Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Charles W. Parrish, M.D.,

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-11-661

Decision No. CR2449

Date: October 12, 2011

DECISION

I grant summary judgment to the Centers for Medicare and Medicaid Services (CMS), sustaining its determination to revoke the Medicare enrollment and billing privileges of Petitioner, Charles W. Parrish, M.D.

I. Background

Petitioner is a physician who has participated in the Medicare program. Wisconsin Physicians Service (WPS), a Medicare contractor acting on behalf of CMS, determined to revoke Petitioner's Medicare enrollment and billing privileges, effective January 28, 2010. This determination was affirmed on reconsideration, and Petitioner requested a hearing. The case was assigned to me for a hearing and a decision.

CMS filed a pre-hearing brief that contains a motion for summary judgment and nine proposed exhibits that are identified as CMS Exhibit (Ex.) 1 – CMS Ex. 9. Petitioner filed a brief and four proposed exhibits that are identified as P. Ex. 1 – P. Ex. 4. I receive the parties' exhibits into the record of this decision.

II. Issue, Findings of Fact, and Conclusions of Law

A. Issue

The issue is whether CMS is authorized to revoke Petitioner's participation in Medicare and his Medicare billing privileges.

B. Findings of Fact and Conclusions of Law

The following material facts are undisputed. On January 28, 2010, the Illinois Department of Healthcare and Family Services (HFS) terminated Petitioner's eligibility to participate in the Illinois Medicaid program. CMS Ex. 1. HFS based this termination decision on findings that Petitioner had no medical documentation for more than 700 Medicaid reimbursement claims that he had submitted during a two-year period from October 1, 2005 through September 30, 2007, and on a recommended decision by a State administrative law judge. CMS Ex. 2 at 1-2; CMS Ex. 3 at 3.

On June 2, 2010, WPS received an updated enrollment application (Form CMS-855I) from Petitioner, seeking to add a new practice location to his service. CMS Ex. 4 at 1-3, 14-19. The cover letter to this document is dated March 29, 2010. *Id.* at 3. However, the FedEx air bill for the document shows that it was sent on June 1, 2010, and delivered on June 2. *Id.* at 1. Both the cover letter and the enrollment application are date stamped June 2, 2010. The cover letter and the application itself report that Petitioner was excluded from the Illinois Medicaid program on January 28, 2010. *Id.* at 3, 13-14.

Regulations governing participation in the Medicare program require a physician to report to CMS any adverse legal action, a change in practice location, or a change of ownership, within 30 days of the event. 42 C.F.R. § 424.516(d)(1). An adverse legal action is defined to mean an exclusion or debarment from a federal or State health care program (a State Medicaid program). 42 C.F.R. § 424.502. CMS is authorized to revoke the Medicare participation and billing privileges of any physician who fails to comply with this reporting requirement. 42 C.F.R. § 424.535(a)(9).

The undisputed facts plainly establish that Petitioner failed to comply with this reporting requirement. He was excluded from participating in the Illinois Medicaid program on January 28, 2010. He did not report that adverse action until June 1, 2010, more than four months after it occurred. That failure is sufficient basis for CMS or its contractor, WPS, to revoke Petitioner's participation in Medicare and his Medicare billing privileges.

Petitioner asserts that he did not receive notice of the adverse State action against him and first learned of it on March 4, 2010. P. Ex. 1 at 1. For purposes of this decision, I am accepting Petitioner's assertion as true. But, even assuming that to be true, Petitioner nevertheless failed to report the adverse State action until June 2010, approximately three months after he learned about it. Thus, by Petitioner's own admission, he reported the adverse action untimely.[1]

Petitioner argues also that he did not receive notice of the HFS proceeding that resulted in his State exclusion from the Illinois Medicaid program. Apparently, by making this assertion, Petitioner challenges HFS's authority to sanction him. However, CMS's authority to revoke Petitioner's Medicare participation and his billing privileges does not derive from the State proceeding against Petitioner, nor does it derive from the merits of that case. It derives from the fact that Petitioner failed to report timely the State's adverse action against him. Petitioner's duty in this case was to report, even if he questioned the validity of the action and even if ultimately he succeeds in overturning the State's action on due process or substantive grounds. He failed to comply with that duty here, and that is enough to authorize CMS or its contractor to revoke Petitioner's Medicare participation.

Additionally, Petitioner argues that, on the merits, CMS should not have revoked his Medicare participation, asserting that he has no prior history of noncompliance with Medicare participation requirements and characterizing his failure to notify as being an isolated incident. However, I have no authority to second-guess CMS's action or to substitute my judgment for that of CMS. CMS's determination to revoke Petitioner's Medicare participation and his billing privileges is an act of discretion. My authority is limited to deciding whether CMS has the discretion to act. It does not extend to questioning CMS's judgment.

CMS argues, as an alternative basis for its action, that it was required to revoke Petitioner's Medicare participation because Petitioner had been "excluded" from participating in the Illinois Medicaid program. CMS cites section 1862(e)(1) of the Social Security Act (Act), and implementing regulations at 42 C.F.R. § 424.535(a)(2)(i), as support for its argument. These sections, in pertinent part, require that the Secretary or CMS revoke the Medicare participation and billing privileges of any individual who has been excluded from participating in Medicare, pursuant to certain enumerated sections of the Act. I find it unnecessary to decide here whether this alternative basis supports CMS's action. I note, however, that all of statutory exclusion sections cited in section 1862 of the Act, and in the

[1] Petitioner does not contend that the anomalous March 29, 2010 date on the cover letter to his June 2010 application means that he actually notified WPS or CMS on March 29, 2010 of the adverse State action against him. *See* CMS Ex. 4 at 3; P. Ex. 1.

implementing regulation, are sections that authorize the *Inspector General* (I.G.) of this Department to exclude an individual on a variety of grounds. Neither the Act nor regulations refer to exclusion actions taken by *State* authorities, as was the case with Petitioner. Consequently, I am uncertain whether I would find CMS's alternate theory to be valid were I to address it.

Finally, CMS revoked Petitioner's participation and billing privileges retroactive to January 28, 2010. Petitioner made no argument as to the propriety of that action, assuming that CMS had the authority to act against Petitioner. Therefore, I do not address it here.

/s/
Steven T. Kessel
Administrative Law Judge