Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Emmanuel Brown, M.D., (NPI: 1841397601)
and Simeon K. Obeng, M.D., (NPI: 1780775346),

Petitioners

v.

Centers for Medicare and Medicaid Services.

Docket Nos. C-10-443 and C-10-481

Decision No. CR2145

Date: June 9, 2010

DECISION

I grant the motions of the Centers for Medicare and Medicaid Services (CMS) for summary judgment, because I conclude that CMS had the authority to revoke each Petitioner's enrollment and billing privileges in the Medicare program for failing to report an adverse legal action under 42 C.F.R. § 424.535(a)(9), effective April 17, 2009. I also agree with CMS that Petitioners may not challenge on equitable grounds CMS's exercise of discretion to revoke enrollment where CMS shows it had authority to revoke and that Petitioners have no right to appeal the duration of a re-enrollment bar resulting from their revocation.

I. Background

Petitioners, Emmanuel Brown, M.D., and Simeon K. Obeng, M.D, are physicians that the District of Columbia (DC) Department of Health licensed. On April 17, 2009, the DC Department of Health summarily suspended Petitioners' licenses to practice medicine.[1]

[1] Petitioners' licenses were suspended for failing to conform to standards of acceptable conduct and prevailing practice within the field of medicine and demonstrating willful or careless disregard for the health, welfare, or safety of a patient. Brown CMS Ex. 1; Obeng CMS Ex. 1. Specifically, Petitioners shared the ultimate responsibility for ordering the administration of a general anesthesia drug to a patient for whom it was not medically indicated. The patient died shortly after administration. *Id*.

Brown CMS Ex. 1; Obeng CMS Ex. 1. Petitioners entered into a settlement (Consent Order) with the DC Board of Medicine, and the license suspensions were lifted on May 6, 2009.[2] Brown CMS Ex. 2; Obeng CMS Ex. 2.

By letters dated June 15, 2009, the Medicare contractor, Highmark Medicare Services (Highmark), revoked Petitioners' enrollment and billing privileges in the Medicare program effective April 17, 2009,[3] for failure to comply with Medicare enrollment criteria, namely that Petitioners did not possess valid state medical licenses. P. Exs. 1, 5 (citing 42 C.F.R. § 424.535(a)(1)). These notices explained that Petitioners could pursue two routes of appeal. First, if Petitioners believed that they were able to correct the deficiencies, Petitioners could submit a corrective action plan (CAP) within 30 days. Also, if Petitioners believed that the determination was not correct, they could request reconsideration before a hearing officer. P. Exs. 1, 5.

Petitioners pursued both avenues. They submitted the Consent Order settlement agreements as their CAPs. P. Exs. 3, 8. Highmark determined that the CAPs were insufficient to establish compliance and affirmed the determination to revoke enrollment. *Id*. Additionally, the contractor established a bar on Petitioners' re-enrollment in the program for a period of one year. *Id*. Petitioners also requested reconsideration. On reconsideration, the contractor determined that Petitioners' enrollment was properly revoked. However, the contractor based the revocation on Petitioners' failure to report the suspension of their medical licenses to the Medicare contractor under 42 C.F.R. § 424.535(a)(9).[4] P. Ex. 4, at 2. The contractor also affirmed the imposition of a one-year bar on re-enrollment in the Medicare program. P. Exs. 4, 9.

Petitioners submitted individual requests for a hearing before an Administrative Law Judge (ALJ). Petitioners' Hearing Requests (HRs). Petitioner Brown's appeal was

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[2] The Maryland Board of Physicians, which likewise suspended Dr. Obeng's license on August 17, 2009 based on the same disciplinary action, also licensed Dr. Obeng. Obeng CMS Ex. 2. This suspension was immediately stayed, and Dr. Obeng was placed on probation subject to the terms of the Consent Order, which he had previously entered into with the DC Board of Medicine. *Id*.

[3] Revocation usually takes effect 30 days after issuance of the revocation notice but, in the case of license suspension, revocation is effective on the date of the suspension. 42 C.F.R. § 424.535(g).

[4] The reconsiderations outlined that, under 42 C.F.R. § 424.535(a)(9), CMS may revoke a supplier's enrollment in the Medicare program for failing to comply with the reporting requirements specified in 42 C.F.R. § 424.516(d)(1)(ii) (requiring the supplier to report any adverse legal action within 30 days), and 42 C.F.R. § 424.502 (defining an adverse legal action as including a "[s]uspension . . . of a license to provide health care by any State licensing authority"). *See* P. Ex. 4, at 2.

initially assigned to Judge Smith, who conducted a Prehearing Conference on March 23, 2010. Petitioner Obeng's appeal was initially assigned to Judge Montaño. Both cases were transferred to me for hearing and decision pursuant to 42 C.F.R. § 498.44, which permits a Board Member to be designated to hear appeals taken under Part 498. I conducted a Prehearing Conference on March 29, 2010, as previously scheduled for Petitioner Obeng. Counsel for Petitioners moved for consolidation of these cases during the Prehearing Conference and then subsequently filed a Consent Motion to Consolidate Appeals. On April 1, 2010, I issued the Order of Consolidation and a revised Prehearing Order governing both appeals.

CMS filed nearly identical Motions for Summary Judgment and Partial Dismissal for Petitioner Brown (Brown CMS Br.) and Petitioner Obeng (Obeng CMS Br.). Eight proposed exhibits accompanied both filings, which in each case, CMS identified as CMS Ex. 1 – CMS Ex. 8.[5] I admit CMS's exhibits without objection.

In my April 1, 2010 revised Prehearing Order, I required Petitioners to label proposed exhibits in a specific manner and submit an exhibit list and witness list with proposed testimony by April 13, 2010. On April 12, 2010, Petitioners submitted a joint response brief (P. Br.), along with nine proposed exhibits. The exhibits were not properly identified, and no exhibit or witness list with proposed testimony was included. After CMS filed its Reply Brief (CMS Reply), Petitioners resubmitted their exhibits, renumbered as P. Ex. 1 – P. Ex. 9, along with a list of witnesses and statements of their proposed testimony (Proposed Testimony). CMS objected to Petitioners' late filing as incomplete (missing a page of P. Ex. 8), untimely, and irrelevant. Petitioners responded to the CMS objection and completed P. Ex. 8 (which, as CMS acknowledged, CMS previously submitted as Brown CMS Ex. 6).

I conclude that Petitioners' late submissions do not prejudice CMS. CMS had an opportunity to reply to Petitioners' late filings and did so. CMS had already received copies of all the exhibits. While the proposed witnesses and their testimony were not previously identified, they were hardly surprising, and I determine below that, in any case, none of the facts as to which Petitioners seek to testify is material to the outcome of these cases. I therefore admit Petitioners' completed exhibits and proposed testimony.

II. Issues

The issues in these cases are:

1. Whether summary judgment is appropriate;

2. Whether, as a matter of law, CMS properly revoked Petitioners' Medicare enrollment and billing privileges on one or both of the asserted bases; and

[5] To distinguish CMS's identically marked exhibits, I refer to these exhibits as either Brown CMS Ex. or Obeng CMS Ex.

3. Whether I have authority to review a one-year bar on re-enrollment in the Medicare program.

III. Discussion and conclusions of law

I make conclusions of law to support my decision in these cases. I set forth each conclusion below as a separate heading.

1. The case can be decided on CMS's motion for summary judgment.

The Departmental Appeals Board (Board) recently reiterated the standards for summary judgment in *Senior Rehabilitation and Skilled Nursing Center*, DAB No. 2300 (2010), as follows:

> Summary judgment is appropriate when the record shows that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. *Kingsville Nursing and Rehabilitation Center*, DAB No. 2234, at 3 (2009), citing *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986). While the Federal Rules of Civil Procedure (FRCP) are not binding in this administrative appeal, we are guided by those rules and by judicial decisions on summary judgment in determining whether the ALJ properly granted summary judgment. *See Thelma Walley*, DAB No. 1367 (1992) . . . . The party moving for summary judgment bears the initial burden of showing that there are no genuine issues of material fact for trial and that it is entitled to judgment as a matter of law. *Kingsville* at 3, citing *Celotex*, 477 U.S. at 323. If the moving party carries its initial burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial.'" *Matsushita Elec. Industrial Co. v. Zenith Radio*, 475 U.S. 574, 587 (1986) (quoting FRCP 56(e)). To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact -- a fact that, if proven, would affect the outcome of the case under governing law. *Id.* at 586 n.11; *Celotex*, 477 U.S. at 322. 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. *U.S. v. Diebold, Inc.*, 369 U.S. 654, 655 (1962).

Senior Rehab., DAB No. 2300, at 3. The Board has also noted that the role of an ALJ in deciding a summary judgment motion differs from the ALJ's role in resolving a case after a hearing. The ALJ should not assess credibility or evaluate the weight of conflicting evidence when resolving a summary judgment motion. *Holy Cross Vill. at Notre Dame*, DAB No. 2291, at 4-5 (2009).

The issues in these cases turn on the interpretation and application of the regulations that govern revocation of enrollment in the Medicare program. The material facts are not

disputed. Petitioners do not deny that the DC Department of Health suspended their licenses to practice medicine from April 17, 2009, through May 6, 2009. P. Br. at 2-3; P. Exs. 2, 7. Petitioners do not dispute that they failed to notify CMS or its contractor that their licenses to practice medicine were suspended. Their main arguments are that they were reinstated before the revocation was issued and that the suspensions did not have to be reported, because their licenses were reinstated within the 30-day reporting period. P. Br. at 6.

Petitioners do proffer evidence, largely in the form of their own testimony, in support of several factual allegations. However, for the reasons explained below, I do not find that the alleged facts are material to any issue before me. In other words, even accepting all facts asserted by Petitioners as true, and drawing all reasonable favorable inferences from them, I could reach no different result under the law. CMS has proffered no witnesses and does not seek to cross-examine either Petitioner.

Therefore, I conclude that summary judgment is appropriate.

2. CMS had the authority to revoke Petitioners' enrollment and billing privileges in the Medicare program for failure to report their license suspensions within thirty days in accordance with 42 C.F.R. § 424.535(a)(9).

A. The revocations were authorized by law.

As previously noted, it is undisputed that the DC Department of Health suspended Petitioners' licenses to practice medicine beginning April 17, 2009, and that their licenses were reinstated on May 6, 2009. P. Exs. 2, 7. Petitioners do not dispute that they did not report the suspension of their licenses. P. Br. at 6.

Instead, Petitioners suggest that, because their licenses were only suspended for 20 days, they were not required to report. P. Br. at 6; Proposed Testimony. They argue that "[t]heir licenses . . . were reinstated before the 30 day reporting period under 42 C.F.R. § 516(d) had expired," and, therefore, "they were no longer required to report any adverse legal action to Highmark." P. Br. at 6. Or, in other words, they assert that "there was no change in their status [at] the end of the 30 day reporting period," so there was no requirement to report the suspensions; "[i]n effect, there was nothing to report." *Id*. Petitioners thus interpret the regulation as requiring reporting within 30 days, **only if** the adverse legal event continues, or will continue, beyond 30 days. They both offer to testify that it was their good faith belief that they were not required to report their suspensions. Proposed Testimony.

I find no support in the plain language of the regulation for Petitioners' purported interpretation. Section 424.516(d) states that "[p]hysicians . . . must report . . . to their Medicare contractor . . . [w]ithin 30 days . . . [a]ny adverse legal action." "Final adverse action" is defined to include "[s]uspension . . . of a license to provide health care by any State licensing authority." 42 C.F.R. § 424.502. No suggestion exists that the adverse

legal action, in these cases the suspension, must persist for longer than 30 days. I see no reason that even one day of suspension would not suffice to invoke the reporting requirement.

Thus, under 42 C.F.R. § 424.535(a)(9), CMS had the authority to revoke Petitioners' enrollment and billing privileges in the Medicare program for failure to report their license suspensions within thirty days.

B. I have no authority to review CMS's discretion to revoke enrollment on the basis of equitable arguments, where it is justified by law.

Petitioners, however, ask me to consider a number of facts and circumstances as undercutting the basis for their revocation for failure to report. They offer to testify that they, in good faith, did not believe that they needed to report the suspension. Proposed Testimony. Petitioners assert that at no time during the period of their license suspensions did they practice medicine or bill Medicare for services. P. Br. at 3-4. They provide details of the events that led to the license suspensions and various laudable actions they undertook after their licenses were suspended. *Id*.; *see* P. Exs. 2, 7. On these grounds, Petitioners argue that CMS should have exercised its discretion to not revoke Petitioners' enrollment in the Medicare program.

As a matter of law, Petitioners' misunderstanding of the regulation is not a defense. They were obligated to notify Medicare that their licenses to practice medicine were suspended, and their failure to do so, in and of itself, justifies revocation of enrollment. I have no general authority to consider equitable arguments in favor of Petitioners where the law authorizes CMS to revoke their billing privileges.

CMS argues that once it has shown that it has legal authority to revoke, its exercise of discretion to invoke that authority in an individual case is not reviewable. *See, e.g.*, Brown CMS Br. at 4 (citing 42 C.F.R § 498.3(b)); *see generally* 42 C.F.R. Part 424, Subpart P. A revocation determination by CMS or its contractor is an "initial determination" that may be appealed. *See* 42 C.F.R. §§ 498.3(b)(17), 424.545(a). Nothing in the regulations, however, 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 an individual case where the authority to revoke is present. *Letantia Bussell, M.D.*, DAB No. 2196, at 12-13 (2008).

C. I reject Petitioners' claim that failure to report cannot properly justify revocation, because there is no meaningful opportunity to correct.

Petitioners contend that failure to report should not form a basis for revocation, because no meaningful opportunity exists to correct. P. Br. at 8. They argue that if a violation of the 30-day reporting requirement was a basis for the revocation, then there would not have been a need for an opportunity to submit a CAP, request reconsideration, or seek an

administrative appeal. Petitioners argue that submitting CAPs, which showed that their medical licenses were current, should have precluded revocation of their enrollment.

The Board recently addressed the issue of an opportunity to correct through a CAP and explained how it is distinct from the contractor reconsideration process:

> After the initial notice of revocation, the supplier has two tracks to seek to avoid revocation and may elect to pursue either or both concurrently. [Medicare Program Integrity Manual (MPIM)], Ch. 10, § 19.A. The supplier, within 60 days, may request "reconsideration" of whether the basis for revocation is erroneous or, within 30 days, it may submit a CAP to demonstrate that it has corrected that basis. If the contractor accepts the CAP, it notifies the supplier, and any reconsideration request is withdrawn. If the contractor denies the CAP, the reconsideration process may proceed to a hearing before a hearing officer, who reviews "the Medicare contractor's reason for imposing a . . . revocation at the time it issued the action . . . ." *Id*. An unfavorable hearing officer decision is appealable to an ALJ, who reviews the basis for the revocation. *Id*. No provision is made for an appeal of the contractor's decision not to reinstate based on the CAP. *Id*. The hearing officer conducting the reconsideration (and the ALJ on appeal of the hearing officer decision) are limited to reviewing the basis for revocation set out in the initial notice, not the merits of any contractor decision that corrective action under a CAP was unacceptable.

DMS Imaging, Inc., DAB No. 2313, at 7-8 (2010) (footnote omitted).

Thus, the contractor's CAP evaluation is: (1) a review of whether the supplier is in current compliance; (2) not an initial determination; and (3) not appealable. On the other hand, the contractor's reconsideration is a determination of whether the contractor was in error at the time the supplier was found deficient. The reconsideration arises from the contractor's initial determination to revoke and is appealable through the administrative process, including the present review.

Nothing in the regulations guarantees to suppliers that the noncompliance will be correctible or ensures an absolute right to correct a deficiency in such a way that would result in overturning the revocation. I note that Petitioners' licenses were initially revoked under section 424.535(a)(1), which provides that "CMS will, when revoking billing privileges on the grounds stated in that regulation, offer a supplier an opportunity to take corrective action in an effort to avoid a final CMS determination of revocation." In this instance, CMS's contractor notified Petitioners that they could submit CAPs to show their corrective action. As explained, however, in reviewing a CAP, the contractor has discretion to decide whether to accept the CAP as sufficient to establish compliance. That Petitioners' CAPs were not accepted does not establish that they were not provided a meaningful opportunity to correct.

As discussed, I grant summary judgment on different grounds than the initial revocation, i.e., the grounds on which the reconsideration was based, Petitioners' failure to report under section 424.535(a)(9). The requirement to report derives from the suspension (however temporary) of Petitioners' licenses. I explain in the next section why I do not accept the claim that Petitioners lacked adequate notice that they were subject to revocation for the failure to report the suspensions, besides the fact of the suspensions themselves. Petitioners do not present a persuasive basis for me to find that they were entitled to a second opportunity to show compliance through another CAP, nor do they show that, even with a second opportunity, they would have been able to demonstrate that they could correct their failure to timely report.

The reconsideration process does not allow for consideration of actions that occurred after the revocation, only whether, at the time of the revocation, there was ground for such revocation. For example, Petitioners could have presented any proof that they reported the suspensions within the required 30 day period but could not cure the failure to report after the 30 days had expired. I do not agree with Petitioners that CMS could only base a revocation on a deficiency that was susceptible to retroactive cure nor do I agree that the review process was somehow rendered meaningless or futile simply, because the basis for Petitioners' revocation is one that is not belatedly correctible.

D. Petitioners received adequate notice that failure to report under 42 C.F.R. § 424.535(a)(9) was a ground for revocation.

Petitioners also appear to argue that they were not provided adequate notice that the revocation was based on their failure to report under section 424.535(a)(9). P. Br. at 9. In these cases, the contractor's initial revocation letter did not indicate that the revocation was issued as a result of Petitioners' failure to report. P. Exs. 1, 5. However, the contractor's reconsideration decisions clearly specified that Petitioners' failure to report under section 424.535(a)(9), was the basis for revocation. P. Exs. 4, 9. Board precedent generally allows CMS to amend its grounds for adverse action as long as the affected party is provided ample opportunity to address and respond to the amended basis. *See, e.g., Kingsville Nursing and Rehabilitation Center*, DAB No. 2234, at 11-12 (2009), and cases cited therein. I have provided Petitioners with a full opportunity to address and respond to the allegations that they failed to report as required.

Petitioners were thus provided ample opportunity to respond to this basis and, indeed, responded through their multiple submissions in this appeal. I therefore find no merit to Petitioners' claims of lack of notice.

For the reasons explained above, I thus grant summary judgment to CMS on the grounds that revocation was authorized based on Petitioners' failure to report their suspensions.

3. I do not rely on CMS's alternative basis for revocation under 42 C.F.R. § 424.535(a)(1), for failing to meet Medicare enrollment requirements under sections 410.20(b) and 424.516.

CMS argues it also had authority to revoke Petitioners' enrollment pursuant to 42 C.F.R. § 424.535(a)(1), because Petitioners no longer met all state licensing requirements, as required of physicians under 42 C.F.R. § 410.20(b), to be eligible to bill Medicare for services. Thus, CMS reasons, by having their medical licenses suspended, Petitioners failed to comply with the applicable enrollment requirements and were subject to revocation. Brown CMS Br. at 3, 7; Obeng CMS Br. at 3, 7; CMS Reply at 2-3.

Petitioners respond that, although their licenses were suspended at one point, the suspension was lifted on May 6, 2009, and they were once again licensed to practice medicine by the time the revocation was imposed on June 15, 2009. P. Br. at 3-4, 6-8. Since they were thus compliant with Medicare requirements that they be licensed and authorized to practice medicine, they argue that revocation was not authorized on this basis.[6]

Section 424.535(a)(1) provides that CMS may revoke a currently enrolled provider or supplier's Medicare billing privileges for noncompliance when "[t]he provider or supplier **is determined not to be in compliance** with the enrollment requirements described in this section, or in the enrollment application applicable for its provider or supplier type, and has not submitted a plan of corrective action as outlined in part 488 of this chapter." (Emphasis added). Among the applicable requirements for a supplier to maintain enrollment is compliance with state licensure needed to provide the relevant type of services. 42 C.F.R. §§ 410.20(b), 424.516.

CMS does not dispute that Petitioners' licenses were reinstated or deny that they were in good standing at the time of revocation. The language of section 424.535(a)(1) uses the present tense in describing a supplier "determined not to be in compliance," rather than a supplier determined not to have been in compliance at some prior point. The MPIM provisions on reconsideration instruct hearing officers to limit the scope of their review to the reason for imposing a revocation "at the time [the contractor] issued the action" and whether the decision was correctly made at that time. MPIM, Ch. 19 (eff. Jan. 4, 2010). It is not clear whether this language implies that the noncompliance status on which a revocation is based must also be one that exists at the time the action is issued.

CMS points to an ALJ decision, which held that a suspension provided a basis for revocation under 424.535(a)(1) even though the petitioner's license in that case was also reinstated by the time that the revocation was issued. CMS Reply Br. at 3 (citing *George E. Smith, M.D.*, DAB CR2074, at 6-8 (2010)). The ALJ in *Smith* treated the petitioner's argument that he was in compliance at the time of the revocation as a claim that he had

[6] Petitioners also assert, and CMS does not dispute, that they neither practiced medicine nor billed Medicare for services rendered during the suspension period.

cured his noncompliance and should not have been revoked. Hence, the ALJ concluded that he had no authority to review CMS's discretionary decision to revoke given that petitioner did not deny noncompliance. *Id.* at 7-8.

I need not resolve whether section 424.535(a)(1) provides a legal basis for revocation here based on a lapse in licensing, while enrolled in the Medicare program, where the lapse was cured before revocation proceeds. Since the failure to report the adverse legal events provides an independent and sufficient basis to support the revocations here, I need not develop the record further to determine whether a suspension that has been lifted prior to revocation may ever be a basis for revocation.

I therefore decline to rely on 42 C.F.R § 424.535(a)(1) as an additional basis for revocation.

4. Petitioners do not have the right to challenge the duration of the re-enrollment bar.

Whenever CMS has properly imposed revocation, it has the authority to determine a length of time between one and three years during which that provider or supplier is barred from re-enrolling under 42 C.F.R. § 424.535(c), which provides:

> 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.

Here, CMS imposed a one-year bar on Petitioners. P. Exs. 3, 8. Petitioners assert that the duration of the re-enrollment bar is "excessive, arbitrary and capricious." HRs. In its submissions, CMS moved for dismissal on this issue, arguing that "the regulations do not permit providers or suppliers to challenge either the establishment of or duration of a re-enrollment bar." *See, e.g.,* Brown CMS Br. at 4. Petitioners did not respond to this motion.

In any case, I could not address this issue, because, as CMS correctly notes, no authority exists to appeal the length of the re-enrollment bar. As I previously discussed, Petitioners' right to a hearing in these cases is limited to challenging whether CMS had authority to revoke Petitioners' enrollment as suppliers in the Medicare program. The right to a hearing is not extended to challenging CMS's judgment as to the duration of this revocation, where it falls clearly within the regulation. 42 C.F.R. §§ 424.535(c), 498.3(b)(17).

Furthermore, CMS imposed the minimum one-year bar on re-enrollment, which the applicable regulation mandates. Therefore, even if I were reviewing the length of the re-enrollment bar, I would have to conclude, as a matter of law, that it was not excessive, arbitrary, or capricious.

For the reasons explained, I have no authority to alter the one-year re-enrollment bar.

IV. Conclusion

Because the undisputed facts establish that each Petitioner violated 42 C.F.R. § 424.535(a)(9), I grant CMS's motion for summary judgment and sustain the revocation of Petitioners' enrollment and billing privileges in the Medicare program. Petitioners remain barred from re-enrollment as suppliers in the Medicare program for a period of one-year.

/s/
Leslie A. Sussan
Board Member