Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

OC Housecalls, Inc.
(NPI: 1053479394 / PTAN: W20842),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-17-605

Decision No. CR4961

Date: October 30, 2017

DECISION

The Medicare enrollment and billing privileges of Petitioner, OC Housecalls, Inc., are revoked pursuant to 42 C.F.R. §§ 424.535(a)(5)(ii) and 424.535(a)(9)[1] based on violations of 42 C.F.R. §§ 424.510(d)(2) and 424.516(d)(1)(iii). The effective date of revocation is March 22, 2016, the date it was determined that Petitioner was not operating a practice location at the address listed in its Medicare enrollment application. 42 C.F.R. § 424.535(g).

I. Procedural History and Jurisdiction

On November 14, 2016, Noridian Healthcare Solutions (Noridian), a Medicare administrative contractor (MAC), notified Petitioner of its initial determination to revoke Petitioner's Medicare enrollment and billing privileges effective March 22, 2016, and to impose a two-year re-enrollment bar. Centers for Medicare & Medicaid Services (CMS) Exhibit (Ex.) 1 at 8-9. Noridian cited 42 C.F.R. §§ 424.535(a)(5) and 424.535(a)(9) as

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[1] Citations are to the 2016 revision of the Code of Federal Regulation (C.F.R.), unless otherwise stated.

authority for the revocation. Noridian alleged that it was determined by an on-site review that Petitioner was not operational at the practice address on file and that Petitioner failed to notify CMS of a change of practice location as required by 42 C.F.R. § 424.516. CMS Ex. 1 at 8.

On December 4, 2016, Petitioner's owner, Lynda Adrig, M.D., requested reconsideration of the initial determination. Dr. Adrig stated in the reconsideration request that she provides care to homebound patients in their homes, assisted living facilities, or wherever they reside; she uses her home office at 511 Newcastle, Irvine, California (511 Newcastle) as Petitioner's practice location where she takes care of practice administration; and she has done so since she started Petitioner in 2003. She stated that it was a mistake to list P.O. Box 3943 Irvine Boulevard # 233, Irvine, California (3943 Irvine) as Petitioner's practice location on a revalidation application as that address was a mail box only. She further stated that when she initially applied for Petitioner's enrollment in Medicare, she listed 511 Newcastle as the practice location and she has never requested that that practice location be changed or deleted. CMS Ex. 1 at 5.

An unidentified Noridian hearing officer issued a reconsidered determination on February 21, 2017. The hearing officer upheld the revocation of Petitioner's Medicare enrollment and billing privileges. The hearing officer found that on March 22, 2016, a site inspector performed an on-site visit to 3943 Irvine, the practice location listed in Petitioner's revalidation application, and Petitioner did not have a practice at that location. The hearing officer cited 42 C.F.R. §§ 424.535(a)(5) and (9) as the legal authority for revocation. CMS Exs. 1 at 1-2.

Petitioner requested a hearing before an administrative law judge (ALJ) on April 13, 2017 (RFH). The case was assigned to me and an Acknowledgement and Prehearing Order (Prehearing Order) was issued on April 28, 2017. Petitioner's request for hearing was timely and I have jurisdiction.

CMS filed a motion for summary judgment and prehearing brief on May 26, 2017 (CMS Br.) with CMS exhibits 1 through 3. On June 27, 2017, Petitioner filed a prehearing brief and response in opposition to the CMS motion (P. Br.), with Petitioner's exhibits (P. Exs.) 1 through 12 and a declaration of Dr. Adrig.[2] CMS filed a reply brief on July 11, 2017 (CMS Reply).

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[2] Petitioner did not mark the declaration of Dr. Adrig as an exhibit. I treat the declaration as P. Ex. 13.

Petitioner did not object to my consideration of the exhibits offered by CMS and CMS Exs. 1 through 3 are admitted as evidence. CMS objected to my consideration of P. Exs. 8 through 12 on grounds that the declarations of Petitioner's patients are not relevant. CMS Reply at 2. Contrary to the CMS argument, the declarations are clearly relevant as evidence that Petitioner was operational even though the site inspection determined Petitioner was not operating a practice at 3943 Irvine. Whether or not Petitioner was operational is an issue under 42 C.F.R. § 424.535(a)(5), one of the two basis for revocation cited by Noridian. Accordingly, the CMS objections to P. Exs. 8 through 12 are overruled and Petitioner's exhibits 1 through 13 are admitted as evidence.

II. Discussion

A. Applicable Law

Section 1831 of the Social Security Act (the Act) (42 U.S.C. § 1395j) establishes the supplementary medical insurance benefits program for the aged and disabled known as Medicare Part B. Administration of the Part B program is through contractors, such as Noridian. 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.[3] Act §§ 1835(a) (42 U.S.C. § 1395n(a)), 1842(h)(1) (42 U.S.C. § 1395u(h)(1)). Petitioner, a physician practice, is a supplier.

The Act requires the Secretary of Health and Human Services (Secretary) to issue regulations that establish a process for enrolling providers and suppliers in Medicare, including the requirement to provide 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. § 424.505, suppliers such as

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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.

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.

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.

Pursuant to 42 C.F.R. § 424.535(a)(5), CMS may revoke a supplier's 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 has otherwise failed to satisfy any of the Medicare enrollment requirements. 42 C.F.R. § 424.535(a)(5)(i) - (ii). Pursuant to 42 C.F.R. § 424.535(a)(9), CMS may revoke a supplier's enrollment and billing privileges if the supplier did not comply with the reporting requirements specified in 42 C.F.R. § 424.516(d)(1)(iii), which requires a physician or a physician organization, such as Petitioner, to report to their Medicare contractor within 30 days any change in practice location.

Generally, when CMS revokes a supplier's Medicare billing privileges for not complying with enrollment requirements, the revocation is effective 30 days after CMS or its contractor mails notice of its determination to the supplier. 42 C.F.R. §§ 424.57(e)(1); 424.535(g). However, when CMS revokes a supplier's billing privileges because the supplier's "practice location" is not operational, the revocation is effective as of the date CMS determined the supplier's practice location was no longer operational. 42 C.F.R. § 424.535(g). After a supplier's Medicare enrollment and billing privileges are revoked, the supplier is barred from re-enrolling in the Medicare program for one to three years. 42 C.F.R. § 424.535(c).

A supplier whose enrollment and billing privileges have been revoked may request reconsideration and review as provided by 42 C.F.R. pt. 498. A supplier submits a written request for reconsideration to CMS or its contractor. 42 C.F.R. § 498.22(a). CMS or its contractor must give notice of its reconsidered determination to the supplier, giving the reasons for its determination and specifying the conditions or requirements the supplier failed to meet, and advising the supplier of its right to an ALJ hearing. 42 C.F.R. § 498.25. If the decision on reconsideration is unfavorable to the supplier, the supplier has the right to request a hearing by an ALJ and further review by the Departmental Appeals Board (the Board). Act § 1866(j)(8) (42 U.S.C. § 1395cc(j)(8)); 42 C.F.R. §§ 424.545, 498.3(b)(17), 498.5(*l*)(2). CMS is also granted the right to request ALJ review of a reconsidered determination with which it is dissatisfied. 42 C.F.R. § 498.5(*l*)(2). A hearing on the record, also known as an oral hearing, is required under the Act. *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743, 748-51 (6th Cir. 2004).

The supplier bears the burden to demonstrate that it meets enrollment requirements with documents and records. 42 C.F.R. § 424.545(c).

B. Issue

Whether summary judgment is appropriate; and

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

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

My conclusions of law are set forth in bold followed by the pertinent findings of fact and analysis.

1. Summary judgment is appropriate.

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

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

Prehearing Order that summary judgment is an available procedural device and that the law as it has developed related to Fed. R. Civ. Pro. 56 will be applied.

Summary judgment is appropriate when there is no genuine dispute as to any 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 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 that used in resolving a case after a hearing. On summary judgment, the ALJ does not make credibility determinations, weigh the evidence, or decide which inferences to draw from the evidence, as would be done when finding facts after a hearing on the record. Rather, on summary judgment, the ALJ construes the evidence in a light most favorable to the non-movant and avoids deciding which version of the facts is more likely true. *Holy Cross Vill. at Notre Dame, Inc.*, DAB No. 2291 at 5 (2009). The Board also has recognized that on summary judgment it is appropriate for the ALJ to consider whether a rational trier of fact could find that the party's evidence would be sufficient to meet that party's evidentiary burden. *Dumas Nursing & Rehab., L.P.*, DAB No. 2347 at 5 (2010). The Secretary has not provided in 42 C.F.R. pt. 498 for the allocation of the burden of persuasion or the quantum of evidence required to satisfy the burden. However, the Board has provided some persuasive analysis regarding the allocation of the burden of persuasion in cases subject to 42 C.F.R. pt. 498. *Batavia Nursing & 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 genuine dispute as to any material fact in this case related to Petitioner's notification to the MAC in March 2014 incorrectly listing a commercial mailbox as Petitioner's practice location and the failure of Petitioner to properly notify CMS or Noridian of its correct practice location as required by 42 C.F.R. § 424.516(d)(1)(iii). Summary judgment is appropriate as to revocation pursuant to 42 C.F.R. §§ 424.535(a)(5)(ii) and (9), for failure to comply with 42 C.F.R. § 424.516(d)(1)(iii). Summary judgment is also appropriate on the effective date of revocation. The issues in

this case that require resolution related to revocation on these bases, 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.

There are genuine disputes of material fact related to whether or not Petitioner was operational at another location at the time of the on-site review based on the written declaration of Lynda M. Adrig, M.D., the sole proprietor of Petitioner (P. Ex. 13) and the declarations of her patients (P. Ex. 8-12). On summary judgment all inferences must be drawn in favor of the non-movant, in this case, Petitioner. CMS is not entitled to judgment as a matter for law for revocation pursuant to 42 C.F.R. § 424.535(a)(5)(i). Therefore, summary judgment is not appropriate for revocation pursuant to 42 C.F.R. § 424.535(a)(5)(i). If CMS wishes to attempt to prove Petitioner was not operational, as that term is defined in 42 C.F.R. § 424.502 as of the date of the on-site review, CMS may file a motion to reopen pursuant to 42 C.F.R. § 498.102(a).

2. Petitioner was required to report completely, accurately, and truthfully in its revalidation enrollment application all information requested by the application. 42 C.F.R. §§ 424.510(d)(1) and (2).

3. In order to maintain active enrollment, Petitioner was required to report to the MAC any change in practice location within 30 days. 42 C.F.R. § 424.516(d)(1)(iii).

4. CMS or the MAC is authorized to revoke the Medicare enrollment and billing privileges of a provider or supplier that is found upon on-site review to fail to satisfy any Medicare enrollment requirement. 42 C.F.R. § 424.535(a)(5)(ii).

5. There is a basis to revoke Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(5)(ii) because Petitioner failed to meet the Medicare enrollment requirement to report its correct practice location to CMS or the MAC. 42 C.F.R. §§ 424.510(d)(1), (2); 424.516(d)(1)(iii).

6. There is also a basis to revoke Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(9) because Petitioner failed to file a CMS-855 within 30 days as required by 42 C.F.R. § 424.516(d)(1)(iii), to report correctly that Petitioner's practice location was 511 Newcastle not 3943 Irvine.

7. Revocation of Petitioner's Medicare enrollment and billing privileges is effective March 22, 2016, the date it was determined by

CMS that Petitioner was not operational at the practice location listed in Petitioner's March 2014 Medicare revalidation enrollment application (CMS-855I). 42 C.F.R. § 424.535(g).

8. I have no authority to review the duration of the bar to re-enrollment imposed by the MAC and CMS.

a. Facts

The material facts are not disputed.

Dr. Lynda Adrig is the sole owner of Petitioner. Dr. Adrig delivers care and services to patients in their residences, including private homes and assisted living facilities. P. Ex. 13 at 1. Petitioner filed an application (Form CMS-855I) to revalidate its Medicare enrollment on October 27, 2013. CMS Ex. 2. Petitioner left "Section 4: Practice Location Information" of the CMS-855I blank, except Petitioner listed: the cities or towns where Dr. Adrig saw patients; 3943 Irvine as a special payment address; and 511 Newcastle as the medical records storage location. CMS Ex. 2 at 16-20; P. Ex. 13 at 2-3. Petitioner did not complete the form to show that she changed, added, or deleted a practice location. CMS Ex. 2 at 17.

On March 7, 2014, in response to correspondence from Noridian and based on a telephone conversation with a Noridian representative, Dr. Adrig provided additional information to Noridian related to Petitioner's revalidation application. Specifically, Dr. Adrig submitted pages 5, 14, 16-18, and 26 of a CMS-855I, with page 16 of the form completed to list 3943 Irvine as Petitioner's practice location. I accept as true for summary judgment Dr. Adrig's testimony that she listed 3943 Irvine as a practice location in error and she intentionally did not check a box to indicate a change of address for the practice location because no change had been made. CMS Ex. 3 at 8, 11; P. Ex. 2 at 2-3; P. Ex. 13 at 3-4. Dr. Adrig, on behalf of Petitioner, also completed the certification statement for the CMS-855I agreeing to be bound by Medicare participation requirements and certifying that all information in the CMS-855I was true, correct, and complete; and agreeing to notify CMS of any changes as required by 42 C.F.R. § 424.516. CMS Ex. 2 at 26; CMS Ex. 3 at 11.

There is no dispute that 3943 Irvine Boulevard is a commercial mailbox and not a location suitable for a medical practice location. CMS Ex. 1 at 11-12; P. Ex. 13 at 4; CMS Br. at 2; P. Br. at 2-3. There is no dispute that on March 22, 2016, a CMS inspector conducted an on-site inspection at 3943 Irvine, the location listed in the March 2014 CMS-855I as Petitioner's practice location. CMS Br. at 2; P. Br. at 2; CMS Ex. 1 at 11-12; CMS Ex. 3 at 11. Petitioner does not dispute that the inspector determined that Petitioner did not operate a practice at 3943 Irvine at the time of the inspection. CMS Br.

at 2; P. Br. at 2-3. There is no dispute that Petitioner operated from the home of Dr. Adrig at 511 Newcastle and she saw patients at their residences. P. Br. at 6.

b. Analysis

Petitioner is required to submit a complete Medicare enrollment application with accurate and truthful responses to all information requested and to ensure that its enrollment information is updated to remain complete, accurate, and truthful. 42 C.F.R. §§ 424.510(d), 424.515, 424.516. In order to maintain an active enrollment status in Medicare, Petitioner had to comply with 42 C.F.R. §§ 424.510(d) and 424.516. Pursuant to 42 C.F.R. § 424.510(d)(2), Petitioner was required to accurately and truthfully provide requested information, including its practice location, in its enrollment and revalidation applications. Pursuant to 42 C.F.R. § 424.516(d)(1)(iii), Petitioner was required to report a change of practice location to the Medicare contractor within 30 days to ensure that CMS and the MAC had accurate information regarding Petitioner's correct practice location. CMS has the right to perform on-site inspections to verify information and confirm that a provider or supplier continues to meet enrollment requirements. 42 C.F.R. §§ 424.510(d)(8), 424.517.

When Petitioner submitted its CMS-855I application to revalidate its Medicare enrollment, the regulations required that the application certification statement be signed by an individual who had authority to bind Petitioner both legally and financially. The signature attests that all information submitted was accurate and that Petitioner was aware of and abides by all applicable statutes, regulations, and program instructions. 42 C.F.R. § 424.510(d)(3)(2013). The CMS-855I Petitioner submitted in March 2014, clearly stated in section 4C that a P.O. Box may not be listed as a practice location. CMS Ex. 3 at 8.

Petitioner bears the burden to demonstrate that it meets enrollment requirements and to produce documents demonstrating compliance with all program participation requirements. 42 C.F.R. § 424.535(c). Petitioner cannot meet its burden in this case related to revocation pursuant to 42 C.F.R. §§ 424.535(a)(5)(ii) and (9), even if I draw all inferences in Petitioner's favor. I accept Petitioner's assertion that 3943 Irvine was never its practice location, but only a correspondence address. I also accept that Dr. Adrig mistakenly listed Petitioner's practice location as 3943 Irvine. P. Br. at 2; CMS Ex. 1 at 5; P. Ex. 13 at 4. Dr. Adrig signed the CMS-855I on March 7, 2014 on Petitioner's behalf, agreeing to be bound by Medicare participation requirements and certifying that all information in the CMS-855I was true, correct, and completed. CMS Ex. 3 at 11. While I accept as true that Petitioner mistakenly listed the commercial mailbox as its practice location, this fact constitutes no defense to Petitioner having incorrectly reported and then failed to report accurately that 3943 Irvine was not a practice location but, rather, just Petitioner's correspondence address.

The regulations grant CMS discretion to revoke enrollment and billing privileges if, upon on-site review or other reliable evidence, CMS determines that a provider or supplier fails to satisfy any Medicare enrollment requirement. 42 C.F.R. § 424.535(a)(5)(ii).[4] In this case, Petitioner concedes that it failed to accurately report its practice location, violating the enrollment requirement of 42 C.F.R. § 424.510(d)(2). Petitioner also violated the Medicare enrollment requirement 42 C.F.R. § 424.516(d)(1)(iii) to report its correct practice location within 30 days of having filed the incorrect information. Accordingly, I conclude Petitioner violated the requirements for maintaining enrollment in Medicare and there is a basis for revocation of Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. §§ 424.535(a)(5)(ii) and (9).

Having found that there is a basis for revocation, I have no authority to review the exercise of discretion by CMS to revoke Petitioners' Medicare enrollment and billing privileges. *Dinesh Patel, M.D.*, DAB No. 2551 at 10 (2013); *Fady Fayad, M.D.*, DAB No. 2266 at 16 (2009), *aff'd*, 803 F. Supp. 2d 699 (E.D. Mich. 2011); *Abdul Razzaque Ahmed, M.D.*, DAB No. 2261 at 16-17, 19 (2009), *aff'd*, 710 F. Supp. 2d 167 (D. Mass. 2010).

Summary judgment is also appropriate as to the effective date of revocation. Pursuant to 42 C.F.R. § 424.535(g):

> (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

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[4] Neither the initial determination (CMS Ex. 1 at 8-9) nor the reconsidered determination (CMS Ex. 1 at 1-4) specifically cite a subsection of 42 C.F.R. § 424.535(a)(5). However, the reconsidered determination specifically states that "[t]he revocation of OC Housecalls, Inc. will be upheld due to . . . the requirement of keeping Medicare enrollment record updated was not done." CMS Ex. 1 at 2. This explanation by the hearing officer was sufficient to give Petitioner notice of the need to address revocation under both 42 C.F.R. § 424.535(a)(5)(ii) and (9).

> 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.**

(Emphasis added). Petitioner does not dispute that at the time of the site visit it had no practice location at 3943 Irvine. Petitioner concedes that the address was a commercial mailbox. Pursuant to 42 C.F.R. § 424.535(g), CMS is authorized to establish an effective date of revocation based on the date CMS determined that Petitioner's practice location was no longer operational. The Noridian investigator found that Petitioner did not have an operational practice at 3943 Irvine on March 22, 2016. Therefore, March 22, 2016, is the correct effective date of revocation.

When a supplier's Medicare enrollment and billing privileges are revoked, the supplier is barred from re-enrolling in the Medicare program for one to three years. 42 C.F.R. § 424.535(c). There is no statutory or regulatory language establishing a right to review the duration of the re-enrollment bar CMS imposes. Act § 1866(j)(8) (42 U.S.C. § 1395cc(j)(8)); 42 C.F.R. §§ 424.535(c), 424.545; 498.3(b), 498.5. The Board has held that the duration of a revoked supplier's re-enrollment bar is not an appealable initial determination listed in 42 C.F.R. § 498.3(b) and not subject to ALJ review. *Vijendra Dave*, DAB No. 2672 at 10-11 (2016).

Petitioner argues that it was operational albeit at a location other than 3943 Irvine. P. Br. at 8-9, 13-16. I accepted that assertion as true for purposes of summary judgment and I have denied summary judgment on Petitioner being non-operational as a basis for revocation pursuant to 42 C.F.R. § 424.535(a)(5)(i). Petitioner's remaining arguments must be resolved against Petitioner as a matter of law. Petitioner argues that Noridian failed to follow CMS policies regarding processing applications. P. Br. at 10-11, 17-20. The gist of Petitioner's argument is that Noridian should have caught Petitioner's mistake of listing 3943 Irvine as a practice location and worked with Petitioner to resolve that mistake. Petitioner cites no statutory or regulatory authority for the proposition that a MAC or CMS has such a duty.[5] Rather, the regulatory scheme places the burden squarely upon the enrolled provider or supplier to ensure that they provide accurate and timely information to CMS and the MAC and to maintain compliance with all enrollment

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[5] CMS and the MAC clearly have discretion to work with a provider or supplier to correct obvious errors but it is not within my jurisdiction to compel the exercise of such discretion. My jurisdiction is limited to conducting de novo review of whether CMS or the MAC has a basis for revocation of Petitioner's Medicare enrollment and billing privileges.

requirements. 42 C.F.R. pt. 424. Petitioner argues that it did not violate 42 C.F.R. § 424.535(a)(9) because there was no change of information to report. P. Br. at 16-17. Petitioner overlooks that Dr. Adrig admittedly reported incorrect information in March 2014, in violation of her certification that the information in the form filed was correct, and then she failed to change that incorrect information by giving CMS and the MAC notice of the correct information. Whether or not Dr. Adrig changed Petitioner's practice location is not the issue, the issue is whether Dr. Adrig gave CMS and the MAC notice of the changed information regarding Petitioner's practice location.

Petitioner also argues that it was prejudiced due to the accumulation of allegedly overpaid claims during a roughly eight-month delay between the site-visit and the revocation. Petitioner argues that had it known about the possible revocation action it could have taken action to mitigate the overpayment exposure. P. Br. at 19-20. Petitioner's arguments could be construed to be that the government should be estopped from proceeding with the revocation or the alleged overpayments. However, as a matter of law, estoppel against the federal government, if available at all, is presumably unavailable absent "affirmative misconduct," such as fraud. *See, e.g.*, *Pacific Islander Council of Leaders*, DAB No. 2091 at 12 (2007); *Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414, 421 (1990). None of the circumstances Petitioner describes suggest fraud on the part of a Noridian staff member or that there was even any intent to mislead Petitioner. Petitioner's arguments may also be construed as a request for equitable relief but I have no authority to grant such relief. *US Ultrasound*, DAB No. 2302 at 8 (2010). I am 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.

III. Conclusion

For the foregoing reasons, Petitioner's Medicare enrollment and billing privileges are revoked pursuant to 42 C.F.R. § 424.535(a)(5)(ii) and 424.535(a)(9). The effective date of revocation is March 22, 2016.

/s/
Keith W. Sickendick
Administrative Law Judge