Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Louis J. Gaefke, D.P.M.
Docket No. A-13-93
Decision No. 2554
December 24, 2013

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Petitioner Louis J. Gaefke, D.P.M., requests review of the May 14, 2013 decision of an Administrative Law Judge (ALJ) sustaining the revocation of Petitioner's Medicare billing privileges. *Louis J. Gaefke, D.P.M.*, DAB CR2785 (2013) (ALJ Decision). The Center for Medicare & Medicaid Services (CMS), through its contractor, Wisconsin Physician Services Insurance Corporation (WPS), acted under regulations authorizing the revocation of the Medicare enrollment and billing privileges of a Medicare supplier or provider who "submits a claim or claims for services that could not have been furnished to a specific individual on the date of service." 42 C.F.R. § 424.535(a)(8). Petitioner does not dispute that his billing agent submitted 35 claims for services that Petitioner could not have delivered to the beneficiaries named in the claims. For the reasons explained below, we sustain the ALJ Decision.

Applicable law

The regulation at 42 C.F.R. § 424.535(a)(8) states that CMS may revoke a provider's or supplier's Medicare billing privileges and any corresponding provider or supplier agreement for the following reason:

> (8) *Abuse of billing privileges*. 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.

The preamble to the final rule publishing this section states:

> 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 … We believe that it is both appropriate and necessary that we have the ability to revoke billing privileges when services could not have been furnished by a provider or supplier. We recognize the impact that this revocation has, and a revocation will not be issued unless sufficient evidence demonstrates abusive billing patterns. Accordingly, we will not revoke billing privileges under § 424.535(a)(8) unless there are multiple instances, at least three, where abusive billing practices have taken place … In conclusion, we believe that providers and suppliers are responsible for the claims they submit or the claims submitted on their behalf. We believe that it is essential that providers and suppliers take the necessary steps to ensure they are billing appropriately for services furnished to Medicare beneficiaries.

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

If CMS revokes a provider's or supplier's billing privileges, the provider or supplier is "barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar."[1] Section 424.535(c). The re-enrollment bar must last for a minimum of one year but may not exceed three years, "depending upon the severity of the circumstances." *Id.* Revocation also results in the termination of the provider's or supplier's agreement with Medicare. *Id*. at 424.535(b).

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

Case Background[2]

Petitioner is a podiatrist licensed to practice in Kansas and Missouri who participated in the Medicare program as a supplier of services.[3] WPS notified him in five letters dated August 3, 2012 (each for a different Provider Transaction Access Number assigned to

[1] The re-enrollment process set forth at 42 C.F.R. § 424.535(d) applies to a provider or supplier seeking to re-establish enrollment in the Medicare program after its billing privileges have been revoked.

[2] The factual information in this section, unless otherwise indicated, is drawn from undisputed findings of fact set forth in the ALJ Decision and undisputed facts in the record and is presented to provide a context for the discussion of the issues raised on appeal. Nothing in this section is intended to replace, modify, or supplement the ALJ's findings of fact or conclusions of law.

[3] 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.

Petitioner) that it was revoking his Medicare billing privileges, effective August 2, 2012, on the basis of 42 C.F.R. § 424.535(a)(8). CMS Ex. 2, at 4-13. The WPS letters did not allege specific facts as the basis for revoking Petitioner's billing privileges under section 424.535(a)(8). WPS also established a three-year bar on Petitioner's re-enrollment in the Medicare program. *Id*. The letters informed Petitioner that he could file a corrective action plan within 30 days, and request reconsideration by WPS within 60 days. *Id*.

Petitioner by e-mail on August 14, 2012 asked the WPS representative who signed the August 2 letters for information on the bases of WPS's determinations including the names of the patients and the dates of service in the claims at issue. The WPS representative replied on August 16, 2012 that he had been told by CMS that none of that information could be released at that time, and advised Petitioner to "follow the appeal's process indicated in the revocation letter." CMS Ex. 2, at 14. Petitioner requested reconsideration on August 28, 2012 and again on October 5, 2012, after receiving the information about the bases for the revocation on October 2, 2013. *Id*. at 1-3; CMS Ex. 3. The information revealed that CMS had determined that the claims warranting revocation under section 424.535(a)(8) comprised at least 27 claims for podiatric services that the claim forms indicated were rendered to eight beneficiaries who had died before the dates of service, and eight additional claims for debriding six or more toenails on eight beneficiaries who had had one foot amputated prior to the dates of service. CMS Ex. 3, at 5-8. A WPS hearing officer denied reconsideration of the revocation on October 10, 2012, on the ground that Petitioner "has submitted claims for services that could not have been furnished." CMS Ex. 1, at 1.

Petitioner timely requested an ALJ hearing. The ALJ admitted each party's exhibits and denied Petitioner's motion to exclude some of CMS's exhibits as sanctions for misconduct in initially refusing to provide information about the allegedly improper claims. ALJ Decision at 3, citing P. Br. at 26 n.3. Petitioner principally argued that all except one of the disputed claims resulted from clerical billing errors by his billing agent, D.A.R.E. Foot Care (also identified as DDK). For the claims for services to eight deceased beneficiaries, Petitioner stated that he or another podiatrist provided services to living patients with the same or similar names as each of the deceased beneficiaries, but D.A.R.E. billing personnel mistakenly submitted the claims using the names and Medicare identification numbers of deceased beneficiaries and, in some cases, mistakenly identified Petitioner as the podiatrist. For the seven of the eight amputee beneficiaries, Petitioner stated that he indicated on the treatment records that the beneficiary was an amputee and reported debriding five toes, but the billing personnel mistakenly submitted claims using the procedure code for debriding six or more toes (code number 11721 vs. 11720 for debriding one to five toes). P. Ex. C. Petitioner noted that the billing agent had previously submitted accurate claims on his behalf for debridement of only one to five toes of each of these beneficiaries. Petitioner also conceded that he did not clearly document that one beneficiary was a partial amputee, and describes this as "an oversight." Request for Review (RR) at 8.

The ALJ concluded that the undisputed submission of the claims for services that could not have been delivered as claimed constituted the submission of improper Medicare claims for services that could not have been furnished to specific individuals on the purported dates of service, authorizing revocation of Petitioner's billing privileges under section 424.535(a)(8). He rejected Petitioner's argument that he was denied due process by WPS's and CMS's delay in providing him information about the claims.[4] The ALJ made the following numbered findings of fact and conclusions of law: 1. Summary judgment is appropriate. 2. The undisputed facts show that Petitioner billed Medicare for services that could not have been provided to a specific beneficiary on the date of service.[5] 3. CMS has a sufficient basis to revoke Petitioner's Medicare billing privileges pursuant to section 424.535(a)(8). 4. The effective date of the revocation of Petitioner's billing privileges is September 2, 2012. 5. Petitioner is not entitled to summary judgment based on his due process arguments. ALJ Decision at 4-11.

Standard of Review

Whether summary judgment is appropriate is a legal issue we address de novo. Summary judgment is appropriate if there are no genuine disputes of fact material to the result. In reviewing whether there is a genuine dispute of material fact, we view proffered evidence in the light most favorable to the non-moving party. *Elant at Fishkill*, DAB No. 2468, at 5-6 (2012) (citations omitted). Our standard of review on a disputed issue of law is whether the ALJ decision is erroneous. *Guidelines -- Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare and Medicaid Programs*, (http://www.hhs.gov/dab/divisions/appellate/guidelines/prosupenrolmen.html).

Analysis

Petitioner does not dispute that he was the Medicare supplier identified in 27 Medicare claims for payment for services rendered to eight beneficiaries who had died before the dates of service, and eight claims for toenail debridement services performed on six or more toes of eight beneficiaries who each had one foot or leg amputated. ALJ Decision at 5; RR at 2, 4-10, 14; CMS Ex. 1, at 44-45 (list of beneficiaries, services claimed, dates of services, and either date of death or amputation). As he did below, Petitioner argues that CMS was not authorized to revoke his billing privileges and enrollment under

---

[4] The ALJ cited section 424.535(g), which makes revocation effective 30 days after CMS or its contractor mails notice of the revocation to the supplier, with certain exceptions that the ALJ concluded did not apply. ALJ Decision at 10. Neither party disputes the ALJ's determination of the effective date of the revocation.

[5] CMS alleged that 31 claims were submitted for services to the eight beneficiaries who had died before the dates of service. CMS Ex. 1, at 44. The ALJ accepted, for the purposes of summary judgment, Petitioner's assertion that four of those 31 claims were duplicates, and CMS does not dispute the ALJ's determination. ALJ Decision at 5, n. 4.

section 424.535(a)(8) because the admittedly incorrect claims were only errors, i.e., that "there is absolutely no evidence of fraud or abuse in this case, but only an isolated series of clerical errors," and because those errors were committed, with one exception, by his billing agent, D.A.R.E. Foot Care. RR at 1-2. For the reasons discussed below, these arguments are without merit.

1. Petitioner's argument that his billing agent was responsible for submission of the improper claims does not demonstrate error in the ALJ Decision or warrant reversing the revocation.

Petitioner relies heavily on his relationship with his biller to allege error in the ALJ Decision. Petitioner argues that he cannot be held vicariously responsible or strictly liable for errors made by D.A.R.E. Foot Care because he "contractually had no control over the manner in which claims were submitted by D.A.R.E." and was "barred from involving himself in the billing process." RR at 15. Petitioner queries whether he was "supposed to travel across the state every time that claims were submitted by D.A.R.E. and stand over the shoulder of the person entering and submitting the claim and double-check each entry[.]" *Id.*

Although the ALJ accepted Petitioner's explanation for the improper claims for purposes of summary judgment, the ALJ found it irrelevant whether they resulted from errors by Petitioner's billing agent because "Petitioner alone is responsible for the accurate billing of his services" and had "voluntarily entered into a contractual relationship with D.A.R.E. Foot Care which, according to him, required him to yield to D.A.R.E. Foot Care his right to personally submit claims to CMS." ALJ Decision at 6-7. Petitioner's "failure to properly supervise the billing for services," the ALJ stated, "is not a defense because otherwise CMS would have no means to stop improper billing" and "suppliers would be protected when acting through an agent." *Id.* at 7. Petitioner disputes the ALJ's conclusion that Petitioner is responsible for D.A.R.E. Foot Care's submission of the improper claims as "without citation to authority." RR at 14.

Petitioner's contention ignores a Medicare supplier's obligation, as CMS noted before the ALJ, to certify on its claims for reimbursement that the claimed services were "medically indicated and necessary for the health of the patient and were personally furnished" by the provider or under his direct supervision or, in the case of claims submitted electronically, that the supplier "will be responsible for all Medicare claims submitted by itself, its employees, or its agents" and that the claims "are accurate, complete and truthful." CMS Exs. 4, 5; CMS Br. at 3. As the Board stated in *Howard B. Reife*, D.P.M., DAB No. 2527 (2013), a case also involving multiple claims for podiatric services to deceased individuals and for debridement of six or more toes on beneficiaries with one foot, some of which were submitted by D.A.R.E. Foot Care as the podiatrist's billing agent, those certifications "are consistent with the preamble language emphasizing that suppliers are responsible for claims submitted on their behalf." *Reife* at 8; 73 Fed.

Reg. at 36,455 ("we believe that providers and suppliers are responsible for the claims they submit or the claims submitted on their behalf [and] that it is essential that providers and suppliers take the necessary steps to ensure they are billing appropriately for services furnished to Medicare beneficiaries.").

As the ALJ correctly concluded, Petitioner as a Medicare supplier is ultimately responsible for the accuracy of his claims for Medicare reimbursement. Accordingly, Petitioner's attempts to distinguish *Reife* are not persuasive. Petitioner argues that the supplier in *Reife* "did not provide undisputed evidence to the ALJ showing who was actually to blame for the errors in the claims," which "allowed the ALJ and the Board to draw conclusions about the appearance of impropriety on the part of Dr. Reife … that are not appropriate here in light of" Petitioner's exhibits. P. Supp. Br. at 1-2. As we noted in *Reife*, however, "Petitioner's efforts to assign blame for the improper billing to his billing agent or his assistant do not relieve him of his responsibility for the improper claims or bar CMS from revoking his billing privileges." *Reife* at 8. As discussed, Medicare suppliers and providers certify that they are responsible for the accuracy of their claims for reimbursement, and the regulation contains no exception for improper claims prepared and submitted by billing agents, which is consistent with the preamble stating that providers and suppliers are responsible for claims submitted on their behalf. As in *Reife*, Petitioner "cites no legal authority relieving suppliers of responsibility for the claims for Medicare reimbursement submitted on their behalf and at their direction." *Id.* Petitioner's position, if adopted, would effectively shield a supplier from any consequences for the submission of an unlimited number of improper claims on his behalf, so long as he could point to an agreement with a billing agent, who is not a party to the supplier's Medicare agreement, to submit the claims. Petitioner's efforts to assign blame for the improper billing to his billing agent or his assistant do not relieve him of his responsibility for the improper claims or bar CMS from revoking his billing privileges.[6]

2. Petitioner's argument that the improper claims resulted from clerical errors does not demonstrate error in the ALJ Decision or warrant reversing the revocation.

The ALJ "accept[ed] as true, solely for purposes of summary judgment, that Petitioner did not intend to defraud Medicare and that all but one of the improper claims resulted from the clerical errors of Petitioner's billing agent." ALJ Decision at 5. He agreed that "Petitioner provided treatment sheets that support his argument" that he "provided care to

---

[6] The ALJ suggested that a supplier could escape liability for the submission of claims covered by section 424.535(a)(8) by showing that a billing agent or other third party "falsely or fraudulently misused his supplier number to bill for services or that he did not authorize them to bill Medicare on his behalf." ALJ Decision at 7. Petitioner has not alleged that D.A.R.E. Foot Care submitted the claims fraudulently, so we do not address the ALJ's statement.

beneficiaries with the same or similar names to the deceased beneficiaries identified on the submitted claims," and that indicated "that he provided treatment to the only foot" of one amputee beneficiary the ALJ cited as an example. *Id*. at 5-6, citing P. Exs. B, C. The ALJ pointed out, however, that Petitioner's exhibits include the erroneous claims forms identifying the deceased beneficiaries as having received the claimed services, or reporting that Petitioner performed debridement of 6 or more toes on the beneficiaries identified on the treatment sheets as having had one foot amputated. *Id*. The ALJ found it dispositive that this undisputed evidence shows "that Petitioner or his billing representative, D.A.R.E. Foot Care, submitted claims for services that could not have been furnished to a specific individual on the date of service." ALJ Decision at 6, citing section 424.535(a)(8) (authorizing revocation where "[t]he 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").

Petitioner relies on CMS's preamble statements that the revocation authority is directed at providers and suppliers engaged in "a pattern of improper billing" and is not intended for "isolated occurrences" or "accidental billing errors," and that CMS would "not revoke billing privileges … unless there are multiple instances, at least three, where abusive billing practices have taken place." 73 Fed. Reg. at 36,455. Petitioner argues that "[i]t is clear from the Federal Register excerpt … that 'abusive billing practices' must have taken place for the regulation to apply" and that "it absolutely cannot be applied in the area of accidental billing errors." RR at 12. Petitioner argues that the revocation is thus "clearly at odds with [section] 424.535(a)(8), which is intended to allow revocations only in instances where there is evidence that the provider has engaged in fraud or abuse." RR at 2.

The regulation, and the preamble when read in the context of the regulation, do not support Petitioner's argument that the revocation was unauthorized because his improper claims resulted from inadvertent errors. The plain language of the regulation contains no requirement that CMS establish that the supplier acted with fraudulent or dishonest intent. The regulatory language also does not provide any exception for inadvertent or accidental billing errors. As the Board stated in *Reife*, the "operative language" of the regulation "does not require that CMS demonstrate that Petitioner intended to defraud Medicare before it may revoke Petitioner's billing privileges," but "simply authorizes revocation where the supplier submits 'a claim or claims for services that could not have been furnished to a specific individual on the date of service,'" including, as is

particularly applicable here, "'where the beneficiary is deceased.'" *Reife* at 5. Petitioner's submission via his billing agent of multiple claims for services that could not have been provided as claimed falls squarely within the conduct the regulation prohibits.[7]

Given the absence from the regulation of any requirement to show fraudulent intent, or exceptions for inadvertent error, the preamble cannot be read in a manner that would effectively bar CMS from taking action against providers or suppliers who submit multiple improper claims, even where the claims were the result of negligence or reckless indifference by the provider or supplier. We also agree with the ALJ that the preamble statements Petitioner cites do not bar CMS from revoking the enrollment of a supplier or provider whose incorrect billing falls within the plain language of the regulation. ALJ Decision at 7-8; RR at 11-13. We need not address, however, the ALJ's conclusion that the preamble language "directly contradicts the plain language of the regulation" because the subject claims here, by their sheer number, fall within the preamble language, in which the Secretary stated a policy of not initiating revocation based on accidental claims but also warned that the submission of three or more improper claims would not be considered accidental.[8] ALJ Decision at 8.

As to Petitioner's reliance on the title of the regulation, "Abuse of billing privileges," which Petitioner argues means that there must be a level of intent that is not stated in the regulation itself, Petitioner has shown no error in the ALJ's conclusion that "the title to a section or subsection is not controlling, does not add elements to the operative language, and may only be used as an interpretative aid." *Id.* at 8; *see also*, *Breton Lee Morgan, M.D.*, DAB No. 2264, at 8 (2009) (citations omitted) (while the title of a statute or section "can aid in resolving an ambiguity in the legislation's text," it "has long been established that the title of an Act 'cannot enlarge or confer powers'"), *aff'd*, *Morgan v. Sebelius,* No. 3:09-1059, 2010 WL 3702608 (D. W.Va. Sept. 15, 2010), *aff'd*, 694 F.3d 535 (4th Cir. 2012). While Petitioner argues that a definition of "abuse" contained in the Merriam-Webster Dictionary is "a corrupt practice or custom," RR at 15, we note that

---

[7] The ALJ also rejected Petitioner's argument that the regulation's focus on claims for services "that could not have been furnished to *a* specific individual on the date of service," as opposed to "*the* specific individual," meant that it does not authorize revocation if the supplier in fact delivered the claimed services to a different individual. ALJ Decision at 9-10; citing P. Br. at 18. The ALJ's determination is consistent with the Board's analysis in *Realhab, Inc.*, DAB No. 2542 (2013), that the purpose of the phrase "to a specific individual" is "to cover situations where a practitioner was available and had the necessary equipment to furnish a service, but could not have furnished the service to the identified beneficiary given that beneficiary's status or location." *Realhab, Inc.* at 16. As the Board stated there, "[l]imiting the term 'abuse of billing' in the context of revocation to situations in which **no** services could possibly have been furnished … would not adequately protect the integrity of the Medicare program." *Id.* at 18 (emphasis in original). Petitioner does not challenge this conclusion by the ALJ.

[8] As the undisputed evidence establishes the submission of multiple improper claims covered by the regulations, we also do not address the ALJ's conclusion that a single improper claim may trigger CMS's authority to revoke billing privileges. ALJ Decision at 8.

another dictionary meaning of abuse is simply "wrong or improper use; misuse: the abuse of privileges." (Dictionary.com). Thus, the apparently negligent submission of 35 claims for services to 16 beneficiaries that could not have been delivered as claimed constituted an abuse of Petitioner's billing privileges covered by the regulation as well as by the preamble and the regulatory title when read in the context of the entire regulation.

Finally, Petitioner's evidence does not establish how the errors occurred nor demonstrate that the errors did not result from multiple instances of negligence or reckless disregard for the accuracy of Petitioner's claims for reimbursement. In this regard, the ALJ did not err in assigning little or no weight to two of Petitioner's testimonial exhibits, the declarations of a podiatrist with expertise in Medicare coding and the D.A.R.E. office manager. Their testimony to the effect that the multiple claims for services that could not have been delivered as claimed were clerical errors or mistakes by billing personnel is simply conclusory and appears to be nothing more than inferences Petitioner wishes to have drawn from the record documentation. In particular, the office manager simply repeats, for 15 of the 16 beneficiaries, that the improper claims were filed "due to a mistake" or "mistakes" committed "by billing personnel at DDK" or "by DDK billing personnel." P. Ex. A, at 3-9. Her opinion is based solely on a review of records, and she does not state that she spoke to any of the billing personnel who completed and submitted the erroneous claims to learn about the mistakes or otherwise explain how the mistakes came to have been made. The declaration of the coding expert similarly provides no specific bases other than the exhibits for his belief that each of the errors was simply a mistake by billing personnel. Additionally, neither witness offered any specific account of how the similarity of beneficiary names could have caused D.A.R.E. Foot Care in three instances to submit claims on behalf of Petitioner for services provided by other podiatrists.

As we stated in *Reife*, "[r]epeatedly making those same errors [submission of at least 35 improper claims by the same entity on behalf of the same supplier] reduces their credibility as 'accidental' and establishes a pattern of improper billing that suggests a lack of attention to detail, considering that [the billing agent] could have differentiated the patients through their birthdates or Medicare numbers." *Reife* at 6. "Nothing in either the preamble language or the regulation requires CMS to establish that the improper claims were not accidental" or "that a supplier's explanation for the improper claims (i.e., similarities among patient names or between the incorrect procedure code

used in the claims and the correct code that would have yielded lower reimbursement) was the result of a carefully concocted story or scheme to cover improper behavior by a supplier acting to defraud Medicare."[9] *Id.*

Petitioner also argues that revocation is not appropriate because the 35 improper claims were identified in a review of claims covering a four-year period (2008 through 2011) during which "77,593 total line items" or claims for a specific service on a specific day were submitted under his provider number. RR at 3-4, citing CMS Ex. 3, at 5-10. However, the record does not indicate that the review scrutinized all of the claims Petitioner submitted during that time period, or that WPS's identification of the improper claims constitutes a determination of the propriety of all of Petitioner's remaining claims. As we stated in *Reife*, there is no requirement in the regulation (or the preamble) establishing a minimum claims error rate or dollar amount that must be exceeded before CMS may revoke billing privileges. *Reife* at 7.

3. Petitioner has not shown error in the ALJ's conclusion that Petitioner is not entitled to summary judgment based on his due process arguments.

Petitioner disputes the ALJ's finding that no prejudice resulted from the passage of some two months before CMS provided Petitioner with specific factual information about the claims on which it based the revocation, which Petitioner said he needed to seek reconsideration and prepare a corrective action plan after WPS and CMS had initially refused to disclose that information. The ALJ concluded that WPS's and CMS's actions, while "far from 'good government,'" did not justify granting Petitioner summary judgment. ALJ Decision at 10. The ALJ found that since CMS later provided the documents from its investigation and Petitioner submitted evidence, Petitioner was given adequate notice and a reasonable opportunity to respond at the hearing level, and had not shown actual prejudice in his ability to defend his case before the ALJ. *Id.* at 11. Petitioner argues that the delay in providing him information about the revocation "deprived [him] of his ability to respond properly to the notices and submit a complete reconsideration request to WPS." RR at 19. He asserts that after the information was received on October 2, 2012 "[a] scramble ensued and some records were collected and sent to WPS on October 5 (the same Friday), but they were by no means complete." *Id.*

---

[9] Petitioner also argues that the three-year re-enrollment bar CMS imposed is excessive absent conduct more severe than present here. RR at 21, citing section 424.535(c) ("re-enrollment bar is a minimum of 1 year, but not greater than 3 years, depending on the severity of the basis for revocation"). Petitioner disputes the ALJ's conclusion that CMS's selection of a reenrollment bar is not a determination subject to ALJ review because it is not a reviewable initial determination under 42 C.F.R. § 498.3(b)(17). ALJ Decision at 3 n.3. We do not address the reviewability of the length of the re-enrollment bar here because, given the number and nature of the improper claims, we would in any case find the length reasonable.

Petitioner has not, however, established that he was prejudiced in his ability to present his case fully before the ALJ. Notably, he does not allege that he possesses additional documentation that he was unable to submit either on reconsideration or before the ALJ. *See* 42 C.F.R. § 498.56(e) (ALJ may admit new evidence upon determination of good cause for not submitting the evidence on reconsideration). The ALJ moreover accepted Petitioner's factual assertions for the purpose of summary judgment, so Petitioner was not prejudiced by any inability to submit additional documentation.[10]

Petitioner's argument that the delay in receiving the information about the improper claims prevented him from developing a corrective action plan (CAP) has no merit in this forum. The Board does not have authority to review a contractor's action on a corrective action plan. The Board stated in *DMS Imaging, Inc.*, DAB No. 2313, at 5 (2010), that "[n]either the Social Security Act nor the implementing regulations provide for administrative review of a contractor's refusal to reinstate a supplier's billing privileges on the basis of a CAP." As we noted there and elsewhere, a contractor's refusal to reinstate a supplier's enrollment or billing privileges based on a CAP is not listed as an appealable "initial determination" under section 498.3(b), and 42 C.F.R. § 405.809 (2012) states that "[a] CMS contractor's refusal to reinstate a supplier's billing privileges based on a corrective action plan is not an initial determination under part 498 of this chapter" (formerly at 42 C.F.R. § 405.879(e)). *Id.* at 5-6; *Pepper Hill Nursing & Rehab. Ctr., LLC*, DAB No. 2395, at 9 (2011). Petitioner has not shown error in the ALJ's conclusion that Petitioner is not entitled to summary judgment based on his due process arguments.

[10] Given the ALJ's obligation to make findings and conclusions based on the record before him as to the ultimate issue of whether CMS had a basis to revoke Petitioner's billing privileges under section 424.535(a)(8), we do not agree with Petitioner that he is entitled to summary judgment in his favor solely because CMS below did not respond to his argument that "he was denied due process in his request for reconsideration because of its intentional withholding of information that he was entitled to receive[.]" P. Reply at 6. Nothing in the regulations authorizes the ALJ to reverse a revocation to sanction CMS for alleged due process violations where CMS had a basis for the revocation under section 424.535(a). Furthermore, here any alleged due process issues, were, as noted above, fully cured by the proceedings before the ALJ. *See, e.g. Green Hills Enterprises, LLC*, DAB No. 2199, at 8 (2008) (and cases cited therein).

Conclusion

For the foregoing reasons, we affirm the ALJ Decision.

/s/

Judith A. Ballard

/s/

Leslie A. Sussan

/s/

Stephen M. Godek
Presiding Board Member