Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Robert Knapp, M.D.
(NPI: 1437268067),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-10-992

Decision No. CR2329

Date: March 1, 2011

DECISION

For the reasons set forth below, I grant the motion of the Centers for Medicare and Medicaid Services (CMS) for summary judgment. Highmark Medicare Services, the CMS contractor, had an undisputed and legitimate basis to revoke Petitioner's enrollment and billing privileges as a supplier in the Medicare program for non-compliance with Medicare enrollment requirements under section 42 C.F.R. § 424.535(a)(1).

I. Background

Petitioner, Robert Knapp, M.D., is a physician who participated as a supplier in the Medicare program. Hearing Request (HR). On March 23, 2010, Petitioner surrendered his medical license to the Pennsylvania State Board of Medicine due to pending criminal charges. CMS Exhibit (Ex.) 1. After learning of the surrender through a report from the Pennsylvania Department of Health, on May 13, 2010, Highmark notified Petitioner that it was revoking his Medicare billing privileges effective March 23, 2010. CMS Exs. 2-3. Specifically, Highmark articulated that Petitioner was not in compliance with the Medicare enrollment requirements set forth in 42 C.F.R. § 424.535(a)(1) because he

lacked a valid state medical license as contemplated under 42 C.F.R. § 410.20(b). The letter further noted that Petitioner failed to comply with the reporting requirements in 42 C.F.R. § 424.516(d)(1)(ii), which requires that a physician report any adverse legal action within 30 days. CMS Ex. 3.

When a provider or supplier is revoked from the Medicare program, CMS automatically reviews all other related Medicare enrollment files to determine if a revocation of the related files is warranted. 42 C.F.R. § 424.535(f). Upon review, the contractor found Petitioner possessed another Medicare Provider Transaction Access Number (PTAN) that he used to continue to bill Medicare and receive payment for services. Substitute physicians that Petitioner recruited for his practice provided these services. By a separate notice letter dated May 13, 2010, the contractor also revoked Petitioner's Medicare billing privileges under the active PTAN effective March 23, 2010. CMS Ex. 4. Upon notice, Petitioner claims to have repaid all monies paid for improperly submitted claims. HR.

On May 24, 2010, Petitioner requested that the contractor reconsider his revocation and reinstate his billing privileges. CMS Ex. 5. On August 23, 2010, the contractor issued its unfavorable determination finding that the contractor properly revoked Petitioner's enrollment and billing privileges in the Medicare program. CMS Ex. 6. Pursuant to 42 C.F.R. § 498.40, Petitioner timely filed a request for an Administrative Law Judge (ALJ) hearing by letter dated August 31, 2010. With Petitioner's hearing request, he included nine supplemental pages, which I have marked as Petitioner's Exhibit 1 (P. Ex. 1). Petitioner later submitted an additional filing that was received on October 14, 2010. It contained largely duplicative documentation and one new document, which I have marked as Petitioner's Exhibit 2 (P. Ex. 2).

This case was originally assigned to Board Member Leslie A. Sussan pursuant to 42 C.F.R. § 498.44, which permits a Member of the Departmental Appeals Board (Board) to hear appeals under Part 498. The case was subsequently transferred to me for decision, and the parties were notified by letter dated October 27, 2010. Pursuant to the September 22, 2010 Acknowledgement and Pre-Hearing Order, CMS filed a motion for summary judgment and supporting memorandum (CMS Br.) on October 21, 2010. CMS accompanied its submission with CMS Exhibits 1-6. On December 13, 2010, my office received Petitioner's reply letter that again contained largely duplicative documentation and two new documents that I have marked as Petitioner's Exhibit 3 (P. Ex. 3). In the absence of objection, I receive into the record of this case P. Exs. 1-3 and CMS Exs. 1-6.

II. Applicable Standard

The Board stated the standard for summary judgment:

> Summary judgment is appropriate when the record shows that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. . . . The party moving for summary judgment bears the initial burden of showing that there are no genuine issues of material fact for trial and that it is entitled to judgment as a matter of law. . . . To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact – a fact that, if proven, would affect the outcome of the case under governing 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.

Senior Rehab. & Skilled Nursing Ctr., DAB No. 2300, at 3 (2010) (citations omitted). The role of an ALJ in deciding a summary judgment motion differs from the ALJ's role in resolving a case after a hearing. The ALJ should not assess credibility or evaluate the weight of conflicting evidence. *Holy Cross Vill. at Notre Dame, Inc*, DAB No. 2291, at 5 (2009). The Board has further stated, "[i]n addition, it is appropriate for the tribunal to consider whether a rational trier of fact could regard the parties' presentation as sufficient to meet their evidentiary burden under the relevant substantive law." *Dumas Nursing and Rehab., L.P.*, DAB No. 2347, at 5 (2010).

III. Issue

The issue in this case is whether a basis exists for CMS to revoke Petitioner's enrollment as a supplier in the Medicare program.

IV. Findings of Fact, Conclusions of Law, and Discussion

I make a single finding and conclusion set out below:

> ***A legitimate basis exists for CMS to revoke Petitioner's enrollment in Medicare.***

There is no dispute that Petitioner relinquished his license to practice medicine in the State of Pennsylvania, effective March 23, 2010, and that CMS subsequently revoked Petitioner's enrollment in Medicare. *See* CMS Ex. 1. CMS also noted that Petitioner failed to timely report the adverse legal action. CMS Exs. 3-4.

The undisputed facts establish that CMS was authorized to revoke Petitioner's enrollment because Petitioner ceased to comply with enrollment requirements due to the surrender of his license to practice medicine. CMS may revoke the billing privileges of a participating Medicare provider for noncompliance with Medicare enrollment requirements. 42 C.F.R.

§ 424.535(a)(1). Such noncompliance includes the surrender of a physician's license to practice medicine. Medicare will pay for a physician's services to its beneficiaries *only* where the physician is licensed to practice medicine in the State where he provides them. 42 C.F.R. § 410.20(b). Thus, a physician who relinquished his license to practice medicine, such as Petitioner, is not in compliance with Medicare enrollment requirements.

Additional grounds to revoke Petitioner's enrollment in Medicare also exist due to Petitioner's failure to report his change in circumstances. Regulations require a participating physician to report to Medicare within 30 days an adverse legal action. 42 C.F.R. § 424.516(d)(1)(ii). Here, it does not appear that Petitioner complied with the regulation. Rather, in this case, Highmark learned of Petitioner's surrender of his medical license indirectly through a report from the Pennsylvania Department of Health. Further, Highmark did not learn of Petitioner's change in circumstances until May 13, 2010, which was nearly two months after Petitioner surrendered his medical license. However, because CMS may revoke Petitioner's enrollment based on his noncompliance with Medicare enrollment requirements, I need not further discuss Petitioner's failure to timely report his change in circumstances. *See Houston v. CMS*, DAB CR2071, at 4 (2010) ("License suspension and failure to inform CMS of a change in circumstances are independent grounds for revocation of enrollment. Either basis, standing alone, is sufficient authority for CMS to revoke Petitioner's enrollment.").

V. Conclusion

CMS had the authority to revoke Petitioner's enrollment and billing privileges for noncompliance with Medicare enrollment requirements under 42 C.F.R. § 424.535(a)(1). I therefore grant the CMS motion for summary judgment.

/s/
Joseph Grow
Administrative Law Judge