Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

David L. Tolliver, D.O.,
(PTAN: 005018D28),

Petitioner

v.

Centers for Medicare & Medicaid Services.

Docket No. C-10-737

Decision No. CR2281

Date: November 23, 2010

DECISION

For the reasons set forth below, I grant the Centers for Medicare & Medicaid Services (CMS) motion for summary judgment. The undisputed evidence establishes that Petitioner, David L. Tolliver, D.O., pled guilty to a felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries and failed to report the criminal conviction and associated loss of his medical licenses. CMS therefore had the authority to revoke Petitioner's enrollment and billing privileges in the Medicare program under 42 C.F.R. §§ 424.535(a)(3) and 424.535(a)(9). I sustain the CMS revocation of Petitioner's enrollment effective September 18, 2008, and associated three-year bar on re-enrollment.

I. The Regulations

Section 424.535(a) of 42 C.F.R. authorizes CMS to "revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement or supplier agreement" for reasons including, as relevant here:

> (3) *Felonies*. The provider, supplier, or any owner of the provider or supplier, within the 10 years preceding enrollment or revalidation of enrollment, was convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the [Medicare] program and its beneficiaries.
>
> > (i) Offenses include—
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> > * * * *
> >
> > (B) Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

Additionally, 42 C.F.R. § 424.535(a)(9) authorizes CMS to revoke billing privileges where a provider or supplier failed to comply with the reporting requirements including the requirement that "[p]hysicians . . . must report . . . to their Medicare contractor . . . [w]ithin 30 days . . . [a]ny adverse legal action." 42 C.F.R. § 424.516(d)(1)(ii). A "[f]inal adverse action" is defined to include "[s]uspension or a revocation of a license to provide health care by any State licensing authority." 42 C.F.R. § 424.502.

When a revocation is based on a "felony conviction, license suspension or revocation . . . the revocation is effective with the date of . . . felony conviction, license suspension or revocation. . . ." 42 C.F.R. § 424.535(g).

Providers or suppliers who have had their billing privileges revoked "are barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar," which is "a minimum of 1 year, but not greater than 3 years depending on the severity of the basis for revocation." 42 C.F.R. § 424.535(c).

II. Background - Undisputed Facts

Petitioner, Dr. Tolliver, is a doctor of osteopathy licensed by the Virginia Board of Medicine, West Virginia Board of Osteopathy, and State Medical Board of Ohio. Petitioner practices dermatology and is the founder of dermatology practices operating at various locations in Virginia and West Virginia. P. Br. On September 4, 2007, Petitioner pled guilty to the felony of filing a false tax return under 26 U.S.C. § 7206(1). P. Ex. 8, 9. On September 18, 2008 Petitioner was sentenced to one-month imprisonment, followed by one-year supervised release including a five-month term of electronically monitored home confinement, and ordered to pay the total of $30,100.00 in criminal monetary penalties. P. Ex. 9.

On October 17, 2008, after the conviction, the West Virginia Board of Osteopathy suspended Petitioner's medical license. P. Ex. 14. On November 3, 2008, the Virginia

Board of Medicine suspended Petitioner's medical license. P. Ex. 12. Then, on February 11, 2009, the State Medical Board of Ohio also revoked Petitioner's license to practice medicine. P. Ex. 16. According to Petitioner, "[a]t no time did Dr. Tolliver see Medicare patients when he was not fully licensed." P. Br. at 5. Petitioner also asserts that he reported his conviction to "medical boards and other insurers; however, he inadvertently failed to notify TrailBlazer," the Medicare contractor, of his conviction, license suspension, or revocation. RH at 5, P. Br. at 5.

By letter dated July 13, 2009, the Medicare contractor revoked Petitioner's Virginia Medicare provider transaction access number (PTAN) based on his conviction, "within the 10 years preceding enrollment or revalidation of enrollment . . . of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries to continue enrollment" citing 42 C.F.R. § 424.535(a)(3), and his failure "to report any adverse legal action to [the] Medicare contractor within 30 days" as required by 42 C.F.R. § 424.516(d)(ii). P. Ex. 1. The contractor revoked Petitioner's enrollment effective September 18, 2008,[1] the date of his conviction, and instituted a three-year bar on re-enrollment under 42 C.F.R. § 424.535(c). P. Exs. 1, 11; *see* P. Br. at 1.

The initial notice also informed Petitioner that he could appeal the decision by requesting reconsideration within 60 days of the date of postmark, he could submit a corrective action plan (CAP) within 30 days, or both. P. Ex. 1. As I will discuss in detail later in this decision, Petitioner timely submitted a letter dated August 10, 2009, which I view as both a CAP and a reconsideration, stating that Petitioner was "currently in compliance" with all Medicare requirements (the CAP) *and* that his enrollment should not have been revoked because his conviction was not detrimental to Medicare and for other reasons (argument for reconsideration). P. Ex. 3. The contractor rejected the CAP by notice letter dated October 15, 2009 and, rather than automatically referring Petitioner's request for reconsideration, the contractor again instructed Petitioner that he had 60 days to seek reconsideration. P. Ex. 4. On December 16, 2009, Petitioner submitted another request for reconsideration, referencing the October 15, 2009 decision upholding the revocation (and noting that Petitioner had now obtained legal representation). On March 26, 2010, the contractor issued an unfavorable reconsideration decision, upholding the revocation and the three-year bar on re-enrollment. P. Ex. 6.

By letter dated May 28, 2010, Petitioner timely requested an Administrative Law Judge (ALJ) hearing pursuant to the instructions in the reconsideration decision. This case was assigned to me for hearing and decision pursuant to 42 C.F.R. § 498.44, which permits designation of a Member of the Departmental Appeals Board (Board) to hear appeals taken under Part 498.

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[1] Petitioner's revocation was initially to take effect November 3, 2008 but was subsequently revised to be effective September 18, 2008. P. Exs. 1, 11.

Pursuant to my Acknowledgement and Prehearing Order, CMS submitted a motion for summary judgment (CMS Br.) and its exhibits 1 - 12. On July 9, 2010 I conducted a telephone conference. I summarized the maters discussed in that conference and set forth further directives and information in my Order Following Telephone Conference (OFTC) issued July 20, 2010, as modified August 2, 2010. In response to questions raised in the OFTC, Petitioner submitted a letter on July 30, 2010, and CMS submitted a letter on August 16, 2010. Petitioner then filed his response to the CMS motion for summary judgment (P. Br.) on August 23, 2010, and his proposed exhibits 1 – 16 on September 3, 2010.

In his July 30, 2010 submission, Petitioner requested that I broaden the scope of my review to also consider the revocation of one of his practice groups, Derm One, PLLC, (Derm One) for which no contractor reconsideration had yet been issued. On August 10, 2010, I ordered CMS to indicate whether it consented to removing the group practice revocation directly to the Administrative Law Judge level without waiting for a contractor reconsideration. CMS did not consent, and I denied the request on August 10, 2010 restricting briefing to the issue of Dr. Tolliver's individual revocation.

On October 12, 2010, Petitioner filed a motion to consolidate the Derm One group practice revocation with the individual revocation of Dr. Tolliver, noting that the Derm One revocation had now been upheld by the contractor after reconsideration. On October 22, 2010, I denied Petitioner's motion to consolidate on the grounds that the issues presented were significantly different and required full briefing which should not delay the resolution of the present matter on which their resolution would not have material impact. The Derm One appeal was separately docketed as C-11-29 and is not addressed in this decision.

III. Issue, Findings of Fact, Conclusions of Law

A. Issues

The issues in this case are:

1. Whether I have jurisdiction to hear this case;

2. Whether, as a matter of law, CMS properly revoked Petitioners' Medicare enrollment and billing privileges on one or both of the asserted bases; and

3. Whether I have authority to review the imposition and length of a three-year bar on re-enrollment in the Medicare program.

B. Applicable Standard

The Board stated the standard for summary judgment as follows:

> Summary judgment is appropriate when the record shows that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. . . . The party moving for summary judgment bears the initial burden of showing that there are no genuine issues of material fact for trial and that it is entitled to judgment as a matter of law. . . . To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact – a fact that, if proven, would affect the outcome of the case under governing law. . . . 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.

Senior Rehab. & Skilled Nursing Ctr., DAB No. 2300, at 3 (2010) (citations omitted). The role of an ALJ in deciding a summary judgment motion differs from the ALJ's role in resolving a case after a hearing. The ALJ should not assess credibility or evaluate the weight of conflicting evidence. *Holy Cross Vill. at Notre Dame, Inc*, DAB No. 2291, at 4-5 (2009).

C. Analysis

CMS has moved for summary judgment. Although Petitioner argues against summary judgment, he does not point to any genuine issue of material fact in controversy. The issues before me are entirely legal in nature and consist of whether I have jurisdiction to hear this appeal, whether the undisputed facts authorize the revocation under the applicable regulations, and whether I may review the application or length of the re-enrollment bar.

My findings and conclusions are in the italicized headings followed by discussions below.

1. I have jurisdiction to review the CMS revocation action.

In the telephone conference, I explained to the parties that the basis of my jurisdiction over this matter was not entirely clear to me based on the record at that point. Both parties agreed to address the issue in writing and subsequently did so. My question arose from the fact that Petitioner had filed a request for reconsideration of the denial of his CAP, but I was uncertain whether Petitioner requested, within the required timeframe, a reconsideration of the revocation notice itself, or that the contractor had issued a

reconsideration of revocation. OFTC at 3 (July 20, 2010). After considering the arguments and reviewing the record as a whole, I conclude that I do have jurisdiction to resolve this dispute as to whether the revocation was imposed properly as a matter of law.

The Board has explained how a CAP is distinct from the contractor reconsideration process:

> After the initial notice of revocation, the supplier has two tracks to seek to avoid revocation and may elect to pursue either or both concurrently. [Medicare Program Integrity Manual (MPIM)], Ch. 10, § 19.A. The supplier, within 60 days, may request "reconsideration" of whether the basis for revocation is erroneous or, within 30 days, it may submit a CAP to demonstrate that it has corrected that basis. If the contractor accepts the CAP, it notifies the supplier, and any reconsideration request is withdrawn. If the contractor denies the CAP, the reconsideration process may proceed to a hearing before a hearing officer, who reviews "the Medicare contractor's reason for imposing a . . . revocation at the time it issued the action . . . ." *Id*. An unfavorable hearing officer decision is appealable to an ALJ, who reviews the basis for the revocation. *Id*. No provision is made for an appeal of the contractor's decision not to reinstate based on the CAP. *Id*. The hearing officer [HO] conducting the reconsideration (and the ALJ on appeal of the hearing officer decision) are limited to reviewing the basis for revocation set out in the initial notice, not the merits of any contractor decision that corrective action under a CAP was unacceptable.

DMS Imaging, Inc., DAB No. 2313, at 7-8 (2010) (footnote omitted). [2]

Thus, the contractor's CAP evaluation is (1) a review of whether the supplier is currently in compliance; (2) not an initial determination; and (3) not appealable. On the other hand, the contractor's reconsideration of a revocation is a determination of whether the contractor was in error at the time the supplier was found deficient. The reconsideration arises from the contractor's initial determination to revoke and is appealable through the administrative process, including the present review.

In the event that a provider or supplier requests both a CAP and a reconsideration simultaneously, the Medicare contractor is directed to "first process and make a determination on the CAP." MPIM Ch. 15, § 15.25. If the contractor does not accept the CAP, a contractor HO who was not involved in the initial determination and CAP review is then to process the reconsideration and determine whether the initial revocation was

[2] Effective September 28, 2010, CMS reorganized the manual cited in the quoted text and moved Ch. 10 to Ch 15. In the current version of the MPIM, the relevant language is at MPIM, Ch. 15, § 15.25. http://www.cms.gov/transmittals/downloads/R354PI.pdf

justified. MPIM Ch. 15, § 15.25. "In reviewing an initial enrollment decision or a revocation, the HO should limit the scope of its review to the Medicare contractor's reason for imposing a denial or revocation at the time it issued the action and whether the Medicare contractor made the correct decision (i.e., denial/revocation)." MPIM Ch. 15, § 15.25.

Upon thorough review, Petitioner's August 10, 2009 letter, even though its subject line includes a reference to a "CAP," is best construed as a combined CAP and request for reconsideration. P. Ex. 3. Specifically, in his August 10, 2009 letter, Petitioner presents the argument that his conviction was not detrimental to the Medicare program. This contention goes to the issue of whether the revocation was erroneous and could reasonably be construed as a request for contractor reconsideration of whether the revocation was imposed improperly. This argument is distinct from the claims made in the letter as to current compliance. The contractor processed the CAP but failed to follow the procedure set out in the manual requiring it to proceed to reconsideration once the CAP was rejected.

In light of the contractor's failure to provide a reconsideration that was timely requested, I view the reconsideration decision issued March 26, 2010, after Petitioner again requested reconsideration upon being notified of the CAP rejection (and advised in writing, incorrectly, that he could seek reconsideration of that decision) as amounting to a belated adverse reconsideration of Petitioner's revocation by the contractor. It furthermore appears that the contractor similarly construed the course of events given its express provision of appeal rights in its reconsideration decision. P. Ex. 6. Nevertheless, even finding favorably for Petitioner on this threshold jurisdictional issue, I can provide him no relief based on my finding that his enrollment was properly revoked for the reasons I explain next.

2. CMS was authorized to revoke Petitioner's enrollment under 42 C.F.R. § 424.535(a)(3), based on his felony conviction.

CMS argues that the revocation is authorized because Petitioner's conviction of a felony charge of filing a false tax return falls within the regulatory description of "[f]inancial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions" which the Secretary has found to be categorically detrimental to the Medicare program. CMS Br. at 8; 42 C.F.R. § 424.535(a)(3)(i)(B). Petitioner disagrees on the ground that the felony charge of which he was convicted "does not speak to his ability to treat patients or his ability to participate honorably in the Medicare Program." P. Br. at 4.

Petitioner notes that the overarching language at section 424.535(a)(3) authorizes revocation only for conviction of a felony offense "that CMS has determined to be

detrimental to the best interests of the program and its beneficiaries." P. Br. at 4. Petitioner argues that CMS has not shown that it made that determination with respect to the conduct underlying Petitioner's conviction. He seeks to distinguish it from the financial crimes mentioned in the regulation because he claims his crime did not include "an element of deception" common to the detrimental financial crimes listed. *Id*. He also points out that his conviction was not program related. *Id*. Further, Petitioner contends that in filing the false tax return he "at no time . . . place[ed] the Medicare Program or any Medicare beneficiary at financial risk." P. Br. at 3.

I find Petitioner's arguments unavailing for two main reasons. First, filing a false tax return is indeed the sort of financial crime that the regulation categorizes as detrimental to the best interest of the Medicare program in dealing with a supplier who will be submitting claims for payment. Second, the Board has made clear that CMS may make a determination that a particular offense is detrimental on a case-by-case basis even if it does not fall within the categorical groups in the regulation about which the Secretary has made blanket determinations. I discuss my reasons for each of these conclusions next.

The Board has held that the presence of an offense among those listed in section 424.535(a)(3)(i)(B) means that CMS has already determined that the offense "is detrimental per se to the best interests of the Medicare program and its beneficiaries." *Letantia Bussell, M.D.*, DAB No. 2196, at 9 (2008). The felony at issue falls squarely under the "financial crimes" umbrella. 42 C.F.R. § 424.535(a)(3)(i)(B). An offense is a financial crime under section 424.535(a)(3)(i)(B) if it is one of the crimes named in that regulation (extortion, embezzlement, income tax evasion, or insurance fraud) or it is "similar" to one or more of the named crimes. *Abdul Razzaque Ahmed, M.D.*, DAB. No. 2261, at 7 (2009), *aff'd sub nom. Ahmed v. Sebelius*, 710 F.Supp.2d 167 (D.Mass. 2010). Filing a false tax return is in the nature of or similar to income tax evasion which is specifically listed in section 424.535(a)(3)(i)(B). The statute which he violated prohibits "Fraud or False Statements." 26 U.S.C. § 7206(1). The one-count to which Petitioner pled guilty states that Petitioner "[w]illfully [made] and subscribe[d] any return, statement, or other document, which contains or is verified by a written declaration that it is made under the penalties of perjury, and which he does not believe to be true and correct as to every material matter." P. Ex. 9. Petitioner's false statement to the federal government resulted in his paying less than the legally required amount of income tax. This is supported by Petitioner's admission that he had to repay back taxes. HR at 7. Just as the Court in *Ahmed* found that, under the circumstances of Dr. Ahmed's crime, obstruction of justice bore "the DNA" of insurance fraud, I conclude that Petitioner's crime partakes of the same nature as income tax evasion.

Even if I did not consider Petitioner's crime to be tantamount to income tax evasion, I would still conclude that it was a "financial crime" within the meaning of the regulation. The Board explained in *Ahmed* that –

> even if Petitioner's felony offense was not similar to one of the crimes named in the regulation, CMS would not necessarily be precluded from finding that it was a financial crime. Financial crimes, the regulation states, are crimes "such as extortion, embezzlement, income tax fraud, insurance fraud and other similar crimes" (emphasis added). The words "such as" imply that the subsequent list of illustrative crimes, including crimes similar to those named in the list, are not the only set of crimes that may be considered "financial."

DAB No. 2261, at 8-10. In upholding the Board's decision, the Court agreed that the regulations use "nonexclusive, illustrative language to enumerate the various felony convictions" and should be read broadly. 710 F.Supp.2d at 174.

I also note the statement in the preamble to the revocation regulation that "[f]elonies that we determine to be detrimental to the best interests of the Medicare program or its beneficiaries include the following . . . financial crimes, such as . . . ***making false statements***, insurance fraud, and other similar crimes . . . ." 71 Fed. Reg. at 20,768 (emphasis added). This language indicates that CMS intended the term "financial crime" in the regulation to be read broadly to include false statements resulting in financial benefit or loss. Petitioner's filing of fraudulent or false tax forms as part of his criminal conduct also constitutes the making of false statements that CMS has determined is detrimental to the best interests of the Medicare program or its beneficiaries. On its face, this crime calls into question whether government can rely on Petitioner's integrity. I therefore reject Petitioner's contention that only financial crimes that require proof of intentional fraudulent deception as an element may be the basis for revocation under section 535(a)(3)(i)(B).

Finally, even if filing false tax return did not amount to a "financial crime" as identified in the regulation, the Board has held that CMS is not limited to the list of felonies specifically identified as detrimental to the Medicare program under section 535(a)(3)(i), but may make a case-by-case determination that a particular crime is detrimental to the program. Thus, the Board analyzed the regulatory language as follows:

> The regulation . . . indicates that crimes detrimental to Medicare "include" those specified in subparagraphs (A) through (D) of section 424.535(a)(3)(i). The words "include" or "including" are not terms of limitation or exhaustion. When followed by a list of items, those words are reasonably read as signifying that the list contains merely illustrative examples of a general proposition or category that precedes the word and is not intended to preclude unmentioned items from being considered supportive or part of the general proposition or category. Puerto Rico Maritime Shipping Auth. v. ICC, 645 F.2d 1102, 1112 n. 26 (D.C. Cir. 1981) ("It is hornbook law that the use of the word 'including' indicates

> that the specified list . . . that follows is illustrative, not exclusive."). Hence, section 424.535(a)(3)(i) is reasonably read as setting out a non-exhaustive list of crimes that may constitute a basis for revocation.

Fady Fayed, M.D., DAB No. 2266, at 8 (2009). Petitioner has provided no persuasive reason to find CMS's determination that this crime is detrimental unreasonable or arbitrary.

Petitioner's argument that "[t]he purpose of 42 C.F.R. § 424.535(a)(3) is not to exclude people like Dr. Tolliver who simply relied on bad advice from professional advisors" merely amounts to a collateral attack on the felony for which Petitioner was convicted. HR at 7. Petitioner cites no authority to show that he may collaterally attack his criminal conviction in this forum. As I have said in a similar case, "CMS's revocation authority here springs from Petitioner having been 'convicted, including guilty pleas and adjudicated pretrial diversions,' and I see nothing in any regulation that authorizes me to ignore or look behind the fact of a conviction or guilty plea and entertain arguments that essentially amount to collateral attacks on the conviction." *Ravindra Patel, M.D*, DAB CR2171 (2010). Petitioner pled guilty in exchange for the benefits of a plea agreement. I find no authority for me to review in this forum whether the basis of the underlying conviction to which Petitioner pled guilty can be challenged.

I also conclude that it is irrelevant that Petitioner's crime was not committed against the Medicare program.[3] *Bussell* at 9. Petitioner confuses "exclusions" imposed by the Inspector General under section 1128(a)(1) of the Act on any individual who "has been convicted of a criminal offense related to the delivery of an item or service under title XVIII [Medicare] or under any State health care program" with CMS's authority to revoke the enrollment of a Medicare supplier. *See* DAB No. 2261, at 13; DAB No. 2266, at 12, 15. Petitioner identifies, and I find, nothing in the statute or regulations limiting CMS's authority to revoke under 42 C.F.R. § 424.535(a)(3) to felonies related to or directly harming Medicare.

For these reasons, I conclude that CMS was authorized to revoke Petitioner's enrollment under 42 C.F.R. § 424.535(a)(3) based on his felony conviction.

3. CMS had the authority to revoke Petitioner's enrollment and billing privileges in the Medicare program under 42 C.F.R. § 424.535(a)(9) for failing to report his criminal conviction and adverse actions against his medical license in multiple states as required by 42 C.F.R. § 424.516(d)(1)(ii).

[3] CMS does not contend that Petitioner's conviction of filing a false tax return falls under subsection 535(a)(3)(C), a "felony that placed the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct."

As previously noted, it is undisputed that Petitioner was convicted of the felony offense of filing false tax returns, had his licenses suspended or revoked in several states and failed to report these adverse actions to the Medicare contractor. HR at 4-5; P. Br. at 5; *see* OFTC at 1. Petitioner argues that, at the time he was sentenced, the regulation requiring him to report all adverse actions against him within thirty days was not yet in place since it became effective only January 1, 2009.[4] He acknowledges, however, that at the time of his conviction, "he was subject to a ninety day reporting period." RH at 4; P. Br. at 5. Since it is undisputed that he failed to report within either time frame and both versions of the reporting requirement put Petitioner on notice that failure to report could result in revocation, the change in the regulations is irrelevant and presents no problem of retroactive enforcement, contrary to Petitioner's arguments.

Petitioner next suggests that the failure to report was not intentional and he should not therefore be bound by the resulting exclusion. Petitioner states that he "did not intentionally conceal the tax offense" or "intentionally mislead" the contractor, rather his "failure to notify TrailBlazer was inadvertent." HR at 4-5; P. Br. at 5. Petitioner's also intimates that because he didn't see Medicare patients while he was not fully licensed, presumably the exclusion should be waived. *Id*. Petitioner's arguments are also irrelevant, since he cannot show that the regulations now or ever included exceptions from the reporting requirements on such bases.

Section 424.516(d) states that "[p]hysicians and nonphysician practitioners . . . must report . . . to their Medicare contractor . . . [w]ithin 30 days . . . [a]ny adverse legal action." A "[f]inal adverse action" is defined to include "[s]uspension or revocation of a license to provide health care by any State licensing authority" and a "conviction of a Federal or State felony offense (as defined in § 424.535(a)(3)(i)) within the last 10 years preceding enrollment, revalidation, or re-enrollment." 42 C.F.R. § 424.502. The regulation does not include an intentionality requirement or provide an exception for inadvertent failures to report. While seeing Medicare patients while he did not posses a valid medical license would raise many additional problems, refraining from doing so does not excuse Petitioner from complying with the reporting requirement.

In addition to his criminal conviction, Petitioner was required to report the suspensions of his licenses in Virginia and West Virginia and the revocation of his license in Ohio, all adverse actions. P. Exs. 9; 12-16. Petitioner failed to report these adverse actions as required. Thus, under 42 C.F.R. § 424.535(a)(9), CMS had the authority to revoke Petitioner's enrollment and billing privileges in the Medicare program for failure to report the adverse actions within thirty days even if I had not concluded, as I did above, that Petitioner's revocation was proper based on the felony conviction.

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[4] The original regulation was 42 C.F.R. § 424.520(b)(2008), which was replaced by 42 C.F.R. § 424.516(d)(1)(ii), effective January 1, 2009.

Therefore, CMS is entitled to summary judgment based on Petitioner's failure to report as required under 42 C.F.R. § 424.535(a)(9) as well.

4. Petitioner does not have the right to challenge the imposition or duration of the re-enrollment bar.

Whenever CMS has properly imposed revocation, it has the authority to determine a length of time between one and three years during which that provider or supplier is barred from re-enrolling. Thus, section 424.535(c) provides:

> After a provider, supplier . . . has had their billing privileges revoked, they are barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar. The re-enrollment bar is a minimum of 1 year but not greater than 3 years depending on the severity of the basis for revocation.

Here, CMS imposed a three-year bar on Petitioner. P. Ex. 1, at 2. Petitioner takes exception to both the application and duration of the re-enrollment bar. HR at 4-6.

In its submissions, CMS moved for dismissal on this issue, arguing that the regulations do not permit providers or suppliers to challenge either the establishment or duration of a re-enrollment bar. CMS Br. at 5. Petitioner, on the other hand, argues that "42 C.F.R. § 498.3(d) sets forth an exhaustive list of fifteen decisions that are not appealable" and that the list "does not include the imposition of a re-enrollment bar." P. Br. at 6. Petitioner argues that if CMS held that the "imposition or length of a re-enrollment [bar] was not subject to appeal, it would have included it in this exhaustive list. . . ." *Id*.

Although Petitioner repeatedly refers to the list of actions not subject to appeal as "exhaustive," the regulation specifically provides that this list is *not* exclusive. Section 498.3(d) states "[a]dministrative actions that are not initial determination (and therefore not subject to appeal under this part) *include but are not limited to* the following" (emphasis added).

Petitioner points to no source of authority in the statute or regulation for me to review the decision to impose a re-enrollment bar. On its face, the regulation requires CMS to impose at least a one-year re-enrollment bar whenever billing privileges are revoked. In light of the mandatory language, I find no basis for me to review the application of a re-enrollment.

As far as Petitioner's challenge to the duration of the re-enrollment bar beyond the one-year minimum, the regulation uses discretionary language allowing CMS to impose a bar of up to three years depending on "the severity of the basis for revocation." 42 C.F.R.

§ 424.535(c). Petitioner again fails to identify authority for me to review CMS's assessment of the severity of the conduct and consequent selection of a re-enrollment bar period. Section 498.3(b)(17) provides Petitioner a right to challenge whether CMS had authority to revoke Petitioner's enrollment as a supplier in the Medicare program, but I do not find any similar basis for challenging CMS's judgment as to the duration of the resulting re-enrollment bar. In any case, as CMS pointed out, the re-enrollment bar duration may be academic in Petitioner's situation where the revocation was based on a felony conviction, since a separate regulation provides CMS with authority to deny enrollment by a supplier who has been convicted of a felony within the preceding 10 years. 42 C.F.R. § 424.530(a)(3); CMS Letter of August 16, 2010, at 6, citing 42 C.F.R. § 424.535(a)(3) and MPIM, § 13.2.

For the reasons explained, I conclude that I have no authority to alter the three-year re-enrollment bar.

IV. Conclusion

The undisputed facts entitle CMS to summary judgment as a matter of law. I therefore grant summary judgment in favor of CMS and sustain the revocation of Petitioner's enrollment, effective September 18, 2008.

/s/
Leslie A. Sussan
Board Member