Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
George E. Smith, M.D., (PTAN: 4J940, 4J940CS31, 4J940C42)	)	Date: February 26, 2010
Petitioner,	)	Docket No. C-09-752 Decision No. CR2074
v.	)	
Centers for Medicare & Medicaid Services.	)	

DECISION

The Medicare enrollment and billing privileges of Petitioner, George E. Smith, M.D., were properly revoked effective April 8, 2008.

I. Background

The Medicare contractor for the Centers for Medicare & Medicaid Services (CMS), Pinnacle Business Solutions, Inc. (Pinnacle), notified Petitioner by letter dated March 23, 2009, that his Medicare Provider Transaction Access Numbers (PTANs) and billing privileges were being revoked effective April 8, 2008. The grounds cited for the revocation were: (1) Petitioner's noncompliance with enrollment requirements due to suspension of Petitioner's license to practice medicine by the Louisiana State Board of Medical Examiners (the Louisiana Board) (42 C.F.R. § 424.535(a)(1)); and (2) Petitioner's failure to report the adverse legal action by the Louisiana Board as required by 42 C.F.R. § 424.516(d)(1)(ii).[1] CMS Exhibit (CMS Ex.) C. Petitioner requested

[1] This provision was added by final rule at 73 Fed. Reg. 69,725; 69,777; 69,939 (Nov. 19, 2008) and 73 Fed. Reg. 80,304 (Dec. 31, 2008) effective January 1, 2009, and is to be codified at 42 C.F.R. § 424.516.

reconsideration by a contractor hearing officer who issued a decision on September 8, 2009. The hearing officer sustained the revocation based upon Petitioner's license suspension and Petitioner's failure to notify the contractor of the adverse legal action. CMS Ex. A, at 3-7.

Petitioner requested a hearing before an administrative law judge (ALJ) by an undated letter postmarked September 16, 2009. The case was assigned to me on September 25, 2009 for hearing and decision, and an Acknowledgement and Prehearing Order was issued at my direction on that date. CMS filed a motion for summary judgment, supporting brief (CMS Brief), and exhibits A through C[2] on October 23, 2009. Petitioner filed an opposing brief and a cross-motion for summary judgment (P. Brief) with exhibits (P. Ex.) 1 and 2 on November 13, 2009. CMS waived a reply by letter dated January 11, 2010. The parties have not objected to my consideration of the offered exhibits. Therefore, CMS exhibits A through C and Petitioner's exhibits 1 and 2 are admitted.

II. Discussion

A. Applicable Law

Section 1831 of the Social Security Act (the Act) (42 U.S.C. § 1395j) establishes the supplementary medical insurance benefits program for the aged and disabled known as Medicare Part B. Payment under the program for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of services and suppliers.[3] Act

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[2] CMS did not mark its exhibits in the manner specified by the Civil Remedies Division Procedure (CRDP), ¶ 9, which was made applicable by my Acknowledgement and Prehearing Order dated September 25, 2009 (Prehearing Order), ¶ 9. However, due to the few exhibits offered there is little chance for confusion and the CMS exhibits are accepted as marked. Petitioner failed to mark his exhibits and they are marked as follows: P. Ex. 1, Affidavit of George Edmond Smith, M.D., dated November 13, 2009; and P. Ex. 2, Consent Order In the Matter of George Edmond Smith, M.D., Louisiana State Board of Medical Examiners, No. 08-I-053, dated October 10, 2008.

[3] A "supplier" furnishes services under Medicare and the term supplier applies to 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) and 1835(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.

§§ 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395(u)(h)(1)). Administration of the Part B program is through contractors. Act § 1842(a) (42 U.S.C. § 1395u(a)). The Act requires the Secretary to issue regulations that establish a process for the enrollment of providers and suppliers, including the right to a hearing and judicial review in the event of denial or non-renewal. Act § 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to 42 C.F.R. § 424.505, a provider or supplier 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. If enrollment is approved, a supplier is issued a National Provider Identifier (NPI) to use for billing Medicare and a PTAN, an identifier for the supplier for inquiries. Medicare Program Integrity Manual (MPIM), CMS Publication 100-08, Chapter 10, Healthcare Provider/Supplier Enrollment, § 6.1.1.

Qualified physician services are covered by the program for those enrolled, subject to some limitations. Act §§ 1832(a) (42 U.S.C. § 1395k(a)); 1861(s)(1) (42 U.S.C. § 1395x(s)(1)). "Physician's services" means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls (with certain exceptions). Act § 1861(q) (42 U.S.C. § 1395x(q)). The term "physician," when used in connection with the performance of any function or action, means, in part, a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she performs such function or action. Act § 1861(r) (42 U.S.C. § 1395x(r)); 42 C.F.R. § 410.20(b). The Medicare program authorizes Medicare Part B payments for services provided by physicians. 42 C.F.R. § 410.20. A physician who wants to bill Medicare or its beneficiaries for Medicare-covered services or supplies must enroll in the Medicare program. 42 C.F.R. § 424.505. Medicare pays a supplier directly for covered services if the beneficiary assigns the claim to the supplier and the supplier accepts it. Medicare may pay a supplier's employer if the supplier is required, as a condition of employment, to turn over the fees for the supplier's services. Medicare will also pay an entity billing for a supplier's services if the entity is enrolled in Medicare and there is a contractual arrangement between the entity and the supplier. Act § 1842(b)(6); 42 C.F.R. §§ 424.55(a), 424.80(a) and (b).

CMS may deny a supplier's enrollment application if a supplier is not in compliance with Medicare enrollment requirements. 42 C.F.R. § 424.530(a)(1). A supplier's enrollment application is considered denied when a supplier is determined to be "ineligible to receive Medicare billing privileges for Medicare covered items or services provided to Medicare beneficiaries" for one or more of the reasons listed in 42 C.F.R. § 424.530. 42 C.F.R. § 424.502. CMS's contractor notifies a supplier in writing when it denies enrollment and explains the reasons for the determination and provides information regarding the supplier's right to appeal. 42 C.F.R. § 498.20(a); MPIM Ch. 10, §§ 6.2, 13.2. The supplier may submit a written request for reconsideration to CMS. 42 C.F.R. § 498.22(a). CMS must give notice of its reconsidered determination to the supplier, giving the reasons for its determination and specifying the conditions or requirements the

supplier failed to meet. 42 C.F.R. § 498.25. If the CMS decision on reconsideration is unfavorable to the supplier, the Act provides for a hearing by an ALJ and judicial review. Act § 1866(j)(2).

If a provider or supplier is accepted for enrollment and granted billing privileges, the enrollee is subject to revalidation every five years. Every five years, the enrollee is required to resubmit and recertify the accuracy of its enrollment information and the information is reverified by the CMS contractor. CMS is also permitted to conduct "off-cycle" revalidation that may be conducted at any time and which may be triggered by random checks, adverse information, national initiatives, complaints, or other reasons that cause CMS to question whether the provider or supplier continues to meet enrollment requirements. 42 C.F.R. § 424.515.

CMS may revoke an enrolled provider's or supplier's Medicare billing privileges and any provider or supplier agreement for any of the reasons listed in 42 C.F.R. § 424.535. Pursuant to 42 C.F.R. § 424.535(a)(1), CMS may revoke a provider's or supplier's enrollment if it is determined that the provider or supplier is not in compliance with enrollment requirements and fails, after being given the opportunity, to achieve compliance before a final determination to revoke billing privileges. Pursuant to 42 C.F.R. § 424.535(a)(9),[4] billing privileges may also be revoked for failure to report the information required by 42 C.F.R. § 424.516(d)(1)(ii) and (iii). Physicians, nonphysician practitioners, and organizations of such individuals must report the following events to the appropriate CMS contractor within 30 days and other changes in enrollment must be reported within 90 days: (1) change of ownership; (2) any adverse legal action; or (3) a change in practice location. The effective date of revocation of billing privileges in the case of license suspension or revocation is the date of the license suspension or revocation. 42 C.F.R. § 424.535(g). The Act provides for a hearing by an ALJ and judicial review of the determination to deny enrollment or re-enrollment. Act § 1866(j)(2).

B. Issue

Whether there was a basis for revocation of Petitioner's supplier number and his billing privileges.

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

1. Summary judgment is appropriate.

CMS moved for summary judgment and Petitioner filed a cross-motion for summary judgment. Petitioner requested that, if summary judgment is not granted, a decision be

[4] See footnote 1.

issued based upon the briefs and documents. P. Brief at 10. There are no genuine issues of material fact in dispute in this case and summary judgment is appropriate. Petitioner does not deny that his license to practice medicine was suspended for six months by the Louisiana Board due to chemical dependency and due to prescribing controlled substances in an improper manner. P. Brief at 1-2, 5; P. Ex. 2. Petitioner does not dispute that he failed to notify CMS or its contractor that his license to practice medicine was suspended by the Louisiana Board. P. Brief at 2, 5-6.

Summary judgment is appropriate and no hearing is required where either: there are no disputed issues of material fact and the only questions that must be decided involve application of law to the undisputed facts; or, the moving party must prevail as a matter of law even if all disputed facts are resolved in favor of the party against whom the motion is made. *See Kingsville Nursing and Rehabilitation Center*, DAB No. 2234, at 3-4 (2009); *Illinois Knight Templar Home*, DAB No. 2274, at 3-4, 8 (2009); *White Lake Family Medicine, P.C.*, DAB No. 1951 (2004); *Lebanon Nursing and Rehabilitation Center*, DAB No. 1918 (2004). A party opposing summary judgment must allege facts which, if true, would refute the facts relied upon by the moving party. *See, e.g.*, Fed. R. Civ. P. 56(c); *Garden City Medical Clinic*, DAB No. 1763 (2001); *Everett Rehabilitation and Medical Center*, DAB No. 1628, at 3 (1997) (in-person hearing required where non-movant shows there are material facts in dispute that require testimony); *Thelma Walley*, DAB No. 1367 (1992); *see also New Millennium CMHC, Inc.*, DAB CR672 (2000); *New Life Plus Center, CMHC*, DAB CR700 (2000).

This case requires an application of the law to the undisputed facts. The issues in this case turn on the legal interpretation of the Act and regulations that govern revocation of billing privileges as discussed hereafter. Neither party asserts that there is a genuine dispute as to a material fact and the evidence does not show such a dispute. Accordingly, summary judgment is appropriate.

2. There was a basis for revocation of Petitioner's billing privileges pursuant to 42 C.F.R. § 424.535(a)(1) because he was not in compliance with the participation requirement to have a license as a physician.

3. There was a basis for revocation of Petitioner's billing privileges pursuant to 42 C.F.R. § 424.535(a)(9) because Petitioner failed to report adverse legal action as required by 42 C.F.R. § 424.516(d)(1)(ii).

In order for a physician to participate in Medicare and receive reimbursement for physician services from Medicare, he or she must be a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she performs such function or action. Act § 1861(r) (42 U.S.C. § 1395x(r)); 42 C.F.R. § 410.20(b)(1). CMS is authorized to revoke a currently enrolled provider's or supplier's billing privileges and any related provider or supplier agreement if the provider or

supplier is determined to no longer meet the conditions for enrollment, subject to an opportunity for the provider or supplier to make corrections before revocation. 42 C.F.R. § 424.535(a)(1).

Petitioner does not dispute that in order to enroll in Medicare to receive reimbursement for physician services he needed to be licensed by the State of Louisiana where he practiced as a physician. Petitioner does not dispute that his license was suspended by the Louisiana Board effective April 8, 2008. Petitioner does not dispute that when his license was suspended by the State of Louisiana he no longer met the requirements for enrollment in Medicare as a physician. Accordingly, I conclude that there was a basis for revocation of Petitioner's billing privileges and enrollment pursuant to 42 C.F.R. § 424.535(a)(1).

CMS is also authorized to revoke billing privileges if a provider or supplier did not comply with the documentation requirements established by 42 C.F.R. § 424.516(d)(1)(ii). 42 C.F.R. § 424.535(a)(9).[5] Pursuant to 42 C.F.R. § 424.516(d)(1)(ii), Petitioner was required to notify CMS of any adverse legal action. Although this provision of the regulation was not effective until January 1, 2009, Petitioner does not dispute that he had an obligation to report the suspension of his license to practice medicine by the Louisiana Board. P. Brief at 6. Petitioner also does not dispute that suspension of his license was an adverse legal action as defined by 42 C.F.R. § 424.502, that he was required to report. P. Brief at 5-7. Accordingly, I conclude that there was a basis for revocation of Petitioner's billing privileges and enrollment pursuant to 42 C.F.R. § 424.535(a)(9).

4. The issue for hearing and decision is whether there is a basis for revocation of Petitioner's billing privileges and enrollment.

I have concluded that CMS had a legal basis for the revocation of Petitioner's billing privileges and Medicare enrollment, pursuant to both 42 C.F.R. § 424.535(a)(1) and (9). Petitioner's right to request ALJ review of the reconsideration decision upholding revocation is granted by section 1866(j)(2) of the Act, as implemented by 42 C.F.R. §§ 424.545; 498.3(1), (5), (7), (15), and (17); and 498.5, which provide a right for review of an initial and/or reconsideration determination of whether a provider qualifies or

[5] Neither the March 23, 2009 Pinnacle notice of revocation (CMS Ex. C, at 2-4) nor the September 8, 2009 reconsideration decision (CMS Ex. A, at 3-7) cited this regulation as the proper basis for exclusion. I conclude, however, that Petitioner was not prejudiced by this error because Petitioner was clearly on notice that the basis for revocation was his **failure to notify CMS** of the adverse legal action by the Louisiana Board. CMS Ex. A, at 4; CMS Ex. C, at 3; P. Brief at 2-3.

whether conditions for coverage are met by a supplier; the effective date of a Medicare provider agreement or supplier approval; and whether to deny or revoke enrollment of a provider or supplier.

Petitioner argues that he cured his noncompliance, and revocation of his billing privileges was improper. P. Brief at 5. Petitioner argues that, although he did not meet enrollment requirements when he was suspended by the Louisiana Board, he is currently in full compliance with enrollment requirements and there is no reason he should not be permitted to participate in Medicare. P. Brief at 4. In support of his argument, Petitioner points out that after entering the consent order with the Louisiana Board on September 5, 2008, his license was reinstated and he was permitted to resume practice. P. Brief at 2. Pursuant to the terms of the consent order, the suspension of Petitioner's license was effective retroactively from April 8, 2008 for a period of six months that ended on the effective date of the consent order; Petitioner's license to practice medicine was reinstated effective the date of the consent order; and he was placed on probation for a period of five years. The consent order was executed by Petitioner on September 5, 2008, but was not effective until accepted by the President of the Louisiana Board on October 10, 2008. CMS Ex. A, at 16-17, 21-22. Petitioner correctly states that the CMS contractor did not notify Petitioner of revocation of his billing privileges for more than five months after his license was reinstated by the Louisiana Board. P. Brief at 2; CMS Ex. B, at 11-13. Petitioner requested reconsideration on May 7, 2009 on grounds that he was then in compliance with enrollment requirements. P. Brief at 3. The evidence shows that Petitioner's first request for reconsideration was signed by Petitioner's counsel and it was rejected on May 29, 2009. CMS Ex. A, at 25. Petitioner's subsequent request for reconsideration dated June 8, 2009, was accepted as timely by the Medicare contractor. CMS Ex. A, at 12-13. Petitioner's reconsideration request was denied on September 8, 2009, on the same grounds on which his billing privileges were revoked. CMS Ex. A, at 3. Petitioner asserts confusion regarding the reconsideration decision as he provided evidence that his license was no longer suspended and that he had resumed practice. P. Brief at 3.

Petitioner also argues that his failure to notify CMS was unintentional and that there were mitigating factors. P. Brief at 4. He argues that at the "pertinent time" he was in an addiction recovery center, and his ability to correspond was limited. P. Brief at 4, 6. He argues that he gave responsibility to his biller to report his suspension and that while most of his providers were notified, he admits that CMS and the Medicare contractor were not. He also asserts that he believed that the Louisiana Board would be spreading the word about his suspension. He states that he was unaware of the failure to notify the Medicare contractor. He further states that he understands that the responsibility to notify the Medicare contractor was his but that his failure to do so was not an attempt to conceal or to mislead. P. Brief at 6. He concludes that he has been punished enough and that his "billing privileges should be reinstated at this time." P. Brief at 6-7.

Petitioner cites no provision of the Act or the regulations that require CMS or its contractors to consider mitigating or other factors when deciding to revoke billing privileges or enrollment. In the preamble for the final rule amending 42 C.F.R. Parts 420, 424, 489, and 498, promulgating requirements for providers and suppliers to establish and maintain Medicare enrollment, effective June 20, 2006. 71 Fed. Reg. 20,753 (April 21, 2006) CMS said:

> In considering whether to revoke enrollment and billing privileges in the Medicare program, we would consider the severity of the offenses, mitigating circumstances, program and beneficiary risk if enrollment was to continue, possibility of corrective action plans, beneficiary access to care, and any other pertinent factors.

Id. at 20,761. However, CMS has not promulgated regulations that require consideration of such factors before revocation. Further, I have no regulatory authority to review the exercise of discretion by CMS to revoke if I find a basis for revocation exists. The Board has previously concluded the scope of review is very limited in these cases. The Board has concluded that CMS is authorized to revoke the enrollment and billing privileges of a provider or supplier if the regulatory requirements for revocation are satisfied, and an ALJ may not substitute his or her judgment for that of CMS in determining whether revocation is appropriate under all the circumstances. *Abdul Razzaque Ahmed, M.D.*, DAB No. 2261 at 19 (2009); *citing Letania Bussell, M.D.*, DAB No. 2196 at 12-13 (2008) (ALJ review is limited to deciding whether CMS "established a legal basis for its actions").

There is a basis for revocation of Petitioner's billing privileges and my jurisdiction does not extend to review of whether CMS or its contractor properly exercised their discretion when deciding to proceed with revocation of Petitioner's billing privileges and enrollment. I thus conclude that Petitioner's arguments that he regained his license prior to revocation of his enrollment and billing privileges and that there were certain mitigating factors, do not weigh in my decision.

Petitioner also argues that the decision of the Medicare contractor to bar Petitioner from re-enrollment for three years (CMS Ex. B, at 13), according to my calculation until April 7, 2011, is not compatible with Petitioner's offenses. P. Brief at 7-8. Petitioner acknowledges that the regulations authorize a re-enrollment bar of from one to three years depending upon the severity of the basis for the revocation. 42 C.F.R. § 424.535(c). Thus, the Medicare contractor and CMS did not exceed their regulatory authority. Petitioner points to no authority for me to review the reasonableness of the duration of a bar to re-enrollment.

III. Conclusion

Petitioner's Medicare enrollment and his billing privileges were properly revoked.

/s/
Keith W. Sickendick
Administrative Law Judge