Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

John M. Shimko, D.P.M.
(NPI: 1194718619),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-898

Decision No. CR4105

Date: August 6, 2015

DECISION

Petitioner, John M. Shimko, D.P.M., challenges the reconsidered determination by Palmetto GBA (Palmetto), an administrative contractor for the Centers for Medicare & Medicaid Services (CMS), which upheld the revocation of Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(8).[1] The contractor determined 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.

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

[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). For purposes of this decision, I apply the version of the regulation in effect at the time the contractor revoked Petitioner's billing privileges, on September 4, 2014.

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 North Carolina. Petitioner participated in the Medicare program as a "supplier" of services.[2] By letter dated September 4, 2014, Palmetto 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" had identified 19 occasions where Petitioner billed Medicare for services provided to beneficiaries who were deceased at the time of service. Palmetto's notice letter stated that it was revoking Petitioner's billing privileges effective September 27, 2014. Palmetto also imposed a three-year bar on Petitioner's re-enrollment in the Medicare program.

On October 14, 2014, Petitioner submitted a corrective action plan (CAP) to Palmetto. Petitioner acknowledged in his CAP that he had submitted Medicare claims that identified deceased beneficiaries, but he explained at length the confusing circumstances often present when a podiatrist performs services in a nursing home environment. On October 23, 2014, Petitioner requested reconsideration of the initial determination to revoke his billing privileges. On November 25, 2014, a Palmetto hearing officer issued a reconsidered determination that upheld the revocation. The hearing officer stated that Petitioner had not provided evidence to dispute the billing errors that resulted in his submitting 19 claims to Medicare for deceased beneficiaries.[3]

By letter dated January 8, 2015, Petitioner requested a hearing before an administrative law judge (ALJ) to challenge the reconsidered determination. This case was assigned to me. On January 14, 2015, I issued an Acknowledgment and Pre-Hearing Order (Pre-Hearing Order), which established general procedures for record development in this case and permitted the parties to file for summary judgment, if appropriate. *See* Pre-Hearing Order ¶ 4. CMS timely filed a motion for summary judgment with a supporting brief (CMS Br.) along with seven proposed exhibits (CMS Exs. 1-7). 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.) and eight proposed exhibits (P. Exs. 1-8). Petitioner also objected (P. Obj.) to the admission of CMS Ex. 6 and CMS Ex. 7, which I discuss below. CMS filed a reply brief (CMS Reply) and opposed summary judgment in favor of Petitioner.

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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] Before me, CMS relies on 17 claims that Petitioner submitted to Medicare for services that identify a beneficiary that was deceased at the time of service. *See* CMS Br. at 5.

II. 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 provide CMS with the authority to revoke the billing privileges of an enrolled provider or supplier if CMS determines that certain circumstances exist. *Id.* § 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.

Id. § 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. *Id.* § 424.535(b). In addition, after revocation CMS must impose a bar on re-enrollment for a minimum of one year, but no more than three years. *Id.* § 424.535(c). Once the re-enrollment bar has expired, the supplier must submit a new enrollment application to re-enroll in the Medicare program. *Id.* § 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. *Id.* § 498.5(*l*)(2).

III. Evidentiary Rulings

Petitioner objects to the admission of CMS Ex. 6 and CMS Ex. 7, which Petitioner calls "new evidence" that was not provided to him at the time of the initial determination or reconsideration level of review. P. Obj. at 1. CMS Ex. 6 is an affidavit from a "Senior Operations Analyst" at Palmetto. CMS Ex. 7 consists of printouts from Medicare's Master Health Insurance Records, which show birth dates and death dates of certain Medicare beneficiaries, as well as the claim information that Petitioner submitted related to those beneficiaries. Petitioner makes no other specific argument to support his objections, but generally notes the bases for his objection to both proposed exhibits are "foundation, authenticity, reliability, hearsay, and the best evidence rule." P. Obj. at 1-2. Petitioner also states that the affiant in CMS Ex. 6 has not yet been subject to cross-examination. P. Obj. at 1.

The regulations grant an ALJ broad discretion with regard to receiving evidence, even if that evidence is generally inadmissible under the Federal Rules of Evidence. 42 C.F.R. § 498.61. There is some restriction on receiving "new evidence" from a provider or supplier at the ALJ level of review in enrollment appeals, although the plain language of the regulation does not limit the "new evidence" that CMS may offer at the ALJ level of review. *See* 42 C.F.R. § 498.56(e). Accordingly, even if CMS Ex. 6 and CMS Ex. 7 are "new evidence" at this level of review, the regulations do not bar their admission.

Petitioner's general objections are overruled. Petitioner has been on notice of the allegations against him, and CMS Ex. 6 and CMS Ex. 7 provide CMS's support of those allegations. Petitioner has had an opportunity to respond to this evidence. Therefore, simply because Petitioner has not seen this evidence before this level of review does not mean they should be precluded from my consideration after Petitioner has had an opportunity to review them and respond to them, which he has. Moreover, Petitioner has not offered any argument or other evidence suggesting that the information included in CMS Ex. 7 is inaccurate or something other than what CMS purports it to be. The evidence appears to be very germane to the full consideration of the case, and therefore appropriate for my consideration. In addition, I find Petitioner's general listing of objections as wholly insufficient to create a dispute over the authenticity or accuracy of the document. I also note that CMS Ex. 6 sufficiently authenticates CMS Ex. 7 for my consideration in this case. CMS Ex. 6 is an affidavit submitted in support of a motion for summary judgment, which Rule 56(c)(4) of the Federal Rules of Civil Procedures generally permits. While I receive CMS Ex. 6 into the record for consideration, I note

that any inferences that may be drawn from that affidavit are construed in favor of Petitioner.

In the absence of any further objections, I receive CMS Exs. 1-7 and P. Exs. 1-8 into the record for consideration.

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 of any material fact in this case. CMS presented evidence showing that Petitioner submitted claims for services that could not have been provided to a specific individual on the date of service. Petitioner does not dispute that he or his billing agent submitted these claims on his behalf, but he argues that the claims at issue contained clerical errors and were "not based on any fraudulent or improper intent." P. Ex. 1 at ¶¶ 6-7; P. Br. 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 regulation applicable in this case does not necessarily require a "pattern of improper billing," which derives solely from the preamble, nor does it expressly exclude clerical errors as a basis for revocation. *See* 42 C.F.R. § 424.535(a)(8). Any evidence or factual inferences that may be drawn showing that the claims submitted by Petitioner or his billing agent 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, solely for purposes of summary judgment, that Petitioner did not intend to defraud Medicare and that the improper claims submitted were the result of clerical errors of Petitioner's billing agent.

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 services.

In support of its motion for summary judgment, CMS presented the results of an investigation that show 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 Ex. 7; CMS Ex. 6 at 2; CMS Ex. 3 at 3; CMS Ex. 2. In response, Petitioner does not directly dispute that he or his billing agent submitted the claims in question. However, Petitioner argues that the billing errors were the result of an "auto-fill" feature of the billing system used by Petitioner's office, and that the services described in the claims at issue were in fact rendered to living Medicare beneficiaries with names similar to those of the deceased Medicare beneficiaries identified in the claims. P. Br. at 2. With regard to all of the claims at issue, Petitioner qualifies them as billing mistakes, accidental, and not rising to the level of abuse or a "pattern of improper claims." P. Br. at 8-9; P. Ex. 1 at ¶¶ 6-7.

The evidence shows that Petitioner or Petitioner's billing agent submitted 17 claims for services that Petitioner performed after the beneficiary identified on the claim had died. CMS Ex. 7. For example, CMS has presented evidence showing that a beneficiary with the initials "W.S.W." was born on October 16, 1926, and died on November 9, 2012. CMS Ex. 7 at 21. Petitioner submitted a Medicare claim for services rendered to W.S.W. on January 18, 2013 (CMS Ex. 7 at 22) and June 21, 2013 (CMS Ex. 7 at 23), both of which occurred after W.S.W. had died. As noted, Petitioner argues that he provided care to living Medicare beneficiaries with the same or similar names to the deceased beneficiaries identified on the submitted claims. Indeed, Petitioner showed that he had previously provided services to W.S.W. (CMS Ex. 2 at 117-19), and provided services on January 18, 2013, and June 21, 2013, to an individual with the same last name as W.S.W. but a different first and middle name. CMS Ex. 2 at 109-16. Yet it is undisputed that

Petitioner then submitted claims as though he had performed those services on W.S.W., who was several months deceased at that point. In another example, a beneficiary with the initials "D.J.S." was born on September 27, 1924, and died on January 21, 2013. CMS Ex. 7 at 17. Petitioner submitted a Medicare claim for services rendered to D.J.S. on February 12, 2013 (CMS Ex. 7 at 18), which occurred after D.J.S. had died. Petitioner's records show that he provided service to another beneficiary with the same first and last names as D.J.S., but those records clearly show the birthday for the beneficiary receiving service was March 30, 1928, distinguishing her from D.J.S., who was ultimately identified on the claim Petitioner submitted. CMS Ex. 4 at 3, 7; CMS Ex. 7 at 18; CMS Ex. 2 at 101. It is clear from the treatment sheets in the record that Petitioner confused D.J.S., a former patient of his, with the actual beneficiary receiving treatment. *See* CMS Ex. 4 at 11. Petitioner has explained that the identification mistakes were "auto-fill" errors in the claims submission process. P. Br. at 12-13; P. Ex. 1 at ¶ 6.

Ultimately, Petitioner's evidence does not create a genuine dispute about whether he or his billing agent submitted the claims at issue to Medicare, or about whether those claims identified deceased beneficiaries as receiving treatment. Regardless of whether Petitioner provided the claimed services to living beneficiaries — which I accept as true for purposes of summary judgment — the claims he submitted to Medicare (or that his agent submitted on his behalf) identified *deceased* Medicare beneficiaries, which is a trigger for CMS's revocation authority under section 424.535(a)(8).[4] Therefore, Petitioner has not come forward with evidence to refute CMS's evidence that shows he submitted claims for services that could not have been provided to a specific beneficiary because that beneficiary was dead.

Petitioner attempts to create a dispute of fact by disputing CMS's evidence that the beneficiaries identified in the 17 claims were in fact deceased at the time of service, although Petitioner offers no evidence demonstrating the contrary to be true. Petitioner relies primarily on *D & G Holdings*, DAB CR3120 (2014), in which another ALJ rejected CMS's attempt to prove the deaths of beneficiaries by listing them in a summary chart. *See* DAB CR3120 at 21. But the ALJ's reasoning in *D & G Holdings* for rejecting CMS's summary evidence (including Rule 10 of the Federal Rules of Evidence) is not applicable to the case before me. Here, CMS has presented evidence of the deaths of beneficiaries through printouts of CMS "Health Insurance Master Records" that CMS, in turn, compiled from the records of the Social Security Administration. CMS Ex. 7; CMS

[4] Petitioner incorrectly states that CMS must show "impossibility of service" in order to revoke under 42 C.F.R. § 424.535(a)(8). P. Br. at 10. Relying on that misunderstanding, Petitioner points out that he provided service on the dates in question and CMS could not prove "impossibility" of that service. P. Br. at 10-13. However, the regulation actually requires that CMS show impossibility of service to a specific individual identified in the claim submitted, which is a much narrower requirement than Petitioner's understanding of the regulatory standard. *See* 42 C.F.R. 424.535(a)(8).

Ex. 6 at ¶ 9. CMS has not simply listed the dates of death as it appears to have done in *D & G Holdings* but instead provided unrefuted evidence from a CMS database showing the dates of death for the 11 Medicare beneficiaries identified in the 17 claims at issue. CMS Ex. 7. The evidence presented here 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. 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.

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

Once CMS had determined that Petitioner submitted a claim or claims that could not have been furnished to specific individuals on the dates of service, it was then authorized to revoke Petitioner's Medicare billing privileges. 42 C.F.R. § 424.535(a)(8). Here, there are 17 instances where Petitioner submitted a claim for a service that could not have been furnished to a specific individual on the date of service because the specific individual identified was deceased at that time. Petitioner has offered statistical estimates of his Medicare claims for payment, arguing that the instances of improper billing leading to revocation were so minor that he was clearly not attempting to defraud Medicare or otherwise have some type of improper pecuniary gain. P. Br. at 2-3. Petitioner repeatedly claims that all of the identified billing errors were "innocent and isolated mistakes." *See* P. Br. at 11.

The operative language of the revocation provision applicable in this case does not require that CMS demonstrate Petitioner intended to defraud Medicare before it may revoke Petitioner's billing privileges. *See* 42 C.F.R. § 424.535(a)(8). It merely requires the existence of improper claims. *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."). In addition, the regulation does not suggest that a certain minimum percentage of total improper claims is tolerable before CMS may revoke a supplier's Medicare billing privileges. 42 C.F.R. § 424.535(a)(8); *see also Howard B. Reife, D.P.M.*, DAB No. 2527 at 7 (2013) ("There is also no requirement in the regulation (or the preamble) establishing a minimum claims error rate . . . that must be exceeded before CMS may revoke billing privileges."). Therefore, Petitioner's claims that he did not act fraudulently by submitting his improper claims and that his error rate was extremely low are not sufficient to negate CMS's authority to revoke Petitioner's billing privileges pursuant to 42 C.F.R. § 424.535(a)(8).

The drafters of the regulation suggest that CMS must demonstrate that Petitioner's billing practices showed a pattern of improper billing, that is, a pattern of making claims that

could not have been furnished to specific individuals on the dates of service. *Id.*; *see* 73 Fed. Reg. at 36,455 ("[T]his basis for revocation is directed at providers and suppliers who are engaging in a pattern of improper billing."). As explained above, CMS demonstrated in 17 instances that Petitioner engaged in such a "pattern of improper billing" for services that could not have been furnished to specific individuals on the dates of service. According to the regulatory drafters, a "pattern of improper billing" occurs when there are three or more instances of improper billing, which is undisputedly the case with Petitioner. 73 Fed. Reg. at 36,455. Despite Petitioner's extrapolation of his improper billing over several years, neither the regulation nor the preamble allow repeated improper billing over an extended period, so long as it is sufficiently spread out over that period. The regulation simply requires "a claim or claims" that are improper before revocation is authorized, and the preamble explains that a "pattern of improper claims" occurs after three or more improper claims without reference to any timeframe of how soon after one another those improper claims must occur. As I noted in *Howard B. Reife, D.P.M.*, DAB CR2728 at 6 (2013), "Repeatedly making [the] same errors [in the Medicare claims at issue] reduces their credibility as 'accidental' and establishes a pattern of improper billing that suggests a lack of attention to detail considering Petitioner could have differentiated the patients through their birthdates or Medicare numbers." Also, Petitioner's argument implies that his errors were evenly spaced out over four years, when the evidence actually shows that 10 of the 17 claims at issue occurred in the first nine months of 2013, and seven of those claims occurred between January 2013 and June 2013. CMS Ex. 3 at 3. Thus, Petitioner's repeated errors in this case are sufficient to establish a "pattern of improper claims" under the standard stated in the preamble. Petitioner's attempt to show that his improper claims were a *de minimus* amount of his overall proper claims submissions is not material. *See Reife*, DAB No. 2527 at 7.

Finally, Petitioner's argument that he provided the services claimed, albeit to living beneficiaries with names similar to those deceased beneficiaries identified in the claims at issue, does not undermine CMS's authority to revoke Petitioner's billing privileges. As another ALJ explained in a similar case addressing a similar argument:

> Petitioner's argument overlooks that the regulation authorizing revocation requires that the improper claim be for services that Petitioner could not have provided to "a *specific* individual," not just "an individual." 42 C.F.R. § 424.535(a)(8) (emphasis added). Contrary to Petitioner's argument, the regulation requires specificity with reference to whom the services were allegedly provided, not a generic identification of any individual. The specific individual identified in a claim must be the specific individual who received the services claimed, otherwise the claim is for services that could not have been provided to "a specific individual," and revocation is permissible. *Id.*

Louis J. Gaefke, D.P.M., DAB CR2785 at 9 (2013), *aff'd*, DAB No. 2554 at 8 n.7. The Board has also concluded that the revocation authority in section 424.535(a)(8) hinges on the appropriate identification of a beneficiary in Medicare claims:

> While section 424.535(a)(8) provides that "abuse of billing privileges" involves submitting a claim or claims "that could not have been furnished to a specific individual on the date of service," 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., DAB No. 2542 (2013) (emphasis added). Thus, for the same reasons as stated in *Gaefke* and *Realhab*, I also reject Petitioner's argument that providing services to a living beneficiary not identified in the Medicare claims at issue absolves him from the revocation of his Medicare billing privileges for submitting Medicare claims that identified beneficiaries who were deceased at the time of service. I also note that Petitioner's argument that he confused his patients' names and identifying information is troubling inasmuch as Petitioner surely should know the identity of the patient to whom he is providing treatment. *See* P. Br. at 2-4; P. Ex. 1 at ¶¶ 4-6; *see also* CMS Ex. 4 at 11 (wrongly identifying D.J.S. as the beneficiary receiving treatment on February 12, 2013, a month after D.J.S. had died).

4. The effective date of the revocation of Petitioner's billing privileges is October 4, 2014.

Palmetto notified Petitioner by notice dated September 4, 2014, that it was revoking his billing privileges effective September 27, 2013. CMS Ex. 1 at 1. It is unclear how the contractor determined the effective date of Petitioner's revocation to be 23 days after the initial revocation notice, although CMS now acknowledges that the effective date the contractor established is improper. CMS Br. at 4 n.2. The regulation provides that the revocation of a provider or supplier's Medicare billing privileges is effective 30 days after CMS or its contractor issues the notice of revocation determination, unless certain exceptions apply. 42 C.F.R. § 424.535(g). None of the exceptions listed in section 424.535(g) apply to this case. Therefore, the effective date of Petitioner's revocation must be, as a matter of law, October 4, 2014.

5. Petitioner has not demonstrated due process violation as there has been an opportunity for Petitioner to present evidence and respond to CMS's allegations.

Petitioner argues that the contractor and CMS violated his due process rights because the revocation notices did not comply with the regulatory requirement that the notice provide Petitioner with enough information to make an adequate response. P. Br. at 18-20.

A zone program integrity contractor for CMS provided Petitioner notice on January 22, 2014 – over eight months before Palmetto revoked his Medicare billing privileges – of 19 claims for 12 separate beneficiaries that were improper. *See* CMS Ex. 3 at 3. Of those claims and beneficiaries identified with the January 22, 2014 letter, 17 claims and 11 beneficiaries form the basis for revoking Petitioner's billing privileges. 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.

Even if there were delays in CMS or its contractor in providing Petitioner with specific information about the improper claims after the initial determination, CMS's actions or omissions do not justify granting Petitioner relief in the form of judgment in his favor or remand to CMS. Petitioner has received timely notice of the action, received specific information about the revocation before CMS rendered the reconsidered determination, and has since had ample opportunity to defend himself at this level. *See Gaefke*, DAB No. 2554 at 10-11. CMS submitted its brief and exhibits first in this proceeding, and Petitioner had an opportunity to, and effectively did respond to these arguments and evidence. CMS submitted all of the documents from its investigation that it relied on to revoke Petitioner's billing privileges as well as a copy of documents Petitioner provided to CMS during the reconsideration stage. CMS Exs. 1, 3. Petitioner, in response, filed a thorough argument, substantive exhibits, and the written testimony of two witnesses (P. Exs. 1-2), all of which has been considered in reaching this decision.

Due process is afforded when, such as here, Petitioner was given 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 facts and CMS is entitled to judgment affirming its revocation of Petitioner's Medicare billing privileges. However, the effective date of the revocation of Petitioner's billing privileges is modified to October 4, 2014.

/s/
Joseph Grow
Administrative Law Judge