**Department of Health and Human Services**
**DEPARTMENTAL APPEALS BOARD**
**Appellate Division**

Robert J. Tomlinson, M.D.
Docket No. A-18-86
Decision No. 2916
December 17, 2018

# FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Robert J. Tomlinson, M.D. (Petitioner) appeals an April 25, 2018 decision by an administrative law judge (ALJ), *Robert J. Tomlinson, M.D.*, DAB CR5079 (ALJ Decision). That decision sustained on summary judgment a determination by the Centers for Medicare & Medicaid Services (CMS) to deny Petitioner's application to enroll in the Medicare program under 42 C.F.R. § 424.530(a)(3) based on his felony conviction for health care fraud within 10 years preceding his application.[1]

We affirm the ALJ's conclusion that CMS had a basis to deny Petitioner's enrollment application under section 424.530(a)(3) given Petitioner's 2010 conviction of a felony offense.[2]

## Legal Background

A "supplier" of Medicare services (which includes physicians and physician practices) must be enrolled in the Medicare program in order to receive payment for items and services covered by Medicare. 42 C.F.R. § 424.505.[3] Supplier enrollment is governed by regulations in 42 C.F.R. § 424.500-424.575. Those regulations authorize CMS to deny a supplier's application to enroll in the Medicare program for any of the "reasons" specified in section 424.530(a).

[1] CMS also based its denial on Petitioner's alleged violation of section 424.530(a)(4), but the ALJ found that he did not need to reach that additional basis given his conclusion that CMS had a legal basis for the denial under section 424.530(a)(3). The ALJ was correct, and we do not address whether section 424.530(a)(4) provided an additional basis for the same reason.

[2] Petitioner entered a guilty plea to one count of federal health care fraud on April 2, 2010; on August 20, 2010, the U.S. District Court for the Western District of Arkansas entered judgment of conviction on that count.

[3] We cite to, and apply, the enrollment regulations in effect on March 1, 2017, the date CMS's contractor issued the initial revocation determinations. *John P. McDonough III, Ph.D., et al.*, DAB No. 2728, at 2 n.1 (2016).

Section 424.530(a)(3), as amended effective February 3, 2015,[4] provides that CMS may deny a supplier's application to enroll in Medicare if the supplier was, "within the preceding 10 years, convicted (as that term is defined in 42 CFR § 1001.2) of a Federal or State felony offense that CMS determines is detrimental to the best interests of the Medicare program and its beneficiaries." 42 C.F.R. § 424.530(a)(3); 79 Fed. Reg. 72,500, 72,531-32 (Dec. 5, 2014). The same amended regulation lists certain felony offenses that are "include[d]" among "but are not limited in scope or severity to" the "felony offense[s] that CMS determines [are] detrimental to the best interests of the Medicare program and its beneficiaries." 42 C.F.R. § 424.530(a)(3)(i). When an enrollment application is denied, the denial becomes effective within 30 days from the initial denial determination. *Id*. § 424.530(e).

A supplier may appeal an enrollment denial determination in accordance with the procedures in 42 C.F.R. Part 498. The supplier must first request "reconsideration" of the initial determination to deny enrollment. 42 C.F.R. §§ 498.5(l)(1), 498.22. If dissatisfied with the reconsidered determination, the supplier may request a hearing before an administrative law judge. *Id*. § 498.40.

## Case Background

1. *Petitioner's felony conviction for health care fraud*

Petitioner is a physician specializing in orthopedic surgery who is currently licensed to practice in Arkansas. ALJ Decision at 1. On August 20, 2010, the United States District Court for the Western District of Arkansas convicted Petitioner, pursuant to his April 2, 2010 guilty plea, of one count of making a false statement in violation of 18 U.S.C. § 1347 based on his submission of false claims for surgical procedures not performed between around July 2002 to around April 2010. *Id*., citing CMS Ex. 5, at 2; Petitioner (P.) Ex. 4; P. Ex. 5. The court sentenced Petitioner to five months' imprisonment and three years of supervised release and ordered him to pay a $100 assessment and $66,497.34 in restitution to multiple victims, including CMS and the Arkansas Medicaid program. ALJ Decision at 5-6; P. Ex. 4, at 2-9.[5]

2. *Licensure, exclusion and revocation actions based on Petitioner's conviction*

Citing his felony conviction, the State of Arkansas revoked Petitioner's medical license on January 11, 2010. On August 24, 2010, CMS, through administrative contractor, Pinnacle Business Solutions (Pinnacle), notified Petitioner that his Medicare billing

[4] *See* 79 Fed. Reg. 72,500, 72,531-32 (Dec. 5, 2014).

[5] On October 3, 2012, Petitioner moved for early termination of his court probation. The court denied the motion on October 17, 2012. P. Ex. 10, at 3.

privileges were being revoked under section 424.535(a)(1) based on the Arkansas license suspension and under section 424.516(d)(1)(ii) based on Petitioner's failure to report that adverse action. ALJ Decision at 2; CMS Ex. 6. Pinnacle established a one-year reenrollment bar pursuant to section 424.535(c). CMS Ex. 6, at 3. On July 29, 2011, the Office of Inspector General (I.G.) notified Petitioner that the I.G. was excluding him from participation in all federal health care programs, including Medicare and Medicaid, for a minimum period of five years based on his 2010 felony conviction. ALJ Decision at 6; P. Ex. 7, at 1.

On December 5, 2011, the Arkansas State Medical Board approved Petitioner's request for reinstatement of his license. P. Ex. 6. On October 6, 2016, the I.G. notified Petitioner that it had accepted his request to have his eligibility to participate as a provider in the Medicare program reinstated, P. Ex. 7, at 2, and on November 22, 2016, the Office of Personnel Management (OPM) notified him that based on the lifting of his I.G. exclusion, it was reinstating his eligibility to participate in the Federal Employees Health Benefit Program (FEHB) effective October 6, 2016, *id*. at 3.

3. *Denial of Petitioner's application to re-enroll in the Medicare program*

On March 1, 2017, Petitioner applied to re-enroll as a supplier in the Medicare program. ALJ Decision at 2; P. Ex. 9. CMS, through its administrative contractor Novitas, notified Petitioner on May 22, 2017 that it was denying his application under section 424.530(a)(3) based on his 2010 felony conviction and under section 424.530(a)(4) because he had not reported on the application his prior license suspension and Medicare revocation. ALJ Decision at 2 (citing CMS Ex. 3). On August 29, 2017, CMS denied Petitioner's request for reconsideration. *Id*. (citing CMS Ex. 1). CMS denied reconsideration based on section 424.530(a)(3) because Petitioner's 2010 felony conviction for health care fraud was a felony that would result in mandatory exclusion from the Medicare program under 424.530(a)(3)(i)(D) and, in the alternative, because CMS determined the felony at issue to be detrimental to the Medicare program and its beneficiaries. CMS Ex. 1, at 4-5. CMS also denied reconsideration of Petitioner's application under section 424.530(a)(4) on the ground that he failed to report on his application the prior Medicare revocation and medical license suspension. *Id*. at 5.

4. *The ALJ hearing and decision*

Petitioner timely requested an ALJ hearing on CMS's denial of his application to re-enroll in the Medicare program. ALJ Decision at 2. The ALJ admitted all of the exhibits submitted by the parties, overruling CMS's objections to P. Exs. 3, 5-8 and 10. *Id.* CMS did not propose any witnesses or ask to cross-examine the witnesses Petitioner proposed so the ALJ proceeded to decide the case on the written record, which included briefing by

the parties. *Id*. at 2-3. The ALJ found no dispute that Petitioner's 2010 felony conviction was within the ten years preceding his application to re-enroll in the Medicare program and concluded that section 424.530(a)(3)(i)(D) applied and authorized the denial. *Id*. at 5. Section 424.530(a)(3)(i)(D) applied, the ALJ found, because Petitioner's felony, health care fraud, was one that would result, and in fact had resulted, in a mandatory exclusion under 42 U.S.C. § 1320a-7(a)(3). *Id*. at 6. The ALJ rejected Petitioner's attempt to collaterally attack his conviction and also rejected Petitioner's argument that CMS's decision was unlawful because of alleged administrative errors committed by Novitas. *Id.* at 6-7. The ALJ agreed with CMS that, because CMS reviewed Novitas's initial determination on reconsideration, "any procedural errors at the initial level amount to harmless error at best."[6] *Id*. Finally, the ALJ rejected Petitioner's equitable arguments:

> But I am not authorized to ignore the controlling regulations simply because Petitioner does not believe his per se felony conviction is in fact detrimental to the Medicare program or its beneficiaries. . . . Nor does his intent to practice in a medically underserved area allow me to fashion equitable remedies on his behalf. Finally, Petitioner's assertion that the CMS hearing officer who issued the reconsideration decision in this attempted to unlawfully "exclude" him is both clearly wrong and entirely irrelevant.

*Id.* at 7 (citations omitted).

**Standard of Review**

The Board reviews a disputed finding of fact to determine whether the finding is supported by substantial evidence, and a disputed conclusion of law to determine whether it is erroneous. *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program*, accessible at http://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/index.html?language=en.

**Discussion**

> ***The ALJ correctly concluded that he must uphold CMS's rejection of Petitioner's application to re-enroll in the Medicare program because Petitioner's felony conviction of health care fraud within ten years preceding his application provided a legal basis for that denial under 42 C.F.R. § 424.530(a)(3).***

[6] The ALJ did not decide whether Novitas, in fact, committed any procedural errors.

A. *The Board, like the ALJ, is bound by the regulations and must uphold CMS's denial of an application where the regulations provide a legal basis for the denial.*

Petitioner does not challenge the following ALJ findings: Petitioner's felony conviction was within 10 years preceding his attempt to re-enroll in the Medicare program; and the felony of which Petitioner was convicted – health care fraud – was one that provided a legal basis for the denial of his application under section 424.530(a)(3)(i)(D). These findings, as the ALJ concluded, plainly provide a legal basis for denial of Petitioner's application under section 424.530(a)(3). Indeed, Petitioner concedes that CMS had the discretion to deny his application under the "plain meaning of the regulation" at 42 C.F.R. § 424.530(a)(3). Reply to CMS's Response to Request for Departmental Appeals Board Review (Reply) at 3. Nonetheless, Petitioner argues that the ALJ erred by relying on the regulations alone, "without considering the applicable policy outlined by CMS in its MPIM (Medicare Provider Integrity Manual) and the record as a whole (including the additional information provided by the Appellant as exhibits to his request for ALJ Review) . . . ."[7] Request for Review (RR) at 5. In particular, Petitioner argues that the ALJ should have overturned the denial because, Petitioner asserts, Novitas did not follow the Adverse Legal Action (ALA) Decision Tree which "instructs MACS [Medicare Administrative Contractors] to refer felony convictions to CMS for further review and to process an enrollment application if a provider was reinstated and reports the expired exclusion." RR at 5. Petitioner further asserts that the Decision Tree "states that for an expired exclusion, a provider's enrollment application 'shall ONLY' be denied for an exclusion after the provider has been reinstated if the exclusion has never been reported." RR at 9 (citing MPIM Ch. 15 § 15.5.3.1).

Petitioner's assertion that the ALJ erred in relying solely on the regulations has no basis in law. So long as an ALJ finds that CMS has shown that one of the regulatory bases for denying a supplier's Medicare enrollment application set out in the reconsideration determination exists, the ALJ (and the Board on appeal) may not refuse to apply the regulation and must uphold the denial. *City of Sugar Land*, DAB No. 2719, at 8 (2016); *Brian K. Ellefsen, DO*, DAB No. 2626, at 6-7 (2016); *see also Stanley Beekman, D.P.M.*, DAB No. 2650, at 10 (2015); *Letantia Bussell, M.D.*, DAB No. 2196, at 12-13 (2008) (applying the same holding in cases involving revocation of enrollment).

[7] Petitioner does not identify the specific "exhibits" to which he refers, but we assume he means those showing the reinstatement of his medical license, the I.G.'s reinstatement of his eligibility to participate in federal health care programs and OPM's reinstatement of his ability to participate in the Federal Employees Health Benefit program. *See* P. Exs. 6 and 7, at 2-3 (originally submitted as attachments F and G to Petitioner's hearing request and resubmitted as exhibits after the ALJ issued his Order Striking Petitioner's Pre-Hearing Exchange based, in relevant part, on Petitioner's failure to conform to the ALJ's directive in his November 3, 2017 order regarding labeling of exhibits).

Petitioner faults the ALJ for what Petitioner characterizes as his "fail[ure] to explain his decision to not follow the mandatory guidelines outlined in the ALJ Decision Tree as he was required to do." [8] RR at 5. However, the ALJ is not required to follow the guidelines or to explain his reasons for not doing so. The MPIM, as Petitioner notes, "was produced by CMS to provide guidance to contractors . . . ." RR at 5. The MPIM does not purport to bind ALJs reviewing denials of enrollment. The MPIM does not have the legal authority of the regulations, which indeed bind the ALJ and constitute the authority an ALJ must follow when deciding whether CMS had a legal basis for denying enrollment. Thus, a failure by a contractor to follow the MPIM (and we make no finding that Novitas failed to do so) cannot be a basis for an ALJ (or the Board) to overrule CMS's decision to deny enrollment when that denial is expressly authorized by the regulations.[9]

Also, as the ALJ and CMS correctly noted, Novitas's decision to deny Petitioner's enrollment application was not, as a matter of fact, the final decision; CMS made the final decision to deny enrollment on reconsideration. The manual provisions on which Petitioner relies are directed at constraining the discretion of contractors and clarifying when they must consult CMS before taking action. They do not purport to interpret the regulation or to provide guidance to the public on compliance. Since CMS reviewed the contractor's action here, any errors by the contractor (and we make no finding that there were errors) would be harmless. Indeed, the decision before the ALJ and the Board is not the contractor's decision; it is, as a matter of law, CMS's decision on reconsideration. 42 C.F.R. §§ 498.5(1), 498.22. We have concluded that the ALJ correctly determined CMS had a legal basis under the regulations to deny enrollment to Petitioner, and our decision

[8] The court cases cited by Petitioner as alleged support for this argument (RR at 6-7) are not relevant. Some involve the deference courts accord agency interpretations or guidance, not whether agency decision makers or administrative adjudicators reviewing their decisions are legally bound by guidance issued to contractors rather than the agency's regulations. *Id.* at 6 (cases cited in first two paragraphs). The "*Acardi* doctrine" Petitioner cites (RR at 6) addresses, not guidelines, but, rather, "[r]egulations with the force and effect of law . . . [that] prescribe the procedure to be followed in processing an alien's application for suspension of deportation." *United States ex rel. Accardi v. Shaughnessy*, 347 U.S. 260, 265 (1954). The decision Petitioner cites as *Herbert v. Burwell,* No. 5:14-cv-00269, 2015 U.S. Dist. LEXIS 97297 (July 27, 2015) – *see* RR at 6, 7, 8 – is irrelevant because it involves failure to provide an explanation specifically required by 42 C.F.R. § 405.1062, a regulation that applies only to Medicare claims appeals (not to provider/supplier enrollment appeals) and to ALJs in the Office of Medicare Hearings and Appeals and the administrative appeals judges and attorney adjudicators on the Medicare Appeals Council who hear those appeals. The regulation does not affect adjudications by ALJs in the Civil Remedies Division of the Departmental Appeals Board or the Board itself. We note that the name of the decision is actually *Ryan v. Burwell,* and can be found on Westlaw as *Ryan v. Burwell,* slip op., No. 5:14–cv–00269, 2015 WL 4545806 (D. Vt. July 27, 2015).

[9] Petitioner submitted to the Board a Motion to Clarify the Record With Respect to Applicable Agency Guidance (Motion). In the motion, Petitioner provides a timeline purporting to "demonstrate[] that CMS and its contractor were aware of the guidance at every level of consideration." Motion at 2. The timeline is irrelevant because their awareness of the Guidance is not material to our decision. Accordingly, we deny the motion.

is not and cannot be altered based on alleged procedural irregularities on the part of Novitas. *Cf. James Shepherd, M.D.*, DAB No. 2793, at 9 (2017) (allegations that contractor did not properly process enrollment application were "not material" in light of regulatory limitations on ALJ and Board review authority, which, in that case, precluded review of enrollment application rejection).

In addition, Petitioner misstates the guidance in MPIM Chapter 15 section 15.5.3.1 on which he relies. That guidance, which appears as a "Note[]" in subsection 1.4 of the ALA Decision Tree, does not state that CMS may not deny a supplier's application if the supplier has been reinstated by the I.G. after an exclusion and has reported the exclusion.[10] Rather, the guidance states that "42 C.F.R. § 424.530(a)(4) shall ONLY be included as a denial reason, if the provider has never reported this adverse action."[11] Thus, the guidance addresses only denial based on the applicant's making false or misleading statements, not denial for other bases stated in the regulations, such as the basis at issue here. Moreover, another statement in subsection 1.4 that immediately precedes the statement erroneously paraphrased by Petitioner directs the contractor to *not* process the application if "there is another reported adverse legal action that precludes the processing of the application" (as there was here in section 424.530(a)(3)). In addition, subsection 1 of the ALA Decision Tree refers to "Initial/Reactivation Applications" and states in important part: "Any actionable ALA reported by a provider shall result in the denial of an application." Petitioner's felony conviction within 10 years preceding his reenrollment attempt was an "actionable ALA."

In sum, the ALJ correctly concluded that section 424.530(a)(3) authorized CMS to deny Petitioner's application to re-enroll as a supplier in the Medicare program based on his conviction of felony health care fraud within the 10 year-period preceding his application.

B. *The Board, like the ALJ, may not review how CMS exercises its discretion.*

At heart, Petitioner's appeal is essentially an attack on how CMS exercised its discretion – that is, to deny, rather than approve, his application – not on CMS's authority under the regulations to take that action. Petitioner argues that CMS should not have denied his Medicare enrollment application because other entities that took adverse legal actions against him based on the same felony conviction subsequently reinstated him in programs within their governance, i.e., the state of Arkansas reinstated his medical license, the I.G.

[10] We note that Petitioner's assertion also appears to assume he reported the exclusion on his application, but that is contradicted by Petitioner's own statement "that he did not include his license suspension, revocation, or exclusion as adverse legal actions because he was advised that these matters were a resolution to his plea agreement to his one count of health care fraud." RR at 2 n.2.

[11] Chapter 15 of the MPIM is available on CMS's website at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c15.pdf.

reinstated his eligibility to participate in federal health care programs and OPM reinstated his eligibility to participate in the FEHB program. Petitioner, in essence, asks the Board to review CMS's exercise of discretion and to conclude that CMS should have determined based on these reinstatements that he was no longer a threat to the Medicare program or its beneficiaries and approved his application to re-enroll as a supplier in the Medicare program. RR at 9.

We decline Petitioner's request. Neither the ALJ nor the Board is allowed to review CMS's exercise of discretion to deny Petitioner's application or to substitute its opinion as to whether Petitioner remains a threat to the Medicare program and its beneficiaries based on his felony conviction. While the regulations afford CMS discretion to revoke or not revoke in a particular case, neither an ALJ nor the Board may review how CMS exercises that discretion or substitute its own discretion. As the Board explained in *Ellefsen*, "The ALJ and CMS are correct that where CMS is legally authorized to deny an enrollment application, an ALJ cannot substitute his or her discretion for that of CMS . . . in determining whether, under the circumstances, denial is appropriate. Nor can the Board." DAB No. 2626, at 7 (citations omitted). In *Ellefsen*, the Board also held, as it has in revocation cases, "that CMS may revoke a provider's or supplier's billing privileges based solely on a qualifying felony conviction, without regard to equitable or other factors." *Id.* at 9. The Board emphasized that while it was remanding the ALJ Decision in *Ellefsen* for clarification as to **whether** the contractor had, in fact, exercised the discretion afforded it by the regulations (the record was not clear that the contractor understood it had discretion), it was not holding that the contractor must explain why it chose to deny Ellefsen's application rather than approve it:

> Thus, while we are remanding this case to the ALJ for clarification as to whether [the contractor] recognized that its denial of Petitioner's application under section 424.530(a)(3) was an action committed to its discretion rather than one mandated by that regulation, we are not suggesting that [the contractor] needed to specifically address the factors that Petitioner has asserted establish that allowing him to participate in the Medicare program would be in the best interests of the program and its beneficiaries or give any other explanation of the reasons underlying its exercise of discretion.

*Id.* at 10; *see also City of Sugar Land* at 8 (citing *Ellefsen* and stating "Even assuming CMS had discretion to refrain from issuing the denial [of enrollment] in these circumstances, it chose not to do so, and we have no authority to review that choice.")

Even if the Board were authorized to review CMS's exercise of discretion, Petitioner, as CMS notes, "cites to no legal authority that CMS is bound to permit participation in the Medicare program simply because the I.G. exclusionary period has expired." CMS Response to Petitioner's Request for Review at 7. Petitioner also fails to address Board authority to the contrary, decisions holding that I.G. exclusions and CMS enrollment determinations "are separate and distinct enforcement tools, each with its own requirements and consequences." *Fady Fayad, M.D.*, DAB No. 2266, at 12 (2006), *aff'd Fayad v. Sebelius*, 803 F. Supp. 699 (E.D. Mich. 2011) (citing *Abdul Razzaque Ahmed, M.D.*, DAB No. 2261, at 13 (2009)). The "supplemental legal authority" Petitioner submitted to the Board as alleged support for his position – citation to 42 C.F.R. §§ 1001.3002, 1001.3003 – actually illustrates that separation and distinction. These regulations, which are among the comprehensive regulations governing I.G. exclusions in 42 C.F.R. Part 1001, address factors the I.G. considers when determining whether to reinstate an individual or entity's eligibility to participate in federal health care programs when the entity or individual's I.G. exclusion has ended; they do not address CMS's separate and independent authority to reinstate a provider or supplier whose Medicare enrollment has been revoked. CMS acts under its own authority in 42 C.F.R. Part 424 of the regulations when making decisions regarding provider and supplier Medicare enrollment, including decisions under section 424.535(d) ("Re-enrollment after revocation"). In addition, as CMS points out, Petitioner "was denied enrollment based on his felony conviction, not his exclusion *per se* by the [I.G.]." CMS Response to Petitioner's Submission of Supplemental Legal Authority at 1.

Likewise, CMS was not required to grant Petitioner's application to participate as a supplier in the Medicare program simply because Arkansas reinstated his medical license or OPM reinstated his eligibility to participate in federal employee health care programs. The federal government is not bound by state action, and the statutes and regulations under which OPM operates are separate and distinct and serve different purposes than those that control CMS's Medicare enrollment determinations.

In sum, we have no authority to overturn the ALJ's decision to uphold CMS's determination, pursuant to section 424.530(a)(3), to deny Petitioner's application to re-enroll in the Medicare program based on his conviction of felony health care fraud within the 10-year period preceding his application.

**Conclusion**

For the reasons stated above, we affirm the ALJ Decision.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Sheila Ann Hegy
Presiding Board Member