Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Mr. Neb, LLC,
(PTAN No.: 6600330001 / NPI: 1669768081),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-16-573

Decision No. CR4740

Date: November 30, 2016

AMENDED DECISION

The Medicare enrollment and billing privileges of Petitioner, Mr. Neb, LLC, are revoked pursuant to 42 C.F.R. §§ 420.206(c)(2), 424.57(e)(1), and 424.535(a)(1),[1] effective January 2, 2016, based on noncompliance with 42 C.F.R. § 424.57(c)(2) and (17) (Supplier Standards 2 and 17).

I. Procedural History and Jurisdiction

Petitioner was a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) participating in Medicare. The National Supplier Clearinghouse (NSC) operated by Palmetto GBA (Palmetto) notified Petitioner by letter dated December 3, 2015, that Petitioner's Medicare enrollment was revoked effective January 2, 2016. NSC cited 42 C.F.R. §§ 405.800, 424.57(e), 424.535(a)(1), and 424.535(g) as the legal authority for the revocation based on noncompliance with 42 C.F.R. §§ 424.57(c)(2)(Supplier Standard 2), 424.57(c)(10) (Supplier Standard 10),

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[1] Citations are to the 2015 revision of the Code of Federal Regulations (C.F.R.), unless otherwise indicated.

424.57(c)(17) (Supplier Standard 17), and 424.57(c)(21) (Supplier Standard 21). NSC notified Petitioner that it was subject to a one-year bar to re-enrollment pursuant to 42 C.F.R. § 424.535(c). Centers for Medicare & Medicaid Services (CMS) exhibit (CMS Ex.) 1 at 18-21.

On January 29, 2016, Petitioner requested reconsideration of the initial determination. CMS Ex. 1 at 13-14. On March 25, 2016, a reconsideration hearing officer upheld the revocation for noncompliance with Supplier Standards, 2, 10, 17, and 21. CMS Ex. 1 at 1-6.[2]

Petitioner requested a hearing before an administrative law judge (ALJ) on May 13, 2016 (RFH). The case was assigned to me for hearing and decision on May 25, 2016, and an Acknowledgment and Prehearing Order (Prehearing Order) was issued at my direction. Petitioner's request for hearing was timely and I have jurisdiction.

On June 24, 2016, CMS filed a motion for summary judgment (CMS Br.) with CMS Exs. 1 through 3. On July 22, 2016, Petitioner filed a cross-motion for summary judgment and response in opposition to the CMS motion (P. Br.), with Petitioner's exhibits (P. Exs.) 1 through 4. CMS filed a reply brief (CMS Reply) on August 8, 2016. Petitioner filed a motion requesting leave to file a sur-reply, which is granted, with an attached sur-reply (P. Reply). No objections have been made to my consideration of CMS Exs. 1 through 3 and P. Exs. 1 through 4 and they are admitted and considered 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 Palmetto. Act § 1842(a) (42 U.S.C. § 1395u(a)). Payment under the program for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of services and suppliers.[3] Act §§ 1834(j)(1) (42 U.S.C. § 1395m(j)(1)); 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395(u)(h)(1)).

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[2] In the "Decision" paragraph, the hearing officer cited Supplier Standards "2, 7, 10, and 21," but there is no allegation of a violation of Supplier Standard 7 and reference to that supplier standard is clearing a scrivener's error.

[3] A "supplier" furnishes services and supplies under Medicare. The term supplier applies to physicians or other practitioners and facilities that are not included within the
(Continued next page.)

The Act requires the Secretary to issue regulations that establish a process for the enrollment of providers and suppliers, including the right to a hearing and judicial review in the event of denial or non-renewal. Act § 1866(j) (42 U.S.C. § 1395cc(j)).

Pursuant to 42 C.F.R. §§ 424.57 and 424.505, a DMEPOS supplier such as Petitioner must be enrolled in the Medicare program to be reimbursed for durable medical equipment, prosthetics, orthotics, or supplies sold or rented to Medicare beneficiaries. The regulations establish detailed requirements that suppliers must meet and maintain to enroll in Medicare and to receive and maintain Medicare billing privileges. 42 C.F.R. pt. 424, subpt. P. DMEPOS suppliers have additional requirements imposed by 42 C.F.R. § 424.57(b) and (c). To receive direct-billing privileges, a DMEPOS supplier must meet and maintain the Medicare application certification standards set forth in 42 C.F.R. § 424.57(c). A DMEPOS supplier must operate and furnish Medicare-covered items in compliance with all applicable federal and state licensure and regulatory requirements. 42 C.F.R. § 424.57(c)(1). A DMEPOS supplier is required to submit completed application and enrollment forms for each separate physical location it uses to furnish DMEPOS, with the exception of warehouses or repair facilities. 42 C.F.R. § 424.57(b)(1). A DMEPOS supplier must provide complete and accurate information in response to questions on its application for Medicare billing privileges and must report to CMS any changes in information supplied on the application within 30 days of the change. 42 C.F.R. §§ 424.57(c)(2); 424.516(c). Additionally, a DMEPOS supplier must permit CMS or its agent to conduct on-site inspections to ascertain supplier compliance with the Medicare enrollment standards. 42 C.F.R. § 424.57(c)(8). Finally, a DMEPOS supplier must at all times be "operational," which means it "has a qualified physical practice location, is open to the public for the purpose of providing health care related services, is prepared to submit valid Medicare claims, and is properly staffed, equipped, and stocked . . . to furnish these items or services." 42 C.F.R. § 424.502.

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

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definition of the phrase "provider of services." Act § 1861(d) (42 U.S.C. § 1395x(d)). A "provider of services," commonly shortened to "provider," includes hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, hospice programs, and a fund as described in sections 1814(g) and 1835(e) of the Act. Act § 1861(u) (42 U.S.C. § 1395x(u)). The distinction between providers and suppliers is important because they are treated differently under the Act for some purposes.

enrollment requirements, such as those established by 42 C.F.R. § 424.57(b) and (c) for DMEPOS suppliers, is also a basis for revocation of billing privileges and enrollment in Medicare. 42 C.F.R. §§ 424.57(e); 424.535(a)(1). After a supplier's Medicare enrollment and billing privileges are revoked, the supplier is barred from reenrolling in the Medicare program for one to three years. 42 C.F.R. § 424.535(c).

A supplier whose enrollment and billing privileges have been revoked may request reconsideration and review as provided by 42 C.F.R. pt. 498. A supplier submits a written request for reconsideration to CMS or its contractor. 42 C.F.R. § 498.22(a). CMS or its contractor must give notice of its reconsidered determination to the supplier, giving the reasons for its determination and specifying the conditions or requirements the supplier failed to meet, and 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. 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 text followed by my findings of fact and analysis.

1. Summary judgment is appropriate.

The parties have filed cross-motions for summary judgment. 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, disposition on the written record alone is not permissible, unless the cross-motions for summary judgment have merit.

Summary judgment is not automatic upon request but is limited to certain specific conditions. The Secretary's regulations that establish the procedure to be followed in adjudicating Petitioner's case are at 42 C.F.R. pt. 498. 42 C.F.R. §§ 405.800, 405.803(a); 424.545(a), 498.3(b)(5), (6), (15), (17). The regulations 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 (Fed. R. Civ. Pro.) 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. The parties were given notice by the 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 issue of material fact for adjudication and/or the moving party is entitled to judgment as a matter of law. 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. 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. 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 differs 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 & Conv. Ctr.*, DAB No. 1904 (2004), *aff'd*, *Batavia Nursing & Conv. Ctr. v. Thompson*, 129 Fed. App'x 181 (6th Cir. 2005).

In this case, I conclude that there is no genuine dispute as to any material fact pertinent to revocation under 42 C.F.R. §§ 420.206(c)(2), 424.57(e), and 424.535(a)(1) that requires a trial. Accordingly, there is a basis for revocation of Petitioner's Medicare enrollment and billing privileges.

> **2. Petitioner was not in compliance with 42 C.F.R. § 424.57(c)(2) and 17 (Supplier Standards 2 and 17).**
>
> **3. There is a basis for revocation of Petitioner's enrollment and billing privileges pursuant to 42 C.F.R. §§ 420.206(c)(2), 424.57(e)(1), and 424.535(a)(1).**
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> **4. The effective date of revocation of Petitioner's enrollment and billing privileges is determined pursuant to 42 C.F.R. § 424.57(e)(1), and is January 2, 2016, which is 30 days after the date of the December 3, 2015 notice of initial determination to revoke.**

The December 3, 2015 notice from NSC advised Petitioner that its Medicare enrollment was revoked based on violation of Supplier Standards, 2, 10, 17, and 21. Supplier Standard 10 (42 C.F.R. § 424.57(c)(10)) requires that a DMEPOS supplier have a comprehensive liability insurance policy of not less than $300,000 that covers both the supplier's place of business, employees, and customers. CMS Ex. 1 at 18-19. Violation of Supplier Standard 10 was also cited as a basis for revocation by the hearing officer in the reconsidered determination. CMS Ex. 1 at 3. CMS does not mention in its motion for summary judgment or reply brief or urge me to conclude the there was a basis for revocation for violation of Supplier Standard 10. I conclude that CMS has elected not to proceed on the alleged violation of Supplier Standard 10 as a basis for revocation.

The remaining Supplier Standards allegedly violated and at issue before me are Supplier Standards, 2, 17, and 21. The three alleged violations of the supplier standards are based on the same set of facts.

a. Facts

Petitioner applied to enroll in Medicare as a DMEPOS supplier, by filing a CMS-855S dated September 19, 2011. CMS Ex. 2 at 1- 25. The application indicates that Petitioner is a partnership either general or limited. CMS Ex. 2 at 8. James D. Moore signed the application as owner of Petitioner with one other owner, Duane M. Johnson, who also signed. CMS Ex. 2 at 23. James Dossie Moore was listed as Owner/President of Petitioner in the National Plan & Provider Enumeration System when Petitioner's National Provider Identifier (NPI) was issued on June 23, 2011. CMS Ex. 2 at 30-31. J.D. Moore was listed on the organization chart as Chief Executive Officer. CMS Ex. 2 at 68. The enrollment application listed James D. Moore and Duane M. Johnson as owners and partners effective September 19, 2011, but did not reflect that either had a five percent or greater direct/indirect ownership. The application also shows that Mr. Moore and Mr. Johnson acquired ownership and managing control of Petitioner on October 1, 2006. CMS Ex. 2 at 16-17. James Moore states in his January 26, 2016 declaration that he has been affiliated with Petitioner since October 2006, and he was part owner of Petitioner until May 13, 2013. P. Ex. 4; CMS Ex. 1 at 23-24.

Petitioner concedes that at the time of the application to enroll in September 2011, James Moore had more than a five percent ownership interest in the company's stock. P. Br. at 2. This concession is consistent with the fact that Mr. Moore was listed as an owner in the application and that only owners with a five percent or greater ownership interest need to be disclosed on the application pursuant to 42 C.F.R. § 420.206(a)(1). The concession is also consistent with the definitions of ownership and controlling interests under the regulations. Ownership interest means "the possession of equity in the capital, the stock, or the profits of the supplier. 42 C.F.R. § 420.201. An indirect ownership interest is "any ownership interest in an entity that has an ownership interest in the supplier." *Id*. According to 42 C.F.R. § 420.201:

> A person with an ownership or control interest has ownership of five percent or more in the supplier; indirect ownership of five percent or more; a combination of direct and indirect ownership totaling five percent or more; owns five percent or more of any mortgage or other instrument secured by the supplier if the secured interest is worth five percent or more of the value of the supplier's property and assets; is an officer or director of a supplier organized as a corporation; or, is a partner in a supplier organized as a partnership.

I conclude based on Petitioner's concession that in September 2011, when Petitioner was enrolled in Medicare, James Moore had an ownership and control interest in Petitioner equal to or greater than five percent.

Petitioner also concedes, consistent with Mr. Moore's declaration (P. Ex. 4), that on May 13, 2013, he sold his ownership interest in Petitioner. P. Br. at 2; RFH at 2-3

b. Analysis

The three Supplier Standards allegedly violated:

> Supplier Standard 2 (42 C.F.R. § 424.57(c)(2)): The supplier must not make or cause to be made any false statement or misrepresentation of material fact in its application for billing privileges. The supplier must provide complete and accurate information. The supplier must report any changes in information on the application within 30 days of the change.
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> Supplier Standard 17 (42 C.F.R. § 424.57(c)(17)): The supplier must comply with 42 C.F.R. § 420.206, which requires disclosure of names and addresses of persons with ownership, financial, or control interests in Petitioner of five percent or more. 42 C.F.R. § 420.206(a)(1). Changes must be reported within 35 days under 42 C.F.R. § 420.206(b)(3).
>
> Supplier Standard 21 (42 C.F.R. § 424.57(c)(21)): The supplier must provide to CMS on request any information required under the Act and regulations.

It is well established that even a single violation of a single supplier standard is an adequate basis for revocation of billing privileges and enrollment. *1866ICPayday.com*, DAB No. 2289 at 13 (2009). Furthermore, 42 C.F.R. § 424.57(e) requires that CMS revoke a supplier's billing privileges if it is determined that the supplier does not meet the standards established by 42 C.F.R. § 424.57(b) and (c). The regulation provides that revocation is effective 30 days after the notice of revocation is sent.

In this case summary judgment in favor of CMS is required based on the application of the law to the undisputed facts. There are no genuine disputes as to any fact material to the decision in this case. Petitioner's alleged defenses are without merit under the applicable regulations and must be resolved against Petitioner as a matter of law. Summary judgment is appropriate as to revocation based on Supplier Standards 2 and 17.

Petitioner concedes that:

1. James Moore had more than a five percent interest in the company's stock when Petitioner enrolled in Medicare and that fact was reported on Petitioner's enrollment application. P. Br. at 2.

2. On May 13, 2013, James Moore sold his ownership interest in Petitioner. P. Br. at 2.

Petitioner has not offered any evidence and does not assert or argue that Petitioner reported within 30 or 35 days of May 13, 2013, that James Moore sold his ownership interest in Petitioner. In fact, Petitioner does not dispute that Petitioner filed no report that James Moore sold his ownership interest in Petitioner.

Supplier Standard 2 (42 C.F.R. § 424.57(c)(2)) is clear that a supplier must not make or cause to be made any false statement or misrepresentation of material fact in its application for billing privileges; the supplier must provide complete and accurate information; and any change of information on the application must be reported within 30 days of the change. Mr. Moore's five percent or greater ownership interest in Petitioner was reported on the CMS-855S Petitioner filed to enroll in Medicare in September 2011. It is undisputed that Mr. Moore failed to report that he sold his ownership interest in Petitioner within 30 or 35 days of May 13, 2013, the date on which he sold his interest. Petitioner argues that the fact that Mr. Moore sold his interest and was no longer an owner was not material, and therefore, reporting was not required by Supplier Standard 2. Petitioner does not cite any source for its definition of material but argues that because Mr. Moore remained the President and CEO of Petitioner the sale of his ownership interest was not material. P. Br. at 2, 5-6; P. Reply at 2-3. CMS asserts simply that the term "material" in the regulation does not relate to the changed information that must be reported. CMS Reply at 2.

For purposes of this analysis, I conclude that Mr. Moore's sale of his ownership interest was material information. Unfortunately, there is no definition of "material" in the regulations. In the absence of a specific definition in the regulations it is necessary to look for the common meaning of the word "material." A common definition of "material" in the legal context is that an item is "[o]f such nature that knowledge of the item would affect a person's decision-making." *Black Law Dictionary"* 998 (8th ed. 2004). It is not difficult to apply this definition and conclude that Mr. Moore's sale of the ownership interest in Petitioner was material information. It is specifically required by 42 C.F.R. § 420.206 that ownership be disclosed and a supplier is responsible to report any change of its ownership on its own initiative without any request by CMS. 42 C.F.R. § 420.206(a), (b)(3). The regulation requires a significant sanction for failure to report. CMS is required to terminate any provider or supplier agreement and revoke the billing number of any entity that fails to report. 42 C.F.R. § 420.206(c)(2). Furthermore, the CMS-855S specifically provides for reporting any change in ownership. CMS Ex. 2 at 17-18. The requirement to report is clear from both the regulation and the form and is

some evidence that a change of ownership, whether acquisition or sale, should be considered material. The material nature of information about a change in ownership becomes clearer when one examines the decisions of CMS that are based on ownership information. The decisions that may be impacted by ownership information include, e.g., whether or not CMS will deny enrollment under 42 C.F.R. § 424.530(a)(2) or (3) or whether or not CMS should revoke enrollment under 42 C.F.R. § 424.535(a)(2) or (3). I conclude that Petitioner's argument that Mr. Moore's sale of his ownership interest in Petitioner was not material and need not be reported is without merit. Indeed, Mr. Moore's sale of his five percent or greater interest in Petitioner was material. He failed to report the sale violating 42 C.F.R. § 420.206(a) and (b)(3) and Supplier Standard 2 (42 C.F.R. § 424.57(c)(2)). Petitioner asserts that Mr. Moore actually converted his ownership interest in Petitioner to a security interest. P. Br. at 3 n. 1, 5-6. I accept the assertion as true for purposes of summary judgment. However, it is the change in an ownership interest or a control interest that must be reported. Nothing in the language of 42 C.F.R. § 420.206(a) supports Petitioner's assertion that converting an ownership interest to a security interest is exempt from the reporting requirement. Further, even though I accept for purposes of summary judgment that in his official capacity as President and CEO he retained some control over Petitioner, the fact that his status changed from a five percent or greater ownership interest to a control interest or an indirect ownership interest must be reported under 42 C.F.R. § 420.206(a) and (b).

Supplier Standard 17 (42 C.F.R. § 424.57(c)(17)) specifically requires that a supplier comply with 42 C.F.R. § 420.206, which requires disclosure of names and addresses of persons with ownership, financial, or control interests in Petitioner of five percent or more and requires that any change be reported within 35 days. 42 C.F.R. § 420.206(a) and (b)(3). Based on the foregoing analysis, I conclude that Petitioner failed to timely report the change in Mr. Moore's ownership interest on May 13, 2013. Accordingly, I conclude that Petitioner violated Supplier Standard 17 based on failure to report the sale of Mr. Moore's ownership interest as required by 42 C.F.R. § 420.206(b)(3). Revocation is required by 42 C.F.R. §§ 420.206(c)(2) and 424.57(e)(1).

Summary judgment is not appropriate as to revocation based on a violation of Supplier Standard 21 (42 C.F.R . § 424.57(c)(21)). The supplier standard requires the supplier to provide to CMS, when CMS requests, any information required under the Act and regulations. According to the reconsidered determination, CMS requested by letter dated October 19, 2015 (CMS Ex. 3) that Petitioner send CMS certain information and Petitioner failed to do so. CMS Ex. 1 at 4. What information was requested by October 19, 2015 letter is not clear. The letter states *"[p]lease update your Medicare file with the most current information in order to be in compliance with this standard."* CMS Ex. 3 at 2. The October 19, 2015 letter did not require Petitioner to submit specific evidence or a new CMS-855S. Petitioner asserted in the request for hearing that the October 19, 2015 letter was never received. RFH at 2. Fact finding would be required related to whether

or not Petitioner was notified and failed to provide CMS information that CMS requested. Therefore, summary judgment is not appropriate as to Supplier Standard 21.

Petitioner argues it was denied the opportunity to file the plan of corrective action prior to revocation as provided for by 42 C.F.R. § 424.535(a)(1). This assertion is factually inaccurate. The notice of the initial determination to revoke specifically stated:

> If you believe that you are able to correct the deficiencies and establish your eligibility to participate in the Medicare program, and if this revocation is based in whole or in part on § 424.535(a)(1), you may submit a corrective action plan (CAP) within 30 calendar days after the postmark of this letter. (Per 42 C.F.R. § 405.809, a CAP cannot be accepted for revocations based exclusively on reasons other than § 424.535(a)(1)). If the revocation is for multiple reasons of which one is §424.535(a)(1), the CAP will only be reviewed with respect to the §424.535(a)(1) basis for revocation.

CMS Ex. 1 at 19. The notice also advised Petitioner it could request reconsideration within 60-calendar days of the postmark date on the letter. The notice letter was dated December 3, 2015, and no postmark date is apparent. CMS Ex. 1 at 18. Based on the date of the letter, Petitioner had at least until January 2, 2016, to submit a CAP and until February 1, 2016, to submit a request for reconsideration. Petitioner complains that the time for filing a CAP expired before it received the notice on January 16, 2016, after the deadline for filing the CAP, a fact I accept as true for purposes of summary judgment. RFH at 1-2; P. Br. at 7-8; P. Reply at 4. However, there is no evidence Petitioner requested additional time to submit the CAP based on the delayed receipt of the revocation determination. Petitioner filed its request for reconsideration on January 29, 2016. Petitioner requested that NSC retract the revocation and allow Petitioner to submit documents to resolve the issue, but Petitioner did not request additional time to submit a CAP. The evidence shows Petitioner was notified it could submit a CAP and a request for reconsideration and Petitioner chose the latter. The regulation provides that CMS may revoke enrollment and billing privileges when a provider or supplier is determined not to be incompliance with enrollment requirements specified in the regulation and on the enrollment application and the provider or supplier has not submitted a CAP. 42 C.F.R. § 424.535(a)(1). That is exactly the situation in this case. Petitioner cannot avoid revocation by simply asserting it did not have the chance to submit a CAP where there is no evidence it even attempted the submission.

Pursuant to 42 C.F.R. § 424.535(a), CMS may revoke an enrolled provider or suppliers Medicare billing privileges and any related provider or supplier agreement for any of the 14 listed reasons. The phrase "CMS may revoke" indicates that revocation on any of the 14 listed grounds is discretionary. Pursuant to 42 C.F.R. § 424.57(e)(1), which applies

only to suppliers of DMEPOS, "CMS revokes" the billing privileges of a supplier found not to meet the special rules applicable to DMEPOS suppliers established by 42 C.F.R. § 424.57(b) and (c). Although 42 C.F.R. § 424.57(e)(1) does not include the words "will" or "shall", the intent of the provision is clear that "CMS revokes" which indicates revocation is mandatory rather than discretionary. Similarly, 42 C.F.R. § 420.206(c)(2) states that CMS terminates or CMS revokes the billing number of any entity that fails to report ownership and control interests as required by 42 C.F.R. § 420.206(b). The regulation does not grant CMS discretion. The regulation does not state that CMS may terminate or revoke. Rather the regulation clearly states that CMS terminates or revokes. I conclude that pursuant to 42 C.F.R. § 420.206(c)(2), CMS is required to terminate any provider or supplier agreement and revoke the billing number of any entity that fails to report, and the regulation does not leave CMS discretion to decide otherwise. Pursuant to 42 C.F.R. § 424.57(e)(1), CMS is also required to revoke the billing privileges and enrollment of any supplier that violates the standards established by 42 C.F.R. § 424.57(b) and (c) and, again, the regulation grants CMS no discretion not to revoke. The requirement to revoke under these regulations is not dependent upon 42 C.F.R. § 424.535(a), which only includes the discretionary bases for revocation of Medicare enrollment and billing privileges.

Petitioner asserts that I must focus on the reasoning set forth in the revocation notice in conducting my de novo review of whether there is a basis for revocation of Petitioner's enrollment and billing privileges. P. Br. at 2, 7 n. 4. Petitioner cites no authority to support its position that my jurisdiction and review is limited to the four corners of the "revocation notice." Whether or not this argument has any merit need not be resolved as I need look no further than the grounds cited in both the initial and reconsideration determination to find that Petitioner failed to timely report the change in ownership.

Revocation in this case is required by 42 C.F.R. §§ 420.206(c)(2), 424.57(e)(1), and authorized by 42 C.F.R. § 424.535(a)(1). Pursuant to 42 C.F.R. § 424.57(e)(1), revocation for noncompliance with the supplier standards established by 42 C.F.R. § 424.57(b) and (c), is effective 30 days after the supplier is sent notice of the revocation. Therefore, the correct effective date for revocation of Petitioner's Medicare enrollment and billing privileges is 30 days after the notice of the revocation was issued. *Neb Group of Arizona*, DAB No. 2573, at 7-8 (2014). Accordingly, I conclude that the effective date of the revocation of Petitioner's Medicare enrollment and billing privileges was January 2, 2016, which is 30 days after issuance of the December 3, 2015 notice of revocation.

To the extent that any of Petitioner's arguments may be construed as a request for equitable relief, I have no authority 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."). 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 ("[a]n ALJ is bound by applicable laws and regulations and may not invalidate either a law or regulation on any ground.").

III. Conclusion

For the foregoing reasons, I conclude that Petitioner's Medicare enrollment and billing privileges are revoked effective January 2, 2016.

/s/
Keith W. Sickendick
Administrative Law Judge