Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Canal Street Pharmacy, Inc.
(PTAN: 5942970001 / NPI: 1851595904),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-16-580

Decision No. CR4745

Date: November 29, 2016

DECISION

The Medicare enrollment and billing privileges of Petitioner, Canal Street Pharmacy, Inc., are revoked pursuant to 42 C.F.R. §§ 424.57(e)(1),[1] effective November 21, 2015, based on noncompliance with 42 C.F.R. § 424.57(c)(2) (Supplier Standard 2).

I. Procedural History and Jurisdiction

Petitioner was a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) participating in Medicare. The National Supplier Clearinghouse (NSC) operated by Palmetto GBA (Palmetto) notified Petitioner by letter dated October 22, 2015, that Petitioner's Medicare enrollment was revoked effective September 20, 2015. NSC cited 42 C.F.R. §§ 405.800, 424.535(a)(1) and (2), and 424.535(g) as the legal authority for the revocation based on noncompliance with 42 C.F.R. §§ 424.57(c)(2)(Supplier Standard 2), 424.57(c)(10) (Supplier Standard 10), and

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[1] Citations are to the 2015 revision of the Code of Federal Regulations (C.F.R.), unless otherwise indicated.

424.535(a)(2). NSC notified Petitioner that it was subject to a three-year bar to re-enrollment pursuant to 42 C.F.R. § 424.535(c). Centers for Medicare & Medicaid Services (CMS) exhibit (Ex.) 1 at 19-21.

On December 11, 2015, Petitioner requested reconsideration of the initial determination. CMS Ex. 1 at 6, 13-14, 58-59. On March 25, 2016, a reconsideration hearing officer upheld the revocation for noncompliance with 42 C.F.R. § 424.57(c)(2) (Supplier Standard 2). CMS Ex. 1 at 4. Petitioner timely requested a hearing before an administrative law judge (ALJ) on May 23, 2016. The case was assigned to me for hearing and decision on May 27, 2016, and an Acknowledgment and Prehearing Order (Prehearing Order) was issued at my direction.

On June 27, 2016, CMS filed a motion for summary judgment (CMS Br.) with CMS Exs. 1 through 5. On July 26, 2016, Petitioner filed a response in opposition to the CMS motion (P. Br.), with Petitioner's exhibits (P. Exs.) 1 and 2. CMS filed a reply brief (CMS Reply) on August 10, 2016. No objections have been made to my consideration of CMS Exs. 1 through 5 and P. Ex. 1 and they are admitted and considered as evidence. CMS objected to my consideration of P. Ex. 2 on grounds that it is not relevant. CMS does not challenge the authenticity of the document. CMS Reply at 6 n.3. I disagree and overrule the objection. P. Ex. 2 purports to be a letter dated July 15, 2012, from Petitioner to Kenny Ho terminating Mr. Ho's employment. Petitioner's theory of defense is that it terminated its relationship with Mr. Ho and the letter is evidence of one step taken by Petitioner to accomplish the termination of the relationship. Not only is P. Ex. 2 admitted, but for purposes of summary judgment I accept as true the representation that Mr. Ho's employment with Petitioner was terminated effective July 15, 2012.

II. Discussion

A. 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. Administration of the Part B program is through contractors, such as Palmetto. Act § 1842(a) (42 U.S.C. § 1395u(a)). Payment under the program for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of services and suppliers.[2] Act §§ 1834(j)(1) (42 U.S.C. § 1395m(j)(1)); 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395(u)(h)(1)).

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[2] A "supplier" furnishes services and supplies under Medicare. 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
(Continued next page.)

The Act requires the 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 § 1866(j) (42 U.S.C. § 1395cc(j)).

Pursuant to 42 C.F.R. §§ 424.57 and 424.505, a DMEPOS supplier such as Petitioner must be enrolled in the Medicare program to be reimbursed for durable medical equipment, prosthetics, orthotics, or supplies sold or rented to Medicare beneficiaries. The regulations establish detailed requirements that suppliers must meet and maintain to enroll in Medicare and to receive and maintain Medicare billing privileges. 42 C.F.R. pt. 424, subpt. P. DMEPOS suppliers have additional requirements imposed by 42 C.F.R. § 424.57(b) and (c). To receive direct-billing privileges, a DMEPOS supplier must meet and maintain the Medicare application certification standards set forth in 42 C.F.R. § 424.57(c). A DMEPOS supplier must operate and furnish Medicare-covered items in compliance with all applicable federal and state licensure and regulatory requirements. 42 C.F.R. § 424.57(c)(1). A DMEPOS supplier is required to submit completed application and enrollment forms for each separate physical location it uses to furnish DMEPOS, with the exception of warehouses or repair facilities. 42 C.F.R. § 424.57(b)(1). A DMEPOS supplier must provide complete and accurate information in response to questions on its application for Medicare billing privileges and must report to CMS any changes in information supplied on the application within 30 days of the change. 42 C.F.R. §§ 424.57(c)(2); 424.516(c). Additionally, a DMEPOS supplier must permit CMS or its agent to conduct on-site inspections to ascertain supplier compliance with the Medicare enrollment standards. 42 C.F.R. § 424.57(c)(8). Finally, a DMEPOS supplier must at all times be "operational," which means it "has a qualified physical practice location, is open to the public for the purpose of providing health care related services, is prepared to submit valid Medicare claims, and is properly staffed, equipped, and stocked . . . to furnish these items or services." 42 C.F.R. § 424.502.

The Secretary has delegated authority to CMS or its Medicare contractor to revoke an enrolled supplier's Medicare enrollment and billing privileges and any supplier agreement for any of the reasons listed in 42 C.F.R. § 424.535. Noncompliance with enrollment requirements, such as those established by 42 C.F.R. § 424.57(b) and (c) for

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"provider of services," commonly shortened to "provider," 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.

DMEPOS suppliers, is also a basis for revocation of billing privileges and enrollment in Medicare. 42 C.F.R. § 424.57(e)(1). After a supplier's Medicare enrollment and billing privileges are revoked, the supplier is barred from reenrolling in the Medicare program for one to three years. 42 C.F.R. § 424.535(c).

A supplier whose enrollment and billing privileges have been revoked may request reconsideration and review as provided by 42 C.F.R. pt. 498. A supplier submits a written request for reconsideration to CMS or its contractor. 42 C.F.R. § 498.22(a). CMS or its contractor 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, and advising the supplier of its right to an ALJ hearing. 42 C.F.R. § 498.25. If the decision on reconsideration is unfavorable to the supplier, the supplier has the right to request a hearing by an ALJ and further review by the Departmental Appeals Board (the Board). Act § 1866(j)(8) (42 U.S.C. § 1395cc(j)(8)); 42 C.F.R. §§ 424.545, 498.3(b)(17), 498.5. A hearing on the record, also known as an oral hearing, is required under the Act. *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743, 748-51 (6th Cir. 2004). The supplier bears the burden to demonstrate that it meets enrollment requirements with documents and records. 42 C.F.R. § 424.545(c).

B. Issue

Whether summary judgment is appropriate; and

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

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 filed a motion for summary judgment which Petitioner opposes.

A provider or supplier denied enrollment in Medicare or whose enrollment has been revoked has a right to a hearing and judicial review pursuant to section 1866(h)(1) and (j) of the Act and 42 C.F.R. §§ 498.3(b)(1), (5), (6), (8), (15), (17); 498.5. A hearing on the record, also known as an oral hearing, is required under the Act. Act §§ 205(b), 1866 (h)(1) and (j)(8); *Crestview*, 373 F.3d at 748-51. A party may waive appearance at an oral hearing, but must do so affirmatively in writing. 42 C.F.R. § 498.66. In this case, Petitioner has not waived the right to oral hearing or otherwise consented to a decision

based only upon the documentary evidence or pleadings. Accordingly, disposition on the written record alone is not permissible, unless the CMS motion for summary judgment has merit.

Summary judgment is not automatic upon request but is limited to certain specific conditions. The Secretary's regulations that establish the procedure to be followed in adjudicating Petitioner's case are at 42 C.F.R. pt. 498. 42 C.F.R. §§ 405.800, 405.803(a), 424.545(a), 498.3(b)(5), (6), (15), (17). The regulations do not establish a summary judgment procedure or recognize such a procedure. However, the Board has long accepted that summary judgment is an acceptable procedural device in cases adjudicated pursuant to 42 C.F.R. pt. 498. *See, e.g.*, *Ill. Knights Templar Home*, DAB No. 2274 at 3-4 (2009); *Garden City Med. Clinic*, DAB No. 1763 (2001); *Everett Rehab. & Med. Ctr.*, DAB No. 1628 at 3 (1997). The Board also has recognized that the Federal Rules of Civil Procedure (Fed. R. Civ. Pro.) do not apply in administrative adjudications such as this, but the Board has accepted that Fed. R. Civ. Pro. 56 and related cases provide useful guidance for determining whether summary judgment is appropriate. Furthermore, a summary judgment procedure was adopted as a matter of judicial economy within my authority to regulate the course of proceedings and made available to the parties in the litigation of this case by my Prehearing Order. The parties were given notice by the Prehearing Order that summary judgment is an available procedural device and that the law as it has developed related to Fed. R. Civ. Pro. 56 will be applied.

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. 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. 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. Generally, the non-movant may not defeat an adequately supported summary judgment motion by relying upon 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. *Mission Hosp. Reg'l Med. Ctr.*, DAB No. 2459 at 4 (2012) (and cases cited therein); *Experts Are Us, Inc.*, DAB No. 2452 at 4 (2012) (and cases cited therein); *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 at 3 (2010) (and cases cited therein); *see also Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986).

The standard for deciding a case on summary judgment and an ALJ's decision-making in deciding a summary judgment motion differs from that used in 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 be done 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 also has recognized that on summary judgment it is appropriate for the ALJ to consider whether a rational trier of fact could find that the party's evidence would be sufficient to meet that party's evidentiary burden. *Dumas Nursing & Rehab., L.P.*, DAB No. 2347 at 5 (2010). The Secretary has not provided in 42 C.F.R. pt. 498, for the allocation of the burden of persuasion or the quantum of evidence required to satisfy the burden. However, the Board has provided some persuasive analysis regarding the allocation of the burden of persuasion in cases subject to 42 C.F.R. pt. 498. *Batavia Nursing & Conv. Ctr.*, DAB No. 1904 (2004), *aff'd*, *Batavia Nursing & Conv. Ctr. v. Thompson*, 129 Fed. App'x 181 (6th Cir. 2005).

In this case, I conclude that there is no genuine dispute as to any material fact pertinent to revocation under 42 C.F.R. § 424.57(e)(1) based on noncompliance with 42 C.F.R. § 424.57(c)(2) that requires a trial. Contrary to Petitioner's assertion, this case does not rely on when Petitioner terminated its relationship with Kenny Ho. P. Br. at 12. Summary judgment is based on Petitioner's failure to report final adverse action against Kenny Ho within 30 days. The material facts are undisputed. This case is resolved based on application of the regulations to the undisputed facts as discussed hereafter. Accordingly, summary judgment is appropriate.

2. Petitioner was not in compliance with 42 C.F.R. § 424.57(c)(2) (Supplier Standard 2).

3. There is a basis for revocation of Petitioner's enrollment and billing privileges pursuant to 42 C.F.R. § 424.57(e)(1).

4. The effective date of revocation of Petitioner's enrollment and billing privileges is determined pursuant to 42 C.F.R. § 424.57(e)(1) and is November 21, 2015, which is 30 days after the date of the October 22, 2015 notice of the initial determination to revoke.

The October 22, 2015 NSC notice of the initial determination to revoke advised Petitioner that revocation was pursuant to 42 C.F.R. §§ 405.800, 424.535(a)(1), 424.535(a)(2), and 424.535(g). NSC also advised Petitioner that Petitioner was found not in compliance with 42 C.F.R. §§ 424.57(c)(2)(Supplier Standard 2), 424.57(c)(10) (Supplier Standard 10), and 424.535(a)(2). CMS Ex. 1 at 19-20. The reconsidered determination shows that Petitioner was found to be in compliance with Supplier Standard 10 based upon the Corrective Action Plan (CAP) submitted by Petitioner. CMS Ex. 1 at 2. The hearing officer that issued the reconsidered determination stated in the "Rationale" section of the reconsidered determination that Petitioner was found noncompliant with 42 C.F.R. § 424.535(a)(2) and 42 C.F.R. § 424.57(c)(2) (Supplier Standard 2). However, in the "Decision" section of the reconsidered determination the hearing officer concluded that Petitioner was not in compliance with Supplier Standard 2.

The hearing officer did not state in the "Decision" section that revocation was upheld based on 42 C.F.R. § 424.535(a)(2).[3] CMS did not request review of the reconsidered determination pursuant to 42 C.F.R. § 498.5(*l*)(2) and agrees that the hearing officer revoked based on 42 C.F.R. § 424.57(c)(2). CMS Br. at 1, 2 n.1, 7, 9; CMS Reply at 12. It is the basis for revocation determined on reconsideration that is subject to review in this proceeding because that is the determination that triggers the right to an ALJ hearing. 42 C.F.R. § 498.5(*l*)(2); *Neb Group of Arizona LLC*, DAB No. 2573 at 7 (2014). Thus, the issue properly before me is whether or not there was a legal basis for revocation of Petitioner's Medicare enrollment and billing privileges based on noncompliance with 42 C.F.R. § 424.57(c)(2) (Supplier Standard 2).

a. Facts

The material facts are not in dispute. Petitioner has been enrolled as a Medicare supplier since 2007. At the time of enrolling, Kenny Ho was listed in the enrollment application as a shareholder of Petitioner. P. Br. at 2, P. Ex. 1 at 1. Petitioner's application to enroll in Medicare, a CMS-855S, was signed and dated April 12, 2007. CMS Ex. 2 at 22. The application shows that Petitioner was newly enrolling in Medicare as a pharmacy and supplier of DMEPOS. CMS Ex. 2 at 4, 7-8. The application listed Tristan Liu, Yuk Tsan Lam, Waiman Chaw, and Kenny Ho as owners, each with a five percent or greater direct/indirect ownership interest, and each was listed as a managing employee and as a director/officer. CMS Ex. 2 at 17-20; P. Ex. 1 at 1. No adverse legal history was reported for any. CMS Ex. 2 at 10, 16-20.

In his affidavit executed on July 26, 2016, Tristan Liu, Petitioner's principal, states that in or about July 2012, he became aware that Kenny Ho had been arrested for driving under the influence. He further testifies that he and the other shareholders determined to remove Kenny Ho from the business and he describes the actions undertaken. P. Ex. 1 at 2. Kenny Ho's employment was terminated July 15, 2012; he was prohibited from participating in Petitioner's business; and his dividends, salary, and other compensation were terminated. However, Mr. Liu admits that Kenny Ho remained a shareholder of Petitioner and Mr. Ho refused to sell or otherwise divest his interest in Petitioner. P. Ex. 1 at 2, P. Ex. 2. Mr. Liu testifies that Kenny Ho's shares were finally cancelled in April 2015. P. Ex. 1 at 3. The documents submitted on reconsideration and as part of the corrective action plan show that the transfer of shares and removal of Kenny Ho as Secretary and Director of the Corporation was completed on or about July 21, 2015.

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[3] The hearing officer cited 42 C.F.R. § 424.57 without citing the applicable subsection, which is 42 C.F.R. § 424.57(c)(2). However, the hearing officer's reference to Supplier Standard 2 makes clear that was the subsection on which she based her decision. CMS Ex. 1 at 2, 4.

CMS Ex. 1 at 24-26, 70-72. Petitioner stated in its request for reconsideration and the CAP that the transaction became final and irrevocable on or about October 9, 2015. CMS Ex. 1 at 14, 16.

Kenny Ho was excluded from the New York Medicaid program effective March 10, 2015. CMS Ex. 3. He was excluded from participation in Medicare and all federal health care programs by the Inspector General, U.S. Department of Health and Human Services, effective September 20, 2015, pursuant to Act § 1128(b)(4) based on his state license revocation, suspension, or surrender. CMS Ex. 1 at 22, 40, 68. Kenny Ho surrendered his pharmacy license but the date of the surrender is not clearly established. CMS Ex. 1 at 23, 69.

On November 19, 2015, Tristan Liu signed and dated a CMS-855S that removed Kenny Ho as an owner, officer, director, and one with managing control, effective July 21, 2015. CMS Ex. 1 at 17, 32, 36, 78, 82.

b. Analysis

The Supplier Standard allegedly violated on reconsideration:

> Supplier Standard 2 (42 C.F.R. § 424.57(c)(2)): The supplier must not make or cause to be made any false statement or misrepresentation of material fact in its application for billing privileges. The supplier must provide complete and accurate information. The supplier must report any changes in information on the application within 30 days of the change.

It is well established that even a single violation of a single supplier standard is an adequate basis for revocation of billing privileges and enrollment. *1866ICPayday.com*, DAB No. 2289 at 13 (2009). Pursuant to 42 C.F.R. § 424.57(e)(1), CMS is required to revoke a supplier's billing privileges if it is determined that the supplier does not meet the standards established by 42 C.F.R. § 424.57(b) and (c). The regulation provides that revocation is effective 30 days after the notice of revocation is sent. Pursuant to 42 C.F.R. § 424.535(a)(1), CMS may revoke the Medicare enrollment and billing privileges of a provider or supplier determined not in compliance with the Medicare enrollment requirements described in 42 C.F.R. subpt. P (42 C.F.R. § 424.500-.570) or the applicable enrollment application.

The reconsidered determination is not a model of clarity. Petitioner argues that the reconsidered determination fails to cite the exact basis for revoking Petitioner's billing privileges. Petitioner criticizes both the hearing officer's findings of fact and a lack of clarity as to which regulatory provision authorizes revocation in this case. P. Br. at 5-8. However, I conclude based on my careful reading of the reconsidered determination, that the hearing officer found based on the admission in Petitioner's request for

reconsideration, that Petitioner learned of Mr. Ho's exclusion from the New York Medicaid program. The exclusion from New York Medicaid was March 10, 2015. The date Petitioner learned of the exclusion is not specifically determined in the reconsidered determination but it was while Petitioner had litigation pending with Mr. Ho, which must have been prior to July 21, 2015, when the matter was settled. P. Ex. 1 at 2-3; CMS Ex. 1 at 14, 16, 59, 62. The hearing officer also considered that Kenny Ho was excluded by the HHS I.G. effective September 20, 2015. CMS Ex. 1 at 2. Petitioner's 2007 application to enroll in Medicare did not reflect any adverse legal history for Kenny Ho. CMS Ex. 2 at 19. The reconsidered determination was based on Petitioner's failure to report within 30 days, that as of March 15, 2015, Kenny Ho was excluded from New York Medicaid and as of September 20, 2015, he was excluded from Medicare and other federal programs. There is no dispute that it was on November 19, 2015, that Petitioner signed and submitted a CMS-855S reflecting Kenny Ho's final adverse legal action history and that he was removed from ownership and a controlling interest in Petitioner. CMS Ex. 1 at 78, 82.

Supplier Standard 2 (42 C.F.R. § 424.57(c)(2)) is clear that a supplier must not make or cause to be made any false statement or misrepresentation of material fact in its application for billing privileges; the supplier must provide complete and accurate information; and any change of information on the application must be reported within 30 days of the change. Kenny Ho's exclusions from New York Medicaid and Medicare are final adverse actions that should have been reported pursuant to 42 C.F.R. § 424.57(c)(2) within 30 days.

> *Final adverse action* means one or more of the following actions:
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> (i) A Medicare-imposed revocation of any Medicare billing privileges.
>
> (ii) Suspension or revocation of a license to provide health care by any State licensing authority.
>
> (iii) Revocation for failure to meet DMEPOS quality standards.
>
> (iv) A conviction of a Federal or State felony offense (as defined in § 424.535(a)(3)(i) within the last 10 years preceding enrollment, revalidation, or re-enrollment.

> (v) An exclusion or debarment from participation in a Federal or State health care program.

42 C.F.R. § 424.57(a).

Pursuant to 42 C.F.R. § 424.535(a), CMS may revoke an enrolled provider or supplier's Medicare billing privileges and any related provider or supplier agreement for any of the 14 listed reasons. The phrase "CMS may revoke" indicates that revocation on any of the 14 listed grounds is discretionary. Pursuant to 42 C.F.R. § 424.57(e)(1), which applies only to suppliers of DMEPOS, "CMS revokes" the billing privileges of a supplier found not to meet the special rules applicable to DMEPOS suppliers established by 42 C.F.R. § 424.57(b) and (c). Although 42 C.F.R. § 424.57(e)(1) does not include the words "will" or "shall" the intent of the provision is clear that "CMS revokes" indicates that revocation is mandatory rather than discretionary. The requirement to revoke under 42 C.F.R. § 424.57(e)(1) is not dependent upon 42 C.F.R. § 424.535(a) which only includes the discretionary bases for revocation of Medicare enrollment and billing privileges.

Revocation in this case is required by 42 C.F.R. § 424.57(e)(1). Pursuant to 42 C.F.R. § 424.57(e)(1), revocation for noncompliance with the supplier standards established by 42 C.F.R. § 424.57(b) and (c), is effective 30 days after the supplier is sent notice of the revocation. Therefore, the correct effective date for revocation of Petitioner's Medicare enrollment and billing privileges is 30 days after the notice of the revocation was issued. *Neb Group of Arizona*, DAB No. 2573 at 7-8 (2014). Accordingly, I conclude that the effective date of the revocation of Petitioner's Medicare enrollment and billing privileges was November 21, 2015, which is 30 days after the October 22, 2015 notice of the revocation was issued. The initial determination and reconsidered determination concluded that revocation was effective retroactively to September 20, 2015, the date of Kenny Ho's exclusion by the HHS I.G. CMS requests that I conclude that revocation should be effective March 10, 2015,[4] based on the date of Kenny Ho's exclusion from New York Medicaid. CMS Br. at 1, 17-19. Retroactive revocation is limited to those specific circumstances listed in 42 C.F.R. § 424.535(g), which include a federal exclusion but not a state exclusion. However, in this case Petitioner is not revoked for federal exclusion pursuant to 42 C.F.R. § 424.535(a)(2), but rather, for violation of 42 C.F.R. § 424.57(c)(2) for failure to report the adverse action against Kenny Ho. Therefore the provision of 42 C.F.R. § 424.535(g) that permits retroactive revocation for federal exclusion has no application in this case.

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[4] CMS did not request a hearing on this issue pursuant to 42 C.F.R. § 498.5(*l*)(2), and arguably waived any right to review on this issue.

Petitioner implies that the hearing officer erred by basing revocation on failure to report Kenny Ho's exclusion from Medicaid rather than his exclusion from the federal Medicare program. Petitioner cites no statutory or regulatory authority for the proposition that the hearing officer on reconsideration is limited to the facts or the legal authority cited in the initial determination. Petitioner also asserts that the lack of clarity in the reconsidered determination resulted in insufficient notice. P. Br. at 5-6, 8-13. I conclude based on my review of the reconsidered determination that it was sufficiently clear as to both the factual and legal basis for revocation in this case. Review of Petitioner's reconsideration request, its request for hearing, its brief before me, and its offered evidence, show that Petitioner was adequately appraised of the factual and legal basis for revocation, and able to defend. Even if notice was less than perfect, the record reflects no prejudice to Petitioner's ability to defend.

To the extent that any of Petitioner's arguments may be construed as a request for equitable relief, I have no authority to grant equitable relief. *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 also required to follow the Act and regulations and have no authority to declare statutes or regulations invalid. *1866ICPayday.com, L.L.C.*, DAB No. 2289 at 14 ("An ALJ is bound by applicable laws and regulations and may not invalidate either a law or regulation on any ground.").

III. Conclusion

For the foregoing reasons, I conclude that Petitioner's Medicare enrollment and billing privileges are revoked effective November 21, 2015.

/s/
Keith W. Sickendick
Administrative Law Judge