Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Carlos E. Fossi, M.D.,
(NPI: 1982627774; PTANs: 11398J, 11398K, 11398X),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-561

Decision No. CR3294

Date: July 11, 2014

DECISION

The Medicare enrollment and billing privileges of Petitioner, Carlos E. Fossi, M.D., are revoked pursuant to 42 C.F.R. § 424.535(a)(10)[1] based on a violation of 42 C.F.R. § 424.516(f), effective October 30, 2013 for one year.

I. Procedural Background and Jurisdiction

First Coast Service Options, Inc. (First Coast), a Medicare contractor, notified Petitioner by letter dated September 30, 2013, that his Medicare enrollment and billing privileges were revoked effective October 30, 2013. First Coast cited 42 C.F.R. § 424.535(a)(10) as the basis for the revocation based on a violation of 42 C.F.R. § 424.516(f). First Coast also barred Petitioner from re-enrolling in the Medicare program for one year, pursuant to 42 C.F.R. § 424.535(c). Centers for Medicare & Medicaid Services (CMS) Exhibit (Ex.) 1 at 8-11.

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[1] References are to the 2013 revision of the Code of Federal Regulations (C.F.R.), unless otherwise stated.

Petitioner requested reconsideration by letter dated October 22, 2013. CMS Ex. 1 at 4-5. Petitioner was notified by letter dated December 31, 2013, that the reconsideration hearing officer declined to overturn the revocation decision. CMS Ex. 1 at 1-3.

Petitioner requested a hearing before an administrative law judge (ALJ) on January 7, 2014. On January 23, 2014, the case was assigned to me for hearing and decision and an Acknowledgement and Prehearing Order (Prehearing Order) were issued. CMS filed a motion for summary judgment (CMS Br.) and CMS Exs. 1 through 8, on February 24, 2014. Petitioner responded by letter dated March 21, 2014 (P. Br.). Petitioner attached to his letter a one-page document titled "Review of Facts" and the first pages of seven CMS-485 forms titled "Home Health Certification and Plan of Care." The one-page "Review of Facts" is treated as part of Petitioner's brief, which is argument and not substantive evidence. The seven CMS-485 forms are treated as Petitioner's exhibits (P. Exs.) 1 through 7, marked in the order in which they appear following Petitioner's letter. CMS filed a reply on April 8, 2014 (CMS Reply). CMS did not object to my consideration of the documents Petitioner submitted with his response, which I treat as being marked P. Exs. 1 through 7, and those documents are admitted as evidence. Petitioner did not object to my consideration of CMS Exs. 1 through 3 and 5 through 8 and those documents are admitted and considered as evidence.

CMS Ex. 4 is not relevant evidence and is not admitted or considered as substantive evidence. There is no dispute that Petitioner entered a contract with Merfi Corp Medical Office effective July 2, 2012. The contract required Petitioner to work 16 hours per week at the rate of $1,500 per week, supervising three physician assistants. The contract specified that Petitioner would "check, revise, and sign all the orders and medical records seen by the three mentioned license (sic) physicians (sic) above." The contract was executed by Petitioner and Isabel Medina, President of Merfi Corp Medical Office. CMS Ex. 3. CMS Ex. 4 incudes documents from *United States v. Isabel Medina*, which appears to have been a criminal case in the United States District Court, Southern District of Florida. Included in CMS Ex. 4 are documents titled "Agreed Factual Basis for Guilty Plea" dated January 7, 2014, and a "Plea Agreement" dated December 18, 2013. The documents reflect that that Isabel Medina agreed to plead guilty to one count of participating in a conspiracy and scheme to defraud Medicare. The "Agreed Factual Basis for Guilty Plea" states that Isabel Medina was the owner and operator of Merfi Corp., which employed physicians and physician assistants who issued prescriptions for home health services. It is stated that Isabel Medina and her co-conspirators used Merfi to provide documents to home health care agencies and patient recruiters in return for kickbacks and bribes. It is stated that the documents provided falsely made it appear that beneficiaries qualified for home health care services when they did not and resulted in the submission of false and fraudulent claims totaling between $20 million and $50 million during the period October 2009 through approximately June 2012. CMS Ex. 4. CMS submitted no evidence that Isabel Medina's plea was found provident and that she was

convicted in accordance with her plea. Furthermore, there is no evidence that Petitioner was involved with the conspiracy except, possibly, the contract between Petitioner and Medina (CMS Ex. 3), which I find insufficient to establish any connection between Petitioner and the conspiracy. CMS refers to CMS Ex. 4 in footnote 4 of its motion for summary judgment. Absent some evidence of Petitioner's involvement in the conspiracy suggested in CMS Ex. 4, it is not clear why evidence related to Medina and her criminal case is offered by CMS, but I do not perceive or suggest any improper purpose. I do conclude that the information in CMS Ex. 4 is not relevant to any issue I must decide. Even if one concluded that the information in CMS Ex. 4 had some minimal relevance, any probative value is clearly outweighed by the risk for unfair prejudicial effect. Accordingly, I conclude that CMS Ex. 4 must be excluded and not admitted as substantive evidence.

II. Discussion

A. Applicable Law

The Act defines "home health services" as

> [I]tems and services [listed in the statute] furnished to an individual, who is under the care of a physician, by a home health agency or by others under an arrangement with them made by such agency, under a plan . . . established and periodically reviewed by a physician, which items and services are, . . . provided on a visiting basis in a place of residence used as such individual's home . . . .

Act § 1861(m) (42 U.S.C. § 1395x(m)). Home health services are covered by Medicare only if a physician certifies that home health services are required for that beneficiary for the reasons specified in the Act. Act §§ 1814(a)(2)(C), 1835(a)(2)(A) (42 U.S.C. §§ 1395f(a)(2)(C)); 1395n(a)(2)(A)).

A home health agency is a public agency or private organization and provides skilled nursing and other health care services to patients in their homes. Act § 1861(o) (42 U.S.C. § 1395x(o)). The Act sets forth requirements for home health agencies participating in the Medicare and Medicaid programs, and authorizes the Secretary of Health and Human Services (the Secretary) to promulgate regulations implementing the statutory provisions. Act §§ 1861(m) and (o), and 1891 (42 U.S.C. §§ 1395x(m) and (o), and 1395bbb).

Pursuant to section 1891(a)(4) of the Act, a home health agency must include the plan of care required by section 1861(m) of the Act as part of its clinical records for a Medicare

beneficiary receiving home health services. Section 1861(o)(3) of the Act requires that a home health agency maintain clinical records on all patients. Section 1861(m) requires that home health services be delivered according to a plan of care established and reviewed by a physician. The foregoing statutory provisions do not require that the physician who established and reviewed the plan of care maintain copies. The term "physician" as used in the Act is defined at section 1861(r), and that section includes no record-keeping requirements.

The regulations generally applicable to ordering medical services for Medicare beneficiaries recognize that the physician has a major role in deciding about patient admissions, testing, drugs, and treatments. Therefore the Act establishes as a condition for Medicare payment that the physician certify, and in some cases recertify, the necessity of medical services. 42 C.F.R. § 424.10. The regulation states that there are no specific procedures or forms required for physician certification and recertification, rather the provider may adopt any procedure or form that permits verification. 42 C.F.R. § 424.11(b). The generally applicable regulations specify that it is the responsibility of the provider,[2] that would be the home health agency in the case of home health services, to obtain required certifications and recertifications and keep them on file for verification by CMS or its contractor if necessary. A physician is a supplier not a provider, and the regulation does not impose a requirement that a physician maintain copies of plans of care or certifications and recertifications. 42 C.F.R. § 424.11(a)

The regulations specifically applicable to home health services provide that Medicare Part A and Part B will pay for home health services only when a physician signs a certification that the individual needs the home health services specified in the regulations. 42 C.F.R. §§ 409.40-.50, 424.22. The contents of the certification are specified by 42 C.F.R. § 424.22(a). The certification must include a statement that a plan of care for furnishing the services has been established and periodically reviewed by a

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[2] A "supplier" furnishes items or services under Medicare and the term supplier applies to physicians or other practitioners and facilities that are not included within the definition of the phrase "provider of services." Act § 1861(d) (42 U.S.C. § 1395x(d)). A "provider of services," 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.

physician who is a doctor of medicine, osteopathy, or podiatric medicine. 42 C.F.R. § 424.22(a)(iii). A physician responsible for performing the initial certification must document that a face-to-face patient encounter, which is related to the primary reason the patient requires home health services, has occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care. The documentation must include an explanation of why the clinical findings of the encounter support that the patient is homebound and in need of services. The face-to-face encounter can be, but need not be, performed by the certifying physician or by a nurse practitioner, clinical nurse specialist, certified nurse midwife, or physician assistant under the supervision of the physician (or for patients admitted to home health direct from an acute or post-acute stay by the physician who cared for the patient during that stay). The documentation of the face-to-face encounter must be in a separate and distinct section of, or an addendum to, the certification, and must be titled, dated and signed by the certifying physician. If the certifying physician does not perform the face-to-face encounter himself, the nonphysician practitioner or other physician who cared for the patient must communicate the clinical findings of that encounter to the certifying physician. 42 C.F.R. § 424.22(a)(1)(v). Recertification is required every 60 days; must be signed and dated by the physician who reviewed the plan of care; and contain the information specified in the regulation. 42 C.F.R. § 424.22(b). Similar requirements for plan of care contents, certification, and recertification for home health services subject to payment by Medicare Part A are found at 42 C.F.R. § 409.43(b). The regulations do not specify a form for the certification and plan of care. However, for home health services the Form CMS-485, "Home Health Certification and Plan of Care" appears to satisfy regulatory certification and recertification requirements, if properly completed. P. Exs. 1-7.

Pursuant to 42 C.F.R. § 424.505, a provider or supplier must be enrolled in the Medicare program and be issued a billing number to have billing privileges and to be eligible to receive payment for services rendered to a Medicare eligible beneficiary. A physician, such as Petitioner, who certifies home health services must maintain and provide CMS access to documentation regarding home health agency certifications as a condition for continued participation in Medicare. 42 C.F.R. § 424.516(f)(2). The regulation specifically requires that:

> (2)(i) A physician who orders/certifies home health services . . . is required to-
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> (A) Maintain documentation (as described in paragraph (f)(2)(ii) of this section) for 7 years from the date of the service; and
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> (B) Upon request of CMS or a Medicare contractor, to provide access to that documentation (as described in paragraph (f)(2)(ii) of this section).

42 C.F.R. § 424.516(f)(2)(i). The documents described in 42 C.F.R. § 424.516(f)(2)(ii) for which records must be maintained and produced when requested, include written or electronic documents related to written orders or certifications or requests for payments for: home health services; durable medical equipment, prosthetics/orthotics, and supplies; clinical laboratory testing; and imaging services.

Section 1842(h)(9) of the Act (42 U.S.C. § 1395u(h)(9)) authorizes the Secretary to revoke for up to one year the enrolment of a physician if the physician fails to maintain or provide access when requested to documents related to certifications for home health services. Consistent with this statutory authority, the regulation at 42 C.F.R. § 424.535(a)(10) provides that CMS may revoke a provider's or supplier's Medicare billing privileges and enrollment for up to a year if "[t]he provider or supplier did not comply with the documentation or CMS access requirements specified in" 42 C.F.R. § 424.516(f).

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 a right to request a hearing by an ALJ and further review by the Departmental Appeals Board (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, 748-750 (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 is a basis for the revocation of Petitioner's Medicare enrollment and billing privileges effective October 30, 2013.

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.

Petitioner has not waived an oral hearing. Therefore, disposition on the written record alone is not permissible unless the CMS motion for summary judgment is meritorious. 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. § 424.545(a)(1). The regulations do not establish or recognize a summary judgment 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 and the Board's interpretative rule has been recognized by the federal courts. *See, e.g., Crestview*, 373 F.3d at 749-50. Although the Federal Rules of Civil Procedure do not apply in administrative adjudications such as this, the Board has accepted that Fed. R. Civ. P. 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 the Prehearing Order, which specified that summary judgment is an available procedural device and that the law as it has developed related to Fed. R. Civ. P. 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. In determining whether there are genuine issues of material fact for trial, the reviewer must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. The party requesting summary judgment bears the burden of showing that there are no genuine issues of material fact for trial and/or that it is entitled to judgment as a matter of law. Generally, the non-movant may not defeat an adequately supported summary judgment motion by relying 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 Hospital Reg'l. Med. Ctr.*, DAB No. 2459, at 5 (2012) (and cases cited therein); *Experts Are Us, Inc.*, DAB No. 2452, at 5 (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 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 parties' evidence would be

sufficient to meet that party's evidentiary burden. *Dumas Nursing and Rehab., L.P.*, DAB No. 2347, at 5 (2010). The Secretary has not provided for the allocation of the burden of persuasion or the quantum of evidence in 42 C.F.R. pt. 498. The Board has, however, provided some persuasive analysis regarding the allocation of the burden of persuasion in cases subject to 42 C.F.R. pt. 498. The Board has allocated to CMS the burden of establishing a prima facie case that a petitioner is not in substantial compliance with relevant statutory or regulatory provisions. Only when CMS has met the burden of making a prima facie case does the burden shift to the petitioner to show by a preponderance of the evidence that the revocation of its enrollment and billing privileges was incorrect. *See Medisource Corp.*, DAB No. 2011, at 2-3, (2006); *citing Batavia Nursing and Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 Fed. App'x 181 (6th Cir. 2005).

There is no dispute that Petitioner failed to provide CMS access to documents related to his certification of home health services for at least seven Medicare beneficiaries. P. Br. at 3. Resolution of this case turns upon application of the law to this undisputed fact. Accordingly, summary judgment is appropriate.

2. There is a basis for revocation of Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(10) for violation of 42 C.F.R. § 424.516(f)(2)(i).

3. Revocation of enrollment is limited to one year pursuant to section 1842(h)(9) of the Act and 42 C.F.R. § 424.535(a)(10)(ii).

a. Facts

Petitioner is a physician residing in Lakeland, Florida. CMS Ex. 1 at 1, 5; CMS Ex. 5 ¶ 10. In 2013, the CMS, Center for Program Integrity, Miami Field Office (Miami Field Office), began an investigation into Petitioner's certification of Medicare beneficiaries for home health services. The investigation was triggered because Medicare program data showed that Petitioner issued 1,200 home health certifications in 2012 and 400 home health certifications in the first three months of 2013. On March 22, 2013, Petitioner was interviewed by Miami Field Office staff. During the interview Petitioner stated that he lived in Lakeland, Florida, which is approximately 200 miles from Miami, Florida. He stated that he had a contract with outpatient clinics in the Miami area to supervise physician assistants and nurse practitioners and sign documents related to certification of patients for home health services. Beginning in 2012 he had such a contract with Merfi Corp and he traveled to Miami every other Friday where he spent four hours at Merfi Corp, otherwise documents were sent to him in Lakeland for review and signature. CMS Ex. 5 at 1-2; CMS Ex. 7; CMS Ex. 8. Petitioner's employment contract with Merfi Corp Medical Office had an effective date of July 2, 2012, and provided that he would work 16 hours each week for a salary of $1,500 per week, supervising three physician assistants

including checking, revising, and signing all orders and medical records for patients seen by the three physician assistants. CMS Ex. 3.

The Miami Field Office requested by letter dated August 15, 2013, that Petitioner submit copies of the complete medical records for 26 Medicare beneficiaries for whom Petitioner certified home health services between the dates of January 2012 and August 15, 2013.[3] The records requested were described in the letter as "Evaluation and Management Visit Documentation, Home Health Certification Documentation, Plans of Care, Prescriptions, Face-to-Face Documentation and all other relevant documentation." CMS Ex. 1 at 12-13; CMS Ex. 5 ¶ 12. Petitioner responded to the request for documents on August 30, 2013, providing adequate records for 12 of the 26 beneficiaries. According to Cecilia Franco, Director of the Miami Field Office, Petitioner provided copies of home health services prescriptions for the remaining 14 beneficiaries but not the plans of care. CMS Ex. 5 ¶ 13; CMS Ex. 6. Director Franco states in her declaration dated February 24, 2014, that Petitioner's failure to provide copies of the plans of care for the 14 beneficiaries is the basis for the revocation of Petitioner's Medicare enrollment and billing privileges. CMS Ex. 5 ¶ 16. The First Coast notice dated September 30, 2013, also states that revocation is based upon Petitioner's failure to provide plans of care for the 14 Medicare beneficiaries identified by the Miami Field Office. CMS Ex. 1 at 8-11.

In his request for reconsideration dated October 22, 2013, Petitioner stated that First Coast's September 30, 2013 letter did not list the 14 beneficiaries for whom documentation was missing and that he needed to know which 14 beneficiaries they were requesting plans of care for so that he could accommodate the request. Petitioner also argued that he did not have access to the pertinent records, stating,

> I work as [an] independent contractor for the clinic that owns the records. My job is to supervise, assist and sign the work of 3 PA and ARNP who see an average of 15-20 patients per day each. I make myself available daily for consultation and assessment via telephone and visit the clinic to review, sign and supervise the records, making sure that all paperwork is in order. However, I do not own the records and I do not

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[3] The evidence shows that the Miami Field Office made demands for records by letters to Petitioner dated April 17, 2013 and July 25, 2013. CMS Ex. 8 at 6-10. There are no allegations in this case that Petitioner failed to produce documents in response to those demands.

> keep any documentation related to the patients per HIPAA regulations. At that time, all records available were submitted.

Petitioner stated that he tried to contact the clinic to obtain the records CMS was requesting, but he was referred to their attorney, who he was contacting to get the records. CMS Ex. 1 at 4-6, 23-25, 27-30.

In his response to the CMS motion for summary judgment, Petitioner states that he "always . . . maintained and reviewed records in the clinics I work for and I have never denied CMS access to them." P. Br. at 2. However, he further states that since February 27, 2014, when he obtained the list of 14 beneficiaries for whom CMS requests records:

> I have been trying to obtain information from the list from different agencies, inquiring one by one, only to find out that a lot of agencies are closed and the ones remaining open, answered that none of those patients were theirs. So far I have been able to obtain 7 out of the 14 records through old copies of records maintained by billing companies.
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> I cannot stress enough the fact that the records exist and I am not denying access to them. There is a Custodian of Records and the records are being withheld because of an ongoing investigation. At this point a subpoena may be the best way to obtain the records in question, because this is beyond my control since I am not the owner of the records . . ."

P. Br. at 2. Petitioner's statements in his reconsideration request and his response to the CMS motion for summary judgment are fully credible. I infer based upon Petitioner's statements that he does not have in his custody and control, and is therefore unable to produce, documents related to certifications and recertification for home health services that he signed and approved, for at least the seven beneficiaries for whom he has not produced such documents in response to First Coast and CMS requests.

b. Analysis

Petitioner does not dispute that he certified home health services for Medicare beneficiaries. He also does not dispute that he has been unable to produce documents related to the certification or recertification for home health services, other than prescription forms, for at least seven of the Medicare beneficiaries.

A physician, such as Petitioner, who certifies home health services must maintain and provide CMS access to documentation regarding home health agency certifications, as a condition for continued participation in Medicare. The regulation states:

> (2)(i) A physician who orders/certifies home health services . . . is required to
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> (A) Maintain documentation (as described in paragraph (f)(2)(ii) of this section) for 7 years from the date of the service; and
>
> (B) Upon request of CMS or a Medicare contractor, to provide access to that documentation (as described in paragraph (f)(2)(ii) of this section).

42 C.F.R. § 424.516(f)(2)(i). The documents described in 42 C.F.R. § 424.516(f)(2)(ii) for which records must be maintained and produced by the certifying physician when requested by CMS include written or electronic documents related to written orders or certifications or requests for payments for: home health services; durable medical equipment, prosthetics/orthotics, and supplies; clinical laboratory testing; and imaging services. Pursuant to section 1861(m) of the Act home health services must be delivered according to a plan of care established and reviewed by a physician. Therefore, I conclude that a plan of care is related to an order for home health services, and is a document that must be maintained by a physician certifying or recertifying home health services and made accessible to CMS upon request. In fact, if a physician uses a Form CMS-485 "Home Health Certification and Plan of Care," as Petitioner did in at least some cases, the plan of care is documented on the same form as the certification.

Petitioner has been unable to produce and make accessible to CMS the plan of care for at least seven Medicare beneficiaries for whom he ordered home health services.[4] Petitioner's reliance upon provisions of the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191 (HIPAA) as a defense is misplaced. He cites no provision of HIPAA that relieves him of the requirement to comply with 42 C.F.R. § 424.516(f)(2) and I have found no such provision. 45 C.F.R. pts. 160, 162, 164. Accordingly, I conclude that Petitioner failed to comply with 42 C.F.R. § 424.516(f)(2)(i)

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[4] CMS asserts in its reply brief that Petitioner failed to provide plans of care for eleven beneficiaries. CMS Reply at 4. It is not necessary for me to resolve this issue of fact because a physician's failure to maintain and provide CMS access to even one certification or recertification and plan of care for home health services constitutes a violation of 42 C.F.R. § 424.516(f)(2) that provides a basis for revocation of enrollment pursuant to 42 C.F.R. § 424.535(a)(10).

and CMS has a basis to revoke his Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(10).

Pursuant to section 1842(h)(9) of the Act and 42 C.F.R. § 424.535(a)(10)(ii), the maximum re-enrollment bar is one year.

III. Conclusion

For the foregoing reasons, Petitioner's Medicare enrollment and billing privileges are revoked for one year beginning on October 30, 2013. Petitioner is reminded that re-enrollment is not automatic but must be accomplished in accordance with the applicable regulations in 42 C.F.R. pt. 424.

/s/
Keith W. Sickendick
Administrative Law Judge