Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

John Crews, III, M.D.
(NPI: 1629169974),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-11-220

Decision No. CR2399

Date: July 18, 2011

DECISION

Petitioner, John Crews, III, M.D., appeals the determination of the Centers for Medicare and Medicaid Services (CMS) to revoke his enrollment and billing privileges as a supplier in the Medicare program for failing to report an adverse legal action to the Medicare contractor. For the reasons set forth below, I find that the undisputed facts establish that CMS had a legitimate basis to revoke Petitioner's enrollment and billing privileges, and I grant the CMS motion for summary judgment.

I. Background

Petitioner is a physician licensed to practice medicine and surgery in the Commonwealth of Virginia and in the Commonwealth of Pennsylvania. CMS Ex. 10, at 3; CMS Ex. 14, at 1. Petitioner practiced medicine in Virginia until 2007, when he moved to Pennsylvania to practice medicine. P. Br. at 1. On July 24, 2008, the Commonwealth of Virginia Board of Medicine (VA Board) notified Petitioner that it had initiated proceedings against Petitioner based on several allegations that he may have violated certain laws and regulations governing the practice of medicine in Virginia. P. Br. at 1-2;

CMS Ex. 11. Disciplinary proceedings against Petitioner followed. CMS Exs. 12-13. On February 6, 2009, the VA Board suspended Petitioner's license to practice medicine pursuant to a Consent Order. P. Br. at 1-2; CMS Ex. 14. The suspension and Consent Order were based on the VA Board's finding of nine separate violations related to inadequate patient care. P. Br. at 1-2; CMS Ex. 14, at 1-4, 8. During this period, Petitioner continued to practice medicine in Pennsylvania.

On June 1, 2010, National Government Services (NGS), the Medicare contractor for the Commonwealth of Virginia, notified Highmark Medicare Services (HMS), the Medicare contractor for the Commonwealth of Pennsylvania, that it had revoked Petitioner's Medicare billing privileges because Petitioner did not have a valid medical license in Virginia. P. Ex. 1. As a result, HMS staff conducted a search revealing that the VA Board suspended Petitioner's license. CMS Exs. 10, 16. By letter dated June 8, 2010, HMS notified Petitioner that he "failed to comply with the reporting requirement specified in 42 C.F.R. § 424.516(d)(1)(ii)," which requires suppliers to report adverse actions to Medicare within 30 days of the reportable event. CMS Ex. 2, at 1. Due to Petitioner's failure to report the suspension of his medical license in Virginia, HMS revoked Petitioner's enrollment as a supplier in the Medicare program, effective May 14, 2010, and instituted a one-year bar on reenrollment. CMS Ex. 2.

By letter dated July 28, 2010, Petitioner, through counsel, responded to the HMS June 8, 2010 revocation letter asserting that "[w]hile it is true that Dr. Crews' Virginia license was suspended, he was represented by a lawyer in those proceedings and believes that he met all of his notification obligations." CMS Ex. 3, at 1. Petitioner's representative continued, "[m]ore importantly, Dr. Crews was always legally authorized to practice in any state in which he rendered services." *Id*. Finally, Petitioner contends that the HMS June 8, 2010 letter was sent to an old address and not received by Petitioner until July 13, 2010. CMS Ex. 3. HMS treated Petitioner's letter as a corrective action plan (CAP), although it was submitted more than 30 days after the revocation. By letter dated August 16, 2010, HMS considered and rejected Petitioner's CAP, not for untimeliness, but for insufficient evidence that he notified the contractor within 30 days as required by the regulations. CMS Ex. 4.

Petitioner timely filed a request for reconsideration by letter dated August 20, 2010. CMS Ex. 5.[1] Counsel for Petitioner again argued that he "was always represented by counsel and believes that all proper notifications with respect to the status of his license were made." *Id*. at 1. On November 19, 2010, HMS issued its reconsideration decision, determining that HMS appropriately revoked his Medicare billing privileges and imposed

[1] I note that the June 8, 2010 and August 16, 2010 HMS letters may have first been directed to a previous or incorrect address for Petitioner. This did not prejudice Petitioner, however, because HMS processed Petitioner's appeals as timely.

a one-year bar on reenrollment.[2] CMS Ex. 9, at 2-3. The contractor explained that the suspension of Petitioner's Virginia medical license was an adverse action requiring notification within 30 days to each Medicare contractor with whom Petitioner is enrolled. *Id*.

Petitioner requested a hearing by letter dated January 17, 2011, and the case was assigned to me for decision. I issued an Acknowledgement and Pre-Hearing Order on January 24, 2011. CMS filed its motion for summary disposition (CMS Br.) accompanied by proposed exhibits (Exs.) 1-15 on February 28, 2011. On March 8, 2011, CMS supplemented its initial filing with proposed Ex. 16 and a proposed witness list. I admit CMS Exs.1-16 without objection.

On March 31, 2011, Petitioner filed his opposition to the CMS motion for summary disposition (P.Br.) and proposed Exs. 1-10. CMS filed a reply brief (CMS Reply) on April 19, 2011, in which it responded to Petitioner's argument and objected to Petitioner's proposed Exs. 9-10.[3] CMS Reply at 2 n.1. CMS argues that the two exhibits are new evidence and should be excluded under 42 C.F.R. §§ 405.874(c)(5) and 498.56(e), because they were not previously presented at the reconsideration level. Petitioner did not respond to the CMS objection. I will, however, admit the contested exhibits into the record because they do not change the outcome of my decision. I therefore admit P. Exs. 1-10 to the record.

II. Applicable Law

The regulations at 42 C.F.R. Part 424, subpart P, set out the requirements for enrollment and reporting of changes to enrollment information. "Providers and suppliers must meet and maintain these enrollment requirements to bill either the Medicare program or its beneficiaries for Medicare covered services or supplies." 42 C.F.R. § 424.500.

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[2] The contractor established Petitioner's revocation took effect on May 14, 2010. Petitioner's revocation, however, should have been effective on the date of his suspension, February 6, 2009, pursuant to 42 CFR § 424.535(g). Nonetheless, Petitioner states that he is not interested in retribution for the revocation period but only in having his billing privileges restored. P. Br. 4-5. Based on either date, the one-year bar on reenrollment is now over.

[3] P. Ex. 9 is an e-mail dated July 1, 2010, on behalf of Petitioner's employer informing him to "immediately cease rounding at [his] facilities until further notice." P. Ex. 10 is a letter, dated March 2, 2009 and directed to the "State Board of Medicine" for Pennsylvania, from Petitioner's attorney. He reported to the Pennsylvania Medical Board a pending civil action against Petitioner in Virginia and provided the Consent Order Petitioner entered into with the VA Board.

Section 424.535 lists the bases on which CMS may revoke a provider's or supplier's Medicare billing privileges and provider or supplier agreement. The bases include a failure to report provision (42 C.F.R. § 424.535(a)(9)) that cross-references 42 C.F.R. § 424.516(d)(1), which specifies:

> (d) *Reporting requirements for physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations.* Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations must report the following reportable events to their Medicare contractor within the specified timeframes:
>
> (1) Within 30 days—
>
> (i) A change of ownership;
> (ii) Any adverse legal action; or
> (iii) A change in practice location.

The regulations define "final adverse action" to include "[s]uspension or revocation of a license to provide health care by any State licensing authority." 42 C.F.R. § 424.502.

Providers or suppliers who have had their billing privileges revoked "are barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar," which is "a minimum of 1 year, but not greater than 3 years depending on the severity of the basis for revocation." 42 C.F.R. § 424.535(c).

III. Issue

The issue is whether CMS was authorized to revoke Petitioner's enrollment as a supplier in the Medicare program.

IV. Discussion

A. Summary judgment is appropriate in this case

CMS argues that it is entitled to summary judgment. The Departmental Appeals Board (Board) stated the standard for summary judgment:

> Summary judgment is appropriate when the record shows that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. . . . The party moving for summary judgment bears the initial burden of showing that there are no genuine issues of material fact for trial and that it is entitled to judgment as a matter of

> law. . . . To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact – a fact that, if proven, would affect the outcome of the case under governing law. . . . 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.

Senior Rehab. & Skilled Nursing Ctr., DAB No. 2300, at 3 (2010) (citations omitted). An ALJ's role in deciding a summary judgment motion differs from its role in resolving a case after a hearing. The ALJ should not assess credibility or evaluate the weight of conflicting evidence. *Holy Cross Vill. at Notre Dame, Inc*, DAB No. 2291, at 5 (2009). The Board has further stated, "[i]n addition, it is appropriate for the tribunal to consider whether a rational trier of fact could regard the parties' presentation as sufficient to meet their evidentiary burden under the relevant substantive law." *Dumas Nursing and Rehab., L.P.*, DAB No. 2347, at 5 (2010).

I have accepted all of Petitioner's factual assertions as true and drawn all reasonable inferences in his favor. In his hearing request, however, Petitioner generally claims, "[t]he status of Dr. Crews' license to practice medicine in Virginia . . . was appropriately reported to Medicare." Hearing Request at 2. This allegation alone, with no supporting proof, is not an offer of evidence of specific facts showing that a dispute exists. A mere scintilla of evidence is insufficient to establish a genuine factual dispute. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574 (1986). Absent any evidence to support Petitioner's blanket assertion, summary judgment is appropriate.

B. The undisputed evidence establishes that Petitioner did not properly report the suspension of his license to practice medicine in Virginia as section 424.516(d)(1)(ii) required, and therefore CMS was authorized to revoke his enrollment in Medicare under section 424.535(a)(9).

Petitioner signed an enrollment application agreeing to notify the Medicare contractor of any final adverse action within 30 days. CMS Ex. 15, at 27. The application stated that a State licensing authority's suspension of a license to provide health care is considered an adverse legal action that he must report. *Id*. at 14-15. It is undisputed that the VA Board suspended Petitioner's license to practice medicine on February 6, 2009. P. Br. at 1-2; CMS Ex. 14, at 8.

Subsection 424.535(a)(9) authorizes CMS to revoke billing privileges where a provider or supplier failed to comply with the reporting requirements including the requirement that "[p]hysicians [and] nonphysician practitioners . . . must report . . . to their Medicare contractor . . . [w]ithin 30 days . . . [a]ny adverse legal action." 42 C.F.R. § 424.516(d)(1)(ii). A "[f]inal adverse action" is defined to include "[s]uspension or

revocation of a license to provide health care by any State licensing authority." 42 C.F.R. § 424.502.

Although, as previously noted, Petitioner states in his hearing request that the status of his "license to practice Medicare in Virginia and Pennsylvania was appropriately reported to Medicare . . . " Petitioner has come forward with no evidence that could support any reasonable inference that Petitioner reported his Virginia medical license suspension to the Pennsylvania Medicare contractor, HMS. As the Board has explained, Petitioner "may not rely on the denials in [his] pleadings or briefs, but must furnish evidence of a dispute concerning a material fact," in this case, evidence that he reported the adverse action to HMS. *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 3 (2010).

Petitioner argues instead that he was licensed in Pennsylvania when providing services in that state and that he believed his attorney made any required disclosures regarding his Virginia license suspension. *See* Hearing Request; P. Br. It is irrelevant that Petitioner presumed that his attorney properly notified the Pennsylvania contractor. It was Petitioner's responsibility to assure that he properly reported all adverse actions to each Medicare contractor with whom he contracted to provide services. It is also irrelevant that Petitioner's attorney may have notified the Pennsylvania Medical Board of his suspension to practice in Virginia. *See* P. Ex. 10. Although, under his state medical license, Petitioner may have been required to report the adverse actions based in Virginia to the Pennsylvania Medical Board, his doing so is not relevant to the reporting requirement at issue in this case – to report the adverse action to HMS.

Petitioner further argues that even assuming CMS is correct that Petitioner failed to report the adverse action to the Medicare contractor, it "was an administrative error," and he has "not committed a substantive violation." P. Br. at 4. Petitioner also states that the "administrative error" was "perhaps the responsibility of [Petitioner], but not caused by him." *Id*. Petitioner further asserts that "[p]rocedurally, CMS' actions against [Petitioner] were much more egregious," for "[h]e was denied the right to be heard, while his billing privileges were revoked, effectively denying him the right to work as a physician." *Id*.

It is well-settled that a Petitioner is not deprived of due process when CMS provides Petitioner sufficient notice of the legal basis for the revocation and a reasonable opportunity to respond at the ALJ hearing level. *See Green Hills Enters., LLC*, DAB No. 2199, at 8 (2008); *see also Abercrombie v. Clarke*, 920 F.2d 1351, 1360 (7th Cir. 1990), *cert. denied*, 520 U.S. 809 (1991) (holding that defects in formal notice may be cured during the course of an administrative proceeding, and due process is satisfied as long as the party is reasonably apprised of, and given opportunity to address, the issues in controversy). The record reflects that, at each level of appeal, the Medicare contractor provided Petitioner his process due under this administrative appeals process, such as reviewing Petitioner's arguments despite untimely requests and issuing a detailed

reconsideration decision. Moreover, the record does not demonstrate that the contractor asserted a continually changing basis for revocation. Rather, the contractor has consistently based Petitioner's revocation on his failure to report the adverse action.

Although the contractor sent at least two of Petitioner's notices to an address that was not current for Petitioner, it is unclear whether that error is attributable to Petitioner or the contractor. Regardless of responsibility, it remains inconsequential to my decision. Petitioner concedes receiving notice, and I have provided Petitioner a reasonable opportunity to respond to CMS's basis for revocation. However, as discussed, Petitioner has offered no evidence in support of his empty assertion that he reported his Virginia medical license suspension to the Pennsylvania Medicare contractor.

Where a regulation speaks clearly on its face and applies to the question before me, I am bound to follow it. *See US Ultrasound*, DAB No. 2302, at 8 (2010) ("Neither the ALJ nor the Board is authorized to provide equitable relief by reimbursing or enrolling a supplier who does not meet statutory or regulatory requirements."). I am without authority to address considerations of equity.

V. Conclusion

The undisputed evidence establishes that CMS was authorized under 42 C.F.R. § 424.535(a)(9) to revoke Petitioner's enrollment and billing privileges for failing to comply with the reporting requirements set out in section 424.516(d)(1)(ii) when Petitioner did not report his Virginia license suspension to the Medicare contractor . I therefore grant the CMS motion for summary judgment.

/s/
Joseph Grow
Administrative Law Judge