Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Anna Gravich, M.D.,	)	Date: August 24, 2007
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-07-230
	)	Decision No. CR1637
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

I affirm the determination of the Medicare Part B Hearing Officer (Hearing Officer) to revoke the Medicare billing privileges of Petitioner, Anna Gravich, M.D.

I. Background

By letter dated September 26, 2006, the Centers for Medicare & Medicaid Services (CMS), acting through the National Heritage Insurance Company, Inc. (NHIC), the Medicare Part B carrier for California, notified Petitioner that her Medicare billing privileges would be revoked effective October 26, 2006, pursuant to 42 C.F.R. § 424.535(a)(3)(i)(B), based on her 1999 federal felony convictions for income tax evasion and subscribing to a false income tax return. Petitioner requested a reconsideration-level carrier hearing. By decision dated December 18, 2006, the Medicare Hearing Officer issued an unfavorable decision which upheld the revocation by the Medicare carrier. By letter dated January 30, 2007, Petitioner requested a hearing to appeal the unfavorable decision by the Medicare Hearing Officer.

I convened a prehearing conference in this matter on March 19, 2007. During the conference, I set a briefing schedule so that the parties could address the issues of this case. Petitioner filed her brief (P. Br.) on April 30, 2007 along with seven exhibits,

Petitioner Exhibits (P. Exs.) 1-7. On May 18, 2007, CMS filed its brief in response (CMS Br.) along with two exhibits, CMS Exhibits (CMS Exs.) 1-2, and four attachments, CMS Attachments (CMS Atts.) 1-4. On June 1, 2007, Petitioner filed her brief in response (P. Response Br.) to CMS's brief. By order dated June 8, 2007, I noted that Petitioner, in a footnote of her Response brief, reserved for an in-person hearing the issue of whether CMS failed to exercise its discretion in making the decision to revoke Petitioner's billing privileges. *See* P. Response Br. at 9, n.4. In a June 8, 2007 Order, I stated that this issue is not a factual issue appropriate for an in-person hearing, but, rather, a legal issue appropriate for briefing. I set a further briefing schedule for the parties to discuss whether I have authority to question CMS's discretion, and, if so, whether CMS should exercise its discretion in this case. Subsequently, on July 3, 2007, Petitioner filed her response to my June 8, 2007 Order. In Petitioner's July 3, 2007 response, she withdrew her claim regarding the exercise, or non-exercise of CMS's discretion, and also withdrew her request for an in-person hearing on this issue. Instead, Petitioner requested that I make my decision based on the written briefs. On July 26, 2007, CMS filed its response to my June 8, 2007 Order and rested on its previous submissions. CMS did not request an in-person hearing in any of its submissions. Because Petitioner has withdrawn its claim concerning CMS's exercise of discretion, I do not discuss the merits of this claim in my decision.

I make my decision based on the applicable law and the parties' briefs and exhibits.

II. Applicable Law

Section 1842(h)(8) of the Social Security Act (Act), 42 U.S.C. § 1395u(h)(8), grants the Secretary of the Department of Health and Human Services (Secretary) discretion to refuse to enter into an agreement, or to terminate or refuse to renew an agreement, with a physician or supplier that "has been convicted of a felony under Federal or State law for an offense which the Secretary determines is detrimental to the best interests, of the program."

Section 1866(j) of the Act, 42 U.S.C. § 1395cc(j), requires the Secretary to "establish by regulation a process for the enrollment of providers of services and suppliers under this title," and grants "[a] provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) under this title is denied" a "hearing and judicial review of such denial under the procedures that apply under subsection (h)(1)(A)." Act, section 1866(j)(1)(A) and (2).

The regulation governing revocation of enrollment provides:

> (a) *Reasons for revocation*. CMS may revoke a currently enrolled provider's or supplier's Medicare billing privileges and any corresponding provider agreement or supplier agreement for the following reasons . . .
>
> (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 program and its beneficiaries . . .
>
> (i) Offenses include . . .
>
> (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.

42 C.F.R. § 424.535.

The Departmental Appeals Board (Board) has held that section 1866(j)(2) of the Act gives appeal rights to suppliers. "Section 1866(j)(2) of the Social Security Act (the Act) gives suppliers appeal rights, for certain determinations involving enrollment, using the procedures that apply under section 1866(h)(1)(A) of the Act. Those procedures are at 42 C.F.R. Part 498 and provide for ALJ [administrative law judge] hearings and Board review."[1] *MediSource Corporation*, DAB No. 2011, at 2 (2006). Further, the Board has recognized the procedures and the burden of persuasion established by the Secretary in the Program Integrity Manual (PIM, Pub. 100-08) at Chapter 10, § 19. "The Medicare Provider Integrity Manual provides: 'The burden of persuasion is on the . . . supplier . . . to show that its enrollment application was incorrectly disallowed or that the revocation of its billing number was incorrect.' [Citing PIM, Ch. 10, § 19.B.] This provision is consistent with the Board's conclusion in provider appeals under 42 C.F.R. Part 498 that a provider must prove substantial compliance by the preponderance of the evidence, once CMS has established a prima facie case that the provider was not in substantial

[1] A proposed rule, not yet effective, would extend to suppliers the due process procedures of 42 C. F. R. Part 498, including the right to a hearing by an ALJ. *See* 72 Fed. Reg. 9479 (March 2, 2007). CMS consents to the application of the procedures in 42 C.F.R. Part 498 to the matter before me.

compliance with relevant statutory or regulatory provisions." *Id.* at 2-3.

III. Issue

The issue in this case is whether CMS was authorized to revoke Petitioner's Medicare billing privileges effective October 26, 2006.

IV. Discussion

I make findings of fact and conclusions of law (Findings) to support my decision in this case. I set forth each Finding below as a separate heading. I discuss each Finding in detail.

1. The regulation found at 42 C.F.R. § 424.535(a)(3)(i)(B) was not applied retroactively.

On or about June 8, 1999, Petitioner was convicted in the United States District Court, Central District of California, Western Division-Los Angeles, of felony income tax evasion, in violation of 26 U.S.C. § 7201, and subscribing to a false income tax return, in violation of 26 U.S.C. § 7206(1). P. Ex. 3. Petitioner has admitted these convictions. P. Br. at 2, n.1. Based on these convictions, CMS revoked Petitioner's Medicare billing privileges, effective October 26, 2006, pursuant to 42 C.F.R. § 424.535(a)(3)(i)(B).

Petitioner argues that the regulation found at 42 C.F.R. § 424.535(a)(3)(i)(B) was applied retroactively. The effective date of this regulation was June 20, 2006. However, the felony convictions upon which CMS rests Petitioner's revocation occurred in 1999. Petitioner argues that under *Bowen v. Georgetown University Hospital*, 488 U.S. 204, 109 S.Ct. 468 (1988), congressional enactments and administrative rules will not be construed to have retroactive effect unless their language requires this result and that therefore 42 C.F.R. § 424.535(a)(3)(i)(B) was applied retroactively in the case before me.

Petitioner's argument is without merit. The regulation at 42 C.F.R. § 424.535(a)(3)(i)(B) implements the statutory provision at section 1842(h)(8) of the Act. Section 1842(h)(8) of the Act was enacted as part of the Balanced Budget Act of 1997, which predates Petitioner's 1999 felony convictions. Section 1842(h)(8) of the Act grants the Secretary discretion to refuse to enter into an agreement, or to terminate or refuse to renew an agreement, with a physician or supplier that "has been convicted of a felony under Federal or State law for an offense which the Secretary determines is detrimental to the best interests of the program or program beneficiaries." *See* H.R. Conf. Rep. 105-217, H.R. Conf. Rep. No. 217, 105th Cong., 1st Sess. 1997, 1997 U.S.C.C.A.N. 176, 1997 WL

541276. Section 1842(h)(8) predates Petitioner's 1999 felony convictions and therefore has not been applied retroactively.

The language of the regulation is clear and unambiguous. The regulation applies to convictions "within 10 years preceding enrollment or revalidation of enrollment" that are determined to be detrimental to the best interests of the program and its beneficiaries. 42 C.F.R. § 424.535(a)(3). The regulations specifically include income tax evasion as an offense which is detrimental to the best interests of the program and its beneficiaries. 42 C.F.R. § 424.535(a)(3)(i)(B).

Further, the Secretary stated in the preamble:

> [W]e believe it is necessary for us to impose the requirements of this regulation on existing providers and suppliers and to establish safeguards to enable us to deny enrollment of unqualified providers and suppliers, and to revoke the billing privileges of egregious offenders whose actions place the Medicare Trust Funds at risk.

71 Fed. Reg. 20,754, 20,773 (2006). Petitioner's conviction for felony income tax evasion has been determined to be detrimental to the best interests of the program and its beneficiaries. It is clear that CMS has applied this regulation to Petitioner exactly as intended, completely consistent with the plain meaning of the language of the regulation and the preamble.

Petitioner's reliance on *Bowen* is misplaced. The regulation at issue in *Bowen* appears to have violated the Administrative Procedures Act (APA), which forbids retroactive rulemaking. I am bound to follow the Secretary's rules. While I may decide whether CMS's interpretations of a regulation are correct or not, I lack authority to find a regulation invalid because the Secretary did not comply with the provisions of the APA. *Vermillion Behavioral Health Center,* DAB CR751 (2001); *Marion Citrus Mental Health Center*, DAB CR864 (2002).

2. Revocation gives rise to appeal rights, while deactivation gives rise to rebuttal rights.

Petitioner argues that since she was not given an initial opportunity to file a rebuttal statement, her billing privileges were improperly revoked. Petitioner is mistaken. The opportunity to file a rebuttal statement only arises when billing privileges are deactivated under 42 C.F.R. § 424.545(b). Petitioner's billing privileges were not deactivated, but were revoked under 42 C.F.R. § 424.535, a different regulation than the one relied on by

Petitioner. Revocation means that a provider's or supplier's billing privileges were terminated. 42 C.F.R. § 424.502. Revocation gives rise to appeal rights, while deactivation gives a petitioner an opportunity to file a rebuttal statement. 42 C.F.R. § 424.545(a) and (b).

3. Petitioner's Medicare billing privileges may be revoked based on a felony income tax evasion conviction which occurred within 10 years prior to enrollment or revalidation of enrollment.

Petitioner claims that a revalidation in this case did not occur and, therefore, Petitioner's billing privileges must be reinstated. Petitioner argues that there was no revalidation, but merely an updating of Dr. Gravich's records based on her notification to the Medicare program of a change of address. Petitioner urges that the updating of Petitioner's file occurred pursuant to 42 C.F.R. § 424.520(b), which requires that, following enrollment, a provider or supplier must report to CMS any changes to the information furnished on the enrollment application.

On or after May 24, 2005, Petitioner submitted a change of information to NHIC on a CMS Form 8551, identifying a new practice location and a new mailing address for purposes of Medicare payments. CMS Ex. 1, at ¶ 9. However, 42 C.F.R. § 424.520(b), under which Petitioner claims she was updating her file, did not go into effect until 2006 and could not have affected Petitioner's May 24, 2005 change of information. At the time that Petitioner submitted her change of information form, procedures for verification and validation of information were then located in section 16 of Chapter 10 of the PIM pursuant to revisions made by CMS's Transmittals 41 and 42 dated May 23, 2003. *Id.* at ¶ 10; CMS Att. 3. The procedures in effect when Petitioner submitted her CMS Form 8551 provided that when a physician (supplier) submitted a change of information, that the verification process was followed to validate the information being changed and, by this method, a supplier's Medicare enrollment was revalidated. *Id.* at ¶ 8. CMS provided me with evidence that the revalidation process in effect at the time Petitioner submitted her Form 8551 was followed by NHIC. CMS Exs. 1, 2.

Petitioner's Medicare billing privileges were revoked pursuant to 42 C.F.R. § 424.535(a)(3). The validation process followed by NHIC in 2005 qualifies as a revalidation of enrollment within the meaning of 42 C.F.R. § 424.535(a)(3). Prior to the new regulations that are currently in effect, procedures already existed for validation, revalidation and changes of information. CMS Atts. 1-4. The previous procedures allowed for existing enrollment information in the system to be checked against new

information. The new regulations merely allow for more structure, but do not change the essence of the revalidation procedures and require all providers and suppliers to undergo the revalidation procedure to ensure continued compliance with Medicare requirements.

V. Conclusion

I conclude that CMS properly revoked Petitioner's Medicare billing privileges.

/s/
Alfonso J. Montano
Administrative Law Judge