Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Gulf South Medical & Surgical Institute, and
Kenner Dermatology Clinic, Inc.
Docket No. A-11-63
Decision No. 2400
July 21, 2011

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Gulf South Medical & Surgical Institute, Inc. (Gulf South) and Kenner Dermatology Clinic, Inc. (Kenner) appeal the April 1, 2011 decision of Administrative Law Judge (ALJ) Joseph Grow upholding the revocation of their Medicare billing privileges. *Gulf South Medical & Surgical Institute, Inc. and Kenner Dermatology Clinic*, DAB CR2345 (2011) (ALJ Decision). The ALJ granted the motion for summary judgment filed by the Centers for Medicare & Medicaid Services (CMS).

We affirm the ALJ's determination that Gulf South and Kenner did not raise a genuine dispute of fact material to the issue of whether CMS had authority to revoke their Medicare billing privileges. As explained below, we do not review the legal basis relied on by the ALJ but uphold the revocation based on the alternative ground on which CMS relied, at 42 C.F.R. § 424.535(a)(9). That section authorizes CMS to revoke a supplier's billing privileges if the supplier fails to timely report an adverse legal action as required by 42 C.F.R. § 424.516(d)(1)(ii).

Relevant legal authority

Title XVIII of the Social Security Act (the Act) establishes the Medicare program, which reimburses health care providers and suppliers for the medical care and services they furnish to Medicare beneficiaries. Act §§ 1811, 1812, 1831, 1832.[1] The Secretary of Health and Human Services (Secretary) administers the Medicare program through contractors such as Pinnacle Business Solutions (Pinnacle), the contractor in this case. Act § 1842(a).

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[1] The current version of the Social Security Act can be found at http://www.socialsecurity.gov/OP_Home/ssact/ssact.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross-reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp Table.

The term "supplier- for purposes of Medicare - means a physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare." 42 C.F.R. § 400.202. Physician services are covered under Medicare Part B only when furnished by one of the specified professionals who is "legally authorized to practice by the State in which he or she performs the functions or actions [that are covered], and who is acting within the scope of his or her license." 42 C.F.R. § 410.20(b).

Section 1866(j) of the Act requires the Secretary to promulgate regulations for a process for the enrollment of providers and suppliers under the Medicare program. The implementing regulations at 42 C.F.R. Part 424, subpart P, set out the enrollment process that Medicare uses to establish eligibility for submitting claims to Medicare and to terminate such eligibility.

Section 434.535 sets forth the standards and process under which CMS or its contractor may revoke a provider or supplier's Medicare billing privileges. As discussed in our analysis section, CMS moved for summary judgment on the bases of section 424.535(a)(1) for noncompliance with Medicare enrollment requirements for physicians and section 424.535(a)(9) for failure to timely report an adverse legal action as required by section 424.516(d)(1)(ii).

Standard of review

Whether summary judgment is appropriate is a legal issue that we address de novo. *Lebanon Nursing and Rehabilitation Center*, DAB No. 1918 (2004). The party moving for summary judgment bears the initial burden of demonstrating that there are no genuine issues of material fact for trial and that it is entitled to judgment as a matter of law. *See Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986); *Everett Rehabilitation and Medical Center*, DAB No. 1628, at 3 (1997). If a 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*, 474 U.S. 574, 587 (1986) (quoting Fed. R. Civ. Pro. 56(e)). In evaluating a summary judgment motion, a tribunal must view the entire record in the light most favorable to the nonmoving party, drawing all reasonable inferences from the evidence in that party's favor. *Madison Health Care, Inc.*, DAB No. 1927 (2004). The standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. *See Departmental Appeals Board, Guidelines—Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs at http://www.hhs.gov/dab/divisions/appellate/guidelines/prov.html.*

Background

The following facts are undisputed or are facts alleged by Gulf South and Kenner that we accept as true for purposes of summary judgment.

Gulf South and Kenner were Louisiana business corporations that were solely owned by Dr. George A. Farber, Sr. P. Ex. 1. Using the CMS 855B enrollment application form, Dr. Farber enrolled Gulf South in Medicare, checking as supplier type "Multispecialty Clinic or Group Practice."[2] CMS Ex. 3, at 6; RR at 5th page; Gulf South CMS 855B enrollment application attached to Petitioners' request for ALJ hearing (P. CMS 855B). Dr. Farber identified himself as the owner and the "Authorized Official" of Gulf South. P. CMS 855B at 29, 41. On the application, Gulf South identified numerous practice locations, including the Kenner Dermatology Clinic. *Id.* at 17. Kenner was also separately enrolled in Medicare using a CMS 855B, with different identifiers. P. Ex. 2, at 3. Gulf South and Kenner "employed over 80 individuals including physicians, nurse practitioners, physician assistants and other licensed professionals" who reassigned to Gulf South or Kenner the Medicare payment rights that Medicare beneficiaries assigned to them. RR at 2nd and 5th page; CMS Ex. 3, at 6; *see* 42 C.F.R. §§ 424.55(a) (governing assignment from a beneficiary to a supplier); 424.80(b) (permitting reassignment to a supplier's employer).

On November 17, 2009, the Louisiana State Board of Medical Examiners notified Pinnacle that it had revoked Dr. Farber's license to practice medicine in Louisiana effective October 20, 2009. CMS Ex. 2.

On November 30, 2009, Pinnacle sent Dr. Farber a "Notice of Revocation of Medicare Billing Privileges." CMS Ex. 1. Pinnacle informed Dr. Farber that, effective October 20, 2009, it was revoking six Provider Transaction Access Numbers (PTANs) "that are associated to the National Provider Identifier (NPI) being revoked." CMS Ex. 1. The revoked NPI was "1073625505" (*id.*), the NPI "for Dr. Farber" (CMS Response at 7).[3] The revoked PTANs associated with this NPI included the PTANs assigned to Gulf South and Kenner. P. Ex. 2, at 1, 3, 6. At the time of this notice, Dr. Farber was not excluded from participating in federal health care programs, nor does the record reflect that he was subsequently excluded.

In the notice, Pinnacle stated that it had "been notified by [the state] that . . . effective October 20, 2009 [Dr. Farber's] license has been revoked and canceled." CMS Ex. 1, at 1. Pinnacle then identified two reasons for revoking the PTANs. Pinnacle cited section 424.535(a)(1), which provides for revocation when a supplier is not in compliance with enrollment requirements "described in this section, or in the enrollment application applicable for this . . . supplier type . . . ." *Id.* Pinnacle also cited 424.516(d)(1)(ii), which requires a physician or physician organization to report "any adverse legal action,"

[2] The CMS 855B is the Medicare application for "Clinic/group Practices and Certain Other Suppliers." See http://www.cms.gov/CMSForms/downloads/cms855b.pdf. .

[3] An NPI is defined as "the standard unique health identifier for health care providers (including Medicare suppliers) . . . ." MPIM Ch. 15, § 15.1.1. PTANs are assigned by Medicare contractors as part of the enrollment process.

such as a license revocation, within 30 days. Such a reporting failure is grounds for revocation under section 424.535(a)(9). *Id.* at 2.

On December 29, 2009, Pinnacle also sent notices addressed specifically to Gulf South and Kenner titled "Revocation of Billing Privileges." P. Ex. 2, at unnumbered 3-8. In those notices, Pinnacle informed Gulf South that it was revoking PTAN 5CS06 and Kenner that it was revoking PTAN 11096. Both of these PTANS were also listed in the November 30, 2009 notice. *Id.* at unnumbered 1. Both revocations were effective October 20, 2009.[4] The notice to Gulf South cited 42 C.F.R. §§ 424.535(a)(1), 424.535(f), and 424.535(h); the notice to Kenner cited 42 C.F.R. §§ 424.535(a)(1) and 424.535(h). *Id.* at 3-8.

Dr. Farber, on behalf of Gulf South and Kenner, requested reconsideration of the revocation of these PTANs. P. Ex. 3, at 4. Dr. Farber did not request reconsideration of the revocation of his billing privileges as a physician. The revocations were upheld by an independent hearing officer employed by Pinnacle. CMS Ex. 3.

Thereafter, Gulf South and Kenner requested ALJ review of the hearing officer's decision. The ALJ upheld the revocation. In his decision, the ALJ identified Gulf South as "Petitioner" but noted that his decision also addressed Kenner. We use the term "Petitioner" below to apply to both Gulf South and Kenner. ALJ Decision at 1 n.1.

Analysis

We affirm the ALJ's determination upholding revocation of Petitioner's Medicare billing privileges because we conclude that Petitioner did not raise a genuine dispute of fact material to the issue of whether the revocations were authorized under section 424.535(a)(9). Below, we discuss CMS's motion for summary judgment, the ALJ Decision, and our basis for concluding that CMS had authority to revoke Petitioner's billing privileges under section 424.535(a)(9).

Before the ALJ, CMS moved for summary judgment on two grounds. First, CMS argued that, because the state had revoked Dr. Farber's medical license, Petitioner "failed to meet the regulatory enrollment requirements as a physician" and therefore the revocation was authorized under section 424.535(a)(1) for noncompliance with these enrollment requirements. CMS MSJ at 5. Second, CMS argued that revocation was authorized under section 424.535(a)(9) because Petitioner had failed to timely report an adverse legal action (Dr. Farber's license revocation) as required by section 424.516(d)(1)(ii). *Id.*

The ALJ agreed with CMS that "Medicare will pay for a physician's services to its beneficiaries only where the physician is licensed to practice medicine in the State where

[4] Gulf South and Kenner did not dispute the effective date of the revocation.

he provides them." *Id.* at 3, citing 42 C.F.R. § 410.20(b) (emphasis in original). "Thus," he stated, "a physician who has his license revoked, such as Petitioner, is not in compliance with Medicare enrollment requirements." *Id.* The ALJ noted that Dr. Farber contended that that Gulf South and Kenner were corporations "separate and independent from [their] owner," and had not suffered any "reportable legal adverse action." *Id.* at 3-4, citing P. Br. at 3. The ALJ noted, however, that under section 424.535(f), CMS "automatically reviews all other related Medicare enrollment files that [a revoked supplier] has an association with (for example, as an owner or managing employee) to determine if the revocation warrants an adverse action of the associated Medicare . . . supplier." *Id.* at 4. Additionally, he pointed to the part of Medicare Program Integrity Manual (MPIM) Chapter 10, section 4.20, that states that, "when a physician solely owns a practice and has his billing privileges revoked, the practice is automatically dissolved for purposes of Medicare enrollment, and all reassignments to the practice are automatically terminated as well." *Id.* He concluded that Dr. Farber's loss of his state medical license therefore constituted "enumerated grounds" to revoke the Medicare billing privileges of his solely-owned corporations. *Id.*

Thus, the ALJ concluded that "CMS had authority to revoke Petitioner's enrollment and billing privileges for noncompliance with Medicare enrollment requirements under 42 C.F.R. § 424.535(a)(1)" and therefore granted CMS's Motion for Summary Judgment. *Id.* He noted that additional grounds may also exist to revoke Petitioner's enrollment under section 424.535(a)(9) based on "Dr. Farber's failure to timely report his change in circumstances," but found it unnecessary to resolve this issue. *Id.*

CMS argues that the ALJ Decision should be upheld because section 424.535(f) provides authority to revoke the enrollment of any entity associated with Dr. Farber without establishing any of the reasons for revocation listed in section 424.535(a) with respect to the associated entity. CMS Response at 7-9. Petitioner questions whether section 424.535(f) provides such authority and contends that the cited MPIM provision does not apply to a business corporation that is solely owned by a physician and is enrolled in Medicare pursuant to a CMS 855B application, as opposed to a physician's professional corporation or limited liability company that uses a CMS 855I application to enroll, with employee reassignment to the owner physician. RR at unnumbered 2-3,6-8; P. Reply. Neither party points to anything specific in the regulations clarifying whether section 424.535(f) independently authorizes adverse action against a wholly-owned business corporation of a physician whose Medicare enrollment was properly revoked. We do not reach CMS's or Petitioner's arguments since we conclude that section 424.535(a)(9) provides authority to revoke Petitioner's billing privileges. We also note that CMS did not cite or rely on section 424.535(f) in moving for summary judgment and that, while the ALJ referred to section 424.535(f) in rejecting Petitioner's argument about corporate status, he did not explicitly address whether section 424.535(f) provided an independent basis for CMS to revoke Petitioner's billing privileges. In declining to reach the parties'

arguments about section 424.535(f) and the MPIM, we express no opinion about their merits.

Below, we first set out section 424.535(a)(9), the regulation it cites, i.e., section 424.516(d)(1)(ii), and the history of the adoption of section 424.516(d)(1)(ii). We then explain why we reject Petitioner's arguments and conclude that section 424.525(d)(1)(ii) required Petitioner to report the state's revocation of Dr. Farber's medical license to Pinnacle within 30 days of that revocation.

Section 424.535(a)(9) provides that "CMS may revoke a currently enrolled . . . supplier's Medicare billing privileges" where "the supplier did not comply with the reporting requirements specified in § 424.516(d)(1)(ii) and (iii) of this subpart." Section 424.516(d) requires "physicians . . . and physician . . . organizations" to report "reportable events" to their Medicare contractor within the specified timeframes.

Section 424.516(d)(1)(ii) defines "any adverse legal action" as a "reportable event" and requires physicians and physician organizations to report such actions within 30 days. Section 424.502 defines a "final adverse action" to include a range of events, including the action at issue here, a "revocation of a license to provide health care by any State licensing authority." Petitioner does not represent that Dr. Farber or anyone else on Petitioner's behalf reported the revocation of Dr. Farber's physician's license to Pinnacle within 30 days of that revocation.

In 2008, the Secretary promulgated a number of amendments to 42 C.F.R. Part 424 that were intended to strengthen reporting requirements and to improve supplier compliance with those requirements and, thereby, to protect the Medicare program. 73 Fed. Reg. 69,726 (Nov. 19, 2008).[5] These changes included defining "final adverse action" in section 424.502 to include revocation of a license to provide health care by any state licensing authority; adopting section 424.516(d)(1)(ii) requiring physicians and physician organizations to report adverse legal actions within 30 days; adopting section 424.535(a)(9) to provide that failure to comply with the reporting requirements of section 424.516(d)(1)(ii) is a reason for revocation; adopting section 424.535(g) to make revocations based on adverse legal actions effective on the date of the action rather than 30 days from the revocation notice; and adopting section 424.565 to enable CMS to assess overpayments back to the date of a final adverse action if a physician organization failed to timely report the action.

In adopting more stringent reporting requirements, CMS explained in the preamble to the final rule that it was doing so because under the present requirements —

[5] These changes were effective January 2009. 73 Fed. Reg. at 69,726.

> physician and [non-physician practitioner] organizations and individual practitioners [in many cases may have little or no incentive] to report a . . . final adverse action, such as a revocation or suspension of a license to a provider of health care by any State licensing authority, or a revocation or suspension of accreditation, because reporting this action may result in the revocation of their Medicare billing privileges. Thus, unless CMS or our designated contractor becomes aware of the conviction or final adverse action through other means, the change may never be reported by a physician . . . organization or individual practitioner.

73 Fed. Reg. at 69,777 (emphasis added). By referring to the license of a provider of health care, CMS indicated it was not concerned merely about the license of an individual physician or organization but any license that authorized the provision of health care services for which Medicare would be billed.

Petitioner asserts that Gulf South, as well as Kenner, is a "separate and independent entit[y] from its sole shareholder" and that it "did not suffer any reportable adverse legal action." RR at 5th page. Petitioner argues, in effect, that there is no requirement that it, as a business corporation owned by Dr. Farber, report the loss of Dr. Farber's license. For the following reasons, we reject this argument and conclude that section 424.516(d)(1)(ii) required Petitioner to report as an adverse legal action the license revocation of Dr. Farber, its physician owner.

- Section 424.516(d)(1)(ii) requires individuals and "physician . . . organizations" to report adverse legal actions, which include license revocations. Section 424.502 defines "physician . . . organization" as "any physician . . . entity that enrolls in the Medicare program as a sole proprietorship or organizational entity." Petitioner does not argue that a business corporation, such as Petitioner, is not a physician organization as that term is defined by section 424.502.

- The section requires physician organizations to report "any adverse legal action." Therefore, by its terms, it is not restricted to actions imposed directly against an organization as opposed to its owner.

- Medicare does not separately cover services of a physician organization such as a multispecialty clinic or group practice, but does cover physician services and services of practitioners such as a physician assistant or nurse practitioner, if they are licensed and, for the other practitioners, may require that they be supervised by a physician. 42 C.F.R. §§ 410.20; 410.74; 410.75. Thus, some services furnished by such a physician organization may no longer be eligible for payment if the physician whose services were being claimed or who was supervising another practitioner had his or her license revoked.

- Petitioner's reading of section 424.516(d)(1)(ii) would undermine the purpose of that section, to provide CMS with information about adverse legal actions that CMS has determined are relevant to evaluating whether a supplier should continue to participate in Medicare. A physician organization, whether organized as a business corporation, limited liability company, or other entity, is controlled by individuals. The adverse legal actions subject to this reporting requirement are relevant to evaluating the eligibility of such individuals, individually or through organizations, to furnish Medicare-covered services or to supervise the furnishing of such services. Requiring physician organizations to report adverse actions against their owners allows CMS to timely evaluate whether the action may affect the organization's ability to provide Medicare-covered services or its trustworthiness to bill only for proper claims.

- That section 424.516(d)(1)(ii) should be read to require a physician organization to report an adverse action against an owner is most evident when considering the subsections of section 424.535(a) that make an adverse legal action against an individual an explicit ground for revoking the organization's billing privileges. For example, under section 424.535(a)(2), an organization's billing privileges may be revoked based on an exclusion or certain other adverse actions imposed on an "owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the . . . supplier." Under section 424.535(a)(3), revocation of an organization may be based on the conviction of "any owner of the . . . supplier." If physician organizations were not required to report these actions against owners, CMS's ability to revoke these organizations' billing privileges under these subsections would be substantially compromised.[6]

- CMS interprets section 424.516(d)(1)(ii) to require a physician organization to report an adverse legal action, such as license revocation, imposed against an owner of the organization, such as Dr. Farber. For example, the current CMS 855B application requires an enrolling physician organization to report all adverse legal actions previously imposed against its owner[s] (including license revocations) when applying and then to "notify the Medicare contractor of any future changes to the information contained in this application in accordance with the timeframes established in 42 C.F.R. § 424.516." *See* http://www.cms.gov/CMSForms/downloads/cms855b.pdf at CMS 855B page 31.

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[6] Section 424.353(e) provides:

If a revocation was due to adverse activity (sanction, exclusion, or felony) against an owner, managing employee, or any authorized or delegated official, or a medical director, supervising physician, or other personnel of the . . . supplier furnishing Medicare reimbursable services, the revocation may be reversed if the . . . supplier terminates . . . . its business relationship with that individual within 30 days of revocation notification.

> Such "changes" would encompass a situation in which the owner is subject to a license revocation after enrollment.

Therefore, we conclude Petitioner was required, under section 424.516(d)(1)(ii), to report the revocation of Dr. Farber's state medical license.

Moreover, we note that Dr. Farber had actual notice that he was required to report, on behalf of Petitioner, adverse legal actions imposed against him. In 2005 when Dr. Farber completed a prior version of the CMS 855B in order to enroll Petitioner in Medicare, he identified himself as the owner and was required to report any adverse legal action, such as license revocation, that had been imposed against him. P. CMS 855B, at 29. He reported there had been no such action. *Id.* The application also informed him that, if such an adverse legal action were to be imposed against him in the "future," he, as the Authorized Official on that application, was required to report the adverse action. P. CMS 855B, at 41. Therefore, Dr. Farber had notice that, if the state revoked his license, he was obligated to report this to Pinnacle on behalf of Petitioner.

We note that the CMS 855B application Dr. Farber signed in 2005 provided that any adverse legal action against an owner should be reported within "90 days of the effective change."[7] P. CMS 855B, at 41. Petitioner does not assert, however, that Dr. Farber ever relied on or was misled by the time standard in the 2005 application. More importantly, in that application, Dr. Farber also certified that Petitioner would "abide by the Medicare laws, regulations and program instructions applicable to this supplier." *Id.* This certification presupposes a duty on Petitioner's management to be informed about changes to Medicare requirements, including, in this case, the adoption of sections 424.535(a)(9) and 424.516(d)(1)(ii) effective January 2009. Also, as courts and the Board have recognized, Medicare providers and suppliers, as participants in the program, have a duty to familiarize themselves with Medicare requirements. *See, e.g., Heckler v. Cmty. Health Servs. of Crawford County, Inc.*, 467 U.S. 51, at 64 (1984); *Waterfront Terrace Inc.*, DAB No. 2320 (2010).

Petitioner also argues that "the ALJ erred by failing to consider the notice given by [the state] to Pinnacle . . . on November 17, 2009" about its revocation of Dr. Farber's license. RR at 3rd page. Petitioner asserts that "[t]his official notice is a legal requirement under State law that Dr. Farber could have and did in fact rely on" as meeting the requirements of section 424.535(a)(9). *Id.*

We reject this argument. First, we see no evidence in the record that Dr. Farber in fact relied on the state's obligation to notify Medicare as fulfilling his obligation or

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[7] Prior to January 1, 2009, suppliers had 90 days to report any changes to the information furnished on the enrollment form, including adverse actions. 42 C.F.R. § 424.520(b) (2008). The rule change discussed above redesignated section 424.520 as section 424.516 and shortened to 30 days the time for physicians and physician organizations to report adverse actions. 73 Fed. Reg. at 69,940.

Petitioner's obligation to notify Pinnacle about the loss of his license. Second, the regulations and CMS 855B put an obligation to timely report the adverse legal action on Petitioner. Petitioner could not reasonably think that notice from the state would satisfy Petitioner's own and independent obligation to report.

Conclusion

For the reasons discussed above, we affirm the ALJ's determination upholding revocation of Petitioner's Medicare billing privileges because we conclude that Petitioner did not raise a genuine dispute of fact material to the issue of whether the revocations were authorized under section 424.535(a)(9).

/s/
Sheila Ann Hegy

/s/
Leslie A. Sussan

/s/
Judith A. Ballard
Presiding Board Member