Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Norman Johnson, M.D.

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-3708

Decision No. CR4524

Date: February 8, 2016

DECISION

The Medicare enrollment and billing privileges of Petitioner, Norman Johnson, M.D., are revoked pursuant to 42 C.F.R. § 424.535(a)(3),[1] effective February 17, 2015.

I. Background

Noridian Healthcare Solutions (Noridian), the Medicare administrative contractor for the Centers for Medicare & Medicaid Services (CMS), notified Petitioner by letter dated February 17, 2015, that his Medicare enrollment and billing privileges were revoked effective February 17, 2015. Noridian stated that revocation was pursuant to 42 C.F.R. § 424.535(a)(3), based on Petitioner's November 3, 2008 felony convictions for failing to file state income tax returns. Noridian also notified Petitioner that he was subject to a three-year bar to re-enrollment effective February 17, 2015, pursuant to 42 C.F.R. § 424.535(c). CMS Exhibit (Ex.) 1.

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[1] References are to the 2014 revision of the Code of Federal Regulations (C.F.R.), the revision in effect at the time of the initial determination in this case, unless otherwise stated.

Petitioner requested reconsideration of the initial determination to revoke his Medicare enrollment and billing privileges on April 16, 2015. CMS Exs. 3, 4. On June 10, 2015, Noridian upheld the revocation on reconsideration, also citing 42 C.F.R. § 424.535(a)(3) as the basis for revoking Petitioner's Medicare enrollment and billing privileges. CMS Ex. 7.

On August 7, 2015, Petitioner timely filed a request for hearing (RFH) before an administrative law judge (ALJ). On August 17, 2015, the case was assigned to me for hearing and decision, and an Acknowledgement and Prehearing Order (Prehearing Order) was issued at my direction.

On September 16, 2015, CMS filed a combined prehearing brief and motion for summary judgment (CMS Br.) with CMS Exs. 1 through 7. On November 16, 2015, Petitioner filed a combined prehearing brief and opposition to CMS's motion for summary judgment (P. Br.), and a witness and exhibit list. Petitioner listed himself as a witness. Petitioner attached Petitioner's exhibit (P. Ex.) 1 to his declaration. P. Ex. 1 is a copy of the first page of the initial determination to revoke dated February 17, 2015, mailed to Petitioner at a different address than appears on the copy of the initial determination marked as CMS Ex. 1. I treat Petitioner's declaration and the copy of the February 17, 2015 letter attached as P. Ex. 1. Petitioner also filed on November 16, 2015, a motion to remand this case to CMS or Noridian pursuant to 42 C.F.R. § 498.56(d). Petitioner attached to his motion for remand his declaration and fifteen letters from individuals attesting to Petitioner's good character. Petitioner filed a "Notice of Errata" on November 17, 2015, to correct an omission from his motion to remand.

On December 1, 2015, CMS filed a reply brief (CMS Reply). Rather than file a separate opposition to Petitioner's motion to remand, CMS opposed the motion in its reply brief. CMS Reply at 2. CMS objected to my consideration of the additional documents Petitioner submitted with his request for remand claiming that Petitioner had failed to show good cause for submitting new documentary evidence for the first time at the ALJ level.

Petitioner's motion for remand is denied. Pursuant to 42 C.F.R. § 498.56(d), I may remand a case to CMS to consider new issues and, if appropriate, a new determination. Pursuant to 42 C.F.R. § 498.78, I may also remand if CMS requests. CMS opposes remand and Petitioner has not identified new issues that CMS should have the opportunity to address. The gist of the motion to remand is Petitioner wants CMS to consider additional mitigating evidence. However, Petitioner points to no legal requirement for CMS to consider mitigating evidence related to revocation and CMS resists the motion for remand, clearly indicating remand to CMS would be futile.

On January 26 and 27, 2016, Petitioner filed a motion for leave to file a sur-reply; a sur-reply (P. Sur-reply); an amended list of exhibits and witnesses; and additional exhibits marked as P. Exs. 8 through 30.[2] The sur-reply is accepted.

The parties have not objected to my consideration of CMS Exs. 1 through 7 and P. Ex. 1 (Petitioner's Declaration and the attached letter) and they are admitted as evidence. P. Exs. 8 through 30 are not admitted as evidence and not considered. P. Exs. 8 through 26 are letters of recommendation, endorsement, or other laudatory comments, and P. Ex. 27 is a certificate of recognition. The issue before me is whether or not there is a basis to revoke Petitioner's enrollment and billing privileges. 42 C.F.R. § 498.5(l)(1)-(2). P. Exs. 8 through 27 are not relevant to the issue before me and not admissible as evidence because they do not have a tendency to make a fact at issue before me more or less probable. Fed. R. Evid. 401. I may only admit evidence that is relevant and material. 42 C.F.R. § 498.60(b)(1). P. Ex. 28 is a document dated January 4, 2016, which purports to reflect Petitioner's various addresses on file with the Medical Board of California. This document is relevant to an argument raised by Petitioner and I consider it relevant for that reason. P. Ex. 28 is admitted. P. Ex. 29 is a copy of a Health Resources and Services Administration webpage that indicates that Big Bear Lake, California is a Primary Care Health Professional and Mental Health Professional Shortage Area. P. Ex. 29 is not relevant to the issue before me, that is, whether or not there is a basis for revocation of Petitioner's Medicare enrollment and billing privileges. P. Ex. 30 includes at pages 1 and 2 another copy of the letter attached to Petitioner's declaration that I have admitted as P. Ex. 1. P. Ex. 30 also includes at pages 3 and 4, a letter from Desert Valley Hospital dated March 10, 2015, ending his hospital privileges; and a letter from Desert Valley Medical Group dated March 10, 2015, ending his affiliation with that physician practice group. P. Ex. 30, pages 1 and 2 are relevant and admitted. P. Ex. 30, pages 3 and 4 are not relevant and not admitted. P. Ex. 30, page 5 is Petitioner's attestation and it is admitted as relevant as a statement of Petitioner.

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[2] Petitioner previously filed P. Ex. 1. There is no record of Petitioner filing exhibits marked P. Exs. 2 through 7. Petitioner began numbering the new exhibits he offered with his sur-reply as P. Ex. 8, apparently due to misunderstanding the Civil Remedies Division Procedures (CRDP) and Prehearing Order. However, there is little risk for confusion based on the incorrectly numbered exhibits. Therefore, P. Exs. 8 through 30 were not rejected for failure to conform to the requirements for marking exhibits under the Prehearing Order and the CRDP.

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. Administration of the Part B program is through contractors, such as Noridian. 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.[3] Act §§ 1835(a) (42 U.S.C. § 1395n(a)), 1842(h)(1) (42 U.S.C. § 1395(u)(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. § 424.505, 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 the authority to revoke enrollment and billing privileges to CMS. 42 C.F.R. § 424.535. CMS or its Medicare contractor may revoke an enrolled supplier's Medicare enrollment and billing privileges and supplier agreement for any of the reasons listed in 42 C.F.R. § 424.535. In this case, CMS revoked Petitioner's Medicare enrollment and billing privileges under 42 C.F.R. § 424.535(a)(3), which provides in pertinent part:

> (a) *Reasons for revocation*. CMS may revoke a currently enrolled provider or supplier's Medicare billing privileges

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[3] 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.

> and any corresponding provider agreement or supplier agreement for the following reasons:
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> * * * *
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> (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.
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> (i) Offenses include –
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> * * * *
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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.

42 C.F.R. § 424.535(a)(3)(i)(B); Act § 1866(b)(2)(D).

The effective date of the revocation is controlled by 42 C.F.R. § 424.535(g). The regulation provides that when revocation is based on a felony conviction, the effective date of revocation is the date of the conviction. 42 C.F.R. § 424.535(g). In this case, CMS, through its contractor Noridian, exercised discretion and determined that the effective date of revocation of Petitioner's Medicare enrollment and billing privileges should be the date of the notice of the revocation, that is, February 17, 2015. I will not disturb the exercise of discretion by CMS. When a supplier's Medicare enrollment and billing privileges are revoked, the supplier is barred from re-enrolling in the Medicare program for one to three years. 42 C.F.R. § 424.535(c). In this case, CMS determined that a three-year bar was appropriate. The regulations grant no right to review of the determination of the duration of the bar. 42 C.F.R. § 424.545.

A supplier whose enrollment and billing privileges have been revoked may request reconsideration and review as provided by 42 C.F.R. pt. 498. 42 C.F.R. § 424.545(a). A supplier submits a written request for reconsideration to CMS or its contractor. 42 C.F.R. § 498.22(a). CMS or its contractor must give notice of its reconsidered determination to the supplier, giving the reasons for its determination, specifying the conditions or requirements the supplier failed to meet, and advising of the right to an ALJ hearing. 42 C.F.R. § 498.25. If the decision on reconsideration is unfavorable to the supplier, the

supplier has the right to request a hearing by an ALJ and further review by the Departmental Appeals Board (the Board). Act § 1866(j)(8) (42 U.S.C. § 1395cc(j)(8)); 42 C.F.R. §§ 424.545, 498.3(b)(17), 498.5. A hearing on the record, also known as an oral hearing, is required under the Act. *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743, 748-51 (6th Cir. 2004). The supplier bears the burden to demonstrate that it meets enrollment requirements with documents and records. 42 C.F.R. § 424.545(c).

B. Issues

Whether summary judgment is appropriate; and

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

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

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

1. Summary judgment is appropriate.

CMS requested summary judgment. As noted above, a supplier whose enrollment has been revoked has a right to a hearing and judicial review, and a hearing on the record is required under the Act. Act §§ 205(b), 1866 (h)(1), (j); 42 C.F.R. §§ 498.3(b)(1), (5), (6), (8), (15), (17), 498.5; *Crestview*, 373 F.3d at 748-51. 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 CMS's motion for summary judgment has merit.

Summary judgment is not automatic upon request but is limited to certain specific conditions. The Secretary's regulations at 42 C.F.R. pt. 498 that establish the procedure to be followed in adjudicating Petitioner's case 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 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. 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. 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. 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).

The standard for deciding a case on summary judgment and an ALJ's decision-making in deciding a summary judgment motion differ from that used in resolving a case after a hearing. 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 Fed. App'x 181 (6th Cir. 2005).

Viewing the evidence before me in a light most favorable to Petitioner and drawing all inferences in Petitioner's favor, I conclude that there are no genuine disputes as to any material facts pertinent to revocation under 42 C.F.R. § 424.535(a)(3) that require a hearing in this case. The issues in this case raised by Petitioner related to revocation under 42 C.F.R. § 424.535(a)(3) must be resolved against him as a matter of law. The

undisputed evidence shows that there is a basis for revocation of Petitioner's Medicare enrollment and billing privileges. Accordingly, summary judgment is appropriate.

2. Petitioner was convicted of felony offenses.

3. The Secretary has determined and provided by regulation that financial crimes such as income tax evasion or similar crimes are detrimental to the Medicare program or its beneficiaries. 42 C.F.R. § 424.535(a)(3)(i)(B).

4. Petitioner was convicted of failing to file income tax returns, which is a financial crime within the meaning of 42 C.F.R. § 424.535(a)(3)(i)(B).

5. There is a basis for revocation of Petitioner's enrollment in Medicare and his billing privileges pursuant to 42 C.F.R. § 424.535(a)(3).

6. Petitioner received adequate notice of the revocation of his Medicare enrollment and billing privileges.

7. The issue for hearing and decision is whether there is a basis for revocation of Petitioner's Medicare enrollment and billing privileges and, if there is a basis for revocation, my jurisdiction does not extend to review of whether CMS properly exercised its discretion to revoke Petitioner's Medicare enrollment and billing privileges.

8. I have no authority to review CMS's determination to impose a three-year bar on Petitioner's Medicare re-enrollment.

9. Petitioner's Medicare enrollment and billing privileges are revoked effective February 17, 2015.

a. Facts

The following facts are undisputed. On November 3, 2008, Petitioner entered pleas of no contest to three felony counts of failure to file state income tax returns in violation of California law, in the Superior Court of the State of California, County of San Bernardino (the state court). Petitioner was convicted on each of the counts. CMS presented no record of the conviction which occurred in November 2008, but Petitioner has not disputed the allegation that he was, in fact, convicted in 2008 as alleged by CMS. CMS Ex. 3; P. Br. at 6, P. Sur-reply at 3; P. Ex. 1.

On April 16, 2015, the state court granted Petitioner's motion to reduce the three felony counts to misdemeanors on condition that he show proof of payment of restitution in excess of $61,500 by May 11, 2015. CMS Ex. 2. On May 11, 2015, the state court granted Petitioner's motion to set aside the convictions; ordered that pleas of not guilty be entered; and dismissed the case pursuant to California Penal Code §§ 1203.4, 1203.4a, and 1203.41. CMS Ex. 5.

b. Analysis

Petitioner does not dispute that in November 2008, within ten years of the revocation action, he was convicted in state court of three felony counts of failure to file state income tax returns. P. Ex. 1 at 2-3. Petitioner does not deny that his conviction in 2008 is a financial crime of the type that the Secretary has determined to be detrimental to the Medicare program or its beneficiaries within the meaning of 42 C.F.R. § 424.535(a)(3)(i)(B). P. Sur-reply at 3. Accordingly, I conclude that there is a basis for revocation of Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(3)(i)(B). Pursuant to 42 C.F.R. § 424.535(g), the effective date of revocation is generally 30 days after CMS or its contractor mails notice of its determination to revoke. However, when the basis for revocation is a felony conviction, such as this case, revocation is effective the date of the felony conviction. In November 2008, when Petitioner was convicted, the regulation then in effect provided that "[r]evocation becomes effective within 30 days of the initial revocation notification." 42 C.F.R. § 424.535(g) (2008). Although generally the regulations in effect at the time of action by CMS or its contractor should control, I conclude that CMS and its contractor properly exercised discretion to make the revocation in this case effective the date of the notification of the initial determination to revoke, rather than the date of Petitioner's conviction. Retroactively revoking Petitioner's Medicare enrollment and billing privileges back to November 2008, going back nearly seven years, had the potential for creating possible significant liability for any Medicare claims paid to or on Petitioner's behalf during the period November 2008 and February 17, 2015. I will not review nor upset the exercise of CMS discretion to apply its regulations in an equitable fashion as it has in this case. Accordingly, the date of revocation of Petitioner's Medicare enrollment and billing privileges is February 17, 2015, as determined by CMS and its contractor. I note that Petitioner does not specifically challenge the effective date determination.

Petitioner argues as his defense in this case that his felony convictions were subsequently reduced to misdemeanors by the state court, which also set aside the convictions, and dismissed the case. Petitioner argues that the state court action effectively deprives CMS of the legal basis for revocation of his Medicare enrollment and billing privileges. Petitioner also argues that his case was dismissed pursuant to California Penal Code § 1203.4, which states, in relevant part, that upon dismissal, "[the defendant] shall thereafter be released from all penalties and disabilities resulting from the offense of which he or she has been convicted . . . ." P. Br. at 6. The gist of Petitioner's argument

is that the California state law bars CMS from using the prior convictions against Petitioner as a basis for revocation. Petitioner further argues that, even if I conclude that CMS is authorized to revoke his Medicare billing privileges based on his felony convictions, I should consider the fact that the charges were reduced and then dismissed as mitigating circumstances. P. Br. at 6.

Petitioner's argument regarding his felony convictions is without merit. There is no dispute that Petitioner was convicted of felony financial crimes similar to tax evasion in November 2008. There is no dispute that Petitioner's felony convictions clearly satisfy the requirements of 42 C.F.R. § 424.535(a)(3)(B). The fact that in 2015, the state court reduced Petitioner's felony convictions to misdemeanors and then dismissed the charges does not change the fact that he was originally convicted of three felony counts of failure to file income tax returns. In this proceeding, it is federal law – not state law – that governs whether a supplier has been "convicted" of an offense, as that term is used in 42 C.F.R. § 424.535(a)(3). *John Hartman, D.O.*, DAB No. 2564 at 3 (2014). The fact that the California state court had the authority to revisit felony convictions entered nearly seven years earlier, does not change the fact that Petitioner was, in fact, lawfully convicted under California law. Petitioner points to no authority for the proposition that CMS is bound to follow California law and treat Petitioner's felony convictions in 2008 as being vacated or otherwise nullified by subsequent state court action under a provision of state law.

In mandating the exclusion of providers and suppliers from participation in Medicare and other federal and state healthcare programs for certain federal and state convictions, Congress has specifically defined "conviction" to include situations "when a plea of guilty or nolo contendere by the individual . . . has been accepted by a Federal, State, or local court" or when the individual has "entered into participation in a first offender, deferred adjudication, or other program or arrangement where judgment of conviction has been withheld." 42 U.S.C. § 1320a-7(i)(3)-(4); Act § 1128(i)(3)-(4).[4] In the exclusion case, *Henry L. Gupton*, DAB No. 2058 (2007), the Board stated that it is "well established" that the term "conviction" under the Act includes "diverted, deferred and

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[4] Revocation and exclusion are two separate and distinct administrative actions enforced by two different agencies within the U.S. Department of Health & Human Services (HHS). *Abdul Razzaque Ahmed, M.D.*, DAB No. 2261 at 13 (2009), *aff'd*, 710 F. Supp. 2d 167 (D. Mass. 2010). The Secretary delegated the authority to impose a mandatory exclusion under section 1128 of the Act to the HHS Inspector General, who administers that program pursuant to 42 C.F.R. pts. 1001 and 1005. The Secretary delegated the authority for revoking a provider's or supplier's Medicare enrollment and billing privileges to CMS in 42 C.F.R. pt. 424.

expunged convictions regardless of whether state law treats such actions as a conviction." *Gupton*, DAB No. 2058 at 8. The Board in *Gupton* explained that the "rationale for the different meanings of 'conviction' for state criminal law versus federal exclusion law purposes follows from the distinct goals involved." *Id.* at 7. The Board stated that while the goals of criminal law generally include punishment, rehabilitation, and deterrence, exclusions "are civil sanctions, designed to protect the beneficiaries of health care programs and the federal fisc . . . ." *Id.* The Board explained further, "in the effort to protect both beneficiaries and funds, Congress could logically conclude that it was better to exclude providers whose involvement in the criminal system raised serious concerns about their integrity and trustworthiness, even if they were not subjected to criminal sanctions for reasons of state policy." *Id.* at 7-8. The Board's analysis in *Gupton* applies equally in this case. The purposes of the revocation authority, protecting beneficiaries and the Medicare trust fund, is served by treating Petitioner's conviction of felony offenses as a basis for revocation, rather than permitting Petitioner to avoid revocation based on a state court determination to expunge or otherwise mitigate the effect of the state court convictions. *Lorrie Laurel, P.T.*, DAB No. 2524 at 5 (2013). I do not mean to suggest that when a state court conviction is reversed and set aside on appeal that the original conviction nevertheless would be a basis for revocation or exclusion but those are not the facts in this case.

I am also not persuaded by Petitioner's argument that the state court action reducing and dismissing the criminal charges should be viewed as a mitigating circumstance. Petitioner cites no authority in support of this argument. There is nothing in the Act or regulations requiring CMS or its contractor to consider mitigating factors or evidence other than the nature of Petitioner's convictions in determining whether to revoke enrollment. Act § 1866(j)(8); 42 C.F.R. § 424.535(a)(3). I conclude for the same reason that I may not consider the numerous letters of recommendation and endorsements or favorable comments Petitioner submitted for my consideration, and for that reason they were not admitted as evidence. There is no regulatory or statutory requirement for CMS or its contractor to consider mitigating evidence when determining whether to revoke. In this case, Petitioner did submit such evidence and CMS actively resisted remand to consider the information. Before me, Petitioner's evidence offered in mitigation is simply irrelevant to the issue of whether or not CMS or its contractor had a basis for revocation.

Petitioner argues that the notice of the initial determination to revoke was defective. P. Br. at 1-2; P. Sur-reply at 1-6. The regulations that govern revocation do not prescribe the content of the notice of the initial determination to revoke Medicare enrollment and billing privileges. 42 C.F.R. pt. 424. However, 42 C.F.R. § 498.20(a), which applies, provides that CMS, or in this case its contractor, mails notice of the initial determination to the affected party and the notice must set forth the basis for the determination, the effect of the determination, and the right to request reconsideration or a hearing, as applicable. The notice of reconsidered determination must also be sent by CMS or its

contractor, state the reasons for the determination, state the legal requirements the affected party failed to meet, and advise the affected party of the right to a hearing. 42 C.F.R. § 498.25(a). In this case, the notice of initial determination stated that Petitioner's Medicare privileges were being revoked effective February 17, 2015, cited the legal and factual basis, advised Petitioner of the right to request reconsideration, and to submit additional information with the request for reconsideration. The notice also advised Petitioner of the three-year re-enrollment bar. CMS Ex. 1. The notice of the reconsidered determination dated June 10, 2015, advised Petitioner that revocation of Medicare privileges was upheld, the reasons for the revocation, the legal basis for the revocation, and that he had the right to request review. CMS Ex. 7. Petitioner thereafter timely requested a hearing before an ALJ. My review reveals that the notices of initial and reconsidered determination satisfied regulatory requirements. Any lack of clarity in the notices was not prejudicial as Petitioner has effectively exercised the rights related to review available to him under the Act and regulations. Petitioner's argument that he did not receive the notice of initial determination directly from the CMS contractor does not reflect any error on the part of the CMS contractor or any prejudice to Petitioner as he timely exercised his right to request reconsideration.[5] P. Br. at 3-4; P. Sur-reply at 5. Petitioner's argument that he was not clear on what material could be submitted on reconsideration is without merit. The regulations governing the reconsideration process are publicly available and Petitioner was represented by counsel. Further, even accepting that he received the second page of the initial determination late, that page contained an invitation for Petitioner to call with any questions, a toll-free number to call, and the hours during which to call. CMS Ex. 1 at 2. Petitioner does not offer evidence that he or counsel called to request clarification or an extension of time to request reconsideration based on his late receipt of the notice of initial determination.

The Act and regulations accord Petitioner a right to notice and the opportunity to have the decision to revoke his enrollment and billing privileges reconsidered and then administratively reviewed by an ALJ, the Board, and the courts. Act § 1866(j)(8) (42 U.S.C. § 1395cc(j)(8)); 42 C.F.R. §§ 424.545, 498.3(b)(17), 498.5, 498.22(a), and 498.25. Petitioner was notified of the revocation; he exercised his right to

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[5] The record reflects that Noridian sent two notice letters to Petitioner on February 17, 2015, at two different mailing addresses. Noridian sent one notice to Petitioner's former employer, Bear Mountain Family Medicine (CMS Ex. 1), and another notice to his employer, Desert Valley Hospital (P. Ex. 1). CMS Ex. 1 contains the following mailing address: "Norman E Johnson MD; Bear Mountain Family Medicine; 41949 Big Bear Blvd; Big Bear Lake, CA 92315-6865." CMS Ex. 1. P. Ex. 1 contains the following mailing address: "Norman E Johnson MD; Desert Valley Med Group; 16850 Bear Valley Rd; Victorville, CA 92395." P. Ex. 1. The two letters are identical in all other respects.

reconsideration; he has received de novo review by an ALJ; and there is no real dispute that there is a factual and legal basis for revocation of his enrollment pursuant to 42 C.F.R. § 424.535(a)(3). Petitioner has received the process due him under the Act and the Secretary's regulations.

Petitioner argues that Noridian failed to exercise discretion not to revoke Petitioner's Medicare enrollment and billing privileges and, therefore, it is not clear officials at Noridian understood that they had discretion not to revoke in this case. I have concluded that there was a basis for revocation. Noridian issued an initial determination to revoke Petitioner's enrollment and billing privileges. A Noridian hearing officer subsequently upheld the revocation on reconsideration. Petitioner requested my de novo review and CMS has advocated before me that there was a proper exercise of discretion to revoke Petitioner's enrollment and billing privileges. Given the facts, whether or not Noridian understood its discretion is not relevant. CMS, which is fully appraised of the facts including the evidence in mitigation offered by Petitioner, has elected to proceed with the revocation. There is no question that CMS could have at any time during the course of this proceeding reopened and revised the reconsidered determination and withdrawn the revocation. 42 C.F.R. § 498.30. CMS did not choose to do so. It is CMS's exercise of discretion at this stage, not the contractor's, that is at issue.

Further, 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)(3). Thus, a regulatory basis for revocation exists.

Petitioner asserts that because of the revocation, he was terminated by his employer and is suffering difficult personal and professional circumstances. Petitioner also argues that the area in which he practices has a shortage of health care professionals and the loss of his health care services would cause a hardship to Medicare patients. P. Ex. 1; P. Br. at 6-7; P. Sur-reply at 2, 3, 6-7. In pointing out that he practices in an underserved area, Petitioner appears to suggest that his situation may warrant a waiver of his revocation. However, Petitioner points to no statutory or regulatory authority for granting a waiver of a revocation.

To the extent that Petitioner's other assertions may be construed as a request for equitable relief, I have no authority to grant equitable relief. *US Ultrasound*, DAB No. 2302 at 8 (2010) ("Neither the ALJ nor the Board is authorized to provide equitable relief by reimbursing or enrolling a supplier who does not meet statutory or regulatory requirements."). Furthermore, I am bound to follow the Act and regulations, and I have

no authority to declare statutes or regulations invalid or ultra vires. *1866ICPayday.com, L.L.C.*, DAB No. 2289 at 14 (2009) (noting that "[a]n ALJ is bound by applicable laws and regulations and may not invalidate either a law or regulation on any ground.").

Petitioner challenges the duration of his three-year re-enrollment bar, arguing that it is "a potentially career-ending punishment." He points out that "[i]t is being imposed nearly eight years after the conviction, during which time [he] continued to be a Medicare provider without having any of [his] practices questioned by CMS." P. Ex. 1; P. Sur-reply at 3, 7.

Under the regulations, the re-enrollment bar after a revocation is a minimum of one year and a maximum of three years. 42 C.F.R. § 424.535(c). There is no statutory or regulatory language establishing a right to review of the duration of the re-enrollment bar CMS imposes. Act § 1866(j)(8); 42 C.F.R. §§ 424.535(c); 424.545; 498.3(b); and 498.5. The Board has held that the duration of a revoked supplier's re-enrollment bar is not an appealable initial determination listed in 42 C.F.R. § 498.3(b), and thus, is not subject to ALJ review. *Vijendra Dave*, DAB No. 2672 at 11 (2016).

Finally, the nearly seven-year delay by CMS in taking the revocation action against Petitioner is not a basis for me to reverse the revocation or reduce the three-year re-enrollment bar. CMS revoked Petitioner's billing privileges pursuant to 42 C.F.R. § 424.535(a)(3), which authorizes it to act within 10 years of a felony conviction. 42 C.F.R. § 424.535(a)(3). Here, Petitioner was convicted in November 2008, and CMS revoked his billing privileges within 10 years of that conviction. Petitioner has identified no statute of limitations that legally bars the revocation, even when so delayed, or any other legal basis for me to invalidate the revocation action.

III. Conclusion

For the foregoing reasons, I conclude that Petitioner's Medicare enrollment and billing privileges are properly revoked pursuant to 42 C.F.R. § 424.535(a)(3), effective February 17, 2015.

/s/

Keith W. Sickendick
Administrative Law Judge