments to which he was not entitled before it may revoke Petitioner's billing privileges. *See* 42 C.F.R. § 424.535(a)(8). The mere existence of improper claims is sufficient to support revocation. *Id.*; *see also Louis J. Gaefke, D.P.M.*, DAB No. 2554 at 7 (2013) ("The plain language of the regulation contains no requirement that CMS establish that the supplier acted with fraudulent or dishonest intent.").[9] Thus, accepting that Petitioner lacked intent to defraud Medicare or to receive improper payments does not remove CMS's basis for revoking his billing privileges.

Similarly, Petitioner's subsequent withdrawal of the claims at issue does not negate CMS's authority to revoke Petitioner's billing privileges. Petitioner represented that he submitted written requests to Cahaba to withdraw the improper claims. *See, e.g.,* P. Mem. at 4. I directed the parties to develop the record to provide additional evidence and argument about Petitioner's withdrawal requests, including how and when they were transmitted to Cahaba. Order to Develop the Record (Oct. 13, 2016). The parties did so. P. Supp.; CMS Supp. However, the parties' submissions fail to shed much additional light on precisely when Petitioner sent the withdrawal requests to Cahaba, whether Cahaba ever received the requests, and what, if any, action Cahaba may have taken based on the requests. This is not surprising, given the lapse of time since the claims were originally submitted (in 2010 and 2011). Significantly, however, because this case is before me on cross-motions for summary judgment, I may not draw any inferences

[9] I note that the reconsidered determination states that Petitioner's billing evidenced a "pattern of fraud." CMS Ex. 2 at 2. It appears that much of Petitioner's argument is intended to rebut this characterization. In my view, however, the reconsidered determination's reference to fraud was error. There is no evidence before me showing that Petitioner or his practice committed fraud. Nevertheless, the number of instances (sixteen in all) in which Petitioner billed for services allegedly furnished to a deceased beneficiary far exceeds the minimum number of claims (i.e., three) that the drafters of the regulation explained would support a finding that a "pattern of improper billing" had occurred. *See* 73 Fed. Reg. at 36,455. This is all that is required to sustain the revocation of Petitioner's Medicare billing privileges.

against Petitioner based on the absence of additional documentation. I therefore accept as true for purposes of this decision that Petitioner submitted the withdrawal requests to Cahaba on or about the dates noted on the requests and that Cahaba received the requests.

At the time I requested the additional briefing, it was my view that proof Petitioner had withdrawn the improper claims without prompting from CMS (or its contractor) would demonstrate that he was a supplier who could be trusted to continue to bill Medicare. Ultimately, however, I have concluded that an evaluation of Petitioner's activities after he submitted the improper claims is not relevant to my review of CMS's revocation decision under the applicable regulations.

It is important to underscore the limited nature of my review in provider and supplier enrollment cases. The regulations do not permit me to substitute my judgment about a supplier's trustworthiness for that of CMS. *See Letantia Bussell, M.D.*, DAB No. 2196 at 13 (2008) ("[T]he right to review of CMS's determination by an ALJ serves to determine whether CMS had the authority to revoke [petitioner's] Medicare billing privileges, not to substitute the ALJ's discretion about whether to revoke" (emphasis in original)). Put another way, I must sustain CMS's decision to revoke a supplier's Medicare billing privileges if I find that there is a basis for the revocation under the regulation on which CMS relies. *See, e.g., John Hartman, D.O.*, DAB No. 2564 at 6 (2014). Thus, under the regulatory scheme, an administrative law judge does not engage in an individualized assessment of a Medicare supplier's trustworthiness based on arguments that appeal to equity or allege mitigating circumstances.[10] Accordingly, in the present case, because I have concluded that Petitioner's improper billing satisfied the criteria described in 42 C.F.R. § 424.535(a)(8), I must find that CMS was authorized to revoke Petitioner's Medicare billing privileges.

In addition, I conclude that Petitioner's actions in submitting withdrawal requests to Cahaba, as well as implementing new billing software and terminating the employment of certain billing employees, represent corrective actions taken to ameliorate past errors and ensure that Petitioner's practice would not again bill for services purportedly rendered to deceased beneficiaries. Such actions do not undermine CMS's basis for revoking billing privileges. As an appellate panel of the Departmental Appeals Board (DAB) has stated, "[a] plan to reduce improper billing in the future does not preclude CMS from taking action about improper claims already submitted." *John P. McDonough, III, Ph.D., et al.*, DAB No. 2728 at 8 (2016).

[10] In the *Bussell* case, an appellate panel of the DAB specifically rejected the supplier's argument that the administrative law judge should evaluate CMS's revocation of billing privileges "subject to judicial discretion, based on the particular aspects of each case." DAB No. 2196 at 13 (internal quotation marks and citation omitted).

This result is consistent with the view that, in pursuing actions to prevent future errors, Petitioner was implementing a CAP. While laudable, such actions do not have a bearing on the issues before me. The regulations do not provide for administrative law judge review of CMS's acceptance or rejection of a CAP. *See* 42 C.F.R. § 405.874(e). The decision to accept or reject a CAP is entirely within CMS's discretion. *See, e.g., Conchita Jackson, M.D.*, DAB No. 2495 at 6 (2013) ("the refusal by CMS or one of its contractors to reinstate a supplier after a correction attempt is not . . . . an action that constitutes an initial determination subject to administrative appeal under section 498.3(b)"). Therefore, Petitioner's actions of this nature are not a basis to overturn CMS's revocation of Petitioner's billing privileges. For the same reasons, Petitioner's contention that CMS failed to afford him a meaningful opportunity to correct his noncompliance is not subject to my review.[11]

Petitioner's attempts to cast doubt on the accuracy of CMS's identification of improper claims are likewise unavailing. Petitioner argues that, at the time CMS revoked his billing privileges, the instances of improper billing were in the past and had not recurred. P. Br. at 6. On that basis, he contends that CMS failed to prove that he is currently engaging in a pattern of abusive billing practices. *Id.* I find this argument unpersuasive. First of all, the record is devoid of evidence regarding whether Petitioner's billing has been free from error at all times since Petitioner submitted the improper claims at issue here. As far as the record reveals, neither CMS nor Petitioner has conducted a review of Petitioner's subsequent claims to determine their accuracy. *See Gaefke*, DAB No. 2554 at 10 (record did not indicate that contractor had scrutinized all claims during the period or that identification of certain improper claims indicated a finding that all remaining claims were proper). Second, and more importantly, neither the regulation nor the preamble establishes a limitations period beyond which revocation is no longer authorized.

Petitioner argues that CMS failed to establish that he engaged in a pattern of abusive billing because it failed to compute the percentage of his improper claims over a sufficiently long time frame. P. Mem. at 16-17. However, neither the regulation nor the preamble establishes a minimum claims error rate or dollar amount that must be exceeded before CMS may revoke billing privileges. *Gaefke,* DAB No. 2554 at 10. Further, the

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[11] Petitioner argues that neither CMS nor Cahaba addressed his CAP. P. Mem. at 4, 15. However, CMS's reconsidered determination addressed all elements included in Petitioner's CAP. CMS Ex. 2. Therefore, I may presume CMS considered and rejected the CAP, or it would not have issued an unfavorable reconsidered determination. *See, e.g., Douglas Bradley, M.D.*, DAB No. 2663 at 14 (2015) (a reviewing official may presume that "government officials have 'properly discharged their official duties' absent 'clear evidence to the contrary.'" (internal citations omitted)). Moreover, there is no requirement that CMS or its contractor explain its reasons for taking a discretionary action. *Brian K. Ellefsen, D.O.*, DAB No. 2626 at 9-10 (2015).

regulatory drafters explained that CMS would regard three instances of improper claims as sufficient to establish a basis for revocation, without regard to the overall number of claims a supplier submitted. *See* 73 Fed. Reg. at 36,455. Similarly, Petitioner's contention that CMS relied on faulty audit techniques (P. Br. at 4) is inapposite because CMS did not rely on extrapolation to identify improper claims. Rather, the specific claims at issue in the present case were identified as improper through direct analysis. For all these reasons, Petitioner's arguments do not prove that CMS lacked a basis to revoke his Medicare enrollment and billing privileges.

4. The revocation of Petitioner's billing privileges is valid notwithstanding that Cahaba, and not CMS, issued the initial determination.

Petitioner argues that CMS cannot prevail because CMS's contractor issued the initial determination revoking Petitioner's Medicare billing privileges. P. Br. at 2. In support of this argument Petitioner relies on interpretive language in the regulatory preamble which states that "CMS, not a Medicare contractor, will make the determination for revocation under the authority at § 424.535(a)(8)." 73 Fed. Reg. at 36,455. However, as an appellate panel of the DAB has observed, interpreting this language to mean that "only CMS – not its contractors – would perform these revocations" is inconsistent with the remaining context in the preamble discussion. *John M. Shimko, D.P.M.*, DAB No. 2698 at 11 (2016). As the *Shimko* decision concluded, the preamble contemplates that CMS will consult with and direct contractors, but clearly states that contractors will issue revocations based on 42 C.F.R. § 424.535(a)(8). *Id.*; *see also McDonough*, DAB No. 2728 at 7. Moreover, in the present case, as in *McDonough*, CMS itself, and not a contractor, issued the reconsidered determination. Accordingly, even if Cahaba had erred by issuing the initial determination, any impropriety would have been cured when CMS issued the reconsidered determination. *McDonough*, DAB No. 2728 at 7.

5. Petitioner has not been deprived of due process, because Petitioner has been given the opportunity to present evidence and respond to CMS's allegations.

Petitioner argues that Cahaba and CMS violated his due process rights in a number of ways, primarily based on his contention that the data analysis undertaken by CMS and its contractors was unreliable. *See, e.g.,* P. Br. at 3-4. Petitioner's due process argument is without merit because, at all relevant times, Petitioner has been on notice of CMS's allegations regarding his noncompliance and has had ample opportunity to respond to CMS's allegations.

By letter dated June 12, 2014, a zone program integrity contractor for CMS provided Petitioner notice of multiple claims that were potentially improper because they appeared to involve beneficiaries who were deceased on the purported dates of service. CMS Ex.

3; P. Ex. 4. Significantly, all of the claims and beneficiaries that are at issue in the present proceeding were identified in the June 12, 2014 letter. *Compare* P. Ex. 4 at 3 *with* CMS Br. Att. A. Petitioner, therefore, has had sufficient notice of the facts that CMS and its contractors used as a basis for revoking his billing privileges and has had repeated opportunities to address these claims. Indeed, CMS and its contractors apparently considered Petitioner's responses when deciding to rely on fewer claims than originally cited as a basis for revoking Petitioner's billing privileges. Moreover, the fact that CMS eliminated some claims from consideration demonstrates, if anything, that CMS was making an effort to identify accurately the claims that were improper. Petitioner's argument to the contrary rings hollow.

Further, even if Petitioner was dissatisfied with responses from CMS or its contractors during the investigation or after the initial determination, CMS's actions or omissions do not justify granting Petitioner relief in the form of judgment in his favor. Petitioner received timely notice of the action and specific information about the revocation before CMS rendered the reconsidered determination, and has since had ample opportunity to defend himself at the administrative law judge level of review. *See Gaefke*, DAB No. 2554 at 10-11.

In summary, due process is afforded when, as in the present case, a party has adequate notice and a reasonable opportunity to respond at the hearing level. *See Green Hills Enters., LLC*, DAB No. 2199, at 9 (2008). Petitioner has not shown any actual prejudice in his ability to defend his case before me. Therefore, I do not find a due process violation. *Id*. at 8. Accordingly, Petitioner has not shown that he is entitled to relief in the form of judgment in his favor or remand to CMS.

IV. Conclusion

For the reasons explained above, I grant summary judgment in favor of CMS. There is no genuine dispute of material fact and CMS is entitled to judgment affirming its revocation of Petitioner's Medicare enrollment and billing privileges.

/s/
Leslie A. Weyn
Administrative Law Judge