Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Robert D. Oakley, M.D.,	)	Date: December 29, 2009
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-09-581
	)	Decision No. CR2051
Centers for Medicare & Medicaid Services.	)	
	)	
	)	

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to revoke the Medicare enrollment of Petitioner, Robert D. Oakley, M.D., for a period of three years.

I. Background

Petitioner is a physician who participated in the Medicare program. Petitioner was licensed to practice medicine in the state of Colorado until May 21, 2008, when an Interim Agreement for Cessation of Practice reached by Petitioner and the Colorado State Board of Medical Examiners (Board) became effective. The State Board reviewed information that raised concerns that Petitioner had a disability that rendered him unable to practice medicine with reasonable skill and safety to patients. Based on this information and in lieu of a summary suspension by the Board, Petitioner voluntarily agreed to cease his practice of medicine while the agreement remains in effect. The agreement states that it will remain in effect until the Board later determines whether Petitioner is able to practice medicine with reasonable skill and safety. CMS Ex. 6. Petitioner did not inform CMS or its Medicare contractor, TrailBlazer Health Enterprises, that he had agreed to cease the practice of medicine for an indefinite period of time in lieu of a summary suspension by the Board. CMS Ex. 6.

On February 16, 2009, TrailBlazer, a contractor acting on CMS's behalf, advised Petitioner that his Medicare billing privileges were revoked. The grounds for revocation were that under the applicable regulations, Petitioner was not in compliance with Medicare enrollment requirements because he did not report the adverse legal action taken against him by the Board.[1] Petitioner requested reconsideration of this determination and reconsideration was denied. Petitioner then requested a hearing and the case was assigned to me for a hearing and a decision.[2]

The parties agreed that this matter could be decided on the basis of the written submissions. CMS therefore submitted its Motion for Summary Disposition of the case, together with its brief in support of the Motion and CMS Exhibits (Exs.) 1-15. Petitioner submitted his responsive brief together with Petitioner Exhibits (P. Exs.) 1-7.[3] CMS then submitted its reply. I receive and admit all of the exhibits into the record of this case.

II. Issue, findings of fact and conclusions of law

A. Issues

The issue in this case is whether a basis exists for CMS to revoke Petitioner's Medicare billing privileges.

B. Findings of fact and conclusions of law

I make findings of fact and conclusions of law (Findings) to support my decision. I set forth each Finding below as a separate heading.

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[1] The regulation requires that these changes be reported to the CMS contractor within 30 days. *See* 42 C.F.R. § 424.516(d)(1). There is no evidence that Petitioner reported the action taken by the Board at all — either within 30 days or 90 days for "other changes."

[2] The contractor's reconsideration decision, at my request, was amended and reissued on August 26, 2009. Petitioner then filed an amended hearing request on September 11, 2009.

[3] CMS argues against the admission of Petitioner's Exhibits (P. Exs.) 6 and 7 because he is precluded from introducing new evidence before me if it was not presented to the contractor before it issued its decision. 42 C.F.R. § 405.874(c)(5). As for P. Exs. 1-5, CMS objects to these as well. These documents are copies of CMS issuances which were issued after the February 2009 revocation action.

1. CMS is authorized to revoke Petitioner's Medicare billing privileges.

CMS revoked Petitioner's Medicare billing privileges pursuant to the authority granted by section 1866(j) of the Social Security Act (Act) and by implementing regulations at 42 C.F.R. § 424.535. The Act empowers the Secretary of this Department to refuse to enter into an agreement, or to terminate an agreement, with any physician or supplier that is not in substantial compliance with the provisions of the Medicare program. Act § 1866(b)(2). The implementing regulation delegates to CMS the Secretary's statutory authority to revoke billing privileges of providers and suppliers. 42 C.F.R. § 424.535(a).

A person whose billing privileges are revoked by CMS for one of the reasons enumerated at 42 C.F.R. § 424.535 may request a hearing to challenge the determination. 42 C.F.R. § 498.3(b)(17). What may be challenged in such a hearing is whether a regulatory basis exists to revoke the provider's billing privileges. What may not be challenged is whether CMS – assuming it has the authority to revoke – properly exercised its discretion to invoke that authority in an individual case. Nothing in the regulations suggests that I may look behind CMS's exercise of discretion and substitute my judgment for that of CMS in deciding whether to revoke billing privileges in the individual case where the authority to revoke is present.

Petitioner contends that CMS is not authorized to revoke his billing privileges notwithstanding these undisputed facts. Petitioner asserts that the Interim Agreement for Cessation of Practice was not a change that he was required to report to the Medicare contractor or an "adverse legal action" requiring reporting under the revised regulations.

I disagree. Under the Act, the 2008 regulations or the regulations that became effective on January 1, 2009, CMS was authorized to revoke Petitioner's billing privileges because Petitioner failed to report changes to the information in his Medicare Enrollment Application. Specifically, at no time prior to receipt of the notice of revocation on February 16, 2009 did Petitioner inform CMS or TrailBlazer that he had reached an agreement with the Board to cease practicing medicine for an indefinite period of time.

Petitioner does not dispute that the regulations in effect at the time of execution of the agreement required Petitioner to report within 90 calendar days any changes to the information in his enrollment application and that failure to do so can result in revocation of the provider/supplier's Medicare billing privileges. 42 C.F.R. § 424.520(b) and 42

C.F.R. § 424.535(a)(1) (2008). Petitioner also does not dispute that in May 2007, he certified to the following by signing his Medicare enrollment application:

> I authorize the Medicare contractor to verify the information contained herein. I agree to notify the Medicare contractor of any future changes to the information contained in this form within 90 days of the effective date of the change.

CMS Ex. 11, at 28 [Petitioner's application for Medicare enrollment dated May 10, 2007]. That application also put the Petitioner on notice that all adverse legal actions must be reported, regardless of whether any records were expunged or any appeals were pending. The application specifically provides that a suspension of a license to provide health care by any State licensing authority, including a voluntary surrender of such a license while a formal disciplinary proceeding is pending before a State licensing authority, is considered an adverse legal action that must be reported. CMS Ex. 11, at 5.

Effective January 1, 2009, the Secretary amended the regulations to require physicians to now report certain events within a 30-day period; all other changes were to be reported within the previous 90-day timeframe. That regulation specifically stated that any adverse legal action, such as suspension or revocation of a license to provide health care by any State licensing authority, must be reported with 30 days of the event. 42 C.F.R. § 424.516(d); 73 Fed.Reg. 69726, 69939 (November 19, 2008). Section 424.535 also was amended to specifically provide for the revocation of a physician's enrollment and billing privileges in Medicare for failure to report any such adverse legal action. Thus, whatever version of the regulations may arguably control this situation, the result is still the same: Petitioner was required to report to CMS and the Medicare contractor that his license was suspended. Under either the 2008 regulations or the 2009 regulations, Petitioner failed to report the required change within 90 days or the more restrictive 30 day period.

Petitioner contends that the Interim agreement to Cessation of Practice is not a suspension of his license to practice Medicine and did not affect Petitioner's eligibility to provide services. P. Brief, 13-14. Again, I disagree. The distinction that Petitioner seeks to make is truly a distinction without a difference. The effect of his agreement with the Board was that he would cease to practice medicine immediately because there were concerns that Petitioner could not practice medicine with reasonable skill and safety to his patients because of an alcohol disorder. He further agreed to desist from the practice of medicine until such time as the Board could evaluate whether Petitioner could resume the practice of medicine with reasonable skill and safety.[4] CMS Ex. 6. Whether the

[4] On June 8, 2009, the Board issued its final order and restricted Petitioner from practicing medicine as a sole practitioner or in any setting as a sole physician and placed Petitioner on probation for five years with restrictions. CMS Ex. 12.

nomenclature calls the event a cessation of Petitioner's medical practice or a suspension of his license to practice medicine, when the duly-empowered state licensing authority ordered Petitioner to stop practicing medicine and that order continues in effect for an indefinite period, the event amounted to a suspension of Petitioner's license and he was thereafter clearly not eligible for Medicare enrollment. It seems almost unnecessary to point out that Medicare enrollment is not an entitlement, and that a provider or supplier must prove its eligibility for enrollment and its continuing eligibility for enrollment.[5] Thus, Petitioner was required to report this information and his failure to do so was a basis for revocation.

2. Petitioner does not have a right to a hearing to challenge the duration of his billing privileges revocation.

CMS has authority to determine the duration of a provider's billing privileges revocation in any case where it has the authority to impose revocation. 42 C.F.R. § 424.535(c):

> After a provider, supplier . . . has had their billing privileges revoked, they are barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar. The re-enrollment bar is a minimum of 1 year but not greater than 3 years depending on the severity of the basis for revocation.

CMS determined to bar Petitioner from re-enrolling for a period of three years, citing this regulation as authority. Petitioner has no right to a hearing to challenge the duration of his revocation. As I discuss above, at Finding 1, Petitioner's right to a hearing in this case is limited to challenging whether CMS has authority to revoke his billing privileges.

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[5] The Order barring Petitioner from practicing medicine is sufficient in and of itself as a basis for revocation; if he cannot practice medicine, he cannot possibly be eligible to enroll in Medicare as a physician. Essentially, if he is not operational he cannot provide the services to Medicare beneficiaries for which he was enrolled to provide. *See* 42 C.F.R. § 424.535(a)(5)(2008). I further note that under section 1128(b)(4) of the Act, and 42 C.F.R. § 1001.501, the Secretary's Inspector General would be authorized to exclude Petitioner from participating in Medicare and any state health care program because his license to practice medicine was suspended or surrendered while a formal disciplinary proceeding concerning the individual's professional competence, professional performance or financial integrity was pending before a State licensing authority and the length of the exclusion is commensurate with the period of time during which the license is suspended or otherwise not in effect.

The regulation which establishes Petitioner's right to a hearing makes this plain. The right to a hearing is limited to challenging CMS's determination whether to revoke billing privileges. It does not extend to challenging CMS's judgment as to the duration of revocation. Thus, a provider or a supplier whose billing privileges are revoked may request a hearing only to challenge CMS's determination "[w]hether to deny or revoke" his or her enrollment. 42 C.F.R. § 498.3(b)(17).

/s/
Richard J. Smith
Administrative Law Judge