Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	Date: January 16, 2009
Leigh Gilburn, D.O., (PTAN: 080015954) (NPI: 1235251562),	)	
	)	Docket No. C-08-621
Petitioner,	)	Decision No. CR1890
v.	)	
Centers for Medicare & Medicaid Services.	)	

DECISION

The Medicare supplier numbers and billing privileges of Petitioner, Leigh Gilburn, D.O., were properly revoked, effective May 17, 2008.

I. Background

The Medicare contractor for the Centers for Medicare & Medicaid Services (CMS), Wisconsin Physicians Service Insurance Corporation (WPS), notified Petitioner by letter dated April 17, 2008, that her Medicare Provider Transaction Access Number (PTAN)[1] was being revoked effective May 17, 2008. The regulatory authority cited for the revocation was 42 C.F.R. § 424.535(a)(3) and (4) based upon Petitioner's July 28, 2006 conviction of tax evasion and two instances of false certification on Medicare forms. CMS Exhibit (CMS Ex.) 1. Petitioner requested reconsideration by a contractor hearing officer who issued a decision on May 23, 2008. The hearing officer sustained the revocation pursuant to 42 C.F.R. § 424.535(a)(3). The hearing officer did not state specifically whether there was also a basis for revocation pursuant to 42 C.F.R. § 424.535(a)(4). CMS Ex. 2.

[1] At the time, a PTAN represented the billing privileges of the supplier and revocation of the PTAN was revocation of billing privileges.

Petitioner requested a hearing before an administrative law judge (ALJ) on July 18, 2008. The case was assigned to me for hearing and decision on July 23, 2008. On August 19, 2008, I convened a prehearing conference by telephone, the substance of which is memorialized in my Order and Schedule for Filing Briefs and Documentary Evidence, dated August 21, 2008. During the prehearing conference, CMS did not object to proceeding pursuant to 42 C.F.R. Part 498.[2] Petitioner did not waive her right to a hearing, but CMS requested the opportunity to file a motion for summary judgment before further case development. With the agreement of the parties, I established a briefing schedule. CMS filed its opening brief (CMS Brief) and CMS Exs. 1 through 7 on September 29, 2008. Petitioner filed a consolidated brief in opposition to the CMS motion for summary judgment, a motion for partial summary judgment, and a brief in support of its motion (referred to collectively as P. Brief) with Petitioner Exhibits (P. Ex.) 1 through 11[3] on November 17, 2008. CMS filed its reply on December 2, 2008 (CMS Reply). The parties have not objected to my consideration of the offered exhibits. Therefore, CMS Exs. 1 through 7 and P. Exs. 1 through 11 are admitted.

II. Discussion

A. Findings of Fact

These findings are based upon the undisputed statements of fact in the parties' pleadings and the documentary evidence admitted.

1. On July 28, 2006, in the U.S. District Court for the District of Alaska, Petitioner pled guilty to one count of attempted tax evasion in violation of 26 U.S.C. § 7201, a felony. CMS Ex. 5, at 14-19, 22-23; P. Ex. 1, at 2.

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[2] CMS proposed regulatory changes on October 25, 1999 (64 Fed. Reg. 57,431) and again on March 2, 2007 (72 Fed. Reg. 9479) to extend appeal rights to suppliers like Petitioner, including the right to hearing by an ALJ, review by the Departmental Appeals Board (the Board), and judicial review. The final rule amending 42 C.F.R. Parts 405, 424, and 498 was not issued until June 27, 2008, and the changes were not effective until August 26, 2008. 73 Fed. Reg. 36,448 (June 27, 2008). Prior to issuance of the final rule and its effective date, CMS consented to hearing by ALJ and review by the Board in supplier cases involving denial of enrollment or revocation of billing privileges.

[3] Petitioner marked her exhibits P. Ex. 1 through 10 and P. Ex. A. I have remarked P. Ex. A as P. Ex. 11.

2. On October 10, 2006, Petitioner was sentenced, based upon her conviction, to five years probation, twelve months of home confinement with electronic monitoring, 100 hours of community service, and to pay a $100 assessment. CMS Ex. 6, at 31-35; CMS Ex. 5, at 23-27.

3. Petitioner's conviction occurred within the ten years preceding her enrollment in Medicare.

4. Petitioner does not deny that on July 16, 2007, she signed a CMS-855I form for the purpose of applying to participate in and receive reimbursement from Medicare for services provided to Medicare-eligible beneficiaries. CMS Ex. 3, at 26.

5. Petitioner does not deny that by signing the CMS-855I form on July 16, 2007, she certified that she had read the form and that the information provided was "true, correct, and complete," and that she understood that if false information was given, she was subject to criminal, civil, and administrative penalties, including revocation of her Medicare billing privileges. CMS Ex. 3, at 25.

6. Petitioner does not deny that the CMS-855I form she signed on July 16, 2007, did not include information that she had been convicted of felony attempted tax evasion by a federal court on July 28, 2006. CMS Ex. 3, at 10.

7. The CMS-855I form that Petitioner signed and certified as true on July 16, 2007, was false or misleading because it did not include information that she had been convicted of a felony on July 28, 2006.

B. Conclusions of Law

1. I have jurisdiction.

2. Summary judgment is appropriate.

3. The Secretary of Health and Human Services (Secretary) has determined and provided by regulation that certain financial crimes or similar crimes are detrimental to the Medicare program and its beneficiaries. 42 C.F.R. § 424.535(a)(3)(i)(B).

4. Petitioner was convicted of attempted tax evasion, which is a financial crime similar to the financial crime of income tax evasion that the Secretary has specified is detrimental to the Medicare program and its beneficiaries.

5. Petitioner pled guilty to and was convicted of a financial crime within the meaning of 42 C.F.R. § 424.535(a)(3)(i)(B).

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

7. The Secretary has provided that certification of false or misleading information as true on an enrollment application by a provider or supplier, is a basis for revocation of the provider's or supplier's billing privileges and participation in Medicare. 42 C.F.R. § 424.535(a)(4).

8. Petitioner certified false or misleading information as true, within the meaning of 42 C.F.R. § 424.535(a)(4), by signing a CMS-855I form on July 16, 2007, since the form did not include information that she had been convicted of felony attempted tax evasion on July 28, 2006.

9. There is a basis for revocation of Petitioner's enrollment in Medicare and her billing privileges pursuant to 42 C.F.R. § 424.535(a)(4).

10. Petitioner's enrollment in Medicare and her billing privileges were properly revoked, effective May 17, 2008.

C. Applicable Law

Section 1831 of the Social Security Act (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.[4] Act §§ 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395(u)(h)(1)).

[4] 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) 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.

Administration of the Part B program is by CMS through its 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), 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)). "Physicians' 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 enrollment 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 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" revalidations 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)(3), if a provider or supplier or the owner of a provider or supplier is convicted of a federal or state felony that the Secretary has determined is detrimental to the program or its beneficiaries, CMS may revoke billing privileges. *See* Act §§ 1842(h)(8), 1866(b)(2)(D) (42 U.S.C. §§ 1395u(h)(8), 1395cc(b)(2)(D)). The regulation specifies that the conviction must have occurred within the ten years preceding enrollment or revalidation of enrollment in Medicare. Offenses that the Secretary has found detrimental to the program and its beneficiaries include financial crimes such as income tax evasion, insurance fraud, and similar crimes. 42 C.F.R. § 424.535(a)(3)(i)(B). The Act provides for a hearing by an ALJ and judicial review of the determination to deny enrollment or renewal of enrollment. Act § 1866(j)(2). The Secretary has by regulation extended the right to ALJ and judicial review to actions involving revocation of billing privileges. 42 C.F.R. § 424.545(a) (2008).

D. Issue

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

E. Analysis

1. Summary judgment is appropriate.

CMS moved for summary judgment and Petitioner filed a cross-motion for partial summary judgment and an opposition to the CMS motion. There are no genuine issues of material fact in dispute in this case and summary judgment is appropriate. Petitioner does not deny that she was convicted pursuant to her guilty plea in the U.S. District Court for the District of Alaska of the felony of attempted tax evasion. She also does not deny that she signed the CMS-855I form, her application for participation in Medicare, and that the form did not include information regarding her conviction.

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 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 undisputed facts. The issues in this case turn on the legal interpretation of the regulation 42 C.F.R. § 424.535 and other regulatory provisions that govern revocation of billing privileges as discussed hereafter. Interpretation of the regulations and application of the regulations to the undisputed material facts are required to resolve this case. Accordingly, summary judgment is appropriate.

2. There is a basis for revocation of Petitioner's enrollment in Medicare and her billing privileges pursuant to 42 C.F.R. § 424.535(a)(3)(i)(B) and 42 C.F.R. § 424.535(a)(4).

The authorized reasons or bases for revocation of enrollment and billing privileges are listed in 42 C.F.R. § 424.535(a) and include: (1) noncompliance with enrollment requirements; (2) provider or supplier conduct resulting in exclusion or debarment or suspension; (3) conviction of a felony detrimental to the best interests of the program and

beneficiaries or that would result in mandatory exclusion pursuant to section 1128(a) of the Act; (4) certification of false or misleading information as true on the enrollment application; (5) determination that the provider or supplier is not operational or not meeting program enrollment requirements based on on-site review; (6) failure to furnish complete and accurate information on reverification; and (7) misuse of a billing number.

There are two bases cited for revocation in this case. The first basis for revocation is 42 C.F.R. § 424.535(a)(3)(i)(B), which provides:

> (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 –
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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.

Petitioner does not dispute the material facts that she was convicted in a federal court of a felony count of attempted tax evasion on July 28, 2006. Petitioner does not dispute that her conviction occurred within the ten years preceding her application to participate in Medicare that she signed on July 16, 2007. The Secretary has specified by regulation, i.e. as a matter of law, that certain financial crimes are detrimental to the program and its beneficiaries. Conviction of attempted tax evasion is, as a matter of law, detrimental to the Medicare program and its beneficiaries. I conclude, as a matter of law, that attempted tax evasion in violation of 26 U.S.C. § 7201 is a similar crime to income tax evasion, a crime that the Secretary has provided is detrimental to the program and its beneficiaries. [5]

[5] CMS asserts that its determination that a particular crime is detrimental to the program is not subject to review. CMS Brief at 11-12; CMS Reply at 5-6. The regulation lists the specific crimes of extortion, embezzlement, income tax evasion, and insurance fraud, and establishes, as a matter of law, that they are detrimental to the program and its beneficiaries. However, the list is not exhaustive ("other similar crimes") and leaves for

The second basis for revocation in this case is 42 C.F.R. § 424.535(a)(4), which provides:

> (4) *False or misleading information.* The provider or supplier certified as "true" misleading or false information on the enrollment application to be enrolled or maintain enrollment in the Medicare program.

Petitioner does not dispute the material fact that she signed the CMS-855I on July 16, 2007. Petitioner does not dispute that the CMS-855I specifically advised her that by signing she was certifying she had read the form and that the information in the form was true, correct, and complete. Petitioner does not dispute that the form also advised her that certifying as true information that was false or misleading would be a basis for revocation of her participation and billing privileges. Petitioner does not dispute that when she signed the CMS-855I on July 16, 2007, the form did not include the information that she had been convicted in the appropriate space on the form where such information should have been entered. I conclude, as a matter of law, that Petitioner certified as true information in her application that was false or misleading within the meaning of 42 C.F.R. § 424.535(a)(4).

Petitioner raises several arguments in her defense that are without merit as is her motion for partial summary judgment. Petitioner argues various facts related to her conduct that resulted in her criminal conviction that might be construed as a collateral attack upon her conviction. P. Brief at 3-4. However, Petitioner cites no authority to show that she may collaterally attack her criminal conviction in this forum or that I have any authority to review the facts underlying her guilty plea. Petitioner pled guilty in exchange for the benefits of a plea agreement that indicates she had the benefit of counsel when making that decision. CMS Ex. 5. I find no authority for me to review in this forum the providence of Petitioner's plea of guilty. However, I note that the facts Petitioner urges me to consider are not inconsistent with the conclusion of the district court that she knowingly admitted being guilty of attempted tax evasion.

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determination what other crimes are similar financial crimes that are detrimental. The CMS contractor makes the initial determination whether or not a crime is similarly detrimental as the crimes listed. Contrary to the CMS assertion that the determination that a similar financial crime is detrimental is not subject to challenge or review, I find no such statutory or regulatory limit upon the scope of review available to Petitioner and CMS points to none.

Petitioner urges me to consider that she was open and forthright about her conviction with her employers, the Alaska State Medical Board, colleagues, and community leaders, that many wrote favorable letters or statements on her behalf, that there was no adverse action related to her medical license by the state licensing authority, and that despite her conviction, she was hired for a new job. P. Brief at 3-6. However, none of these factors negates her conviction or that she signed an application that was false or misleading due to omitted information regarding her conviction. She urges me to consider that she disclosed her conviction on the Minnesota Uniform Credentialing Application she signed. P. Brief at 6, 12-13. Petitioner blames administrative staff for omitting the information that she had been convicted from the CMS-855I and that she did not falsify the form.[6] P. Brief at 6-8, 11-14. Petitioner argues that CMS concedes that she did not falsify her CMS-855I. P. Brief at 11. Actually, CMS agreed to accept as true for purposes of the motion for summary judgment that Petitioner did not make the erroneous entry on her CMS-855I that she had "no" adverse legal actions/convictions. CMS Brief at 15 n.6. I too accept as true, for purposes of ruling upon summary judgment, Petitioner's assertion that administrative staff incorrectly entered information on the CMS-855I. Viewing the evidence in a light most favorable to Petitioner, even to the extent of accepting as true the alleged fact that she did not make the erroneous entry, negates any dispute about the source of the entry. Accepting as true the fact that Petitioner did not make the entry on the CMS-855I also negates Petitioner's argument that there are material facts in dispute, precluding entry of summary judgment for CMS. P. Brief at 12. Furthermore, the source of the false or missing entry on the CMS-855I is not a material fact in this case as the regulation does not focus upon who entered information on an application. Rather, the regulation imposes the burden to ensure information is true, correct, and complete upon the applicant and specifically states that the provider or supplier's certification of false or misleading information on an application is a basis for revocation of billing privileges. 42 C.F.R. § 424.535(a)(4). Thus, the material fact is that Petitioner signed the CMS-855I with false or misleading information certifying it was true, and, even if the section regarding adverse legal actions/convictions was blank, the information was not true, but was false and misleading because the conviction was not disclosed.

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[6] The evidence shows that the Medicare contractor requested additional information from Petitioner by letter dated July 27, 2007, and Petitioner signed another certification in conjunction with providing the additional information. CMS Ex. 3, at 36-41. I find it unnecessary, in the interest of judicial economy, to consider the facts related to the second certification as there are two independent bases for revocation discussed in this decision.

Partial summary judgment will not lie for Petitioner on the same rationale, i.e. the accepted fact that Petitioner did not make the erroneous entry is not the conduct that is the basis for revocation. Rather, the basis for revocation is the false certification of false or misleading information as true. Petitioner states that "it defies logic to believe that [she] purposefully intended to deceive Medicare. . . ." P. Brief at 13. To the extent that Petitioner's argument implies that the regulation requires a particular mens rea or element of intent on the part of the provider or supplier who falsely certifies information as true and complete, I am not persuaded. The regulation includes no language that one would expect to find in a statute or regulation that includes an element of intent. Petitioner also points to no authority in support of its position. The form itself is clear that by signing, Petitioner certified that she had read the form and that the information provided in the form was true, correct, and complete. I conclude that there is no requirement for the evidence to show that Petitioner intended to deceive or mislead CMS or its contractors.

Petitioner argues that exclusion from participation in Medicare based upon a conviction of attempted tax evasion is not mandated by section 1128(a) of the Act (42 U.S.C. § 1320a-7(a)), but rather exclusion for such a conviction is permissive, i.e., within the Secretary's discretion under section 1128(b) (42 U.S.C. § 1320a-7(b)). Petitioner concludes by asserting that the CMS motion for summary judgment should be denied based upon "well-established canons of statutory construction and given the unique factual circumstances of this matter." P. Brief at 14-15. Congress, in section 1128 of the Act, required the Secretary to exclude a provider or supplier from participation in Medicare, Medicaid, and all federal health care programs for certain convictions and granted the Secretary discretion to exclude for other conduct. The Secretary has delegated the exclusion program under section 1128 to the Inspector General (I.G.), who administers the program pursuant to 42 C.F.R. Chapter V, Parts 1001 and 1005. Whether or not the Secretary or the I.G. may exclude a supplier or provider from participation based upon a conviction for attempted tax evasion is not an issue I need resolve. My construction of the regulations governing revocation of Medicare billing privileges is not inconsistent with Petitioner's assertion that the Act and regulation grant the Secretary and his designees discretion to determine whether or not a provider's or supplier's billing privileges should be revoked.

I agree with Petitioner that Congress did not mandate revocation of billing privileges for attempted tax evasion. In this case, the CMS contractor exercised the discretion on behalf of CMS and the Secretary and determined revocation of billing privileges was appropriate based upon Petitioner's offense being detrimental to the program and its beneficiaries. In I.G. exclusion cases, the regulation specifically provides that the ALJ may not review the I.G.'s exercise of discretion to impose a permissive exclusion pursuant to 1128(b). 42 C.F.R. § 1005.4(c)(5). There is no such restriction upon my authority to review the

Medicare contractor's exercise of discretion in revoking billing privileges or the CMS adoption or ratification of such action. *See* Act § 1866(j)(2) and 42 C.F.R. Part 498. However, review of the actual decision-making of either the contractor or CMS is unnecessary, as I may provide Petitioner de novo review of the decision to exclude her, including whether her offense was similar to the offenses listed in the regulation and whether revocation was appropriate.

As discussed above, I concluded that attempted tax evasion is similar to the listed offense of income tax evasion and detrimental to the program and its beneficiaries. I also concluded that Petitioner falsely certified her application as discussed above. In this case, I find de novo that the undisputed facts support conclusions that there are two regulatory bases for revoking Petitioner's Medicare billing privileges. Petitioner points to no evidence that there was any abuse of discretion by the contractor or CMS that requires a remedy, except to the extent that Petitioner argues that her openness about her conviction, her work in under-served communities, her favorable recommendations, her ability to get a job, and other considerations are inconsistent with a decision to revoke billing privileges. However, accepting as true for purposes of summary judgment the facts urged by Petitioner and considering those facts de novo, I also conclude that revocation based on either Petitioner's conviction or her false certification is fully supported.

Petitioner argues that revocation of her billing privileges is in conflict with the "express purposes of the Act." P. Brief at 15. Petitioner's theory is that she serves an under-served community, that she has the respect of her patients, the community, and her colleagues, and all are aware of her conviction. She argues that revocation of her billing privileges causes a detriment to the Medicare beneficiaries she served or would serve. P. Brief at 8-9, 15-16. Petitioner offers affidavits of two individuals who make general assertions that revocation of Petitioner's billing privileges will cause a detriment to Medicare program beneficiaries. P. Exs. 2, 4. However, no evidence is offered that shows the actual number of Medicare beneficiaries that are impacted. Petitioner's assertion that International Falls now has only two physicians to provide "C-Section coverage" (P. Brief at 16) is not good evidence of detrimental impact upon the community without some evidence that there are Medicare-eligible beneficiaries who actually require such services. Similarly, evidence that loss of Petitioner's services in the community may cause other doctors to "burn out and leave" (P. Brief at 16; see P. Exs. 2, 4) is not credible as it is purely speculative.

Petitioner argues that there is no evidence that she has or will cause harm to the Medicare program. P. Brief at 16-17. However, the fact that Petitioner was convicted of a felony and subsequently falsified her application to participate in Medicare are more than sufficient evidence to support a conclusion that she is too unreliable to be entrusted with access to limited Medicare funding.

Petitioner argues that her revocation is excessive and inconsistent with the Act and regulations and contrary to fundamental notions of fairness and due process. The regulations in effect on the effective date of revocation of Petitioner's billing privileges did not specify that a revocation must be in effect a certain period prior to Petitioner reapplying. 42 C.F.R. § 424.535 (2007). The plain language of the regulation was that reapplication could occur after or in lieu of the appeals process. *Id.* Under the revision to 42 C.F.R. § 424.535(c) effective August 26, 2008, a provider or supplier is barred from reenrollment for a minimum of one year but not more than three years. 73 Fed. Reg. 36,448, 36,461 (June 27, 2008) (to be codified as 42 C.F.R. § 424.535(c)). Whether CMS may impose some minimum period of exclusion under the old regulation or whether the revised regulation should be applied retroactively to Petitioner's case are not issues presented by the facts before me.[7] Although both parties discuss the period that Petitioner's revocation may be in effect (CMS Brief at 17; CMS Reply at 6-8, P. Brief at 17-21), that issue is not before me as the evidence does not show that Petitioner has been denied an opportunity to reapply under the old regulation, that CMS has attempted to retroactively apply the new regulation, or that CMS or its contractor has denied Petitioner's reapplication on grounds that Petitioner's billing privileges have not been revoked for a particular period. I will not provide an advisory opinion regarding issues not presented by the facts before me. However, there is no question that under the revised regulation, if Petitioner reapplies for enrollment and enrollment is denied, she may appeal in accordance with 42 C.F.R. Part 498. 73 Fed. Reg. 36,448, 36,461 (to be codified at 42 C.F.R. § 424.545(a)).

Petitioner argues that she was denied due process because neither the contractor notice of revocation nor the hearing officer decision stated when she was eligible to reenroll and she was effectively subject to an indefinite period of revocation. Petitioner relies upon legislative history related to exclusion authority under section 1128 of the Act, but fails to demonstrate that the legislative history cited has any application to revocation of billing privileges. I find no provisions of 42 C.F.R. Parts 405, 424, or 498 that require that a notice of revocation advise a supplier of when it is eligible to reapply. The general

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[7] Counsel for CMS takes the position that the old version of the regulation controls. CMS Brief at 7.

requirements for notice are that an affected party be advised of the initial or reconsidered determination, of the basis for the determination, and of the right for further review. 42 C.F.R. § 498.20. Furthermore, a specific statement in the notice of revocation regarding when a supplier may reapply is unnecessary given that both the old regulation and the revised regulation specifically address when reapplication may occur. 42 C.F.R. § 424.535(c). Even if the notice of revocation should have included a statement regarding when Petitioner could reapply, I find that the omission was not prejudicial.

III. Conclusion

Petitioner's Medicare supplier number and her billing privileges were properly revoked.

/s/
Keith W. Sickendick
Administrative Law Judge