Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Conchita Jackson, M.D.
Docket No. A-13-11
Decision No. 2495
February 4, 2013

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Conchita Jackson, M.D. (Petitioner) requests review of the September 19, 2012 decision of Administrative Law Judge (ALJ) Joseph Grow. *Conchita Jackson, M.D.*, DAB CR2615 (2012) (ALJ Decision). The ALJ sustained the January 25, 2012 reconsideration determination by the Centers for Medicare & Medicaid Services (CMS), through its contractor, First Coast Service Options (FCSO), revoking Petitioner's Medicare enrollment and billing privileges and barring her reapplication for three years because she did not report an adverse legal action on her enrollment application and, in fact, falsely and misleadingly certified that there was no such action.

On appeal to the Board, Petitioner does not dispute the ALJ's conclusion that "CMS was justified in their *original* determination to revoke." P. Br. at 1 (emphasis in original). Instead, Petitioner argues that the subject of her appeal was the "subsequent determination, whereby CMS found [her] noncompliant with the agreed upon corrective action plan (CAP)." *Id.* Petitioner argues that she timely and fully complied with the requirements for submitting a CAP and that CMS failed to consider her compliance with the CAP due to a series of CMS "missteps." *Id.* at 2.

As explained below, the CAP process gives a supplier an opportunity to correct deficiencies that resulted in the denial of its application or the revocation of its billing privileges. In contrast, the reconsideration process gives a supplier the opportunity to show that its Medicare application was incorrectly denied or that its billing privileges were revoked erroneously. Under the Social Security Act (Act) and regulations, an adverse reconsideration determination is subject to administrative appeal. Act § 1866(j)(8); 42 C.F.R. §§ 424.545 and 405.874 and Part 498. However, neither the Act nor regulations provide for appeal of CMS's (or the CMS contractor's) denial of a CAP. In this case, the ALJ, on appeal from FCSO's reconsideration decision, properly reviewed and sustained CMS's revocation determination based on Petitioner's failure to disclose an adverse legal action on her enrollment application. The ALJ also correctly concluded that he had no authority to review the denial of Petitioner's CAP. Accordingly, Petitioner has provided no basis for reversing the ALJ Decision.

Applicable law and guidance

The regulation at 42 C.F.R. § 424.535(a) provides that CMS may revoke a supplier's Medicare billing privileges and any corresponding supplier agreement for the following reasons –

> (1) *Noncompliance*. The 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…. All providers and suppliers are granted an opportunity to correct the deficient compliance requirement before a final determination to revoke billing privileges, except for those imposed under paragraphs (a)(2), (a)(3), or (a)(5) of this section.
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> (4) *False or misleading information*. The provider or supplier certified as "true" misleading or false information on the enrollment application ... in the Medicare program.

Section 424.516(d)(ii) of the regulations provides that to enroll and maintain enrollment in the Medicare program, a physician must report to the Medicare contractor within 30 days any adverse legal action. Section 1866(j)(8) of the Act provides administrative and judicial hearing rights to suppliers whose Medicare billing privileges are revoked.[1] CMS implemented section 1866(j) by providing administrative hearing rights for revoked suppliers in 42 C.F.R. §§ 424.545 and 405.874 and Part 498.

Under section 424.545(a), a "supplier whose Medicare enrollment has been revoked may appeal CMS' decision in accordance with part 498, subpart A of this chapter." Part 498 sets forth "Appeals Procedures for Determinations that Affect Participation in the Medicare Program." Section 498.3(b) provides that a supplier may appeal CMS "initial determinations" and lists the types of actions that constitute initial determinations. Section 498.3(b)(17), applicable here, provides that "[w]hether to ... revoke a ... supplier's Medicare enrollment in accordance with ... § 424.535 of this chapter" is an initial determination.

[1] Section 1866(j)(8) provides:

> (2) Hearing rights in cases of denial or non-renewal.—A provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) under this title is denied may have a hearing and judicial review of such denial under the procedures that apply under subsection (h)(1)(A) to a provider of services that is dissatisfied with a determination by the Secretary.

While the language of this section does not specifically refer to hearing rights for enrolled providers and suppliers whose billing privileges are revoked, CMS has interpreted it as providing hearing rights in such cases. *See, e.g.,* 42 C.F.R. § 498.1(g); 72 Fed. Reg. 9479 (March 2, 2007).

Background of the case

The following facts from the ALJ Decision and the record are undisputed.

In a letter dated August 24, 2010, Petitioner was notified by the State of Florida, Agency for Health Care Administration (AHCA) that she was suspended from participation in the Florida Medicaid program because she had not paid a fine for her failure to maintain plans of care in recipients' medical records. CMS Ex. 9, at 8-9. Petitioner did not dispute the suspension sanction and paid the fine on September 23, 2010. *Id.* at 4-5. An AHCA order dated November 5, 2010 found the fine paid in full, concluded that the sanction was final, and adjudged the matter closed. *Id.*

On November 4, 2010, while still suspended from Florida's Medicaid program, Petitioner submitted an application for enrollment and billing privileges in the Medicare Program (Form CMS-855I). CMS Ex. 2. In section 3 of the application, "Final Adverse Actions/Convictions," Petitioner answered "NO" to the question whether she had any final adverse legal actions imposed against her. *Id.* at 10. The form listed "adverse legal actions" as including any "suspension from participation in a Federal or State health care program." Petitioner's supporting documents (CMS-855I Medicare enrollment application at 12-13). By letter dated April 27, 2011 Petitioner was accepted for enrollment in the Medicare program. CMS Ex. 7.

By letter from FCSO dated May 26, 2011, Petitioner was notified that her Medicare enrollment and billing privileges had been revoked effective May 4, 2011 and that she was not eligible to reapply for enrollment in Medicare for three years pursuant to 42 C.F.R. §§ 424.535(a)(1) and (a)(4) because she had failed to disclose the final adverse action on her Medicare enrollment application and, in addition, had falsely indicated there was no such action. CMS Ex. 8. Because the application did not disclose and indeed denied the existence of the adverse action (notwithstanding Petitioner's certification that the information in the application was true), FCSO considered it false and misleading. *Id.* at 2. The May 26, 2011 letter notified Petitioner that if she disagreed with the determination she could "[s]ubmit a corrective action plan (CAP) within 30 days from the date of this letter." *Id.* The letter explained that "a CAP is a formal method to reopen a previously submitted application," that the CAP must be in writing, identified as a CAP, and signed by an authorized person. *Id.* The letter instructed, "To further expedite the processing of your CAP, you should use the attached form, include all documentation that supports/corrects any deficiencies and/or provide additional supporting information." *Id.*

The May 26, 2011 letter further explained that Petitioner could "also appeal this determination by requesting a reconsideration [in writing] within 60 days from the date of this letter." *Id.* The letter stated that a "reconsideration is an independent review of your case and will be conducted by a person who was not involved in the initial

determination." *Id.* The letter also instructed that "[t]o expedite the processing of your reconsideration request, you should use the attached form, state the issues, or the findings of fact with which you disagree, the reasons for disagreement, and attach all supporting documentation." *Id.*

Petitioner asserts that "on or about June 6, 2011 [Petitioner's] office timely submitted a CAP, which included a June 3, 2011 synopsis … detailing the incident and [Petitioner's] willingness to resolve the issue through remedial measures." P. Br. before ALJ at 1-2; *see also* P. Br. at 2. CMS Exhibit 9, identified by CMS in its list of exhibits as "Petitioner's CAP/Documentation of Adverse Action by AHCA, dated June 29, 2011," includes the referenced June 3, 2011 synopsis and an undated FCSO form titled "Provider Enrollment Corrective Action Plan (CAP) or Reconsideration Request." CMS Ex. 9, at 3. The form is signed by Petitioner's representative and filled out to indicate Petitioner submitted a CAP and requested reconsideration. *Id.*

By letter dated September 2, 2011, FCSO notified Petitioner that it had received and reviewed Petitioner's CAP and found it to be "incomplete or missing" a form CMS 855I for Petitioner indicating the sanction by the AHCA. CMS Ex. 11. Accordingly, the letter stated, the CAP "did not contain verifiable evidence that [Petitioner was] in compliance with enrollment requirements since the information submitted [was] incomplete or missing and the [Petitioner] cannot be enrolled based on the information submitted with the CAP." *Id.*

By letter dated January 25, 2012, FCSO denied Petitioner's reconsideration request. CMS Ex. 1. The letter recited the regulatory requirements for provider and supplier enrollment in the Medicare program, including the requirement in section 424.516 that a provider or supplier report any adverse legal action. *Id.* at 2. The letter stated that FCSO "properly revoked the provider number in this case based on guidelines established for Medicare enrollment." *Id.* at 4. The letter also discussed Petitioner's corrective action submissions and attempted communications between the parties relating to the CAP. In addition, the letter stated, "the reconsideration request has been denied for not receiving all requested information timely." CMS Ex. 1, at 4.

Petitioner then requested an ALJ hearing. The ALJ sustained the revocation, concluding that "CMS legitimately revoked Petitioner's enrollment and billing privileges because Petitioner certified the truthfulness of false information on her enrollment application." ALJ Decision at 3. The ALJ also noted that he did not have the authority to review the denial of the CAP. *Id.* at 1, n.1, *citing* 42 C.F.R. § 424.545(a), 42 C.F.R. § 498.3(b)(17), and *DMS Imaging, Inc.*, DAB No. 2313, at 5-8 (2010).

Standard of review

The Board's standard of review on a disputed factual issue is whether the ALJ decision is supported by substantial evidence in the record as a whole. *Guidelines -- Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program*, www.hhs.gov/dab/divisions/appellate/guidelines/prov.html. The standard of review on a disputed issue of law is whether the ALJ decision is erroneous. *Id.*

Analysis

As summarized above, Petitioner does not contest the basis for the revocation set out in FCSO's May 26, 2011 notice. Rather, Petitioner argues that her appeal involves "the subsequent determination, whereby CMS found [her] noncompliant with the agreed upon [CAP]."[2] P. Br. at 1. Petitioner contends that "CMS failed to follow their own procedures and guidelines in administering the CAP," that "the compliance with the resulting CAP is the issue," and that the ALJ did not address this issue. *Id.* at 2. Incorporating by reference the arguments she made before the ALJ, Petitioner argues that the reconsideration decision erroneously "alleges that [she] did not timely submit the missing/incomplete supporting documentation to continue the process of Medicare application." P. Br. before ALJ at 2. According to Petitioner, she submitted the requested information within the time frames allotted. Petitioner also argues that CMS's reliance on *DMS Imaging* is misplaced because she is not contesting the denial of the CAP but instead is appealing CMS's "failure to afford her the opportunity to complete the CAP…." *Id.* at 3.

Petitioner's appeal arguably could be read, as CMS contends, as appealing only the ALJ's decision that he had no authority to review the CAP denial. CMS Br. at 1-2, n.3. However, Petitioner's appeal also cites CMS's reconsideration determination, although apparently confusing this with the CAP decision. For that reason, we also address the ALJ's decision upholding the reconsideration decision. The ALJ Decision on that issue is supported by substantial evidence on the whole record and free from legal error. Consistent with the Act and regulations, the ALJ properly limited the scope of his review to the basis for revocation set out in the initial notice of revocation -- that is, whether Petitioner certified the truthfulness of false information on her enrollment application.

[2] The meaning of Petitioner's reference to an "agreed upon CAP" is unclear. While the record shows that FCSO, as required, gave Petitioner an opportunity to submit a CAP that would correct her failure to disclose her suspension from the Medicaid program in her application, the record contains no evidence that FCSO ever agreed that she had submitted an acceptable CAP. Indeed, the record clearly shows that FCSO rejected Petitioner's CAP because it did not contain the information needed to correct the failure to disclose. *See* CMS Ex. 11 (FCSO letter of September 2, 2011).

The ALJ concluded, and Petitioner does not deny, that she did not disclose her suspension from participation in the Florida Medicaid program and that this omission constituted a violation of section 424.535(a)(4) for which CMS had a basis to revoke her Medicare enrollment and billing privileges. Moreover, the ALJ observed –

> In her request for hearing, a now represented Petitioner still minimizes her failure to report her suspension contending that the omission was due to administrative oversight by her office staff in failing to list one prior AHCA action against Petitioner. Petitioner identifies the adverse action in a footnote explaining it as a finding of one plan of care document missing from one patient file and that "AHCA closed the case after [Petitioner's] office paid a $500 fine for the minor infraction." The word "suspension" appears nowhere in Petitioner's hearing request, or even in her response brief for that matter. Yet, Petitioner's own documents clearly notify her that she was suspended from the program.

ALJ Decision at 4. We conclude that the ALJ did not err in upholding the revocation based on the admitted facts.

On the issue clearly raised by Petitioner here, the denial of her CAP, the ALJ did not err in concluding that he did not have authority to review FSCO's denial of that CAP. ALJ Decision at 1, n. 1; CMS Ex. 11, at 2. Section 424.535(a)(1) provides that providers and suppliers whose billing privileges have been revoked for noncompliance with enrollment requirements described in section 424.535, or in the enrollment application applicable for its provider or supplier type, and who have not submitted a corrective action plan under part 488, must be granted an opportunity to correct before the revocation becomes final, except for a revocation imposed under paragraphs (a)(2), (a)(3) or (a)(5) of section 424.535. However, the regulations "do not indicate that a supplier may challenge a contractor's rejection of a CAP proffered after notice of revocation." *DMS Imaging, Inc.*, DAB No. 2313, at 6 (2010). As the Board explained in *DMS Imaging*, the refusal by CMS or one of its contractors to reinstate a supplier after a correction attempt is not listed as an action that constitutes an initial determination subject to administrative appeal under section 498.3(b). *Id.* In addition, section 405.874(e) states:

> (e) *Reinstatement of provider or supplier billing privileges following corrective action*. If a provider or supplier completes a [CAP] and provides sufficient evidence to the CMS contractor that it has complied fully with the Medicare requirements, the CMS contractor **may** reinstate the provider's or supplier's billing privileges. . . . **A CMS contractor's refusal to reinstate a supplier's billing privileges based on a [CAP] is not an initial determination under part 498 of this chapter.**

(Emphasis added.) Thus, the regulations do not establish appeal rights for a supplier to challenge a contractor's refusal to reinstate a supplier's billing privileges on the basis of a CAP.[3]

Consistent with the regulations and providing additional guidance, the CMS Medicare Program Integrity Manual (MPIM) in effect during the relevant period here explained that 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. MPIM, Ch. 10, § 19.A (December 12, 2008) (available at http://www.cms.gov/RegulationsandGuidance/ Guidance/Transmittals/downloads/ R275PI.pdf.).[4] The supplier, within 30 days, may submit a CAP to correct the deficiencies (if possible) that resulted in the revocation. *Id.* The CAP must "contain, at a minimum, verifiable evidence of … supplier compliance with enrollment requirements." *Id.* Thus, the CAP "is not merely a plan to make corrections at some future time but rather must explain and provide evidence that corrections have been made [to reestablish] compliance." *DMS Imaging* at 4, n.1. The manual states that the contractor must process the CAP within 60 days. *Id.* If the contractor accepts the CAP, the manual continues, it notifies the supplier, and any reconsideration request (discussed below) is withdrawn. *Id.* There is no provision for a supplier to appeal a CAP denial.

Alternatively or in addition to submitting a CAP, the supplier, "within 60 days after the postmark of the notice" of revocation, may request "reconsideration" of whether the basis for revocation was erroneous. (If the contractor denies a concurrent CAP request, the supplier may continue with the reconsideration process.) The matter proceeds to a hearing before a hearing officer, whose review is limited to "the Medicare contractor's reason for imposing a ... revocation at the time it issued the action and whether the Medicare contractor made the correct decision (i.e., … revocation)." *Id.* An unfavorable hearing officer decision is appealable to an ALJ, who reviews the basis for the revocation at the time the contractor issued the notice of revocation. Thus, the hearing officer

[3] "Reinstatement" following acceptable corrective action made within 30 days of the initial revocation notice is distinct from "re-enrollment," which is the only option for a supplier who has exhausted any challenge to a final CMS revocation determination. *Compare* 42 C.F.R. §§ 405.874(e) and 424.535(d). Once a revocation has become final (either because the contractor declined to reinstate the supplier after submission of a CAP or because the supplier did not prevail in challenging the basis for the revocation), the regulations do not permit reinstatement based on acceptable corrections. Instead, the supplier may only reenroll by submitting a new application and new documentation which must be validated as if the entity applying were a new supplier. 42 C.F.R. § 424.535(d). In addition, revoked suppliers are subject to a reenrollment bar of a minimum of one year. 42 C.F.R. § 424.535(c). *DMS Imaging* at 7.

[4] The MPIM provisions were subsequently revised and redesignated at Chapter 15, § 25 (Appeals Process), effective December 24, 2012, available at http://www.cms.gov/Regulations-and-Guidance/Guidance/ Manuals/Downloads/pim83c15.pdf.

conducting the reconsideration, and the ALJ on appeal of the hearing officer reconsideration decision, are limited to reviewing the basis for revocation set out in the initial notice, and may not review the merits of any contractor decision that corrective action under a CAP was insufficient. The same limited scope of review applies to the Board when it reviews an ALJ decision.

As explained above, the ALJ does not have authority to review the merits of a contractor's decision that a supplier's CAP was unacceptable, including a decision that a CAP did not contain "verifiable evidence of … supplier compliance with enrollment requirements." MPIM Ch. 10, § 19.A; 42 C.F.R. § 405.874(e). Here, FCSO denied Petitioner's CAP because "the CAP plan was reviewed and was found to be incomplete or missing information," and thus "did not contain verifiable evidence [that Petitioner was] in compliance with the enrollment requirements …." CMS Ex. 11.

Our decision here is consistent with the Board's decision in *DMS Imaging*, where the Board determined that the regulations preclude ALJ review of a contractor's rejection of a supplier's CAP. We find unpersuasive Petitioner's argument that *DMS Imaging* is inapplicable here because, according to Petitioner's characterization, her appeal challenges FCSO's "failure to afford her the opportunity to *complete* the CAP," not the rejection of the CAP. P. Br. before ALJ at 3 (emphasis added). The opportunity to correct noncompliance provided under section 424.535(a)(1), as detailed in the MPIM, was explained to Petitioner in the May 26, 2011 notice of revocation. Specifically, Petitioner was notified that she could attempt to correct the deficiency in her enrollment application by submitting a CAP, including all of the evidence necessary to verify her compliance with the enrollment requirements, within 30 days. CMS Ex. 8. The record further shows that FCSO determined as of September 2, 2011 that Petitioner had yet to provide all of the information and/or documentation needed to correct the deficiencies in her enrollment application. CMS Ex. 11. Thus, the record shows, and Petitioner does not deny, that she was provided at least the 30-day opportunity for correction to which she was entitled under the regulations and policy guidance. Petitioner also does not deny that the CAP initially submitted within that time was incomplete. The sufficiency (including the completeness) of the CAP submitted within that time frame and whether CMS should have afforded Petitioner further opportunity to "complete" the CAP are not initial determinations subject to ALJ or Board review.

We note that the January 25, 2012 reconsideration determination letter may have caused some confusion about Petitioner's appeal rights in this case. The reference heading ("RE") on the letter read "Request for Reconsideration for Corrective Action Plan . . ." rather than referencing the May 26, 2011 notice of revocation for which Petitioner had correctly been afforded an opportunity to request reconsideration. In addition, although the letter correctly explained that the reconsideration determination was based on the documentation in Petitioner's Medicare provider enrollment file at the time the initial notice to revoke was issued and that any evidence demonstrating compliance after the

date of the revocation was excluded from the scope of review, the letter also discussed Petitioner's corrective action submissions and attempted communications between the parties relating to the CAP. CMS Ex. 1, at 3-4. Further, while the letter stated that FCSO properly revoked Petitioner's enrollment and billing privileges based on established Medicare enrollment guidelines, it also stated that the reconsideration request was "denied for not receiving all requested information timely." *Id.* at 4. This language could have led Petitioner to conclude that her right to appeal the determination reconsidering the revocation of her Medicare enrollment and billing privileges included the opportunity to challenge the denial of her CAP. While not entirely clear, the language in the letter alone could not (and did not) create a right to appeal the CAP determination where neither Congress nor CMS has provided such a right.

Conclusion

For the reasons stated above, we uphold the ALJ Decision sustaining the revocation of Petitioner's Medicare enrollment and billing privileges effective May 4, 2011 and barring her reapplication for three years.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Sheila Ann Hegy
Presiding Board Member