Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Andrew M. Scanameo (Practice)
(NPI: 1851402986 / PTAN: K3385)
&
Andrew Scanameo, M.D. (Physician)
(NPI: 1144212291 / PTAN: 41724Z)

Petitioners,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-17-698

Decision No. CR5001

Date: December 21, 2017

DECISION

The Medicare enrollment and billing privileges of Petitioners, Andrew M. Scanameo (practice) and Andrew Scanameo, M.D. (physician) are revoked pursuant to 42 C.F.R. § 424.535(a)(8)(i),[1] effective December 10, 2016.

I. Background

Petitioners are a physician and his solely-owned practice, both enrolled in Medicare with billing privileges. The Centers for Medicare & Medicaid Services (CMS) notified Petitioners by letter dated November 10, 2016, that their Medicare billing numbers and billing privileges were revoked effective December 10, 2016. CMS cited 42 C.F.R. § 424.535(a)(8)(i) as the basis for the revocation. CMS further informed Petitioners that they were subject to a three-year bar to re-enrollment pursuant to 42 C.F.R. § 424.535(c), to begin 30 days after the date of CMS's letter. CMS Exhibit (Ex.) 3. A reconsidered

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

determination was requested on behalf of both Petitioners by letter dated January 5, 2017. CMS Ex. 4. On April 3, 2017, a CMS Hearing Officer issued two reconsidered determinations upholding the revocations effective December 10, 2016. CMS Exs. 5, 10.

Petitioners filed a request for hearing before an administrative law judge (ALJ) on May 16, 2017. On June 12, 2017, the case was assigned to Judge Scott Anderson for hearing and decision and an Acknowledgement and Prehearing Order (Prehearing Order) was issued. The case was reassigned to me on August 25, 2017, upon Judge Anderson's departure.

On July 17, 2017, CMS filed a motion for summary judgment and brief in support of its motion (CMS Br.) and CMS Exs. 1 through 14. Petitioners filed a response on August 21, 2017 (P. Br.) with Petitioners' Exhibits (P. Exs.) 1 and 2. The parties have not objected to my consideration of the offered exhibits and all are admitted.

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. Payment under the program for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of services and suppliers.[2] Act §§ 1835(a) (42 U.S.C. § 1395n(a)), 1842(h)(1) (42 U.S.C. § 1395u(h)(1)). Petitioners, a physician and his practice, are suppliers.

The Act requires the Secretary of Health and Human Services (Secretary) to issue regulations that establish a process for the enrollment in Medicare of providers and

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[2] A "supplier" furnishes services under Medicare and includes physicians or other practitioners and facilities that are not included within the definition of the phrase "provider of services." Act § 1861(d) (42 U.S.C. § 1395x(d)). A "provider of services," commonly shortened to "provider," includes hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, hospice programs, and a fund as described in sections 1814(g) (42 U.S.C. § 1395f(g)) and 1835(e) (42 U.S.C. § 1395n(e)) of the Act. Act § 1861(u) (42 U.S.C. § 1395x(u)). The distinction between providers and suppliers is important because they are treated differently under the Act for some purposes.

suppliers, including the right to a hearing and judicial review of certain enrollment determinations, such as revocation of enrollment and billing privileges. Act § 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to 42 C.F.R. § 424.505, suppliers such as Petitioners must be enrolled in the Medicare program and be issued a billing number to have billing privileges and to be eligible to receive payment for services rendered to a Medicare-eligible beneficiary.

The Secretary has delegated the authority to revoke enrollment and billing privileges to CMS. 42 C.F.R. § 424.535. CMS or its Medicare contractor may revoke an enrolled supplier's Medicare enrollment and billing privileges and supplier agreement for any of the reasons listed in 42 C.F.R. § 424.535. If CMS revokes a supplier's Medicare billing privileges, the revocation becomes effective 30 days after CMS or one of its contractors mails the revocation notice to the supplier, subject to some exceptions not applicable in this case. 42 C.F.R. § 424.535(g). After a supplier's Medicare enrollment and billing privileges are revoked, the supplier is barred from re-enrolling in the Medicare program for a minimum of one year, but no more than 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. 42 C.F.R. § 424.545(a). 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 the 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 unless waived. *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743, 748-51 (6th Cir. 2004). CMS is also granted the right to request ALJ review of a reconsidered determination with which it is dissatisfied. 42 C.F.R. § 498.5(*l*)(2). The supplier bears the burden to demonstrate that it meets enrollment requirements with documents and records. 42 C.F.R. § 424.545(c).

B. Issues

Whether summary judgment is appropriate;

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

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

My conclusions of law are set forth in bold followed by the undisputed facts and analysis.

1. Summary judgment is appropriate.

CMS filed a motion for summary judgment and Petitioners oppose the motion. As noted above, a supplier whose enrollment has been revoked has a right to a hearing and judicial review, and a hearing on the record is required under the Act. Act §§ 205(b), 1866(h)(1), (j); 42 C.F.R. §§ 498.3(b)(5), (6), (8), (15), (17), 498.5; *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, Petitioners have 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 summary judgment is appropriate as I conclude it is in this case.

Summary judgment is not automatic upon request but is limited to certain specific conditions. The Secretary's regulations at 42 C.F.R. pt. 498 that establish the procedures to be followed in adjudicating Petitioners' case do not establish a summary judgment procedure or recognize such a procedure. However, the Board has long accepted that summary judgment is an acceptable procedural device in cases adjudicated pursuant to 42 C.F.R. pt. 498. *See, e.g.*, *Ill. Knights Templar Home*, DAB No. 2274 at 3-4 (2009); *Garden City Med. Clinic*, DAB No. 1763 (2001); *Everett Rehab. & Med. Ctr.*, DAB No. 1628 at 3 (1997). The Board also has recognized that the Federal Rules of Civil Procedure do not apply in administrative adjudications such as this, but the Board has accepted that Fed. R. Civ. Pro. 56 and related cases provide useful guidance for determining whether summary judgment is appropriate. A summary judgment procedure is described and made available in the adjudication of this case by the Civil Remedies Division Procedures § 19.a., a copy of which was provided to the parties at docketing.

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. In determining whether there are genuine issues of material fact for trial, the ALJ must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. The party requesting summary judgment bears the burden of showing that there are no genuine issues of material fact for trial and/or that it is entitled to judgment as a matter of law. Generally, the non-movant may not defeat an adequately supported summary judgment motion by relying upon the denials in its pleadings or briefs but must furnish evidence of a dispute concerning a material fact, i.e., a fact that would affect the outcome of the case if proven. *Mission Hosp. Reg'l Med. Ctr.*, DAB No. 2459 at 5 (2012) (and cases cited therein); *Experts Are*

Us, Inc., DAB No. 2452 at 5 (2012) (and cases cited therein); *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 at 3 (2010) (and cases cited therein); *see also Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986).

The standard for deciding a case on summary judgment and an ALJ's decision-making in deciding a summary judgment motion differ from that used in resolving a case after a hearing. On summary judgment, the ALJ does not make credibility determinations, weigh the evidence, or decide which inferences to draw from the evidence, as would be done when finding facts after a hearing on the record. Rather, on summary judgment, the ALJ construes the evidence in a light most favorable to the non-movant and avoids deciding which version of the facts is more likely true. *Holy Cross Vill. at Notre Dame, Inc.*, DAB No. 2291 at 5 (2009). The Board also has recognized that on summary judgment it is appropriate for the ALJ to consider whether a rational trier of fact could find that the party's evidence would be sufficient to meet that party's evidentiary burden. *Dumas Nursing & Rehab., L.P.*, DAB No. 2347 at 5 (2010). The Secretary has not provided in 42 C.F.R. pt. 498 for the allocation of the burden of persuasion or the quantum of evidence required to satisfy the burden of persuasion. However, the Board has provided some persuasive analysis regarding the allocation of the burden of persuasion in cases subject to 42 C.F.R. pt. 498. *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd*, *Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 F. App'x 181 (6th Cir. 2005).

In its notice of initial determination dated November 10, 2016, CMS alleged that data analysis showed that from December 1, 2011 to September 19, 2016, Petitioners' practice billed Medicare for services provided to 37 Medicare beneficiaries who were deceased on the claimed date of service.[3] CMS Ex. 3. CMS alleges in its brief that there were a total of 94 claims to Medicare for an unspecified number of beneficiaries who were dead on the claimed dates of service. CMS Br. at 1. Petitioners dispute that 13 of the claims were for their patients. Petitioners do not dispute that they filed or had filed on their behalf the remaining 81 claims alleged by CMS. P. Br. at 2. CMS admits that it is unclear why there is a discrepancy between the CMS allegation of 94 claims for services to deceased Medicare beneficiaries and Petitioners' assertion and concession that only 81 of the claims were for Petitioner's patients. CMS Br. at 4 n.1. For purposes of summary

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[3] CMS offered as evidence only the initial determination for the physician (NPI: 1144212291) with a list of 58 claims for 37 beneficiaries attached and did not offer the initial determination addressed to the practice (NPI: 1851402986). However, there is no issue that initial determinations were issued for both (CMS Ex. 4 at 1) and the reconsidered determinations for both are in evidence (CMS Exs. 5, 10). The error does not affect my jurisdiction and causes no prejudice to either party.

judgment, I accept Petitioners' assertion that only 81 claims are related to their patients and are involved in this case. Petitioners also assert that no payment has been received on any of the claims, which I also accept as true for purposes of summary judgment. P. Br. at 2. CMS has elected in this case to proceed only upon ten claims related to the eight beneficiaries listed in the reconsidered determinations (CMS Exs. 5, 10). CMS Br. at 4 n.1. One of those claims I do not consider because it was filed within a month of the date of death of the beneficiary (CMS Exs. 5, 7 – A.K. date of death July 26, 2015 with claim for date of service of August 4, 2015). The facts as to the remaining nine claims related to seven beneficiaries are not disputed by Petitioners, including that the claims were filed by Petitioners or on their behalf and the Medicare beneficiaries named in the claims were dead for more than a month on the claimed dates of service. There are no genuine disputes of material fact related to the nine claims that I conclude are an adequate basis for revocation pursuant to 42 C.F.R. § 424.535(a)(8)(i).

Petitioners argue that incorrect billing is an insufficient basis for revocation pursuant to 42 C.F.R. § 424.535(a)(8)(i). P. Br. at 2. But, this is a legal issue, not a dispute of fact and not a bar to summary judgment. No hearing is required to resolve this issue of law.

Petitioners argue that some of the claims originally cited by CMS relate to death summaries or discharge on death summaries, which can only be prepared after a beneficiary is dead. P. Br. at 2. I limit my review to the nine claims related to seven beneficiaries considered on reconsideration with more than a month between the date of death of the beneficiary and the claimed date of service. None of the claims I consider are alleged by Petitioners to involve death related care and services.

Viewing the evidence before me in a light most favorable to Petitioners and drawing all inferences in Petitioners' favor, I conclude that there are no genuine disputes as to any material facts pertinent to revocation under 42 C.F.R. § 424.535(a)(8)(i) that require a hearing in this case. The issues in this case raised by Petitioners related to revocation under 42 C.F.R. § 424.535(a)(8)(i) must be resolved against Petitioners as a matter of law.

The undisputed evidence shows that there is a basis for revocation of Petitioners' Medicare enrollment and billing privileges and CMS is entitled to judgment as a matter of law. Accordingly, summary judgment is appropriate.

2. Billing privileges are abused, within the meaning of 42 C.F.R. § 424.535(a)(8)(i), when three or more claims are submitted to Medicare for services that could not have been furnished to the specific individuals identified in the claims on the dates the services were claimed to have been delivered.

3. Between about April 4, 2012 and January 8, 2016, Petitioners, or others on their behalf, submitted to Medicare nine claims for care and services purportedly delivered to seven Medicare-eligible beneficiaries who were deceased before the claimed dates of service; the claims were, therefore, false and constituted an abuse of billing privileges under 42 C.F.R. § 424.535(a)(8)(i).

4. It is no defense to a revocation action for abuse of billing privileges under 42 C.F.R. § 424.535(a)(8)(i) that the false claims were due to inadvertent or unintentional errors of Petitioners' agents or employees or others.

5. There is a basis for revocation of Petitioners' Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(8)(i).

6. The effective dates of revocation in this case were December 10, 2016, 30 days after the dates of the notices of initial determination to revoke. 42 C.F.R. § 424.535(g).

The regulation provides:

> (8) *Abuse of billing privileges.* Abuse of billing privileges includes either of the following:
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> (i) The provider or supplier submits a claim or claims for services that could not have been furnished to a specific individual on the date of service. These instances include but are not limited to the following situations:
>
> (A) Where the beneficiary is deceased.
>
> (B) The directing physician or beneficiary is not in the state or country when services were furnished.
>
> (C) When the equipment necessary for testing is not present where the testing is said to have occurred.

42 C.F.R. § 424.535(a)(8)(i) (italics in original). The regulation provides Petitioners notice that billing privileges and Medicare enrollment may be revoked for an abuse of billing privileges. 5 U.S.C. §§ 551(4), 552(a)(1). The elements of the CMS prima facie case for revocation based on the language of 42 C.F.R. § 424.535(a)(8)(i) are: (1) the provider or supplier submitted one or more claims for services; and (2) the services for

which a claim or claims were submitted could not have been delivered to the specific Medicare beneficiary on the date the service was claimed to have been delivered to him or her. *Realhab, Inc.*, DAB No. 2542 at 16-17 (2013). Although the plain language of the regulation seems clear enough at first blush, there have been several Board decisions that discussed the regulatory history of the regulation for clarification of what was intended to be a sufficient basis for revocation. *Proteam Healthcare, Inc.*, DAB No. 2658 (2015); *Ronald J. Grason, M.D.*, DAB No. 2592 at 8 (2014); *Realhab, Inc.*, DAB No. 2542 at 16; *Howard B. Reife, D.P.M.*, DAB No. 2527 at 1-2 (2013). CMS, the proponent of the regulation, explained in comments to the final rulemaking in 2008:

> CMS, not a Medicare contractor, will make the determination for revocation under the authority at § 424.535(a)(8). We will direct contractors to use this basis of revocation after identifying providers or suppliers that have these billing issues. We have found numerous examples of situations where **a physician claims to have furnished a service to a beneficiary more than a month after their recorded death**, or when the provider or supplier was out of State when the supposed services had been furnished. **In these instances, the provider has billed the Medicare program for services *which were not provided* and has submitted Medicare claims *for services to a beneficiary who could not have received the service which was billed*.** This revocation authority is not intended to be used for isolated occurrences or accidental billing errors. Rather, this basis for revocation is directed at providers and suppliers who are engaging in a pattern of improper billing . . . . We believe that it is both appropriate and necessary that we have the ability to revoke billing privileges when services could not have been furnished by a provider or supplier. We recognize the impact that this revocation has, and a revocation will not be issued unless sufficient evidence demonstrates abusive billing patterns. **Accordingly, we will not revoke billing privileges under § 424.535(a)(8) *unless there are multiple instances, at least three,* where abusive billing practices have taken place** . . . . **In conclusion*, we believe that providers and suppliers are responsible for the claims they submit or the claims submitted on their behalf*. We believe that it is essential that providers and suppliers take the necessary steps to ensure they are billing appropriately for services furnished to Medicare beneficiaries.**

73 Fed. Reg. 36,448, 36,455 (June 27, 2008) (emphasis added). Based on this regulatory history, I conclude that CMS must also show as part of its prima facie case that there were at least three claims for services that could not have been delivered to the Medicare beneficiary named in the claims. Furthermore, the drafters specifically cite as an example of possible abuse the situation when a physician bills for services purportedly delivered to a Medicare-eligible beneficiary more than a month after the beneficiary's recorded date of death. I do not conclude based on the drafters' language that a claim for care and services delivered within 30 days of the date of death of a beneficiary is not an example of abuse of billing privileges, but in this case, out of an abundance of caution, I do not consider the claim related to A.K. (CMS Exs. 5, 7) whose date of death (July 26, 2015) is within nine days of the claimed date of service (August 4, 2015). Not considering the claim related to A.K. avoids an issue that the claim may have been for death-related care and services, which Petitioner points out should not be considered abuse. I note that the drafters of the regulation also state that only CMS and not a Medicare contractor will make the determination to revoke pursuant to 42 C.F.R. § 424.535(a)(8). 73 Fed. Reg. at 36,455; 79 Fed. Reg. 72,500, 72,513-521 (December 5, 2014). In this case, CMS issued both the initial and reconsidered determinations. CMS Exs. 3, 5, 10.

a. Facts

By letter dated October 13, 2016, CMS notified Petitioners that it was reviewing claims related to beneficiaries listed in the letter. CMS requested that Petitioners provide medical records for the beneficiaries for services rendered during a specified period. CMS Ex. 1. Petitioners responded on October 26, 2016. CMS Ex. 2.

CMS notified Petitioners by letters dated November 10, 2016, that their Medicare enrollment and billing privileges were revoked effective December 10, 2016, pursuant to 42 C.F.R. § 424.535(a)(8)(i) for abuse of billing privileges. CMS alleged that Petitioners abused billing privileges by submitting claims for care or services delivered to Medicare beneficiaries on claimed dates of service after their dates of death. CMS attached to the initial determination a list of 58 claims for 37 beneficiaries. CMS Ex. 3. CMS did not offer as evidence the separate notice of initial determination that was sent to the practice, which may or may not have listed other claims and beneficiaries.

Petitioners requested reconsideration on January 5, 2017. The gist of Petitioners' arguments were that the claims were clerical billing errors, not abuse, and that care and services delivered related to death are also not abuse. Petitioners also alleged that two claims for beneficiaries on the CMS list with the initial determination were not his patients, specifically L.S. and A.B. CMS Ex. 4. On April 3, 2017, CMS issued two reconsidered determinations, one related to the physician Petitioner and the other related to his practice. CMS Exs. 5, 10. Each reconsidered determination listed four specific

examples, none of which were related to L.S. or A.B., the beneficiaries Petitioners alleged were not their patients. As already noted, I conclude that CMS has elected to proceed in this case upon only the claims related to the examples of the eight Medicare beneficiaries addressed in the reconsidered determinations. The reconsidered determination for Andrew Scanameo (NPI: 1851402986) (CMS Ex. 5) lists the following examples of alleged abuse of billing privileges: M.A. (CMS Ex. 6); A.K. (CMS Ex. 7); G.M. (CMS Ex. 8); and L.B. (CMS Ex. 9). I do not consider the example of A.K. as the date of death in that example is only nine dates prior to the claimed date of service and further development would be needed to rule out that the claim was not for death-related services. The date of claimed services is also within the one-month window identified by the drafters of 42 C.F.R. § 424.535(a)(8)(i). 73 Fed. Reg. at 36,455. The reconsidered determination for Andrew Scanameo, M.D. (NPI: 1144212291) (CMS Ex. 10) lists the following examples of alleged abuse of billing prvileges: S.C. (CMS Ex. 11); L.B. (CMS Ex. 12); D.W. (CMS Ex. 13); and W.C. (CMS Ex. 14). CMS Br. at 4 n.1.

The facts alleged in the reconsidered determinations related to the claims for services to M.A., G.M., L.B. (CMS Ex. 9), S.C., L.B. (CMS Ex. 12), D.W., and W.C. are not disputed by Petitioners, including that claims were filed by Petitioners or on Petitioners' behalf and that the Medicare beneficiaries named in the claims were dead on the claimed dates of service as alleged in the reconsidered determinations. CMS Ex. 4; P. Br.

b. Analysis

I conclude that the undisputed facts establish a prima facie case of abuse of billing privileges under 42 C.F.R. § 424.535(a)(8)(i). The elements of the CMS prima facie case for revocation pursuant to 42 C.F.R. § 424.535(a)(8)(i) are met because it is undisputed that nine claims were submitted by or on behalf of Petitioners for services that could not have been furnished to seven specific beneficiaries on the claimed date of service because each of the beneficiaries was dead at the time for more than 30 days.

I further conclude that Petitioners have neither rebutted the CMS prima facie case nor established any defense. Petitioners argue that mere billing errors are not sufficient to establish abuse of billing privileges. P. Br. at 2. But, CMS is not required to show that Petitioners intended to either defraud or abuse billing privileges, and accidental or inadvertent billing errors have been found to be a sufficient basis for revocation. The Board has upheld determinations that abuse in the context of 42 C.F.R. § 424.535(a)(8) occurs when a provider bills Medicare for services that could not have been provided to the Medicare beneficiary to whom the claim is related. *Realhab, Inc.*, DAB No. 2542 at 15. The Board has commented that a common definition of abuse is misuse, or wrong or improper use, and that the negligent submission of multiple erroneous claims for services that could not have been delivered to beneficiaries amounts to abuse. *Louis J. Gaefke, D.P.M.*, DAB No. 2554 at 9 (2013); *Howard B. Reife, D.P.M.*, DAB No. 2527 at 6. CMS

is not required to show that Petitioners intended to defraud Medicare before it revokes their enrollment and billing privileges. The regulation only requires the existence of claims for services that could not have been delivered. 42 C.F.R. § 424.535(a)(8); *Louis J. Gaefke, D.P.M.*, DAB No. 2554 at 7 ("The plain language of the regulation contains no requirement that CMS establish that the supplier acted with fraudulent or dishonest intent. The regulatory language also does not provide any exception for inadvertent or accidental billing errors."). It is irrelevant whether or not the claims were actually paid by CMS. Petitioners' implied argument that they should not be held responsible for innocent staff or clerical errors is without merit. Petitioners are ultimately responsible as a matter of law for ensuring that their claims for Medicare reimbursement were accurate and for any errors in those claims. *Louis J. Gaefke, D.P.M.*, DAB No. 2554 at 5-6 (citing 73 Fed. Reg. at 36,455). Petitioners cannot avoid responsibility for their claims by the simple expedient of shifting responsibility and liability to staff or others. It is undisputed that Petitioners filed nine claims for services to seven deceased Medicare beneficiaries who had been dead for over a month at the time the claimed services were supposed to be delivered. Petitioners, Petitioners' staff, or a billing agent filed the claims. Petitioners, as the enrolled suppliers, are responsible to ensure compliance with Medicare requirements. 42 C.F.R. §§ 424.510(d)(3); 424.516. As the drafters of 42 C.F.R. § 424.535(a)(8) stated:

> In conclusion, we believe that providers and suppliers are responsible for the claims they submit or the claims submitted on their behalf. We believe that it is essential that providers and suppliers take the necessary steps to ensure they are billing appropriately for services furnished to Medicare beneficiaries.

73 Fed. Reg. at 36,455.

Under the regulations, the re-enrollment bar after a revocation is a minimum of one year and a maximum of three years. 42 C.F.R. § 424.535(c). There is no statutory or regulatory language establishing a right to review of the duration of the re-enrollment bar CMS imposes. Act § 1866(j)(8); 42 C.F.R. §§ 424.535(c), 424.545, 498.3(b), and 498.5. The Board has held that the duration of a revoked supplier's re-enrollment bar is not an appealable initial determination listed in 42 C.F.R. § 498.3(b), and thus, is not subject to ALJ review. *Vijendra Dave, M.D.*, DAB No. 2672 at 11 (2016).

To the extent Petitioners' arguments, including the statements admitted as P. Exs. 1 and 2, may be construed as a request that I grant equitable relief, I have no authority to do so. *US Ultrasound*, DAB No. 2302 at 8 (2010). I am required to follow the Act and regulations and have no authority to declare statutes or regulations invalid. *1866ICPayday.com, L.L.C.*, DAB No. 2289 at 14 (2009).

III. Conclusion

For the foregoing reasons, the Medicare enrollment and billing privileges of Petitioners are revoked pursuant to 42 C.F.R. § 424.535(a)(8)(i), effective December 10, 2016.

/s/
Keith W. Sickendick
Administrative Law Judge