**Department of Health and Human Services**
**DEPARTMENTAL APPEALS BOARD**
**Appellate Division**

George M. Young, M.D.
Docket No. A-16-87
Decision No. 2750
November 18, 2016

# FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Petitioner George M. Young, M.D. appeals the decision of an Administrative Law Judge (ALJ) upholding the determination of the Centers for Medicare & Medicaid Services (CMS) to revoke Petitioner's Medicare enrollment and billing privileges for one year. *George M. Young, M.D.*, DAB CR4539 (March 1, 2016) (ALJ Decision). The revocation arose from a determination of a CMS contractor (upheld on reconsideration) that Petitioner did not provide CMS access to medical documentation for items of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) he ordered for Medicare beneficiaries.

As explained below, we find no error in the ALJ Decision and uphold the revocation.

## Authorities

The Social Security Act (Act)[1] provides for CMS to regulate the enrollment of providers and suppliers in the Medicare program. Act § 1866(j)(1)(A), 42 U.S.C. § 1395cc(j)(1)(A). The implementing regulations in 42 C.F.R. Part 424, subpart P, set out the enrollment process that CMS uses to establish eligibility for submitting claims to Medicare and to terminate such eligibility.

Within Part 424, subpart P, is 42 C.F.R. § 424.535, which sets out the standards and process under which CMS (or its contractor) may revoke a provider's or supplier's Medicare billing privileges. Applicable here, section 424.535(a)(10) provides:

[1] The current version of the Act can be found at http://www.socialsecurity.gov/OP_Home/ssact/ssact-toc.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross-reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp Table.

> (10) *Failure to document or provide CMS access to documentation.*
>
> (i) The provider or supplier did not comply with the documentation or CMS access requirements specified in § 424.516(f) of this subpart.
> (ii) A provider or supplier that meets the revocation criteria specified in paragraph (a)(10)(i) of this section, is subject to revocation for a period of not more than 1 year for each act of noncompliance.

The regulations in 42 C.F.R. Part 424, subpart P also set out specific requirements for enrolling and maintaining enrollment in Medicare. One such requirement, set out in section 424.516(f), concerns maintenance of, and provision of access to, documentation. Section 424.516(f) provides, in part:

> (2)(i) A physician who orders/certifies home health services and the physician or, when permitted, other eligible professional who orders items of DMEPOS or clinical laboratory or imaging services is required to –
>
> (A) Maintain documentation (as described in paragraph (f)(2)(ii) of this section) for 7 years from the date of the service; and
> (B) Upon request of CMS or a Medicare contractor, to provide access to that documentation (as described in paragraph (f)(2)(ii) of this section).
>
> (ii) The documentation includes written and electronic documents (including the NPI of the physician who ordered/certified the home health services and the NPI of the physician or, when permitted, other eligible professional who ordered the items of DMEPOS or the clinical laboratory or imaging services) relating to written orders or certifications or requests for payments for items of DMEPOS and clinical laboratory, imaging, and home health services.

42 C.F.R. § 424.516(f)(2).[2]

The effect of revocation is to terminate any provider agreement and to bar the provider or supplier "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(b), (c). The re-enrollment bar lasts between one year and three years. *Id.* § 424.535(c).

[2] NPI (National Provider Identifier) is the "the standard unique health identifier for health care providers (including Medicare suppliers) . . . ." Medicare Program Integrity Manual (MPIM), Pub. 100-08, Ch. 15, § 15.1.1.

A provider or supplier whose Medicare enrollment has been revoked may request reconsideration by CMS or its contractor, and then appeal the reconsideration decision to an ALJ and then to the Board 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[3]

Petitioner is a physician who has been licensed to practice in Florida since 1990 and who, until the revocation that is the subject of this appeal, was enrolled as a "supplier"[4] in the Medicare program. CMS Ex. 1; P. Ex. 2 (Petitioner's declaration), at ¶ 2. In October 2011, Petitioner began working as a staff physician at the Sleep Medicine Center (SMC). P. Ex. 2, at ¶¶ 3, 4, 6. In that capacity, he prepared medical histories of and examined patients who were referred to SMC by their primary care physicians, to ascertain whether the patients had symptoms of sleep apnea. *Id.* ¶¶ 7, 9. H.Z., Ph.D., the owner of SMC, then reviewed Petitioner's records, i.e., the histories and examination reports, and determined whether the patients should undergo testing (such as a polysomnogram). *Id.* ¶¶ 4, 5, 13. H.Z. and his staff then conducted sleep studies (such as titration studies) as deemed necessary or appropriate for the patients. *Id.* ¶¶ 14, 15. "If[,] after reviewing the sleep studies, it was recommended the patient be prescribed durable medical equipment, [Petitioner] . . . then sign[ed] a prescription for the same." *Id.* ¶ 17. Petitioner's employment as a staff physician at SMC ended in October 2012. *Id.* ¶¶ 3, 18.

By letter dated January 6, 2015, CMS asked Petitioner to provide medical documentation, including "written and electronic documents relating to written orders, certifications or requests for payments," supporting billing for items of DMEPOS ordered for 14 named Medicare beneficiaries. CMS Ex. 2, at 1. The letter added that CMS was requesting, specifically, physician's orders, prescriptions, progress notes, and patient information sheets. *Id.* The letter also asked Petitioner to provide the requested documents by January 13, 2015. *Id.* at 2. Petitioner, by his attorney, responded to CMS's request by letter dated January 13, 2015, stating that he "tried to locate [the requested] records,

[3] The factual information in this section is drawn from the ALJ Decision and the record before the ALJ and is not intended to add to or modify the ALJ's findings.

[4] The term "supplier" means, "unless the context otherwise requires, a physician or other practitioner, a facility or other entity (other than a provider of services [as defined in Act § 1861(u)]) that furnishes items or services" under the Medicare program. Act § 1861(d); *see also* 42 C.F.R. § 400.202 (a "supplier" is "a physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare"). "Providers," for purposes of Medicare, include hospitals, skilled nursing facilities, and home health agencies. 42 C.F.R. § 400.202.

however, the facility at which he was employed which has possession of the records [referring to SMC] cannot be located." CMS Ex. 3. Petitioner's attorney indicated that he had attempted, unsuccessfully, to call CMS's Center for Program Integrity, which requested the documents, and offered to "further explain the situation . . . or furnish any other explanation that [CMS] seek[s]." *Id.*[5]

By letter dated February 19, 2015, CMS, by a contractor, informed Petitioner that his Medicare enrollment and billing privileges were being revoked, effective March 21, 2015,[6] pursuant to 42 C.F.R. § 424.535(a)(10), for failure to submit the requested medical records. CMS Ex. 1, at 4. The letter informed Petitioner that he was barred from re-enrollment for one year. *Id.* at 5, citing 42 C.F.R. § 424.535(c). Petitioner filed a timely appeal and, on May 27, 2015, CMS, by its contractor, issued a reconsidered determination affirming the revocation pursuant to section 424.535(a)(10). P. Ex. 4. On July 21, 2015, CMS issued a "corrected" reconsidered determination. CMS Ex. 1, at 1-3.[7]

Petitioner then sought ALJ review. On March 1, 2016, the ALJ issued a decision upholding the revocation. The ALJ issued his decision based on the written record. He determined that an in-person hearing need not be held because Petitioner offered written direct testimony of one witness (Petitioner's declaration), and CMS neither proposed to call any witnesses nor asked to cross-examine Petitioner. ALJ Decision at 3.[8] The ALJ determined that "CMS had a legitimate basis to revoke Petitioner's Medicare enrollment and billing privileges because Petitioner violated 42 C.F.R. § 424.535(a)(10)." *Id.* at 4.

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[5] CMS's January 6, 2015 letter request for records included only the 14 beneficiaries' names and dates of birth. The letter did not otherwise specify, for instance, the time period within which the requested records were generated, the dates of service, or the types of DMEPOS items ordered for the beneficiaries; nor did it indicate that the request pertained to the named beneficiaries for whom DMEPOS items were ordered based on sleep testing at SMC. It is nevertheless evident, based on Petitioner's declaration (P. Ex. 2) and his attorney's March 18, 2015 letter to the CMS contractor (CMS Ex. 4, at 2-4), that Petitioner determined that the beneficiaries identified in the request were among those he saw while he was a staff physician at SMC.

[6] With exceptions not relevant here, revocation takes effect 30 days after CMS or its contractor mails its notice of revocation to the provider or supplier. 42 C.F.R. § 424.535(g).

[7] The body of page 1 of the May 27, 2015 determination refers not to Petitioner but to M.R., M.D.; page 2 identifies the corporate name of a pharmacy, referring to it as the "provider." P. Ex. 4, at 1, 2. Nothing in the record suggests that Dr. M.R. or the pharmacy has anything to do with Petitioner's case. The earlier references to Dr. M.R. and the pharmacy appear to have been errors. The May 27, 2015 and July 21, 2015 determinations otherwise appear to be substantively similar. *Compare id. and* CMS Ex. 1, at 1, 2.

[8] The ALJ also overruled CMS's objection to the admission of two documents included in Petitioner's Exhibit 3 on the ground that Petitioner failed to submit them prior to the ALJ proceedings and admitted the two documents, along with all other exhibits submitted by the parties. Neither party asserts error concerning the ALJ's issuance of a decision based on the written record or raises any specific dispute concerning the ALJ's evidentiary ruling.

Petitioner, the ALJ found, violated that regulation because he "did not provide the [requested] documentation to CMS or its contractor at the time of the original request" but instead "responded that he was unable to produce the requested documentation because his former employer [SMC] was in sole possession of the documents." *Id.*, citing CMS Ex. 3.

The ALJ also noted Petitioner's statements in his brief to the ALJ that he later provided the CMS contractor "voluminous records" with his request for reconsideration, records Petitioner asserted were "exactly" the documents CMS had requested (ALJ Decision at 5, citing P. Br. at 8, 10-11), and Petitioner's view that CMS was "nit pick[ing]" because CMS determined that some of the records were not detailed enough and that Petitioner did not produce his own records. *Id.*, quoting P. Br. at 9. The ALJ found, however, that the documents Petitioner eventually provided were less than fully responsive to the request because, for instance, while Petitioner provided 14 prescriptions, he did not provide "all the related orders, progress notes and patient information sheets as CMS requested." *Id.* The ALJ noted, too, that "Petitioner did not sign the vast majority of" the records he submitted to the contractor, and that "[m]ost of the records were either signed by another physician or were forms filled out by the patients." *Id.* Moreover, the ALJ determined, Petitioner submitted "detailed written orders" for eight of the beneficiaries. *Id.* at 5-6, quoting Medicare Program Integrity Manual (MPIM), CMS Pub. 100-08, Chapter 5, § 5.2.3 (describing "Detailed Written Orders").

The ALJ noted, moreover, Petitioner's argument that it was impractical to require him to maintain separate copies of the records and that, even if he were required to maintain separate copies, an exception is appropriate given that the delay in producing the records was due to circumstances specific to his case and beyond his control. According to Petitioner, he had no ownership interest in SMC and was not a custodian of the records at issue, and SMC's owner "absconded with the records" after closing SMC sometime after Petitioner's employment as a staff physician at SMC ended, but before Petitioner received CMS's document request.[9] *Id.* at 6, quoting P. Br. at 11; P. Ex. 2, ¶ 19. The ALJ noted, too, Petitioner's quarrel with what Petitioner characterized as CMS's requiring a physician like him, an employee, to maintain his own copies of records at home or elsewhere. ALJ Decision at 6, citing P. Br. at 7-8, 11.

[9] Petitioner states that he was able to obtain the records that he belatedly submitted to CMS from three sources: the DMEPOS supplier that provided the items to the beneficiaries; a third-party company that maintained electronic medical records for SMC; and from H.Z.'s attorney. P. Ex. 2, at ¶¶ 11, 26-30, 32, 35, 36. Petitioner states that neither he, nor H.Z.'s attorney, knows of H.Z.'s whereabouts, but that H.Z.'s attorney provided him (Petitioner) the records he (the attorney) had in his possession. *Id.*, ¶¶ 33, 34, 36.

The ALJ found Petitioner's arguments unavailing because Petitioner is "legally responsible for maintaining and producing the requested records" and, also, "must maintain, and retain for 7 years, documentation pertaining to ordered and certified services for durable medical equipment." *Id.*, citing 42 C.F.R. § 424.516(f)(2) and quoting the preamble to the Final Rule, 77 Fed. Reg. 25,284, 25,310 (April 27, 2012)[10] (section 424.516(f) "places the responsibility for the maintenance of records on both the ordering and certifying physician and the provider and supplier"). The ALJ also noted CMS's clarification that this responsibility extends to situations involving "physician referral for DMEPOS at a hospital or nursing home discharge, [where] '[t]he physician or other eligible profession[al] who signed the order or certification is responsible for maintaining and disclosing the documentation.'" *Id.*, quoting 77 Fed. Reg. at 25,310. Lastly, the ALJ determined that Petitioner's reliance on preamble language in the April 27, 2012 Final Rule as support for his position that he should be "excused from the document retention and production requirements because the delay in production of the records was outside of his control" (*id.*, citing P. Br. at 7-8) was misplaced because the "full discussion [in the preamble] describes situations where, despite good faith efforts, documentation was lost or destroyed due to circumstances beyond the supplier's control during the seven year retention period" (*id.* at 6-7). The preamble, the ALJ noted, described two examples of such circumstances, "systems malfunction or a natural disaster," for which suppliers who demonstrate good faith efforts to maintain the documentation should not be penalized in the same manner as a supplier who "'intentionally or carelessly disregards the documentation requirements.'" *Id.* at 7, quoting 77 Fed. Reg. at 25,310. The ALJ said, "Here I do not find Petitioner's lack of maintaining documents out of his control but rather a function of disregarding the documentation requirements, which provides CMS a legitimate basis for not granting an exception[,]" a discretionary determination which he, the ALJ, was not authorized to review. *Id*., citing *Letantia Bussell, M.D.* at 13 ("[T]he right to review of CMS's determination by an ALJ serves to determine whether CMS had the authority to revoke . . ., not to substitute the ALJ's discretion about whether to revoke"(emphasis in original).).

The ALJ upheld CMS's determination to revoke Petitioner's enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(10), with a re-enrollment bar of one year from March 21, 2015. *Id.*

[10] The Interim Final Rule (with comment period) was published on May 5, 2010, at 75 Fed. Reg. 24,437. The rulemaking, among other things, implemented certain provisions of section 6406 of the Patient Protection and Affordable Care Act (Pub. L. No. 111-148), for the purpose of enhancing Medicare program integrity. More specifically, as applicable here, the rulemaking amended sections 1842(h) and 1866(a)(1) of the Social Security Act to require a physician or supplier to maintain and, upon the Secretary's request, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certification for home health services, or referrals for other items and services written or ordered by such physician or supplier, and to authorize disenrollment of such a physician or supplier for not more than one year for failure to do so.

## Standard of review

The Board's standard of review on a disputed factual issue is whether the ALJ decision is supported by substantial evidence on the whole record. The Board's 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 Program* (*Guidelines*), available at http://www.hhs.gov/dab/divisions/appellate/guidelines/prosupenrolmen.html.

## Analysis

Before the Board, Petitioner, in essence, reasserts the arguments he raised before the ALJ.[11] The gravamen of his argument on appeal, as it was below, is that his ability to comply with CMS's records request was hampered by extenuating circumstances beyond his control. Petitioner says that H.Z. closed SMC and "went 'AWOL,'" taking SMC's records with him. Request for Review (RR) at 3, 4. Petitioner asserts that neither he, nor H.Z.'s attorney, nor the U.S. government, could find H.Z. *Id.* at 4. Petitioner alleges that, despite the hurdles he faced, he did everything in his power to comply with the document request and eventually was able to secure and submit to CMS "almost 1,000 pages" of records. *Id.* at 12; *see also* P. Ex. 2, at ¶¶ 36, 37. According to Petitioner, while "the regulation relating to the recordkeeping requirements does not prescribe the intent, *mens rea*, or level of fault required" for revocation, the regulatory preamble (77 Fed. Reg. at 25,310) "clearly" contemplates "some degree of fault" and "some intent" given that it discusses circumstances like "systems malfunctions or natural disasters" outside the provider's or supplier's control. Reply at 1-2; RR at 8 (quoting 77 Fed. Reg. at 25,310). He says that H.Z. "essentially stole[ ]" his records and "absconded" with them, and that the "theft of his records," an act of "malfeasance," is "an equivalent type of circumstance beyond his control." Reply at 2 and 2 n.1; RR at 8 and 13 n.6. He maintains that revocation should be reversed because there was "not a *legal* basis to

[11] In a letter to the parties dated May 5, 2016, the Board acknowledged Petitioner's request for oral argument before the Board (Request for Review (RR) at 13) and asked Petitioner to state his reasons for requesting oral argument no later than the date of filing of his reply brief. *See Guidelines*, "Development of the Record on Appeal," at ¶ (g). In his reply brief, Petitioner expressed his belief that this case is one "of great public importance" as it "presents significant and novel issues regarding the burdens upon a doctor and the concomitant standard of fault required to revoke a doctor's Medicare privileges for failing to maintain or produce records." Reply Brief (Reply) at 3. In Petitioner's view, "while the legislative history to the rule alludes to situations beyond a doctor's control, which necessarily implies some degree of fault is needed, this has not been explored in any detail whatsoever in the prior decisions of either ALJs or the [Board]." *Id.* Having carefully considered Petitioner's stated reasons for the request in light of the issues presented in this case, the record below, and the ALJ Decision, we have decided not to hold oral argument because the parties have had full opportunity to present their arguments in their written submissions, and Petitioner has not articulated with specificity the reasons why written argument alone would be inadequate or how oral argument, rather than written argument alone, would aid the resolution of this appeal.

revoke his [billing] privileges because the regulation at hand requires some degree of fault as set forth by its legislative history, which is not present in his case." Reply at 2 (emphasis in original). CMS urges the Board to uphold the ALJ Decision.[12]

For the reasons set out below, we conclude that the ALJ correctly determined that CMS had a lawful basis to revoke Petitioner's enrollment and billing privileges under 42 C.F.R. § 424.535(a)(10) for noncompliance with 42 C.F.R. § 424.516(f)(2). The ALJ Decision is supported by substantial evidence and is free of legal error and, accordingly, we uphold it.

*1. Petitioner failed to comply with 42 C.F.R. § 424.516(f)(2).*

Where, as here, a petitioner challenges revocation of enrollment in Medicare, our review, and the ALJ's, is confined to determining the basis for revocation stated in the reconsidered determination. *Letantia Bussell, M.D.* at 13 ("Once the ALJ found that [the requirements] for revocation were present . . ., the ALJ was obliged to uphold the revocation, as are we."); *Stanley Beekman, D.P.M.*, DAB No. 2650, at 10 (2015) (review under 42 C.F.R. Part 498 of a revocation determination is limited to determining whether there is a legal basis for the determination); *Precision Prosthetic, Inc.*, DAB No. 2597, at 11 (2014) (explaining that 42 C.F.R. § 498.5(l) "limits ALJs to considering the basis or bases for denial or revocation of enrollment and billing privileges set forth in the . . . reconsidered determination"). Here, CMS, by its contractor, upheld the revocation on reconsideration pursuant to section 424.535(a)(10), which authorizes CMS to take such an action for noncompliance with section 424.516(f). Hence, the inquiry before the ALJ and the Board is whether that basis for revocation is grounded in law and fact. It is.

By its plain language, section 424.516(f)(2) requires a physician, like Petitioner, who orders DMEPOS items billed to Medicare, to do two things. First, he or she must maintain documents, written and electronic, related to written orders or certifications or requests for payments for DMEPOS items for a period of seven years. Second, he or she must provide CMS or its contractor access to those documents upon request.

Petitioner does not dispute that the documents CMS requested were those generated while he was a physician at SMC (October 2011 to October 2012), or that the beneficiaries whose names appear on CMS's request were SMC patients for whom he, as a physician at SMC, ordered DMEPOS items, or that the document retention and disclosure requirement was in effect at all relevant times. Petitioner therefore was

[12] In its response brief, CMS states that the ALJ "granted summary judgment" for CMS. CMS Response at 1, 3. This is inaccurate. Below, CMS moved for summary judgment, and Petitioner opposed the motion. ALJ Decision at 2. But, other than acknowledging the motion and opposition in the "Background and Procedural History" section of his decision, the ALJ did not further discuss the motion. We interpret the ALJ Decision to mean that the ALJ in effect denied the motion inasmuch as he made findings of fact and conclusions of law, rather than determine that there was or was not a genuine dispute of material fact.

required by regulation to maintain those records related to written orders or certifications or requests for payments for DMEPOS items ordered for those beneficiaries for a seven-year period, within which CMS's 2015 document request fell. Before the Board, Petitioner does not dispute that he himself did not maintain any of those documents. He makes instead arguments to the effect that his ability to produce the documents for purposes of compliance with CMS's 2015 request was hampered because he himself was not in a position to maintain the documents personally or exercise direct control over them since he was not an owner of SMC but merely was a staff physician employed by SMC. As we will address later, these arguments have no merit. To the extent Petitioner failed to maintain the documents, he did not comply with the regulation. Nor did Petitioner provide CMS "access" to the documents encompassed within section 424.516(f)(2)(ii) "upon request" in the sense that he failed to produce any requested document by the due date CMS stated in its request.[13]

Petitioner eventually secured and sent to the CMS contractor hundreds of pages of documents with his reconsideration request.[14] While Petitioner does not expressly dispute specific factual findings the ALJ made concerning the documents Petitioner later produced, for instance, that they did not include "detailed written orders for eight of the beneficiaries" (ALJ Decision at 6), he points out that he did produce 14 durable medical equipment prescriptions and states that "prescriptions" can be "viewed as 'physician's orders.'" RR at 9; ALJ Decision at 5 ("Petitioner provided 14 prescriptions"). Petitioner also asserts that "progress notes" and "patient information sheets" are "certainly within the other records [he] produced[.]" RR at 9. Petitioner also says that it "should not be surprising" that some of the records do not bear his signature but that of another physician (or other physicians) since other physicians working at SMC signed some of them. *Id.* at 9-10. Petitioner also states that the term "detailed" is "subjective," and appears to be asserting his belief that the written orders he produced included sufficient details. *Id.* at 9.

We need not resolve the specific question of whether the hundreds of pages of documents Petitioner later submitted with his reconsideration request fully comply with section 424.516(f)(2)(ii) in every way, though CMS determined they did not fully comply, and the ALJ agreed, for the reasons he gave in his decision. *See* CMS Ex. 1, at 2 (corrected notice of revocation, stating "Medical records received were not those of [Petitioner] as requested."); ALJ Decision at 5-6. Regardless of specific questions about, for instance, the level of detail DMEPOS written orders must contain, Petitioner failed to maintain the

[13] CMS provided Petitioner one week to produce (or provide access to) the requested records (due date January 13, 2015). CMS Ex. 2, at 2. Petitioner did not object to the amount of time CMS allowed for production of the requested documents.

[14] Before the Board, Petitioner does not question that the record on which the ALJ made his decision accounts for all of the documents Petitioner submitted to the contractor.

documents as he is required to do under section 424.516(f)(2). Moreover, he does not specifically dispute the ALJ's fact-finding by pointing to specific evidence in the record to show that contrary to the ALJ's fact-finding, he did produce or provide CMS access to all of the documents to fully comply with the regulation. Because he failed to comply with section 424.516(f)(2), CMS had a lawful basis to proceed with revocation under section 424.535(a)(10).

*2. Section 424.516(f)(2)(i)(A) requires the ordering physician to maintain the documents described in section 424.516(f)(2)(ii).*

As discussed above, Petitioner argues, in essence, that circumstances beyond his control (i.e., H.Z. closed SMC and absconded with the records)[15] prevented Petitioner from providing CMS access to those documents described in 42 C.F.R. § 424.516(f)(2)(ii) when CMS asked for access to them in 2015, years after their creation, allegedly made difficult by H.Z.'s closure of SMC and "theft" of documents, and Petitioner's status as a staff physician-employee of SMC. These arguments do not specifically go to the requirement that the ordering physician, Petitioner, maintain the documents as they are created and retain them for a period of seven years for purposes of providing CMS access to them should CMS or its contractor request to see them sometime during that period.

As the ALJ noted, the regulatory preamble expressly provides that, even in instances of "referral to home health care or for DMEPOS at a hospital or nursing home discharge," in which records "would typically be retained in that hospital's or nursing home's records, not by the physician in his/her records," "[t]he physician or other eligible professional who signed the order or certification is responsible for maintaining and disclosing the documentation." 77 Fed. Reg. at 25,310; ALJ Decision at 6 (quoting preamble). Thus, CMS contemplated that even physicians who may not have immediate, ready access to and direct control over medical documents (as, for example, a doctor who owns his or her own practice and keeps the medical documents within his or her medical office might) would be expected to adhere to the record retention and disclosure requirements.

Petitioner argues, in sum, that the preamble contemplates some degree of fault on the part of the physician who is later asked to produce documents, but that he bears no fault for his inability to produce the documents immediately on request, given H.Z.'s alleged act of "malfeasance" in "absconding" with the records after closing SMC. Regardless of H.Z.'s alleged actions, which Petitioner himself said took place after he left his position

[15] Petitioner states, however, that the relief he seeks, that is, "reversal" of the determination to revoke, is not "the *equitable* overturning of CMS's decision to revoke . . . ." Reply at 2 (emphasis in original). While Petitioner has clarified that he is not seeking equitable relief, we note that even if he were, neither the Board nor an ALJ would be able to grant such relief. *See, e.g., Amber Mullins, N.P.*, DAB No. 2729, at 6 (2016); *US Ultrasound*, DAB No. 2302, at 8 (2010).

at SMC, Petitioner, as ordering physician, was required to maintain the records as they were developed in the course of his examining patients for possible need for DMEPOS items, i.e., during the period he was a physician at SMC, between October 2011 and October 2012. As we said, much of what Petitioner complains of, H.Z. closing SMC and absconding with the records, concerns the hurdles Petitioner encountered in trying to obtain the records to respond to CMS in 2015; it does not, however, excuse Petitioner's failure to maintain records from the time they came into existence through a period of seven years as required under the regulation. Therefore, despite arguments about lack of fault on Petitioner's part as to the events that transpired after his employment at SMC, Petitioner may be held responsible for complying with the regulation.

*3. The ALJ did not err in determining that CMS was "not required to make an exception" for Petitioner based on his arguments about circumstances beyond his control.*

The regulatory preamble contemplates CMS discretion on whether or not to revoke under certain circumstances that, despite "good faith effort . . . to comply with [the] rule," "arise outside . . . of the control of" providers or suppliers subject to the records retention and disclosure requirements. 77 Fed. Reg. at 25,310. It is reasonable, also, to read the preamble's mention of "systems malfunction or a natural disaster" as two examples of "circumstances beyond the provider's [or supplier's] control." *Id.* CMS said that "we may conduct an analysis based on the specific facts and circumstances involved in a particular case" to make a determination about revocation, since under "§ 424.535(a), a revocation action is discretionary." *Id.* This is precisely the point. It is within CMS's discretion to determine whether a particular physician's circumstances warrant a decision not to pursue revocation. The ALJ's statement that "CMS was not required to make an exception" for Petitioner based on his arguments concerning circumstances beyond his control, ALJ Decision at 6, goes to this very point. To the extent CMS exercised its discretion in ultimately deciding to go forward with revocation in Petitioner's case, it is not for the ALJ and the Board to look behind that exercise of discretion to ask whether he or she, or the Board, standing in CMS's shoes, would reach the same decision to revoke. *Sandra E. Johnson, CRNA*, DAB No. 2708, at 16 (2016); *see also Brian K. Ellefsen, D.O.*, DAB No. 2626 (2015) (where CMS has legal authority to deny an enrollment application, neither the ALJ nor the Board may substitute discretion as to whether denial was appropriate, but may review whether CMS exercised that discretion). As stated earlier, the inquiry for the ALJ and the Board is to determine whether the stated basis for revocation, as found in the decision on reconsideration, is grounded in law and fact. If it is, then upholding the determination to revoke is proper.

## Conclusion

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

/s/
Christopher S. Randolph

/s/
Constance B. Tobias

/s/
Susan S. Yim
Presiding Board Member