Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Charles Buhse, M.D.,
(NPI: 1225037856 / PTAN: IN2370005),
Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-16-710

Decision No. CR4774

Date: January 13, 2017

DECISION

The Medicare enrollment and billing of Petitioner, Charles Buhse, M.D., are revoked pursuant to 42 C.F.R. § 424.535(a)(9) for failure to report an adverse legal action within 30 days as required by 42 C.F.R. § 424.516(d)(1)(ii).[1] Revocation is effective October 24, 2015, 30 days after the September 24, 2015 notice to Petitioner that his enrollment and billing privileges were revoked. 42 C.F.R. § 424.535(g).

I. Background and Procedural History

Wisconsin Physicians Service Insurance Corporation (WPS), a Medicare administrative contractor, notified Petitioner by letter dated September 24, 2015, that his Medicare billing privileges were revoked effective September 7, 2015, pursuant to 42 C.F.R. § 424.535(a)(1) and (9). WPS also advised Petitioner that he was subject to a one-year bar to re-enrollment. CMS Ex. 1 at 65-66. WPS notified Petitioner by letter dated

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[1] Citations are to the 2014 revision of the Code of Federal Regulations (C.F.R.), unless otherwise stated.

January 11, 2016, that according to the Centers for Medicare & Medicaid Services (CMS) information was received from the Government Accountability Office (GAO) that Petitioner had failed to report the suspension of his medical license to Medicare. The letter further advised that Petitioner's Medicare enrollment and billing privileges were revoked pursuant to 42 C.F.R. § 424.535(a)(9) for failure to report the adverse action against his medical license as required by 42 C.F.R. § 424.516(d)(1)(ii). CMS Exhibit (Ex.) 1 at 54-55.

Petitioner requested reconsideration of the initial determination.[2] WPS notified Petitioner by letter dated May 9, 2016, that revocation of his Medicare enrollment and billing privileges was upheld on reconsideration. The hearing officer determined, based on a report from CMS, that Petitioner failed to report the suspension of his medical license to CMS as required by 42 C.F.R. § 424.516(d)(1)(ii) and that revocation was appropriate pursuant to 42 C.F.R. § 424.535(a)(9) for failure to report. The hearing office took no action related to the effective date of revocation. CMS Ex. 1 at 1-3.

Petitioner filed a request for hearing before an administrative law judge (ALJ) on July 8, 2016 (RFH). On July 20, 2016, the case was assigned to me for hearing and decision and an Acknowledgment and Prehearing Order (Prehearing Order) was issued at my direction.

CMS filed a motion for summary judgment and prehearing brief (CMS Br.) with CMS Exs. 1 through 3 on August 19, 2016. On September 19, 2016, Petitioner filed his prehearing brief requesting remand, and his opposition to CMS's motion for summary judgment (P. Br.) with no exhibits. On October 14, 2016, CMS waived filing a reply brief. Petitioner has not objected to my consideration of CMS Exs. 1 through 3 and they are admitted and considered as evidence, except for CMS Ex. 1 at 32, which is not relevant because it relates to a different practitioner.

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. Administration of the Part B program is through contractors, such as

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[2] There was some confusion about the filing of Petitioner's request for reconsideration. However, WPS agreed to treat the request as timely filed. CMS Ex. 1 at 4-64.

WPS. Act § 1842(a) (42 U.S.C. § 1395u(a)). Payment under the program for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of services and suppliers. Act §§ 1835(a) (42 U.S.C. § 1395n(a)), 1842(h)(1) (42 U.S.C. § 1395u(h)(1)). Petitioner, a physician, is a supplier.

The Act requires the Secretary of Health and Human Services (Secretary) to issue regulations that establish a process for enrolling providers and suppliers in Medicare, including the requirement to provide the right to a hearing and judicial review of certain enrollment determinations, such as revocation of enrollment and billing privileges. Act § 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to 42 C.F.R. § 424.505, suppliers such as Petitioner 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.

Suppliers must submit complete, accurate, and truthful responses to all information requested in the enrollment application. 42 C.F.R. § 424.510(d)(2). Pursuant to 42 C.F.R. §§ 424.502 and 424.510(d)(3), a supplier's application to enroll in Medicare must be signed by an authorized official, that is, one with authority to bind the provider or supplier both legally and financially. The regulation provides that the signature attests to the accuracy of information provided in the application. The signature also attests to the fact that the provider or supplier is aware of and abides by all applicable statutes, regulations, and program instructions. 42 C.F.R. § 424.510(d)(3). Suppliers must meet basic requirements depending on their type of service. 42 C.F.R. §§ 424.505, 424.516, 424.517. Suppliers are subject to additional requirements to maintain active enrollment status, including reporting requirements. 42 C.F.R. § 424.516(b) – (e). Physicians, such as Petitioner, are required to report within 30 days a change in ownership, any adverse legal action, or a change in practice location. 42 C.F.R. § 424.516(d). Reporting must be accomplished using the enrollment application (CMS-855) applicable to the type of supplier or provider. 42 C.F.R. §§ 424.510, 424.515.

The Secretary has delegated the authority to revoke enrollment and billing privileges to CMS. 42 C.F.R. § 424.535. CMS or its Medicare contractor may revoke an enrolled supplier's Medicare enrollment and billing privileges and supplier agreement for any of the reasons listed in 42 C.F.R. § 424.535. Pursuant to 42 C.F.R. § 424.535(a)(9), CMS may revoke Medicare enrollment and billing privileges when a provider or supplier fails to comply with the reporting requirements in 42 C.F.R. § 424.516(d)(1)(ii), which requires that physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations report any adverse legal action within 30 days. 42 C.F.R. § 424.516(d)(1)(ii). Adverse legal actions include a "[s]uspension or revocation of a license to provide health care by any State licensing authority." 42 C.F.R. § 424.502.

If CMS revokes a supplier's Medicare billing privileges, the revocation becomes effective 30 days after CMS or one of its contractors mails the revocation notice to the

supplier, subject to some exceptions not applicable in this case. 42 C.F.R. § 424.535(g). After a supplier's Medicare enrollment and billing privileges are revoked, the supplier is barred from re-enrolling in the Medicare program for one to three years. 42 C.F.R. § 424.535(c).

A supplier whose enrollment and billing privileges have been revoked may request reconsideration and review as provided by 42 C.F.R. pt. 498. A supplier submits a written request for reconsideration to CMS or its contractor. 42 C.F.R. § 498.22(a). CMS or its contractor 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, and advising the supplier of its right to an ALJ hearing. 42 C.F.R. § 498.25. If the decision on reconsideration is unfavorable to the supplier, the supplier has the right to request a hearing by an ALJ and further review by the Departmental Appeals Board (the Board). Act § 1866(j)(8) (42 U.S.C. § 1395cc(j)(8)); 42 C.F.R. §§ 424.545, 498.3(b)(17), 498.5(l)(2). CMS is also granted the right to request ALJ review of a reconsidered determination with which it is dissatisfied. 42 C.F.R. § 498.5(l)(2). A hearing on the record, also known as an oral hearing, is required under the Act. *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743, 748-51 (6th Cir. 2004). The supplier bears the burden to demonstrate that it meets enrollment requirements with documents and records. 42 C.F.R. § 424.545(c).

B. Issues

The issues in this case are:

> Whether or not summary judgment is appropriate; and
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> Whether there is a basis for revocation of Petitioner's Medicare enrollment and billing privileges.

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

My conclusions of law are set forth in bold followed by my findings of fact and analysis.

1. Summary judgment is appropriate.

CMS has requested summary judgment. A supplier whose enrollment has been revoked has a right to a hearing and judicial review, and a hearing on the record is required under the Act. Act §§ 205(b), 1866 (h)(1), (j); 42 C.F.R. §§ 498.3(b)(1), (5), (6), (8), (15), (17), 498.5; *Crestview*, 373 F.3d at 748-51. A party may waive appearance at an oral hearing but must do so affirmatively in writing. 42 C.F.R. § 498.66. In this case, Petitioner has

not waived the right to oral hearing or otherwise consented to a decision based only upon the documentary evidence or pleadings. Accordingly, disposition on the written record alone is not permissible, unless CMS's motion for summary judgment has merit.

Summary judgment is not automatic upon request but is limited to certain specific conditions. The Secretary's regulations that establish the procedure to be followed in adjudicating Petitioner's case are at 42 C.F.R. pt. 498. The regulations do not establish a summary judgment procedure or recognize such a procedure. However, the Board has long accepted that summary judgment is an acceptable procedural device in cases adjudicated pursuant to 42 C.F.R. pt. 498. *See, e.g.*, *Illinois Knights Templar Home*, DAB No. 2274, at 3-4 (2009); *Garden City Med. Clinic*, DAB No. 1763 (2001); *Everett Rehab. & Med. Ctr*., DAB No. 1628, at 3 (1997). The Board also has recognized that the Federal Rules of Civil Procedure do not apply in administrative adjudications such as this, but the Board has accepted that Federal Rule of Civil Procedure 56 and related cases provide useful guidance for determining whether summary judgment is appropriate. Furthermore, a summary judgment procedure was adopted as a matter of judicial economy within my authority to regulate the course of proceedings and made available to the parties in the litigation of this case by my Prehearing Order paragraph II.G. The parties were given notice by the Prehearing Order that summary judgment is an available procedural device and that the law as it has developed related to Federal Rule of Civil Procedure 56 will be applied. The parties were advised that a fact alleged and not specifically denied, may be accepted as true for purposes of ruling upon a motion for summary judgment. The parties were also advised that on summary judgment evidence is considered admissible and true unless a specific objection is made. Prehearing Order ¶ II.G.

Summary judgment is appropriate when there is no genuine dispute as to any issue of material fact for adjudication and/or the moving party is entitled to judgment as a matter of law. In determining whether there are genuine issues of material fact for trial, the reviewer must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. The party requesting summary judgment bears the burden of showing that there are no genuine issues of material fact for trial and/or that it is entitled to judgment as a matter of law. Generally, the non-movant may not defeat an adequately supported summary judgment motion by relying upon denials in its pleadings or briefs but must furnish evidence of a dispute concerning a material fact, i.e., a fact that would affect the outcome of the case if proven. *Senior Rehab. & Skilled Nursing Ctr*., DAB No. 2300, at 3 (2010) (and cases cited therein); *Anderson v. Liberty Lobby, Inc*., 477 U.S. 242, 248 (1986).

The standard for deciding a case on summary judgment and an ALJ's decision-making in deciding a summary judgment motion differs from resolving a case after a hearing. On summary judgment, the ALJ does not make credibility determinations, weigh the evidence, or decide which inferences to draw from the evidence, as would be done when

finding facts after a hearing on the record. Rather, on summary judgment the ALJ construes the evidence in a light most favorable to the non-movant and avoids deciding which version of the facts is more likely true. *Holy Cross Vill. at Notre Dame, Inc*., DAB No. 2291, at 5 (2009). The Board also has recognized that on summary judgment it is appropriate for the ALJ to consider whether a rational trier of fact could find that the party's evidence would be sufficient to meet that party's evidentiary burden. *Dumas Nursing & Rehab., L.P*., DAB No. 2347, at 5 (2010). The Secretary has not provided for the allocation of the burden of persuasion or the quantum of evidence in 42 C.F.R. pt. 498. However, the Board has provided some persuasive analysis regarding the allocation of the burden of persuasion in cases subject to 42 C.F.R. pt. 498. *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd*, *Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 Fed. App'x 181 (6th Cir. 2005).

Petitioner argues that he should be permitted a hearing at which he can testify about his efforts to notify various regulatory authorities about the suspension of his Ohio medical license. P. Br. at 1. Petitioner fails, however, to explain how those facts are material to the issues before me. In fact, there is no dispute that Petitioner failed to notify CMS of the suspension of his Ohio license prior to October 2015, a fact which I accept as true for purposes of summary judgment. Petitioner has cited no legal authority for the proposition that his attempts to notify other authorities satisfies his obligation under 42 C.F.R. § 424.516(d)(1)(ii). Accordingly, I conclude that Petitioner has not identified a genuine dispute of material fact that makes a trial necessary.

The material facts in this case are not disputed and there is no genuine dispute as to any material fact that requires a trial. The issues in this case that require resolution are issues of law related to the interpretation and application of the regulations that govern enrollment and billing privileges in the Medicare program to the undisputed facts of this case. Accordingly, summary judgment is appropriate.

Petitioner requested in its prehearing brief that I remand this matter to CMS for further consideration of Petitioner's "due process/notice issues." P. Br. at 5. However, I conclude that all notices to Petitioner were sufficiently clear to avoid any prejudice to Petitioner and that remand is unnecessary to have CMS consider an issue that I may resolve. Accordingly, Petitioner's motion to remand is denied.

2. Petitioner failed to report to CMS or its contractor an adverse legal action involving his license to practice medicine within 30 days in violation of 42 C.F.R. § 424.516(d)(1)(ii).

3. Petitioner's violation of 42 C.F.R. § 424.516(d)(1)(ii) is a basis for revocation of Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(9).

4. Revocation is effective October 24, 2015, 30 days after the September 24, 2015 notice to Petitioner that his enrollment and billing privileges were revoked. 42 C.F.R. § 424.535(g).

a. Facts

The material facts are not disputed and any inferences are drawn in Petitioner's favor on summary judgment.

On June 10, 2010, Petitioner's license to practice medicine in Ohio was suspended indefinitely. P. Br. at 2; CMS Ex. 1 at 5, 8, 10, 17-18, 25-26, 38, 41.

Petitioner did not notify CMS of the suspension of his Ohio medical license, within 30 days of June 10, 2010. CMS Ex. 1 at 6, 8.

CMS notified Petitioner by letter dated August 7, 2015, that it had discovered a final adverse legal action that Petitioner had failed to report. The CMS letter cited 42 C.F.R. § 424.516(d)(1)(ii) and recited the requirement of physicians to report final adverse legal actions within 30 days. The letter specifically listed license suspension as an adverse action that had to be reported. The letter requested that Petitioner submit a CMS-855 reporting any final adverse legal action not previously disclosed to Medicare. The letter advised Petitioner that the information could be reported on-line through the Provider Enrollment, Chain and Organization System (PECOS). CMS granted Petitioner 30 days from the postmark of its August 7, 2015 letter to file the information requested by CMS. CMS Ex. 1 at 67-68.

WPS notified Petitioner of the initial determination to revoke by letter dated September 24, 2015, with an effective date of revocation of September 7, 2015. The rationale for establishing the effective date of revocation as September 7, 2015 is not stated in the initial determination. CMS Ex. 1 at 65-66. I note that September 7, 2015 is 30 days after the deadline for reporting established by the CMS letter dated August 7, 2015, and I conclude that is the basis for choosing the effective date of revocation. On January 11, 2016, WPS issued an amended initial determination, clarifying the basis for revocation as 42 C.F.R. § 424.535(a)(9) for failure to report an adverse legal action in violation of 42 C.F.R. § 424.516(d)(1)(ii). The January 11, 2016 letter refers to the CMS August 7, 2015 letter as having been sent on August 8, 2015, and states that because Petitioner had not reported the adverse information in 30 days as requested his Medicare enrollment and billing privileges were revoked. CMS Ex. 1 at 54.

Petitioner signed a CMS-855I reporting the adverse legal action against his Ohio medical license on October 19, 2015, 73 days after the CMS August 7, 2015 letter and 43 days beyond the deadline established by that letter. CMS Ex. 1 at 46.

b. Analysis

Petitioner's license to practice medicine in Ohio was suspended indefinitely on June 10, 2010. P. Br. at 2; CMS Ex. 1 at 5, 8, 10, 17-18, 25-26, 38, 41. Petitioner agreed by enrolling in Medicare that he was aware of and would abide by all applicable statutes, regulations, and program instructions. 42 C.F.R. § 424.510(d)(3). Pursuant to 42 C.F.R. § 424.516(d)(1)(ii) (2009), Petitioner had 30 days, that is not later than July 10, 2010, to report the suspension of his Ohio medical license, which is an adverse legal action under 42 C.F.R. § 424.502 (2009). There is no dispute that Petitioner did not report the suspension to CMS or WPS by July 10, 2010.

CMS gave Petitioner a second chance to report when it notified him by letter dated August 7, 2015, that he could report any adverse legal action within 30 days and avoid revocation. CMS Ex. 1 at 67-68. There is no dispute that Petitioner failed to report the suspension of his Ohio license by September 7, 2015.

Accordingly, I conclude that Petitioner failed to report within 30 days the suspension of his Ohio medical license in violation of 42 C.F.R. § 424.516(d)(1)(ii), which is a basis for revocation pursuant to 42 C.F.R. § 424.535(a)(9). I have no authority to review the exercise of discretion by CMS or its contractor to revoke where there is a basis for revocation. *Abdul Razzaque Ahmed, M.D.*, DAB No. 2261 at 19 (2009), *aff'd*, *Ahmed v. Sebelius*, 710 F.Supp. 2d 167 (D. Mass. 2010). The scope of my authority is limited to determining whether there is a legal basis for revocation of Petitioner's Medicare enrollment and billing privileges. *Id.*

Petitioner argues that CMS and WPS did not adequately notify Petitioner of the basis for revocation of his Medicare enrollment and billing privileges because no detail about the nature of the final adverse legal action was provided. Petitioner admits he understood he had 30 days to respond or revocation could occur but he simply did not know to which adverse legal action CMS and WPS referred. He complains because the letter did not tell him specifically what adverse legal action he failed to report. Petitioner also complains because the September 7, 2015 letter cited an incorrect legal basis for revocation, causing him confusion. Petitioner argues that the notices were so inadequate as to amount to a deprivation of due process and that he suffered prejudice. RFH at 1-2; P. Br. at 4-5.
I have carefully reviewed the CMS and WPS letters. The August 7, 2015 CMS letter and the September 24, 2015 WPS letter do not specifically refer to the suspension of Petitioner's Ohio medical license. CMS Ex. 1 at 65-68. However, the January 11, 2016 WPS letter clearly states that the revocation was based on Petitioner's failure to report the suspension of his medical license, though not specifically the Ohio medical license. CMS Ex. 1 at 54. I conclude that there was no prejudice to Petitioner because the letters of August 7, 2015 and September 24, 2015 did not state with more clarity the basis for revocation. The regulation requires that the initial determination state the basis or reasons for the determination, the effect of the determination, and the affected party's

right to reconsideration or a hearing. 42 C.F.R. § 498.20(a). The September 24, 2015 WPS notice of initial determination met the regulatory requirement for satisfactory notice even though it did not specifically refer to the suspension of Petitioner's Ohio medical license. Further, both the August 7 and September 24, 2015 notices were clear enough that part of the issue was Petitioner's failure to report adverse legal action. Even if Petitioner was unclear as to which adverse legal action, he agreed by enrolling in Medicare to report all adverse legal actions. I note that Petitioner has filed no affidavit or declaration or asserted in any of the documents he submitted to WPS and CMS that he had no recollection of having his medical license suspended in Ohio and I am not required to draw any favorable inference for purposes of summary judgment in that regard. Finally, it is important to understand that under 42 C.F.R. § 424.516(d)(1)(ii), Petitioner had an affirmative duty to report the suspension of his medical license even with no notice from CMS or WPS. I conclude that the WPS and CMS notices were sufficient to give Petitioner notice of what he needed to defend, specifically the basis for revocation. The notices did not prejudice Petitioner's ability to defend the revocation action and did not amount to a deprivation of due process.[3]

The effective date of revocation established by the September 24, 2015 initial determination is legally incorrect. The effective date of revocation is determined pursuant to 42 C.F.R. § 424.535(g), which provides:

> (g) *Effective date of revocation.* Revocation becomes effective 30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier, except if the revocation is based on Federal exclusion or debarment, felony conviction, license suspension or revocation, or the practice location is determined by CMS or its contractor not to be operational. When a revocation is based on a Federal exclusion or debarment, felony conviction, license suspension or revocation, or the practice location is determined by CMS or its contractor not to be operational, the revocation is

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[3] Indeed, CMS granted Petitioner more process than he was due by sending him the August 7, 2015 notice and offering an opportunity to cure his violation of 42 C.F.R. § 424.516(d)(1)(ii) and avoid revocation. CMS and WPS also granted Petitioner an opportunity for reconsideration even though he missed the deadline for filing his request by issuing the January 19, 2016 clarification of the initial determination.

> effective with the date of exclusion or debarment, felony conviction, license suspension or revocation or the date that CMS or its contractor determined that the provider or supplier was no longer operational.

42 C.F.R. § 424.535(g). In this case, revocation was not based on the suspension of Petitioner's Ohio medical license. Revocation was based on Petitioner's failure to report the suspension. Accordingly, revocation was effective 30 days after the notice of the initial determination to revoke, which was October 24, 2015.

When a supplier's Medicare enrollment and billing privileges are revoked, the supplier is barred from re-enrolling in the Medicare program for one to three years. 42 C.F.R. § 424.535(c). In this case, the bar is the minimum allowed.

Petitioner argues that he was always properly licensed in Indiana where he practices and the suspension in Ohio was for administrative noncompliance and nothing related to his care for his patients. RFH at 2. Petitioner's arguments are effectively requests for equitable relief. I do not have the authority to grant equitable relief in any form. *US Ultrasound*, DAB No. 2302, at 8 (2010), ("Neither the ALJ nor the Board is authorized to provide equitable relief."). Petitioner points to no authority by which I may grant him relief from the applicable regulatory requirements. I have no authority to declare statutes or regulations invalid or ultra vires. *1866ICPayday.com, L.L.C.*, DAB No. 2289, at 14 (2009) ("An ALJ is bound by applicable laws and regulations and may not invalidate either a law or regulation on any ground.").

III. Conclusion

For the foregoing reasons, Petitioner's Medicare enrollment and billing privileges are revoked pursuant to 42 C.F.R.§ 424.535(a)(9) based on a violation of 42 C.F.R. § 424.516(d)(1)(ii), effective October 24, 2015.

/s/
Keith W. Sickendick
Administrative Law Judge