Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Scott Jensen, M.D., Inc.
(NPI: 1851437412),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-16-794

Decision No. CR4812

Date: March 23, 2017

DECISION

Petitioner, Scott Jensen, M.D., Inc. (Petitioner), is a medical practice that is owned by Scott Jensen, M.D. Petitioner's Medicare billing privileges were deactivated as a result of its failure to timely provide enrollment information in response to a revalidation request. Petitioner's billing privileges were subsequently reactivated effective January 27, 2016, the date Noridian Healthcare Solutions (Noridian), a Medicare administrative contractor, received Petitioner's enrollment application to reactivate its billing privileges. Petitioner has appealed Noridian's assignment of a January 27, 2016 effective date for the reactivation of its billing privileges. For the reasons discussed below, I conclude that the effective date of Petitioner's reactivated billing privileges remains January 27, 2016.

I. Background

On December 8, 2014, Noridian sent Petitioner a letter requesting that it revalidate its Medicare enrollment. Centers for Medicare & Medicaid Services (CMS) Exhibit (Ex.) 1 at 1, 4. Noridian mailed the letter to two separate addresses, 21321 E. Ocotillo Road in

Queen Creek Road, in Queen Creek, AZ, and 1425 S. Higley Road in Gilbert, AZ.[1] CMS Ex. 1 at 1, 4. After Noridian did not receive a revalidation application in response to its December 8, 2014 request, Noridian deactivated Petitioner's Medicare billing privileges on March 20, 2015. *See* CMS Ex. 2. On January 27, 2016, Petitioner submitted an enrollment application to reactivate its billing privileges. *See* P. Ex. 1 at 2. Noridian informed Petitioner, in a letter dated February 17, 2016, that it had approved the application, at which time it assigned a new Provider Transaction Access Number (PTAN), with an effective date of billing privileges of January 27, 2016. CMS Ex. 4 at 1.

Petitioner requested reconsideration of the effective date of its reactivated Medicare billing privileges, at which time it explained that it discovered in October 2015 that its billing privileges had been deactivated "when [it] was doing some routine records checks and noticed that [it] had not been paid by [M]edicare since August." CMS Ex. 5 at 3. Scott Jensen, M.D., explained that he had asked his biller to investigate the issue, and Dr. Jensen reported that the biller "indicated she had investigated the issue . . . and assured [him] that all was in good standing and that the issue would be remedied shortly." CMS Ex. 5 at 3. Dr. Jensen further explained that Petitioner's failure to timely revalidate was due to a "lack of integrity and competence" by the practice's biller, explaining:

> However, after several weeks passed and I continued to submit claims without forthcoming payments, it became obvious that I may have been deceived by my biller as to our [M]edicare status. I investigated further and confirmed that there was indeed legitimate neglect by my biller to manage our outstanding unpaid claims, [M]edicare and otherwise. So I began to make plans to get a professional billing service in December 2015 and dismissed our biller in January 2016. During the setup process with our new billing service (NY Med Billing), we for the first time became aware that our active [M]edicare status was completely dropped in March of 2015. Needless to say, we had amassed around $100,000 of outstanding claims by this time over that time period.

CMS Ex. 5 at 3-4. Petitioner also explained:

> I am hoping for an extension of mercy on your part to allow us to backdate our eligibility to April 1, 2015, when our active provider status was dropped due to my biller's neglect. I reiterate my reasons . . . I draw your attention to the fact that the disregarding of renewal requests and

[1] Neither party submitted a copy of the enrollment information that was on file at the time of the revalidation request, so I make no finding regarding whether the revalidation requests were mailed to the correct addresses. Petitioner has not alleged that either letter was mailed to an incorrect address.

> [M]edicare update protocols led to our active status being cancelled for nearly 10 months (4/1/15 – 1/27/16) was committed by one individual, whose lack of integrity and competence does not reflect the good faith of the providers who were seeing the patients.

CMS Ex. 5 at 3-4.

In a reconsidered determination dated June 9, 2016, Noridian denied Petitioner's request for an earlier effective date of its reactivated Medicare billing privileges. CMS Ex. 6. Noridian explained that "[t]he provider had 120 days to revalidate from the date of deactivation in order to maintain the current PTANs and effective date," and "[i]f not revalidated within the 120 days the provider would have to reactivate." CMS Ex. 6 at 2.

Petitioner submitted a request for hearing that was received at the Civil Remedies Division on August 6, 2016. CMS filed a pre-hearing brief and motion for summary disposition (CMS Br.), along with six exhibits (CMS Exs. 1 - 6). Petitioner filed a response (P. Br.) and five exhibits (Petitioner Exhibits (P. Exs.) 1- 5). In the absence of any objections, I admit CMS Exs. 1 - 6 and P. Exs. 1 - 5 into the record.

Petitioner has offered the testimony of Dr. Jensen, and CMS has not requested an opportunity to cross-examine this witness. A hearing for the purpose of cross-examination of witnesses is therefore unnecessary. *See* Acknowledgment and Pre-Hearing Order §§ 8, 9, and 10. I consider the record in this case to be closed, and the matter is ready for a decision on the merits.[2]

II. Issue

Whether CMS had a legitimate basis for establishing January 27, 2016, as the effective date of the reactivated billing privileges for Petitioner.

III. Jurisdiction

I have jurisdiction to decide this case. 42 C.F.R. §§ 498.3(b)(15), 498.5(*l*)(2).

[2] CMS has argued that summary disposition is appropriate. It is unnecessary in this instance to address the issue of summary disposition, as neither party has requested an in-person hearing.

IV. Findings of Fact, Conclusions of Law, and Analysis[3]

1. ***On December 8, 2014, Noridian sent a revalidation request to Petitioner.***

2. ***Noridian did not receive a completed enrollment application for purposes of revalidation within 120 days of its request and subsequently deactivated Petitioner's PTAN on March 20, 2015.***

3. ***Noridian received Petitioner's enrollment application seeking reactivation of its billing privileges on January 27, 2016.***

4. ***An effective date earlier than January 27, 2016, is not warranted for the reactivation of billing privileges for Petitioner.***

Petitioner is considered to be a "supplier" for purposes of the Social Security Act (Act) and the regulations. *See* 42 U.S.C. §§ 1395x(d), 1395x(u); *see also* 42 C.F.R. § 498.2. A "supplier" furnishes services under Medicare and the term applies to physicians or other practitioners that are not included within the definition of the phrase "provider of services." 42 U.S.C. § 1395x(d). A supplier must enroll in the Medicare program to receive payment for covered Medicare items or services. 42 C.F.R. § 424.505. The regulations at 42 C.F.R. Part 424, subpart P, establish the requirements for a supplier to enroll in the Medicare program. 42 C.F.R. §§ 424.510 - 424.516; *see also* Act § 1866(j)(1)(A) (authorizing the Secretary of the U.S. Department of Health and Human Services to establish regulations addressing the enrollment of providers and suppliers in the Medicare program). A supplier that seeks billing privileges under Medicare must "submit enrollment information on the applicable enrollment application." 42 C.F.R. § 424.510(a). "Once the provider or supplier successfully completes the enrollment process . . . CMS enrolls the provider or supplier into the Medicare program." 42 C.F.R. § 424.510(a), (d).

To maintain Medicare billing privileges, a supplier must revalidate its enrollment information at least every five years. 42 C.F.R. § 424.515. CMS (or its contractor) reserves the right to perform off-cycle revalidations in addition to the regular five-year revalidations and may request that a provider or supplier recertify the accuracy of the enrollment information when warranted to assess and confirm the validity of the enrollment information maintained by CMS. 42 C.F.R. § 424.515. Off-cycle revalidations may be triggered as a result of random checks, information indicating local

[3] My findings of fact and conclusions of law are set forth in italics and bold font.

health care fraud problems, national initiatives, complaints, or other reasons that cause CMS to question the compliance of the provider or supplier with Medicare enrollment requirements. 42 C.F.R. § 424.515(d). When CMS notifies a supplier that it is time to revalidate, the supplier must provide the requested information and documentation within 60 calendar days of CMS's notification. 42 C.F.R. § 424.515(a)(2).

CMS is authorized to deactivate an enrolled supplier's Medicare billing privileges if the enrollee fails to comply with revalidation requirements within 90 days of CMS's notice to revalidate. 42 C.F.R. § 424.540(a)(3). If CMS deactivates a supplier's Medicare billing privileges, "[n]o payment may be made for otherwise Medicare covered items or services furnished to a Medicare beneficiary." 42 C.F.R. § 424.555(b). The regulation authorizing deactivation explains that "[d]eactivation of Medicare billing privileges is considered an action to protect the provider or supplier from misuse of its billing number and to protect the Medicare Trust Funds from unnecessary overpayments." 42 C.F.R. § 424.540(c).

The reactivation of an enrolled provider or supplier's billing privileges is governed by 42 C.F.R. § 424.540(b), and the process for reactivation is contingent on the reason for deactivation. If CMS deactivates a provider or supplier's billing privileges due to an untimely response to a revalidation request, such as in this case, the enrolled provider or supplier may apply for CMS to reactivate its Medicare billing privileges by completing the appropriate enrollment application or recertifying its enrollment information, if deemed appropriate. 42 C.F.R. § 424.540(a)(3), (b)(1).

Noridian deactivated Petitioner's billing privileges after it requested that Petitioner revalidate its enrollment information and Petitioner did not provide a timely response. CMS Exs. 1, 2. More than a year after Noridian initially requested that Petitioner complete the revalidation process (CMS Ex. 1), Petitioner submitted an enrollment application for purposes of revalidation that Noridian received on January 27, 2016. *See* P. Ex. 1 at 2; CMS Ex. 4 at 1-2. Noridian accepted Petitioner's application and reactivated its billing privileges and assigned a new PTAN, effective January 27, 2016. CMS Ex. 4 at 1-2.

The pertinent regulation with respect to the effective date of reactivation, as cited by Noridian in its reconsidered decision, is 42 C.F.R. § 424.520(d). CMS Ex. 4 at 1; *Arkady B. Stern, M.D.*, DAB No. 2329 at 4 (2010). Section 424.520(d) states that "[t]he effective date for billing privileges . . . is the later of – (1) [t]he date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor; or (2)

[t]he date that the supplier first began furnishing services at a new practice location." [4] The Departmental Appeals Board has explained that the "date of filing" is the date "that an application, however sent to a contractor, is actually received." *Alexander C. Gatzimos, MD, JD, LLC*, DAB No. 2730 at 5 (2016) (emphasis omitted). Accordingly, based on the date of filing of Petitioner's enrollment application more than 120 days after deactivation, Noridian reactivated Petitioner's billing privileges effective January 27, 2016. 42 C.F.R. § 424.520(d).

I construe that Petitioner is seeking an effective date of billing privileges dating back to the date of deactivation on March 20, 2015.[5] However, Petitioner does not identify any authority supporting an earlier effective date for the reactivation of its billing privileges.

While Petitioner's failure to provide a response to the revalidation request resulted in more than an eight month lapse in its billing privileges, only a few years ago such a failure to respond to a revalidation request could have resulted in a revocation of billing privileges and an enrollment bar for a minimum of one year. 42 C.F.R. § 424.535(b), (c) (2010) (stating that "[w]hen a provider's or supplier's billing privilege is revoked any provider agreement in effect at the time of revocation is terminated effective with the date of revocation" and "[a]fter a . . . supplier . . . has had their billing privileges revoked, they are barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar," which is a minimum of one year and no more than three years.). The Secretary's former authority to revoke billing privileges and establish a re-enrollment bar was implemented through a final rule published on June 27, 2008, and the regulatory amendment had a stated purpose "to prevent providers and suppliers from being able to immediately re-enroll in Medicare after their billing privileges were revoked." 76 Fed. Reg. 65,909, 65,912 (October 24,

[4] At the time of the reconsidered determination, policy guidance contained in the MPIM instructed that "[t]he PTAN and effective date shall remain the same if the revalidation application was received prior to 120 days after the date of deactivation" and "[i]f the revalidation is received more than 120 days after deactivation, a new PTAN and effective date shall be issued to the provider or supplier . . . ." MPIM, ch. 15 § 15.29.4.3 (rev. 578, issued February 25, 2015, effective May 15, 2015). The Secretary recently revised portions of section 15.29.4.3 and related sections of the MPIM, but those revisions do not substantively impact the discussion herein. (Revision 666, issued August 5, 2016, and effective September 6, 2016).

[5] Petitioner does not explicitly request an effective date of billing privileges of March 20, 2015 in its brief, but it is contextually apparent that Petitioner is seeking the earliest possible effective date of reactivated billing privileges.

2011), citing 73 Fed. Reg. 36,448. When the Secretary later determined, in subsequent rulemaking, that this basis for revocation and a re-enrollment bar should be eliminated through removing the pertinent language in 42 C.F.R. § 424.535(c), the Secretary's final rule explained:

> In our October 24, 2011, proposed rule, we proposed to revise § 424.535(c) to eliminate the re-enrollment bar in instances where providers and suppliers have had their billing privileges revoked under § 424.535(a) solely for failing to respond timely to a CMS revalidation request or other request for information. As we explained in the proposed rule, we believe that this change is appropriate because the re-enrollment bar in such circumstances often results in unnecessarily harsh consequences for the provider or supplier and causes beneficiary access issues in some cases . . . . Moreover, *there is another, less restrictive regulatory remedy available* for addressing a failure to respond timely to a revalidation request. This remedy was identified in proposed § 424.540(a)(3).

77 Fed. Reg. at 29,009 (May 16, 2012) (emphasis added). The final rule further stated:

> We do not believe that the finalization of our proposed revision to § 424.535(c) will impact our ability to prevent or combat fraudulent activity in our programs. Providers and suppliers that fail to respond once or repeatedly to a revalidation or other informational request *will still be subject to adverse consequences*, including—as explained below—the deactivation of their Medicare billing privileges.

77 Fed. Reg. at 29,010 (emphasis added). Finally, in amending section 424.540(a)(3), as referenced above, the final rule stated:

> We proposed to add a new § 424.540(a)(3) that would allow us to deactivate, rather than revoke, the Medicare billing privileges of a provider or supplier that fails to furnish complete and accurate information and all supporting documentation within 90 calendar days of receiving notification to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information. While the deactivated provider or supplier would still need to submit a complete enrollment application to reactivate its billing privileges, *it would not be subject to other, ancillary consequences that a revocation entails*; for instance, a prior revocation must be reported in section 3 of the Form CMS-855I application, whereas a prior deactivation need not.

77 Fed. Reg. at 29,013 (emphasis added). Thus, while the rulemaking explained that the regulatory amendment was intended to mitigate the "unnecessarily harsh consequences" of revocation and a mandatory enrollment bar for a supplier's failure to respond to a revalidation request, the final rule recognized that there was a "less restrictive regulatory remedy available for addressing a failure to respond timely to a revalidation request" and that a supplier "will still be subject to adverse consequences" that included "the deactivation of their Medicare billing privileges." The final rule implemented section 424.540(a)(3), which specified that deactivation of billing privileges, rather than revocation, was appropriate, and stated that deactivation "does not have any effect on a provider or supplier's participation agreement or any conditions of participation." [6] 42 C.F.R. § 424.540(a)(3), (c).

Although section 424.540(a)(3) indicates that the deactivation does not have any effect on the supplier's participation agreement or conditions of participation, deactivation nonetheless may cause "adverse consequences," most significantly, the loss of billing privileges. The effective date of reactivation of billing privileges is governed by 42 C.F.R. § 424.520, "Effective date of Medicare billing privileges," which states, in pertinent part, that the effective date for billing privileges, as applicable to this case, is "[t]he date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor." 42 C.F.R. § 424.520(d)(1). The June 9, 2016 reconsidered determination explicitly relied on 42 C.F.R. § 424.520(d) in determining that the effective date of Petitioner's reactivated billing privileges was correctly determined to be January 27, 2016. CMS Ex. 6 at 1. Noridian correctly applied section 424.520(d), and an effective date earlier than January 27, 2016 is not warranted. CMS Ex. 6 at 1.

In requesting reconsideration, Petitioner's owner argued that he was not at fault for the failure to timely revalidate, but rather, the practice's billing coordinator ignored the revalidation request. CMS Ex. 5 at 2. Petitioner explained that as a result of "neglect" and "disregard" by its biller, it was unaware of the revalidation request. CMS Ex. 5 at 3. In a declaration submitted nearly seven months later, Petitioner's owner did not reference the billing coordinator's inaction with respect to the revalidation request. P. Ex. 1; *see* CMS Ex. 5 at 4. Rather, Petitioner argued that he had carefully reviewed his office's file

[6] A physician or supplier participation agreement can be made through a Form CMS-460. When a physician or supplier enters into such an agreement, it "enters into an agreement with the Medicare program to accept assignment of the Medicare Part B payment for all services for which the participant is eligible to accept assignment under the Medicare law and regulations." Form CMS-460. A supplier such as Petitioner is not subject to conditions of participation. *See* 42 C.F.R. pts. 482 and 485.

and could not locate a revalidation request in the file.[7] P. Ex. 1. Petitioner's repeated statements that it has been unable to locate a revalidation request in its file do not appear to equate to an allegation that it never received the request or that CMS, or it contractor, never sent the request. P. Ex. 1; P. Br. This is particularly true in light of Petitioner's previous concession that it did not timely respond to the revalidation request because a former billing coordinator failed to act on it due to the "lack of integrity and competence." CMS Ex. 5 at 4. Petitioner has not argued that it *did not receive* the revalidation request, nor has Petitioner alleged at any time that Noridian mailed the request to an address other than the address(es) listed in the enrollment information on file at the time of the revalidation request. *See* P. Br.; CMS Ex. 1. Petitioner has not shown that its failure to respond to the revalidation request in a timely manner is due to any fault of CMS or Noridian.

Petitioner argues that the deactivation of its billing privileges was procedurally improper and legally ineffective because "[t]here is nothing in CMS' disclosures to indicate that the revalidation request here was warranted, particularly where a revalidation of Dr. Jensen's practice had been completed only four months earlier." P. Br. at 6. First, Petitioner does not cite any authority in support of its argument that it can challenge the deactivation of its billing privileges. *See* 42 C.F.R. § 498.3. In fact, Petitioner *cannot* challenge its deactivation in this proceeding. *See, e.g., William Goffney, Jr., M.D.,* DAB No. 2763 at 5 (2017) (stating "neither section 424.545(b) nor any other regulation provides appeal rights from the contractor's deactivation determination or any rebuttal determination.") Second, Petitioner does not provide any authority in support of its contention that CMS lacked the authority to ask it to revalidate its Medicare enrollment. *See* 42 C.F.R. § 424.515 (discussing periodic and off-cycle revalidation requests). Third, and most significantly, Petitioner fails to recognize that its argument is based on a misunderstanding of fact, in that Petitioner submitted evidence that its *owner*, Scott Jensen, M.D., rather than the *practice*, had revalidated *his* enrollment four months earlier. *See* P. Ex. 4 (screen shot showing that Scott Jensen (NPI 1033106497) submitted an internet-based Form CMS-855I application for his individual Medicare enrollment as physician). For obvious reasons, Petitioner and Dr. Jensen are separate entities, as one is a medical practice, whereas the other is an individual physician. As such, a practice and a physician separately revalidate enrollment information when requested to do so. Petitioner has not supported its allegation that CMS improperly requested it to revalidate its enrollment information.

[7] Based on Petitioner's assertions that its previous biller acted with "neglect" and that she disregarded the revalidation request, and also lacked integrity and competence, it should not be a surprise to Petitioner that documents pertaining to the revalidation request may have not been included in its file, even if Petitioner received those documents. CMS Ex. 5 at 3-4.

Petitioner next argues that "CMS has also failed to disclose any facts to establish that the deactivation in this case was done in compliance with the procedures set out in the [Medicare Program Integrity Manual (MPIM)] for deactivating a provider's enrollment." P. Br. at 6. Without citing to any evidence, or citing to a specific subsection of the MPIM, Petitioner recites numerous revalidation policies contained in the MPIM and alleges that "CMS has not shown that any of these procedures were carried out in this case, nor even that it made the direct contact with Dr. Jensen required by 42 C.F.R. § 424.515 as part of the revalidation process since there is no evidence that Dr. Jensen actually received the revalidation request." P. Br. at 7. In the absence of any prior allegation that CMS violated its own policy, either in the request for reconsideration or the request for hearing, Petitioner fails to demonstrate why CMS should have pre-emptively addressed its own compliance with MPIM provisions. Further, Petitioner's current position stands in stark contrast to its position only months earlier, in which it conceded that its billing coordinator was aware of the requirement to revalidate, but had disregarded the request and neglected to notify Petitioner's owner of the revalidation request. CMS Ex. 5 at 2-4. Petitioner has provided no support for why CMS had to "establish that the deactivation in question complied with its own internal procedures."

Based on the evidence that CMS mailed the revalidation notice to two separate addresses, and Petitioner's previous concession that its billing coordinator ignored the revalidation request, Petitioner has not established that CMS did not adhere to its policies with respect to notification of the revalidation request. However, I recognize that the evidence does not establish that CMS provided notice of Petitioner's deactivation, as discussed in Chapter 15 of the MPIM. *See* CMS Ex. 2. Yet, even if CMS failed to provide notice of the deactivation of Petitioner's billing privileges, Petitioner has not established it is entitled to any relief on that basis. While Petitioner may be correct that Noridian failed to provide notice of deactivation, Petitioner has not identified any authority that allows an administrative law judge to reverse the deactivation of its billing privileges on that basis. Simply stated, there is limited recourse available to a supplier who seeks an earlier effective date of reactivated billing privileges following deactivation, and I do not have authority to reverse a deactivation.[8] *See* 42 C.F.R. § 498.3. If CMS and its contractors do not adhere to sub-regulatory policy, such as providing notice of deactivation, there is little recourse with respect to the deactivation because there is no right of appeal for such a determination. 42 C.F.R. § 498.3. Petitioner may challenge only the effective date of its reactivation, and Petitioner has not demonstrated that any other effective date is warranted based on the application of 42 C.F.R. § 424.520(d).

[8] In fact, CMS has argued, in addressing the same issue in another case, that even if the petitioner "asserts that CMS did not provide proper or sufficient notice of revalidation or deactivation," as Petitioner has done in the instant case, there is no "legal authority which imposes such obligations on CMS." *Gloria Johnson, NP*, DAB CR4803 at 9 (2017).

Finally, Petitioner argues that "CMS should be estopped from refusing to allow Petitioner to recover the billings that would never [have] been denied had CMS' contractor not acted improperly." P. Br. at 9. I preliminarily note that my jurisdiction is limited to reviewing the effective date of Petitioner's reactivated billing privileges, and Petitioner does not cite to any authority empowering me to estop CMS from denying Petitioner reimbursement for services rendered following its deactivation. Nonetheless, since Petitioner has alleged affirmative misconduct on the part of Noridian, I will address Petitioner's arguments regarding estoppel, with a focus on the factual basis underpinning Petitioner's arguments.

Petitioner argues that estoppel is applicable here, in that "Noridian's silence about Dr. Jensen's deactivation in the face of *months* of Medicare bills it continued to receive from him, as well as its statement in August 2015 that his billing privileges were intact, certainly establish a false representation and wrongful misleading silence about a statement of fact." P. Br. at 8. While Petitioner blames Noridian's silence, it forgets that it had asserted that its failure to timely revalidate and promptly revalidate after its deactivation was due to the missteps of its former billing coordinator (stating, in pertinent part: "[t]he problem began without my knowledge, with my billing coordinator receiving warning emails since December of 2014, which we understand according to [M]edicare, advised her to update our status on the PECOS website;" "[u]nbeknownst to me, she apparently ignored these requests" and "[i]n consequence of our being unaware of these notices, I and my nurse practitioner continued to see [M]edicare patients throughout this time period;" and, "my former biller indicated that she had investigated the issue, speaking to a PECOS representative . . . and assured me that all was in good standing" and "[h]aving no cause to question her integrity at this point, I felt for that moment a false sense of security.") CMS Ex. 5 at 2-4. Petitioner further explained that its biller committed "legitimate neglect" and handled both Medicare and other claims to the point that she "had nearly driven our practice into extinction." CMS Ex. 5 at 3.

It is puzzling that Petitioner squarely blamed its biller's "lack of integrity and competence" for its deactivation and delay in submitting an application for purposes of reactivation (CMS Ex. 5 at 3), only to now contend that it has been financially harmed because of Noridian's purported "false representation and wrongful misleading silence about a statement of fact." P. Br. at 8. While Petitioner currently argues that "Noridian was the only conduit through which Dr. Jensen could maintain his enrollment and billing privileges," he ignores that he previously argued that "our active provider status was dropped due to my biller's neglect," which seemingly asserts that his *biller* was the "conduit" who handled Petitioner's Medicare enrollment and billing privileges. CMS Ex. 5 at 3. Petitioner has not demonstrated, in support of its equitable estoppel argument, that there was affirmative misconduct on the part of any government official, which is one of the requirements for a defense of equitable estoppel. *See, e.g., Illinois Dep't of Children & Family Servs.*, DAB No. 2734, at 8 (2016) (stating that the government cannot be estopped "absent, at a minimum, a showing that the traditional requirements for estoppel

are present, to include that government's employees or agents engaged in "affirmative misconduct"), citing *Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414, 421 (1990). While Petitioner argues that *Brandt v. Hickel*, 427 F.2d 53 (9th Cir. 1970), states that erroneous advice can constitute affirmative misconduct, it presents no support that the *Brandt* decision is applicable to the facts at hand or binding on these proceedings. To the extent that Petitioner feels that equitable estoppel is triggered based on his allegation that Noridian erroneously informed it in August 2015 that its billing privileges were intact, I remind Petitioner of the inconsistency of its accounts regarding the August 2015 contact with Noridian.[9] Petitioner's owner states the following in his declaration, without any reference to the involvement of the billing coordinator:

> Our file does contain a record that in August 2015, we contacted Norma at PECOS [telephone number omitted] to ask about the status of our Medicare billing privileges because we were not receiving as many payments as usual for services that we had provided to Medicare patients.
>
> Norma advised that there had been a glitch with our Medicare billing privileges, but that the glitch had been fixed and that we should start receiving payments shortly.

P. Ex. 1 at 2. Petitioner previously discussed the August 2015 contact with "Norma" in its request for reconsideration, at which time it presented a more doubtful portrayal of the veracity of the information in its file, stating:

> After expressing my concerns, my former biller indicated that *she had investigated the issue*, speaking to a PECOS representative (Norma @ [telephone number omitted] and assured me that all was in good standing and that the issue would be remedied shortly. *Having no cause to question her integrity at this point, I felt for that moment a false sense of security.*
>
> However, after several weeks passed and I continued to submit claims without forthcoming payments, *it became obvious that I may have been deceived by my biller as to our [M]edicare status . . . .*

CMS Ex. 5 at 3 (emphasis added). Thus, while Petitioner's owner recounted that he erroneously relied on his billing coordinator's account that "Norma" had advised that "all was in good standing," Petitioner relies on precisely the same account to accuse Noridian of making a "false representation" regarding its enrollment status in August 2015. P. Br.

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[9] Petitioner also alleges that "Medicare payments essentially stopped altogether" and this amounts to "wrongful misleading silence," but Petitioner has not submitted any evidence in support of this allegation, to include the specific dates of the claims it submitted. P. Br. at 5, 8.

at 8; P. Ex. 1 at 2; CMS Ex. 5 at 2-4. Petitioner has presented no probative evidence of affirmative misconduct by any government official; Petitioner's failure to timely revalidate its enrollment may have ultimately been due to affirmative misconduct, but such misconduct was not committed by a government employee or agent.

To the extent that Petitioner is otherwise requesting equitable relief in the form of an earlier effective date of reactivated billing privileges, I am unable to grant equitable relief. *US Ultrasound*, DAB No. 2302 at 8 (2010) ("[n]either the ALJ nor the Board is authorized to provide equitable relief by reimbursing or enrolling a supplier who does not meet statutory or regulatory requirements.").

In the absence of any basis to grant an earlier date for the reactivation of billing privileges, the January 27, 2016 effective date for the reactivation of Petitioner's billing privileges must stand.

V. Conclusion

I uphold the January 27, 2016 effective date of the reactivation of Petitioner's Medicare billing privileges.

/s/
Leslie C. Rogall
Administrative Law Judge