Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Chaplin Liu, M.D.
Docket No. A-19-115
Decision No. 2976
October 31, 2019

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Chaplin Liu, M.D. (Petitioner) appeals the June 24, 2019 decision of an administrative law judge (ALJ) affirming the reconsidered determination by a Centers for Medicare & Medicaid Services (CMS) Medicare contractor setting the effective date of Petitioner's reactivated Medicare billing privileges as April 25, 2017, the date the contractor received Petitioner's enrollment application that it approved. *Chaplin Liu, M.D.*, DAB CR5355 (2019) (ALJ Decision).

For the reasons discussed below, we conclude that the ALJ Decision is supported by substantial evidence and free from legal error, and that the effective date the ALJ affirmed is compelled by the controlling regulation. Petitioner's arguments point to the difficulties he encountered navigating the contractor's reenrollment process. These arguments either go to the validity of contractor determinations that ALJs and the Board are not authorized to review – the deactivation of billing privileges and the rejection of enrollment applications – or are appeals to equity that are not grounds for the Board to set an earlier effective date.

Applicable Law

A physician or other "supplier" of Medicare services must enroll (and maintain enrollment) in the Medicare program to receive payment for Medicare-covered items and services furnished to Medicare beneficiaries. 42 C.F.R. §§ 400.202 (defining supplier), 424.500, 424.502, 424.505, 424.510, 424.516.[1] The Medicare enrollment process includes: (1) identifying a supplier; (2) validating the supplier's eligibility to provide items or services to Medicare beneficiaries; (3) identifying and confirming the supplier's practice locations and owners; and (4) granting the supplier Medicare billing privileges. *Id*. § 424.502 (defining "Enroll/Enrollment").

[1] Some of the regulations governing Medicare enrollment and billing privileges were revised effective November 4, 2019. 84 Fed. Reg. 47,794, 47,852 (Sept. 10, 2019). We apply the regulations as in effect during all times relevant to this appeal.

CMS in administering the Medicare program delegates certain program activities to private contractors that function as CMS's agents – in this case, Noridian Healthcare Solutions, Inc. (Noridian). *See* Social Security Act (Act) §§ 1816, 1842, 1866, 1874, 1874A; 42 C.F.R. Part 421.[2]

To maintain Medicare billing privileges, an enrolled supplier must "revalidate" enrollment every five years by resubmitting and recertifying the enrollment information. 42 C.F.R. § 424.515. CMS "contacts [the] supplier directly when it is time to revalidate their enrollment information," and the supplier "must submit to CMS the applicable enrollment application with complete and accurate information and applicable supporting documentation within 60 calendar days." *Id*. § 424.515(a).

CMS may "deactivate" the Medicare billing privileges of a supplier that "does not furnish complete and accurate information and all supporting documentation within 90 calendar days of receipt of notification from CMS to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information." *Id*. § 424.540(a)(3). "Deactivate" means "that the . . . supplier's billing privileges were stopped, but can be restored upon the submission of updated information." *Id*. § 424.502. A supplier whose billing privileges are deactivated (for reasons other than failure to submit any Medicare claims for one year) "must complete and submit a new enrollment application to reactivate its Medicare billing privileges" unless CMS permits the supplier to recertify that the enrollment information currently on file with Medicare is correct. *Id*. § 424.540(b)(1).

CMS may reject a supplier's enrollment application if the "supplier fails to furnish complete information on the . . . enrollment application within 30 calendar days from the date of the contractor request for the missing information." *Id*. § 424.525(a)(1). After CMS rejects an enrollment application, "the . . . supplier must complete and submit a new enrollment application and submit all supporting documentation for CMS review and approval." *Id*. § 424.525(c). If CMS approves an enrollment application, the effective date of a supplier's billing privileges is the later of either: "(1) The date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor; or (2) The date that the supplier first began furnishing services at a new practice location." *Id*. § 424.520(d).

[2] The current version of the Act can be found at https://www.ssa.gov/OP_Home/ssact/ssact-toc.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross-reference table for the Act and the United States Code can be found at https://www.ssa.gov/OP_Home/comp2/G-APP-H.html.

The determination of the effective date of a supplier's billing privileges is an "initial determination" subject to review under 42 C.F.R. Part 498. 42 C.F.R. § 498.3(a)(1), (b)(15). A supplier may request contractor reconsideration of the effective date, and may thereafter request a hearing before an ALJ on the reconsidered determination, and may request review of the ALJ decision by the Departmental Appeals Board (Board). 42 C.F.R. §§ 498.5(*l*), 498.5(f); *see Victor Alvarez, M.D.*, DAB No. 2325, at 3 (2010) (approval of enrollment with a specific effective date is in essence a denial of enrollment with an earlier effective date and the supplier has a right to reconsideration review of the effective date of enrollment under section 498.5(*l*)).

Neither the rejection of an enrollment application nor the deactivation of billing privileges (e.g., for failure to timely submit requested enrollment information), however, is an "initial determination" subject to review under 42 C.F.R. Part 498. *Id*. § 498.3(b). Thus, "[e]nrollment applications that are rejected are not afforded appeal rights," and a supplier "whose billing privileges are deactivated may file a rebuttal in accordance with [42 C.F.R.] § 405.374," by filing a written statement with the contractor, but has no right to appeal the contractor's determination on deactivation to an ALJ or the Board. *Id*. §§ 424.525(d), 424.545(b).

Background

This background information is taken from the ALJ Decision and from the parties' briefing, and we note the relevant areas of dispute. We make no new findings of fact in this background section.

By letter of June 14, 2016, Noridian instructed Petitioner to revalidate his Medicare enrollment by August 31, 2016, and, by letter of November 18, 2016, Noridian informed Petitioner that his billing privileges had been "stopped" – i.e., deactivated – on November 10, 2016 because he had failed to revalidate his Medicare enrollment as instructed. ALJ Decision at 1-2 (citing CMS Exhibits (Exs.) 1, 3); CMS Ex. 3. Petitioner contends he timely filed a paper revalidation application, which Noridian denies receiving, and Petitioner denies receiving a Noridian letter of September 21, 2016 stating that it had not received a revalidation application from Petitioner by August 31, 2016. ALJ Decision at 2 (citing Petitioner's Brief (P. Br.) at 3, 8; CMS Ex. 2; P. Exs. 2, 15).

Petitioner then filed a CMS-855I revalidation application online on November 28, 2016, and Noridian requested additional information and documents from Petitioner on December 12, 2016. *Id*. (citing CMS Exs. 4, at 1; 5). Petitioner responded by fax on December 13, 2016, to provide information for the application as well as the requested documents. Noridian, via email of December 15, 2016, told Petitioner that the requested information had to be entered on the application online instead of sent on a piece of paper

by fax, and warned that Petitioner's application would be rejected if he did not complete it online by January 11, 2017. *Id*. (citing CMS Exs. 6; 7); CMS Ex. 7, at 1. Petitioner denies receiving this email. *Id*. (citing P. Br. at 6, 9). Petitioner therefore did not make the required changes to his online application. ALJ Decision at 2. By email of January 11, 2017, Noridian again informed Petitioner that his billing privileges had been stopped as of November 10, 2016. *Id*. (citing CMS Ex. 8).

Petitioner then submitted another revalidation application that Noridian received on April 25, 2017; Noridian approved this application on May 11, 2017 and granted Petitioner Medicare enrollment effective April 25, 2017, the date it received the application, with a lapse in coverage from November 10, 2016 through April 24, 2017. *Id*. (citing CMS Exs. 9, at 1; 10).

Petitioner requested reconsideration to challenge the lapse in billing privileges from November 10, 2016 through April 24, 2017. Noridian denied reconsideration on the grounds that Noridian correctly assigned the effective date under 42 C.F.R. § 424.520(d) based on its receipt on April 25, 2017 of the enrollment application that Noridian approved, and that Petitioner did not provide evidence to definitely support an earlier effective date. *Id*.; CMS Ex. 13. Petitioner timely appealed the reconsidered determination to the ALJ.

Before the ALJ, Petitioner, CMS filed a brief and motion for summary judgment and 13 proposed exhibits (CMS Exs. 1-13), and Petitioner filed a brief in response and 17 proposed exhibits, including statements of three witnesses. The ALJ admitted the exhibits in the absence of any objections and decided the case on the written record as CMS did not ask to cross-examine any of Petitioner's witnesses. ALJ Decision at 2-3.

ALJ Decision

The ALJ concluded that "the effective date of reactivation for Petitioner's Medicare billing privileges is April 25, 2017," the date "Noridian received Petitioner's application to reactivate his Medicare billing privileges" that "Noridian subsequently approved." ALJ Decision at 4-5 (emphasis removed). The ALJ cited 42 C.F.R. § 424.520(d) as setting the "effective date for Medicare billing privileges for physicians" as "either: 1) the date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor; or 2) the date the supplier first began furnishing services at a new practice location." *Id*. at 4. The ALJ also cited the preamble to the final regulation stating that the "'date of filing' is the date that the Medicare contractor 'receives' a signed enrollment application that the Medicare contractor is able to process to approval." *Id*. (citing 73 Fed. Reg. 69,726, 69,769 (Nov. 19, 2008)).

The ALJ found that Petitioner's arguments either questioned the validity of the deactivation of his billing privileges and the subsequent rejection of his revalidation application, actions that the regulations withhold from ALJ review, or were appeals to fairness and equity that are not permissible grounds to reverse CMS actions that are consistent with governing regulations.

First, Petitioner argued to the ALJ that he "timely responded to Noridian's June 14, 2016 request to revalidate his Medicare enrollment by mailing a paper copy of Form CMS 8551 on June 28, 2016." *Id*. at 5 (citing P. Br. at 3-5, 8-11). Moreover, Petitioner contended that he "remained unaware that Noridian did not receive his submission because he never received Noridian's September 21, 2016 past due notice," and never got Noridian's communications in December 2016 requesting revisions. *Id*. at 5, 6 (citing P. Br. at 3, 4, 8-10). The ALJ concluded that, under the applicable regulations, she had "no authority to review Noridian's decision to deactivate Petitioner's billing privileges" and "no authority to review Noridian's decision to reject Petitioner's November 28, 2016 revalidation application," and thus no authority to grant Petitioner an earlier effective date based on Petitioner's complaints about the deactivation and the rejection. *Id*. at 6 (emphasis removed). The ALJ observed that a deactivation "is not an 'initial determination'" for which the regulations provide ALJ review but is subject to "a separate review process," and that ALJs "are not authorized to review a contractor's decision to reject an enrollment application. *Id*. at 5-7 (citing 42 C.F.R. §§ 424.545(a), (b), 498.3(b), 424.525(d); *Willie Goffney, Jr., M.D.*, DAB No. 2763, at 4-5 (2017), *aff'd Goffney v. Azar*, 2:17-CV-8032 (C.D. Cal. Sept. 25, 2019); *James Shepard, M.D.*, DAB No. 2793, at 3 (2017)).

The ALJ also pointed out that Petitioner had not produced a copy of the application he mailed in June 2016, did not have a postal receipt, and did not mail the application certified mail or return receipt requested, despite Noridian's recommendation in its revalidation request to obtain proof of receipt for mailing. *Id*. at 5 (citing CMS Ex. 1, at 1). The ALJ noted, in any case, that Petitioner's claim that he submitted an application in June 2016 was "only relevant, if at all, to whether Noridian acted properly in deactivating Petitioner's billing privileges" which the ALJ did "not have jurisdiction to review" under the regulations. *Id*. at 5-6.

The ALJ also rejected Petitioner's arguments "that Noridian staff failed to assist him in submitting a complete revalidation application" and "should have provided more effective assistance to him and his staff so that they could have completed the revalidation process timely." *Id*. at 5, 6. The ALJ found that she "may not set aside the lawful exercise of discretion by CMS or its contractor based on principles of equity" and

thus "cannot grant Petitioner equitable relief" from the effective date determination based on Petitioner's complaint. *Id*. at 7 (emphasis removed) (citing *US Ultrasound*, DAB No. 2302, at 8 (2010); *Cent. Kan. Cancer Inst.*, DAB No. 2749, at 10 (2016), *appeal dismissed*, *Cent. Kan. Cancer Inst., P.A. v. Dep't of Health & Human Servs.*, 2:17-cv-02012 (D. Kan. June 2, 2017); *Shepard, M.D.*, DAB No. 2793, at 9).

The ALJ accordingly affirmed Noridian's determination that the effective date of Petitioner's Medicare billing privileges is April 25, 2017. *Id*.

Standard of Review

The standard of review on a disputed factual issue is whether the ALJ decision is supported by substantial evidence in the record as a whole. The standard of review on a disputed issue of law is whether the ALJ decision is erroneous. *See Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program*, at https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/enrollment/index.html.

Analysis

1. The ALJ correctly determined the effective date of Petitioner's billing privileges.

Petitioner identifies no error in the ALJ's determinations that the applicable regulation sets the effective date of Medicare billing privileges as the "date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor," or that the date of filing here would be when Noridian, the contractor, received a signed enrollment application from Petitioner that it was "able to process to approval." ALJ Decision at 4; 42 C.F.R. § 424.520(d); 73 Fed. Reg. at 69,769. Petitioner does not argue that the ALJ incorrectly cited or applied the regulation. *See* P. Appeal of ALJ Decision (P. App.). Petitioner does not dispute the ALJ's finding that the revalidation enrollment application that Noridian was able to and did process to approval was the application received on April 25, 2017, and approved on May 11, 2017. *Id*. Nor does Petitioner contend that either of his two earlier revalidation applications – the one he reports having filed by mail in June 2016, which Noridian denies receiving, leading to the deactivation, or the application Petitioner filed online on November 28, 2016, that Noridian rejected – was processed to approval, warranting an earlier effective date. *Id*. These undisputed facts supported the ALJ's affirmation of an effective date of April 25, 2017, the date of receipt. ALJ Decision at 4-5 (citing CMS Ex. 9, at 1; 10).

Petitioner's reports of mailing an enrollment application in June 2016 and of not receiving Noridian letters or emails in September and December 2016 relate in any event to the deactivation of Petitioner's billing privileges and the later rejection of the application Petitioner filed in November 2016, actions that, as the ALJ correctly stated, are beyond the ALJ's authority to consider, as the regulations do not provide for ALJ (or Board) review of the deactivation of billing privileges or the rejection of enrollment applications. *Id*. at 5-7. As noted, the appeal regulation listing the types of "initial determinations" that a supplier or provider may appeal to an ALJ (following contractor or CMS reconsideration) does not include either the rejection of an enrollment application or the deactivation of billing privileges (e.g., for failure to timely submit requested enrollment information). 42 C.F.R. § 498.3(b). The enrollment regulations additionally state that "[e]nrollment applications that are rejected are not afforded appeal rights," and limit the recourse of a supplier "whose billing privileges are deactivated" to "fil[ing] a rebuttal" with the contractor. *Id*. §§ 424.525(d), 424.545(b), 405.374.

A Medicare supplier or provider may appeal the denial of an enrollment application for cause, e.g., non-compliance with the enrollment requirements, disqualifying felony criminal convictions, or providing false or misleading information. The regulations do not provide such appeal rights to providers or suppliers whose applications are merely rejected for reasons including failing to supply complete information or documentation within 30 days after being requested to provide the missing information or documentation. *Id*. §§ 424.525, 424.530. Similarly, a supplier or provider may appeal the revocation of Medicare enrollment, resulting in a bar on re-enrollment of one to three years, but the regulations grant no such appeal rights for deactivation, which "does not have any effect on a provider or supplier's participation agreement or any conditions of participation" and does not result in any set bar on reactivation. *Id*. §§ 424.535, 424.540; *see Frederick Brodeur, M.D.*, DAB No. 2857, at 14 (2018) ("'Deactivate[d]' means that the provider or supplier's billing privileges were stopped, but can be restored upon the submission of updated information," while "Revoke/Revocation" means that the provider or supplier's billing privileges are terminated . . . and the supplier's enrollment is terminated.").

In *Ramarao Kaza, M.D. and Ramarao Kaza, M.D., P.C.*, DAB No. 2924 (2019), the appellants asserted that the contractor mistakenly required him to recertify himself and his practice because, according to appellants, the contractor "confused his enrollments with that of another physician." *Kaza* at 10. The appellants argued that the contractor therefore should not have deactivated Dr. Kaza's enrollments when he failed to successfully recertify. *Id*. The Board, however, found that these questions were "not material to the only issue the Board is authorized to hear in this case—that of the effective date of the reactivation of his billing privileges" because "CMS's determination to deactivate [the appellants'] billing privileges is not subject to appeal . . . [n]or is

CMS's rejection of Dr. Kaza's enrollment applications." *Id*. (citations omitted) (also holding that, "[b]ecause Dr. Kaza's argument of mistaken identity, at its essence, challenges CMS's decision to request recertification of his enrollments, the subsequent deactivation of his billing privileges, and the rejection of his applications, it is not subject to Board review"). The issues Petitioner raises here concerning the deactivation and the rejection of the revalidation application he filed in November 2016 are similarly not material to the only issue legally before us, the effective date of Petitioner's billing privileges which, as in *Kaza*, "is dictated by the date on which [the contractor] received the application[]" that was "ultimately approved." *Id*.

As CMS points out, the Board has held that to evaluate claims that a contractor improperly rejected an earlier enrollment application would make "a nullity" of the prohibition of appeals relating to rejected enrollment applications. *E.g.*, *Lindsay Zamis, M.D., a Prof'l Corp.*, DAB No. 2802, at 9 (2017); *Shepard, M.D.*, DAB No. 2793, at 8; CMS Resp. at 12. This reasoning applies as well to the deactivation of Petitioner's billing privileges, as it would amount to the Board or the ALJ reviewing the validity of the deactivation without any regulatory or other source of such authority.

The ALJ thus did not err in concluding she lacked authority to review either the deactivation of Petitioner's billing privileges or the rejection of the enrollment application he filed in November 2016. The ALJ also correctly found that Petitioner's reports of filing an earlier application that Noridian says it did not receive, and of not receiving Noridian letters or emails, are not germane to the justiciable issues. They go only to the validity of the deactivation of Petitioner's billing privileges and the subsequent rejection of his enrollment application, actions that are not within the ALJ's or the Board's authority to review. *See, e.g.*, *Wishon Radiological Med. Grp., Inc.*, DAB No. 2941, at 7-8 (2019) (citations omitted) (holding that the right to appeal a determination of the effective date does not permit a supplier to also challenge the rejection of an earlier application, and that the effective date cannot be determined by reference to the filing date of an application not subsequently approved by the contractor).

2. The concerns Petitioner raises about contractor processing of enrollment applications furnish no grounds to grant Petitioner an earlier effective date of his billing privileges.

Petitioner does not specifically dispute the ALJ's determination that under the applicable regulation at 42 C.F.R. § 424.520(d), the effective date of Petitioner's Medicare billing privileges is April 25, 2017, the date Noridian received the enrollment application that it approved. Instead, Petitioner expresses concerns about the difficulties he says he and other physicians have encountered when attempting to navigate the process for updating and maintaining their Medicare enrollments.

In particular, Petitioner cites problems encountered using PECOS, CMS's online system for submitting and updating enrollment applications, which Petitioner describes as "inefficient, burdensome, and unfriendly" and "old and problematic" in contrast to "more modern programs" used by banks and online businesses that are "user friendly and efficient."[3] P. App. at 2. As an example, Petitioner points out that the "unspecified information that was missing" from PECOS that he was ordered to provide included his office address, despite his having practiced in that location for over 25 years. *Id*. He denies that his office "disrespected the process and refused to recertify PECOS and ignored the law" and asserts that his office "really tried to comply" and "called [Noridian] many times during this process" that led to the deactivation "only to have the [Noridian] front desk say the application was in process" rather than telling him what specific information was needed. P. Reply at 5

Petitioner cites, as confirming these problems with PECOS, a September 2018 letter he received from the Director of the Provider Enrollment & Oversight Group of the CMS Center for Program Integrity, apologizing for inconveniences Petitioner experienced during the revalidation process and noting that a new version of PECOS, PECOS 2.0, will focus on reducing provider burdens and improving contractor efficiency, among other goals.[4] The introduction of the PECOS 2.0, he argues, shows that the earlier version he used "has inherent problems and that the process of implementation is dysfunctional – and needs revision and upgrade." P. Reply at 2.

Petitioner also avers that contractor emails requesting revalidation information "can be in jeopardy of not being received due to spam filtering" because the contractor "uses company [i.e., .com] email rather than CMS.gov to send important CMS reminders," which, Petitioner says, led to "[a] warning from [the] California Medical Association" that "this problem that could have been pervasive in Region IX with . . . a spike in PECOS fallouts," and he reports that his office "never received important emails that the representative of [Noridian] sent to us." P. App. at 1; P. Reply at 2. Petitioner posits that solo practitioners like himself "are more likely to fall out of PECOS process thus adding

[3] PECOS, the Provider Enrollment, Chain and Ownership System, "is an internet-based Medicare enrollment system through which providers and suppliers can submit enrollment applications, view, print, and update enrollment information, and track the status of submitted enrollment applications." *UpturnCare Co., d/b/a Accessible Home Health Care*, DAB No. 2632, at 3 n.4 (2015). PECOS is available at https://pecos.cms.hhs.gov (visited Oct. 28, 2019).

[4] Petitioner's proffer of exhibits to the ALJ did not include this letter, which was issued after the ALJ's deadline for Petitioner's filing of proposed exhibits. The appeal regulations, however, forbid the Board from admitting into the record in Medicare enrollment appeals evidence not proffered to the ALJ. *See* 42 C.F.R. § 498.86(a) ("Except for provider or supplier enrollment appeals, the Board may admit evidence into the record in addition to the evidence introduced at the ALJ hearing (or the documents considered by the ALJ if the hearing was waived) . . . ."). This letter, which Petitioner filed with his request for review of the ALJ Decision, is retained in the administrative record but is not admitted to the record for decision; we do not consider it in rendering this decision but cite it only to provide context to Petitioner's arguments.

more pressure to the solo practitioner's stress in dealing with new realities of CMS and care of patients," which "can affect patient care and may lead to increased morbidity and mortality since the provider may be more focused on the refusal of payment and financial viability rather than on the clinical issues regarding patients." P. App. at 2-3. Petitioner advises that many physicians "are feeling 'burnt out' and are retiring or joining larger groups which have better efficiencies of scale to deal with CMS and State requirements" and asks if "you are comfortable with not paying me for five to six months of hard and sometimes risky work caring for very sick CMS beneficiaries." *Id*. at 3-4.

The concerns Petitioner raises, however sympathetic a picture they evoke, are not legal grounds for the Board or an ALJ to set an earlier effective date for Petitioner's Medicare billing privileges, where CMS's determination of that date is, as explained above, consistent with the governing regulation, for two reasons. First, as explained above, to the extent Petitioner argues that these problems navigating the enrollment process resulted in Noridian unfairly or wrongly deactivating his billing privileges and rejecting the application he filed in November 2016 to restore his billing privileges, neither the Board nor ALJs may review the validity of deactivations of billing privileges or the rejection of enrollment applications.

Second, the Board "has repeatedly held that it, and ALJs, are bound by the applicable regulations and cannot alter an effective date based on principles of equity." *Gaurav Lakhanpal, MD*, DAB No. 2951, at 7 (2019) (citing *Shepard, M.D.*, DAB No. 2793, at 9 (quoting *Vijendra Dave, M.D.*, DAB No. 2672, at 8 (2016) and citing *Cent. Kan. Cancer Inst.* at 10 (The Board "is bound by the regulations, and may not choose to overturn the agency's lawful use of its regulatory authority based on principles of equity."))); *Decatur Health Imaging, LLC*, DAB No. 2805, at 11 (2017) ("Equitable considerations . . . provide no basis to . . . assign an earlier effective date."). Here, the governing regulation compels an effective date of April 25, 2017, and we may not adjust that date based on equitable grounds. *See Kaza* at 10 ("To the extent that Dr. Kaza argues that the reactivation dates should be set retroactively to the date that CMS deactivated his billing privileges because the situation in which Dr. Kaza finds himself is somehow unfair, the Board has no authority to provide any equitable relief."). Thus, the Board is not permitted to reverse CMS's determination of the effective date where it is consistent with the regulations based on Petitioner's accounts of his interactions with PECOS and Noridian, whether to ameliorate Petitioner's inconvenience and potential loss of reimbursement, to "send a message" to CMS, or for other reasons that sound in equity.

CMS cites the Board decision *US Ultrasound*, DAB No. 2302, at 8 for the well-established principle that neither ALJs nor the Board may provide equitable relief. CMS Resp. at 6, 15. Petitioner distinguishes that decision on the ground that it involved "reading routine outpatient or inpatient ultrasounds" instead of Petitioner "risking [his] own safety driving in the middle of the night to evaluate and treat critically ill CMS

recipients and other patients in the Emergency Room or Intensive Care Unit." P. Reply at 3. We are aware of nothing in the regulations that permits us to assign an earlier effective date than that mandated by the regulation in consideration of the nature of a supplier's practice and the severity of the illnesses of the patients he treats.

Conclusion

We affirm the ALJ Decision upholding Noridian's determination that the effective date of Petitioner's Medicare billing privileges is April 25, 2017.

/s/
Christopher S. Randolph

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member