Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Jeffrey D. Lubell, DPM
(PTAN: 0928430001),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-380

Decision No: CR3192

Date: April 7, 2014

DECISION

The Medicare enrollment and billing privileges of Petitioner, Jeffrey D. Lubell, DPM, are revoked pursuant to 42 C.F.R. §§ 424.57(d) and 424.535(a)(1),[1] effective July 2, 2013, based on noncompliance with 42 C.F.R. § 424.57(c)(7)(i)(C) (supplier standard 7).

I. Procedural History and Jurisdiction

The Medicare contractor, Palmetto GBA (Palmetto),[2] notified Petitioner by letter dated June 17, 2013, that his Medicare billing privileges and provider agreement were revoked effective March 26, 2013. Centers for Medicare & Medicaid Services (CMS) exhibit

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[1] The 2012 revision of the Code of Federal Regulations (C.F.R.) is cited, unless otherwise indicated.

[2] The notice was issued by the National Supplier Clearinghouse Supplier Audit and Compliance Unit (SACU), which is operated by Palmetto.

(Ex.) 1 at 21. Palmetto cited 42 C.F.R. §§ 405.800, 424.57(e),[3] 424.535(a)(1), 424.535(a)(5)(ii), and 424.535(g), as the authority for revocation based on Petitioner's noncompliance with 42 C.F.R. §§ 424.57(c)(2), (c)(7), (c)(10), and (c)(21).[4] CMS Ex. 1 at 21-22. Palmetto also notified Petitioner that he was subject to a two-year bar to re-enrollment pursuant to 42 C.F.R. § 424.535(c). CMS Ex. 1 at 21.

Petitioner submitted a request for reconsideration that Palmetto received on August 20, 2013. CMS Ex. 1 at 10, 25-27. Palmetto notified Petitioner by letter dated September 24, 2013, that it upheld the revocation of Petitioner's enrollment and billing privileges based on violation of supplier standard 7, 42 C.F.R. § 424.57(c)(7). CMS Ex. 1 at 1-7. However, Palmetto also found that Petitioner was in compliance with 42 C.F.R. § 424.57(c)(2), (c)(10), and (c)(21), contrary to Palmetto's initial determination. CMS Ex. 1 at 4-5.

Petitioner requested a hearing before an administrative law judge (ALJ) by letter dated November 20, 2013. The case was assigned to me for hearing and decision on December 13, 2013, and an Acknowledgement and Prehearing Order (Prehearing Order) was issued at my direction. No issue has been raised as to the timeliness of Petitioner's request for hearing, the parties do not challenge my authority to decide this case, and I conclude that I have jurisdiction.

On January 10, 2014, CMS filed a combined prehearing brief and motion for summary judgment (CMS Br.), with CMS Exs. 1 through 3. On February 18, 2014, Petitioner filed his opposition to the CMS motion for summary judgment (P. Br.), with Petitioner's exhibit (P. Ex.) A.[5] On February 25, 2014, CMS filed a reply brief (CMS Reply).[6] The

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[3] The citation to 42 C.F.R. § 424.57(e) was a clerical error as that provision relates to revalidation of billing privileges every three years, which is not an issue in this case. I conclude that Palmetto intended to cite 42 C.F.R. § 424.57(c) which includes supplier standard 7.

[4] These regulatory requirements are known as durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) supplier standards 2, 7, 10, and 21.

[5] Petitioner's exhibit was not correctly marked as required by the Prehearing Order. However, the exhibit was not returned to Petitioner for correction because there was no potential for confusion based on the incorrect marking.

[6] In its reply brief, CMS requested that I order Petitioner to show cause why he should not be sanctioned for the untimely filing of his brief and exhibit. CMS Reply at 6-7. A request for sanctions should have been by separate motion filed in accordance with Civil

(Footnote continued next page.)

parties have not objected to my consideration of the exhibits and CMS Exs. 1 through 3 and P. Ex. A are admitted as evidence.

II. Discussion

A. Applicable Law

Section 1831 of the Social Security Act (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.[7] Act §§ 1835(a) (42 U.S.C. § 1395n(a)), 1842(h)(1) (42 U.S.C. § 1395(u)(h)(1)). Petitioner is a DMEPOS supplier.

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. § 424.505, a 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. 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). Among other requirements, a DMEPOS supplier must maintain a physical facility on an appropriate site. 42 C.F.R.

(Footnote continued from preceding page.)

Remedies Division Procedure (CRDP) § 15, to ensure that Petitioner had an opportunity to respond. I will not sanction CMS for failure to comply with the CRDP, but I will not consider the CMS request further. I note that CMS failed to cite any prejudice it suffered and a sanction against Petitioner is unlikely in any case. I will not delay the decision in this case to consider whether sanctions are appropriate.

[7] A "supplier" furnishes services 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 "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.

§ 424.57(c)(7). An appropriate site for the physical facility must meet certain criteria, including that the practice location is in a location accessible to the public, Medicare beneficiaries, and CMS and its agents, and that the practice location must be accessible and staffed during posted hours of operation. 42 C.F.R. § 424.57(c)(7)(i)(B), (C). 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). 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 the authority to revoke enrollment and billing privileges to CMS. 42 C.F.R. § 424.535. CMS or its Medicare contractor may revoke an enrolled supplier's Medicare enrollment and billing privileges and supplier agreement for any of the reasons listed in 42 C.F.R. § 424.535. Specifically, CMS may revoke supplier's enrollment and billing privileges if the supplier is determined not to be in compliance with the enrollment requirements. 42 C.F.R. § 424.535(a)(1). CMS may also revoke a currently enrolled supplier's Medicare enrollment and billing privileges if CMS determines, upon on-site review, that the supplier is no longer operational to furnish Medicare covered items or services, or the supplier fails to satisfy any or all of the Medicare enrollment requirements, or has failed to furnish Medicare covered items or services as required by the statute or regulations. 42 C.F.R. § 424.535(a)(5)(ii). 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 the 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, 748-751 (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. Issues

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.

A provider or supplier denied enrollment in Medicare or whose enrollment had 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. §§ 424.454(a), 498.3(b)(1), (5), (6), (8), (15), (17), 498.5. The Act requires a hearing on the record, also known as an oral hearing. Act §§ 205(b), 1866 (h)(1) and (j); *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743, 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 decision based only upon the documentary evidence or pleadings. Accordingly, disposition on the written record alone is not permissible, unless CMS' motion for summary judgment has merit.

Summary judgment is not automatic upon request. Rather, it is limited to certain specific conditions. The procedures established by 42 C.F.R. pt. 498 related to ALJ hearings applicable in this case do not include a summary judgment procedure. However, appellate panels of the Board have long recognized the availability of summary judgment in cases subject to 42 C.F.R. pt. 498, and the federal courts have recognized the Board's interpretative rule. *See, e.g.*, *Crestview*, 373 F.3d at 749-750. Furthermore, I adopted a summary judgment procedure as a matter of judicial economy within my authority to regulate the course of proceedings and made it available to the parties in the litigation of this case by my Prehearing Order. Prehearing Order §§ II.D, II.G.

Summary judgment is appropriate when there is no genuine dispute as to any issue of material fact for adjudication 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 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. *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 differ 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 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 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 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 for the allocation of the burden of persuasion or the quantum of evidence in 42 C.F.R. pt. 498. The Board, however, 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 & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 Fed. App'x 181 (6th Cir. 2005).

In deciding that summary judgment is appropriate, I note that Petitioner did not challenge the material facts in this case: Petitioner was a DMEPOS supplier at the time of the inspections; Petitioner's hours of operation, as stated in his Medicare Enrollment Application (CMS Form 855S), dated February 14, 2013, were 1 p.m. to 4 p.m. on Mondays and 9 a.m. to 12 p.m. on Tuesday, Thursday, and Saturday; Palmetto's inspector attempted to inspect Petitioner's location on Thursday, March 21, 2013 at or about 10:40 a.m. and Tuesday, March 26, 2013 at or about 10:55 a.m., when, according to Petitioner, he should have been open; and, by Petitioner's own admission, his facility was not open at the times of the visits.

I conclude, after viewing the evidence before me in the light most favorable to Petitioner and drawing all inferences in Petitioner's favor, that there is no dispute as to any material fact in this case that requires a trial. The issues in this case that require resolution are issues of law related to the interpretation and application of the regulations that govern enrollment and billing privileges in the Medicare program and application of the law to the undisputed facts of this case. The issues in this case must be resolved against Petitioner as a matter of law and the undisputed evidence shows that there is a basis for

the revocation of Petitioner's Medicare billing privileges effective July 2, 2013. Accordingly, I conclude summary judgment is appropriate.

2. There was a basis to revoke Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 57(d) and 424.535(a)(1) for violation of 42 C.F.R. § 424.57(c)(7)(i)(C) (supplier standard 7).

3. The effective date of revocation is July 2, 2013.

a. Facts

The facts are not disputed and any inferences are drawn in favor of Petitioner. On March 21, 2013 at or about 10:40 a.m., a SACU investigator attempted to inspect Petitioner's facility at the address on file with CMS: 628 E. 222nd Street, Euclid, Ohio 44123. The investigator found the door locked and the office appeared not to be open. The investigator returned to Petitioner's facility on March 26, 2013 at or about 10:55 a.m., and again found the door locked and the office appeared not open and accessible. CMS Ex. 1 at 2-3, 18-19; CMS Ex. 2; CMS Ex. 3 at 7. Petitioner admits that his office at 628 E. 222nd Street, Euclid, Ohio was not open for business and that the investigator could not gain access at 10:40 a.m. on March 21, 2013 or at 10:55 a.m. on March 26, 2013. P. Br. at 4; Petitioner's More Definite Statement at 1-2. Petitioner does not deny that 10:40 a.m. and 10:55 a.m. are within the range of hours he stated his office was open in the CMS Form 855S that he signed on February 14, 2013. CMS Ex. 3 at 7. Petitioner does not deny that March 21, 2013 was Thursday and March 26, 2013 was Tuesday, days of the week when his CMS Form 855S show that he would be open to the public from 9 a.m. to 12 p.m. CMS Ex. 3 at 7. Petitioner does not deny that he did not check the "By Appointment Only" block on his CMS Form 855S dated February 14, 2013. CMS Ex. 3 at 7. Petitioner has not offered any evidence that his posted hours stated that he was available by appointment only or that his office was not opened on holidays or during the "Holy Days."

The SACU investigator checked blocks on his "Site Verification Survey Form" which state that the facility did not appear to have inventory present and that the facility did not appear to be operational. CMS Ex. 1 at 18; CMS Ex. 2 at 5. However the investigator's pictures show that visibility through the window and door were obscured by binds or curtains. CMS Ex. 1 at 19; CMS Ex. 2 at 6. The investigator does not state in his comments in the report how he could see the interior of the office so that he could determine that no inventory was present. The investigator also does not explain in his report how he determined that Petitioner was not prepared to submit valid Medicare claims or that Petitioner was not properly staffed, equipped, and stocked, when open, to provide items or services that Petitioner was authorized to provide as a DMEPOS supplier consistent with his enrollment in Medicare. CMS Ex. 2 at 5. The investigator's report supports a conclusion that he inferred based on the fact that the office was not open

and he could not gain access that Petitioner did not have inventory present and that Petitioner was not operational. The SACU investigator also states in his report that no hours were posted at Petitioner's facility but there are clearly labels or signs on the office door and the lower right and left corners of the office window that are unreadable due to the poorly framed pictures.[8] I do not access the credibility of witnesses on summary judgment but draw inferences in favor of Petitioner as the non-movant.

b. Analysis

Palmetto informed Petitioner that revocation was based on his noncompliance with the following supplier standards: 42 C.F.R. § 424.57(c)(2), because he failed to report changes in his hours of operation; 42 C.F.R. § 424.57(c)(7), because his business was not open when an inspector attempted to conduct two site visits during Petitioner's reported hours of operation and Petitioner's hours were not posted; and, 42 C.F.R. § 424.57(c)(10) and (c)(21), because he failed to provide a certificate of liability insurance upon request. CMS Ex. 1 at 21-22. Palmetto notified Petitioner by letter dated September 24, 2013, that the revocation of his enrollment and billing privileges was upheld on reconsideration based on the facts that Petitioner's facility was not open when the SACU investigator attempted inspections and Petitioner's hours of operation were not posted and, therefore, the evidence does not show that Petitioner was in compliance with supplier standard 7 (42 C.F.R. § 424.57(c)(7)). CMS Ex. 1 at 3-5. The reconsideration hearing officer found that Petitioner was in compliance with 42 C.F.R. § 424.57(c)(2) (supplier standard 2 – reporting changes), (c)(10) (supplier standard 10 – insurance), and (c)(21) (supplier standard 21 – responding to requests for information), contrary to Palmetto's initial determination. CMS Ex. 1 at 4-5. Although the reconsideration hearing officer sets forth the definition of operational and states that a supplier must be operational, she did not specifically find or conclude that the Petitioner was not operational and therefore subject to revocation of enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(5). Rather, she concluded that revocation was appropriate because Petitioner failed to show compliance with supplier standard 7 (42 C.F.R. § 424.57(c)(7)). Accordingly, I conclude that the specific issue before me is whether or not Petitioner was in compliance with 42 C.F.R. § 424.57(c)(7) (supplier standard 7). Whether or not there was a basis for revocation pursuant to 42 C.F.R. § 424.535(a)(5) because Petitioner was not operational is not at issue before me because it was not a basis for revocation upheld on reconsideration. However, 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).

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[8] The investigator did provide a clear picture of the window for the Divine Beauty Center, which demonstrates his ability with the camera. However, that picture is not relevant to the case before me.

CMS argues before me that Petitioner was not "operational" as defined in 42 C.F.R. § 424.502 and the facility was not accessible to the public, Medicare beneficiaries, CMS, or its agents, as required by supplier standard 7, 42 C.F.R. § 424.57(c)(7), on the dates the SACU investigator could not gain access to Petitioner's facility. CMS Br. at 1, 6-8. CMS argues that a violation of either of these provisions constitutes a sufficient basis to revoke Petitioner's billing privileges and participation in Medicare pursuant to 42 C.F.R. § 424.535(a)(5)(ii). CMS Br. at 1. The CMS argument shows that CMS conflates revocation pursuant to 42 C.F.R. § 424.535(a)(1), which authorizes CMS to revoke enrollment and billing privileges based on noncompliance with enrollment requirements including the special payment rules for DMEPOS suppliers such as supplier standard 7, and revocation pursuant to 42 C.F.R. § 424.535(a)(5), which authorizes CMS to revoke because it has determined that a supplier is no longer operational. The Board recognized this distinction in *Complete Home Care*, DAB No. 2525 at 6 (2013), concluding that it did not need to decide whether or not a supplier was operational where it found a single violation of 42 C.F.R. § 424.57(c)(7)(i)(C). The evidence that Petitioner was closed to the public on the dates of the two inspections, during hours when he should otherwise be open, is some evidence that Petitioner was no longer operational. However, whether a facility is open to the public during posted hours of operation is only one of the criteria established by 42 C.F.R. § 424.502 for deciding whether a supplier is operational. An analysis of whether a facility is "operational" within the meaning of 42 C.F.R. § 424.502 also requires consideration evidence related to the other factors listed in the regulation such as whether or not Petitioner was prepared to submit valid Medicare claims, whether the facility was properly staffed, equipped, and stocked to furnish items or services the supplier was authorized to furnish by its Medicare enrollment. However, whether or not Petitioner was operational within the meaning of 42 C.F.R. § 424.502 is not at issue in this case because violation of 42 C.F.R. § 424.535(a)(5) was not the basis for revocation upheld on reconsideration.

Supplier standard 7, 42 C.F.R. § 424.57(c)(7), requires that Petitioner maintain an appropriate site that meets specified criteria, including that it be accessible and staffed during posted hours of operation and which CMS or its agents can inspect to ensure compliance with participation requirements. Petitioner does not deny the facility was not accessible and staffed during normal hours of operation when the SACU investigator attempted to conduct either inspection. Accordingly, Petitioner was noncompliant with 42 C.F.R. § 424.57(c)(7)(i)(C) and there is a basis for the revocation of Petitioner's enrollment and billing privileges pursuant to the authority of 42 C.F.R. §§ 424.57(d) and 424.525(a)(1).

In this case, Petitioner was not in compliance with the special enrollment requirement for DMEPOS suppliers established by 42 C.F.R. § 424.57(c)(7)(i)(C) because Petitioner's facility was admittedly unstaffed and inaccessible to the public during his hours of operation. I accept for summary judgment purposes that Petitioner's hours were posted

as Petitioner asserts and were consistent with the hours he reported in the CMS Form 855S that he signed on February 14, 2013. CMS Ex. 3. Furthermore, while 42 C.F.R. § 424.535(a)(1) contemplates that Petitioner would be allowed to file a corrective action plan, in this case that would be a needless act because Petitioner cannot correct his admitted violation of supplier standard 7.

Pursuant to 42 C.F.R. § 424.57(d) the effective date of the revocation of Petitioner's billing privileges and Medicare enrollment is July 2, 2013, which is 15 days after the June 17, 2013 notice of the initial determination was issued. The March 26, 2013 effective date listed in the notice of initial determination is incorrect as a retroactive effective date would be authorized in this case only if revocation was based on a determination that Petitioner was no longer operational. 42 C.F.R. § 424.535(g).

Petitioner urges me to consider the fact that the dates on which he closed his facility fell during "the most Holy Days in the Jewish and Christian calendars . . . ." P. Br. at 1. Petitioner's argument is not persuasive. Supplier standard 7 makes no exception for religious holidays and Petitioner presented no evidence that whatever signage he did have posted stated that his facility was closed for religious holidays. While I accept, for purposes of summary judgment, Petitioners assertions that patients "were made aware of the religious observance/holiday closure" (P. Br. at 4), such notice does not meet the requirement of supplier standard 7 that Petitioner remain accessible and staffed during posted hours of operation. *Complete Home Care, Inc.*, DAB No. 2525 at 6. Petitioner also does not deny that his facility was not open and accessible to the SACU investigator.

To the extent that Petitioner's arguments may be construed to be that the regulations are unconstitutional in content or application (P. Br. at 5), I have no authority to find invalid a regulation or the Act on constitutional grounds and I am limited to applying the regulations and Act consistent with the Constitution. *Golden Living Ctr.—Grand Island Lakeview*, DAB No. 2364 at 3 (2011), *citing Northern Montana Care Center*, DAB No. 1930 (2004). I also have no authority to fashion any equitable relief for Petitioner by shortening the period of his two-year bar to reenrollment. *Complete Home Care*, *Inc.* DAB No. 2525 at 7.

III. Conclusion

For the foregoing reasons, I conclude that Petitioner's Medicare enrollment and billing privileges are revoked effective July 2, 2013.

/s/

Keith W. Sickendick
Administrative Law Judge