**Department of Health and Human Services**

**DEPARTMENTAL APPEALS BOARD**

**Civil Remedies Division**

CompRehab Wellness Group, Incorporated,

Petitioner

v.

Centers for Medicare & Medicaid Services.

Docket No. C-10-897

Decision No. CR2317

Date: February 4, 2011

# DECISION

I sustain the determination of the Centers for Medicare and Medicaid Services (CMS) to revoke the Medicare billing privileges of CompRehab Wellness Group, Incorporated (Petitioner), because CMS found it to be nonoperational. Petitioner failed to prove that it satisfied all Medicare requirements for a comprehensive outpatient rehabilitation facility (CORF).

## I. Background

Petitioner was a CORF in Miami, Florida. On March 11, 2010, investigators for SafeGuard Services, LLC (SGS) and a Medical Review Nurse for IntegriGuard, LLC, conducted an on-site inspection of Petitioner on behalf of CMS. As a result of the inspection, First Coast Service Options, Inc. (FCSO), a CMS contractor, notified Petitioner that its Medicare billing number and billing privileges were being revoked effective March 11, 2010, pursuant to 42 C.F.R. § 424.535(a)(1). CMS Ex. 7. Among its findings, the April 23, 2010 revocation letter noted that: (1) Petitioner's owner and operator, Maria Fuentes, failed to produce valid business tax receipts for four independent contractors who were employed by Petitioner; (2) Ms. Fuentes did not possess any medical professional license to act as the coordinator although Petitioner

designated her as such; and (3) Petitioner's designated Medical Director, Pedro Bosch, M.D., only visited once a month to sign documents. CMS Ex. 7. On April 28, 2010, FCSO issued a corrected letter to Petitioner. CMS Ex. 1; P. Ex. 1. This letter notified Petitioner that its Medicare billing number was being revoked pursuant to 42 C.F.R. § 424.535(a)(5)(i) because CMS determined, based on the on-site inspection, that it was no longer operational. CMS Ex. 1; P. Ex. 1. On May 6, 2010, Petitioner submitted a corrective action plan (CAP) and sought reconsideration. CMS Ex. 4; P. Ex. 2.

In a reconsideration decision dated August 5, 2010, a Medicare Hearing Officer affirmed FCSO's decision to revoke Petitioner's Medicare billing number. P. Ex. 4. The Hearing Officer also denied Petitioner's CAP. *Id.* The Hearing Officer determined further that FSCO had used the incorrect regulatory citation to revoke Petitioner's billing privileges on April 28, 2010, and amended the regulatory citation "to reflect that [Petitioner] was noncompliant with Medicare enrollment requirements per 42 C.F.R. § 424.535(a)(1) [as opposed to 42 C.F.R. § 424.535(a)(5)]." P. Ex. 4, at 2. The Hearing Officer held that Petitioner "failed to meet the conditions of participation for a CORF per 42 C.F.R. § 485.58 and failed to furnish services required of a CORF per 42 C.F.R. § 485.51(a), § 485.55, § 485.62(a)(7), § 485.62(c)(1), § 485.70, § 410.100." *Id.* The Hearing Officer concluded by stating that she agreed with FCSO that, at the time of the inspection, Petitioner "was not in compliance with multiple regulatory citations required for a CORF in Medicare." *Id.*

On August 9, 2010, Petitioner filed a hearing request with the Civil Remedies Division (CRD) of the Departmental Appeals Board (Board) to appeal the reconsideration decision. This case was initially assigned to Board Member Leslie A. Sussan pursuant to 42 C.F.R. § 498.44, which permits a Board Member to hear appeals under 42 C.F.R. part 498. An Acknowledgment and Pre-hearing Order was sent to the parties on August 16, 2010.

On September 17, 2010, CMS filed for summary judgment. With its brief (CMS Br.), CMS submitted eleven exhibits (CMS Exs. 1-11), including the affidavits of four proposed witnesses. CMS stated that if I determined that summary judgment was not appropriate based on the record before me, CMS also was submitting its brief as its pre-hearing brief and moved for a decision without a hearing. On October 18, 2010, Petitioner filed a brief (P. Br.) that it characterized as a cross-motion for summary judgment, a response to CMS's motion for summary judgment, and a pre-hearing brief. With its brief, Petitioner submitted twelve exhibits (P. Exs. 1-12), including the affidavits of two proposed witnesses. On October 25, 2010, this case was reassigned to me for hearing and decision. On November 24, 2010, CMS filed a brief in opposition to Petitioner's motion for summary judgment and reply in support of its motion for summary judgment.

I deny CMS's motion for summary judgment. I find there are material facts in dispute as to whether Petitioner had designated a qualified professional to be its coordinator pursuant to 42 C.F.R. § 485.58(c) and whether Petitioner had a facility physician to provide medical direction, medical care services, consultation, and medical supervision of nonphysician staff pursuant to 42 C.F.R. § 485.58(a)(1)(i). Although the parties submitted direct testimony of proposed witnesses, neither party requested to cross-examine any witness, so, in accordance with Board Member Sussan's prehearing order, I am deciding this case on the written record. In the absence of objection, I receive into the record of this case CMS Exs. 1-11 and P. Exs. 1-12.

## II. Applicable Law

A provider applying for enrollment in the Medicare program "must be operational to furnish Medicare covered items or services." 42 C.F.R. § 424.510(d)(6). The regulations define "operational" as follows:

> *Operational* means the provider or supplier 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 (as applicable, based on the type of facility or organization, provider or supplier specialty, or the services or items being rendered), to furnish these items or services.

42 C.F.R. § 424.502 (emphasis added).

The Social Security Act (Act) defines a CORF, in part, as a facility that is primarily engaged in providing (by or under the supervision of physicians) diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons and provides at least the following comprehensive outpatient rehabilitation services: (i) physicians' services (rendered by physicians who are available at the facility on a full-or part-time basis); (ii) physical therapy; and (iii) social or psychological services. *See* 42 U.S.C. §1395x(cc)(2)(A)&(B).

A CORF must also comply with health and safety requirements found at 42 C.F.R. § 485.54 through § 485.66, called "conditions of participation," to participate in the Medicare program. Each condition represents a broad category of CORF services and is set forth in a single regulation, which is divided into subparts called standards. Compliance with a condition of participation is determined by the manner and degree to which the provider satisfies the standards within the condition. 42 C.F.R. §§ 488.1, 488.26(b). If deficiencies are of such character as to "substantially limit the provider's . . . capacity to furnish adequate care or which adversely affect the health and safety of

patients," the provider is not in compliance with conditions of participation. 42 C.F.R. § 488.24(b).

CMS may revoke a provider's Medicare billing privileges if it determines, based on an on-site review, that the provider is no longer operational to furnish Medicare covered items or services, or is not otherwise meeting Medicare enrollment requirements. 42 C.F.R. § 424.535(a)(5)(i). Section 1866(j)(2) of the Act (42 U.S.C. § 1395cc(j)(2)) provides administrative and judicial hearing rights to providers or suppliers whose Medicare billing privileges are revoked.[1] CMS implemented section 1866(j) by providing for administrative hearing rights for revoked providers or suppliers in 42 C.F.R. Parts 424.545, 405.874, and Part 498. These procedures provide for hearings by Administrative Law Judges (ALJs) of this forum and for review of the resulting ALJ decisions by the Board.

In provider and supplier appeals under section 1866(j)(1) of the Act and 42 C.F.R. Part 498, CMS must make a *prima facie* showing that the provider or supplier has failed to comply substantially with federal requirements. *See Medisource Corp.*, DAB No. 2011 (2006). To prevail, the provider or supplier must overcome CMS's *prima facie* showing by a preponderance of the evidence. *Batavia Nursing and Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd, Batavia Nursing and Convalescent Ctr. v. Thompson*, 129 Fed. Appx. 181 (6th Cir. 2005).

## III. Issue

The issue in this case is whether CMS had the authority to revoke Petitioner's Medicare billing privileges by determining Petitioner was not operational because it did not meet the requirements of a CORF.

## IV. Discussion

My findings of fact and conclusions of law are set forth in italics and bold in the discussion captions of this decision.

[1] While the plain language of this section does not specifically refer to hearing rights for enrolled providers and suppliers whose billing privileges are revoked, CMS has interpreted it as authority for providing hearing rights in such situations. *See, e.g.*, 42 C.F.R. § 498.1(g); 72 *Fed. Reg.* 9479 (March 2, 2007).

### *A. Petitioner was not operational because it had deficient staffing at the time of the inspection, and, therefore, it failed to meet all Medicare conditions of participation of a CORF.*

As stated above, a CORF must comply with regulatory requirements known as conditions of participation in order to participate in the Medicare program. 42 C.F.R. § 485.54 through § 485.66. The following CORF condition of participation, with subparts (i.e. standard-level requirements), is relevant to my analysis:

> **Condition of participation: Comprehensive rehabilitation program.**
>
> The facility must provide a coordinated rehabilitation program that includes, at a minimum, physicians' services, physical therapy services, and social or psychological services. These services must be furnished by personnel that meet the qualifications set forth in §§ 485.70 and 484.4 of this chapter and must be consistent with the plan of treatment and the results of comprehensive patient assessments.
>
> (a) *Standard: Physician services.* (1) A facility physician must be present in the facility for a sufficient time to—
> (i) Provide, in accordance with accepted principles of medical practice, medical direction, medical care services, consultation, and medical supervision of nonphysician staff;
> (ii) Establish the plan of treatment in cases where a plan has not been established by the referring physician;
> (iii) Assist in establishing and implementing the facility's patient care policies; and
> (iv) Participate in plan of treatment reviews, patient case review conferences, comprehensive patient assessment and reassessments, and utilization review.
> (2) The facility must provide for emergency physician services during the facility operating hours.
> (b) *Standard: Plan of treatment.* For each patient, a physician must establish a plan of treatment before the facility initiates treatment. The plan of treatment must meet the following requirements:
> (1) It must delineate anticipated goals and specify the type, amount, frequency and duration of services to be provided.
> (2) It must be promptly evaluated after changes in the patient's condition and revised when necessary.
> (3) It must, if appropriate, be developed in consultation with the facility physician and the appropriate facility professional personnel.

> (4) It must be reviewed at least every 60 days by a facility physician who, when appropriate, consults with the professional personnel providing services. The results of this review must be communicated to the patient's referring physician for concurrence before treatment is continued or discontinued.
> (5) It must be revised if the comprehensive reassessment of the patient's status or the results of the patient case review conference indicate the need for revision.
> (c) *Standard: Coordination of services.*
> The facility must designate, in writing, a qualified professional to ensure that professional personnel coordinate their related activities and exchange information about each patient under their care. Mechanisms to assist in the coordination of services must include—
> (1) Providing to all personnel associated with the facility, a schedule indicating the frequency and type of services provided at the facility;
> (2) A procedure for communicating to all patient care personnel pertinent information concerning significant changes in the patient's status;
> (3) Periodic clinical record entries, noting at least the patient's status in relationship to goal attainment; and
> (4) Scheduling patient case review conferences for purposes of determining appropriateness of treatment, when indicated by the results of the initial comprehensive patient assessment, reassessment(s), the recommendation of the facility physician (or other physician who established the plan of treatment), or upon the recommendation of one of the professionals providing services.
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> ***
>
> (e) *Standard: Scope and site of services*—
> (1) *Basic requirements.* The facility must provide all the CORF services required in the plan of treatment and, except as provided in paragraph (e)(2) of this section, must provide the services on its premises.
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> ***

42 C.F.R. § 485.58.

### *1. Petitioner lacked a qualified professional who was coordinating services, a requirement for a CORF.*

Under 42 C.F.R. § 485.58(c), a CORF "must designate, in writing, a qualified professional to ensure that professional personnel coordinate their related activities and

exchange information about each patient under their care." Petitioner had designated its owner and operator, Maria Fuentes, as its coordinator. P. Br. at 12. However, CMS points out that Ms. Fuentes did not possess a medical professional license to operate in this capacity and argues she was not qualified to serve as a service coordinator.

Petitioner argues that "qualified professional" is not defined in the statute, regulations, or the State Operations Manual (SOM), CMS's guidance to surveyors and contractors. P. Br. at 12-13. Petitioner argues, moreover, that CMS has provided no authority for its assertion that a person who is designated as the "qualified professional" must have a medical professional license. Petitioner asserts that neither Florida law nor 42 C.F.R. § 424.535(a)(5) requires that the "qualified professional" referenced in 42 C.F.R. § 485.58(c) hold a medical professional license. Thus, in Petitioner's view, in the absence of any licensure requirement or any definition of "qualified professional," CMS has no basis for its determination that Ms. Fuentes, Petitioner's Administrator, is precluded from the role of coordinator of activities of Petitioner's professional personnel. *Id.*

As additional support for its position, Petitioner relies on SOM guidance, noting that "[t]he qualifications of an administrator may vary among facilities, i.e., some administrators may be health professionals while others may be business managers." P. Br. at 12; SOM 485.56(b). However, this section refers to the role of the administrator who is responsible for the overall management of the CORF, not the coordinator position described in 42 C.F.R. § 485.58(c). As such, the interpretative guidance contained in SOM § 485.56(b) is relevant to my analysis only to show that the agency guidance does not delineate a similar distinction between health professionals and business managers for the coordinator position.

The relevant SOM provision relating to the coordinator position states, in part:

> [i]t is, therefore, important that the facility take steps to assure that services are provided in an efficient, effective and coordinated manner. The facility must designate in writing one professional to oversee the coordination of CORF services that the facility has developed. This responsibility can be performed concurrently with the assigned person's normal professional duties. . . .*Review CORF policies/procedures to ensure the CORF provides in-service education regarding the importance of coordinating patient services. Evidence may also appear in the medical record in assessments, progress notes, interdisciplinary treatment team meetings, discharge planning meetings, etc. Verify that the individual identified as the coordinator is qualified to perform this function.*

SOM § 485.58(c).

Although the regulation does not specifically prescribe the qualifications needed to be a coordinator under 42 C.F.R. § 485.58(c), a responsible interpretation of the regulation would require that specialized education and experience are necessary for the role of coordinator. I find it is reasonable to require that the qualified professional referenced in 42 C.F.R.§ 485.58(c) would at a minimum be qualified by education and experience in the type of services that a CORF provides, namely, rehabilitative services. This would be expected considering the duties of the coordinator include understanding a patient's status so that the coordinator can communicate pertinent information to all patient care personnel and make periodic clinical record entries. 42 C.F.R. § 485.58(c)(2), (3).

Petitioner offered the affidavit of its designated coordinator, Ms. Fuentes, who states that she has been Petitioner's Administrator since May 11, 2006. P. Ex. 11, at 1. Ms. Fuentes states that her job duties "include insuring that the professional personnel contracted with [Petitioner] coordinate their related activities and exchange information about each patient under their care." P. Ex. 11, at 2.

I find that Ms. Fuentes' affidavit contains no support that she possesses any education or experience in any rehabilitative service involving CORF core function areas: physician services, physical therapy and social or psychological services. P. Ex. 11. Contrary to Petitioner's claim that Ms. Fuentes is "certainly qualified" (P. Br. at 13), her affidavit is devoid of any specialized education or experience that would constitute reasonable professional qualification for a CORF coordinator. Moreover, it is undisputed that Ms. Fuentes does not possess any medical professional license. Based on the foregoing, I agree that CMS had a legitimate basis to find that Ms. Fuentes was not qualified to be the coordinator. Petitioner thus failed to have a qualified professional to coordinate services pursuant to 42 C.F.R. § 485.58(c). By failing to meet the requirement of 42 C.F.R. § 485.58(c), Petitioner failed to provide a core service of a CORF and was in violation of a condition of participation for a CORF.

### *2. Petitioner lacked a facility physician on staff who was providing the required level of medical direction, medical care services, consultation, and medical supervision of nonphysician staff, a required service of a CORF.*

CMS contends further that, at the time of the on-site inspection, Petitioner failed to demonstrate that it was providing the requisite physician services at its location, a standard-level requirement. Specifically, a facility physician must be present in the facility for a sufficient time to provide, in accordance with accepted principles of medical practice, medical direction, medical care services, consultation, and medical supervision of nonphysician staff. 42 C.F.R. § 485.58(a)(1)(i).

I note that, in its April 28, 2010 letter to Petitioner, FCSO alleged that "Ms. Fuentes confirmed that [the Medical Director's] level of involvement does not allow for providing physician services in accordance with accepted principles of medical practice, direction, consultation and supervision of non-physician staff – all conditions of participation for operating a [CORF]." P. Ex. 1, at 1-2. CMS asserts that Ms. Fuentes conceded that the designated Medical Director, Pedro Bosch, M.D., only visited the facility once a month and only to sign documents. CMS Ex. 8, at 3; CMS Ex. 10, at 2.

Responding to CMS's allegations, Petitioner relies on the statements in Dr. Bosch's affidavit (P. Ex. 12). Petitioner asserts that Dr. Bosch "is available to the facility on an as needed basis to see patients who require medical services and consultation." P. Br. at 14. Petitioner notes that Dr. Bosch "regularly reviews patient records and assesses patient needs." *Id.* Moreover, Petitioner asserts Dr. Bosch "is available telephonically to provide direction and consultation to non-physician staff." *Id.*

Petitioner contends that the regulation at 42 C.F.R. § 485.58(a) requires only that a physician be present in the facility for a sufficient time to provide services and does not require a physician's presence if his or her services are not needed. In Petitioner's view, the position of facility physician is administrative in nature. As support for this argument, Petitioner points to section 485.58(a) of the SOM, claiming that it "stresses that the CORF physician services are primarily administrative in nature." P. Br. at 14.

I find Petitioner's arguments to be unpersuasive that Dr. Bosch's availability on an ad hoc basis, and by telephone, suffices to meet the regulatory requirement. The SOM states, "[t]he facility physician may be associated with the facility on either a part-time or full-time basis. If part-time, it is important to determine that the physician is effectively performing required responsibilities." SOM § 485.58(a). The SOM states further, "CORF physician services are <u>administrative</u> in nature: consultation with and medical supervision of non-physician staff, establishment and review of the plan of treatment, and other medical and facility administration activities." SOM § 485.58(a). (Emphasis in original). Based on the interpretative guidance of the SOM, I find that a physician who is at least part-time at the facility, and is <u>actively directing the rehabilitative services</u>, would be providing physician services in accordance with 42 C.F.R. § 485.58(a)(1). This is also in accordance with the statutory requirement that a governing CORF physician be available at the facility on a full or part-time basis. 42 U.S.C. § 1395x(cc)(2)(B)(i)&(D).

In the case before me, however, I have examined Dr. Bosch's affidavit and find that it is devoid of any mention of the active functions and responsibilities required by a facility physician. In fact, it is questionable whether Dr. Bosch visited the facility even once a month. Although Ms. Fuentes apparently told the investigators that Dr. Bosch came into the facility once a month, Dr. Bosch, in his affidavit, fails to state how often he visits the facility. P. Ex. 12. According to the SGS inspection, Ms. Fuentes stated Dr. Bosch was not on a set schedule, and it was unknown when he would be on the premises. CMS Ex.

8, at 3. I note further that the investigators reported Ms. Fuentes also informed them Petitioner had not had a Medicare patient at its location since August 2009. CMS Ex. 5, at 4; CMS Ex. 11, at 9.

Based on the foregoing, I agree with CMS's finding that Petitioner did not have a designated facility physician to provide the required level of services pursuant to 42 C.F.R. § 485.58(a). By failing to meet the requirement of 42 C.F.R. § 485.58(a), Petitioner failed to provide a core service of a CORF and was in violation of a condition of participation for a CORF.[2]

### *B. CMS provided due process to Petitioner*.

Petitioner argues that "CMS' notice of revocation was legally insufficient" and "appropriate procedures were not followed for revocation of the provider's number." P. Br. at 2, 8. Nevertheless, Petitioner acknowledges in its brief that the justification for the revocation is based on the determination by CMS's investigators that Petitioner was non-operational. *Id.* at 2. Petitioner claims that there was "significant confusion on the part of CMS" as to which section of the regulations permitted the immediate revocation of its provider number. *Id.* Petitioner asserts, moreover, that CMS did not even cite to any specific regulatory provision in its brief as the basis for the revocation but only cited generally to the revocation regulation, i.e. 42 C.F.R. § 424.535. Petitioner notes further that CMS "has repeatedly asserted" that it revoked Petitioner's provider number on the grounds that the March 11, 2010 on-site inspection found Petitioner to be "non-operational." *Id.*

It is true that there was considerable shifting on CMS's part as to which subsection of 42 C.F.R. § 424.535 formed the basis for its revocation decision. However, I do not find that Petitioner's procedural due process rights were violated as a result. The Board has consistently held that after an administrative appeal has commenced, a federal agency may assert and rely on new or alternative grounds for the challenged action or determination as long as the non-federal party has notice of, and a reasonable opportunity to respond to, the asserted new grounds during the administrative proceeding. *Green Hills Enters.*, LLC, DAB No. 2199 (2008). *See also Abercrombie v. Clarke*, 920 F.2d 1351, 1360 (7th Cir. 1990), *cert. denied*, 520 U.S. 809 (1991) (holding that defects in formal notice may be cured during the course of an administrative proceeding, and due process is satisfied as long as the party is reasonably apprised of, and given opportunity

[2] As another basis for revoking Petitioner's Medicare billing privileges, CMS alleged that Petitioner had also failed to produce valid county business tax receipts for four independent contractors who were employed by Petitioner. Because I am already finding that Petitioner had not met all of the legal requirements of a CORF based on deficient staffing conditions, I decline to address this alleged violation.

to address, the issues in controversy); *St. Anthony Hosp. v. Sec'y, Dep't of Health and Human Servs.*, 309 F.3d 680, 708 (10th Cir. 2002) ("To establish a due process violation [in an administrative proceeding] , an individual must show he or she has sustained prejudice as a result of the allegedly insufficient notice.").

It is evident from CMS's briefs that CMS chose to revoke Petitioner's Medicare billing privileges under 42 C.F.R. § 424.535(a)(5)(i) on the grounds that Petitioner was no longer operational. As stated by CMS, based on the fact that Petitioner failed to have a designated facility physician and a designated coordinator of services, it "concluded that [Petitioner] was no longer operational as a CORF." CMS Br. at 5.

Moreover, I note from Petitioner's arguments that Petitioner clearly intended to respond to and rebut CMS's determination that it was found nonoperational. In fact, Petitioner cites previous ALJ decisions, claiming that they stand for the proposition that a provider's status is nonoperational only if it is "closed and not providing any services to patients." P. Br. at 6. Petitioner's reliance on these decisions is not persuasive, and I do not agree that a determination about whether a CORF is operational is only limited to whether the facility was open and an employee was on the premises to speak to investigators. For a CORF to be found operational, it must provide all of the required core services and meet all the conditions of participation as previously discussed in Section IV.A.

Petitioner also argues that it did not receive 30 days' notice of the pending revocation of its billing privileges. P. Br. at 7. Pursuant to 42 C.F.R. § 424.535(g), when a revocation is based on CMS's determination that a provider is nonoperational, the effective date of the revocation is the date that CMS ultimately determined the provider was no longer operational. Accordingly, because CMS determined that Petitioner was nonoperational under 42 C.F.R. § 424.535(a)(5), the effective date of revocation is the date of the on-site inspection –March 11, 2010. Although other circumstances provide for 30 days' notice of revocation, under the facts of this case, Petitioner was not entitled to receive such notification.

Petitioner made the further assertion that its CAP addressed every basis listed in the notice of revocation letter. P. Br. at 16. Moreover, Petitioner contends that it did not receive the opportunity to address, in a CAP, the additional bases for revocation cited in CMS's August 5, 2010 reconsideration decision. P. Br. at 7, 8. In Petitioner's view, the regulations permitted it to submit a CAP, and its revocation should not have taken effect until 30 days after CMS rejected its CAP. I do not agree with Petitioner. Petitioner's provider number was revoked pursuant to 42 C.F.R. § 424.535(a)(5)(i) based on its nonoperational status. The opportunity to submit a CAP extended by 42 C.F.R. § 424.535(a)(1) does not apply to the revocation of billing privileges under section 424.535(a)(5). *A To Z DME, LLC*, DAB No. 2303 (2010), at 9. Because 42 C.F.R.

§ 424.535(a)(5)(i) does not require CMS to permit a provider to submit a plan of corrective action prior to revocation, I lack the authority to consider any arguments by Petitioner regarding CMS's rejection of its CAP. *See A To Z DME, LLC*, at 10. Moreover, even if Petitioner was entitled to submit a CAP, CMS's decision whether or not to reinstate a provider based on a CAP is not an initial determination and not reviewable by an ALJ. 42 C.F.R. § 405.874(e).

## V. Conclusion

For the reasons explained above, I sustain CMS's determination to revoke Petitioner's Medicare billing privileges on the basis that it was nonoperational. Petitioner failed to show that it met all Medicare requirements for a CORF.

/s/
Joseph Grow
Administrative Law Judge