Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Phyllis Barson, M.D.
(NPI: 1578676748),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-11-800

Decision No. CR2510

Date: February 28, 2012

DECISION

The Medicare enrollment and billing privileges of Petitioner, Phyllis Barson, M.D., are revoked, effective January 13, 2011, for noncompliance with enrollment requirements and failure to report an adverse legal action.

I. Background

On March 9, 2011, the Centers for Medicare and Medicaid Services (CMS) revoked Petitioner's enrollment and billing privileges effective January 13, 2011, pursuant to 42 C.F.R. § 424.535(a)(1), due to the suspension of her Maryland medical license, which caused Petitioner to no longer meet the requirements for participation in Medicare. Social Security Act (Act) § 1861(r) (42 U.S.C. § 1395x(r)); 42 C.F.R. § 410.20(b). CMS also cited 42 C.F.R. § 424.516(d)(1)(ii) as a reason for revoking Petitioner's license, as she failed to report the adverse legal action to CMS. CMS Exhibit (CMS Ex.) 4.

Petitioner submitted a Corrective Action Plan (CAP) by letter dated April 6, 2011, in which she indicated that her license would be reinstated three months after the anticipated approval of a consent order on about April 19, 2011. CMS Ex. 5, at 5. On July 7, 2011, Highmark, the CMS contractor, issued a reconsideration decision. The reconsideration

decision indicates that Petitioner's April 6, 2011 letter was treated as a request for reconsideration because the time for submitting a CAP had lapsed. CMS Ex. 5, at 1. The hearing specialist also concluded that revocation was appropriate on both grounds cited by Highmark in the March 9, 2011 notice of revocation. CMS Ex. 5.

On September 19, 2011, Petitioner requested a hearing before an administrative law judge (ALJ). This case was assigned to me for hearing and decision. I issued an Acknowledgement and Prehearing Order (Prehearing Order) on September 20, 2011. On October 19, 2011, CMS filed a Motion for Summary Judgment (CMS Br.) with CMS exhibits (Exs). 1 through 6. Petitioner filed a Response to Motion for Summary Judgment (P. Br.) and Petitioner's exhibit (P. Ex.) 1.[1] CMS waived a reply by letter dated December 12, 2011. Petitioner did not object to my consideration of CMS Exs. 1 through 6, and they are admitted. CMS filed no objection to my consideration of P. Ex. 1. Petitioner correctly states that P. Ex. 1 is new evidence under 42 C.F.R. § 498.56(e), as it was not considered on reconsideration. P. Br. at 2, n.1, 4-5. The information in P. Ex. 1 was available at the time of reconsideration and reflects the status of Petitioner's license as of May 2, 2011 through the date of reconsideration. I find good cause pursuant to 42 C.F.R. §498.56(e)(2), and P. Ex. 1 is admitted.

II. Discussion

A. Applicable Law

Section 1831 of 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.[2] Act §§ 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395(u)(h)(1)). Administration of the Part B

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[1] Petitioner did not mark the exhibit in the manner specified by the Civil Remedies Division Procedure (CRDP) ¶ 9 and my Prehearing Order, ¶ 9. I have correctly marked the document P. Ex. 1.

[2] A "supplier" furnishes services under Medicare, and the term supplier applies to physicians or other practitioners and facilities that are not included within the definition of the phrase "provider of services." Act § 1861(d) (42 U.S.C. § 1395x(d)). A "provider of services" includes hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, hospice programs, and a fund as described in sections 1814(g) and 1835(e) of the Act. Act § 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.

program is through contractors, such as Highmark Medicare Services. Act § 1842(a) (42 U.S.C. § 1395u(a)).

The Act requires that the Secretary of Health and Human Services (the Secretary) 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 § 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 supplier is issued a National Provider Identifier (NPI) to use for billing Medicare and a Provider Transaction Access Number (PTAN), an identifier of the supplier for inquiries. Medicare Program Integrity Manual, CMS Publication 100-08, Chapter 10, Healthcare Provider/Supplier Enrollment, § 6.1.1.

Medicare Part B covers qualified physician services of physicians enrolled in Medicare, subject to some limitations. Act §§ 1832(a) (42 U.S.C. § 1395k(a)); 1861(s)(1) (42 U.S.C. § 1395x(s)(1)). "Physician's services" are professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls (with certain exceptions). Act § 1861(q) (42 U.S.C. § 1395x(q)). The term "physician," when used in connection with the performance of any function or action, includes a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, and a chiropractor, if legally authorized to practice medicine and surgery by the state in which he or she performs such function or action and subject to the limitations specified in the Act. Act § 1861(r) (42 U.S.C. § 1395x(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.

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)(1), CMS may revoke a provider's or supplier's enrollment if it is determined that the provider or supplier is not in compliance with enrollment requirements and fails, after being given the opportunity, to achieve compliance before a final determination to revoke billing privileges. Pursuant to 42 C.F.R. § 424.535(a)(9), billing privileges may also be revoked for failure to report the information required by 42 C.F.R. § 424.516(d)(1)(ii) and (iii). Physicians, non-physician practitioners, and organizations of such individuals must report the following events to the appropriate CMS contractor within 30 days, and other changes in enrollment must be reported within 90 days: (1) change of ownership; (2) any adverse legal action; or (3) a change in practice location. The effective date of revocation of billing privileges in the case of license suspension or revocation is the date of the license suspension or

revocation. 42 C.F.R. § 424.535(g). Re-enrollment in Medicare is barred for a period of one to three years following revocation of billing privileges, depending upon the severity of the reason for revocation. 42 C.F.R. § 424.535(c). A provider or supplier whose enrollment and billing privileges are revoked may request review of the revocation decision in accordance with 42 C.F.R. Part 498. 42 C.F.R. § 424.545.

B. Issues

The issues in this case are:

Whether summary judgment is appropriate; and

Whether there is a basis for the revocation of Petitioner's Medicare enrollment and billing privileges.

C. Findings of Fact, Conclusions of Law, and Analysis

My conclusions of law are set forth in bold text followed by my findings of fact and analysis.

1. Summary judgment is appropriate.

CMS has requested summary judgment. The Secretary's regulations that establish the procedure to be followed in adjudicating Petitioner's case are at 42 C.F.R. Part 498. 42 C.F.R. § 424.545(a)(1). The regulations do not establish a summary judgment procedure or recognize such a procedure. However, the Departmental Appeals Board (the Board) has long accepted that summary judgment is an acceptable procedural device in cases adjudicated pursuant to 42 C.F.R. Part 498. The Board has also recognized that the Federal Rules of Civil Procedure are not applicable in administrative adjudications such as this, but the Board has accepted that Federal Rule of Civil Procedure 56 and related cases provide useful guidance for determining whether summary judgment is appropriate.

Summary judgment is appropriate when there is no genuine dispute as to any issue of material fact for adjudication and/or the moving party is entitled to judgment as a matter of law. 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. The party requesting summary judgment bears the burden of showing that there are no genuine issues of material fact for trial and/or that it is entitled to judgment as a matter of law. Generally, the non-movant may not defeat an adequately supported summary judgment motion by relying on the denials in its pleadings or briefs but must furnish evidence of a dispute concerning a material fact, *i.e.*, a fact that would affect the outcome of the case if proven. *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 at 3 (2010) (and cases cited therein). The

standard for deciding a case on summary judgment and an ALJ's decision-making in deciding a summary judgment motion differs from resolving a case after a hearing. On summary judgment, the ALJ does not make credibility determinations, weigh the evidence, or decide which inferences to draw from the evidence, as would occur when finding facts after a hearing on the record. Rather, on summary judgment, the ALJ construes the evidence in a light most favorable to the non-movant and avoids deciding which version of the facts is more likely true. *Holy Cross Vill. at Notre Dame, Inc*, DAB No. 2291 at 5 (2009). The Board has also recognized that, on summary judgment, it is appropriate for the ALJ to consider whether a rational trier of fact could find that the parties' evidence would be sufficient to meet that party's evidentiary burden. *Dumas Nursing and Rehab., L.P.*, DAB No. 2347, at 5 (2010). The Secretary has not provided for the allocation of the burden of persuasion or the quantum of evidence in 42 C.F.R. Part 498. However, the Board has provided some persuasive analysis regarding the allocation of the burden of persuasion in cases subject to 42 C.F.R. Part 498. *Batavia Nursing and Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd*, *Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 Fed. App'x 181 (6th Cir. 2005).

The material facts in this case, as discussed hereafter, are not disputed. The issues in this case that require resolution are issues of law related to the interpretation and application of the regulations that govern the revocation of enrollment and billing privileges in the Medicare program to the undisputed facts of this case. Accordingly, summary judgment is appropriate.

2. There was a basis for the revocation of Petitioner's enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(1), because she was not legally authorized to practice medicine as a physician due to the suspension of her license. Act § 1861(r); 42 C.F.R. § 410.20(b).

3. There was a basis for revocation of Petitioner's enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(9), because Petitioner failed to report adverse legal action as required by 42 C.F.R. § 424.516(d)(1)(ii).

Petitioner does not dispute that, on January 13, 2011, the Maryland State Board of Physicians (Maryland Board) entered an Order of Summary Suspension suspending Petitioner's license to practice medicine. CMS Ex. 1; CMS Ex. 3; P. Ex. 1; P. Br. at 1. Petitioner avers, and for purposes of summary judgment I accept as true, that she subsequently entered into a consent order with the Maryland Board.[3] The consent order

[3] Petitioner has not submitted a copy of the May 2, 2011 consent order. However, for summary judgment, I accept that the basic terms are reflected in P. Ex. 1.

issued on May 2, 2011: terminated the summary suspension imposed on January 13, 2011; imposed a new 90-day suspension beginning the date of the consent order; and imposed probation for a minimum period of two years. P. Ex. 1; P. Br. at 1-2. I accept as true for purposes of ruling on summary judgment that the suspension of Petitioner's license concluded on about August 1, 2011, and her license was reinstated. P. Ex. 1; P. Br. at 2. Petitioner does not dispute that she failed to report to CMS or a CMS contractor that the Maryland Board had suspended her medical license. P. Br. at 5; Hearing Request at 2.

The summary suspension imposed on January 13, 2011, and the 90-day suspension imposed on May 2, 2011, were not permanent suspensions or revocations of Petitioner's license to practice medicine in Maryland. However, pursuant to January 13, 2011 summary suspension order, Petitioner was required to surrender her medical license. CMS Ex. 1, at 26. Maryland law provides that, upon suspension of a medical license, "the holder shall surrender the license certificate to the Board." Md. Code Ann., Health Occ. § 14-407 (2011). Therefore, during the suspension of her license from January 13 through August 1, 2011, Petitioner was not legally allowed to practice medicine. In fact, it is a felony under Maryland law to practice, attempt to practice, or offer to practice medicine without a license, subject to a fine not exceeding $10,000 or imprisonment not exceeding five years or both, as well as possible civil fines of up to $50,000 payable to the Maryland Board. Md. Code Ann., Health Occ. § 14-606.

Highmark notified Petitioner of two grounds for the revocation of her billing privileges: (1) Maryland suspended Petitioner's license to practice medicine, and she no longer satisfied the requirement of section 1861(r) of the Act, as implemented by 42 C.F.R. § 410.20(b), as she was no longer legally authorized to practice medicine or surgery in Maryland; and (2) Petitioner failed to report the suspension of her medical license by Maryland, an adverse legal action for which reporting is required by 42 C.F.R. § 424.516(d)(1)(ii). CMS Ex. 4, at 1. I conclude that revocation of Petitioner's billing privileges and enrollment was justified on both grounds.

Section 1861(r) of the Act and 42 C.F.R. § 410.20(b) are clear that, to participate in Medicare and to seek reimbursement for physician services provided to a Medicare beneficiary, the physician must be legally authorized to practice medicine by the state in which the physician provides the services. Petitioner does not dispute that she could not legally provide physician services in Maryland during the suspension of her license to practice medicine. CMS may revoke the billing privileges of any currently enrolled provider or supplier, ending their participation in Medicare, for many reasons. Noncompliance with the enrollment requirements is an authorized basis for revocation of Medicare billing privileges and enrollment. 42 C.F.R. § 424.535(a)(1). Petitioner could not legally practice medicine in Maryland while her license was suspended, and she no longer met the enrollment requirement of section 1861(r) of the Act and 42 C.F.R. §

410.20(b). Therefore, revocation of Petitioner's enrollment and billing privileges was authorized by 42 C.F.R. § 424.535(a)(1).

Petitioner argues that the contractor mistakenly relied on the Maryland Board's January 13, 2011 suspension order and, instead, should have considered the final consent order, which included different terms and conclusions and was available before Highmark issued its reconsideration. P. Br. at 4. Petitioner's argument is without merit. The fact that the contractor hearing officer did not consider the Maryland Board's action on May 2, 2011, has no impact upon the result in this case. Similarly, the fact that after August 1, 2011, Petitioner regained her license and ability to practice medicine subject to the terms of her probation has no impact. Petitioner did not have a medical license and could not legally practice medicine in Maryland from January 13 to August 1, 2011. Therefore, she did not meet the requirements for Medicare enrollment during that period and revocation was authorized pursuant to 42 C.F.R. § 424.535(a)(1).

Revocation was also authorized by 42 C.F.R. § 424.535(a)(9) because Petitioner did not report the suspension of her Maryland medical license. Enrolled physicians are required to report to their Medicare contractor any adverse legal action within thirty days of the action. 42 C.F.R. § 424.516(d)(1)(ii). The phrase "adverse legal action" is not specifically defined in 42 C.F.R. Part 424. But the ordinary or usual meaning of the individual words support a conclusion that the drafters of the regulation intended the phrase to refer to some legal action or action pursuant to or under color of law that is hostile to or contrary to the interest, concern, or position of one against whom the action was taken. *Black's Law Dictionary* 31, 58, 912 (18th ed. 2004); *Merriam-Webster Dictionary*, http://www.merriam-webster.com/dictionary (2011). This interpretation has been accepted by an appellate panel of the Board in *Akram A. Ismail, M.D.*, DAB No. 2429, at 10-11 (2011). Petitioner does not suggest that the suspension of her license in Maryland was not an adverse legal action. Petitioner does not dispute that she failed to report the adverse legal action of the Maryland Board. Hearing Request at 2; P. Br. at 5. Petitioner violated the reporting requirement established by 42 C.F.R. § 424.516(d)(1)(ii). Therefore, revocation of her billing privileges was also authorized by 42 C.F.R. § 424.535(a)(9).

Petitioner contends that she reasonably "believed that any necessary reporting had occurred." P. Br. at 5. She argues that she "did not fully understand this obligation" and "regrets any misunderstanding that may have occurred on her part." Hearing Request at 2. Petitioner's pleas of ignorance are no defense. The regulation places the burden upon the Medicare participant to report "[a]ny adverse legal action." 42 C.F.R. § 424.516(d)(l)(ii). There are no exceptions to the requirement to report. The regulation requires reporting even if an appeal of the suspension is pending. *Akram A. Ismail, M.D.*, DAB No. 2429, at 11. Petitioner argues that the revocation of her license serves no valid governmental purpose. P. Br. at 5. Petitioner is in error. A physician's failure to report the suspension of a medical license creates the situation in which the physician could

continue to submit claims for reimbursement by Medicare, even though the physician was not qualified to deliver services without a license and not qualified to participate in Medicare. The government has a legitimate goal of preventing Medicare fraud and imposing the burden upon practitioners to report their ineligibility furthers that goal. 73 *Fed. Reg.* 69,726, 69,777 (Nov. 19, 2008); *Akram A. Ismail, M.D.*, DAB No. 2429, at 11; *Gulf South Medical* & *Surgical Institute,* DAB No. 2400, at 8 (2011). Petitioner did not have a medical license and could not legally practice medicine in Maryland beginning January 13, 2011, due to the suspension. Petitioner did fulfill the participation requirement to report the adverse legal action to CMS, and her billing privileges and enrollment were properly revoked.

III. Conclusion

For the foregoing reasons, I conclude that there was a basis for the revocation of Petitioner's billing privileges and enrollment in Medicare.

/s/
Keith W. Sickendick
Administrative Law Judge