Department of Health and Human Service

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	
John E. Roberts, P.A. (PTAN: 0M98680)	Date: November 23, 2009
Petitioner,	
	Docket No. C-09-602
v.	Decision No. CR2034
Centers for Medicare & Medicaid Services.	

DECISION

The application to participate in Medicare of Petitioner, John E. Roberts, P.A. was properly denied and his billing privileges were properly revoked, effective April 24, 2008.

I. Background

The Medicare contractor for the Centers for Medicare and Medicaid Services (CMS), Wisconsin Physicians Service Insurance Corporation (WPS), notified Petitioner by letter dated December 29, 2008, that his Medicare Provider Transaction Access Number (PTAN)[1] was being revoked effective April 24, 2008. The regulatory authority cited for the revocation was 42 C.F.R. § 424.535 based upon Petitioner's felony conviction on April 24, 2008. CMS Exhibit (CMS Ex.) 3. Petitioner requested reconsideration by a contractor hearing officer who issued a decision in the form of a letter dated May 21, 2009. The hearing officer upheld denial of Petitioner's enrollment in Medicare and sustained the revocation of Petitioner's billing privileges pursuant to 42 C.F.R. § 424.535 based upon Petitioner's felony conviction. CMS Ex. 1, at 1-2.

[1] The PTAN represents 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) by letter dated July 19, 2009. The case was assigned to me for hearing and decision on July 24, 2009, and an Acknowledgement and Prehearing Order (Prehearing Order) was issued at my direction on that date. On August 19, 2009, CMS filed a motion with the title "Centers for Medicare and Medicaid Services' Combined Motion and Memorandum of Law in Support of Summary Affirmance," which I treat as a motion for summary judgment[2] (CMS Brief) and exhibits 1 through 6. Petitioner filed a response (P. Brief) with exhibits (P. Ex.) 1 through 4 on September 19, 2009. CMS filed its reply on September 29, 2009. The parties have not objected to my consideration of the offered exhibits. Therefore, CMS exhibits 1 through 6 and Petitioner's exhibits 1 through 4 are admitted.

II. Discussion

A. Applicable Law

Section 1831 of the Social Security Act (the Act) (42 U.S.C. § 1395j) establishes the supplementary medical insurance benefits program for the aged and disabled known as Medicare Part B. Payment under the program for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of services and suppliers.[3] Act §§ 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395(u)(h)(1)). Administration of the Part B program is through contractors. Act § 1842(a) (42 U.S.C. § 1395u(a)). The Act requires the Secretary of Health and Human Services (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

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[2] Summary judgment procedures are established by paragraph II. 7 of the Prehearing Order.

[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) 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.

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)).

"Physician's Services" means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls (with certain exceptions). Act § 1861(q) (42 U.S.C. § 1395x(q)). The term "physician," when used in connection with the performance of any function or action, means, in part, a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she performs such function or action. Act § 1861(r) (42 U.S.C. § 1395x(r)); 42 C.F.R. § 410.20(b). The phrases "physician's assistant" and "nurse practitioner" are defined by section 1861(aa)(5) of the Act and their services and related supplies may be covered to the same extent as physicians services pursuant to section 1861(s)(2)(H) and (K) of the Act. The Medicare program authorizes Medicare Part B payments for services provided by physicians (42 C.F.R. § 410.20) and physician assistants (42 C.F.R. § 410.74). A physician's assistant 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" revalidation that may be conducted at any time and which may be triggered by random checks, adverse information, national initiatives, complaints, or other reasons that cause CMS to question whether the provider or supplier continues to meet enrollment requirements. 42 C.F.R. § 424.515.

CMS may revoke an enrolled provider's or supplier's Medicare billing privileges and any provider or supplier agreement for any of the reasons listed in 42 C.F.R. § 424.535. Pursuant to 42 C.F.R. § 424.535(a)(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 § 1866(b)(2)(D) (42 U.S.C. § 1395cc(b)(2)(D)). The regulation specifies that the conviction must have occurred within the 10 years preceding enrollment or revalidation of enrollment in Medicare. The regulation lists offenses that CMS has found detrimental to the program or its beneficiaries. 42 C.F.R. § 424.535(a)(3)(i). The Act provides for a hearing by an ALJ and judicial review of the determination to deny enrollment or re-enrollment or to revoke billing privileges. Act § 1866(j)(2).

B. Issue

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

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

1. Summary judgment is appropriate.

CMS filed a motion for summary judgment to which Petitioner filed a response. Petitioner does not argue that summary judgment is inappropriate but argues the merits of his case and offers evidence in support of his arguments. There are no genuine issues of material fact in dispute in this case and summary judgment is appropriate. Petitioner does not deny that he was convicted of the felony cited by CMS as the basis for its actions.
P. Brief at 2.

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 Illinois Knights Templar Home*, DAB No. 2274, at 3-4, 8 (2009);

Kingsville Nursing and Rehabilitation Center, DAB No. 2234, at 3-4 (2009); *White Lake Family Medicine, P.C.,* DAB No. 1951 (2004); *Lebanon Nursing and Rehabilitation Center*, DAB No. 1918 (2004). A party opposing summary judgment must allege facts which, if true, would refute the facts relied upon by the moving party. *See, e.g.*, Fed. R. Civ. P. 56(c); *Garden City Medical Clinic*, DAB No. 1763 (2001); *Everett Rehabilitation and Medical Center*, DAB No. 1628, at 3 (1997) (in-person hearing required where non-movant shows there are material facts in dispute that require testimony); *Thelma Walley*, DAB No. 1367 (1992); *see also New Millennium CMHC, Inc.*, DAB CR672 (2000); *New Life Plus Center, CMHC,* DAB CR700 (2000).

This case requires an application of the law to the undisputed facts. The issues in this case turn on the legal interpretation of the regulations, 42 C.F.R. §§ 424.530 and 424.535, and other regulatory provisions that govern denial of enrollment and revocation of billing privileges, as discussed hereafter. Petitioner does not dispute that he was convicted of a felony as alleged by CMS. Neither party asserts that there is a genuine dispute as to a material fact and the evidence does not show such a dispute. Interpretation of the regulations and application of the regulations to the undisputed facts are required to resolve this case. Accordingly, summary judgment is appropriate.

2. The CMS notice to Petitioner of the basis for its action was sufficient in this case.

The CMS contractor, WPS, sent Petitioner a letter dated December 29, 2008. The letter advised Petitioner that his PTAN, 0M98680, was being revoked "based on 42 CFR §424.535" effective April 24, 2008. The letter advised that the revocation was based on the fact that on April 24, 2008, Petitioner was convicted of a felony offense of tampering with evidence. The letter advised Petitioner of the right to request reconsideration. CMS Ex. 3.

The WPS hearing officer sent Petitioner a letter dated May 21, 2009. The letter advised Petitioner that the hearing officer decided to deny Petitioner's request for reconsideration. The hearing officer based his decision upon Petitioner's conviction and cited 42 C.F.R. § 424.535(3), though it is apparent from the quoted language that the correct cite should have been 42 C.F.R. § 424.535(a)(3). CMS Ex. 1, at 1.

Although not raised as an issue by Petitioner, the lack of clarity of both the notice of the initial determination and the reconsideration determination are a concern in this case. CMS is required to notify an affected party of an initial determination and the notice is required to set forth the basis or reasons for the initial determination, the effect of the determination, and the affected party's right to request reconsideration or a hearing. 42 C.F.R. § 498.20(a). The notice of a reconsidered determination to an affected party must state: the reason for the determination, what conditions or requirements of law were not satisfied by the affected party; and the right to a hearing. 42 C.F.R. § 498.25.

The notice of initial determination dated December 29, 2008 cited 42 C.F.R. § 424.535 as the basis for the adverse action against Petitioner. The hearing officer notice was little more specific with its incorrect reference to 42 C.F.R. § 424.535(3). The regulation cited in both determinations actually lists eight grounds for revocation of enrollment and billing privileges: (1) noncompliance with participation requirements; (2) misconduct including prior exclusion from Medicare, Medicaid, or other federal health care programs and suspension or debarment from any federal program; (3) conviction of a felony that CMS determined detrimental to the best interests of Medicare and its beneficiaries; (4) provision of false or misleading misinformation on the enrollment application; (5) a failed on-site review; (6) inadequate reverification information; (7) misuse of billing number; and (8) abuse of billing privileges. 42 C.F.R. § 424.535(a). The notice of initial determination did not specify which of the eight bases for revocation applied in Petitioner's case. The notice of the reconsideration decision did not accurately cite the regulation but did indicate that subsection 3 applied. However, the reconsideration decision did not specify which of the four subsections of 42 C.F.R. § 424.535(a)(3) actually applied.

The issue regarding adequacy of the notices is whether Petitioner had sufficient notice so that he could prepare to defend against the adverse action. I conclude Petitioner had sufficient notice. Both notices specifically cite Petitioner's April 24, 2008, felony-conviction of tampering with evidence. While the exact legal basis for revocation of Petitioner's billing privileges is not correctly cited in either notice, Petitioner's response reflects that he understood that the basis for revocation was 42 C.F.R. § 424.535(a)(3). P. Brief at 3-4. Further, Petitioner's two arguments, i.e., his offense is not specifically enumerated and he is a person of honesty and integrity who has provided years of excellent care, are not dependent upon which subsection of 42 C.F.R. § 424.535(a)(3) is the basis for his exclusion. Accordingly, I conclude that Petitioner had adequate information to prepare his defense and any defect in the notices of the initial and reconsideration determinations were not prejudicial.

3. Petitioner was convicted of an offense for which his exclusion is required by section 1128(a)(4) of the Act (42 U.S.C. § 1320a-7(a)(4)).

4. The issue for hearing and decision is whether there is a basis for denial of Petitioner's enrollment and revocation of Petitioner's billing privileges and my jurisdiction does not extend to review the issue of whether CMS properly exercised its discretion to revoke Petitioner's Medicare enrollment and billing privileges if I find there was a basis for such action.

5. There is a basis for denial of Petitioner's application for enrollment in Medicare and revocation of his billing privileges pursuant to 42 C.F.R. §§ 424.530(a)(3)(i)(D) and 424.535(a)(3)(i)(D).

a. Facts

Petitioner signed an application for enrollment to participate in Medicare, a CMS form CMS-855I, on December 11, 2008, in which he indicated that he was changing his Medicare information. Petitioner stated in the application that he had been subject to an adverse legal action in the form of license suspension on April 28, 2008, based upon a charge of tampering with evidence. CMS Ex. 1, at 3-15.

Petitioner stated in a letter dated January 15, 2009, that he was convicted in April 2008, in Gladwin, Michigan, of the offense of tampering with evidence. Petitioner stated in his letter that he wrote two prescriptions for narcotics for his former office manager; that both prescriptions had medical justification as he had seen the patient and she was doing physical therapy for her medical condition; that he failed to document the examinations other than to record the prescriptions on her charts; that the patient was caught selling the narcotic medication he prescribed; and he panicked and created documentation of his examinations that he gave to the police; and subsequently he admitted to creating the documents. He admits that he pled guilty to the offense of tampering with evidence. CMS Ex. 1, at 36-38; P. Ex. 4.

A felony information filed in the 80th Judicial District, 55th Judicial Circuit, State of Michigan, shows that Petitioner was charged with the following violations of Michigan law: Count 1, tampering with evidence by knowingly and intentionally removing, altering, concealing destroying, or otherwise tampering with evidence to be offered in an official proceeding; Counts 2 and 3, intentionally placing false information on a chart in a medical record by intentionally or willfully placing or directing another to place in a patient's medical record or chart information that he knew was misleading or inaccurate in regard to the diagnosis, treatment, or cause of the patient's condition; and Counts 4 and 5, delivery or manufacture of a narcotic, specifically hydrocodone. CMS Ex. 2, at 11-12. On April 29, 2008, Petitioner pled guilty to Count 1, tampering with evidence, a felony, in exchange for no jail but four years probation. CMS Ex. 2, at 10, 13-14.

An Administrative Complaint before the State of Michigan, Department of Community Health Bureau of Health Professions Task Force on Physician's Assistants Disciplinary Subcommittee was offered as evidence by CMS. Petitioner does not dispute the facts alleged in the Administrative Complaint (the Complaint). According to the Complaint, Petitioner was employed as a physician's assistant at the Beaverton Medical Clinic (Clinic) in Gladwin, Michigan. A former employee of the Clinic referred to as MR, told law enforcement that she obtained prescriptions for Vicodin (a combination of acetaminophen and the narcotic hydrocodone) from Petitioner and that Petitioner gave

her the prescriptions because they were friends. Law enforcement subpoenaed MR's records from Petitioner and also obtained a Michigan Automated Prescription System report that showed Petitioner had prescribed 400 tablets of Vicodin for MR from June 27, 2006 through August 6, 2007. After receiving the subpoena, Petitioner enlisted a medical assistant at the clinic and created fraudulent medical records indicating that Petitioner examined MR on March 13 and June 18, 2007 for low back pain. Clinic staff subsequently gave MR's medical record to law enforcement. A Clinic staff member subsequently told law enforcement that Petitioner attempted to have her assist him create a false medical record for MR but she refused; that Petitioner never performed a physical examination for MR; that Petitioner was aware that MR had obtained at least one prescription for Vicodin under false pretenses in the past; and that she told Petitioner she believed that MR was selling the Vicodin that Petitioner prescribed. Subsequently, the staff member that did assist Petitioner with creating the false medical record entries, confessed to law enforcement admitting to assisting with the falsification and that the false records were released pursuant to the subpoena. On September 21, 2007, Petitioner admitted to law enforcement that he created false records to indicate that he physically examined MR on March 13 and June 18, 2007, but he denied that he knew MR was selling the Vicodin he prescribed for her. However, the Complaint alleges that law enforcement searched Petitioner's office on September 21, 2007 and found letters that indicated he knew MR was selling the Vicodin that he prescribed for her. CMS Ex. 2, at 2-4.

Petitioner's enrollment application was denied and his billing privileges were revoked by WPS, as discussed above.

Hydrocodone is a Schedule II controlled substance. 21 C.F.R. § 1308.12(b)(1)(vi). Vicodin is a Schedule III controlled substance. 21 C.F.R. § 1308.13(e)(1)(iii)-(v).

b. Analysis

Denial of a provider's or supplier's enrollment application based upon conviction of a felony is provided for by 42 C.F.R. § 424.530(a)(3) as follows:

> (a) Reasons for denial. CMS may deny a provider's or supplier's enrollment in the Medicare program for the following reasons:
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> * * * *
>
> (3) Felonies. If within the 10 years preceding enrollment or revalidation of enrollment, the provider, supplier, or any owner of the provider or supplier, 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. CMS considers the severity of the underlying offense.

(i) Offenses include--(A) Felony crimes against persons, such as murder, rape, or assault, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

(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.

(C) Any felony that placed the Medicare program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct).

(D) Any felonies outlined in section 1128 of the Act.

Revocation of a currently enrolled provider's or supplier's billing privileges and any corresponding provider or supplier agreement based upon conviction of a felony is authorized by 42 C.F.R. § 424.535(a)(3) as follows:

> (a) Reasons for revocation. CMS may revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement or supplier agreement for the following reasons:
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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--
>
> (A) Felony crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.
>
> (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.
> (C) Any felony that placed the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.
> (D) Any felonies that would result in mandatory exclusion under section 1128(a) of the Act.

Neither the notice of initial determination dated December 29, 2008, nor the notice of reconsideration dated May 21, 2009, accurately cited the regulatory basis for the denial of Petitioner's application or the revocation of his billing privileges. However, it is clear from both notices that the basis for the adverse action was Petitioner's felony conviction of the offense of tampering with evidence. I have concluded that Petitioner had adequate notice of the basis for the denial and revocation to effectively exercise his right to review.

Based upon my review of all the evidence, I conclude that there is a basis for denial of Petitioner's application pursuant to 42 C.F.R. § 424.530(a)(3)(i)(D) and for revocation of his billing privileges pursuant to 42 C.F.R. § 424.535(a)(3)(i)(D).[4] I conclude that the bases for revocation established by 42 C.F.R. § 424.535(a)(3)(i)(A), (B), and (C) have no application in this case. The facts do not establish that Petitioner's offense was a crime against a person such as murder, rape, assault, and other similar crimes as required by 42 C.F.R. § 424.535(a)(3)(i)(A). The facts do not show that Petitioner's offense placed either the Medicare program or a Medicare beneficiary at immediate risk for harm as required by 42 C.F.R. § 424.535(a)(3)(i)(C). I further conclude that Petitioner's offense was not a financial crime within the meaning of 42 C.F.R. § 424.535(a)(3)(i)(B). The evidence shows no financial motive[5] and the crime for which Petitioner was convicted,

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[4] I note that for denial of enrollment it is sufficient for the prospective provider or supplier to have been convicted of any felony listed in section 1128 of the Act. However, for revocation of billing privileges, there is the more specific requirement that the provider or supplier have been convicted of a felony for which the Secretary is required to exclude the provider or supplier from participation in all federal health care programs by section 1128(a) of the Act. Because I conclude that the more specific requirement of 42 C.F.R. § 424.535(a)(3)(i)(D) is met in this case and is a sufficient basis for both denial of enrollment and revocation of billing privileges, I conclude it is not necessary to further discuss 42 C.F.R. § 424.530(a)(3)(i)(D).

[5] I do not mean to suggest that a financial motive is required for the application of 42 C.F.R. § 424.535(a)(3)(i)(D). However, evidence of a financial motive may help identify an offense as an offense similar to the example financial crimes listed in that regulatory provision.

given the underlying facts, was not a crime similar to embezzlement, income tax evasion, or insurance fraud. Mich. Comp. Laws § 750.483a(5) and (6) (2001); CMS Ex. 6.

Revocation is permitted under 42 C.F.R. § 424.535(a)(3)(i)(D) based upon any felonies that would result in mandatory exclusion pursuant to section 1128(a) of the Act. Section 1128(a) of the Act requires that the Secretary exclude from participation in any federal health care program an individual or entity convicted of: (1) a program related crime; (2) patient neglect or abuse; (3) a felony related to health care fraud; or (4) a felony conviction related to a controlled substance. The evidence does not show that Petitioner's felony conviction was a program related crime, involved patient neglect or abuse, or involved health care fraud. However, section 1128(a)(4) of the Act mandates that the Secretary exclude from participation in any federal health care program an individual convicted in a federal or state court for "an offense which occurred after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996 [August 21, 1996], ..., of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance." The facts in this case satisfy the requirement of section 1128(a)(4) in that they show that Petitioner was convicted of a felony relating to the unlawful prescription of a controlled substance. Hydrocodone and Vicodin are both controlled substances. Petitioner was convicted of the offense of tampering with evidence and the facts show that he committed the offense by creating false medical records to make it appear that prescriptions for narcotic pain medication that he provided a friend were legitimately written. Therefore, there is the required nexus or common sense connection between Petitioner's conduct and the offense of which he was convicted to support the conclusion that his felony conviction was related to the unlawful prescription of a controlled substance. *See e.g.*, *Paul D. Goldenheim, M.D., Howard R. Udell, Michael Friedman*, DAB No. 2268 at 11 (2009); *Muhamad Salah Zobi*, DAB CR1324 (2005). I conclude that Petitioner's felony conviction subjects him to mandatory exclusion pursuant to section 1128(a)(4) of the Act. There is no dispute that his conviction occurred within the ten years preceding the enrollment application he signed on December 11, 2008. Accordingly, I conclude that there is a basis for revocation of his billing privileges pursuant to 42 C.F.R. § 424.535(a)(3)(i)(D).

Petitioner argues that tampering with the evidence is not a crime enumerated in either 42 C.F.R. §§ 424.530(a)(3) or 424.535(a)(3) and that CMS has no authority to deny Petitioner enrollment or revoke his billing privileges. P. Brief at 3-4; P. Ex. 3, at 2. This argument has no merit. Revocation of Petitioner's billing privileges is authorized under 42 C.F.R. § 424.535(a)(3)(i)(D), which encompasses any "felonies that would result in mandatory exclusion under section 1128(a) of the Act." There is no specific enumeration of felony offenses under either 42 C.F.R. §§ 424.530(a)(3)(i)(D) or 424.535(a)(3)(i)(D), rather a class of offenses are described in those regulations that the Secretary has specified are per se detrimental to Medicare and its beneficiaries, and Petitioner's argument is inapposite.

In his request for reconsideration, Petitioner argued that his offense should not be treated by CMS as being detrimental to the best interest of the program or its beneficiaries. This argument is also without merit. The regulation establishes that a felony offense that subjects one to mandatory exclusion pursuant to section 1128(a) of the Act is detrimental. 42 C.F.R. § 424.535(a)(3)(i)(D). Because the regulation establishes that a felony offense that subjects one to mandatory exclusion pursuant to section 1128(a) of the Act is per se detrimental, CMS has the discretion to decide whether or not to revoke enrollment and billing privileges on that basis. CMS is otherwise bound by the regulation, which grants no discretion to conclude that an offense described by 42 C.F.R. § 424.535(a)(3)(i)(D) is not detrimental. Petitioner submitted with his request for reconsideration and with his brief to me numerous letters attesting to his excellent service to the community among other things. CMS Ex. 1, at 39-89, 97-143; P. Ex. 1. Petitioner also submitted the consent order of the Michigan licensing authority suspending Petitioner's physician assistant license for a period of six months from June 26, 2008 through December 28, 2008, with provision for automatic reinstatement of his license with specified limitations. P. Ex. 2. Petitioner misunderstands the limited scope of my review. CMS is authorized by the Secretary to revoke billing privileges if a supplier was convicted of a felony offense that CMS has determined is detrimental to Medicare or its beneficiaries, if the conviction occurred within 10 years preceding enrollment or revalidation of enrollment. The elements are satisfied in this case and I must sustain the revocation and denial of enrollment. Once I have found that there is a basis to deny enrollment or revoke billing privileges, I have no authority to review the judgment of CMS to exercise its authority deny or revoke. *Abdul Razzaque Ahmed, M.D.*, DAB No 2261 at 19 (2009).

III. Conclusion

Petitioner's supplier numbers and his billing privileges were properly revoked effective April 24, 2008, the date of his conviction. Petitioner was properly denied enrollment or reenrollment in Medicare.

/s/

Keith W. Sickendick
Administrative Law Judge