Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	
Robert F. Tzeng, M.D.,	DATE: April 3, 2008
Petitioner,	App. Div. Docket No. A-08-31
- v. -	Decision No. 2169
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Robert F. Tzeng, M.D., a California-based physician, appeals a September 27, 2007 decision by Administrative Law Judge (ALJ) José A. Anglada upholding a Medicare contractor's determination, pursuant to 42 C.F.R. § 424.535(a)(3), to revoke Dr. Tzeng's Medicare billing privileges because of his 1998 conviction for income tax evasion. Robert F. Tzeng, M.D., DAB CR1665 (2007) (ALJ Decision). Section 424.535(a)(3) authorizes the Centers for Medicare & Medicaid Services (CMS) to revoke the Medicare billing privileges of a physician with a felony conviction that it finds detrimental to the Medicare program if the conviction occurred within 10 years preceding the physician's "enrollment or revalidation of enrollment." Dr. Tzeng contends, as he did below, that the revocation was unlawful because his 1998 conviction did not occur within 10 years preceding enrollment or revalidation of enrollment. Dr. Tzeng also contends that section 424.535(a)(3), as applied to him, is impermissibly retroactive. Although our analysis of these contentions differs from the ALJ's, we agree with him that the contentions are meritless and thus affirm his ultimate conclusion that CMS lawfully revoked Dr. Tzeng's 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.[2] 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 when it is found to meet Medicare program requirements), 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 enrollment requirements and procedures.[3] Final Rule, *Medicare*

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

[2] "Providers" are hospitals, nursing facilities, or other medical institutions. 42 C.F.R. § 400.202. "Suppliers" include physicians and other non-physician health care practitioners. Id. (stating that, unless the context indicates otherwise, "[s]upplier means a physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare").

[3] 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.

(continued...)

Program; Requirements for Providers and Suppliers to Establish and Maintain Medicare Enrollment, 71 Fed. Reg. 20,754 (Apr. 21, 2006) (Final Rule).[4] 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;
>
> (2) Validation of the provider's or supplier's eligibility to provide items or services to Medicare beneficiaries;
>
> (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.

42 C.F.R. § 425.502.

In section 424.510, the subpart P regulations set out requirements for enrolling in the Medicare program, one of which is the submission of verifiable "enrollment information on the applicable enrollment application." 42 C.F.R. § 424.510(a),

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[3](...continued)
No. 108-173, § 936, 117 Stat. 2066, 2411-12 (2003).

[4] 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.

(d)(4). Since at least the mid-1990s, the "applicable enrollment application" has been the CMS-855.[5]

In section 424.515, the subpart P regulations specify what an enrolled provider or supplier must do to "maintain" its Medicare billing privileges:

> To maintain Medicare billing privileges, a provider or supplier (other than a DMEPOS 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.[6] 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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[5] See 61 Fed. Reg. 37,278 (July 17, 1996); 64 Fed. Reg. 3637, 3643 (Jan. 25, 1999).

[6] 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."[7] 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, the subpart P regulations authorize 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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> * * *
>
> (B) Financial crimes, such as extortion, embezzlement, *income tax evasion*, insurance

[7] 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").

> fraud and other similar crimes for which the 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. Tzeng that his 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. Tzeng was convicted on February 4, 1998 of federal income tax evasion. NHIC further indicated that its revocation decision was based on section 424.535(a)(3)(i)(B), which, as indicated, authorizes CMS to revoke the Medicare billing privileges of a physician who has been convicted of felony income tax evasion within 10 years preceding enrollment or revalidation of enrollment. Id.

After a contractor hearing officer affirmed NHIC's decision (CMS Exhibit 2), Dr. Tzeng requested an ALJ hearing. CMS and Dr. Tzeng subsequently agreed that an in-person hearing was unnecessary and that the ALJ could render a decision concerning the validity of the revocation based on their briefs and documentary evidence.

While Dr. Tzeng admitted to having been convicted of felony income tax evasion in February 1998,[8] he contended that section 424.535(a)(3) was inapplicable because his conviction did not occur within 10 years preceding enrollment or revalidation of enrollment. Petitioner's Response Br. in CRD Dkt. No. C-06-324, at 8-9 (June 21, 2007). Dr. Tzeng also contended that his felony offense was not "detrimental to the best interests of the [Medicare] program and its beneficiaries," contrary to what section 424.535(a)(3) requires. Id. at 7, 9-11. Finally, Dr. Tzeng contended that the revocation was based on an unlawful retroactive application of section 424.535(a)(3). Id. at 3-7.

The ALJ rejected all of these contentions and upheld the revocation. Regarding the latter contention, the ALJ found that there was no retroactivity in this case because section 424.535(a)(3) "implements" section 1842(h)(8) of the Act and because that statutory provision was in effect when Dr. Tzeng was convicted of income tax evasion.[9] ALJ Decision at 6. Section 1842(h)(8) authorizes the Secretary of HHS to terminate or refuse to renew Medicare's "agreement with a physician or supplier under this subsection" if the Secretary determines that the physician or supplier has been convicted of an offense that is "detrimental to the best interests of" Medicare.[10] Because that provision predates Dr. Tzeng's conviction, said the ALJ, it was "not relevant to Petitioner's appeal that the Secretary established in 2006 that income tax evasion is an offense that is detrimental to the best interests of the Medicare program or program beneficiaries." Id.

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

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[8] In a brief submitted to the ALJ, Dr. Tzeng affirmed that, on February 4, 1998, he was convicted in the United States District Court for the Central District of California of one count of felony income tax evasion in violation of 26 U.S.C. § 7201. Petitioner's Response Brief (dated June 21, 2007) at 2.

[9] Section 1842(h)(8) was enacted as part of the Balanced Budget Act of 1997. Pub. L. No. 105-33, § 4302(b), 111 Stat. 382.

[10] The "agreement" to which section 1842(h)(8) refers is an agreement with Medicare to become a "participating physician or supplier." Act § 1842(h)(1).

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

In this appeal, Dr. Tzeng abandons his contention that the 1998 income tax evasion conviction was not detrimental to the best interests of the Medicare program or its beneficiaries.[11] However, Dr. Tzeng reasserts his other two contentions: first, that his 1998 conviction was not a valid or sufficient basis for revocation because it did not occur within the 10-year period specified in section 424.535(a)(3); and, second, that he is being subjected to an unlawful retroactive application of section 424.535(a)(3). We find no merit to either contention.

A. *Dr. Tzeng's February 1998 conviction for income tax evasion occurred within the 10 years preceding enrollment or revalidation of enrollment.*

As noted, section 424.535(a)(3) permits CMS to revoke a provider's or supplier's billing privileges based on a felony conviction (including one for income tax evasion) that occurred "within the 10 years preceding enrollment or revalidation of enrollment." According to Dr. Tzeng, the term "enrollment," as used in the phrase "within the 10 years preceding enrollment," refers to a provider's or supplier's "initial" Medicare enrollment. P. Br. at 2. Dr. Tzeng asserts that he initially enrolled in Medicare in 1983, that he remained continuously enrolled until February 17, 2007 (the effective date of the challenged revocation), and that his income tax conviction occurred in 1998, more than 10 years after initial enrollment. P. Br. at 3. Thus, he maintains that his conviction did not occur "within 10 years preceding enrollment" within the meaning of section 424.535(a)(3). Id.

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[11] That contention is meritless in any event. In publishing section 424.535(a)(3), CMS determined that income tax evasion is, as a matter of law, "detrimental to the best interests" of Medicare. 71 Fed. Reg. at 20,768 (indicating that the felonies listed in section 424.535(a)(3) are ones that CMS has determined to be detrimental to the best interests of the Medicare program and its beneficiaries).

Dr. Tzeng also asserts that he has "never been asked to resubmit or recertify the accuracy of his enrollment application for purposes of revalidating his enrollment as a Medicare provider." P. Br. at 4 (emphasis in original). Thus, he contends that there is no basis to find that his conviction occurred within 10 years preceding "revalidation of enrollment." Id.

CMS does not dispute Dr. Tzeng's assertions that he was first enrolled in 1983 and remained continuously enrolled from 1983 to February 2007, nor does CMS claim that its contractor sent a revalidation request to Dr. Tzeng prior to revoking his billing privileges. Instead, CMS contends that Dr. Tzeng misinterprets section 424.535(a)(3) as giving "safe harbor" to convicted felons who are neither "prospective" enrollees nor enrollees seeking revalidation. Response Br. at 5-6. CMS asserts that Dr. Tzeng's interpretation has "the illogical effect of discriminating among convicted felons based on the arbitrary circumstance of their Medicare enrollment status, rather than the character of the antecedent conduct deemed to be detrimental to the Medicare program," and thus subverts the congressional objective of "'protect[ing] beneficiaries and the Medicare Trust Funds by preventing unqualified, fraudulent, or excluded providers and suppliers from providing items or services to Medicare beneficiaries or billing the Medicare program or its beneficiaries.'" Response Br. at 5-6 (quoting 71 Fed. Reg. at 20,754).

We find it unnecessary to address the interpretive issues raised by CMS because we find that Dr. Tzeng's conviction occurred within the timeframes specified in section 424.535(a)(3). We note first that the term "enrollment" in the subpart P regulations is defined as a "process" that Medicare uses to establish a provider's or supplier's eligibility to submit claims for Medicare covered services. 42 C.F.R. § 424.502. That process involves not only submission of the standard application form, but CMS's review – and, if necessary, verification – of information bearing upon an applicant's eligibility. Id. § 424.502 (defining the term "enrollment" to include CMS's "[v]alidation of the provider's or supplier's eligibility to provide items or services to Medicare beneficiaries"), 424.520(a) (stating that CMS "enrolls" a provider or supplier when "CMS verifies that it meets" certain requirements).[12]

[12] See also 42 C.F.R. §§ 424.510(d)(4) (information submitted on the enrollment application "must be such that CMS can validate it for accuracy at the time of submission"),

(continued...)

We further note that CMS's objective in issuing the subpart P regulations was to have *all* providers and suppliers – including those (like Dr. Tzeng) currently participating in the Medicare program – re-establish or verify their program eligibility. To that end, the new regulations require all providers and suppliers to submit a completed Medicare enrollment application, the CMS-855, or to update and certify the accuracy and completeness of information on a previously submitted CMS-855. 42 C.F.R. § 424.515; 71 Fed. Reg. at 20,758-79. By requiring existing program participants to submit the standard enrollment application or verify their program eligibility, the new regulations effectively require them to re-enroll in the program.

Shortly after June 20, 2006, CMS's contractor acquired and reviewed information relating to Dr. Tzeng's 1998 income tax evasion conviction. Because a prior conviction is an occurrence that may affect a physician's eligibility for Medicare enrollment (see, e.g., section 1128 of the Act and 42 C.F.R. § 424.530(a)(2)), and because Dr. Tzeng was obligated to re-establish his eligibility for Medicare enrollment after June 20, 2006, the contractor was engaged in an "enrollment" process when it acquired and reviewed information about Dr. Tzeng's 1998 conviction. 42 C.F.R. § 424.502 (defining enrollment as a "process" that includes validation of eligibility). The conviction occurred less than 10 years before that process began. We thus conclude that Dr. Tzeng's conviction occurred within 10 years preceding enrollment.

Alternatively, we conclude that the conviction occurred within 10 years preceding "revalidation of enrollment." As noted, section 424.515 requires all providers and suppliers "currently billing the Medicare program" to "complete the applicable enrollment application." Information provided on the application is a basis for revalidation of the current participant's enrollment.[13] According to the Final Rule's preamble, revalidation is a "process" in which the provider or supplier is asked to submit an

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[12](...continued)
424.510(d)(8) (stating that CMS "reserves the right, when deemed necessary, to perform on-site inspections of a provider or supplier to verify that the enrollment information submitted to CMS or its agents is accurate and to determine compliance with Medicare enrollment requirements").

[13] 71 Fed. Reg. at 20,759 (stating that CMS would verify the accuracy of reported information on the applicable CMS-855 "[a]s part of the revalidation process").

enrollment application (or to update information on a previously submitted application) and to certify the accuracy of required enrollment information.[14] The revalidation process is intended to "ensure that [CMS] collect[s] and maintain[s] complete and current information on all Medicare providers and suppliers and ensure[s] continued compliance with Medicare requirements." 71 Fed. Reg. at 20,768.

Shortly after the effective date of the Final Rule, CMS's contractor obtained information about Dr. Tzeng's 1998 conviction, information that he would have been required to provide in a CMS-855 after a formal revalidation request.[15] CMS never made such a request, and Dr. Tzeng contends that this fact precludes a finding that his conviction occurred within 10 years preceding revalidation of enrollment. However, section 424.535(a)(3) does not require that the disqualifying conviction occur within 10 years preceding a *request* for revalidation. It merely provides that the conviction must have occurred within 10 years preceding "revalidation." As indicated, revalidation is a process that involves not only the submission of information by the participant, but CMS *verification* of continued eligibility for enrollment. 71 Fed. Reg. at 20,759 (stating the information submitted by an existing provider or supplier should include "any new or changed documentation" that is required by CMS to "verify the provider or supplier's continued eligibility to furnish services to beneficiaries in the Medicare program"). Because the acquisition and review of information about a prior conviction was undertaken to verify Dr. Tzeng's continued eligibility for enrollment in Medicare, that exercise was an attempt to revalidate his enrollment.

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[14] 71 Fed. Reg. at 20,758-59 (describing the requirements of section 424.515) and 20,765 ("We expect that a fee-for-service contractor would notify the provider or supplier in writing regarding the need to revalidate its enrollment information. Once notified, providers and suppliers would be expected to review, update, and submit any changes and supporting documentation regarding the enrollment record within 60 days.").

[15] The applicable enrollment application requires a physician to list any "adverse legal actions" levied or imposed upon him and to attach copies of official documentation relating to the adverse action. 68 Fed. Reg. 22,150 (CMS-855 for physicians and other suppliers). These adverse actions include "any felony conviction" whether or not healthcare-related. Id. at 22,151.

Dr. Tzeng would have us conclude that revalidation does not occur unless or until CMS requests revalidation, but the regulations do not compel that conclusion. To be more specific, there is nothing in section 424.515 that says or implies that revalidation is initiated or triggered *only* by a CMS request for information to the provider or supplier. In fact, section 424.515(d) suggests that revalidation may commence upon CMS's receipt of information from a source other than the provider or supplier: that provision states that CMS "reserves the right to perform off cycle revalidations in addition to the regular 5-year revalidations," and that off cycle revalidations "*may be triggered as a result of* random checks, information indicating local health care fraud problems, national initiatives, complaints, or other reasons that cause CMS to question the compliance of the provider or supplier with Medicare enrollment requirements" (italics added).

In any event, we can see no legitimate purpose for requiring CMS to make a revalidation request after coming into possession of information (such as a prior conviction) that demonstrates the physician's ineligibility or noncompliance with program requirements. In these circumstances, requiring CMS to ask the physician to revalidate his enrollment and then wait up to 60 days for the physician's response before determining that revalidation is underway for purposes of the 10-year rule would potentially subvert the goal of the Final Rule, which is to protect the Medicare program and its beneficiaries from untrustworthy or unqualified providers and suppliers.

B. *The revocation of Dr. Tzeng's billing privileges was not based on a retroactive application of 42 C.F.R. § 424.535(a)(3).*

Relying on Landgraf v. USI Film Products, 511 U.S. 244 (1994), Dr. Tzeng contends that the revocation was based on an impermissible retroactive application of section 424.535(a)(3). P. Br. at 5-9. He asserts that Congress did not authorize HHS to apply this regulation retroactively. Id. at 5-6. He further asserts that revocation under this regulation attached a "new disability" (loss of Medicare enrollment) to events completed before its promulgation (his income tax offense and resulting conviction). Id. at 6-7. Finally, Dr. Tzeng suggests that section 424.535(a)(3) altered the legal landscape that he relied upon in deciding to waive his constitutional rights and plead guilty to income tax evasion. Id. at 7-8. Dr. Tzeng asserts that, had he known in 1998 that CMS would issue section 424.535 and find income tax evasion to be "detrimental" to the Medicare

program, he "may not have decided to enter into a plea agreement at all." Id. at 7-8.

Landgraf held that a law is not retroactive merely because it is applied in a case arising from conduct that predates the law's enactment or because it "upsets expectations based in prior law[.]" 511 U.S. at 269 & n.24. Rather, a law operates retroactively if it "would impair rights a party possessed when he acted, increase a party's liability for past conduct, or impose new duties with respect to transactions already completed." Id. at 280; see also 511 U.S. at 270 (stating that a court must ask "whether the new provision attaches new legal consequences to events completed before its enactment"). The conclusion that a particular law operates retroactively should reflect a "judgment concerning the nature and extent of the change in the law and the degree of connection between the operation of the new rule and a relevant past event." Id. at 270. In turn that judgment should be informed or guided by "familiar considerations of fair notice, reasonable reliance, and settled expectations[.]" Id.

We conclude that section 424.535(a)(3), as applied to Dr. Tzeng, does not have retroactive effect. To the contrary, the regulation's effect — loss of enrollment and billing privileges beginning on February 17, 2007 — is wholly prospective. The regulation does not invalidate or impose additional requirements regarding payment claims made before its effective date, nor does it alter, or have the effect of altering, Dr. Tzeng's enrollment status in the period between the commission of his felony offense and the revocation's effective date.

Furthermore, Dr. Tzeng has made no attempt to show that he possessed — or that revocation impaired — a vested right in remaining eligible for Medicare participation following his criminal offense and resulting conviction.[16] Prior to the

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[16] Courts that have considered the issue have almost without exception concluded that a physician or other health care practitioner or entity does not have a protected interest in continuing eligibility for Medicare participation or reimbursement. See, e.g., Erickson v. United States ex. rel. Dept. of Health and Human Serv., 67 F.3d 858, 862 (9th Cir. 1995); Koerpel v. Heckler, 797 F.2d 858, 863-65 (10th Cir. 1986); Cervoni v. Secretary of Heath, Ed. and Welfare, 581 F.2d 1010, 1018-19 (1st Cir. 1998); Gellman v. Sullivan, 758 F. Supp. 830, 833-34 (E.D.N.Y. 1991); but see Ram v. Heckler, 792 F.2d 444, 447 (continued...)

effective date of the Final Rule, the law gave Dr. Tzeng no promise or assurance that his enrollment status would not be affected in the future by new regulations designed to strengthen safeguards against untrustworthy or unqualified providers and suppliers.

We thus see no basis to conclude that CMS's application of section 424.535(a)(3) "impair[ed] rights that [Dr. Tzeng] possessed when he acted" or "impose[d] new duties with respect to transactions already completed." The regulation merely permitted CMS to consider information about prior convictions to determine his eligibility for future Medicare participation. Cf. Association of Accredited Cosmetology Schools v. Alexander, 979 F.2d 859, 863-66 (D.C. Cir. 1992) (holding that a rule which allowed the Department of Education to determine eligibility for a federal loan program based on pre-rule default rates was not retroactive because it did not "undo[ ] past eligibility" but merely "look[ed] at schools' past default rates in determining future eligibility").

In addition, we do not agree that revocation "increased [Dr. Tzeng's] liability for past conduct." Revocation is a remedial measure whose purpose is not to punish the program participant for past misconduct but to protect the program and its beneficiaries from fraud, abuse, and other harm that might arise in the future. Thus, while CMS's revocation decision is a consequence of Dr. Tzeng's 1998 felony conviction, CMS did not exact punishment or hold Dr. Tzeng accountable or "liable" for his crime. Instead, CMS acted to protect the Medicare program and its beneficiaries from a physician who it had reason to believe might harm the program.

The remedial character of the governing law supported our rejection of a physician's retroactivity claim in Narendra M. Patel, DAB No. 1736 (2000), aff'd, Patel v Thompson, 319 F.3d 1317 (11th Cir. 2003). Patel involved the exclusion of a physician under section 1128 of the Act. In October 1998, the HHS Inspector General (I.G.) notified the petitioner, Dr. Patel, of its decision to exclude him from federal health care programs for 10 years pursuant to section 1128(a)(2), which requires the exclusion of any individual or entity that has been convicted of

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[16](...continued)
(4th Cir. 1986) (stating that the plaintiff physician's "expectation of continued participation in the Medicare program is a property interest protected by the Due Process Clause of the Fifth Amendment" but laying out no reasoning for that assertion).

a criminal offense "relating to neglect or abuse of patients in connection with the delivery of a health care item or service." DAB No. 1736, at 2. The statute required the I.G. to exclude Dr. Patel for a minimum of five years, but in its regulations the I.G. retained discretion to impose a longer exclusion. Id. at 3. Title 42 C.F.R. § 1001.102(b) lists the "aggravating" factors that the I.G. "may" consider in deciding whether to lengthen the period of exclusion beyond the mandatory minimum. Id. Section 1001.102(b) was amended in October 1998 to add two new aggravating factors, which the I.G. invoked to increase Dr. Patel's exclusion period from five to 10 years. Id.

In his appeal to the Board, Dr. Patel complained that the new aggravating factors had been applied retroactively to increase his exclusion period because the factors were added to section 1001.102(b) following his conviction (and after a state license revocation proceeding that was the basis for the I.G.'s reliance on one of the new aggravating factors). DAB No. 1736, at 23-24. However, the Board concluded that the I.G. had not applied the law retroactively because section 1001.102(b) did nothing more than guide or channel the I.G.'s discretion to increase the mandatory minimum exclusion period — discretion that the I.G. possessed prior to Dr. Patel's offense and medical license revocation. Id. at 25-26. The Board further indicated that the regulations "plainly did not provide for novel legal consequences to attach to conduct innocent at the time it was undertaken," and that Dr. Patel knew or should have known before he engaged in the conduct that the I.G. had authority under the pre-October 1998 regulations to impose an exclusion longer than the minimum. Id. at 26-27. In addition, and of particular relevance here, the Board observed that exclusion under section 1128 is a "future-oriented and remedial form of relief, rather than a backward-looking consequence for a past act." Id. at 25.

The Eleventh Circuit Court of Appeals upheld the Board's retroactivity ruling on the latter ground. Relying on a prior circuit decision[17] which held that section 1128 of the Act was a remedial not a punitive statute, the court determined that applying the new aggravating factors to Dr. Patel did not implicate retroactivity concerns outlined in Landgraf because the action taken by the I.G. was "prospective and intended to protect current and future federal medical program recipients from 'abusers of these programs.'" 319 F.3d at 1319-20. That reasoning is equally applicable to the revocation of Dr. Tzeng's billing privileges in view of section 424.535(a)(3)'s overriding

[17] Manocchio v. Kusserow, 961 F.2d 1539 (11th Cir. 1992).

remedial purpose. 71 Fed. Reg. at 20,773-74 (indicating that the Final Rule's provisions enable CMS "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").

Finally, we note that Dr. Tzeng has not alleged, much less shown, that considerations of reasonable reliance, fair notice, or settled expectations ought to be weighed in his favor. He does not, for example, allege or prove that he actually relied to his detriment on pre-June 2006 law governing Medicare enrollment, saying only that he "may" have decided to go to trial on the income tax evasion charge had he known that CMS would (in the Final Rule) classify his offense as "detrimental to the best interests of the program and its beneficiaries." Furthermore, Dr. Tzeng does not question the ALJ's reliance on section 1842(h)(8) or deny that this provision notified him prior to his conviction that CMS might limit or terminate his relationship with Medicare based on a determination that the conviction was detrimental to the best interests of Medicare. Nor does Dr. Tzeng suggest a reason why it would have been reasonable for him to expect that CMS would not make such a determination.[18] If anything, income tax evasion demonstrates untrustworthiness in dealings with the government, a trait that the Medicare program would understandably want to discourage or avoid.

[18] We note, and reject, Dr. Tzeng's suggestion that absent a list of specific felonies considered detrimental to the Medicare program, the statute does not provide notice that the Secretary could determine that tax evasion is such a felony. P. Br. at 7. If anything, Congress's not specifying the felonies encompassed by the statute indicates that the statute authorizes the Secretary to determine on a case-by-case basis what felonies are detrimental to the Medicare program.

Conclusion

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

/s/
Judith A. Ballard

/s/
Leslie A. Sussan

/s/
Sheila Ann Hegy
Presiding Board Member