Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Akram Ismail
(PTAN 698444),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-11-326

Decision No. CR2387

Date: June 23, 2011

DECISION

The Medicare enrollment and billing privileges of Petitioner, Akram Ismail, are revoked, effective May 4, 2010, for noncompliance with enrollment requirements and failure to report adverse legal action.

I. Background

The Centers for Medicare and Medicaid Services (CMS) notified Petitioner by letter dated August 4, 2010, that his Medicare enrollment and billing privileges were revoked, effective May 4, 2010, pursuant to the Social Security Act (the Act) § 1861(r) (42 U.S.C. § 1395x(r)) and 42 C.F.R. § 424.535(a)(1) due to the suspension of his New Jersey medical license; and pursuant to 42 C.F.R. § 424.516 (d)(1)(ii) due to his failure to report adverse legal action to CMS. CMS Exhibit (CMS Ex.) 1.

Petitioner's October 4, 2010 request for reconsideration of the initial revocation decision was received by the CMS contractor on October 7, 2010. CMS Ex. 2. On December 29,

2010, a contractor hearing officer issued a reconsideration decision revoking Petitioner's billing privileges. CMS Ex. 7.

On March 3, 2011, Petitioner requested a hearing before an Administrative Law Judge (ALJ). This case was assigned to me for hearing and decision. I issued an Acknowledgment and Prehearing Order on March 7, 2011. On April 7, 2011, CMS filled a Motion for Summary Judgment (CMS Br.) with CMS Exs. 1 through 10. On May 5, 2011, Petitioner filed a Brief in Opposition to CMS's Motion for Summary Judgment (P. Br.) with Petitioner's exhibits (P. Exs.) 1 through 3. CMS filed a Reply Brief (CMS Reply) on May 20, 2011. The parties have filed no objections to CMS Exs. 1 through 10 and P. Exs. 1 through 3 and they are admitted. Petitioner requested an oral hearing and oral argument on the motion. P. Br. at 11-12. However, summary judgment is appropriate and no oral hearing is necessary. Further, both parties have filed their briefs on the motion and Petitioner offers no explanation for how oral argument will aide my understanding of the parties' arguments or assist my ruling or decision. The motion for oral argument is, therefore, denied.

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. 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. § 1395u(a)).

The Act requires the Secretary of Health and Human Services (the Secretary) to issue regulations that establish a process for the enrollment of providers and suppliers,

[1] A "supplier" furnishes services under Medicare and the term supplier applies to physicians or other practitioners and facilities that are not included within the definition of the phrase "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, and a fund as described in sections 1814(g) and 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.

including the right to a hearing and judicial review in the event of denial or non-renewal. Act § 1866(j) (42 U.S.C. § 1395cc(j)). 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 and to be eligible to receive payment for services rendered to a Medicare eligible beneficiary. If enrollment is approved, a supplier is issued a National Provider Identifier (NPI) to use for billing Medicare and a PTAN, an identifier of the supplier for inquiries. Medicare Program Integrity Manual (MPIM), CMS Publication 100-08, Chapter 10, Healthcare Provider/Supplier Enrollment, § 6.1.1.

Qualified physician services are covered by Medicare Part B, subject to some limitations for those physicians enrolled in Medicare. Act §§ 1832(a) (42 U.S.C. § 1395k(a)); 1861(s)(1) (42 U.S.C. § 1395x(s)(1)). "Physician's services" are 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," when used in connection with the performance of any function or action, includes a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, and a chiropractor, if legally authorized to practice medicine and surgery by the state in which he or she performs such function or action and subject to the limitations specified in the Act. Act § 1861(r) (42 U.S.C. § 1395x(r)); 42 C.F.R. § 410.20(b). 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.

CMS may revoke an enrolled provider's or supplier's Medicare billing privileges and any provider or supplier agreement for any of the reasons listed in 42 C.F.R. § 424.535. Pursuant to 42 C.F.R. § 424.535(a)(1), CMS may revoke a provider's or supplier's enrollment if it is determined that the provider or supplier is not in compliance with enrollment requirements and fails, after being given the opportunity, to achieve compliance before a final determination to revoke billing privileges. Pursuant to 42 C.F.R. § 424.535(a)(9), billing privileges may also be revoked for failure to report the information required by 42 C.F.R. § 424.516(d)(1)(ii) and (iii). Physicians, non-physician practitioners, and organizations of such individuals must report the following events to the appropriate CMS contractor within 30 days and other changes in enrollment must be reported within 90 days: (1) change of ownership; (2) any adverse legal action; or (3) a change in practice location. The effective date of revocation of billing privileges in the case of license suspension or revocation is the date of the license suspension or revocation. 42 C.F.R. § 424.535(g). The Act provides for a hearing by an ALJ and judicial review of the determination to deny enrollment or re-enrollment. Act § 1866(j)(2).

B. Issues

The issues in this case are:

> Whether summary judgment is appropriate; and
>
> Whether there is a basis for the 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 text followed by my findings of fact and analysis.

1. Summary judgment is appropriate.

CMS has requested summary judgment. The Secretary's regulations that establish the procedure to be followed in adjudicating Petitioner's case are at 42 C.F.R. Part 498. 42 C.F.R. § 424.545(a)(1). The regulations do not establish a summary judgment procedure or recognize such a procedure. However, the Departmental Appeals Board (the Board) has long accepted that summary judgment is an acceptable procedural device in cases adjudicated pursuant to 42 C.F.R. Part 498. The Board has also recognized that the Federal Rules of Civil Procedure are not applicable 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.

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 on upon the 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). 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 has also recognized that on summary judgment it is appropriate for the ALJ to consider whether a rational trier of fact could find that the parties' evidence would be sufficient to meet that party's evidentiary burden. *Dumas Nursing and 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. Part 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. Part 498. *Batavia Nursing and Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 Fed. App'x 181 (6th Cir. 2005).

The material facts in this case, as discussed hereafter, are not disputed and there is no genuine dispute as to any material fact that requires a trial. In fact, Petitioner concedes that the facts are not disputed but requests an oral hearing and oral argument on the CMS motion. P. Br. at 11-12.[2] Although Petitioner did not specifically request summary judgment in his favor, that is indeed the gist of his argument and I have carefully considered whether summary judgment in favor of Petitioner may be appropriate. The issues in this case that require resolution, are issues of law related to the interpretation and application of the regulations that govern the revocation of enrollment and billing privileges in the Medicare program to the undisputed facts of this case. Accordingly, summary judgment is appropriate.

[2] Petitioner states that he would testify regarding his Florida license renewal and the requirements that he had to meet to qualify to have his license renewed through 2013, including continuing medical education and updating his practice profile. Petitioner states that a representative of the Florida Department of Health would testify that Petitioner's Florida license is still active, that Petitioner is complying with all Florida licensure and regulatory requirements, and that Petitioner is abiding by the terms of the suspension of his license. P. Br. at 2. I accept these facts as true for purposes of this decision, but they are not material to resolution of the issues in this case and do not affect the outcome.

2. There was a basis for the revocation of Petitioner's enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(1), because he was not legally authorized to practice medicine as a physician due to the suspension of his license. Act § 1861(r) (42 U.S.C. § 1395x(r)); 42 C.F.R. § 410.20(b).

3. There was a basis for revocation of Petitioner's enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(9) because Petitioner failed to report adverse legal action as required by 42 C.F.R. § 424.516(d)(1)(ii).

Petitioner does not dispute that on about December 14, 2009, the Florida Department of Health entered an Emergency Suspension Order (ESO) against Petitioner. CMS Ex. 5; CMS Ex. 6, at 2; P. Ex. 1; P. Br. at 3. It is not disputed, for purposes of ruling upon this motion, that the ESO issued by Florida is not a permanent suspension or a revocation of Petitioner's license to practice medicine in Florida, but Petitioner admits that under the Florida ESO, he cannot treat patients or practice medicine.[3] CMS Ex. 6, at 2; P. Ex. 2, at 2. In fact, it is a third degree felony under Florida law to offer to practice, attempt to practice, or practice with a suspended license. Fla. Stat. § 456.065(d)1 (2010).

Petitioner does not deny that effective May 4, 2010, the New Jersey State Board of Medical Examiners suspended his license to practice medicine in New Jersey based on the ESO issued by the Florida Department of Health. CMS Ex. 6, at 2; P. Br. at 3. The New Jersey Board suspended Petitioner's New Jersey Medical license until Petitioner's license is reinstated by Florida, with no restrictions, conditions, or probation. CMS Ex. 6, at 2; CMS Ex. 10; P. Br. at 3. It is also a crime in New Jersey to engage in the practice of medicine while one's license or permit to practice medicine is suspended. N.J Rev. Stat. § 2C:21-20 (2011).

[3] Petitioner advises me that the Florida Department of Health and the Florida Board of Medicine have not imposed any discipline against Petitioner. Rather, an amended complaint has been filed against Petitioner and he has requested a formal administrative hearing, which has not yet occurred due to pending criminal charges. P. Br. at 3-4. I accept these statements as true for purposes of ruling upon the motion for summary judgment. Petitioner notes that it is possible that he could be absolved of all charges and, if so, the suspension of his license would be terminated. P. Br. at 4. Of course, Petitioner may advise CMS, or its contractor, if he is acquitted of the criminal charge and the suspensions are lifted.

Petitioner does not deny that he never reported the Florida or the New Jersey suspension of his license to CMS or its contractor.

The CMS contractor, Highmark, notified Petitioner of two grounds for the revocation of his billing privileges: (1) New Jersey suspended Petitioner's license to practice medicine and he no longer satisfied the requirement of section 1861(r) of the Act, as implemented by 42 C.F.R. § 410.20(b), as he was no longer legally authorized to practice medicine or surgery; and (2) Petitioner failed to report the suspension of his medical license by New Jersey, an adverse legal action for which reporting is required by 42 C.F.R. § 424.516(d)(1)(ii). CMS Ex. 1, at 1.

Section 1861(r) of the Act and 42 C.F.R. § 410.20(b) are clear that in order to participate in Medicare and to seek reimbursement for physician services provided to a Medicare beneficiary, the physician must be legally authorized to practice medicine by the state in which he provides the services. Petitioner does not dispute that he could not legally provide physician services in New Jersey during the suspension of license to practice medicine.[4] CMS may revoke the billing privileges of any currently enrolled provider or supplier, ending their participation in Medicare, for many reasons. Noncompliance with the enrollment requirements for a provider of supplier type is an authorized basis for revocation of Medicare billing privileges and participation. 42 C.F.R. § 424.535(a)(1). Petitioner could not legally practice medicine in New Jersey after his license was suspended and he no longer met the enrollment requirement of section 1861(r) of the Act and 42 C.F.R. § 410.20(b). Therefore, revocation of his billing privileges was authorized by 42 C.F.R. § 424.535(a)(1).

Revocation was also authorized by 42 C.F.R. § 424.535(a)(9) because Petitioner did not report the suspension of his New Jersey medical license. Enrolled physicians are required to report to their Medicare contractor any adverse legal action within thirty days. This condition for maintaining enrollment is established by 42 C.F.R. § 424.516(d)(1)(ii). The phrase "adverse legal action" is not specifically defined in 42 C.F.R. Part 424. But the ordinary or usual meaning of the individual words support a conclusion that the drafters of the regulation intended the phrase to refer to some legal action or action pursuant to or under color of law that is hostile to or contrary to the interest, concern, or position of one against whom the action was taken. *See Black's Law Dictionary* 31, 58, 912 (18th ed. 2004); *Merriam-Webster Dictionary*, http://www.merriam-webster.com/dictionary (2011). Petitioner does not urge me to conclude that the

[4] Petitioner also does not dispute that he could not legally practice medicine in Florida during the suspension of his Florida license. However, the suspension of his Florida license was not the basis for the revocation of his billing privileges and Medicare participation in this case.

suspension of his license in New Jersey was not an adverse legal action. Petitioner does not dispute that he failed to report the adverse legal action of the New Jersey Board. Petitioner violated the reporting requirement established by 42 C.F.R. § 424.516(d)(1)(ii).[5] Therefore, revocation of his billing privileges was authorized by 42 C.F.R. § 424.535(a)(9).

Petitioner argues that the Act and the regulations: (1) do not specifically define the phrase "legally authorized to practice medicine;" or (2) address whether a "temporary or non-final suspension" renders one "not legally authorized to practice medicine." P. Br. at 6. These arguments are nonsensical and verge on being frivolous given the fact that Petitioner does not dispute that he cannot legally practice medicine in either Florida or New Jersey, while his licenses are suspended. Petitioner also does not specifically assert that the suspensions of his licenses were not adverse legal actions.

Petitioner argues that he is complying with Florida and New Jersey licensing requirements and, therefore, he is in compliance with enrollment requirements. P. Br. at 8-9. However, whether or not Petitioner complies with state licensing requirements is not the issue. The requirement for being enrolled and maintaining enrollment under the Act and regulations is based on whether Petitioner is legally authorized to practice medicine. In this case, Petitioner does not dispute that he may not legally practice medicine in either New Jersey or Florida, while his licenses are suspended. Thus, he does not meet current enrollment requirements, even though he may meet state licensing requirements.

Petitioner argues that because the federal regulations do not distinguish between permanent and temporary suspensions, CMS cannot rely upon the regulations. P. Br. at 9-10. The fact that the regulations do not distinguish between temporary and permanent exclusions does not benefit Petitioner. The absence of a distinction in the regulations should be construed to mean that any such distinction has no impact. Section 1861(r) of the Act specifically requires that a physician must be legally authorized to practice medicine by the state in which he provides the services. If the impact of a suspension, whether temporary or permanent, is that a physician is no longer legally authorized to practice medicine, the physician is no longer in compliance with participation requirements and revocation is authorized.

[5] The hearing officer concluded that the reporting requirement did not apply to Petitioner as his Medicare file in New Jersey had been deactivated since 1994. CMS Ex. 7, at 3. The hearing office did not provide any analysis or citation of authority for that conclusion. However, even if the hearing officer's conclusion is correct, Petitioner is nevertheless subject to revocation of his billing privileges because he was not legally authorized to practice medicine due to the suspension of his license.

Petitioner argues that CMS cannot revoke his billing privileges because the regulations do not specifically provide that a temporary or contingent suspension constitutes either an adverse legal action or a final adverse action. P. Br. at 11. Petitioner correctly states that the regulations do not define the phrase "adverse legal action" as used in 42 C.F.R. § 424.516(d)(1)(ii). However, Petitioner points to the definition of "final adverse action" in 42 C.F.R. § 424.502, and argues that the definition limits the obligation to report under 42 C.F.R. § 424.516(d)(1)(ii) to only final adverse legal actions. The gist of Petitioner's argument is that his suspensions are not permanent or final and he had no obligation to report to CMS. Petitioner's argument is without merit. If the drafters of 42 C.F.R. § 424.516(d)(1)(ii) intended for only "final adverse action" to be reportable, they would have used that phrase given the fact they specifically defined that phrase in 42 C.F.R. § 424.502. Rather, the use of the phrase "adverse legal action" in 42 C.F.R. § 424.516(d)(1)(ii) was clearly intended to be broadly construed to require that all "adverse legal action" be reported, not just the subset of final adverse legal actions. The suspension of Petitioner's licenses caused him to no longer be legally authorized to practice medicine in either New Jersey or Florida. The suspensions were legal actions adverse to the interests of Petitioner and reporting was required.

III. Conclusion

For the foregoing reasons, I conclude that there was a basis for the revocation of Petitioner's billing privileges and enrollment in Medicare.

/s/
Keith W. Sickendick
Administrative Law Judge