Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	
Fady Fayad, M.D.	DATE: August 18, 2009
Petitioner,	Civil Remedies CR1887 App. Div. Docket No. A-09-65
- v. -	Decision No. 2266
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Fady Fayed, M.D. (Petitioner) appeals the January 13, 2009 decision by Administrative Law Judge (ALJ) Richard J. Smith, DAB CR1887 (ALJ Decision). Based on Petitioner's 2007 felony conviction for conspiracy to defraud the United States, the ALJ upheld a determination by the Centers for Medicare & Medicaid Services (CMS) to revoke Petitioner's Medicare billing privileges pursuant to 42 C.F.R. § 424.535(a)(3). That regulation authorizes CMS to revoke a physician's Medicare billing privileges if the physician has been convicted, within 10 years preceding enrollment or revalidation of enrollment, of a felony offense that CMS has determined to be detrimental to the best interests of the Medicare program and its beneficiaries.

Petitioner contends that the ALJ Decision should be overturned because: (1) he did not receive "proper notice" of CMS's revocation determination; (2) CMS misled him about the basis for that determination; (3) he was deprived of his constitutional right to due process; (4) the CMS contractor that issued the

initial revocation determination lacked the authority to issue it; and (5) CMS failed to weigh all relevant factors in deciding to revoke his billing privileges.
Because Petitioner's contentions either lack merit or are beyond the Board's jurisdiction to adjudicate, we affirm the ALJ Decision in its entirety.

Legal Background

The Medicare program provides health insurance benefits to persons 65 years and older and to certain disabled persons. Social Security Act (Act) § 1811.[1] Medicare is administered by CMS, a component of the Department of Health and Human Services (HHS). CMS in turn delegates certain program functions to private insurance companies that function as CMS's agents in administering the program. See Act §§ 1816, 1842, 1874A; 42 C.F.R. § 421.5(b); United States ex rel. Rahman v. Oncology Associates, P.C., 198 F.3d 502, 512 & n.2 (4th Cir. 1999); Hillman Rehabilitation Center, DAB No. 1663, at 24 n.18 (1998) (citing cases and noting that the federal courts have held that Medicare contractors act as agents of the federal government), aff'd, Hillman Rehabilitation Ctr. v. U.S. Dep't of Health and Human Servs., No. 98-3789 (GEB) (D.N.J. May 13, 1999).

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

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

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

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

The regulations also authorize CMS to revoke the Medicare billing privileges (enrollment) of a provider or supplier under certain circumstances. CMS's revocation authority is found in 42 C.F.R. § 424.535, which provides in relevant part as follows:

> (a) *Reasons for revocation.* CMS may revoke a currently enrolled provider or supplier's billing privileges and any corresponding provider agreement or supplier agreement for the following reasons:
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> * * *
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> (3) *Felonies*. The provider, supplier, or any owner of the provider or supplier, within the 10 years preceding enrollment or revalidation of enrollment, was convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries.
>
> (i) Offenses include –
>
> (A) Felony crimes against persons . . .
>
> (B) Financial crimes . . .
>
> (C) Any felony that placed the Medicare program or its beneficiaries at immediate risk . . .

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

> (D) Any felonies that would result in mandatory exclusion under section 1128(a) of the Act.

Thus, under section 424.535(a)(3), CMS may revoke the Medicare billing privileges of a supplier if, within ten years of its enrollment or revalidation of enrollment, the supplier has been convicted of a felony offense that CMS has determined to be detrimental to the best interests of Medicare and its beneficiaries. Subparagraphs (A)-(D) of section 424.535(a)(3)(i) specify certain felonies that CMS has determined to be detrimental to the best interests of Medicare and its beneficiaries. Letantia Bussell, M.D., DAB No. 2196, at 9-10 (2008).

A revocation determination by CMS or its contractor is an "initial determination" that may be appealed under the procedures found in 42 C.F.R. Part 498, subparts B-E. See 42 C.F.R. §§ 498.3(b)(17), 424.545(a).

Case Background

The material facts of this case are undisputed. Petitioner, a Michigan physician, signed or otherwise assisted in the submission of federal immigration forms which falsely certified that applicants for naturalized United States citizenship had physical or mental disabilities. See CMS Ex. 2, at 2; CMS Ex. 3, at 4-5 (question 36); CMS Ex. 4. For this conduct, Petitioner was convicted in July 2007 of conspiracy to defraud the United States, a felony. CMS Ex. 1, at 4.

In December 2007, Petitioner reported his conviction to Wisconsin Physicians Service (WPS), the Medicare Part B contractor for Michigan. CMS Ex. 1, at 1, 3. WPS subsequently notified Petitioner, in a letter dated March 15, 2008, that his Medicare billing privileges were being revoked. CMS Ex. 6, at 1. Paragraph two of the March 15 letter described the basis for the revocation as follows:

> After careful review, we have determined that Fady Fayad's billing privileges are subject to revocation based on 42 CFR 424.535(3)[.] The provider within the 10 years preceding enrollment or revalidation of enrollment, was convicted of a Federal or State felony offense that CMS had determined to be detrimental to

> the best interests of the program and its beneficiaries.

Id.[4] WPS enclosed with the March 15 letter a copy of section 424.535. Id. at 1, 3-5.
At Petitioner's request, WPS reconsidered its revocation determination. CMS Ex. 7, at 1; CMS Ex. 9. The reconsideration was performed by a WPS hearing officer, who, after quoting section 424.535 in full, concluded that WPS had properly revoked Petitioner's billing privileges based on "information presented in . . . case documents that you were convicted, within 10 years preceding the revalidation of your Medicare enrollment, of a Federal felony offense." CMS Ex. 9, at 3. Dissatisfied with the reconsideration decision, Petitioner requested a hearing before the ALJ, alleging lack of due process and other deficiencies that, in his view, invalidated the revocation determination.

Shortly after Petitioner filed his ALJ hearing request, CMS moved for summary disposition, contending that the ALJ's review of the revocation determination should be limited to deciding the following issues: (1) whether Petitioner had been convicted of a felony; (2) whether the conviction had occurred within 10 years preceding his enrollment or revalidation of enrollment in Medicare; and (3) whether CMS had determined that his felony offense was detrimental to the best interests of the Medicare program and its beneficiaries. October 28, 2008 Motion for Summary Disposition (MSD) at 9-10. Regarding the third issue, CMS did not dispute Petitioner's assertion that his crime was not one of the crimes in section 424.535(a)(3)(i)(A)-(D) that CMS has determined to be detrimental to the best interests of Medicare as a matter of law. CMS Reply Br. in Support of MSD at 4 n.2. However, CMS stated that it had made a case-specific determination that Petitioner's conviction for assisting in the submission of false immigration forms was detrimental to Medicare and its beneficiaries. MSD at 11-14; CMS Reply Br. in Support of MSD at 4 n.2 and 10 n.9. CMS asserted that section 424.535(a)(3) permits it to make such a case-specific determination and to revoke a supplier's billing privileges based on that determination. MSD at 12-13. CMS also contended

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[4] The March 15 notice letter incorrectly cited the applicable regulation as section "424.535(3)." The correct citation is 424.535(a)(3).

that determining whether a crime is detrimental to Medicare is a matter of agency discretion that an ALJ is not authorized to review. Id. Even if an ALJ has the authority to review such an exercise of discretion, said CMS, the circumstances demonstrated that it acted reasonably in revoking Petitioner's billing privileges because of similarities between his felony and the felonies specified in section 424.535(a)(3)(i)(A)-(D):

> For instance, Dr. Fayad's felony conviction is similar in character to the financial crimes, including embezzlement or insurance fraud, for which revocation is directed by § 424.535(a)(3)(i)(B) given that his actions were illegal and deceptive. When Dr. Fayad certified under penalty of perjury that he had examined the applicants, . . . he acted dishonestly and fraudulently. CMS, therefore, acted reasonably when it concluded that such an individual, who provided false information regarding aliens' medical conditions on government forms for at least 6 individuals and perhaps as many as 24 over a two-year period, could also falsify forms when submitting billing information to Medicare. Moreover, it is Dr. Fayad's history of untrustworthy actions that increase[s] the likelihood that he may pose a risk to the Medicare program and its beneficiaries.

Id. at 13-14 (footnote omitted). Finally, CMS asserted that, contrary to what Petitioner seems to think, section 1128(a) of the Act, which requires the Secretary of HHS (Secretary) to exclude from federal health care programs individuals and entities that are convicted of certain types of felonies, "did not form any basis for its decision to revoke [Petitioner's] Medicare enrollment and billing privileges in this instance." CMS Reply Br. in Support of MSD at 5.

Granting CMS's motion for summary disposition, the ALJ found the following to be undisputed facts: (1) Petitioner had been convicted of a federal felony offense on July 26, 2007; and (2) CMS had determined that Petitioner's offense of conviction was detrimental to the best interests of the Medicare program and its beneficiaries. ALJ Decision at 4 (section IV), 5. The ALJ also held that CMS's determination that Petitioner's offense was detrimental to Medicare was an act of discretion that he was not authorized to review or "look behind." Id. at 6 (quoting Dr. Randy Barnett, DAB CR1786, at 3-4 (2008)). The ALJ also declined to consider the merits of Petitioner's constitutional

due process claims, finding them "beyond [his] authority to consider." Id. at 6. Based on these and other findings of fact and conclusions of law, the ALJ upheld the revocation of Petitioner's billing privileges.

Standard of Review

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

Discussion

In this appeal, the parties do not dispute the applicability and meaning of the controlling regulation. Section 424.535(a)(3) permits CMS to revoke a supplier's billing privileges if the following conditions are met: (1) the supplier was convicted of a felony offense; (2) CMS has determined that the supplier's felony offense is detrimental to the best interests of the Medicare program and its beneficiaries; and (3) the conviction occurred within 10 years of the supplier's enrollment or revalidation of enrollment in Medicare.

The ALJ expressly found that the first two of these conditions were met. He found that Petitioner had been convicted of a felony (conspiracy to defraud the United States). ALJ Decision at 4. And he found that CMS had determined that this felony was detrimental to the best interests of Medicare and its beneficiaries. Id. at 4, 5 (stating that the parties "agree that CMS in fact made the determination that the crime was detrimental to the best interests of the Medicare program and its beneficiaries"). Petitioner does not challenge those findings on appeal, nor does he dispute CMS's determination that his felony conviction occurred within 10 years of his enrollment or revalidation of enrollment in Medicare.

Petitioner asserts that CMS did not "point to the specific section of the statute they based their decision on." RR at 9. CMS construes that statement as a claim by Petitioner that a revocation must be based on a crime that fits within one of the categories of crimes specified in section 424.535(a)(3)(i)(A)-

(D) that CMS has determined to be detrimental to Medicare as a matter of law. CMS disagrees with that claim, as do we. Section 424.535(a)(3) expressly authorizes CMS to issue a revocation based on any conviction that it "has determined to be detrimental" to Medicare. The regulation then indicates that crimes detrimental to Medicare "include" those specified in subparagraphs (A) through (D) of section 424.535(a)(3)(i). The words "include" or "including" are not terms of limitation or exhaustion. When followed by a list of items, those words are reasonably read as signifying that the list contains merely illustrative examples of a general proposition or category that precedes the word and is not intended to preclude unmentioned items from being considered supportive or part of the general proposition or category. Puerto Rico Maritime Shipping Auth. v. ICC, 645 F.2d 1102, 1112 n. 26 (D.C. Cir. 1981) ("It is hornbook law that the use of the word 'including' indicates that the specified list ... that follows is illustrative, not exclusive."). Hence, section 424.535(a)(3)(i) is reasonably read as setting out a non-exhaustive list of crimes that may constitute a basis for revocation. As further support for that reading, we note that section 424.535(a)(3) does not limit the reach of CMS's revocation authority to crimes that CMS has determined via rulemaking to be detrimental to Medicare. In other words, the regulation does not preclude CMS from making a case-specific, or adjudicative, determination that a crime or category of crime not specified in the regulation is detrimental to the best interests of Medicare. Cf. SEC v. Chenery Corp., 332 U.S. 194, 202-203 (1947) (holding that administrative agencies have broad discretion to proceed either through rulemaking or through adjudication). Section 424.535(a)(3) simply states that a revocation may be based on a conviction that CMS "has determined" to be detrimental to Medicare without specifying the manner or context in which such a determination must be made. Furthermore, nothing in the regulation's preamble conflicts with CMS's view that a revocation may be based on a crime not specified in subparagraphs (A) through (D) of section 424.535(a)(3)(i). 71 Fed. Reg. at 20,761 (Final Rule); 68 Fed. Reg. 22,064, 22,070-72 (April 5, 2003) (Proposed Rule).

For these reasons, we conclude that Petitioner has not raised a colorable argument that CMS lacked a basis for revoking his billing privileges under the terms of the regulation.

1. *Petitioner received timely and adequate notice of the basis for the challenged revocation determination.*

Petitioner contends that the March 15, 2008 notice of revocation issued by WPS (CMS's contractor) was "deficient on its face" insofar as it failed to comply with instructions contained in the Medicare Program Integrity Manual (MPIM).[5] RR at 3. When WPS issued the notice, chapter 10, section 13.2 of the MPIM contained the following instructions regarding contractor-issued revocation notices:

> [I]t is imperative that all revocation letters contain sufficient factual and background information so that the reader understands why the revocation occurred. It is not enough to simply list one of the revocation reasons. All applicable statutes and regulations, as well as a detailed factual rationale for the contractor's decision, must be identified in the letter. For instance, if a provider is revoked based on the submission of false information, the carrier must identify in its letter the falsified information, how and why the carrier determined it was false, the regulation in question, etc. If there were multiple reasons for revocation, the letter shall state as such and shall furnish all of the aforementioned statutes, regulations, facts, etc. applicable to each reason.

MPIM, ch. 10, § 13.2 (Rev. 230, effective Jan. 1, 2008) (emphasis added).

Petitioner contends that the March 15 revocation notice was deficient because it did not cite applicable statutes and regulations or contain a "detailed factual rationale" for WPS's determination. RR at 3. According to Petitioner, "[n]o effort was made to explain in the notice, as required, why exactly revocation was occurring, or what offense justified the revocation." RR at 4. In addition, says Petitioner, "CMS ignored [his] repeated pleas for clarification . . . regarding these very issues." Id.

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[5] The relevant provisions of the MPIM are available on CMS's website at http://www.cms.hhs.gov/manuals/downloads/pim83c10.pdf

In our view, the March 15 notice adequately informed Petitioner of the basis for the revocation. Contrary to Petitioner's assertion, the notice identified the applicable regulation. Paragraph two of the notice states that Petitioner's revocation was based on section 424.535. The notice then quotes section 424.535(a)(3)'s text and indicates that Petitioner's billing privileges were "subject to revocation" based on that text. By quoting that text and stating that it was the basis for the revocation, the March 15 notice advised Petitioner that the revocation was based on a conviction which had occurred within the prescribed 10-year period and that CMS had determined to be detrimental to Medicare. This was, in short, the legal and factual basis for the revocation. Although the notice letter did not identify the conviction by name or date, Petitioner does not claim that he was unable to deduce that the revocation was based on his 2007 federal conspiracy conviction, which he himself had recently reported to WPS.

Even if we were to conclude that the March 15 notice failed to comply with the MPIM's notice instructions, or with applicable regulatory notice requirements,[6] we would not overturn the revocation because CMS cured any notice deficiency during the ALJ proceeding. As we outlined in the Case Background section, CMS explained and clarified the factual and legal bases for the revocation in briefs supporting its motion for summary disposition. The Board has held that a federal agency may clarify its reasons for a challenged determination, or assert new reasons for that determination, during the ALJ proceeding as long as the non-federal party has adequate notice of the reasons and a reasonable opportunity to respond during that proceeding.

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[6] Unlike the Medicare statute and regulations, CMS instructions do not have the force and effect of law and are not binding on the Board. See Massachusetts Executive Office of Health and Human Services, DAB No. 2218, at 12 (2008). The regulatory notice requirements applicable to an initial revocation determination are contained in 42 C.F.R. § 498.20(a). That regulation provides that CMS will mail notice of an initial determination "setting forth the basis or reasons for the determination, the effect of the determination, and the party's right to reconsideration, if applicable, or to a hearing." Petitioner does not allege that the March 15 notice of revocation violated section 498.20(a).

See Green Hills Enterprises, LLC, DAB No. 2199, at 8 (2008) (and cases cited therein). "The Board has also held that, even assuming inadequate notice [of the basis for a federal agency's determination], it will not find a due process violation absent a showing of resulting prejudice." Id. In this case, there was no prejudice since Petitioner had sufficient opportunity to respond to the briefs supporting CMS's motion for summary disposition,[7] which adequately specified the bases for the revocation. Furthermore, Petitioner does not claim that notice deficiencies impaired his ability to defend himself before the ALJ or the Board.

To the extent that Petitioner is claiming that the revocation should be overturned because he lacked sufficient notice of the basis of CMS's revocation determination *at the reconsideration stage* (i.e., during the hearing before WPS's hearing officer), we stress that Petitioner subsequently received a de novo hearing before the ALJ concerning the validity of the revocation determination. In general, the ALJ proceeding is not an appellate or quasi-appellate review of the adequacy of the federal agency's decision-making or review process. Rather, the ALJ hearing under 42 C.F.R. Part 498 is a de novo proceeding in which the ALJ determines the legality of the challenged determination based on the evidence presented in that proceeding. See Vitas Healthcare Corp. of California, DAB No. 1782, at 4 (2001) (stating that the ALJ hearing is a "de novo proceeding to be resolved on the evidence in the record developed before the ALJ, and is not a quasi-appellate review of the correctness of HCFA's determination based on the evidence HCFA had at the time it acted"[8]); Beechwood Sanitarium, DAB No.

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[7] The ALJ's October 7, 2008 Order Following Prehearing Conference permitted Petitioner to file a response to CMS's initial brief supporting the motion for summary disposition as well as a response to CMS's "reply brief" in support of the motion.

[8] Prior to 2001, CMS was known as the Health Care Financing Administration (HCFA). See Notice, Department of Health and Human Services, *Centers for Medicare & Medicaid Services; Statement of Organization, Functions and Delegations of Authority; Reorganization Order*, 66 Fed. Reg. 35,437 (July 5, 2001).

1906, at 28 (2004) (noting that the record of a nursing home enforcement appeal, which, like a revocation appeal, is brought pursuant to regulations in 42 C.F.R. Part 498, "is not restricted to the facts or evidence that were available to CMS when it made its decision").

Relying on section 1128(c)(3) of the Act, a notice provision applicable to "exclusions," Petitioner contends that the March 15 notice should have specified the "minimum period of exclusion or the period of exclusion." RR at 3-4. This contention is meritless. Section 1128 of the Act authorizes, and in some case requires, the Secretary to exclude from participation in federal health care programs individuals or entities that have been convicted of certain felonies specified in statute. Exclusion under section 1128 and revocation under section 424.535 are separate and distinct enforcement tools, each with its own requirements and consequences.[9] See Abdul Razzaque Ahmed, M.D., DAB No. 2261, at 13 (2009). The determination at issue in this case is not a determination to exclude Petitioner pursuant to section 1128 of the Act but a determination to revoke his billing privileges pursuant to 42 C.F.R. § 424.535(a)(3). Consequently, the requirement in section 1128(c)(3) that the Secretary specify the minimum or other period of exclusion is inapplicable here.

For the reasons discussed, we conclude that Petitioner received adequate and timely notice of CMS's revocation determination.

2. *CMS did not mislead Petitioner about the basis for the revocation determination.*

Petitioner next contends that CMS or its contractor "systematically and deliberately misled" him to believe that his revocation was based on section 424.535(a)(3)(i)(D), which

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[9] Exclusions under section 1128 are made by the HHS Office of Inspector General (OIG), not by CMS, and may be appealed under an administrative appeals process separate from the appeals process for enrollment denials and revocations. Compare 42 C.F.R. Part 1005 (setting out the appeal rights of individuals and entities whom the OIG has excluded pursuant to section 1128) with 42 C.F.R. § 424.545 (Oct. 1, 2008) (specifying that providers and suppliers whose Medicare enrollment has been revoked have appeal rights under 42 C.F.R. Part 498, subpart A).

indicates that crimes warranting mandatory exclusion under section 1128(a) of the Act are detrimental to the best interests of Medicare. RR at 4-5. Petitioner asserts that he defended himself at the reconsideration and ALJ hearing stages with the belief that CMS had revoked his billing privileges pursuant to section 424.535(a)(3)(i)(D). Id. He further asserts that revocation was improper under section 424.535(a)(3)(i)(D) because his crime did not, in fact, subject him to mandatory exclusion under section 1128(a). Id.

We see no evidence that CMS misled Petitioner, deliberately or otherwise, about the basis for revocation. In the March 15, 2008 revocation notice, WPS stated that Petitioner's revocation was based on language in section 424.535(a)(3). The notice did not cite section 424.535(a)(3)(i)(D) or state that Petitioner had committed a crime that would subject him to exclusion under section 1128. Likewise, the WPS hearing officer made no finding that Petitioner was subject to exclusion under section 1128 or that revocation was based on section 424.535(a)(3)(i)(D). Although the hearing officer's decision could have been clearer in stating the legal basis for the revocation, CMS promptly clarified that matter in the ALJ proceeding. Among other things, CMS clearly indicated during that proceeding, in a brief to which Petitioner had an opportunity to respond, that section 1128(a) was not the basis for his revocation. See CMS Reply Br. in Support of MSD at 5; supra footnote 7.

In short, Petitioner's claim that CMS misled him about the grounds for revocation is factually unfounded. Petitioner should have been aware of those grounds after reading CMS's motion for summary disposition, if not before. The ALJ proceeding afforded Petitioner an adequate opportunity to be heard concerning the revocation's legality.

3. *Petitioner's due process claims are meritless or beyond the Board's authority to adjudicate.*

Petitioner contends that he was deprived of his constitutional right to due process because he was not given "proper notice called for by the statute," was not made aware of the "minimum period of exclusion," and was not "sufficiently informed" of the factual basis for the revocation determination. RR at 6. We find no merit to these assertions for the reasons discussed earlier.

Petitioner also contends that the Due Process Clause required CMS to hold a *pre*-revocation hearing on the issues. RR at 10, 16. This contention is a challenge to the constitutionality of the Secretary's regulations because they afford affected suppliers only a *post*-revocation hearing. The ALJ correctly refused to entertain that challenge. The Board has consistently held that ALJs may not declare a statute or regulation to be unconstitutional and refuse to apply or follow the statute or regulation on that basis. Sentinel Medical Laboratories, Inc., DAB No. 1762, at 9 (2001) (finding it "well established that administrative forums, such as this Board and the Department's ALJs, do not have the authority to ignore unambiguous statutes or regulations on the basis that they are unconstitutional"), aff'd sub nom., Teitelbaum v. Health Care Financing Admin., No. 01-70236 (9th Cir. Mar. 15, 2002), reh'g denied, No. 01-70236 (9th Cir. May 22, 2002).[10]

Petitioner asserts that "if [he] was not convicted of a felony requiring mandatory revocation, but rather under the permissive branch of the statute [presumably referring to section 1128(b)], then due process must be afforded, and an evidentiary hearing should have occurred to determine if the offense was in fact detrimental and to determine the other facts surrounding this specific case and this specific defendant." RR at 10. This argument is meritless because it erroneously equates (or confuses) revocation under section 424.535 of the regulations with exclusions under section 1128 of the Act.[11]

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[10] In declining to address Petitioner's constitutional claims, the ALJ suggested that he was precluded from adjudicating constitutional claims of any type. In fact, the Board has held only that ALJs may not declare a statute or regulation to be unconstitutional and refuse to apply or follow the statute or regulation on that basis. Sentinel Medical Laboratories, Inc. The Board has held that it may consider a constitutional claim to the extent that it challenges the manner in which a regulation is interpreted or applied in a particular case. Id. at 11-12.

[11] There is no such thing as "mandatory revocation." Revocation is a matter of discretion, even when the crime is one that CMS has determined to be detrimental to the best interests of Medicare. See infra pg. 15.

For the reasons discussed, we reject Petitioner's contention that he was deprived of his constitutional right to due process of law.

4. *Revocation may be based on conviction for a crime that is unrelated to health care or a health care program.*

Throughout his appeal brief Petitioner insinuates that the revocation of his enrollment is illegal because he was not convicted of a crime related to a health care program or health care fraud. See, e.g., RR at 2, 5, 6. This insinuation stems from his mistaken attempt to conflate the statutory provisions governing exclusions and the regulatory provisions governing revocations. Under section 1128(a) of the Act, the OIG must exclude an individual or entity from Medicare and other federal health care programs when that individual or entity has been convicted of felony crimes that have some relationship to a health care program or health care fraud.[12] However, section 424.535(a)(3) permits CMS to revoke Medicare enrollment for crimes that have no such relationship. For example, section 424.535(a)(3)(i)(B) permits CMS to revoke a supplier's billing privileges based on a "financial crime" without requiring that the crime be related to a health care program or health care fraud. Consequently, we reject Petitioner's suggestion that his revocation was improper because his crime was not related to a health care program or health care fraud.

5. *CMS may revoke a supplier's billing privileges based solely on a qualifying felony conviction, without regard to equitable or other factors.*

Petitioner suggests that, despite his conviction, revocation was unwarranted because of equitable and other factors. See RR at 2-3, 6. Petitioner alleges that he never received a financial benefit from fraudulently completing immigration forms and instead only sought "to assist a few persons seeking citizenship." RR at 2. Petitioner also asserts that he has always "exercised his Medicare billing privileges without

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[12] Section 1128(a) requires the Secretary to exclude individuals or entities that have been convicted of health care "program-related" crimes or crimes relating to "patient abuse," "health care fraud," or "controlled substances."

incident and without any known complaints" and "has at all times taken the utmost care to adhere to Medicare and Medicaid policies." RR at 2-3, 6. He also asserts that revocation will destroy his medical practice, which "primarily serviced elderly patients in their homes fulfilling an important need in the community." RR at 3, 5. Finally, he asserts that the revocation would have "grave affects [sic] not only on [his] ability to earn a living, but it also deprives hundreds of needy patients their doctor of choice." RR at 16.

In Ahmed, the Board held that its proper role in reviewing a revocation determination under section 424.535(a)(3) is to decide whether CMS had sufficient legal grounds for that determination. DAB No. 2261, at 17. Under that regulation, CMS "may" (in its discretion) revoke the billing privileges of a supplier that was convicted, within the prescribed ten-year period, of a felony crime that CMS has determined to be detrimental to the best interests of Medicare and its beneficiaries. If CMS proves that the supplier was convicted of such a crime, and that the supplier's conviction was the basis for the challenged revocation, then the Board must sustain the revocation, regardless of other factors, such as the scope or seriousness of the supplier's criminal conduct and the potential impact of revocation on Medicare beneficiaries, that CMS might reasonably have weighed in exercising its discretion. DAB No. 2261, at 16-17, 19. The Board "may not substitute [its] discretion for that of CMS in determining whether revocation is appropriate under all the circumstances." Id. at 19.

In this case, the record establishes that CMS had a valid legal predicate – namely, a qualifying conviction for a felony that CMS determined to be detrimental to Medicare – to revoke Petitioner's billing privileges. CMS's decision to revoke Petitioner's billing privileges based on the existence of that legal predicate is a discretionary judgment that we may not review. But even if that judgment were subject to review, Petitioner has not explained how his claims of proper billing behavior, lack of financial motive, and harm to his patients and medical practice are even relevant to CMS's exercise of its discretion. Accordingly, we would not find an abuse of discretion based on those claims.

We note that Petitioner does not challenge CMS's determination that his crime was "detrimental to the best interests" of Medicare. That determination was distinct from the decision to revoke because CMS could have refrained from revoking Petitioner's billing privileges despite its determination that the crime was detrimental to Medicare. The ALJ held that CMS's

determination that Petitioner's felony was detrimental to Medicare was beyond the scope of his review. ALJ Decision at 6. We find it unnecessary to examine that jurisdictional statement because Petitioner does not dispute that his conspiracy offense was detrimental to the best interests of Medicare. In any event, we would affirm CMS's determination that Petitioner's crime was detrimental to Medicare because it evidenced a lack of trustworthiness in his dealings with the federal government. The record indicates that Petitioner assisted in the submission of six to 24 false medical waivers, suggesting deep involvement in the conspiracy. CMS Ex. 2, at 2, 7. CMS could reasonably infer from Petitioner's willingness to assist in the submission of false medical information on federal immigration forms that he posed a threat to the Medicare program.

6. *WPS had the legal authority to issue the revocation determination.*

Petitioner contends that the revocation determination is unlawful because it was made by an entity – WPS, a private insurance company, acting as CMS's agent – to whom there has not been a valid delegation of authority from the Secretary or CMS to make that determination. RR at 10-14. According to Petitioner, only the Secretary is authorized "to make the initial determination as to which offenses require[ ] revocation under the act." RR at 12. Petitioner asserts that neither the Secretary nor CMS has the statutory authority to delegate or subdelegate the function of making revocation determinations to a private CMS contractor, and that any such delegation to WPS violates his right to due process because WPS's interests are adverse to his own. RR at 10. Petitioner also contends that the WPS "had no standards to follow" in issuing the revocation determination. RR at 12. "In the present matter," says Petitioner, "it appears as though the [WPS] Hearing Officer is actually creating substantive law, determining their own guidelines, and deciding for themselves which crimes require revocation." Id.

As a preliminary matter, it is clear, and Petitioner does not dispute, that under existing delegations of authority, CMS administers Medicare on behalf of the Secretary[13] and, pursuant

[13] See Act § 1871(a)(1) ("The Secretary shall prescribe such regulations as may be necessary to carry out the

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to these delegations, may revoke the billing privileges of providers and suppliers under conditions prescribed by section 424.535. It is also clear and undisputed that CMS has re-delegated many day-to-day program functions, including the task of issuing revocations in appropriate cases, to private insurance companies such as WPS. See 42 C.F.R. § 421.5(b) & subparts B-E; MPIM Ch. 10, § 13.2 § 13.2 (Rev. 214, effective July 2, 2007) (authorizing Part B carriers to issue revocations pursuant to section 424.535); see also Schweiker v. McClure, 456 U.S. 188, 190-91 (1982) (describing extent to which private insurance carriers act as the Secretary's agent in the Medicare Part B program).

"When a statute delegates authority to a federal officer or agency, subdelegation to a subordinate federal officer or agency is presumptively permissible absent affirmative evidence of a contrary congressional intent." U.S. Telecom, Assoc. v. F.C.C., 359 F.3d 554, 566 (D.C. Cir. 2004). However, "[t]here is no such presumption covering subdelegations to outside parties." Id. Subdelegations to outside parties – whether private or governmental – "are assumed to be improper absent an affirmative showing of congressional authorization." Id. Thus, the issue here is whether Congress authorized CMS to subdelegate its revocation authority to WPS and other private insurance companies. On that issue Petitioner's argument completely overlooks statutory provisions that authorize CMS's use of contractors. Section 1842 of the Act provides that the administration of Medicare Part B, the part of Medicare under which physicians receive payment, "shall be conducted through contracts with medicare administrative contractors under section 1874A." Section 1874A(a) in turn authorizes CMS (as the Secretary's delegatee) to "enter into contracts with any eligible entity to serve as a medicare administrative contractor with respect to the performance of any or all of the functions described in" section 1874A(a)(4). The "functions" described in

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administration of the insurance programs under this subchapter"); Department of Health and Human Services, *Statement of Organization, Functions, and Delegations of Authority*, 49 Fed. Reg. 35,247 (Sept. 6, 1984) (delegating Medicare administrative functions to CMS, known until 2001 as HCFA); Centers for Medicare & Medicaid Services; Statement of Organization, Functions and Delegations of Authority; Reorganization Order, 66 Fed. Reg. 35,437 (July 5, 2001).

section 1874A(a)(4) include "[d]etermining . . . the amount of the payments required pursuant to this title to be made to providers of services, suppliers and individuals," and "[p]erforming such other functions, including . . . functions under the Medicare Integrity Program under section 1893, as are necessary to carry out the purposes of this title" (emphasis added). The statute defines the term "medicare administrative contractor" to include any "agency, organization, or other person with a contract under this section," without regard to whether that agency, organization, or person is private or public. Act § 1874A(a)(3)(A).

According to CMS, the chief aim of section 424.535(a)(3) and the other regulations governing Medicare enrollment is to prevent "unqualified, fraudulent, or excluded providers and suppliers from providing items or services to Medicare beneficiaries or billing the Medicare program or its beneficiaries." 66 Fed Reg. at 20,773-74. A primary purpose of Medicare is to promote beneficiary access to high quality medical care. Cf. Act § 1802(a) (stating that beneficiaries are entitled under Medicare to benefits obtained from any institution, agency, or person "qualified to participate" in the program); Amgen, Inc. v. Scully, 234 F. Supp.2d 9, 21 (D.D.C. 2002) (noting that a purpose of Medicare is "to make the best of modern medicine available to the elderly"), aff'd on other grounds sub nom., Amgen, Inc. v. Smith, 357 F.3d 103 (D.C. Cir. 2004). The degree to which Medicare beneficiaries enjoy such access depends partly on Medicare's fiscal integrity and the integrity and professional qualifications of health care practitioners and entities enrolled in the program. Revocation helps ensure access to high quality medical care by removing from the program practitioners and entities that pose a risk to its fiscal integrity and the well-being of program beneficiaries. For these reasons, we conclude that revoking the billing privileges of a Medicare supplier is a program function that is "necessary to carry out the purposes" of the Medicare program and thus may be lawfully delegated to a Medicare contractor pursuant to section 1874A. Even if we were to conclude that revocation is not necessary to carry out Medicare program purposes, we would find the subdelegation lawful because HHS has, in effect, retained final authority over contractor-issued revocation determinations by subjecting them to review, when challenged, by departmental ALJs and this Board. See 42 C.F.R. § 424.545(a) (stating that an affected supplier may appeal a revocation under 42 C.F.R. Part 498); National Park & Conservation Assoc. v. Stanton, 54 F.Supp.2d 7, 19 (D.D.C. 1999) (holding that a

delegation by a federal agency to a private entity is lawful if the agency exercises "final reviewing authority" over the private party's policies or actions).

Petitioner's allegation that WPS was not impartial is meritless or would, at best, establish only harmless error. The fact that the revocation was issued by a private contractor is not, in itself, proof of a conflict of interest. In Schweiker v. McClure, 456 U.S. 188 (1982), the Supreme Court held that contractor hearing officers who decide Medicare Part B claims function in a quasi-judicial capacity and are thus presumed to be unbiased. 456 U.S. at 195. That presumption may be rebutted by a "showing of conflict of interest or some other specific reason for disqualification." Id. The Court noted that carriers operate under contracts that require compliance with standards prescribed by the Act and the Secretary, id. at 197, and further stated that "[t]he fact that a hearing officer is or was a carrier employee does not create a risk of partiality analogous to that possibly arising from the professional relationship between a judge and a former partner or associate." Id. n.11. Here, Petitioner has not identified a plausible source of the alleged bias or conflict of interest. Moreover, even if Petitioner's allegation of bias were true, it would not justify overturning the revocation because Petitioner received due process (including a de novo hearing) following the reconsideration decision.

Finally, we find no merit to Petitioner's assertion that WPS "had no standards to follow" in issuing the initial determination. RR at 12. The MPIM instructs its contractors about the regulatory criteria that must be met to support revocation. MPIM, Ch. 10, § 13.2 (specifying the grounds that a contractor may use to revoke a supplier's billing privileges). Relevant here, the MPIM authorizes a contractor to issue a revocation "without prior approval from CMS" if the supplier, within 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 to continue enrollment." Id. We see no evidence that WPS failed to follow these instructions or that it "created" new law (as Petitioner contends).[14]

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[14] Whether a contractor, as opposed to CMS itself, may

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Conclusion

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

_____/s/_____
Stephen M. Godek

_____/s/_____
Leslie A. Sussan

_____/s/_____
Sheila Ann Hegy
Presiding Board Member

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independently make a determination that a crime not specified in section 424.535(a)(3)(i) is detrimental to the best interests of Medicare is not specifically addressed in the MPIM instructions. Petitioner's appeal does not clearly raise that issue, and we, therefore, decline to address it. Moreover, the ALJ expressly found that the parties "agree that CMS in fact made [that] determination," and Petitioner does not challenge that finding on appeal.