Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	
Abdul Razzaque Ahmed, M.D.,	DATE: July 2, 2009
Petitioner,	Civil Remedies CR1864 App. Div. Docket No. A-09-41
- v. -	Decision No. 2261
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Abdul Razzaque Ahmed, M.D. (Petitioner), a Massachusetts physician, appeals the November 14, 2008 decision by Administrative Law Judge (ALJ) Keith W. Sickendick, DAB CR1846 (ALJ Decision). Based on Petitioner's November 2007 guilty plea to obstruction of a criminal investigation of health care offenses, the ALJ upheld a determination by the Centers for Medicare & Medicaid Services (CMS) to revoke Petitioner's Medicare "billing privileges" (that is, his Medicare enrollment) pursuant to 42 C.F.R. § 424.535(a)(3)(i)(B). That regulation authorizes CMS to revoke the billing privileges of a Medicare supplier who has been convicted of a felony "financial crime" within ten years preceding his enrollment or revalidation of enrollment in Medicare.

Petitioner contends that the ALJ erred in upholding the revocation because: (1) obstruction of a criminal investigation of health care offenses is not a financial crime within the meaning of section 424.535(a)(3)(i)(B); (2) CMS's contractor failed to conduct an enrollment revalidation process prior to issuing the initial revocation determination; and (3) the ALJ improperly rejected his due process claim.

Upon consideration of the briefing and oral argument in this appeal, we find no merit to these contentions. We thus affirm the ALJ Decision in its entirety.

Legal Background

The Medicare program provides health insurance benefits to persons 65 years and older and to certain disabled persons. Social Security Act (Act) § 1811.[1] Medicare is administered by CMS, a component of the Department of Health and Human Services (HHS). CMS in turn delegates program functions to private contractors. See Act §§ 1816, 1842, 1874A.

In order to participate in Medicare, "providers" and "suppliers" — a physician is a "supplier" under Medicare law — must "enroll" in the program.[2] 42 C.F.R. § 424.500. "Enrollment" in Medicare confers program "billing privileges" - that is, the right to claim and receive Medicare payment for health care services provided to program beneficiaries. Id. §§ 424.502, 424.505.

In an April 21, 2006 final rule (Final Rule), CMS issued regulations — found in 42 C.F.R. § 424.500 et seq. — that establish procedures and requirements for obtaining and maintaining Medicare enrollment.[3] The regulations require enrollment applicants to submit "enrollment information" on the appropriate enrollment application, including information about any felony convictions or other "adverse legal actions." 42 C.F.R. § 424.510(a); Robert F. Tzeng, M.D., DAB No. 2169, at 11 n.15 (2008) (indicating that Medicare's supplier enrollment

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[1] The current version of the Social Security Act can be found at www.ssa.gov/OP_Home/ssact/comp-ssa.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section.

[2] "Providers" are hospitals, nursing facilities, or other medical institutions. 42 C.F.R. § 400.202. "Suppliers" include physicians and other non-physician health care practitioners. Id. (stating that, unless the context indicates otherwise, "[s]upplier means a physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare").

[3] Final Rule, *Medicare Program; Requirements for Providers and Suppliers to Establish and Maintain Medicare Enrollment*, 71 Fed. Reg. 20,754 (Apr. 21, 2006).

application requires the applicant to report adverse legal actions).

The regulations also require periodic "revalidation" — that is, resubmission and recertification — of a provider's or supplier's enrollment information. See 42 C.F.R. § 424.515. The regulations require revalidation every five years, but CMS may perform off cycle revalidations "when warranted to assess and confirm the validity of [its] enrollment information[.]" Id. § 424.515(d). "Off cycle revalidations may be triggered as a result of random checks, information indicating local health care fraud problems, national initiatives, complaints, or other reasons that cause CMS to question the compliance of the provider or supplier with Medicare enrollment requirements." Id. The Final Rule's preamble indicates that the "revalidation process . . . ensure[s] that [CMS] collect[s] and maintain[s] complete and current information on all Medicare providers and suppliers and ensure[s] continued compliance with Medicare requirements." 71 Fed. Reg. at 20,768. The revalidation process "further ensures that Medicare beneficiaries are receiving services furnished only by legitimate providers and suppliers, and strengthens [CMS's] ability to protect the Medicare Trust Funds." Id.

CMS may revoke the billing privileges of a supplier or provider under certain circumstances. That authority is found in section 424.535, which provides in relevant part as follows:

> (a) *Reasons for revocation.* CMS may revoke a currently enrolled provider or supplier's billing privileges 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.
>
> (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.
>
> * * *
>
> (D) Any felonies that would result in mandatory exclusion under section 1128(a) of the Act.

(Emphasis added).

Case Background

Petitioner is a dermatologist who specializes in the diagnosis and treatment of autoimmune skin blistering diseases. On November 5, 2007, Petitioner pled guilty in federal district court to obstruction of a criminal investigation of health care offenses, a felony violation of 18 U.S.C. § 1518. CMS Ex. 5, at 4, 26-27. That statute, one of several under the rubric of "obstruction of justice" (see 18 U.S.C. pt. I, ch. 73), penalizes anyone who "willfully prevents, obstructs, misleads, or attempts to prevent, obstruct, mislead, or delay the communication of information or records relating to a violation of a Federal health care offense to a criminal investigator . . . ."

On November 8, 2007, three days after Petitioner entered his guilty plea, the National Heritage Insurance Co. (NHIC), a CMS contractor, notified him by letter that his Medicare billing privileges were being revoked pursuant to 42 C.F.R. § 424.535(a)(3)(i)(B), which authorizes CMS to revoke a supplier's billing privileges based on a conviction for a "financial crime" that occurred "within the 10 years preceding enrollment or revalidation of enrollment." P. Ex. 9.

Petitioner asked for a reconsideration of the initial revocation determination. P. Ex. 10. On March 12, 2008, a NHIC hearing officer affirmed that determination. CMS Ex. 1.

Petitioner then requested an ALJ hearing, contending that the revocation was legally improper because: (1) his offense — obstruction of a criminal investigation of health care offenses — is not a "financial crime"; (2) his felony conviction did not occur within 10 years preceding his "enrollment or revalidation of enrollment" in Medicare; and (3) NHIC "abused its discretion and denied [Petitioner's] right to due process" by revoking his

billing privileges without first inquiring about "either the causes of [his] actions or the effects of the revocation on patients seeking care for the rare and deadly diseases [he] treats." May 9, 2008 Request for Hearing.

On cross-motions for summary judgment, the ALJ upheld the revocation of Petitioner's Medicare billing privileges. In support of that decision, the ALJ concluded that:

- "The Secretary of Health and Human Services (Secretary) has determined and provided by regulation that financial crimes or similar crimes are detrimental to the Medicare program or its beneficiaries." ALJ Decision at 3 (Conclusions of Law ¶ 2).

- Petitioner's felony offense was a "financial crime" within the meaning of section 424.535(a)(3)(i)(B) because it was similar to insurance fraud. Id. at 3 (Conclusions of Law ¶¶ 3-4); and

- Petitioner's felony conviction occurred within 10 years preceding his enrollment or revalidation of enrollment in Medicare. Id. at 2 (Findings of Fact ¶ 3).

The ALJ also rejected Petitioner's argument that his revocation is illegal because CMS failed to conduct a pre-revocation revalidation process that allowed him to petition against revocation. ALJ Decision at 9. The ALJ held that Petitioner was entitled only to post-revocation process consisting of reconsideration of the initial revocation determination by the contractor's hearing officer, a hearing before an ALJ, and Board review of the ALJ decision. Id. at 9-10.

In addition, the ALJ held that the regulations do not require CMS to consider "mitigating factors" or the potential impact of the revocation on Medicare beneficiaries when deciding whether to revoke a supplier's billing privileges under section 424.535(a)(3). ALJ Decision at 11-12. Finally, the ALJ held that he could not review whether CMS or its contractor "properly exercised its discretion when deciding to proceed with revocation" based on Petitioner's felony conviction. Id. at 12.

Petitioner filed a timely request for review of the ALJ Decision, reiterating many of the contentions he made to the ALJ. On June 11, 2009, the Board held oral argument to consider these contentions.[4]

Standard of Review

The Board's standard of review on a disputed factual issue is whether the ALJ decision or ruling is supported by substantial evidence in the record. *Guidelines — Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare* (at http://www.hhs.gov/dab/guidelines/prosupenrolmen.html). The standard of review on a disputed issue of law is whether the ALJ decision or ruling is erroneous. Id.

Discussion

Section 424.535(a)(3) provides that CMS may revoke a supplier's billing privileges if two conditions are satisfied: (1) the supplier was convicted of a felony offense that CMS has determined to be detrimental to the best interests of Medicare and its beneficiaries; and (2) the conviction occurred within 10 years preceding the supplier's enrollment or revalidation of enrollment in Medicare. The ALJ concluded that both conditions were satisfied in Petitioner's case and, therefore, CMS was justified in revoking his billing privileges. We affirm that conclusion.

1. *The ALJ properly concluded that Petitioner's November 5, 2007 conviction was for a felony offense — specifically, a felony "financial crime" — that CMS has determined to be detrimental to the best interests of Medicare and its beneficiaries.*

Citing 42 C.F.R. § 424.535(a)(3)(i)(B), the ALJ held that CMS has determined that "financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes" are detrimental to the best interests of Medicare

[4] CMS attached to its response brief two exhibits that were not part of the record before the ALJ: CMS Exhibits A-1 and A-2. At oral argument, Petitioner stated that he had no objection to their admission. We therefore make CMS Exhibits A-1 and A-2 part of the record of this case.

and its beneficiaries. See ALJ Decision at 3 (Conclusions of Law ¶ 2). Petitioner does not dispute that holding, and we concur with it. See Request for Review (RR) at 1-2 (listing the ALJ's conclusions of law with which Petitioner disagrees); Letantia Bussell, M.D., DAB No. 2196, at 9 (2008) (holding that CMS has determined that the crimes specified in section 424.535(a)(3)(i) are "detrimental per se" to Medicare).

CMS revoked Petitioner's billing privileges because it found that the felony offense to which he had pled guilty — obstruction of a criminal investigation of health care offenses — is a financial crime under section 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. Because Petitioner's offense is not named in section 424.535(a)(3)(i)(B), the ALJ considered whether it is similar to a named crime.

To resolve that issue, the ALJ examined the conduct and circumstances underlying Petitioner's offense. During the Petitioner's November 5, 2007 plea colloquy, the government indicated that the following facts were the basis for his offense. From 1997 through 2001, Petitioner's medical practice focused on the treatment of two autoimmune skin blistering diseases: pemphigus and pemphigoid. CMS Ex. 5, at 21. Petitioner treated these diseases with intravenious immunoglobulin (IVIg). Id. From 1997 through 2001, the applicable Medicare coverage policy authorized coverage of IVIg treatment for pemphigus but denied coverage for pemphigoid. Id. at 21-22. In early 2000, Medicare noticed that it had been paying Petitioner millions of dollars for IVIg treatment. Id. at 22. Many of Petitioner's Medicare coverage claims for IVIg purported to be on behalf of patients with "dual diagnoses" of pemphigus and pemphigoid. Id. The United States Attorney began an investigation to determine whether these diagnoses were fraudulent. Id. In June 2000, investigators served Petitioner with a subpoena that sought medical records of the patients whom he had treated with IVIg. Id. In response to the subpoena, Petitioner produced treatment files for 94 such patients, many of whom were Medicare beneficiaries. Id. Petitioner had supplemented these patient files with backdated documents, including correspondence and immunopathology reports, that falsely indicated that patients suffering from pemphigoid, the disease for which Medicare did not cover IVIg treatment, also suffered from pemphigus, the disease for which Medicare covered IVIg treatment. Id. at 22-23.

Petitioner admitted these facts during the plea colloquy. CMS Ex. 5, at 25. In addition, he stated in a brief to the ALJ that he had "placed false letters and immunopathology reports into his patients' files to bolster the reimbursements he received from Medicare . . . ." Petitioner's August 1, 2008 Memorandum in Opposition to Respondent's Motion for Summary Judgment at 14.

The ALJ found that the conduct establishing Petitioner's offense consisted of the creation and submission to investigators of documents that concealed or bolstered "false claims" for Medicare coverage of IVIg treatment:

> . . . Petitioner admits that he knew that he was not entitled to reimbursement from Medicare unless he provided IVIg treatment based on a diagnosis of pemphigus. Petitioner nevertheless claimed reimbursement for IVIg treatment for patients as if they had a diagnosis of pemphigus, even though he did not have a documented diagnosis of pemphigus when the claims were made to Medicare. When investigators subpoenaed his records, he created documents to show a diagnosis of pemphigus and, thus, obstructed the investigation and covered or bolstered his prior false claims.

ALJ Decision at 10-11. Based on these findings, the ALJ concluded that Petitioner's offense was "significantly similar" to insurance fraud, one of the crimes named in section 424.535(a)(3)(i)(B). Id. at 11.

The ALJ's conclusion that Petitioner's offense was similar to insurance fraud is not legally erroneous. Preliminarily, we note that common law definitions do not bind ALJs or the Board, and there is no indication that the Secretary of HHS intended that the enrollment and revocation regulations necessarily be limited by such definitions. Kansas Advocacy & Protective Services, DAB No. 2079, at 7 (2007 (citing cases). Nonetheless, we may consider those definitions in determining whether one crime is similar to another.

Under common law definitions, fraud generally requires a false statement or misrepresentation of material fact that the defendant makes with knowledge of its falsity and with the intent or purpose that it induce action or forbearance by another. See United States v. Kenrick, 221 F.3d 19, 28 (1st Cir. 2000) (en banc) (common law fraud "requires an intent to induce action by the plaintiff in reliance on the defendant's misrepresentation"); Indemnified Capital Invs., SA. v. R.J. O'Brien & Assocs., Inc.,

12 F.3d 1406, 1412 (7th Cir.1993) (stating that the elements of common law fraud include: "(1) a false statement of material fact, (2) knowledge or belief of the falsity by the party making it, (3) intention to induce the other party to act, (4) action by the other party in reliance of the truth of the statements, and (5) damage to the other party resulting from such reliance" (citation omitted)); Holmes v. Grubman, No. 06-5246-cv, 2009 WL 1531964, at *6 (2d Cir. June 3, 2009) (holding that "forbearance, an induced failure to act, has long been recognized as a valid basis for claims sounding in fraud"). Insurance fraud involves a false statement or misrepresentation in connection with a claim or application for insurance or insurance benefits. Cf. 18 U.S.C. § 1347(2) (providing that a person commits health care fraud — a species of insurance fraud — if he knowingly or willfully uses, or attempts to use, "false or fraudulent pretenses, representations, or promises" to obtain the money or property of a health care benefit program "in connection with the delivery of, or payment for, health care benefits, items, or services").

Elements of insurance fraud are present in the facts which the government identified as the basis for Petitioner's guilty plea and to which Petitioner admitted in entering the plea. Under circumstances clearly showing that he did so knowingly and willfully, Petitioner created and submitted to criminal investigators various backdated documents which falsely indicated that Medicare patients with pemphigoid whom he had treated with IVIg also had documented diagnoses of pemphigus. The acts of creating and submitting the documents constituted false statements or misrepresentations of fact regarding the medical condition of his patients, and Petitioner has admitted that these false statements were made to bolster claims for Medicare coverage of his patients' IVIg treatment. The false statements were material to those coverage claims because when the claims were made (sometime between 1997 and 2001), Medicare covered IVIg for pemphigus but not for pemphigoid. Although Petitioner made the false statements after he claimed and received Medicare payments on his patients' behalf, the false statements were, as Petitioner admitted, an attempt to justify the payments retroactively and thereby frustrate any attempt to recover them.

In short, Petitioner admitted making *false statements of fact* regarding Medicare patients on whose behalf he obtained insurance (Medicare) payments. The statements were *material* to the validity of his claims for those payments. And Petitioner *knew that these statements* — that the Medicare patients had documented diagnoses of pemphigus — *were false*. Finally, Petitioner made the statements in whole or part to *induce*

forbearance of action by the government — in particular, a relenting or abandonment of its investigation of the Medicare payments he received for IVIg treatment. For these reasons, we agree with the ALJ that Petitioner's offense was similar to insurance fraud.

Morever, 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."

Petitioner contends that the ALJ's conclusion that he was convicted of a financial crime is erroneous because the statutory elements of his offense do not include the taking, transferring, or harboring of money or property. RR at 12. Petitioner asserts that his conviction rested solely on the following facts: (1) that he placed false letters and immunopathology reports into his patients' files; and (2) these false documents impeded the government's investigation. Id. at 14. According to Petitioner, the ALJ improperly "looked beyond the conviction to other allegations and admissions to conclude that [his] conduct was 'similar to the crime of financial fraud' and therefore [that he] had engaged in a 'financial crime.'" Id. Petitioner further contends that the ALJ improperly considered whether the government's allegations and his admissions proved that he had engaged in "Medicare fraud," of which he was never convicted. Id. Petitioner submits that the proper inquiry is "whether, as a matter of law, obstruction of justice is properly viewed as a 'financial crime' under 42 C.F.R. § 424.535(a)(3)(i)(D)." Id. Finally, Petitioner contends that the ALJ's treatment of obstruction as a financial crime is inconsistent with how Congress treated obstruction of justice under section 1128 of the Act, which permits, and in some cases mandates, the exclusion of a supplier or provider from Medicare and other federal health care programs based on convictions for certain types of offenses. Id. at 12-14.

We note at the outset that Petitioner's contentions entirely fail to acknowledge the context and nature of his offense. Petitioner did not plead guilty to a generic obstruction of justice charge. He pled guilty to obstructing an *investigation of suspected health care fraud*, an investigation that implicated, or potentially implicated, hundreds of thousands of dollars of

Medicare payments to him. The offense was inextricably linked to Medicare's finances. The ALJ found, and Petitioner does not dispute, that Petitioner created and submitted false documents in an attempt to support or conceal prior false or invalid claims for Medicare payment for IVIg treatment. Petitioner's assertion that his offense lacks any financial component is further belied by his forfeiture of $2.9 million to the federal government as part of the plea agreement. Petitioner consented to this forfeiture, admitting that the forfeited funds were "derived, directly or indirectly, from gross proceeds traceable to the commission of the offense" to which he pled guilty. CMS Ex. 4, at 4, 7; CMS Ex. A-1.

We find no merit in Petitioner's contentions for other reasons. First of all, the ALJ did not misperceive the key legal issue. That issue was whether Petitioner's offense was "similar" to one of the financial crimes named in section 424.535(a)(3)(i)(B). The ALJ squarely addressed that issue, expressly finding that Petitioner's offense was similar to insurance fraud. The ALJ did not, as Petitioner suggests, pronounce him guilty of health care fraud based on the evidence of record.

Moreover, the ALJ committed no error when he considered the conduct and circumstances underlying Petitioner's guilty plea in deciding whether Petitioner's offense was similar to insurance fraud. The regulations prescribe no method or criteria for judging whether an offense is similar to one of the financial crimes named in section 424.535(a)(3)(i)(B). Absent explicit regulatory guidance to the contrary, and given section 424.535(a)(3)'s remedial purpose to protect the Medicare program and beneficiaries from disreputable actors, it is reasonable to conclude that a supplier's offense of conviction is similar to a financial crime when the facts and circumstances that are admitted to be the basis for the conviction would appear to satisfy one or more elements of a named financial crime.

Petitioner contends that the decision in Letantia Bussell, M.D., supports his view that we may not "look past the crime" to which he pled guilty by considering "additional facts and allegations" which suggest that he may have committed Medicare fraud. Reply Br. at 3. The ALJ did not look beyond Petitioner's crime, however. Rather, he focused on the conduct and circumstances that the government alleged were the bases of Petitioner's guilty plea. In any event, Bussell does not support Petitioner's apparent view that CMS or the ALJ may not consider the conduct and circumstances underlying his felony offense in order to determine whether it is a financial crime. The primary issue in Bussell was not whether a particular crime was, or was similar

to, a financial crime. The issue was whether the ALJ properly found that income tax evasion — Dr. Bussell's offense and a crime expressly named in section 424.535(a)(3)(i)(B) — was "detrimenal per se" to Medicare. DAB No. 2169, at 2, 9. The Board held that income tax evasion and the other crimes specified in that regulation are detrimental per se to Medicare, and that once CMS establishes that a supplier was convicted of such a crime within the prescribed 10-year period, then the ALJ must treat a revocation based on that crime as "a reasonable and permissible exercise of the discretion granted to it under section 424.535(a)(3)[.]" Id. at 9-10, 12-13. Here, there is no dispute that Petitioner's offense is detrimental to Medicare if, in fact, it is a financial crime within the meaning of section 424.535(a)(3)(i)(B).

Petitioner's argument that his offense did not involve the "taking, transferring, or harboring" of money is meritless. He admitted to the ALJ that he created and submitted false documents for the purpose of protecting his receipt and possession of prior Medicare payments for IVIg treatment, and his forfeiture of $2.9 million is a measure of his taking and profit. Moreover, proof of pecuniary loss or illicit gain is not always a necessary element of a financial crime. For example, the federal health care fraud statute, 18 U.S.C. § 1347, punishes not only successful health care frauds but any "attempt [ ] to execute a scheme or artifice" to defraud a health care program (emphasis added). Thus, actual pecuniary loss or gain is not a necessary element of that crime. Cf. Neder v. United States, 527 U.S. 1, 24-25 (1999) (noting that the common-law elements of damages and justifiable reliance on the defendant's misrepresentations "plainly have no place in the federal fraud statutes"); United States v. Kenrick, 221 F.3d at 26 n.2 (pecuniary loss is not a necessary element of proof for a bank fraud conviction under 18 U.S.C. § 1344).

We also find no merit to Petitioner's contention that treating obstruction of justice as a financial crime is inconsistent with section 1128 of the Act. Section 1128(a), known as the "mandatory exclusion" provision, requires the Secretary of HHS to exclude a person who has been convicted of a "felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct" (emphasis added). Section 1128(b), the "permissive exclusion" provision, permits CMS to exclude person for a "misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct." Act § 1128(b)(1) (emphasis added). Section 1128(b) also authorizes permissive exclusion for "[a]ny individual or entity that has been convicted, under Federal or

State law, in connection with the interference with or obstruction of any investigation into any criminal offense described in paragraph (1) or in subsection (a) [i.e., section 1128(a)]." Act § 1128(b)(2) (emphasis added). According to Petitioner, this statutory scheme shows that Congress "decided to treat obstruction differently from financial crimes and deliberately left open the possibility that a provider who merely obstructed or interfered with an investigation would be allowed to continue to participate in Medicare." RR at 13. Petitioner further asserts that "Congress's mandate for the distinct treatment of obstruction of justice" is reflected in section 424.535(a)(3). Id. Petitioner points out that while this regulation authorizes revocation of billing privileges if the supplier or provider has been convicted of a felony that would result in mandatory exclusion under section 1128(a), no such authorization exists when the offense is one (like obstruction of justice) for which permissive exclusion is authorized under section 1128(b). RR at 13.

We reject this argument for two reasons.[5] First, revocation under section 424.535 and exclusion under section 1128 are distinct remedial tools, each with its own set of prerequisites and consequences for the provider or supplier. Nothing in section 1128's text suggests that the distinction between offenses warranting mandatory exclusion and offenses warranting permissive exclusion should inform CMS's judgment about whether a particular offense warrants revocation of enrollment. Section 1128 does not even mention enrollment revocation. We thus do not agree with Petitioner that the exclusion statute requires CMS to exempt from revocation a supplier guilty of obstructing justice.

Second, we are bound to follow CMS's regulations, and nothing in the controlling regulation precludes CMS from finding that Petitioner's offense is "similar" to a financial crime under appropriate circumstances or from finding that the offense is detrimental to the best interests of Medicare and its beneficiaries. In four subparagraphs, (A) through (D), section 424.535(a)(3)(i) lists categories of felonies that CMS has

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[5] We express no opinion about the legal premise of Petitioner's section 1128(a) argument, which is that a felony conviction for obstruction of an investigation of health care offenses would not under any circumstances constitute a "felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct" under section 1128(a)(3) for exclusion purposes.

determined to be detrimental to Medicare and its beneficiaries. Felonies similar to financial crimes are mentioned in subparagraph (i)(B), and felonies that warrant mandatory exclusion under section 1128(a) are mentioned separately in subparagraph (i)(D). These two categories of felonies are thus portrayed as distinct although equally valid bases for revoking a supplier's billing privileges. Nothing in the regulation's text or the Final Rule's preamble indicates that the inclusion of subparagraph (i)(D) was intended to limit the scope of felonies that CMS might find to be a financial crime under section 424.535(a)(3)(i)(B).[6] Had the regulation's drafters intended such a limitation, they could have easily specified it.

For the reasons discussed, we affirm the ALJ's conclusion that the crime for which Petitioner was convicted was similar to insurance fraud and thus a valid basis for revocation under section 424.535(a)(3)(i)(B).

2. *The ALJ properly concluded that Petitioner's conviction occurred within 10 years preceding a revalidation of enrollment.*

Relying on the Board's decision in Robert F. Tzeng, M.D., the ALJ found that a "revalidation" of Petitioner's enrollment occurred in November 2007 when CMS's contractor "obtained information that Petitioner was convicted and then determined that revocation of enrollment and billing privileges was required[.]"[7] ALJ Decision at 8. The ALJ also found that Petitioner's conviction had occurred within ten years preceding the revalidation of his

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[6] A reasonable explanation for the fact that the felonies mandating exclusion under section 1128(a) are included in section 424.535(a)(3)(i) is that CMS is required by statute to ensure that no program payment is made to suppliers or providers who have been excluded from participating in federal health care programs. See, e.g., Act § 1862(e)(1)(A).

[7] The ALJ's statement that revocation was "required" was a misstatement since the regulation, as the ALJ recognized elsewhere in his decision, authorizes but does not mandate revocation for conviction of a felony described in section 424.535(a)(3). See, e.g., ALJ Decision at 5. However, the misstatement is not material to the ALJ Decision, since that decision was based on CMS's authority to revoke, not a requirement to revoke, and the holding is otherwise consistent with the regulation and our decision in Tzeng.

enrollment in Medicare.[8] Id. at 2 (Finding of Fact ¶ 3). Accordingly, the ALJ concluded, "Petitioner's enrollment in Medicare and his billing privileges were properly revoked, effective November 5, 2007." Id. at 3 (Conclusions of Law ¶ 8).

Petitioner contends the ALJ's findings and conclusion are erroneous on various grounds. RR at 7-12. First, he asserts that the ALJ "misread" or misapplied Tzeng. RR at 10-11. However, Tzeng supports the ALJ's conclusion that a revalidation occurred in November 2007. In Tzeng, the Board held that a CMS contractor had done a revalidation when it acquired and reviewed information about a supplier's conviction in order to determine whether the supplier should remain enrolled in the Medicare program. DAB No. 2169, at 11. Likewise, in this case, a revalidation occurred in November 2007 when CMS or its contractor acquired and reviewed information that Petitioner had pled guilty to obstruction of a criminal investigation of health care offenses.

Petitioner contends that Tzeng is inapposite because "at no point has CMS demonstrated or even alleged that it acquired information about [Petitioner's] conviction as part of a larger effort to determine whether it was appropriate to allow [him] to maintain his billing privileges." RR at 11. "To the contrary," says Petitioner, "all indications are that NHIC and CMS did not consider any facts other than the fact of the conviction in making the decision to revoke [his] billing privileges." RR at 11.

In a broader but related vein, Petitioner argues that CMS failed to conduct a proper revalidation process, with his participation, before revoking his billing privileges. RR at 8-11; Oral Argument Transcript at 10-16. Prior to revocation, says Petitioner, CMS should have deliberated about whether revocation was an appropriate response to his felony conviction in light of the potential impact on his "Medicare patients' ability to obtain

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[8] The ALJ stated that Tzeng's characterization of revalidation "appears to be at odds with revalidation procedures established by CMS in" chapter 10, section 9 of the Medicare Provider Integrity Manual (MPIM). ALJ Decision at 8 n.4. The ALJ did not specify the inconsistency, however, and we see nothing in the cited manual provision that is inconsistent with Tzeng's holding that revalidation occurs when CMS independently acquires and reviews information bearing upon a supplier's eligibility or fitness to participate in Medicare.

appropriate care for their rare and potentially life-threatening conditions." RR at 8. There is no evidence, Petitioner says, that CMS or NHIC considered — or that it had sufficient time to weigh — this or other "relevant factors" specified in the Final Rule's preamble, including the "'severity of [the offense], mitigating circumstances, program and beneficiary risk if enrollment was to continue, possibility of corrective action plans, [and] beneficiary access to care'" in reaching its decision to revoke his billing privileges. RR at 9 (citing 71 Fed. Reg. 20,761), 12. Petitioner asserts that revalidation "is an important prerequisite to a revocation because it affords the provider an opportunity to participate in CMS's evaluation of the conduct underlying the felony and ensures that CMS will consider critical facts before the decision to revoke is made and finalized." RR at 8 (emphasis in original). In short, Petitioner contends that the ALJ committed an error of law when he concluded that CMS could revoke his billing privileges without engaging in the type of pre-revocation process he describes. Id.

We find no merit to this argument. In essence, Petitioner contends that section 424.535(a)(3) precludes CMS from issuing an initial revocation determination based on a felony conviction unless: (1) CMS shows that it conducted a revalidation process in which it deliberated about the factors that might be relevant to such a determination; and (2) the provider or supplier received an opportunity to inform or participate in those deliberations.[9] However, the regulations specify no such

[9] In connection with this argument, Petitioner cites as erroneous the ALJ's statement (in Conclusion of Law 6 and repeated in Discussion Heading E.2. of his Analysis) that "CMS or its contractor is not required to conduct a revalidation of enrollment before revoking a provider's or supplier's billing privileges pursuant to 42 C.F.R. § 424.535(a)(3)." RR at 7. We do not read the ALJ's statement as literally as Petitioner does. The ALJ applied our holding in Tzeng and held with respect to Petitioner here that a revalidation occurred when the CMS contractor obtained and reviewed information about his conviction. ALJ Decision at 8. The ALJ also squarely rejected Petitioner's argument that "CMS or its contractor must engage in a revalidation procedure that permits Petitioner's participation prior to revocation" (emphasis added). Id. at 9. We read the ALJ's decision, therefore, as being based principally on the absence in the regulation of any procedural requirements that CMS must follow when revalidating or revoking a provider's billing privileges (such as allowing a supplier's participation). The ALJ also discussed what he seemed to believe were other bases for

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procedural hurdles for an initial revocation determination based on a felony conviction. For example, section 424.535(a)(3) does not require CMS (or its contractor) to notify a supplier that revocation is being contemplated, nor does it require CMS to allow the supplier an opportunity to petition against a proposed or contemplated revocation. Furthermore, nothing in the Final Rule's preamble even remotely suggests that section 424.535(a)(3) entitles a provider or supplier to a pre-revocation hearing or other process. The ALJ correctly held that Petitioner was entitled only to post-revocation administrative review.[10]

Petitioner's complaint that CMS did not consider, or lacked adequate time to consider, certain factors before issuing its initial revocation determination is irrelevant because the adequacy of CMS's pre-revocation deliberations is not subject to administrative review. As we discuss in the next section, the scope of administrative review before the ALJ and the Board is limited to determining whether CMS had a sufficient legal predicate — namely, a qualifying felony that occurred within the prescribed ten-year period — for its revocation determination, irrespective of the method it used to make that determination.

As Petitioner notes, the Final Rule's preamble identifies some factors that CMS would consider in deciding whether to revoke. However, as the ALJ noted, ALJ Decision at 12, CMS has not promulgated regulations that require CMS to consider those factors before revoking a supplier's billing privileges based on a felony that it has determined to be detrimental to the best interests of Medicare. Under section 424.535(a)(3), CMS may —

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upholding the revocation even if he had accepted Petitioner's assertion that no revalidation occurred. Id. However, we need not and do not address those other bases here, or decide whether they would provide additional or alternative grounds for upholding a revocation, since we have concluded, as did the ALJ, that a revalidation did occur here, and the ALJ's decision is correct under our existing precedent.

[10] When the regulations confer pre-revocation due process rights, they clearly specify them. For example, section 424.535(a)(1) permits CMS to revoke a supplier's enrollment based on noncompliance with enrollment requirements but permits the supplier "an opportunity to correct the deficient compliance requirement before a final determination to revoke billing privileges."

in its discretion — revoke a supplier's billing privileges based solely on its receiving notice of a conviction of, or guilty plea to, a felony that it has determined to be detrimental to Medicare and its beneficiaries.

Moreover, assuming that the cited preamble language relates to CMS's revocation determinations in particular cases as Petitioner suggests (as opposed, for example, to determining grounds for revocation more generally), that language relates to all possible grounds for revocation. In addition to authorizing revocation for a qualifying felony conviction, section 424.535 authorizes revocation for, among other things, noncompliance with enrollment requirements, "misuse" of a billing number, providing false or misleading enrollment information, and failing to remain operational. The preamble does not specify whether, or to what extent, the mitigating or other factors mentioned in the passage would be considered in deciding whether to revoke based on a qualifying felony conviction (rather than on some different ground). Clearly, some of the factors — such as the possibility of corrective action — would not be germane to such a decision.

For the reasons discussed, we affirm the ALJ's conclusion that Petitioner was convicted of obstruction of a criminal investigation of health care offenses within ten years preceding revalidation of his enrollment in Medicare.

3. *Petitioner's due process contention lacks merit, and CMS's revocation determination was not arbitrary or capricious.*

Petitioner contends that he has been denied due process because he had no opportunity to present mitigating evidence or information — including "information regarding his uniquely at-risk patient population" — to CMS before NHIC issued the initial revocation determination. RR at 15. Petitioner further contends that the administrative appeals process does not afford due process because "neither the hearing officer or the ALJ had the ability to consider facts such as patients' ability to access care or the availability of sanctions other than total revocation." Id. Petitioner asserts that "NHIC['s] and CMS's complete failure to conduct any sort of proper pre-revocation fact-finding or to conduct a revalidation as required by the regulations renders their decision arbitrary, capricious, and without any rational basis." Id.

We reject these contentions. The revocation was not arbitrary or capricious because it was, as we concluded in the previous two sections, based upon a legally proper interpretation and application of section 424.535(a)(3). Neither the Act nor the regulations required CMS to afford Petitioner the opportunity to participate in its pre-revocation deliberations.

Furthermore, Petitioner's suggestion that the ALJ should have weighed factors other than his conviction in deciding whether revocation was justified overlooks the limited scope of administrative review. CMS is legally entitled to revoke a supplier's billing privileges if: (1) the supplier was convicted of a felony crime that CMS has determined to be detrimental to the best interests of Medicare and its beneficiaries; and (2) the conviction occurred within ten years preceding the supplier's enrollment or revalidation of enrollment in Medicare. 42 C.F.R. § 424.535(a)(3). If these conditions are satisfied, then the ALJ and the Board must sustain the revocation; we may not substitute our discretion for that of CMS in determining whether revocation is appropriate under all the circumstances. Letania Bussell, M.D. at 12-13 (holding that the scope of ALJ review is limited to deciding whether CMS "established a legal basis for its actions"). Because CMS proved that these two legal conditions for revocation were satisfied with respect to Petitioner, the ALJ correctly concluded that his billing privileges had been "properly revoked."

Finally, we do not read Petitioner's appeal briefs as stating a constitutional due process claim. Petitioner contends only that he was denied "process guaranteed to [him] by the applicable regulations." RR at 15. As discussed, the regulations do not require CMS or the Board to provide a pre-revocation hearing, nor do they require CMS, the ALJ, or the Board to consider mitigating or other factors in deciding whether to proceed with or uphold a revocation. The ALJ correctly held that Petitioner received all the process he was due under the regulations.

However, even if Petitioner is asserting here that the Due Process Clause required CMS to afford him a pre-revocation hearing, or requires an ALJ or the Board to review CMS's exercise of its discretionary authority, he provides no legal argument to support that constitutional claim, and the Board would lack the authority to entertain it in any event. See Sentinel Medical Laboratories, Inc., DAB No. 1762, at 9 (2001) (finding it "well established that administrative forums, such as this Board and the Department's ALJs, do not have the authority to ignore unambiguous statutes or regulations on the basis that they are unconstitutional"), aff'd, Teitelbaum v. Health Care Financing

Admin., No. 01-70236 (9th Cir. Mar. 15, 2002), reh'g denied, No. 01-70236 (9th Cir. May 22, 2002); Northern Montana Care Center, DAB No. 1930, at 10 (2004) (declining to consider a claim that regulations limiting the scope of administrative review deprived the nursing home of its constitutional right to due process).

Conclusion

For the reasons discussed, we affirm the ALJ Decision upholding the revocation of Petitioner's Medicare billing privileges.

Stephen M. Godek

Leslie A. Sussan

Sheila Ann Hegy
Presiding Board Member