Department of Health and Human Services

# DEPARTMENTAL APPEALS BOARD

## Appellate Division

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| In the Case of: | |
| Letantia Bussell, M.D., | DATE: September 4, 2008 |
| Petitioner, | Civil Remedies CR1712<br>App. Div. Docket No. A-08-91 |
| - v. - | Decision No. 2196 |
| Centers for Medicare & Medicaid Services. | |

## FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Letantia Bussell, M.D., a California-based dermatologist, appeals a December 14, 2007 decision by Administrative Law Judge (ALJ) Carolyn Cozad Hughes upholding a Medicare contractor's determination, pursuant to 42 C.F.R. § 424.53(a)(3), to revoke Dr. Bussell's Medicare billing privileges because of her conviction for income tax evasion. Letantia Bussell, M.D., DAB CR1712 (2007) (ALJ Decision). Dr. Bussell raises two issues on appeal: first, that her April 28, 2008 request for review is timely because she did not receive the ALJ Decision until April 24, 2008; and second, that her felony conviction is not detrimental to the Medicare program and its beneficiaries as required for revocation of billing privileges under 42 C.F.R. Part 424. 42 C.F.R. 424.535(a)(3). A provider may appeal an adverse ALJ decision by filing a request for review within 60 days of receipt of the decision. 42 C.F.R. § 498.82(a)(2). Receipt is presumed to be five days from the date of the decision absent a showing to the contrary. 42 C.F.R. § 498.22(b)(3). We have determined that Dr. Bussell has made a sufficient showing that she did not receive the ALJ Decision until April 24, 2008, and, therefore, we find her appeal to be timely.

Section 424.535(a)(3) authorizes the Centers for Medicare & Medicaid Services (CMS) to revoke the Medicare billing privileges of a physician who, within the past ten years, was convicted of a felony that CMS finds to be detrimental to the Medicare program and its beneficiaries. Dr. Bussell contends her felony tax evasion conviction is not detrimental because section 424.535 does not identify tax evasion as detrimental per se. Dr. Bussell further argues that CMS failed to show that her felony conviction was both detrimental to the best interests of the program *and* detrimental to the program's beneficiaries, as she contends was required by section 424.535(a)(3), and that revocation always requires an exercise of judicial discretion based on the particular circumstances of the case. We disagree with all three contentions and affirm the ALJ's conclusion that CMS lawfully revoked Dr. Bussell's Medicare billing privileges.

Legal Background

The Medicare program provides health insurance benefits to persons 65 years and older and to certain disabled persons. Social Security Act (Act) § 1811.[1] Medicare is administered by CMS, a component of the Department of Health and Human Services (HHS). Private insurance companies under contract with CMS process claims for Medicare coverage and perform other program functions. See Act § 1842.

In order to receive Medicare payment for services furnished to program beneficiaries, a medical provider or supplier – the term "supplier" encompasses a physician – must be "enrolled" in Medicare. 42 C.F.R. § 424.505. A key purpose of enrollment is to ensure that providers and suppliers are compliant with eligibility and other requirements for program participation and payment. 42 C.F.R. §§ 424.520(a) (stating that CMS enrolls a provider or supplier upon finding that Medicare program requirements are met), 424.502 (defining "enrollment" as a process that includes "[v]alidation of the provider's or supplier's eligibility to provide items or services to Medicare beneficiaries").

In April 2006, responding to concern about the participation in Medicare of unqualified or fraudulent providers and suppliers, CMS published a final rule that established standard Medicare

[1] The current version of the Act can be found at http://www.socialsecurity.gov/OP_Home/ssact/ssact-toc.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section.

enrollment requirements and procedures.[2] Final Rule, *Medicare Program; Requirements for Providers and Suppliers to Establish and Maintain Medicare Enrollment*, 71 Fed. Reg. 20,754 (Apr. 21, 2006) (Final Rule).[3] These requirements and procedures are codified in 42 C.F.R. Part 424, subpart P, and are referred to here as the subpart P regulations. The effective date of the Final Rule was June 20, 2006. Id.

In section 424.505, the subpart P regulations state that a provider or supplier "must be enrolled in the Medicare program" in order to receive Medicare "billing privileges" (i.e., the privilege to bill Medicare for covered services furnished to Medicare beneficiaries). The terms "enroll" and "enrollment" are defined to mean –

> the process that Medicare uses to establish eligibility to submit claims for Medicare covered services and supplies. The process includes —
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> (1) Identification of a provider or supplier;
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> (2) Validation of the provider's or supplier's eligibility to provide items or services to Medicare beneficiaries;
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> (3) Identification and confirmation of the provider or supplier's practice location(s) and owner(s); and
>
> (4) Granting the provider or supplier Medicare billing privileges.

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[2] In 2003, Congress directed the Secretary of HHS to "establish by regulation a process for the enrollment of providers of services and suppliers" and also establish "procedures under which there are deadlines for actions on applications for enrollment[.]" Act § 1866(j)(1)(A)-(B); Pub. L. No. 108-173, § 936, 117 Stat. 2066, 2411-12 (2003).

[3] To a substantial degree, the new regulations consolidate and codify existing enrollment policies, practices, and requirements. The Final Rule states that it "consolidates current regulations found throughout the C*ode of Federal Regulations* and more clearly defines what Medicare expects from providers and suppliers furnishing items or rendering services to the Medicare beneficiaries." 71 Fed. Reg. at 20,773.

42 C.F.R. § 424.502.

Section 424.510 sets out requirements for enrolling in the Medicare program, including the submission of verifiable "enrollment information on the applicable enrollment application." 42 C.F.R. § 424.510(a), (d)(4). It is not disputed that the "applicable enrollment application" is the CMS-855 form.[4]

Section 424.515 specifies what an enrolled provider or supplier must do to "maintain" its Medicare billing privileges:

> To maintain Medicare billing privileges, a provider or supplier . . . must resubmit and recertify the accuracy of its enrollment information every 5 years. *All providers and suppliers currently billing the Medicare program or initially enrolling in the Medicare program are required to complete the required enrollment application.* The provider or supplier then enters a 5-year revalidation cycle once a completed enrollment application is submitted and validated.

(Italics added.). The Final Rule's preamble clarifies that, except for physicians who "opt-out" of Medicare, all providers and suppliers, including those already enrolled in the program as of June 20, 2006 (the Final Rule's effective date), must submit to CMS a completed enrollment application (the CMS-855) if they have not already done so, or update and certify the accuracy and completeness of information on a previously submitted CMS-855.[5] Section 424.515(a)(1) states that "CMS contacts each provider or supplier directly when it is time to revalidate their enrollment

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[4] See 61 Fed. Reg. 37,278 (July 17, 1996); 64 Fed. Reg. 3637, 3643 (Jan. 25, 1999).

[5] 71 Fed. Reg. at 20,759 ("We would require that all providers and suppliers currently in the Medicare program complete, in its entirety, the CMS 855 at least once if they have not done so in the past."), 20,764 ("All providers and suppliers, including those currently billing Medicare, will be required to complete and submit an enrollment application."), and 20,759 ("For those providers and suppliers who initially enrolled in the Medicare program via the CMS 855, we would furnish a copy of the information currently on file for their review, request that they make any changes, and certify via their signature that the information is accurate, complete, and truthful.").

information."[6] Section 424.515(a)(2) allows the provider or supplier 60 days to respond to a revalidation request.

In addition to establishing requirements for enrolling and maintaining enrollment in Medicare, subpart P authorizes CMS to revoke a provider's or supplier's billing privileges in some circumstances. Section 424.535 provides in relevant part:

> **§ 424.535 Revocation of enrollment and billing privileges in the Medicare program**
>
> (a) *Reasons for revocation.* CMS may revoke a currently enrolled provider or supplier's billing privileges and any corresponding provider agreement or supplier agreement for the following reasons:
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> * * *
>
> (3) *Felonies*. The provider, supplier, or any owner of the provider or supplier, *within the 10 years preceding enrollment or revalidation of enrollment*, 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.*
>
> (i) Offenses include –
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> * * *
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> (B) Financial crimes, such as extortion, embezzlement, *income tax evasion*, insurance fraud and other similar crimes for which the

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[6] CMS indicated in the Final Rule's preamble that it would "phase-in" the revalidation process for current program participants, focusing first on providers and suppliers who have not previously submitted a Medicare enrollment application. 71 Fed. Reg. at 20,764-65 (stating that CMS would focus first on "new applicants" and existing enrollees who have not completed and submitted a CMS-855, and further stating that while a provider or supplier "may voluntarily submit an enrollment application at any time, we will instruct our contractors to process new enrollment applications first, request and process enrollment applications for providers and suppliers currently billing the program second, and initiate revalidation activities for most providers and suppliers third").

> individual was convicted, including guilty pleas and adjudicated pretrial diversions.

(Italics added.).

In its regulatory preamble, CMS summarized the purpose of the Final Rule as follows:

> The primary goal of this final rule, through standard enrollment requirements and periodic revalidation of the enrollment information, is to allow us to collect and maintain (keep current) a unique and equal data set on all current and future providers and suppliers that are or will bill the Medicare program for items or services rendered to our beneficiaries. By achieving this goal, we will be better positioned to combat and reduce the number of fraudulent and abusive providers and suppliers in the Medicare program, thereby protecting the Trust Funds and the Medicare beneficiaries.

71 Fed. Reg. at 20,774.

Case Background

By letter dated January 18, 2007, the National Heritage Insurance Co. (NHIC), a CMS contractor, notified Dr. Bussell that her Medicare billing privileges would be revoked effective February 17, 2007. CMS Ex. 1. NHIC indicated in the letter that it had obtained information showing that Dr. Bussell was convicted of federal income tax evasion on February 6, 2002. NHIC based its revocation decision on section 424.535(a)(3)(i)(B), which authorizes CMS to revoke the Medicare billing privileges of a physician who has been convicted of felony income tax evasion within the 10 years preceding enrollment or revalidation of enrollment.[7] Id.

After a contractor hearing officer affirmed NHIC's decision (CMS Exhibit 2), Dr. Bussell requested an ALJ hearing. CMS and Dr. Bussell subsequently agreed that an in-person hearing was unnecessary and that the ALJ could render a decision concerning

[7] Since Dr. Bussell was enrolled in the Medicare program at the time her billing privileges were revoked in February 2007, it is undisputed that her 2002 conviction occurred within ten years of her enrollment or revalidation of enrollment in the program. Reply Br. at 3.

the validity of the revocation based on their briefs and documentary evidence.

While Dr. Bussell admitted to having been convicted of felony income tax evasion in February 2002,[8] she contended that section 424.535(a)(3) allows revocation of Medicare billing privileges only if the felony conviction is "detrimental to both the best interests of the Medicare program and its beneficiaries." Petitioner's Response Br. in CRD Dkt. No. C-07-514, at 7. Dr. Bussell argued that her offense was not detrimental to Medicare beneficiaries because the quality of care she provided to her patients was not affected by her offense. Id. Dr. Bussell also argued that the specific circumstances surrounding her conviction[9] and her lack of prior disciplinary action in the Medicare program required the ALJ to exercise discretion in determining whether her billing privileges were properly revoked. Id. at 8.

The ALJ upheld the revocation, stating that she did not have the authority to review CMS's exercise of discretion. ALJ Decision at 2. Both 42 C.F.R. § 424.535(a)(3) and section 1842(h)(8) of the Act give CMS the discretion to revoke Medicare billing privileges when a physician has a felony conviction that it determines to be "detrimental to the best interests" of Medicare. In particular, the regulation lists "income tax evasion" as an offense for which billing privileges may be revoked. ALJ Decision at 1. The ALJ stated that the Secretary had determined tax evasion to be detrimental to Medicare "as a matter of law." Id. at 3. Thus, the ALJ concluded that she did not have the authority to second-guess CMS's exercise of discretion in deciding to revoke Dr. Bussell's billing privileges given that her undisputed conviction gave CMS a legal basis for its determination. Id.

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[8] At a telephone prehearing conference before the ALJ, the parties agreed that there was no factual dispute as to Dr. Bussell's February 6, 2002 conviction for felony tax evasion in violation of 26 U.S.C. § 7201 in the United States District Court for the Central District of California. ALJ Order (dated August 10, 2007) at 1.

[9] Dr. Bussell claimed that her conviction was due to poor tax advice from her accountant and illegal conduct by her business manager and attorney. Petitioner's Response Br. in CRD Dkt. No. C-07-514, at 5-6.

Standard of Review

The Board's standard of review on a disputed factual issue is whether the ALJ decision or ruling is supported by substantial evidence in the record. *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare* (at http://www.hhs.gov/dab/guidelines/prosupenrolmen.html). The standard of review on a disputed issue of law is whether the ALJ decision or ruling is erroneous. Id.

Discussion

A. *Dr. Bussell's April 28, 2008 request for review is timely.*

Although the ALJ Decision is dated December 14, 2007, Dr. Bussell asserts in her pro se filing dated April 28, 2008 that her request for review is timely because she did not receive the decision until April 24, 2008 after it was "resent" on March 27, 2008. P. Br. at 2. Dr. Bussell provides a photocopy of a postal return receipt form dated March 27, 2008. Id. at Ex. 1.

We take judicial notice that the Civil Remedies Division (CRD) of the Departmental Appeals Board has a return receipt indicating that an earlier mailing of the decision, postmarked December 18, 2007, was returned "unclaimed" to CRD. CRD also has a record of re-sending the decision on March 27, 2008. It is irrelevant whether, as Dr. Bussell suggests, the misspelling of her name resulted in the failure of delivery of the first mailing, or whether some other cause was involved. Id. at 2.

The evidence of the returned mailing of the ALJ Decision in the case record substantiates Dr. Bussell's assertion that she never received the earlier mailing. Her statements about the date when delivery actually occurred are corroborated by the case record evidence of the re-sending date and Dr. Bussell's delivery receipt.

The regulatory presumption that receipt is calculated as five days from the date of the notice is rebuttable by a showing to the contrary. 42 C.F.R. § 498.22(b)(3). The record here supports an adequate showing that Dr. Bussell did not receive the original mailing of notice of the December 14, 2007 decision, and that she received the decision only after the March 27, 2008 mailing. Even assuming that delivery of the March 27, 2008 mailing was effectuated within five days of mailing,

Dr. Bussell's filing on April 28, 2008 is timely. Thus, we next address the merits in this case.

B. *CMS has determined the felonies listed in section 424.535(a)(3)(i) to be detrimental* per se *to the best interests of the Medicare program and its beneficiaries.*

As previously noted, section 424.535(a)(3) permits CMS to revoke a supplier's Medicare billing privileges based on conviction for a felony offense that it determines to be "detrimental to the best interests of the program and its beneficiaries." Among the offenses listed are "financial crimes, such as . . . income tax evasion." Section 424.535(a)(3)(i)(B). According to Dr. Bussell, the language in this section means that while felony tax evasion may result in revocation, it is not detrimental per se to the program and beneficiaries. P. Br. at 3.

Dr. Bussell argues that the regulatory text does not explicitly state that all offenses listed in section 424.535(a)(3)(i) are detrimental per se. Id. While the regulatory language, read alone, arguably might support a reading that CMS has discretion to determine whether a particular instance of a listed offense is detrimental, the regulatory preamble illuminates the agency's intention. The preamble specifically establishes that "felonies that we determine to be detrimental to the Medicare program or its beneficiaries include . . . income tax evasion." 71 Fed. Reg. 20,768 (emphasis added). When section 424.535(a)(3) is considered in the context of the preamble, it is clear that CMS has determined that income tax evasion by a provider is detrimental per se to the program and its beneficiaries. Thus, the ALJ correctly states that "as a matter of law," income tax evasion is detrimental to Medicare.[10] ALJ Decision at 2.

The discretion that section 424.535(a)(3) grants to CMS lies in CMS's authority to decide whether to revoke billing privileges based on a felony conviction, such as income tax evasion, that is detrimental per se to Medicare. In the instant case, CMS

[10] The Board recently addressed this issue in Robert F. Tzeng, M.D., DAB No. 2169 (2008). Although the matter of detriment was not at issue in Dr. Tzeng's appeal, the Board stated that such an argument would be meritless in any event because CMS determined when it published the regulation that income tax evasion is detrimental as a matter of law. Id. at 8, n.11.

obtained information that Dr. Bussell was convicted of felony income tax evasion, a per se detrimental offense.

Once CMS established this legal basis on which to proceed, its subsequent action to revoke was a reasonable and permissible exercise of the discretion granted to it under section 424.535(a)(3).[11]

C. *Use of the word "and" in section 424.535(a)(3) in place of "or" used in section 1842(h) of the Social Security Act does not create a higher standard for detriment.*

Section 1842(h)(8) of the Act, which authorizes the Secretary to terminate agreements with providers and suppliers who have been convicted of felony offenses, requires that the Secretary find the conviction to be "detrimental to the best interest of the program or program beneficiaries" (emphasis added) before billing privileges may be revoked. This language differs from that in the regulation later promulgated, which states that the conviction must be detrimental to "the program and its beneficiaries."[12] 42. C.F.R. § 424.535(a)(3) (emphasis added). Dr. Bussell contends that this change in wording between the Act

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[11] Furthermore, even were we to accept Dr. Bussell's reading, which we do not, the determination that her income tax evasion was detrimental to the program and beneficiaries would clearly be within CMS's discretion to make and in no way arbitrary or capricious.

[12] Dr. Bussell also asserts that the wording in 42 C.F.R. § 424.535 should control over the wording of section 1842(h) of the Act because the regulation was promulgated after the statute. This argument is meritless. Section 424.535(a)(3) is CMS's implementation of the statute, not a replacement for the statute. Agencies must defer to "the expressed intent of Congress" when construing the statutes governing the regulations. Chevron U.S.A., Inc. v. Natural Res. Def. Council, 467 U.S. 837, 843 (1984). Hence, the statute controls over the regulation even though the implementing regulation is, of course, issued after the statute. While an agency may, by regulation, choose to limit the exercise of discretion granted by statute, the agency may not by regulation seek to expand its discretion beyond that granted by statute. In this section, therefore, we address not which legal authority existed first, but whether the regulatory language narrowed the scope of CMS's discretion by requiring a two-prong finding as Dr. Bussell contends. We conclude it did not.

and the regulation is significant in that it creates a higher standard for detriment, requiring CMS to show that the conviction harmed both the Medicare program and its beneficiaries. P. Br. at 3-4. This higher standard, according to Dr. Bussell, would protect the "well-treated patients" of a "caring competent physician" from losing access to a provider. Id. For the reasons explained below, we do not agree with Dr. Bussell's premise that the regulations create a different, narrower test for whether an offense is "detrimental."

Dr. Bussell cites to nothing to support her suggestion that the regulatory reference to detriment to the program and its beneficiaries was intended to impose an additional requirement on CMS to show that some separate detriment would impact an individual beneficiary as well as the program. On the contrary, the preamble to the regulation phrases the determination of detriment in terms of program "or" beneficiaries, just as the statute does. 71 Fed. Reg. 20,768. The preamble thus suggests that the agency did not intend to create a meaningful distinction between the two phrasings.

CMS could reasonably read the "and" in the regulation to reflect its conclusion that the interests of the program and the beneficiaries are aligned so that any detriment to one entity inevitably conflicts with the interests of the other. Under that reading, the finding that an offense is detrimental to the program or its beneficiaries is the same as a finding that the offense is detrimental to the program and its beneficiaries. We note in this regard that the statute does not imply that the "detrimental" determination is to be made about any specific individual beneficiaries but rather about beneficiaries collectively. Beneficiaries as a collective group have interests in the program that go well beyond whether a physician's health care is competent.

Contrary to Dr. Bussell's theory, CMS's reading that the regulation merely intended to track the statute is more consistent with the purpose behind both, i.e., to protect the program and its beneficiaries from potential harm in dealing with those guilty of certain kinds of criminal behavior. The preamble indicates that financial crimes undermine the honesty and integrity of the physicians providing services and claiming payment under the Medicare program, thereby placing the entire program in jeopardy. Id. Protecting the Medicare program from financial irresponsibility and fraud is an essential part of protecting beneficiaries by assuring that funds are available to provide them with necessary services and to preserve their access to providers who operate with integrity.

Finally, even had we accepted Dr. Bussell's interpretation of the regulation, we would have concluded that CMS reasonably concluded that an income tax evasion conviction meets the two-prong standard that she suggests. Dr. Bussell contends that her offense did not harm Medicare beneficiaries because the quality of care that she provided to her patients was unaffected by the conviction. Contrary to Dr. Bussell's assertions, however, beneficiaries' access to care is not dependent on any one physician. As the preamble makes clear, irresponsible handling of federal funds by any physician could affect the availability of care for all beneficiaries, not only the beneficiaries under Dr. Bussell's care. The quality of Dr. Bussell's care is simply not relevant to the issue of whether financial misconduct is detrimental to the best interests of Medicare beneficiaries as a whole.

D. *The ALJ did not have authority to substitute her own discretion for that of CMS in determining whether Medicare billing privileges should be revoked.*

Dr. Bussell's final contention that the ALJ should have reviewed CMS's determination as a case-specific exercise of discretion is without merit. Dr. Bussell asserts that revocation of Medicare billing privileges must be "subject to judicial discretion, based on the particular aspects of each case." Reply Br. at 5. CMS disputes Dr. Bussell's contention, arguing that neither the ALJ nor this Board have the authority to "interject [ourselves] into the discretionary enforcement processes of CMS." Response Br. at 8.

Section 1842(h) of the Act explicitly places the authority to make the determination of whether an offense is detrimental with the Secretary. The implementing regulations at section 424.535(a)(3) delegate that authority to CMS, not to the ALJ.

Furthermore, the regulations, as we have found above, embody CMS's determination that income tax evasion is an offense detrimental to the program and to its beneficiaries. CMS made this determination with regard to felony income tax evasion after a formal notice and comment rulemaking procedure. Moreover, contrary to Dr. Bussell's contentions, nothing in the regulation constrains CMS to make its determination individually on a case-

by-case basis, and the administrative burden of doing so would be substantial.[13]

The ALJ's review of CMS's revocation of Dr. Bussell's Medicare billing privileges is thus limited to whether CMS had established a legal basis for its actions. Once Dr. Bussell acknowledged that she was indeed convicted of income tax evasion, the legal basis for CMS's action was established. In other words, the right to review of CMS's determination by an ALJ serves to determine whether CMS had the authority to revoke Dr. Bussell's Medicare billing privileges, not to substitute the ALJ's discretion about whether to revoke. Michael J. Rosen, M.D., DAB No. 2096 (2007), at 14. Once the ALJ found that both elements required for revocation were present (i.e. (1) felony conviction and (2) CMS's determination that the offense is detrimental), the ALJ was obliged to uphold the revocation, as are we.

[13] In Tzeng, we stated that Congress's omission of a specific list of felonies considered to be detrimental to Medicare from section 1842(h) of the Act "indicates that the statute authorizes the Secretary to determine on a case-by-case basis what felonies are detrimental to the Medicare program." Tzeng, DAB No. 2169 at 16 n.18. This statement is distinguishable from Dr. Bussell's argument. The authority to make a case-by-case determination as to what felonies are detrimental is specifically given to the Secretary, not to the ALJ. The quoted language from Tzeng refers to the Secretary's authority to determine that particular felonies as a class are detrimental. Once the Secretary, as here, has exercised that authority by regulation as to a class of felonies, an ALJ cannot revisit that determination in an individual case where the conviction of an offense in the class is undisputed.

Conclusion

For the reasons discussed, we affirm the ALJ Decision upholding the revocation of Dr. Bussell's billing privileges.

/s/
Judith A. Ballard

/s/
Sheila Ann Hegy

/s/
Leslie A. Sussan
Presiding Board Member