RENATO C. DOMINGUEZ, M.D., DAB CR5035 (2018)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD
Civil Remedies Division

RENE TO C. DOMINGUEZ, M.D.
(NPI: 1851408538 / PTAN: AH471V),
Petitioner
v.
Centers for Medicare & Medicaid Services

Docket No. C-17-1064
Decision No. CR5035
March 12, 2018

DECISION


I. Procedural History and Jurisdiction

Petitioner was enrolled in Medicare as a physician with billing privileges. First Coast Service Options, Inc. (First Coast), a Medicare administrative contractor (MAC), notified Petitioner by letter dated March 16, 2017, that Petitioner’s Medicare enrollment and billing privileges were revoked effective April 15, 2017. The MAC cited 42 C.F.R. § 424.535(a)(10) as the authority for revocation based on the fact that Petitioner failed to maintain and to provide access to documents requested by CMS or its contractor. The MAC imposed a re-enrollment bar of one year. Centers for Medicare & Medicaid Services (CMS) Exhibit (Ex.) 1 at 11-12.

Petitioner requested reconsideration by letter dated May 8, 2017. CMS Ex. 1 at 8-9. CMS notified Petitioner by letter dated July 21, 2017, that the revocation of his enrollment and billing privileges was upheld on reconsideration. CMS Ex. 1 at 1-7.

Petitioner requested a hearing before an administrative law judge (ALJ) on August 8, 2017 (RFH). On August 31, 2017, the case was assigned to me for hearing and decision and an Acknowledgment and Prehearing Order (Prehearing Order) was issued at my direction. Petitioner’s request for hearing was timely; the parties have not challenged my authority to decide this case; and I have jurisdiction.

On October 2, 2017, CMS filed a motion for summary judgment and prehearing brief (CMS Br.), with CMS Exs. 1 through 6. On October 30, 2017, Petitioner filed his brief, cross-motion for summary judgment and response in opposition to the CMS motion (P. Br.) with Petitioner’s exhibits (P. Exs.) 1 through 6. On November 15, 2017, CMS waived filing a reply brief. The parties have not objected to my consideration of CMS Exs. 1 through 6 and P. Exs. 1 through 6 and all are admitted as evidence.
II. Discussion

A. Applicable Law

Section 1831 of the Social Security Act (Act) (42 U.S.C. § 1395j) establishes the supplementary medical insurance benefits program for the aged and disabled known as Medicare Part B. Administration of the Part B program is through the MACs, such as First Coast. Act § 1842(a) (42 U.S.C. § 1395u(a)). Payment under the program for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of services and suppliers. Act §§ 1815, 1817, 1834(j)(1) (42 U.S.C. §§ 1395g, 1395i, 1395m(j)(1)); 1835(a) (42 U.S.C. § 1395n(a)); and 1842(h)(1) (42 U.S.C. § 1395u(h)(1)). Petitioner, a physician, is a supplier.

The Act requires the Secretary of Health and Human Services (Secretary) to issue regulations that establish a process for the enrollment in Medicare of providers and suppliers, including the right to a hearing and judicial review of certain enrollment determinations, such as revocation of enrollment and billing privileges. Act § 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to 42 C.F.R. §§ 424.500 and 424.505, a supplier such as Petitioner must be enrolled in the Medicare program and be issued a billing number to have billing privileges and to be eligible to receive payment for services rendered to a Medicare-eligible beneficiary.

The Secretary has delegated authority to CMS or its Medicare contractor to revoke an enrolled supplier’s Medicare enrollment and billing privileges for any of the reasons listed in 42 C.F.R. § 424.535. The supplier bears the burden to demonstrate that it meets enrollment requirements with documents and records. 42 C.F.R. § 424.545(c). If CMS revokes a supplier’s Medicare billing privileges for not complying with enrollment requirements, then the revocation is effective 30 days after CMS or its contractor mails notice of its determination to the supplier. 42 C.F.R. § 424.535(g).

The Secretary has issued regulations that establish the right to a hearing and judicial review of certain enrollment determinations. Act § 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to sections 1866(h)(1) and (j)(8), a provider or supplier whose enrollment application or renewal application is denied or whose Medicare enrollment and billing privileges are revoked is entitled to a hearing before an ALJ and Departmental Appeals Board (Board) review, followed by judicial review. Pursuant to 42 C.F.R. § 424.545(a), a provider or supplier denied enrollment in Medicare or whose Medicare enrollment and billing privileges are revoked has the right to administrative and judicial review in accordance with 42 C.F.R. pt. 498. Appeal and review rights are specified by 42 C.F.R. § 498.5.

B. Issues

Whether summary judgment is appropriate; and

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

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

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

1. Summary judgment is appropriate.
The parties filed cross-motions for summary judgment.

Page 4

A provider or supplier denied enrollment in Medicare or whose enrollment has been revoked has a right to a hearing and judicial review pursuant to sections 1866(h)(1) and (j)(8) of the Act and 42 C.F.R. §§ 498.3(b)(1), (5), (6), (8), (15), (17), and 498.5. A hearing on the record, also known as an oral hearing, is required under the Act. Act §§ 205(b), 1866 (h)(1) and (j)(8); Crestview Parke Care Ctr. v. Thompson, 373 F.3d 743, 748-51 (6th Cir. 2004). A party may waive appearance at an oral hearing, but must do so affirmatively in writing. 42 C.F.R. § 498.66. In this case, Petitioner has not waived the right to oral hearing or otherwise consented to a decision based only upon the documentary evidence or pleadings. Accordingly, disposition on the written record alone is not permissible, unless the CMS motion for summary judgment has merit.

Summary judgment is not automatic upon request but is limited to certain specific conditions. The Secretary’s regulations that establish the procedure to be followed in adjudicating Petitioner’s case are at 42 C.F.R. pt. 498. 42 C.F.R. §§ 405.800, 405.803(a), 424.545(a), 498.3(b)(5), (6), (15), (17). The regulations do not establish a summary judgment procedure or recognize such a procedure. However, the Board has long accepted that summary judgment is an acceptable procedural device in cases adjudicated pursuant to 42 C.F.R. pt. 498. See, e.g., Ill. Knights Templar Home, DAB No. 2274 at 3-4 (2009); Garden City Med. Clinic, DAB No. 1763 (2001); Everett Rehab. & Med. Ctr., DAB No. 1628 at 3 (1997). The Board also has recognized that the Federal Rules of Civil Procedure (Fed. R. Civ. Pro.) do not apply in administrative adjudications such as this, but the Board has accepted that Fed. R. Civ. Pro. 56 and related cases provide useful guidance for determining whether summary judgment is appropriate. Furthermore, a summary judgment procedure was adopted as a matter of judicial economy within my authority to regulate the course of proceedings and made available to the parties in the litigation of this case by my Prehearing Order. The parties were given notice by the Prehearing Order that summary judgment is an available procedural device and that the law as it has developed related to Fed. R. Civ. Pro. 56 will be applied.

Summary judgment is appropriate when there is no genuine dispute as to any issue of material fact for adjudication and/or the moving party is entitled to judgment as a matter of law. The party requesting summary judgment bears the burden of showing that there are no genuine issues of material fact for trial and/or that it is entitled to judgment as a matter of law. In determining whether there are genuine issues of material fact for trial, the reviewer must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party’s favor. Generally, the non-movant may not defeat an adequately supported summary judgment motion by relying upon the denials in its pleadings or briefs but must furnish evidence of a dispute concerning a material fact, i.e., a fact that would affect the outcome of the case if proven. Mission Hosp. Reg’l Med. Ctr., DAB No. 2459 at 4 (2012) (and cases cited therein); Experts Are Us, Inc., DAB No. 2452 at 4 (2012) (and cases cited therein); Senior Rehab. & Skilled Nursing Ctr., DAB No. 2300 at 3 (2010) (and cases cited therein); see also Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248 (1986).
Deciding a case on summary judgment is different than deciding a case on the merits after a hearing or when a hearing is waived. On summary judgment, the ALJ does not make credibility determinations, weigh the evidence, or decide which inferences to draw from the evidence, as would be done when finding facts after a hearing on the record. Rather, on summary judgment, the ALJ construes the evidence in a light most favorable to the non-movant and avoids deciding which version of the facts is more likely true. 

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

In this case, I conclude that there is no genuine dispute as to any material fact pertinent to revocation pursuant to 42 C.F.R. § 424.535(a)(10)(i) based on a violation of 42 C.F.R. § 424.516(f)(1)(i)(A) that requires a trial. There is no dispute, and in fact, Petitioner admits that he failed to maintain documents required by 42 C.F.R. § 424.516(f)(1)(i)(A) for three of five patients for seven years. P. Br. at 5-7. Resolution of this case turns upon application of the law to the undisputed facts. Accordingly, summary judgment is appropriate.

2. Petitioner violated 42 C.F.R. § 424.516(f)(1)(i)(A) by failing to maintain required documents for three patients for seven years from the dates he ordered clinical laboratory services for those patients.

3. There is a basis for revocation of Petitioner’s Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(10)(i) for noncompliance with the requirement of 42 C.F.R. § 424.516(f)(1)(i)(A) to maintain required documents.

a. Facts

I accept Petitioner’s rendition of the facts for purposes of summary judgment. The material facts are not disputed and any inferences are drawn in Petitioner’s favor on summary judgment.
from Salud and provided copies with his letter. P. Ex. 5; CMS Ex. 1 at 32. It is undisputed that Salud was the entity that billed and received Medicare payment for services provided by Petitioner to the three Medicare-eligible beneficiaries whose records Petitioner obtained from Salud and delivered to the ZPIC. Petitioner does not dispute that the records contained orders for clinical laboratory services. P. Br. at 2.

Although there is no dispute Petitioner ultimately provided records for all five of the Medicare beneficiaries as requested by ZPIC, there is no dispute that Petitioner did not maintain records for three of the five but had to request copies from Salud to provide to the ZPIC. P. Br. at 2; CMS Br. at 5, 7. Petitioner does not dispute that he ordered clinical laboratory services for each of the three Medicare beneficiaries for whom he had to obtain copies of records from Salud. Petitioner does not dispute that seven years had not elapsed from the dates he ordered the clinical laboratory services for the three beneficiaries and his receipt of the request for copies of those records from the ZPIC. P. Br. at 2; CMS Ex. 5.

b. Analysis

The regulations applicable in this case are clear and require no interpretation, only application. Providers or suppliers, including physicians, that furnish covered ordered items of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), clinical laboratory services, imaging services, or home health services are required to maintain documents for seven years from the date the service was ordered. 42 C.F.R. § 424.516(f)(1)(i)(A). The regulation further requires that upon request the provider or supplier must give CMS or a Medicare contractor access to that documentation, including written and electronic documents. 42 C.F.R. § 424.516(f)(1)(i)(B). The documents that must be maintained and made accessible to CMS include written and electronic documents with the National Provider Identifier (NPI) for the ordering physician or other eligible professional, written orders, certifications, and requests for payment. The regulations specifically provide that failure to maintain the documents required to be maintained by 42 C.F.R. § 424.516(f)(1)(i)(A) or to permit CMS access to the documents as required by 42 C.F.R. § 424.516(f)(1)(i)(B) is a basis for revocation of Medicare enrollment and billing privileges. 42 C.F.R. § 424.535(a)(10)(i).

Petitioner does not dispute and, in fact, has conceded that he did not maintain records, including his orders for clinical laboratory services, for three former patients for seven years from the dates of those orders. Accordingly, I conclude that Petitioner violated 42 C.F.R. § 424.516(f)(1)(i)(A) and that violation is a basis for revocation of Petitioner’s Medicare enrollment and billing privileges. The re-enrollment bar of one year is the minimum authorized by 42 C.F.R. § 424.535(c).

In provider and supplier enrollment cases, an ALJ reviews the basis for revocation cited in the reconsidered determination. Neb Group of Arizona LLC, DAB No. 2573 at 7 (2014); 42 C.F.R. § 498.5(l)(2). I have no authority to review the exercise of discretion by CMS or its contractor to revoke where there is a basis for revocation. Abdul Razzaque Ahmed, M.D., DAB No. 2261 at 19 (2009), aff’d, Ahmed v. Sebelius, 710 F. Supp. 2d 167 (D. Mass. 2010). The scope of my authority is limited to determining
whether there is a legal basis for revocation of Petitioner’s Medicare enrollment and billing privileges. *Id.*

I have concluded that there is a basis for CMS to revoke Petitioner’s Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(10)(i).

To the extent that any of Petitioner’s arguments may be construed to be a request for equitable relief, I have no authority to grant equitable relief. *US Ultrasound*, DAB No. 2302 at 8 (2010). I am also required to follow the Act and regulations and have no authority to declare statutes or regulations invalid. *1866/CPayday.com, L.L.C.*, DAB No. 2289 at 14 (2009).

III. Conclusion

For the foregoing reasons, I conclude that Petitioner’s Medicare enrollment and billing privileges are revoked pursuant to 42 C.F.R. § 424.535(a)(10)(i) for failure to comply with the documentation requirements of 42 C.F.R. § 424.516(f)(1)(i)(A).

/s/

Keith W. Sickendick
Administrative Law
Judge

Footnotes

1. Citations are to the 2016 revision of the Code of Federal Regulations (C.F.R.), unless otherwise stated.

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

3. There is no dispute that Salud is now known as Medgroup Medical Center. P. Ex. 5; CMS Ex. 1 at 32.