Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Lesley Barbour, M.D., LLC
(NPI: 1164819322 / PTAN: 429080),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-16-744

Decision No. CR4767

Date: January 9, 2017

DECISION

The Medicare enrollment and billing privileges of Petitioner, Lesley Barbour, M.D., LLC, are revoked pursuant to 42 C.F.R. § 424.535(a)(5)(ii),[1] for failure to provide complete, accurate, and truthful responses in its Medicare enrollment application, in violation of 42 C.F.R. § 424.510(d)(2)(i). The effective date of revocation is December 31, 2015, the date it was determined that Petitioner was not operating a practice location at the address listed in its Medicare enrollment application. 42 C.F.R. § 424.535(g).

I. Procedural History and Jurisdiction

On May 3, 2016, Novitas Solutions (Novitas), a Medicare administrative contractor (MAC), notified Petitioner of its initial determination to revoke Petitioner's Medicare enrollment and billing privileges effective December 31, 2015, and to impose a two-year re-enrollment bar. Novitas cited 42 C.F.R. § 424.535(a)(5) as authority for the revocation and alleged that Petitioner was determined to not be operational at the address visited by

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[1] Citations are to the 2015 revision of the Code of Federal Regulation (C.F.R.), unless otherwise stated.

a site inspector. Novitas also cited 42 C.F.R. § 424.535(a)(9) as authority for revocation and alleged that Petitioner failed to notify the Centers for Medicare & Medicaid Services (CMS) of a change of address as required by 42 C.F.R. § 424.516. CMS Ex. 3.

Petitioner requested reconsideration by letter dated May 11, 2016. Petitioner argued that the address visited by the site inspector was a mailing and correspondence address, not a clinic where she saw patients as she treated patients in their homes or assisted living facilities. CMS Ex. 4.

A Novitas hearing officer issued a reconsidered determination on June 23, 2016. The hearing officer upheld the revocation. The hearing officer found the Provider Enrollment, Chain and Enrollment System (PECOS) listed Petitioner's practice location as 8100 Wyoming Boulevard NE, Suite M4 #340, Albuquerque, New Mexico. The hearing officer found that on December 31, 2015, a site visit was conducted at 8100 Wyoming Boulevard NE, Suite M4 #340, Albuquerque, New Mexico and Petitioner was not operating a clinic at that location. The hearing officer noted that Petitioner admitted that no patients were seen at the address on file as patients were seen in their home or assisted living facility. The hearing officer found that Petitioner failed to report in her Medicare enrollment application (CMS-855I) the actual location where services were provided to Medicare-eligible beneficiaries in violation of 42 C.F.R. § 424.510. The hearing officer found that Petitioner does not dispute that the practice was not operating at the address on file. The hearing officer concluded that revocation should be upheld. CMS Ex. 1.

Petitioner requested a hearing before an administrative law judge (ALJ) by letter dated July 15, 2016 (RFH). The case was assigned to me and an Acknowledgement and Prehearing Order (Prehearing Order) was issued on July 26, 2016. Petitioner's request for hearing was timely and I have jurisdiction.

CMS filed a motion for summary judgment and prehearing brief on August 25, 2016 (CMS Br.) with CMS exhibits (Exs.) 1 through 9. On October 21, 2016, Petitioner filed a prehearing brief (P. Br.), which includes a request for summary judgment in favor of Petitioner. Petitioner offered no exhibits for my consideration. CMS filed a reply brief on November 4, 2016 (CMS Reply). Petitioner has not objected to my consideration of CMS Exs. 1 through 9 and all are admitted as evidence.

II. Discussion

A. Applicable Law

Section 1831 of the Social Security Act (the Act) (42 U.S.C. § 1395j) establishes the supplementary medical insurance benefits program for the aged and disabled known as Medicare Part B. Administration of the Part B program is through contractors, such as

Novitas. Act § 1842(a) (42 U.S.C. § 1395u(a)). Payment under the program for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of services and suppliers.[2] Act §§ 1835(a) (42 U.S.C. § 1395n(a)), 1842(h)(1) (42 U.S.C. § 1395u(h)(1)). Petitioner, a physician, is a supplier.

The Act requires the Secretary of Health and Human Services (Secretary) to issue regulations that establish a process for enrolling providers and suppliers in Medicare, including the requirement to provide the right to a hearing and judicial review of certain enrollment determinations, such as revocation of enrollment and billing privileges. Act § 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to 42 C.F.R. § 424.505, suppliers such as Petitioner must be enrolled in the Medicare program and be issued a billing number to have billing privileges and to be eligible to receive payment for services rendered to a Medicare-eligible beneficiary.

The Secretary has delegated the authority to revoke enrollment and billing privileges to CMS. 42 C.F.R. § 424.535. CMS or its Medicare contractor may revoke an enrolled supplier's Medicare enrollment and billing privileges and supplier agreement for any of the reasons listed in 42 C.F.R. § 424.535.

Pursuant to 42 C.F.R. § 424.535(a)(5), CMS may revoke a supplier's enrollment and billing privileges if CMS determines, upon on-site review, that the supplier is no longer operational to furnish Medicare-covered items or services, or has otherwise failed to satisfy any of the Medicare enrollment requirements. 42 C.F.R. § 424.535(a)(5)(i) - (ii). Generally, when CMS revokes a supplier's Medicare billing privileges for not complying with enrollment requirements, the revocation is effective 30 days after CMS or its contractor mails notice of its determination to the supplier. 42 C.F.R. §§ 424.57(e)(1); 424.535(g). However, when CMS revokes a supplier's billing privileges because the supplier's "practice location" is not operational, the revocation is effective as of the date

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[2] A "supplier" furnishes services under Medicare and includes physicians or other practitioners and facilities that are not included within the definition of the phrase "provider of services." Act § 1861(d) (42 U.S.C. § 1395x(d)). A "provider of services," commonly shortened to "provider," includes hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, hospice programs, and a fund as described in sections 1814(g) (42 U.S.C. § 1395f(g)) and 1835(e) (42 U.S.C. § 1395n(e)) of the Act. Act § 1861(u) (42 U.S.C. § 1395x(u)). The distinction between providers and suppliers is important because they are treated differently under the Act for some purposes.

CMS determined the supplier's practice location was no longer operational. 42 C.F.R. § 424.535(g). After a supplier's Medicare enrollment and billing privileges are revoked, the supplier is barred from re-enrolling in the Medicare program for one to three years. 42 C.F.R. § 424.535(c).

A supplier whose enrollment and billing privileges have been revoked may request reconsideration and review as provided by 42 C.F.R. pt. 498. A supplier submits a written request for reconsideration to CMS or its contractor. 42 C.F.R. § 498.22(a). CMS or its contractor must give notice of its reconsidered determination to the supplier, giving the reasons for its determination and specifying the conditions or requirements the supplier failed to meet, and advising the supplier of its right to an ALJ hearing. 42 C.F.R. § 498.25. If the decision on reconsideration is unfavorable to the supplier, the supplier has the right to request a hearing by an ALJ and further review by the Departmental Appeals Board (the Board). Act § 1866(j)(8) (42 U.S.C. § 1395cc(j)(8)); 42 C.F.R. §§ 424.545, 498.3(b)(17), 498.5(*l*)(2). CMS is also granted the right to request ALJ review of a reconsidered determination with which it is dissatisfied. 42 C.F.R. § 498.5(*l*)(2). A hearing on the record, also known as an oral hearing, is required under the Act. *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743, 748-51 (6th Cir. 2004). The supplier bears the burden to demonstrate that it meets enrollment requirements with documents and records. 42 C.F.R. § 424.545(c).

B. Issue

Whether summary judgment is appropriate; and

Whether there was a basis for the revocation of Petitioner's billing privileges and Medicare enrollment.

C. Findings of Fact, Conclusions of Law, and Analysis

My conclusions of law are set forth in bold followed by the pertinent findings of fact and analysis.

1. Summary judgment is appropriate.

Both parties request that I consider whether summary judgment is appropriate. P. Br. at 1 n.1; CMS Br. and Reply.

A provider or supplier denied enrollment in Medicare or whose enrollment has been revoked has a right to a hearing and judicial review pursuant to section 1866(h)(1) and (j) of the Act and 42 C.F.R. §§ 498.3(b)(1), (5), (6), (8), (15), (17); 498.5. A hearing on the record, also known as an oral hearing, is required under the Act. Act §§ 205(b), 1866 (h)(1) and (j)(8); *Crestview*, 373 F.3d at 748-51. A party may waive appearance at an

oral hearing, but must do so affirmatively in writing. 42 C.F.R. § 498.66. In this case, Petitioner has not waived the right to oral hearing or otherwise consented to a decision based only upon the documentary evidence or pleadings. Accordingly, disposition on the written record alone is not permissible, unless the cross-motions for summary judgment have merit.

Summary judgment is not automatic upon request, but is limited to certain specific conditions. The Secretary's regulations at 42 C.F.R. pt. 498 that establish the procedure to be followed in adjudicating Petitioner's case do not establish a summary judgment procedure or recognize such a procedure. However, the Board has long accepted that summary judgment is an acceptable procedural device in cases adjudicated pursuant to 42 C.F.R. pt. 498. *See, e.g.*, *Ill. Knights Templar Home*, DAB No. 2274 at 3-4 (2009); *Garden City Med. Clinic*, DAB No. 1763 (2001); *Everett Rehab. & Med. Ctr.*, DAB No. 1628 at 3 (1997). The Board also has recognized that the Federal Rules of Civil Procedure do not apply in administrative adjudications such as this, but the Board has accepted that Fed. R. Civ. Pro. 56 and related cases provide useful guidance for determining whether summary judgment is appropriate. Furthermore, a summary judgment procedure was adopted as a matter of judicial economy within my authority to regulate the course of proceedings and made available to the parties in the litigation of this case by my Prehearing Order, para. II.D and G. The parties were given notice by my Prehearing Order that summary judgment is an available procedural device and that the law as it has developed related to Fed. R. Civ. Pro. 56 will be applied.

Summary judgment is appropriate when there is no genuine dispute as to any material fact for adjudication and/or the moving party is entitled to judgment as a matter of law. In determining whether there are genuine issues of material fact for trial, the reviewer must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. The party requesting summary judgment bears the burden of showing that there are no genuine issues of material fact for trial and/or that it is entitled to judgment as a matter of law. Generally, the non-movant may not defeat an adequately supported summary judgment motion by relying upon the denials in its pleadings or briefs but must furnish evidence of a dispute concerning a material fact, i.e., a fact that would affect the outcome of the case if proven. *Mission Hosp. Reg'l Med. Ctr.*, DAB No. 2459 at 4 (2012) (and cases cited therein); *Experts Are Us, Inc.*, DAB No. 2452 at 4 (2012) (and cases cited therein); *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 at 3 (2010) (and cases cited therein); *see also Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986).

The standard for deciding a case on summary judgment and an ALJ's decision-making in deciding a summary judgment motion differ from that used in resolving a case after a hearing. On summary judgment, the ALJ does not make credibility determinations, weigh the evidence, or decide which inferences to draw from the evidence, as would be done when finding facts after a hearing on the record. Rather, on summary judgment,

the ALJ construes the evidence in a light most favorable to the non-movant and avoids deciding which version of the facts is more likely true. *Holy Cross Vill. at Notre Dame, Inc.*, DAB No. 2291 at 5 (2009). The Board also has recognized that on summary judgment it is appropriate for the ALJ to consider whether a rational trier of fact could find that the party's evidence would be sufficient to meet that party's evidentiary burden. *Dumas Nursing & Rehab., L.P.*, DAB No. 2347 at 5 (2010). The Secretary has not provided in 42 C.F.R. pt. 498 for the allocation of the burden of persuasion or the quantum of evidence required to satisfy the burden. However, the Board has provided some persuasive analysis regarding the allocation of the burden of persuasion in cases subject to 42 C.F.R. pt. 498. *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd*, *Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 Fed. App'x 181 (6th Cir. 2005).

There is no genuine dispute as to any material fact in this case and summary judgment is appropriate as to both the basis for revocation and the effective date of revocation. The issues in this case that require resolution are issues of law related to the interpretation and application of the regulations that govern enrollment and billing privileges in the Medicare program and application of the law to the undisputed facts of this case. The undisputed facts show that there is a basis for revocation of Petitioner's Medicare enrollment and billing privileges with a retroactive effective date.

2. It is a requirement for enrolling in Medicare that a provider or supplier provide "[c]omplete, accurate, and truthful responses" for all sections of the applicable enrollment application (CMS-855). 42 C.F.R. § 424.510(d)(2)(i).

3. CMS or its contractor is authorized to revoke the Medicare enrollment and billing privileges of a provider or supplier that fails to satisfy any Medicare enrollment requirement. 42 C.F.R. § 424.535(a)(5)(ii).

4. There is a basis to revoke Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(5)(ii) because Petitioner violated the enrollment requirement established by 42 C.F.R. § 424.510 by failing to give a complete, accurate, and truthful response related to Petitioner's practice location in its initial enrollment application (CMS-855I).

5. Revocation of Petitioner's Medicare enrollment and billing privileges is effective December 31, 2015, the date it was determined by CMS that Petitioner was not operational at the practice location listed in Petitioner's Medicare enrollment application (CMS-855I). 42 C.F.R. § 424.535(g).

a. Facts

The material facts are not disputed.

On or about May 15, 2015, Dr. Barbour signed the certification statement on a CMS-855I to enroll Petitioner, Dr. Barbour's LLC, in Medicare. CMS Ex. 5 at 55. The application was completed to reflect that Petitioner was a new enrollee in Medicare. CMS Ex. 5 at 9. In section 4C of the CMS-855I, Petitioner listed its practice location as 8100 Wyoming Boulevard NE, Suite M4 #340, Albuquerque, NM 87113-1962. The box on the form identifying this location as a "[g]roup practice office/clinic" was checked. The CMS-855I was also completed to state that the first Medicare patient was seen at this practice location on May 1, 2015. CMS Ex. 5 at 36. Section 4D of the CMS-855I, which requires that the city/town, state and ZIP code be entered for all locations where services are rendered in patients' homes, was not completed. CMS Ex. 5 at 37. The CMS-855I lists 8100 Wyoming Boulevard NE, Suite M4 #340, Albuquerque, New Mexico as Petitioner's correspondence address and it is the address entered on the Medicare Participating Physician Agreement. CMS Ex. 5 at 13 (section 2B), 65.

On December 31, 2015 at 11:00 a.m. at the request of Novitas, a site inspector visited 8100 Wyoming Boulevard NE, Suite M4 #340, Albuquerque, NM 87113-1962, the address reported by Petitioner as its practice location. The inspector found that the address was a commercial mailbox in a UPS Store® and not a medical office. CMS Ex. 2.

Petitioner concedes that the practice location listed in the CMS-855I for Petitioner that Dr. Barbour signed on May 15, 2015, is a mailing address and not a practice location. CMS Ex. 4 at 3; P. Br. at 2.

I accept as true for purposes of summary judgment, Petitioner's assertion that it was operational at the time of the December 13, 2015, site visit in that Dr. Barbour was visiting Medicare-eligible beneficiaries at their home or in an assisted living facility. P. Br. at 2-3.

b. Analysis

It is the basis for revocation determined on reconsideration that is subject to review in this proceeding because that is the determination that triggers the right to an ALJ hearing.

42 C.F.R. § 498.5(*l*)(2); *Neb Group of Arizona, LLC*, DAB No. 2573 at 7 (2014). CMS and Petitioner are not entitled to ALJ review of the initial determination.[3]

Petitioner mischaracterizes the hearing officer's reconsidered determination asserting that that determination was "based *solely* on Petitioner being non-operational due to the fact that Petitioner did not have a physical location to render services." P. Br. at 2 (emphasis in original). In fact, the hearing officer did not make any determination as to whether or not Petitioner might have been operational at some location other than 8100 Wyoming Boulevard NE, Suite M4 #340, Albuquerque, New Mexico. The hearing officer found that at the time of the site visit PECOS listed Petitioner's practice location as 8100 Wyoming Boulevard NE, Suite M4 #340, Albuquerque, New Mexico. The hearing officer found that on December 31, 2015, a site visit was conducted at 8100 Wyoming Boulevard NE, Suite M4 #340, Albuquerque, New Mexico and Petitioner was not operating a clinic at that location. The hearing officer noted that Petitioner admitted in the reconsideration request that no patients were seen at the address on file as patients were seen in their home or assisted living facility. The hearing officer found that Petitioner failed to report in her Medicare enrollment application (CMS-855I) the actual location where services were provided to Medicare-eligible beneficiaries in violation of 42 C.F.R. § 424.510. The hearing officer found that Petitioner does not dispute that the practice was not operational at the address on file. Based on her findings the hearing officer concluded that there was a basis for revocation under 42 C.F.R. § 424.535(a)(5), without specifying whether subparagraph (i) or (ii) applied. CMS Ex. 1. The hearing officer did not find that Petitioner was not operational. The hearing officer found that Petitioner was not operating a practice at the address she told CMS she was operating from in the CMS-855I Dr. Barbour signed on May 15, 2015. Considering the concession that the address listed as a practice location in the CMS-855I was only ever a mailbox, the hearing officer's conclusion that Petitioner had not reported completely, accurately, and truthfully as required by 42 C.F.R. § 424.510 is well-founded. The hearing officer did not specifically cite the subsection of 42 C.F.R. § 424.510 applicable, but that is easily discerned from the reconsidered determination to be 42 C.F.R. § 424.510(d)(2). I conclude that the notice provided Petitioner by the reconsidered determination satisfied the requirement of 42 C.F.R. § 498.25. The hearing officer correctly cited the controlling regulations and explained the application of the regulations to the undisputed facts

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[3] CMS argues that CMS had a basis to revoke pursuant to 42 C.F.R. § 424.535(a)(9). CMS Br. at 7. But revocation on that basis was not upheld by the hearing officer on reconsideration and CMS did not preserve the issue by requesting ALJ review pursuant to 42 C.F.R. § 498.5(*l*)(2). I also note that there is no evidence of any change of practice location by Petitioner. I do not consider further revocation based on 42 C.F.R. § 424.535(a)(9).

established the basis for revocation. The hearing officer also advised Petitioner of the right to request a hearing.

Petitioner's failure to accurately report its practice location and the fact that Medicare-eligible beneficiaries were being seen in their homes or assisted living facilities, is a failure to satisfy the enrollment requirement of 42 C.F.R. § 424.510(d)(2) and is a basis for revocation under 42 C.F.R. § 424.535(a)(5)(ii).

Petitioner argues that under 42 C.F.R. § 424.535(a)(5) only CMS and not its contractor may decide to revoke Petitioner's enrollment based on the language of 42 C.F.R. § 424.535(a)(5), which refers to what "CMS determines." The Board has rejected a similar argument in cases involving revocation under 42 C.F.R. § 424.535(a). *Fady Fayad, M.D.*, DAB No. 2266 at 17-20 (2009), *aff'd*, *Fady Fayad v. Sebelius*, 803 F.Supp.2d 699 (E.D Mich. 2011); *John P. McDonough III, Ph.D. Geriatric Psychological Specialists, and GPS II, LLC*, DAB No. 2728 at 6 (2016). I find the Board's analysis in *Fayad* and *McDonough* persuasive. Congress clearly expressed that Medicare Part B is to be administered through MACs such as Novitas. Act § 1842(a). It is not inconsistent with the intent of Congress that CMS uses the MACs to exercise authority delegated by the Secretary to CMS to revoke Medicare enrollment and billing privileges. I further note that before me it is CMS represented by the Office of General Council for the Department of Health and Human Services that is pursuing this revocation action, not Novitas. I conclude that Petitioner's argument is without merit.

Summary judgment is also appropriate as to the effective date of revocation. Pursuant to 42 C.F.R. § 424.535(g):

> (g) *Effective date of revocation.* Revocation becomes effective 30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier, except if the revocation is based on Federal exclusion or debarment, felony conviction, license suspension or revocation, **or the practice location is determined by CMS or its contractor not to be operational**. When a revocation is based on a Federal exclusion or debarment, felony conviction, license suspension or revocation, **or the practice location is determined by CMS or its contractor not to be operational**, **the revocation is effective** with the date of exclusion or debarment, felony conviction, license suspension or revocation or **the date that CMS or its contractor determined that the provider or supplier was no longer operational.**

(Emphasis added). Petitioner does not dispute that at the time of the site visit it had no practice location at 8100 Wyoming Boulevard NE, Suite M4 #340, Albuquerque, New Mexico, only a mailbox. Pursuant to 42 C.F.R. § 424.535(g), CMS is authorized by regulation to establish an effective date of revocation based on the date CMS determined that Petitioner's **practice location** was no longer operational. The Novitas investigator found that Petitioner had no operational practice location at 8100 Wyoming Boulevard NE, Suite M4 #340 in Albuquerque, New Mexico on December 31, 2015, and that is the correct effective date of revocation.

When a supplier's Medicare enrollment and billing privileges are revoked, the supplier is barred from re-enrolling in the Medicare program for one to three years. 42 C.F.R. § 424.535(c). There is no statutory or regulatory language establishing a right to review of the duration of the re-enrollment bar CMS imposes. Act § 1866(j)(8) (42 U.S.C. § 1395cc(j)(8)); 42 C.F.R. §§ 424.535(c), 424.545; 498.3(b), 498.5. The Board has held that the duration of a revoked supplier's re-enrollment bar is not an appealable initial determination listed in 42 C.F.R. § 498.3(b) and not subject to ALJ review. *Vijendra Dave*, DAB No. 2672 at 10-11 (2016).

To the extent that Petitioner's arguments may be construed as a request for equitable relief, I have no authority to grant such relief. *US Ultrasound*, DAB No. 2302 at 8 (2010) ("Neither the ALJ nor the Board is authorized to provide equitable relief by reimbursing or enrolling a supplier who does not meet statutory or regulatory requirements."). I am also required to follow the Act and regulations and have no authority to declare statutes or regulations invalid. *1866ICPayday.com, L.L.C.*, DAB No. 2289 at 14 ("An ALJ is bound by applicable laws and regulations and may not invalidate either a law or regulation on any ground.")

III. Conclusion

For the foregoing reasons, Petitioner's Medicare enrollment and billing privileges are revoked pursuant to 42 C.F.R. § 424.535(a)(5)(ii), for failure to provide complete, accurate, and truthful responses in its Medicare enrollment application, in violation of 42 C.F.R. § 424.510(d)(2)(i). The effective date of revocation is December 31, 2015.

/s/
Keith W. Sickendick
Administrative Law Judge