Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Absolute Home Healthcare, Inc.
(CCN: 14-8291; NPI: 1043514573),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-1368

Decision No. CR4883

Date: July 7, 2017

DECISION

The Medicare enrollment and billing privileges of Petitioner, Absolute Home Healthcare, Inc., are revoked pursuant to 42 C.F.R. § 424.535(a)(5)(i),[1] for noncompliance with 42 C.F.R. § 424.516(e)(2). The revocation is effective August 5, 2014. 42 C.F.R. § 424.535(g). Petitioner's provider agreement is terminated effective August 5, 2014, pursuant to 42 C.F.R. § 424.535(b), due to the revocation of Petitioner's enrollment and billing privileges.

I. Procedural History and Jurisdiction

Palmetto GBA (Palmetto), a Medicare Administrative Contractor (MAC), notified Petitioner by letter dated October 27, 2014, that Petitioner's Medicare enrollment and

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[1] Citations are to the 2014 revision of the Code of Federal Regulations (C.F.R.), unless otherwise stated.

billing privileges were revoked pursuant to 42 C.F.R. § 424.535(a)(5), and its provider agreement terminated effective August 5, 2014. Palmetto also notified Petitioner that it was subject to a two-year bar to re-enrollment pursuant to 42 C.F.R. § 424.535(c). Centers for Medicare & Medicaid Services (CMS) Exhibit (Ex.) 1 at 104-05.

Petitioner requested reconsideration on November 22, 2014 and December 8, 2014. CMS Ex. 1 at 7, 19-20. On January 21, 2015, a CMS hearing officer issued a reconsidered determination upholding the revocation of Petitioner's Medicare enrollment and billing privileges. CMS Ex. 1 at 1-3.

Petitioner requested a hearing before an administrative law judge (ALJ) on February 19, 2015. On March 18, 2015, the case was assigned to me for hearing and decision, and an Acknowledgement and Prehearing Order (Prehearing Order) was issued at my direction. A hearing was convened by video teleconference (VTC) on August 21, 2015, and a transcript (Tr.) was prepared. CMS Exs. 1 through 8 were offered and admitted as evidence. Tr. 18-19. Petitioner offered Petitioner's exhibits (P. Exs.) 1 through 5. Tr. 19. P. Exs. 1 through 3 and 5 were admitted as evidence. Tr. 20-34. CMS elicited the testimony of one witness, Tanesha Norman, a Provider Enrollment Manager at Palmetto. Tr. 36-59. Petitioner called one witness, its president, administrator, and co-owner, Basil Ohakosim. Tr. 62-88.

CMS filed its post-hearing brief on October 23, 2015 (CMS Br.). Petitioner filed its post-hearing brief on November 9, 2015 (P. Br.). CMS and Petitioner filed their post-hearing reply briefs on December 9, 2015 (CMS Reply; P. Reply, respectively).

II. Discussion

A. Applicable Law

Sections 1811 through 1821 of the Social Security Act (the Act) (42 U.S.C. §§ 1395c-1395i-5) establish the hospital insurance benefits program for the aged and disabled known as Medicare Part A. Section 1831 of the Act (42 U.S.C. § 1395j) establishes the supplementary medical insurance benefits program for the aged and disabled known as Medicare Part B.[2] Administration of both the Part A and B programs is through MACs,

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[2] In the case of Medicare-eligible beneficiaries not enrolled in Medicare Part B, home health services are paid under Part A subject to the limitations specified in section 1812(a)(3) of the Act. Home health services are also covered under Medicare Part B for those enrolled. Act § 1832(a)(2)(A). Thus, home health agencies, which are defined as providers by section 1861(u) of the Act, may be reimbursed under Part A or Part B depending upon the facts of the particular case.

such as Palmetto. Act §§ 1816, 1842(a) (42 U.S.C. §§ 1395h, 1395u(a)). Payment under the programs for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of services and suppliers.[3] Act §§ 1815, 1817, 1834(j)(1) (42 U.S.C. §§ 1395g, 1395i, 1395m(j)(1)); 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395u(h)(1)). Petitioner, a home health agency, is a provider.

The Act requires the Secretary of Health and Human Services (Secretary) to issue regulations that establish a process for the enrollment in Medicare of providers and suppliers, including the right to a hearing and judicial review of certain enrollment determinations, such as revocation of enrollment and billing privileges. Act § 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to 42 C.F.R. §§ 424.500 and 424.505, a provider such as Petitioner 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.

Providers must submit complete, accurate, and truthful responses to all information requested in the enrollment application. 42 C.F.R. § 424.510(d)(2). Pursuant to 42 C.F.R. §§ 424.502 and 424.510(d)(3), an application to enroll in Medicare must be signed by an authorized official, i.e., one with authority to bind the provider or supplier both legally and financially. Subsection 424.510(d)(3) provides that the signature attests to the accuracy of information provided in the application. The signature also attests to the fact that the provider or supplier is aware of and abides by all applicable statutes, regulations, and program instructions. 42 C.F.R. § 424.510(d)(3). Providers must meet basic requirements depending on their type of service. 42 C.F.R. §§ 424.505, 424.516, 424.517. Providers are also subject to additional screening requirements depending upon the type of service they provide. 42 C.F.R. § 424.518.

The Secretary has delegated authority to CMS or its Medicare contractor to revoke an enrolled provider's Medicare enrollment and billing privileges and any provider agreement for any of the reasons listed in 42 C.F.R. § 424.535. The provider bears the

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[3] A "supplier" furnishes services under Medicare and includes 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) (42 U.S.C. § 1395f(g)) and 1835(e) (42 U.S.C. § 1395n(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.

burden to demonstrate that it meets enrollment requirements with documents and records. 42 C.F.R. § 424.545(c). Generally, when CMS revokes a provider's Medicare billing privileges for not complying with enrollment requirements, then the revocation is effective 30 days after CMS or its contractor mails notice of its determination to the provider. 42 C.F.R. § 424.535(g). However, when, as in this case, CMS revokes a provider's billing privileges because the provider's practice location is not operational, the revocation is effective as of the date CMS determined the provider was no longer operational at the practice location. 42 C.F.R. § 424.535(g). After a provider's Medicare enrollment and billing privileges are revoked, the provider is barred from re-enrolling in the Medicare program for one to three years. 42 C.F.R. § 424.535(c).

The Secretary has issued regulations that establish the right to a hearing and judicial review of certain enrollment determinations. Act § 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to section 1866(h)(1) and (j)(8), a provider or supplier whose enrollment application or renewal application is denied or whose Medicare enrollment is revoked and corresponding agreement, if any, is terminated is entitled to a hearing before an ALJ and Departmental Appeals Board (Board) review, followed by judicial review. Pursuant to 42 C.F.R. § 424.545(a), a provider or supplier denied enrollment in Medicare or whose Medicare enrollment and billing privileges are revoked has the right to administrative and judicial review in accordance with 42 C.F.R. pt. 498. Appeal and review rights are specified by 42 C.F.R. § 498.5.

The Secretary's regulations do not address the allocation of the burden of proof or the standard of proof. 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. The standard of proof is a preponderance of the evidence. CMS has the burden of coming forward with the evidence and making a prima facie showing of a basis for revocation of Petitioner's enrollment. Petitioner bears the burden of persuasion to rebut the CMS prima facie showing by a preponderance of the evidence or to establish any affirmative defense. *Batavia Nursing & Convalescent Inn*, DAB No. 1911 (2004); *Batavia Nursing & Convalescent Ctr*., DAB No. 1904 (2004), *aff'd*, *Batavia Nursing & Convalescent Ctr. v. Thompson,* 129 F. App'x 181 (6th Cir. 2005); *Emerald Oaks*, DAB No. 1800 (2001); *Cross Creek Health Care Ctr.*, DAB No. 1665 (1998); *Hillman Rehab. Ctr*., DAB No. 1611 (1997) (*remand*), DAB No. 1663 (1998) (*aft. remand*), *aff'd*, *Hillman Rehab. Ctr. v. United States*, No. 98-3789 (GEB), 1999 WL 34813783 (D.N.J. May 13, 1999).

"Prima facie" means generally that the evidence is "[s]ufficient to establish a fact or raise a presumption unless disproved or rebutted." *Black's Law Dictionary* 1228 (8th ed. 2004). The Board has stated that CMS makes a prima facie showing of noncompliance if the evidence CMS relies on is sufficient to support a decision in its favor absent an effective rebuttal. *Hillman Rehab. Ctr.*, DAB No. 1611 at 8 (1997). A provider can overcome CMS's prima facie case either by rebutting the evidence upon which that case rests or by proving facts that affirmatively show statutory or regulatory compliance. *Tri-*

County Extended Care Ctr., DAB No. 1936 (2004). "An effective rebuttal of CMS's prima facie case would mean that at the close of the evidence, the provider had shown that the facts on which its case depended (that is, for which it had the burden of proof) were supported by a preponderance of the evidence." *Id.* at 4 (quoting *Western Care Mgmt. Corp.*, DAB No. 1921 (2004)).

B. Issue

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

C. Findings of Fact, Conclusions of Law, and Analysis

My conclusions of law are set forth in bold followed by the pertinent findings of fact and analysis. I have carefully considered all the evidence and the arguments of both parties, though not all may be specifically discussed in this decision. I discuss in this decision the credible evidence given the greatest weight in my decision-making.[4] I also discuss any evidence that I find is not credible or worthy of weight. The fact that evidence is not specifically discussed should not be considered sufficient to rebut the presumption that I considered all the evidence and assigned such weight or probative value to the credible evidence that I determined appropriate within my discretion as an ALJ. There is no requirement for me to discuss the weight given every piece of evidence considered in this case, nor would it be consistent with notions of judicial economy to do so. Charles H. Koch, Jr., *Admin. L. & Prac.* § 5:64 (3d ed. 2013).

1. Pursuant to 42 C.F.R. § 424.516(e)(2), Petitioner was required to report to CMS or its contractor a change of address within 90 days of the change.

2. Providers and suppliers enrolling in Medicare or reporting changes to enrollment information must use the enrollment application – CMS-855 – of the type applicable to the provider or supplier. 42 C.F.R. §§ 424.510-.515.

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[4] "Credible evidence" is evidence that is worthy of belief. *Black's Law Dictionary* 596 (8th ed. 2004). The "weight of evidence" is the persuasiveness of some evidence compared to other evidence. *Id.* at 1625.

3. An enrollment application is not considered filed with a MAC until it is received by the MAC. *Alexander C. Gatzimos, MD, JD, LLC,* DAB No. 2730 (2016).

4. Petitioner violated 42 C.F.R. § 424.516(e)(2) by not reporting its change of practice location to CMS or its contractor within 90 days of the change using the appropriate CMS-855.

5. There is a basis to revoke Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(5)(i) for noncompliance with the requirement of 42 C.F.R. § 424.516(e)(2) to give notice of a change of enrollment information within 90 days.

6. Petitioner has failed to show that the MAC received the proper enrollment application reporting Petitioner's change of address within 90 days of the change.

7. The effective date of revocation of Petitioner's Medicare enrollment and billing privileges is August 5, 2014. 42 C.F.R. § 424.535(g).

Initially, it is necessary to establish the scope of review, i.e., my jurisdiction, in this case. In the initial determination dated October 27, 2014, Palmetto determined that revocation was authorized by 42 C.F.R. § 424.535(a)(5) on grounds that an August 5, 2014 site review determined that Petitioner was "no longer operational to furnish Medicare covered items or services and is not meeting Medicare enrollment requirements under statute or regulation to supervise treatment of or to provide Medicare covered items or services for Medicare patients." CMS Ex. 1 at 104. In the January 21, 2015 reconsidered determination, CMS determined and specifically stated that revocation was authorized pursuant to 42 C.F.R. § 424.535(a)(5) because "Palmetto did not receive" notice that Petitioner had changed its practice location. CMS Ex. 1 at 2. The reconsideration hearing officer does not state in the paragraph entitled "Decision" that revocation was based on Petitioner not being operational. The hearing officer specifically stated under the section of the reconsidered determination entitled "Facts" that the initial determination was based on a conclusion that Petitioner was no longer operational but the hearing officer did not state that as grounds for revocation in the "Decision" section of the reconsidered determination. CMS Ex. 1 at 1-2.[5]

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[5] The reconsidered determination incorrectly cites 42 C.F.R. § 424.516(d)(1) as the authority for the requirement that Petitioner report any change of practice location within 30 days. CMS Ex. 1 at 2. CMS agrees that the reconsidered determination is in error.
Footnote continued next page.

CMS asserted at hearing (Tr. 28-34, 96-98) and argues in post-hearing briefing (CMS Br. at 6-15) that I may consider whether or not Petitioner was operational as a basis for revocation even though that basis is not cited as the basis for revocation in the reconsidered determination issued by CMS. Despite CMS's arguments, I conclude based on the Board decisions in *Neb Group of Arizona, LLC*, DAB No. 2573 at 7 (2014) and *Benson Ejindu*, DAB No. 2572 at 5 (2014), that whether or not revocation on grounds that Petitioner was not operational within the meaning of 42 C.F.R. § 424.502 at the time of the on-site review is not before me as that was not the basis for revocation determined on reconsideration. Pursuant to 42 C.F.R. § 498.5(*l*)(2), CMS had the right to request ALJ review of the reconsidered determination but did not do so. I conclude that CMS is now precluded from arguing that an additional basis for revocation exists based on Petitioner being not operational within the meaning of 42 C.F.R. § 424.502. There is no dispute that Petitioner was no longer operating a practice at the address on file with CMS at the time of the on-site review, but that is a different issue from whether Petitioner remained operational within the meaning of 42 C.F.R. § 424.502, albeit at a separate location. Accordingly, I conclude that the basis for revocation of Petitioner's Medicare enrollment and billing privileges and the termination of Petitioner's provider agreement at issue before me is whether or not Petitioner complied with the Medicare enrollment requirement of 42 C.F.R. § 424.516(e)(2) to notify CMS of its change of practice location within 90 days of the change.

a. Facts

Petitioner enrolled in Medicare as a provider of home health services, i.e., a home health agency, effective November 1, 2011. Petitioner listed in its enrollment application (CMS-855A) a practice location at 413 Homeland Road, Matteson, Illinois 60443 (Homeland Road location). Petitioner's application also listed multiple geographic areas where services would be delivered as required by the form. CMS Ex. 2, at 1, 25, 35-45. The Homeland Road location is also the residence of Basil Ohakosim and his wife, Petitioner's co-owners, and has been since Petitioner's enrollment. P. Ex. 2; Tr. 63-64.

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(Footnote continued.)

CMS Br. at 1 n.1. Petitioner, a home health agency, is not subject to 42 C.F.R. § 424.516(d)(1), which applies only to physicians, nonphysician practitioners, and their practice organizations. Rather, Petitioner is subject to the requirement of 42 C.F.R. § 424.516(e)(2) to report any changes to enrollment information within 90 days. Petitioner in its post-hearing brief also recognized that 42 C.F.R. § 424.516(e)(2) is the applicable regulation. P. Br. at 1. The erroneous citation in the reconsidered determination caused no prejudice to the parties, who were aware of the error and were not impaired in their ability to defend their positions in this proceeding.

Petitioner subsequently moved its office from the Homeland Road location to 4440 W. Lincoln Highway, Suite 305, Matteson, Illinois 60443 (Lincoln Highway location). There is no doubt Petitioner was no longer operating at the Homeland Road location at the time of the site survey on August 5, 2014. CMS Ex. 1 at 17, 106; P. Ex. 2 at 1.

Mr. Ohakosim, Petitioner's president and administrator (Tr. 63) testified that Petitioner moved its primary office location to the Lincoln Highway location on or about August 1, 2012. P. Ex. 2 at 1; Tr. 63-67. He testified he was aware that he had to report the change of address to Palmetto using a CMS-855, though he testified in response to my questioning that he was not aware it had to be a CMS-855A rather than a CMS-855B. Tr. 67, 80, 82. On or about August 15, 2012, Mr. Ohakosim signed a CMS-855B that reflected that Petitioner added the Lincoln Highway location as a correspondence address and practice location effective August 15, 2012. CMS Ex. 1 at 8-16; P. Ex. 2; Tr. 65-66. Mr. Ohakosim testified he mailed the CMS-855B to Palmetto on August 15, 2012, through the U.S. Postal Service. He testified that he received a tracking number so he could track receipt by Palmetto but the receipt with the tracking number could not be located. Tr. 66, 70, 80; P. Ex. 2 at 1. He agreed on cross-examination that he never received any acknowledgment from Palmetto that the CMS-855B was received. Tr. 81. Mr. Ohakosim also signed an Electronic Funds Transfer Agreement and submitted a voided check bearing the Lincoln Highway location address, on September 24, 2012. A facsimile sheet reflects a transmission date of September 24, 2012. CMS Ex. 3. Mr. Ohakosim testified that the agreement was sent to Palmetto but Petitioner has not shown receipt of the facsimile transmission by Palmetto. Mr. Ohakosim testified that the form listed the Homeland Road location as Petitioner's special payments address. Tr. 71-73. The evidence is consistent that Petitioner's move from the Homeland Road location to the Lincoln Highway location occurred in early August 2012. Mr. Ohakosim admitted that he signed and dated a CMS-855A on December 1, 2014, that he sent to Palmetto. CMS Ex. 4 at 14; Tr. 74. In that CMS-855A he reported the change to the Lincoln Highway location effective December 1, 2014. CMS Ex. 4 at 10-12. Palmetto received the CMS-855A on December 4, 2014 and rejected it on December 8, 2014, because Petitioner's enrollment and billing privileges were revoked effective August 5, 2014. CMS Ex. 4 at 1. Mr. Ohakosim testified that he submitted the CMS-855A under the mistaken impression that was all that was needed to regain Petitioner's billing privileges. Tr. 74-75. Mr. Ohakosim's testimony is credible.

Tanesha Norman, a Provider Enrollment Manager at Palmetto, testified that the practice location on file for Petitioner at the time of the August 5, 2014 site visit was the Homeland Road location. Ms. Norman testified that when Petitioner moved to a new practice location, it was required to notify Palmetto of the move by submitting a CMS-855A application. Tr. 39; CMS Ex. 8 at 1. Ms. Norman testified that she examined the records of Palmetto and found no evidence that Petitioner reported a new practice location prior to the August 5, 2014 site visit. Tr. 40, 43. She also testified that a CMS-855B is not the appropriate form for a home health agency such as Petitioner to use to

report an enrollment change. She testified that had Palmetto received a CMS-855B from Petitioner in 2012, receipt of the document would have been recorded and the document would have been returned to Petitioner with a letter advising Petitioner to submit the correct CMS-855A form. Tr. 44-46; CMS Ex. 8 at 2. Ms. Norman testified based on her examination of Palmetto records that Palmetto had no record of receiving either a CMS-855A or CMS-855B form from Petitioner in August 2012 or at any point prior to August 5, 2014. She testified that Palmetto records show that a CMS-855A was received from Petitioner in December 2014, but it was rejected because Petitioner's Medicare enrollment and billing privileges had already been revoked. Tr. 40, 47; CMS Ex. 8 at 2. I accept as credible Ms. Norman's testimony, which is consistent with her declaration. CMS Ex. 8.

Petitioner has not presented a certified or registered mail receipt, a courier service receipt, or other evidence that Palmetto received any CMS-855 form reporting Petitioner's change of address within 90 days of the change of Petitioner's practice location during about August 1 to 15, 2012. Petitioner has also not presented evidence that it notified CMS and Palmetto of the change of address within 90 days of the change using the CMS Provider Enrollment, Chain, and Ownership System (PECOS), which allows providers and suppliers to file a CMS-855 online. Tr. 42-43.

b. Analysis

As a condition for maintaining Medicare enrollment, a provider or supplier is required to provide CMS notice of any change in its enrollment information, including a change of practice location, using the appropriate CMS-855 enrollment application. 42 C.F.R. §§ 424.510-.515. A provider, such as Petitioner, is required as a condition of enrollment to report a change of address to CMS or its contractor within 90 days of the change. 42 C.F.R. § 424.516(e)(2). A provider or supplier must be able to demonstrate that it meets enrollment requirements and to produce the documents necessary to show it is in compliance with enrollment requirements. 42 C.F.R. § 424.545(c).

Pursuant to 42 C.F.R. § 424.535(a)(5)(i), CMS may revoke a provider's Medicare enrollment and billing privileges if CMS determines upon on-site review that:

> (1) The provider is no longer operational to furnish Medicare covered items or services; or
>
> (2) The provider has failed to satisfy any of the Medicare enrollment requirements.

In this case, there is no dispute that Petitioner moved from the Homeland Road location to the Lincoln Highway location during about August 1 to 15, 2012. There is no dispute that an investigator attempted to conduct a site inspection on August 5, 2014, at the Homeland Road location, but Petitioner was not operational at that practice location.

Pursuant to 42 C.F.R. § 424.516(e)(2), Petitioner had 90 days from the date of its move to report its change of practice location from the Homeland Road location to the Lincoln Highway location. Although Petitioner mailed a CMS-855B form to Palmetto to report its new address in August 2012, Palmetto had no record of receiving that application. The evidence shows that Palmetto had no record of receiving any CMS-855 application, either a CMS-855A or a CMS-855B, from Petitioner reporting the change in practice location within 90 days of the change in early August 2012.

In *Gatzimos*, DAB No. 2730, the Board interpreted the regulations and the regulatory history and determined that it is the receipt of a CMS-855 enrollment application by the MAC that constitutes filing under the Medicare enrollment regulations, not the mailing of the CMS-855 form by the provider or supplier. *Gatzimos*, DAB No. 2730 at 1. The credible evidence is that Palmetto received no CMS-855 from Petitioner within 90 days of the move of Petitioner's practice location in early August 2012. Accordingly, I conclude that CMS has made a prima facie showing that Petitioner did not comply with 42 C.F.R. § 424.516(e)(2). Although Petitioner's evidence is credible that a CMS-855 form was mailed to Palmetto in August 2012, Petitioner has failed to meet its burden to show that Palmetto received the application. Accordingly, I conclude there is a basis for revocation of Petitioner's enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(5)(i) and termination of the related provider agreement pursuant to 42 C.F.R. § 424.535(b).

The effective date of revocation is determined pursuant to 42 C.F.R. § 424.535(g), which provides:

> (g) *Effective date of revocation.* Revocation becomes effective 30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier, except if the revocation is based on Federal exclusion or debarment, felony conviction, license suspension or revocation, **or the practice location is determined by CMS or its contractor not to be operational.** When a revocation is based on a Federal exclusion or debarment, felony conviction, license suspension or revocation, **or the practice location is determined by CMS or its contractor not to be operational, the revocation is effective with the date** of exclusion or debarment, felony conviction, license suspension or revocation or the date that **CMS or its contractor determined that the provider or supplier was no longer operational.**

42 C.F.R. § 424.535(g) (emphasis added). The preponderance of the evidence shows that when the site visit occurred at the Homeland Road location on August 5, 2014, Petitioner

no longer had a practice operational at that location. Therefore, August 5, 2014, is the date that CMS determined that the practice location was not operational. Accordingly, pursuant to 42 C.F.R. § 424.535(g), August 5, 2014 is the effective date of revocation of Petitioner's Medicare enrollment and billing privileges.

To the extent that Petitioner's arguments may be construed as a request for equitable relief, I have no authority to grant such relief. *US Ultrasound*, DAB No. 2302 at 8 (2010). 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 (2009).

III. Conclusion

For the foregoing reasons, I conclude that Petitioner's Medicare enrollment and billing privileges are revoked effective August 5, 2014, pursuant to 42 C.F.R. § 424.535(a)(5)(i) for failure to comply with 42 C.F.R. § 424.516(e)(2). Petitioner's provider agreement is terminated effective August 5, 2014, pursuant to 42 C.F.R. § 424.535(b), due to the revocation of Petitioner's enrollment and billing privileges.

/s/
Keith W. Sickendick
Administrative Law Judge