Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Augusto Rojas, M.D. (PTANs: A41262, A41262A, WA41262A, & WA41262B),	)	Date: June 2, 2008
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-08-78
	)	Decision No. CR1797
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

The Medicare enrollment and billing privileges of Petitioner, Augusto Rojas, M.D., were properly revoked, effective February 17, 2007.

I. Background

The Centers for Medicare & Medicaid Services' (CMS's) Medicare contractor, National Heritage Insurance Company, notified Petitioner by letter dated January 18, 2007, that his Medicare Provider Identification Numbers (currently referred to as Provider Transaction Access Numbers (PTANs)) were revoked effective February 17, 2007. The notice advised Petitioner that the revocation was based on his felony conviction in the U.S. District Court, Eastern District of California, on March 16, 1998, of filing false tax returns. CMS Exhibit (CMS Ex.) 1. Petitioner's request for reconsideration of the decision was denied by a contractor hearing officer (hearing officer) on September 7, 2007. The hearing officer cited as grounds that Petitioner was convicted on March 16, 1998 in the U.S. District Court, Eastern District of California, of one count of mail fraud in violation of 18 U.S.C. § 1341 and one count of false tax returns in violation of 26 U.S.C. § 7206(l). CMS Ex. 2.

Petitioner requested a hearing before an administrative law judge (ALJ) by letter dated October 25, 2007. The case was assigned to me for hearing and decision on November 28, 2007. On January 8, 2008, I convened a prehearing conference by telephone, the substance of which is memorialized in my Order and Schedule for Filing Briefs and Documentary Evidence dated January 9, 2008. During the prehearing conference, CMS agreed that proceedings in this case are subject to 42 C.F.R. Part 498. The parties agreed that this case may be decided based upon the briefs of the parties and the documentary evidence and Petitioner waived the right to an oral hearing to present testimony. I established a briefing schedule that was subsequently extended at the request of Petitioner. CMS filed its opening brief (CMS Brief) and CMS Exhibits 1 through 3 (CMS Exs.) on February 1, 2008. Petitioner filed an opposition on March 10, 2008 with Petitioner's Exhibits (P. Exs.) marked A, B, and C; an amended opposition on March 21, 2008 with its previously submitted exhibits remarked as 1 through 3; and a request for judicial notice on March 27, 2008. CMS filed its reply on April 7, 2008. Petitioner requested judicial notice of an undated letter addressed to him from the Office of the Inspector General (I.G.), Department of Health and Human Services. Judicial notice is not appropriate and I have marked the letter attached to the request as P. Ex. 4, pages 1 and 2. The parties have not objected to my consideration of the offered exhibits and CMS Exhibits 1 through 3 and Petitioner Exhibits 1 through 4 are admitted.

II. Discussion

A. Findings of Fact

These findings are based upon the undisputed statements of fact in the parties' pleadings and the documentary evidence admitted.

1. On about March 16, 1998, Petitioner was convicted in the U.S. District Court, Eastern District of California, of one count of mail fraud in violation of 18 U.S.C. § 1341 and one count of false tax returns in violation of 26 U.S.C. § 7206(1), both felonies.

2. Petitioner was enrolled in Medicare and authorized to accept assignment of claims and receive payment through Medicare on January 18, 2007, when the contractor notified him that his enrollment was being revoked effective February 17, 2007.

3. Petitioner's conviction occurred within the 10 years preceding his enrollment or revalidation of enrollment in Medicare.

4. CMS has determined and provided by regulation that financial crimes such as income tax evasion or similar crimes are detrimental to the Medicare program or its beneficiaries. 42 C.F.R. § 424.535(a)(3)(B).

5. Petitioner was convicted of mail fraud and false tax returns, which are financial crimes similar to the financial crimes that CMS has found are detrimental to the Medicare program or its beneficiaries.

B. Conclusions of Law

1. I have jurisdiction.

2. There is a basis for revocation of Petitioner's enrollment in Medicare and his billing privileges.

3. The CMS action to revoke Petitioner's enrollment is not barred by the doctrine of equitable estoppel.

4. Petitioner's enrollment in Medicare and his billing privileges were properly revoked effective February 17, 2007.

C. Applicable Law

Section 1831 of the Social Security Act (the Act) (42 U.S.C. § 1395j) establishes the supplementary medical insurance benefits program for the aged and disabled known as Medicare Part B. Payment under the program for services rendered to Medicare eligible beneficiaries, may only be made to eligible providers of services and suppliers.[1] Act, sections 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395(u)(h)(1)). Administration of the Part B program is through contractors. Act, section 1842(a) (42 U.S.C. § 1395u(a)). The Act requires the Secretary of Health and Human Services (Secretary) to issue regulations that establish a process for the enrollment of providers and suppliers, including the right to a hearing and judicial review in the event of denial or non-renewal. Act, section 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to 42 C.F.R. § 424.505, a provider or supplier must be enrolled in the Medicare program and be issued a billing number to have billing privileges and to be eligible to receive payment for services rendered to a Medicare eligible beneficiary. If enrollment is approved, a

[1] A "supplier" furnishes services under Medicare and includes physicians or other practitioners and facilities that are not a "provider of services." Act, section 1861(d) (42 U.S.C. § 1395x(d)). A "provider of services," commonly shortened to "provider," includes hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, hospice programs, or are subject to section 1814(g) and section 1835(e) of the Act. Act, section 1861(u) (42 U.S.C. § 1395x(u)). The distinction between providers and suppliers is important because they are treated differently under the Act for some purposes.

supplier is issued a National Provider Identifier (NPI) to use for billing Medicare and a Provider Transaction Access Number (PTAN), an identifier for the supplier for inquiries. Medicare Program Integrity Manual (MPIM), Chapter 10 – Healthcare Provider/Supplier Enrollment, § 6.1.1.

Qualified physician services are covered by the program for those enrolled, subject to some limitations. Act, sections 1832(a), 1861(s)(1) (42 U.S.C. §§ 1395k(a), 1395x(s)(1)). "Physician's Services" means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls (with certain exceptions). Act, section 1861(q) (42 U.S.C. § 1395x(q)). The term "Physician," when used in connection with the performance of any function or action, means, in part, a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she performs such function or action. Act, section 1861(r) (42 U.S.C. §1395(x)(r)); 42 C.F.R. § 410.20(b). The Medicare program authorizes Medicare Part B payments for services provided by physicians. 42 C.F.R. § 410.20. A physician who wants to bill Medicare or its beneficiaries for Medicare-covered services or supplies must enroll in the Medicare program. 42 C.F.R. § 424.505. Medicare pays a supplier directly for covered services if the beneficiary assigns the claim to the supplier and the supplier accepts it. Medicare may pay a supplier's employer if the supplier is required, as a condition of employment, to turn over the fees for the supplier's services. Medicare will also pay an entity billing for a supplier's services if the entity is enrolled in Medicare and there is a contractual arrangement between the entity and the supplier. Act, section 1842(b)(6); 42 C.F.R. §§ 424.55(a), 424.80(a) and (b).

CMS may deny a supplier's enrollment application if a supplier is not in compliance with Medicare enrollment requirements. 42 C.F.R. § 424.530(a)(1). A supplier enrollment is considered denied when a supplier is determined to be "ineligible to receive Medicare billing privileges for Medicare-covered items or services provided to Medicare beneficiaries" for one or more of the reasons listed in 42 C.F.R. § 424.530. 42 C.F.R. § 424.502. CMS's contractor notifies a supplier in writing when it denies enrollment and explains the reasons for the determination and information regarding the supplier's right to appeal. 42 C.F.R. § 498.20(a); MPIM Ch. 10, §§ 6.2, 13.2. The supplier may submit a written request for reconsideration to CMS. 42 C.F.R. § 498.22(a). CMS must give notice of its reconsidered determination to the supplier, giving the reasons for its determination and specifying the conditions or requirements the supplier failed to meet. 42 C.F.R. § 498.25. If the CMS decision on reconsideration is unfavorable to the supplier, the Act provides for a hearing by an ALJ and judicial review. Act, section 1866(j).

If a provider or supplier is accepted for enrollment and granted billing privileges, the enrollee is subject to revalidation every five years. Every five years, the enrollee is required to resubmit and recertify the accuracy of its enrollment information and the information is reverified by the CMS contractor. CMS is also permitted to conduct "off-cycle" revalidations, which may be conducted at any time and which may be triggered by random checks, adverse information, national initiatives, complaints, or other reasons that cause CMS to question whether the provider or supplier continues to meet enrollment requirements. 42 C.F.R. § 424.515.

CMS may revoke an enrolled provider's or supplier's Medicare billing privileges and any provider or supplier agreement for any of the reasons listed in 42 C.F.R. § 424.535. Pursuant to 42 C.F.R. § 424.535(a)(3), if a provider or supplier or the owner of a provider or supplier is convicted of a federal or state felony that CMS has determined is detrimental to the program or its beneficiaries, CMS may revoke billing privileges. *See* Act, section 1866(b)(2)(D) (42 U.S.C. § 1395cc(b)(2)(D)). However, the regulation specifies that the conviction must have occurred within the 10 years preceding enrollment or revalidation of enrollment in Medicare. Offenses that CMS has found detrimental to the program or its beneficiaries include financial crimes such as income tax evasion, insurance fraud, and similar crimes. 42 C.F.R. § 424.535(a)(3)(B). The Act provides for a hearing by an ALJ and judicial review of the determination to deny enrollment or re-enrollment. Act, section 1866(j).

D. Issue

Whether Petitioner's enrollment in Medicare and his billing privileges were properly revoked.

E. Analysis

Petitioner does not deny that on or about March 16, 1998, he was convicted in the U.S. District Court, Eastern District of California, of one count of mail fraud in violation of 18 U.S.C. § 1341 and one count of false tax returns in violation of 26 U.S.C. § 7206(1), both felonies. There is no dispute that Petitioner was enrolled in Medicare and authorized to accept assignment of claims and receive payment through Medicare on January 18, 2007, when the contractor notified him that his enrollment was being revoked effective February 17, 2007. Neither party has offered Petitioner's application for enrollment nor other evidence to show when he applied or was accepted for enrollment. However, because there is no dispute that he was enrolled on January 18, 2007, it is reasonable to infer that his application for enrollment was submitted and accepted prior to that date.

Petitioner argues that CMS should be estopped from revoking Petitioner's enrollment and billing privileges.[2] Petitioner's theory is based upon facts that are not disputed by CMS. Petitioner's Exhibit 4 is an undated letter addressed to him from the I.G., which notifies him that based upon his conviction in the U.S. District Court, Eastern District of California, the I.G. was excluding him from participation in Medicare, Medicaid, and all federal health care programs pursuant to section 1128(a) of the Act (42 U.S.C. § 1320a-7(a)). However, a letter from the I.G. dated December 18, 2002, advised Petitioner that after review, the I.G. determined that the action to exclude Petitioner did not meet the statutory requirements of section 1128(a)(1) of the Act. P. Ex. 3. Petitioner argues that CMS and the I.G. are both part of H.H.S., and that CMS should be estopped from revoking Petitioner's Medicare enrollment because the I.G. determined Petitioner's conviction did not meet the statutory requirement for exclusion, and "its implied determination that the offenses were not detrimental to the best interest of the program." P. Brief at 4-5.

Petitioner's argument that CMS should be estopped is without merit. Section 1128(a) of the Act requires that the Secretary exclude from participation in Medicare, Medicaid, and any federal health care program any individual who has been convicted of a criminal offense related to the delivery of an item or service under Medicare or a state health care program. The mandatory exclusion is triggered by a conviction of a criminal offense when the offense is related to the delivery of an item or service under Medicare or a state health care program. The Act gives no discretion to the Secretary but rather mandates exclusion when the elements of the statute are satisfied. The I.G. notice dated December 18, 2002, states the I.G. determined that the I.G. exclusion action did not meet the statutory requirements of section 1128(a)(1), without further explanation. P. Ex. 3. However, because there is no question that Petitioner was convicted, the most likely reason for the I.G. not pursing the exclusion action is that the I.G. determined that the offenses for which Petitioner was convicted were not related to the delivery of an item or service under Medicare or a state health care program. The I.G. decision not to pursue the exclusion action based upon section 1128(a)(1) would not have involved a

---

[2] Petitioner also mentions, but cites no authority for the proposition, that Petitioner's conviction occurred prior to the effective date of 42 C.F.R. § 424.535, thus the regulation is being applied retroactively in violation of the *ex post facto* clause (U.S. Const. art. I, § 9). P. Brief at 5. The *ex post facto* clause relates only to the penal or criminal laws of the United States. *See* 16A C.J.S. *Constitutional Law* §§ 582, 584, 586 (Westlaw 2008). Non-penal, civil laws may be applied retroactively or retrospectively without offending the *ex post facto* clause. *Id.* It is clear from their plain language, that neither section 1866(b)(2)(D) of the Act nor 42 C.F.R. § 424.535 are penal.

determination that Petitioner's offenses were "not detrimental to the best interest of the program," contrary to Petitioner's assertion. P. Brief at 4-5. Section 1128(a)(1) neither requires nor permits consideration of "the best interest of the program" as the elements of the statute are either met or they or not.

Petitioner relies upon a California case, *Munoz v. State of California*, 33 Cal.App.4th 1767, 1785; 39 Cal.Rptr.2d 860 (Cal.Ct.App. 1995), as the source for the elements of an equitable estoppel defense. The case involved the daughter of a deceased California prisoner who sought to obtain permission to file a late tort claim against the state under the California Tort Claims Act. The daughter alleged that prison medical personnel failed to treat her father for cancer, which led to his wrongful death. The trial court found that the daughter's attorney filed the application for leave to present a late tort claim after the one-year period for filing expired. The trial court further found, that even if the application had been timely received, the daughter's failure to file the tort claim timely within six months was not excusable because her delay in filing was not attributable to state employees. Thus, the daughter's tort claim was time barred. The daughter argued the state should be equitably estopped from asserting timeliness as a bar as its employees had not timely responded to her attorney's request for her father's medical records. 33 Cal. App. at 1772-75, 1785. The daughter argued that California employees acted affirmatively to deny her attorney the medical records of her father. The California Appellate court commented that a public entity, presumably a California entity within that court's jurisdiction, could be estopped from asserting limitations of the California tort claims statutes where its employees prevented or deterred timely filing of a claim by some affirmative act. The court identified the elements necessary for the affirmative defense of equitable estoppel as:

> (1) the party to be estopped must be apprised of the facts; (2) the party to be estopped must intend his or her conduct to be acted upon or must act so that the party asserting estoppel had a right to believe it was so intended; (3) the other party must be ignorant of the true state of facts; and (4) the other party must rely upon the conduct to his or her injury.

33 Cal.App. at 1785. The California court rejected the daughter's estoppel defense. Petitioner never explains how this California case involving assertion of the affirmative defense of equitable estoppel in a California case involving the California Tort Claims Act has any application in the case before me. Even if it did apply, Petitioner fails to show the required elements. The only act of a government employee that Petitioner points to is the decision of the I.G. that Petitioner's conviction did not require his exclusion from Medicare. Certainly, the I.G. decision did not cause Petitioner to enroll in Medicare as Petitioner was already enrolled, otherwise there would have been no need to consider his exclusion at all. Petitioner does not argue that the I.G. action prevented him from withdrawing from the Medicare program, and I would not find such argument

credible anyway. The issue under the *Munoz* decision that Petitioner overlooks or ignores is whether or not the decision of the I.G. amounted to the affirmative act of a government employee that prevented or deterred Petitioner from exercising a right under the law or was otherwise detrimental to Petitioner. Petitioner argues that he relied upon the I.G. decision and built-up his medical practice caring for Medicare eligible patients. P. Brief at 6. Petitioner does not explain how building up his practice and receiving payment from Medicare for services he delivered to his Medicare eligible beneficiaries between 2002 and 2007 caused him any injury. Petitioner simply does not show that his reliance upon the decision of the I.G. caused him any harm or detriment. The elements of estoppel listed by the Court in *Munoz*, clearly require that the party asserting estoppel must have relied upon the act of the government employee to his detriment. Petitioner also argues that he was ignorant of the fact that CMS might exclude him for the same conviction that the I.G. determined was not a basis for exclusion. P. Brief at 6. I appreciate that Medicare is a highly complicated program and that the Act and the regulations have many complicated provisions. I am not prepared to accept ignorance of the law as an excuse.

Petitioner cited no authority for the proposition that the California appellate decision has any application to this case, because it does not. Rather, it is necessary to look to federal law and the result is that Petitioner's estoppel defense has no merit. The decisions of the United States Supreme Court in *Office of Personnel Management v. Richmond*, 496 U.S. 414, 110 S.Ct. 2465, 110 L.Ed.2d 387 (1990) and *Heckler v. Community Health Services of Crawford County, Inc.*, 467 U.S. 51, 104 S.Ct. 2218, 81 L.Ed.2d 42, 5 Soc.Sec.Rep.Ser. 29 (1984) make clear that estoppel will generally not lie against the government in cases involving benefits to be paid from the Treasury, particularly in the complicated area of Medicare.[3] In *Heckler*, the Court commented that for the equitable doctrine of estoppel to be available, the party claiming the estoppel must have relied to his detriment upon the conduct of the party against whom estoppel is asserted. 467 U.S. at 59. For the reasons already discussed Petitioner has not shown any detriment due to his reliance upon the conduct of any federal agency or employee.

---

[3] It has been consistently held that ALJs do not have the authority to hear and decide claims of estoppel against CMS or the Secretary related to alleged dilatory processing of applications. *GranCare Home Health Service & Hospice*, DAB CR464 (1997); *The Rivers Health Care Resources, Inc.*, DAB CR446 (1996); *SRA, Inc. D/B/A St. Mary Parish Dialysis Center*, DAB CR341 (1994); *T.L.C. Mental Health Center*, DAB CR636 (1999); *Therapeutic Rehabilitation Centers, Inc.*, DAB CR531 (1998). However, I find no similar limit to my jurisdiction where Petitioner asserts estoppel as a defense in an enforcement action. *Accord Stacy Ann Battle, D.D.S.,* DAB No. 1843 (2002).

Petitioner was convicted of felony offenses in 1998. Petitioner does not deny that his conviction occurred within the 10 years preceding his enrollment or revalidation. CMS has determined and provided by regulation that financial crimes such as income tax evasion or similar crimes are detrimental to the Medicare program or its beneficiaries. 42 C.F.R. § 424.535(a)(3)(B). Petitioner was convicted of mail fraud and false tax returns. Petitioner does not dispute that his crimes are similar to the financial crimes that CMS has found are detrimental. Petitioner's defense of equitable estoppel has no merit. Accordingly, I conclude that CMS had a basis to revoke Petitioner's billing privileges and CMS is not estopped from doing so.

III. Conclusion

Petitioner's enrollment in Medicare and his billing privileges were properly revoked.

/s/
Keith W. Sickendick
Administrative Law Judge