Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Access Foot Care, Inc., and Robert Metnick, D.P.M.
Docket No. A-16-3
Decision No. 2752
December 8, 2016

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Petitioners Access Foot Care, Inc. (Access), and Robert Metnick, D.P.M. (Dr. Metnick), appeal the August 11, 2015 decision of an Administrative Law Judge (ALJ) sustaining the revocation of Petitioners' Medicare billing privileges. *Access Foot Care, Inc./Robert Metnick, D.P.M.*, DAB CR4113 (2015) (ALJ Decision). The Centers for Medicare and Medicaid Services (CMS), through its contractor, First Coast Service Options, Inc. (FCSO), revoked the suppliers' Medicare billing privileges because they submitted "claims for services that could not have been furnished to a specific individual on the date of service" pursuant to Title 42 of the Code of Federal Regulations (C.F.R.), section 424.535(a)(8). Petitioners did not dispute that they submitted 13 claims for payment to Medicare for services Petitioners could not have delivered to the named beneficiaries. For the reasons explained below, we sustain the ALJ Decision.

Applicable legal authorities

The Social Security Act provides for CMS to regulate the enrollment of providers and suppliers in the Medicare program. Social Security Act § 1866(j)(1)(A); 42 U.S.C. § 1395cc(j)(1)(A). The regulations in 42 C.F.R. Part 424, subpart P, set out the requirements for establishing and maintaining Medicare billing privileges. In order to receive payment for services furnished to Medicare beneficiaries, a provider or supplier must be "enrolled" in Medicare and maintain active enrollment status.[1] 42 C.F.R. §§ 424.500, 424.505, 424.510, 424.516. 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:

[1] The term "suppliers" also includes physicians and other non-physician health care practitioners. 42 C.F.R. § 400.202 (stating that, unless the context indicates otherwise, "[s]upplier means a physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare."

> (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.[2]

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 supplier's billing privileges, the supplier is "barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar." 42 C.F.R. § 424.535(c).[3] The re-enrollment bar must last for a minimum of one year but may not exceed three years, "depending upon the severity of the basis for revocation." *Id.* Revocation also results in the termination of the provider's or supplier's agreement with Medicare. *Id.* § 424.535(b).

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[2] This subsection was substantially revised effective February 3, 2015 (79 Fed. Reg. 72,500, 72,532 (Dec. 5, 2014)), however, we apply the regulation as in effect at the time of the notice of revocation.

[3] While we note that CMS has issued a Proposed Rule which would increase the maximum reenrollment bar from three years to 10 years (with certain exceptions) (81 Fed. Reg. 10,720, 10,732, 10751 (Mar. 1, 2016)), we apply the regulation as in effect at the time of the notice of revocation.

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), 498.3(b)(17), 498.5(l)(1)-(3), 498.22(a).

Case Background[4]

1. *Notice of Revocation and Petitioners' response*

Dr. Metnick is the owner of Access, a podiatry practice group. P. Ex. 14, at 1; CMS Ex. 1, at 6, 8, 15, 17. Through Access, Dr. Metnick submitted 13 claims to CMS for services rendered to 11 beneficiaries who were deceased on the claimed dates of service. ALJ Decision at 2, citing CMS Exs. 2, 6, 7. In separate but substantially identical letters dated October 3, 2014, addressed respectively to Dr. Metnick and to Access, FCSO notified Petitioners that it was revoking their Medicare billing privileges for a period of one year, effective November 2, 2014, on the basis of 42 C.F.R. § 424.535(a)(8). P. Exs. 1, 2. Dr. Metnick received the letter addressed to Access but he did not simultaneously receive the letter addressed to him.[5] In the letters, FCSO describes Petitioners' abuse of billing privileges, stating in pertinent part:

> Your Medicare privileges are being revoked effective November 2, 2014, for the following reasons:
>
> **42 CFR § 424.535(a)(8) Abuse of Billing Privileges**
>
> **Specifically:** Dr. Robert Metnick, 5% owner of Access Foot Care, Inc., previous data analysis revealed that Dr. Metnick had submitted billing for ten deceased beneficiaries. As a result, Dr. Metnick received education regarding appropriate methods of billing. . . . A subsequent data analysis was conducted on claims billed by Dr. Metnick, through Access Foot Care, Inc., and it was found that the provider continued to bill for eleven additional deceased beneficiaries after he received education and submitted a compliance plan.

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[4] Background information is drawn, unless otherwise indicated, from the ALJ Decision and the record before the ALJ and is not intended to substitute for his findings.

[5] Although FCSO's letter addressed to Dr. Metnick was sent via certified mail on October 3, 2014, FCSO acknowledges that the letter addressed to Dr. Metnick was not delivered simultaneously with the letter FCSO sent to Access. *See* CMS Ex. 2 at ¶ 7. The parties acknowledge that a representative from FCSO notified Dr. Metnick in January 2015 that FCSO had revoked his Medicare billing privileges, effective November 2, 2014, but the record is silent as to how FCSO provided this notice. P. Request for Hearing at 2. On February 3, 2015, Dr. Metnick received the revocation letter addressed to him from FCSO, dated October 3, 2014. *Id.* We discuss this in more detail below.

P. Ex. 1 (bold type in the original); *see also* P. Ex. 2 (letter to Metnick). FCSO also notified Petitioners that they could submit a corrective action plan (CAP) within 30 days, and that they could request reconsideration within 60 days. *Id.*

On October 16, 2014, attorney JKW wrote to FCSO, on behalf of both petitioners, seeking additional information. P. Ex. 6. Specifically, JKW wrote:

> [t]his law firm represents Access Foot Care Inc. and its owner, Robert Metnick, DPM. [. . .] I am responding to your letter of October 3, 2014 (attached) to request additional information.

Id. at 1.[6] FCSO responded by letter dated October 27, 2014, with the requested information. P. Ex. 7. Petitioners elected to submit a CAP and to request reconsideration, utilizing attorneys from one law firm, including JKW, for the CAP and attorneys from another law firm, including EMB (later EMF)[7], for the reconsideration request. *See* P. Exs. 3, 4, 6. On October 29, 2015, JKW submitted a proposed CAP on behalf of Access and Dr. Metnick. P. Ex. 3. By letter to attorney EMB dated December 31, 2014, FCSO rejected the CAP submitted by attorney JKW. P. Ex. 8.

On November 17, 2014, attorney EMB timely filed a reconsideration request on behalf of Access. P. Ex. 4. In the narrative attached to the reconsideration request form, counsel states: "As is evident from these explanations, neither Dr. Metnick nor Access has knowingly or intentionally billed for services provided to deceased beneficiaries." *Id.* at 5.

On January 9, 2015, attorney EMF wrote to First Coast to supplement Access's reconsideration request. P. Ex. 5. The 65-page supplement (which EMF incorporated by reference into the original reconsideration request) consists of previous submissions to FCSO from JKW and from EMF on Petitioners' behalf. *Id.* at 1, 12. On February 3, 2015, Dr. Metnick received written notice of revocation of his individual billing privileges dated October 3, 2014 (P. Ex. 2; CMS Ex. 4). P. Request for Hearing (RFH) at 2.

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[6] The letter mentioned here is the letter addressed to Access.

[7] It appears from the law firm's letterhead that the attorney changed surnames between November 2014 and January 2015. *See* P. Exs. 4, 5.

2. *CMS's Reconsidered Determination*

On March 31, 2015, CMS issued a reconsidered determination, addressed to attorney JKW and "Access Foot Care, Inc/Robert Metnick, DPM." CMS upheld FCSO's initial determination to revoke Petitioners' Medicare billing privileges, concluding:

> All of the documentation in the file for Access Foot Care Inc. (Access) has been reviewed and the decision has been made in accordance with Medicare guidelines, as outlined in 42 CFR §424.535. Based on CMS' analysis, the unfavorable decision rendered by FCSO stands that there was an abuse of billing privileges when Dr. Metnick billed for services that were alleged to have been rendered to 10 deceased beneficiaries.
>
> **The reconsideration submitted on behalf of Dr. Metnick** claimed unintended and inadvertent billing entry errors as the crux of the revocation reason. The provider further attributed the revocation reason to patient identifier errors, transposing errors, and patient name similarities. The reconsideration also claims that CMS did not provide reimbursement for the claims submitted; however, Dr. Metnick was on notice that there were multiple and continuous billing errors when each claim was denied. CMS has become aware, through subsequent data analysis of Dr. Metnick's billing, that these errors have continued; therefore CMS does not view this abuse of billing privilege as a clerical error or oversight.

CMS Ex. 11, at 2 (emphasis added). Petitioners sought ALJ review.

3. *Petitioners' Request for ALJ Hearing*

Petitioners made four contentions in their request for hearing: 1) FCSO failed to properly notify Dr. Metnick that it had revoked his individual Medicare billing number; 2) Petitioners did not engage in abusive billing practices; 3) FCSO's findings were improper; and 4) the one year revocation period is "excessive and punitive." *See* RFH. Regarding notice of the revocation of Dr. Metnick's billing number, Petitioners contend that, although Dr. Metnick learned "[i]n January 2015 . . . that his individual PTAN had apparently been revoked," it was not until "on or around February 3, 2015 [that] Dr. Metnick received correspondence from FCSO regarding the revocation of his individual billing privileges, which was dated October 3, 2014." RFH at 2. Petitioners argued that Dr. Metnick's "individual Medicare billing privileges were revoked without proper notice and without being afforded any appeal rights." *Id.*

CMS moved for summary judgment, arguing that the material facts in the case – that Petitioners had "submitted 13 claims to CMS for services allegedly provided to 11 beneficiaries who were deceased on the alleged dates of service" – were not in dispute. CMS Motion for Summary Judgment and Brief in Support (CMS MSJ). In addition, CMS argued, in sum, that Dr. Metnick received sufficient notice of revocation when he received the notice addressed to Access, that he was afforded reasonable opportunity to respond to the notice, and that the delayed notice resulted in no prejudice to Dr. Metnick's due process rights. *See* CMS MSJ at 6-7.

ALJ Decision

The ALJ granted summary judgment for CMS as to both Access and Dr. Metnick. ALJ Decision. In his decision, the ALJ rejected Petitioners' contention that their intentions (when they filed claims for services they could not have provided) were relevant and material to the outcome of the appeal. Specifically, the ALJ found, Petitioners' intentions notwithstanding, that it was undisputed that Dr. Metnick caused Access to "submit 13 claims for podiatric services that he allegedly provided to Medicare beneficiaries who were, in fact, deceased at the time that the services allegedly were rendered." ALJ Decision at 2. He rejected as immaterial Petitioners' argument that the claims were submitted accidentally, "and thus, cannot be the basis for revocation," concluding that –

> [o]n its face, 42 C.F.R. § 424.535(a)(8) does not distinguish between false claims that are filed accidentally and those that are fraudulent or filed with willful disregard of their truth. The regulation states only that the filing of claims on behalf of beneficiaries who are deceased on the purported service dates is grounds for revocation. [. . .] The regulation does not require proof of intent to defraud or even negligence to justify revocation.

Id. at 3, citing *Howard B. Reife D.P.M.*, DAB No. 2527, at 4 (2013). Further, the ALJ found that Petitioners "concede that they submitted claims for eight beneficiaries who were deceased on the purported services dates . . . [and] [t]hey do not deny that they may have filed the other claims asserted by CMS . . . ." *Id*. at 3-4. Thus, the ALJ concluded that "the undisputed facts" satisfied the requirement that CMS show that "there are 'multiple instances, at least three, where abusive billing practices have taken place'" as explained in the preamble to the final rule publishing section 424.535(a)(8),[8] found at 73 Fed. Reg. at 36,455. *Id*. at 3.

[8] The ALJ acknowledged that 42 C.F.R. § 424.535(a) was amended in December 2014 and correctly applied the version of the regulation in effect at the time CMS revoked Petitioners' billing privileges. We note that the ALJ Decision refers to 42 C.F.R. §§ "424.538(a)" and "484.538(a)" which we conclude are typographical errors. *See* ALJ Decision at 4.

The ALJ rejected Petitioners' contentions that revocation should not apply because they were not paid for the claims at issue, that CMS erred in not accepting Petitioners' proposed CAP, and that the one year bar to re-enrollment was excessive. The ALJ concluded that the fact that Petitioners "gained no remuneration from the claims that are at issue" is "no defense," that Petitioners' have "no right to a hearing to challenge CMS's determination not to accept a corrective action plan" (citing 42 C.F.R. §498.3(b)), and that "applicable regulations specify that where participation and billing privileges are revoked, the period during which re-enrollment is prohibited must be a minimum of one year," citing 42 C.F.R. § 424.535(c). *Id.* at 5. The ALJ did not address Petitioners' argument that Dr. Metnick was denied due process because CMS did not properly provide notice of the revocation of his billing privileges. This appeal followed.

Standard of Review

Whether summary judgment is appropriate is a legal issue that we address de novo. *Mission Hosp. Reg'l Med. Ctr.*, DAB No. 2459, at 6 (2012), *aff'd, Mission Hosp. Reg'l Med. Ctr. v. Sebelius,* No. SACV 12-01171 AG (MLGx), 2013 WL 7219511 (C.D. Cal. May 31, 2013), *aff'd, Mission Hosp. Reg'l Med. Ctr. v. Burwell*, 819 F.3d 1112 (9th Cir. 2016); *1866ICPayday.com*, DAB No. 2289, at 2 (2009), citing *Lebanon Nursing & Rehab. Ctr.*, DAB No. 1918 (2004).

Summary judgment is appropriate if there is no genuine issue of fact material to the result and the moving party is entitled to judgment as a matter of law. *See Livingston Care Ctr.*, DAB No. 1871, at 5 (2003), *aff'd*, *Livingston Care Ctr. v. U.S. Dept. of Health & Human Servs*., 388 F.3d 168, 172-73 (6th Cir. 2004); *Everett Rehab. & Med. Ctr.*, DAB No. 1628, at 3 (1997), citing *Travers v. Shalala*, 20 F.3d 993, 998 (9th Cir. 1994). The Board construes the facts in the light most favorable to the appellant and gives it the benefit of all reasonable inferences. *See Livingston Care Ctr*. at 5.

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/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/enrollment/index.html?language=en.

Analysis

The administrative record supports the ALJ's entry of summary judgment for CMS because it is undisputed that Petitioners submitted 13 claims for podiatric services which could not have been delivered because the named beneficiaries were deceased on the dates of service. In affirming the ALJ, we first address the ALJ's grant of summary

judgment in favor of CMS. Next, we address Petitioners' contentions that Dr. Metnick was denied his appeal rights because Dr. Metnick's individual Medicare billing privileges were revoked without proper notice.

1. *Summary judgment was appropriate in this case*.

In their request for review, Petitioners argue that the ALJ erred because: 1) the ALJ failed to recognize that, in Petitioners' view, 42 C.F.R. § 424.535(a)(8) distinguishes between accidental false claims and fraudulent or willful false claims, and 2) the ALJ found that Petitioners engaged in a pattern of abusive claims and that the claims at issue were not mere "accidents." Request for Review at 1, 6. These arguments are without merit. Petitioners do not challenge on appeal to the Board the ALJ's decision upholding the one-year duration of the revocation or declining to review CMS's decision to deny the requested CAP. We find no error in these portions of the ALJ's decision. Therefore, we leave these portions of the ALJ's decision undisturbed without further comment.

a. Section 424.535(a)(8) does not distinguish between accidental false claims and fraudulent or willful false claims; the ALJ did not apply a strict liability standard to Petitioners' appeal; and section 424.535(a)(8) does not contain a good faith exception.

In their request for review, Petitioners argue that the ALJ failed to distinguish their accidental improper claims from fraudulent and willful improper claims. They contend that the ALJ erred by applying a "strict liability" standard to their accidental false claims instead of applying an exception for good faith mistake, stating, in pertinent part -

> The regulation as written and interpreted, including by [the ALJ] in this case, significantly overreaches by failing to distinguish between "false claims that are filed accidentally and those that are fraudulent or filed with willful disregard for the truth." *See* Decision, p. 3. In other words, honest providers are compared to, and disciplined the same as, those providers who intentionally engage in improper and sometimes illegal conduct. . . .
>
> The intended purpose of 42 C.F.R. § 424.535(a)(8), based on the commentary to the Final Rule, is to punish providers and suppliers "who are engaging in a pattern of improper billing." 73 FR 36448, at *36455. It "is ***not*** intended to be used for isolated occurrences or accidental billing errors." *Id*. (emphasis added)[.] Since the rule and its interpretations have provided little guidance regarding what is considered a "pattern of improper billing" versus "isolated occurrences or accidental billing errors," CMS, its contractors, and Administrative Law Judges with the Office of Medicare Hearings and Appeals have all applied this regulation using strict liability. By way of example, [the ALJ] points out that, "The regulation states only

> that the filing of claims on behalf of beneficiaries who are deceased on the purported service dates is grounds for revocation." Decision, p. 3. In other words, the act of filing the claim in and of itself rises to the level of revocable conduct. . . .
>
> The drafters made clear that the value in this regulation is to "enable [DHHS] to take an important step in protecting the expenditure of public monies for service providers whose motive and billing practices are questionable, at best, and at worst, of a sort that might prompt an aggressive response from the law enforcement community." [Citation omitted.] Through their commentary, the drafters inferred an intent to carve-out an exception for those providers who inadvertently and accidentally but in good faith submit improper claims and do not have questionable motives or billing practices.

Request for Review at 3-4.[9]

Neither the preamble to the Final Rule nor the plain language of the regulation establishes a strict liability standard for improper billing or creates an exception for accidental billing. To the contrary, the Final Rule establishes that CMS and its contractors will exercise discretion in determining whether revocation for improper billing is appropriate.

The preamble to the Final Rule does provide guidance as to what may show a pattern of abusive billings by stating that CMS will *not* revoke Medicare billing privileges for improper billing *unless* the improper billing consists of "multiple instances" of abusive billing. The preamble further explains that improper billing is abusive if, for example (as is the case here), "a provider or supplier submits a claim or claims for services that could not have been furnished to a beneficiary." 73 Fed. Reg. at 35,455, 36,457. The preamble explains that this policy arises from CMS's experience with "numerous examples of situations where a physician or other practitioner has billed for services furnished to beneficiaries that are undeliverable, including but not limited to situations where the beneficiary was deceased." *Id.* While Petitioners may disagree with the way CMS exercised its discretion in this case, it is not true that CMS or the ALJ applied a strict liability standard when analyzing Petitioners' abusive billing. The theory of "strict liability" is a tort concept which in prior cases we have found to be inapplicable in the administrative enforcement context. *Libertywood Nursing Ctr.* DAB No. 2433, at 14 (2011), *aff'd Libertywood Nursing Ctr. v. Sebelius*, 512 F. App'x 285 (4th Cir. 2013),

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[9] Contrary to what Petitioner indicates, the Administrative Law Judges of the Office of Medicare Hearings and Appeals do not review CMS's provider and supplier enrollment determinations. A supplier whose Medicare enrollment has been revoked may request that CMS reconsider such determination, and may seek ALJ review of the reconsideration decision, as well as appeal the ALJ's decision to the Board, in accordance with the procedures at 42 C.F.R. Part 498. *See* 42 C.F.R. § 424.535(b)-(c).

citing *Briarwood Nursing Ctr.*, DAB No. 2115, at 11 n.8 (2007). Nothing Petitioners have presented in this case changes our view. Moreover, revocation is not a mandatory consequence but a measure which CMS may take after exercising discretion. Here, it was not improper for CMS to determine that Petitioners' multiple improper billings were abusive, and the ALJ did not err when he affirmed CMS's determination based upon the exercise of its discretion pursuant to the policy set forth and published in the Preamble to the Final Rule.

Petitioners also mistakenly assert that CMS must demonstrate that abusive billing practices by a supplier or provider are fraudulent or dishonest before it may revoke Medicare billing privileges. The Board has long held, most recently in *John P. McDonough III, Ph.D.*, *Geriatric Psychological Specialists, and GPS II, LLC*, DAB No. 2728 (2016), that the plain language of the regulation does not require CMS to establish fraudulent or dishonest intent to revoke a supplier's billing privileges under this section and that "[t]he regulatory language also does not provide any exception for inadvertent or accidental billing errors." *McDonough* at 7 (*citing Louis J. Gaefke, D.P.M.*, DAB No. 2554, at 7 (2013)). The Board has rejected the contention that a supplier who has submitted claims for "services that could not have been furnished to a specific individual on the date of service" under section 424.535(a)(8) must also be proven to have done so intentionally. *Patrick Brueggeman*, *D.P.M.*, DAB No. 2725, at 8 (2016). The Board further stated in *Brueggeman*, "'[n]othing 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.'" DAB No. 2725, at 11, quoting *Gaefke* at 9-10 and *Howard B. Reife, D.P.M.*, DAB No. 2527, at 6 (2013). Similarly, the Board also recently "rejected . . . the idea that a supplier's intent in submitting improper claims of the kind described in section 424.535(a)(8) is relevant in a revocation case based on that subsection." *John M. Shimko, D.P.M.*, DAB No. 2689, at 5-6 (2016).

Petitioners argue that "[t]he ALJ erred in his findings of fact that the claims at issue were not mere 'accidents.'" Request for Review at 6. However, this argument is based on only part of a statement in the ALJ's decision, and Petitioners ask us to conclude that the ALJ's decision turned on whether the Petitioners' improper claims were intentional acts and not accidents. The ALJ wrote:

> [T]he undisputed facts establish that Petitioners' claims were *not* mere "accidents," at least not in the sense that they comprised only one or two innocent mistakes. Petitioners filed multiple false claims.

ALJ Decision at 3 (italics in original). This statement, taken in its entirety, shows that, while the ALJ noted that the billing errors were not accidents, under the framework from the preamble, he did not base his decision to uphold CMS's determination on that fact. The ALJ based his conclusion that revocation for abusive billing practices was appropriate here on the fact that there were multiple instances of improper billing (i.e., for services which could not be performed) which the preamble specifically identifies as an appropriate basis for revocation as abusive billing. *See* 73 Fed. Reg. at 36,455. The ALJ went on to state that "the regulation is not dependent on proving bad intentions." ALJ Decision at 4. Thus, the ALJ's analysis turns not on the cause of Petitioners' billing errors but on the undisputed fact that Petitioners repeated the error 13 times.

Ultimately, the ALJ did not err by declining to apply a non-existent exception for accidental improper claims. Similarly, the ALJ did not apply a strict liability standard, and therefore did not err, in finding CMS authorized to revoke on the basis identified in the regulatory history. Petitioners' arguments to the contrary provide no basis for the Board to depart from its established line of cases on these issues and to reverse the ALJ.

b. Petitioners engaged in a pattern of abusive billing under 42 C.F.R. § 424.535(a)(8) when they submitted 13 improper claims.

As we discussed above, Petitioners argue that their conduct does not satisfy the criteria for revocation because they "did not engage in a pattern of abusive claims as defined in 42 C.F.R. § 424.535(a)(8)." Request for Review at 5. Petitioners contend that they have "provided facts and explanations explaining why the 13 claims at issue do not establish a pattern." *Id*. at 5. However, Petitioners' contentions do not constitute a dispute of fact but rather are a dispute over the ALJ's legal interpretation of the applicable regulatory authority. In other words, the facts Petitioners proffer would be material only if they affected a relevant legal issue, which the ALJ concluded they did not. Our standard of review in such cases is whether the ALJ's decision is erroneous. *See Guidelines.* As explained below, we agree with the ALJ.

In arguing that no pattern of abusive billing practices was established, Petitioners dispute the meaning of the word "pattern" as used in the Final Rule, urging instead adoption of a dictionary definition for the word. Petitioners assert:

> Merriam-Webster defines pattern as "the regular and repeated way in which something happens or is done" or "something that happens in a regular and repeated way." The inadvertent submission of 13 claims out of 8,509 is clearly not the result of a regular and repeated way or action.

Request for Review at 5. Whether or not Petitioners have cited correctly a dictionary definition for the word "pattern," it is irrelevant to the ALJ's analysis, and the ALJ did not err by not applying it. There is no dispute that Petitioners submitted to FCSO 13 improper claims for payment. As the Board has recognized, the applicable definition of a pattern of abusive billing for purposes of revocation is in the preamble to the Final Rule. "[T]he submission of a claim for services that could not have been provided to the specific individual identified in the claim on the date of services was an abuse of billing privileges that could lead to revocation, and the preamble provided notice that the submission of at least three such claims would not be viewed as merely accidental." *McDonough* at 8.

Despite arguing that their conduct fails to meet the dictionary definition of a pattern, Petitioners acknowledge in their Request for Review that the ALJ applied the language in the Final Rule in formulating his analysis. Petitioners write:

> [I]n deciding how many instances are enough to uphold the revocation determination, [the ALJ] relies solely on an interpretive statement by the Secretary in 2008. More specifically, 73 Fed. Reg. 36,448, 36,455 (June 27, 2008) states "that revocations can be implemented where there are 'multiple instances, at least three, where abusive billing practices have taken place.'"

Request for Review at 6. Petitioners further observed that - -

> [n]either the Secretary, nor [the ALJ], provide clarification or guidance regarding the period of time over which these alleged abusive billing practices must occur in order for a pattern to be established. Here, the conduct occurred over a lengthy period of time and represents a very small fraction of [Petitioners'] total claims for that time period. This must be considered when determining whether revocation is appropriate, which it is not.

Id. The period of time at issue, however, is a mere seven months (February 2013 through August 2013). *Id*. at 5. Petitioners argue that the ALJ merely "parrots the language in the revocation regulation without full and fair consideration of the facts and circumstances in the case." *Id*. at 2. Petitioners ignore the discussion in the ALJ's decision of what he considered in arriving at his conclusion. In fact, the ALJ considered all of the facts and circumstances surrounding CMS's revocation decision. The ALJ wrote:

> These claims were not the first time that Petitioner Metnick had submitted claims for services allegedly rendered to beneficiaries who were deceased on the purported service dates. Petitioners previously had done the same

> thing and had filed a compliance plan that supposedly assured that they would not do so again. (Citations omitted.) [. . .] They [submitted improper claims] not once, but on multiple occasions. And, they did so after having been caught doing the same thing previously.

ALJ Decision at 2.

> The claims that are the basis for CMS's revocation determination were not the first instances of false claims filed by Petitioners. There was a previous episode and, like the current episode, they involved claims filed on behalf of beneficiaries who were deceased on the dates of purported service.

Id. at 3.

Petitioners' submission of 13 improper claims over seven months equals nearly two improper claims per month. Petitioners submitted 10 more improper claims than are needed to constitute a pattern under the Final Rule. Consequently, we find no merit in Petitioners' suggestion that the definition of a pattern set forth in the Final Rule is unclear or inadequate, or that Petitioners' conduct failed to constitute a pattern under the regulation.

Because Petitioners raised no genuine dispute of material fact before the ALJ, we conclude that the ALJ did not err in finding a pattern of abusive billing practices under 42 C.F.R. § 424.535(a)(8) or in granting summary judgment for CMS.

2. *Dr. Metnick received adequate notice of revocation and has been afforded appeal rights*.

Having reviewed and considered the entire record below, we conclude that Dr. Metnick received adequate notice of revocation and was afforded, and exercised, his appeal rights.

The Board has generally held that CMS can cure notice deficiencies during subsequent ALJ proceedings. *Green Hills Enters., LLC*, DAB No. 2199, at 8 (2008); *Fady Fayad, M.D.*, DAB No. 2266, at 10-11 (2009), *aff'd*, *Fayad v. Sebelius*, 803 F. Supp. 2d 699 (E.D. Mich. 2011). We have also held that no violation of due process occurs where deficient notice results in no prejudice. *Dinesh Patel*, *M.D.*, DAB No. 2551, at 8 (2013) (finding that there was no prejudice resulting from alleged inadequate notice where Petitioner did not "claim that the alleged notice deficiency impaired his ability to defend

himself before either the ALJ or the Board.").[10] In *Fayad*, the Board rejected Petitioner's argument that he had received insufficient and misleading notice of CMS's basis for revoking the physician's Medicare privileges (due to criminal conviction), holding that "[a]lthough the notice letter did not identify the conviction by name or date," the notice "advised Petitioner that the revocation was based on a conviction which had occurred within the prescribed 10-year period" and was "based on section 424.535." DAB No. 2266, at 10. In addition, the Board declined to overturn the revocation "because CMS cured any notice deficiency during the ALJ proceeding." *Id.* In *Patel*, the Board rejected Petitioner's argument that he "did not have adequate notice of the basis for the revocation of his Medicare billing privileges because CMS did not identify the specific subparagraph of section 424.535(a)(3) on which it relied." DAB No. 2551, at 7. Citing its decision in *Fayad* (which cited *Green Hills*), the Board concluded that "[g]iven the entirety of the factual circumstances surrounding Petitioner's [criminal] conviction set forth in the notice letter, we conclude that Petitioner should have reasonably understood that CMS revoked his Medicare billing privileges pursuant to section 424.535(a)(3)(i)(D) . . . ." *Id.* at 8. The Board reiterated its previously held opinion that it "will not find a due process violation absent a showing of resulting prejudice." *Id.* at 11, quoting *Fayad* at 11. By contrast, the deficiency here was late notice, and not incomplete or misleading notice.

Although Petitioners contend that Dr. Metnick's Medicare billing privileges were revoked without proper notice and without him being afforded appeal rights, evidence in the record does not support Petitioners' contention. Petitioners acknowledge learning in January 2015 of the October 3, 2014 revocation of Dr. Metnick's Medicare enrollment and billing privileges.[11] CMS and its contractor, FCSO, treated submissions made for Access as having been made for Dr. Metnick as well. Regarding the delayed notice to Dr. Metnick, Petitioners state:

> FCSO was contacted regarding this glaring deficiency; however, its position is that it considers Access and Dr. Metnick the same for purposes of revocation.

[10] These decisions follow a line of Board decisions in appeals of sanctions imposed on nursing homes by CMS (*e.g.,* termination of the provider agreement or imposition of civil monetary penalties) based on its finding that the nursing home failed to comply substantially with Medicare participation requirements. *See, e.g., Livingston Care Center*, DAB No. 1871 (2003), *aff'd*, *Livingston Care Ctr. v. U.S. Dep't of Health and Human Servs.,* 388 F. 3d 168 (6th Cir. 2004) (holding that defects in formal notice may be cured during the course of an administrative proceeding, and that as long as the party is reasonably apprised of the issues in the controversy during the proceeding and is given an opportunity to address those issues, the due process requirement is satisfied).).

[11] Petitioners do not explain how they learned in January 2015 that Dr. Metnick's Medicare enrollment and billing privileges had been revoked simultaneously with those of Access effective November 2, 2014.

RFH at 3. Thus, it appears Dr. Metnick was in touch with FCSO and received actual notice that revocation affected both Petitioners. Petitioners' submissions throughout the administrative review process show that Dr. Metnick was reasonably apprised of what was at issue and that he was given an opportunity to address those issues. In particular, as we discuss below, the language Petitioners used when seeking a CAP with FCSO clearly shows that Dr. Metnick was well aware that his Medicare enrollment and billing privileges were pending revocation.

3. *The Proposed Corrective Action Plan*

On December 31, 2014, FCSO denied the proposed CAP JKW had submitted on October 29, 2014.[12] *See* CMS Ex. 12, at 12-17; 23-24. The proposed CAP clearly reflects Petitioners' focus on reinstating *Dr. Metnick* to good standing with CMS and FCSO. *See id*. at 16. Notably, Petitioners do not argue that a CAP submitted exclusively in Dr. Metnick's name would have differed in any material way from the CAP FCSO denied. In fact, the substance of the CAP request is largely articulated as a request from *Dr. Metnick* promising corrective actions to be performed by *Dr. Metnick*. For example:

- The first line in JKW's cover letter is "[t]his firm represents the aforementioned Medicare provider relative to the revocation of *his* Medicare Part B billing privileges which is scheduled to go into effect on November 2, 2014." CMS Ex. 12, at 12 (emphasis added).
- The second paragraph begins "[a]s *Dr. Metnick's* counsel, I can unequivocally state *he is remorseful* that *his* Medicare number was accidentally used to bill for services for beneficiaries who had previously passed away." *Id*. (emphasis added).
- The next paragraph begins "Dr. Metnick personally verifies the patient's identity against the name on the room and verbally with the nursing assistant who is employed by the nursing facility." *Id*. The next three pages of the proposed CAP further detail Dr. Metnick's proposed remedial steps, including,
    - "Dr. Metnick and his new billing manager have implemented the following measures" (*id*. at 13);
    - "[w]e will immediately engage the services of Medical Compliance Associates, Inc. (MCA) to assess Dr. Metnick's knowledge of all podiatry billing and coding guidelines" (*id*.);

[12] The proposed CAP, submitted by attorney JKW, is captioned, in pertinent part:

Re: Access Foot Care Inc.
Robert Metnick, DPM
PTAN: K0540
NPI: 12575579740

- "Dr. Metnick will agree to a compliance audit to be completed on a sample of forty (40) encounters for Medicare Part B beneficiaries by MCA at the completion of a six month probationary period" (*id*. at 15);
- "Dr. Metnick will agree to a follow-up compliance review of a sample of another forty (40) encounters for Medicare Part B beneficiaries by MCA at the completion of one (1) year of probation" (*id*. at 16);
- "We are confident the compliance measures described above will prevent further errors and lead to Dr. Metnick being restored as a provider in good standing with First Coast Service Options and CMS. With this in mind, we are respectfully requesting that First Coast Service Options conditionally reinstate Dr. Metnick's Medicare number upon his completion of the aforementioned compliance training and implementation of the recommended claims processing measures." *Id*.

Petitioners thus fail to explain how, if at all, a CAP submitted on behalf of Dr. Metnick in his individual capacity would have offered any different actions or corrections or otherwise materially differed. Therefore, we conclude that the ALJ did not err in accepting CMS's conclusion that the CAP applied to Dr. Metnick as well as to Access.

4. *The Reconsideration Request*

CMS also treated the reconsideration request as though it had been submitted on behalf of both Access and Dr. Metnick. When CMS denied the reconsideration request, CMS addressed the denial letter to attorney JKW and "Access Foot Care, Inc/Robert Metnick, DPM." CMS Ex. 11. Under the section titled "SUMMARY OF CASE: Reconsideration" CMS states:

> All of the documentation in the file for Access Foot Care Inc. (Access) has been reviewed and the decision has been made in accordance with Medicare guidelines, as outlined in 42 CFR §424.535. Based on CMS' analysis, the unfavorable decision rendered by FCSO stands that there was an abuse of billing privileges when Dr. Metnick billed for services that were alleged to have been rendered to 10 deceased beneficiaries.
>
> The **reconsideration submitted on behalf of Dr. Metnick** claimed unintended and inadvertent billing entry errors as the crux of the revocation reason.

Id. at 2 (emphasis added). Thus, the record below shows that Dr. Metnick's appeal rights were understood to have been asserted and preserved both by FCSO and by CMS. In addition, by delivering the notice letter addressed to Dr. Metnick on February 3, 2015, CMS cured the alleged notice deficiency prior to the start of the ALJ proceedings.

Petitioners also fail to argue that late delivery of the notice letter prejudiced Dr. Metnick in any way. Dr. Metnick's proposed corrective actions show that he was aware of what was at issue in the revocation determination. As indicated above, the notice letters were identical, except for the addressees. Despite the delay in delivery of the notice letter addressed to Dr. Metnick, Petitioners concede that CMS's contractor, FCSO, notified Petitioners, presumably verbally, of Dr. Metnick's revocation in January 2015. *See* P. Ex. 14. It is unclear to us, and Petitioners do not explain, what separate defenses or arguments Petitioners could have offered on Dr. Metnick's behalf which they did not also offer on behalf of Access. CMS issued its reconsidered determination on March 31, 2015, addressing both Access and Dr. Metnick, thus preserving Dr. Metnick's appeal rights. Petitioners received an ALJ review *de novo* on the revocation of both Access's and Dr. Metnick's Medicare billing privileges. As we discussed in the background section, nothing in the notice delivered in February 2015 to Dr. Metnick could reasonably be believed to have caused surprise or differed in any way from the notice addressed to Access and delivered in October 2014.

We also find significant what Petitioners did *not* do after Petitioners received the revocation notice addressed to Dr. Metnick on February 3, 2015. Petitioners did not write to CMS to supplement Access's then-pending reconsideration request with evidence and argument exclusive to Dr. Metnick. Petitioners did not request an extension from CMS of the deadline by which to submit a separate reconsideration request for Dr. Metnick. Petitioners point to no evidence and make no argument on behalf of Dr. Metnick not also submitted on behalf of Access, and thus fail to demonstrate that Dr. Metnick was prejudiced in any way by the late notice of revocation from CMS. In the absence of any argument that he was prejudiced, or of an actual showing of such prejudice, we cannot conclude that Dr. Metnick was denied due process by the late notice from FCSO.

Therefore, we will not overturn the revocation as to Dr. Metnick. We conclude that Dr. Metnick received adequate notice of the revocation, that Dr. Metnick was afforded a reasonable opportunity to respond to the notice, and that Dr. Metnick was not prejudiced by the late notice of revocation.

Conclusion

For the reasons set out above, the Board affirms the ALJ Decision upholding the revocation of Petitioners' Medicare enrollment and billing privileges for a period of one year.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Christopher S. Randolph
Presiding Board Member