Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Eric Innes, D.C.,
(NPI: 1043462096),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-09-762

Decision No. CR2094

Date: March 18, 2010

DECISION

The Medicare enrollment application of Petitioner, Eric Innes, D.C., was properly denied.

I. Background

On December 16, 2008, Petitioner, a chiropractor licensed in the State of Florida, signed a Medicare Enrollment Application, CMS Form 8551, that he mailed on December 17, 2008. CMS Ex. 1, at 5-25. First Coast Service Options (FCSO), the Centers for Medicare & Medicaid Services (CMS) contractor, notified Petitioner by letter dated April 3, 2009, that his Medicare enrollment application was denied. The notice advised Petitioner that the denial was pursuant to 42 C.F.R. § 424.530(a)(3)(B) and based on his felony conviction for federal tax evasion. The notice further advised Petitioner that he could file a corrective action plan (CAP) within 30 calendar days of the date of the notice and that he could also request reconsideration of the determination to deny his enrollment. Centers for Medicare and Medicaid Services Exhibit (CMS Ex.) 1, at 26-27. Petitioner submitted a CAP dated April 13, 2009. CMS Ex. 1, at 28-30. FCSO notified Petitioner by letter dated August 1, 2009 that his CAP was not acceptable. CMS Ex. 1, at 35-36. Petitioner also requested reconsideration of the initial determination to deny his

application by letter dated April 13, 2009. CMS Ex. 1, at 31-34. The hearing officer issued a reconsideration decision on August 18, 2009, in which she upheld the denial of Petitioner's application based upon his federal conviction for tax evasion in December 2005. CMS Ex. 1, at 1-4.

Petitioner requested a hearing before an administrative law judge (ALJ) by letter dated September 21, 2009. The case was assigned to me on October 5, 2009 for hearing and decision and an Acknowledgement and Prehearing Order was issued at my direction. CMS filed a motion for summary judgment and supporting brief (CMS Brief) and CMS exhibits 1 and 2 on November 4, 2009. Petitioner did not file a response to the CMS motion. Therefore, on January 7, 2010, I issued an order for Petitioner to show cause not later than January 22, 2010, why this case should not be dismissed for abandonment. On January 20, 2010, Petitioner filed a response to the CMS motion (P. Brief). On February 2, 2010, I issued an order (with a copy of Petitioner's response attached) directing that CMS reply to Petitioner's response or file a written waiver of its right to reply. On February 10, 2010, CMS advised my office that it waived further reply. No objection has been made to my consideration of CMS Exs. 1 and 2 and they are admitted as evidence.

II. Discussion

A. Applicable Law

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

---

[1] A "supplier" furnishes services under Medicare and includes physicians or other practitioners and facilities that are not a "provider of services." Act § 1861(d) (42 U.S.C. § 1395x(d)). A "provider of services," commonly shortened to "provider," includes hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, hospice programs, or a fund described by section 1814(g) and section 1835(e) of the Act. Act § 1861(u) (42 U.S.C. § 1395x(u)). The distinction between providers and suppliers is important because they are treated differently under the Act for some purposes.

§ 1395u(a)). The Act requires the Secretary of Health and Human Services (Secretary) to issue regulations that establish a process for the enrollment of providers and suppliers. Pursuant to 42 C.F.R. § 424.505, a provider or supplier must be enrolled in the Medicare program and be issued a billing number to have billing privileges to be eligible to receive payment for services rendered to a Medicare-eligible beneficiary.

Qualified physician services are covered by Medicare for those enrolled, subject to some limitations. Act §§ 1832(a), 1861(s)(1) (42 U.S.C. §§ 1395k(a), 1395x(s)(1)). "Physician's services" means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls (with certain exceptions). Act § 1861 (q) (42 U.S.C. § 1395x(q)). The term "physician," includes a chiropractor who is licensed as such by a state or is legally authorized to perform the services of a chiropractor in a state where licensing is not required, and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of sections 1861(s)(1) and 1861(s)(2)(A) and only with respect to treatment by means of manual manipulation of the spine to correct a subluxation that he is legally authorized to perform by the state or jurisdiction in which treatment is provided. Act § 1861(r) (42 U.S.C. § 1395(x)(r)); 42 C.F.R. §§ 410.20(b)(5) and 410.21. The Medicare program authorizes Medicare Part B payments for services provided by physicians. 42 C.F.R. § 410.20. A physician who wants to bill Medicare or its beneficiaries for Medicare-covered services or supplies must enroll in the Medicare program. 42 C.F.R. § 424.505.

Section 1842(h)(8) of the Act (42 U.S.C. § 1395u(h)(8)) gives the Secretary discretion to refuse to enter into an agreement or to terminate or refuse to renew an agreement with a physician or supplier that "has been convicted of a felony under Federal or State law for an offense which the Secretary determines is detrimental to the best interests of the program." The Secretary has delegated the authority to accept or deny enrollment applications to CMS. Pursuant to the Secretary's regulations, CMS may deny a provider's or supplier's enrollment application if the provider or supplier is not in compliance with Medicare enrollment requirement. 42 C.F.R. § 424.530(a)(1). CMS may also deny a provider's or supplier's enrollment based upon conviction of certain felonies. The regulation provides:

> (a) *Reasons for denial*. CMS may deny a provider's or supplier's enrollment in the Medicare program for the following reasons . . .
>
> * * * *
>
> (3) *Felonies.* If within the 10 years preceding enrollment or revalidation of enrollment, the provider, supplier, or any owner of the provider or supplier, was convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its

> beneficiaries. CMS considers the severity of the underlying offense.
> (i) Offenses include ─
>
> *** * * ***
>
> (B) Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

42 C.F.R. § 424.530(a)(3).

A supplier enrollment is considered denied when a supplier is determined to be "ineligible to receive Medicare billing privileges for Medicare-covered items or services provide to Medicare beneficiaries" for one of more of the reasons listed in 42 C.F.R. § 424.530. 42 C.F.R. § 424.502. When a supplier's enrollment application has been denied, the CMS contractor notifies the supplier in writing and explains the reasons for the determination and provides information regarding the supplier's right to appeal. 42 C.F.R. § 498.20(a); Medicare Program Integrity Manual (MPIM), Chapter 10 - Healthcare Provider/Supplier Enrollment, §§ 6.2, 13.2. The supplier may submit a written request for reconsideration to CMS. 42 C.F.R. § 498.22(a). CMS must give notice of its reconsidered determination to the supplier, giving the reasons for its determination and specifying the conditions or requirements the supplier failed to meet. 42 C.F.R. § 498.25. If the CMS decision on reconsideration is unfavorable to the supplier, the Act provides for a hearing by an ALJ and judicial review. Act § 1866(j) (42 U.S.C. § 1395cc(j)).

B. Issue

Whether Petitioner met the requirements for participation in Medicare when the reconsideration decision was made. 73 Fed. Reg. 36,448, 36,452 (June 24, 2008).

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

My conclusions of law are set forth in bold followed by the pertinent facts and analysis.

1. Summary judgment is appropriate.

Summary judgment is appropriate and no hearing is required where either: there are no disputed issues of material fact and the only questions that must be decided involve application of law to the undisputed facts; or, the moving party must prevail as a matter of law even if all disputed facts are resolved in favor of the party against whom the motion is made. *See White Lake Family Medicine, P.C.*, DAB No. 1951 (2004); *Lebanon*

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

There is no dispute that on December 2, 2005, Petitioner was convicted in the U.S. District Court, Southern District of Florida of three felony counts of federal tax evasion. P. Brief at 2-3; Request for Hearing at 2-4; CMS Ex. 1, at 7-10. Petitioner identifies no other material fact that is in dispute. Petitioner advances only arguments that I may not consider in deciding this case. This case must be decided against Petitioner as a matter of law based on the undisputed material facts. Accordingly, summary judgment is appropriate.

2. There is a proper basis for denial of Petitioner's enrollment application.

Petitioner admits that on December 2, 2005, he was convicted in the U.S. District Court, Southern District of Florida of three felony counts of federal tax evasion. CMS Ex. 1, at 9. On December 17, 2008, Petitioner mailed his Medicare Enrollment Application requesting to enroll in the Medicare program as a chiropractor. CMS Ex. 1, at 5-25. Petitioner revealed the fact of his conviction and his sentence in his enrollment application. CMS Ex. 1, at 7-10. Petitioner cannot dispute that his December 2005 conviction occurred within the 10 years preceding the filing of his enrollment application in December 2008.

Section 1842(h)(8) of the Act is clear that the Secretary may refuse to enroll a provider or supplier who has a felony conviction of an offense that the Secretary determines is detrimental to the best interests of the program. The Secretary has specifically provided by regulation that felony tax evasion is an offense that is detrimental to the best interest of the program. The Secretary has further provided that if conviction of felony tax evasion occurred within 10 years preceding the date of application for enrollment the application may be denied on that basis by CMS or its contractor. 42 C.F.R. § 424.530(a)(3)(i)(B). Accordingly, I conclude that CMS had a legal basis to deny Petitioner's enrollment in Medicare.

Petitioner asks that I allow him to re-enroll[2] in the Medicare program. P. Brief at 1. Petitioner argues that it is in the government's best interest to permit him to participate in Medicare because: (1) he earns more money to pay toward his tax debt; and (2) he provides a service to Medicare-eligible beneficiaries in his area. He also argues that the facts of his case show he is no threat to the Medicare program. Petitioner argues that he never evaded taxes rather he concluded that he had no obligation to pay taxes. Petitioner states that he was released from federal prison in August 2008; his chiropractic license was reinstated in August 2008; and he has been practicing since September 2008. He graduated from Cleveland Chiropractic College in 1976 and has been in practice since 1977. He also states he paid taxes until 1992 when he determined there was no legal requirement for him to pay taxes. Petitioner asserts that he currently pays his taxes and is making payment of back taxes, interest, and penalties. He asserts that the offenses of which he was convicted are not detrimental to the best interests of the Medicare program. P. Brief; Request for Hearing.

The Secretary has specifically identified a felony conviction of tax evasion to be detrimental to the best interests of the program. 42 C.F.R. § 424.530(a)(3)(i)(B). I am bound to follow the Secretary's regulations and have no authority to determine that Petitioner's offense of tax evasion is not detrimental. Furthermore, the regulations specifically grant CMS the discretion to deny Petitioner's enrollment based upon his conviction of an offense that the Secretary has determined is detrimental to the best interests of the program. I have no authority under the Act or regulations to look behind CMS's exercise of its discretion or to substitute my judgment for that of CMS. *Letantia Bussell*, *M.D.*, DAB No. 2196, at 12-13 (2008); *cf. Michael J. Rosen, M.D.*, DAB No. 2096 (2007), at 14. Accordingly, I conclude that Petitioner's objections and arguments are without merit.

III. Conclusion

Petitioner's application to enroll in Medicare was properly denied.

/s/
Keith W. Sickendick
Administrative Law Judge

---

[2] Petitioner states that he was previously enrolled in Medicare and he requests to "re-enroll." Request for Hearing at 1; P. Brief at 1. The application process to which Petitioner is subject does not distinguish between initial enrollments and re-enrollments.