Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Urology Group of NJ, LLC
(NPI: 1154579647),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-16-786

Decision No. CR4878

Date: July 5, 2017

DECISION

Petitioner, Urology Group of NJ, LLC, is a medical practice. Petitioner's Medicare enrollment and billing privileges were deactivated on April 5, 2016, as a result of its failure to timely provide enrollment information in response to a request that it update its enrollment information. Petitioner's billing privileges were subsequently reactivated effective April 28, 2016, the day a Medicare administrative contractor, Novitas Solutions (Novitas or "the contractor"), received Petitioner's enrollment application to reactivate its billing privileges. Petitioner has appealed the contractor's assignment of an April 28, 2016 effective date for the reactivation of its billing privileges, asserting that the 23-day gap in billing privileges resulted in a "nearly one million dollar loss" in anticipated Medicare payments. For the reasons discussed below, I conclude that the effective date of Petitioner's reactivated billing privileges remains April 28, 2016.

I. Background

One of Petitioner's owners, Dr. Yitzhak Berger, died on October 18, 2015. Centers for Medicare & Medicaid Services (CMS) Exhibit (Ex.) 2 at 3; *see* CMS Ex. 1 at 2. In

December 2015, the Social Security Administration provided notice of Dr. Berger's passing to Novitas. CMS Ex. 1 at 2. On December 9, 2015, Novitas mailed a letter to Petitioner informing it that Novitas had learned of Dr. Berger's passing and requesting that Petitioner "submit a [Form] CMS 855B change request to delete this individual as a Partner."[1] CMS Ex. 3 at 1. The letter explained that pursuant to 42 C.F.R. § 424.540(a)(2), Petitioner was required to submit this information within 90 calendar days of the date of the letter to avoid deactivation of Medicare billing privileges. CMS Ex. 3 at 1. The letter further explained that, pursuant to 42 C.F.R. § 424.516, Petitioner is required to "submit updates and changes to [its] enrollment information in accordance with specified timeframes," and those changes include changes in ownership. CMS Ex. 3 at 1-2.

After Petitioner did not submit a response to the December 2015 letter, Novitas sent another letter, dated April 5, 2016, informing Petitioner that its Medicare enrollment had been deactivated because Petitioner had not submitted the requested information regarding its change in ownership. CMS Ex. 4 at 1; *see* CMS Ex. 1 at 3.

On April 25, 2016, Petitioner submitted a Form CMS-855B, along with a cover letter explaining that it wished to remove five partners from its enrollment record, to include Dr. Berger.[2] CMS Ex. 5 at 1. Novitas received the submission on April 28, 2016. CMS Ex. 5 at 2.

Novitas approved Petitioner's reactivation enrollment application on May 10, 2016, and assigned an effective date of reactivated enrollment and billing privileges of April 28, 2016. CMS Ex. 6 at 1-2.

Petitioner submitted a request for reconsideration of the effective date assigned for its reactivated enrollment and billing privileges on June 14, 2016 (CMS Ex. 2), at which time its president, Alan P. Krieger, M.D., alleged that Petitioner did not receive either the December 9, 2015 and April 5, 2016 letters. CMS Ex. 2 at 3-4. Petitioner argued that "[a]lthough Novitas did not provide its reasoning for determining the reactivation effective date, based on the established April 28, 2016 date it is evident that Novitas was following CMS' policy guidance in Section 15.27.1.2 of Chapter 15 of the Medicare

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[1] Novitas had previously informed Petitioner, on July 30, 2014, that "[t]o maintain an active enrollment status in the Medicare Program, regulations found at 42 [C.F.R. §] 424.516 require submittal of any changes or updates to your enrollment information in accordance with specified timeframes," to include changes in ownership. CMS Ex. 8 at 1 (emphasis omitted).

[2] Tracking information via the U.S. Postal Service website indicates that Petitioner mailed the application via first class mail on April 25, 2016, and it was received on April 28, 2016. *See* CMS Ex. 5 at 2.

Program Integrity Manual ("MPIM")." CMS Ex. 2 at 4. Petitioner further argued that "CMS' interpretive manual guidance conflicts with and violates the Medicare regulations at 42 C.F.R. § 424.540(c)." CMS Ex. 2 at 4.

Novitas issued a letter on July 28, 2016, in which it denied Petitioner's request for reconsideration. CMS Ex. 7. Novitas explained that Petitioner did not provide the requested information updating its ownership information within 90 days of the death of Dr. Berger, as required by 42 C.F.R. § 424.540(a)(2). CMS Ex. 7 at 2.

Petitioner submitted a request for hearing that was received at the Civil Remedies Division on August 2, 2016. CMS filed a pre-hearing brief and motion for summary judgment (CMS Br.), along with eight exhibits (CMS Exs. 1 - 8). Petitioner filed a response brief and response to CMS's motion for summary judgment (P. Br.) and nine exhibits (Petitioner Exhibits (P. Exs.) 1 - 9). In the absence of any objections, I admit CMS Exs. 1 - 8 and P. Exs. 1 - 9 into the record.

CMS has offered the written direct testimony of Robin Fry, a Novitas Provider Relations Hearing Specialist, and Petitioner has submitted the written direct testimony of Dr. Krieger. Neither party has requested an opportunity to cross-examine the opposing party's witness. A hearing for the purpose of cross-examination of witnesses is therefore unnecessary. *See* Acknowledgment and Pre-Hearing Order §§ 8, 9, and 10. I consider the record in this case to be closed, and the matter is ready for a decision on the merits.[3]

II. Issue

Whether CMS had a legitimate basis for establishing April 28, 2016, as the effective date of the reactivated billing privileges for Petitioner.

III. Jurisdiction

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

IV. Findings of Fact, Conclusions of Law, and Analysis[4]

1. One of Petitioner's owners, Dr. Yitzhak Berger, died on October 18, 2015.

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

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

2. ***On December 9, 2015, after learning of Dr. Berger's death, Novitas mailed a letter directing Petitioner to update its ownership information on its enrollment record.***

3. ***After Petitioner did not update its enrollment information, Novitas notified Petitioner that it had deactivated its Medicare enrollment and billing privileges, effective April 5, 2016.***

4. ***Petitioner submitted an enrollment application to reactivate its enrollment on April 28, 2016.***

5. ***An effective date earlier than April 28, 2016, is not warranted for the reactivation of Petitioner's Medicare enrollment and billing privileges.***

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

CMS is authorized to deactivate an enrolled supplier's Medicare billing privileges if the enrollee fails to report certain changes of information, such as a change in ownership, within 90 days of when the change occurred, or does not provide complete and accurate information within 90 days of a request for such information. 42 C.F.R. § 424.540(a)(2), (3). If CMS deactivates a supplier's Medicare billing privileges, "[n]o payment may be made for otherwise Medicare covered items or services furnished to a Medicare beneficiary." 42 C.F.R. § 424.555(b). The regulation authorizing deactivation explains that "[d]eactivation of Medicare billing privileges is considered an action to protect the provider or supplier from misuse of its billing number and to protect the Medicare Trust Funds from unnecessary overpayments." 42 C.F.R. § 424.540(c).

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

Novitas deactivated Petitioner's billing privileges after it notified Petitioner that it was aware of the death of one of Petitioner's owners and Petitioner failed to respond to its request that Petitioner update its enrollment information. CMS Exs. 1, 3. More than six months after Dr. Berger's passing, and more than four months after Novitas requested that Petitioner submit updated enrollment information, Petitioner submitted an enrollment application that Novitas received on April 28, 2016. CMS Exs. 3 at 1; 5 at 1-2. Novitas accepted Petitioner's application, and reactivated its billing privileges and assigned a new PTAN, effective April 28, 2016. CMS Ex. 6.

The pertinent regulation with respect to the effective date of reactivation is 42 C.F.R. § 424.520(d). *Arkady B. Stern, M.D.*, DAB No. 2329 at 4 (2010). Section 424.520(d) states that "[t]he effective date for billing privileges . . . is the later of – (1) [t]he date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor; or (2) [t]he date that the supplier first began furnishing services at a new practice location." The Departmental Appeals Board (DAB) has explained that the "date of filing" is the date "that an application, however sent to a contractor, is actually received." *Alexander C. Gatzimos, MD, JD, LLC*, DAB No. 2730 at 5 (2016) (emphasis omitted). In the instant case, the date of filing is April 28, 2016, the date Novitas received the new enrollment application.

While Petitioner feels that my analysis is lacking in another decision in which I upheld the effective date of reactivated billing privileges, I will nonetheless rely on a similar analytical framework in concluding that Novitas correctly determined that the effective date of Petitioner's reactivated billing privileges is April 28, 2016. *See* P. Br. at 6 (stating, in response to CMS's discussion of my previous decision in *Paramjit Fagoora, M.D.*, DAB No. CR4703 (2016), that "the cases cited by CMS do not reflect the in-depth legal analysis presented [by Petitioner] and, therefore, should not be considered either persuasive or controlling.").

While Petitioner's failure to respond to a request for information resulted in an approximately three-week lapse in its billing privileges that it alleges resulted in a "nearly one million dollar loss" in anticipated Medicare payments (P. Br. at 7),[5] only a

[5] Elsewhere in its brief, Petitioner reports a loss of approximately $821,000 resulting from the period of deactivation. P. Br. at 4.

few years ago such a failure to respond to a request for information could have resulted in a revocation of billing privileges and an enrollment bar for a minimum of one year. 42 C.F.R. § 424.535(b), (c) (2010) (stating that "[w]hen a provider's or supplier's billing privilege is revoked any provider agreement in effect at the time of revocation is terminated effective with the date of revocation" and "[a]fter a . . . supplier . . . has had their billing privileges revoked, they are barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar," which is a minimum of one year and no more than three years.). The Secretary's former authority to revoke billing privileges and establish a re-enrollment bar was implemented through a final rule published on June 27, 2008, and the regulatory amendment had a stated purpose "to prevent providers and suppliers from being able to immediately re-enroll in Medicare after their billing privileges were revoked." 76 Fed. Reg. 65,909, 65,912 (October 24, 2011), citing 73 Fed. Reg. 36,448. When the Secretary later determined, in subsequent rulemaking, that this basis for revocation and a re-enrollment bar should be eliminated through removing the pertinent language in 42 C.F.R. § 424.535(c), the Secretary's final rule explained:

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

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

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

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

> We proposed to add a new § 424.540(a)(3) that would allow us to deactivate, rather than revoke, the Medicare billing privileges of a provider

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

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

Although section 424.540(a)(3) indicates that the deactivation does not have any effect on the supplier's participation agreement or conditions of participation, deactivation nonetheless may cause "adverse consequences," most significantly, the loss of billing privileges. The effective date of reactivation of billing privileges is governed by 42 C.F.R. § 424.520, "Effective date of Medicare billing privileges," which states, in pertinent part, that the effective date for billing privileges, as applicable to this case, is "[t]he date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor." 42 C.F.R. § 424.520(d)(1). The July 28, 2016 reconsidered determination was consistent with 42 C.F.R. § 424.520(d) in its determination that the effective date of Petitioner's reactivated billing privileges was correctly determined to be April 28, 2016. CMS Ex. 7 at 2. Novitas correctly applied section 424.520(d), and an effective date earlier than April 28, 2016 is not warranted. CMS Ex. 7 at 2.

Petitioner argues that CMS's policy to base the effective date of reactivated billing privileges on the date of the enrollment application that is submitted for purposes of reactivation "is wholly inconsistent with the Medicare statute and the entire body of Medicare regulations . . . " Petitioner devotes much argument to this point, contending at

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[6] A supplier such as Petitioner is not subject to conditions of participation. *See* 42 C.F.R. pts. 482 and 485.

length that Section 15.27.1.2 of the Medicare Program Integrity Manual (MPIM), which is internal policy guidance to Medicare administrative contractors, is invalid and does not comport with the controlling regulations. P. Br. at 4-13. However, in upholding CMS's assignment of an April 28, 2016 effective date for Petitioner's reactivated billing privileges, it is unnecessary for me to look to the MPIM. Rather, the relevant regulations, 42 C.F.R. §§ 424.520(d)(1) and 424.540(c), are dispositive without the need to further rely on sub-regulatory CMS polices, as supported by the aforementioned analysis of relevant rulemaking.

The DAB has reached a similar conclusion without the need for any reliance on MPIM provisions. In addressing nearly identical issues as presented here, the DAB determined that "CMS correctly determined the effective date as required by the applicable law" in an instance in which the Medicare administrative contractor treated the filing of an April 31, 2015 Medicare enrollment application as an application to reactivate billing privileges that had been deactivated due to inactivity. *Willie Goffney, Jr., M.D.*, DAB No. 2763 at 1-2 (2017). In its decision, the DAB recognized the differences between revocation and deactivation, stating:

> Deactivation also differs from revocation in several ways, particularly in that revocation terminates a Medicare provider or supplier agreement and requires imposition of an enrollment bar of at least one year, neither of which occurs with deactivation. *Compare* 42 C.F.R. § 424.535(a), (b), (c) with § 424.540(c).

Willie Goffney, Jr., M.D., DAB No. 2763 at 3. The DAB further discussed that a deactivation action is not reviewable, and "[t]he only action in the reconsidered determination which is appealable is thus the initial determination of the effective date of the enrollment application reinstating [the petitioner]."[7] *Willie Goffney, Jr., M.D.*, DAB No. 2763 at 3-5. With respect to the August 31, 2015 effective date assigned for Dr. Goffney's reactivated billing privileges, which was the same date Dr. Goffney submitted the enrollment application that was accepted as a reactivation application, the DAB explained:

[7] The DAB also explained: "Moreover, neither [42 C.F.R. §] 424.545(b) nor any other regulation provides appeal rights from the contractor's deactivation determination or any rebuttal determination. *See also Arkady B. Stern, M.D.*, DAB No. 2417 at 3 n.4 (2011) (Petitioner argues on appeal that deactivation was improper, but the DAB "does not have the authority to review" deactivation under circumstances of this case, *citing* 42 C.F.R. §§ 424.545(b) and 498.3(b)); *Andrew J. Elliott, M.D.*, DAB No. 2334 at 4 n.4 (2010) (DAB "does not have authority to review" a deactivation)." *Willie Goffney, Jr., M.D.*, DAB No 2763 at 5.

> The governing law on how CMS (and its Medicare contractors) determine the effective date for physicians applying for Medicare billing privileges is set by regulation as follows:
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> > The effective date for billing privileges for physicians . . . is the later of . . . [t]he date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor; or . . . [t]he date that [an enrolled physician] . . . first began furnishing services at a new practice location.
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> 42 C.F.R. § 424.520(d). The date on which the approved application was filed was August 31, 2015, and Petitioner asserts that he had long been providing services at the same practice location. [internal citation omitted] Therefore, as the ALJ correctly concluded, the only date on which billing privileges arising from the approved application could become effective is August 31, 2015.

Willie Goffney, Jr., M.D., DAB No. 2763 at 7. As such, the DAB determined that the ALJ had properly granted summary judgment because August 31, 2015, the date of the application, "was the earliest possible effective date for Petitioner's reactivation." *Willie Goffney, Jr., M.D.*, DAB No. 2763 at 1. Further, and quite significantly, the DAB unambiguously stated that "[i]t is certainly true that [the petitioner] may not receive payment for claims for services during any period when his billing privileges were deactivated." *Willie Goffney, Jr., M.D.*, DAB No. 2763 at 6. The circumstances of the *Goffney* case are nearly indistinguishable from the instant case, in that Petitioner's billing privileges were deactivated and CMS determined that the effective date of Petitioner's reactivated billing privileges should be the date Petitioner submitted the Medicare enrollment application that served to reactivate its billing privileges. While Petitioner argues, at length, that CMS and its contractor relied on internal policy that contradicts the controlling regulations, I note that the *Goffney* decision does not rely on any sub-regulatory policy, but rather, is based on a correct interpretation of 42 C.F.R. §§ 424.520(d) and 424.540(c).

Petitioner also argues, unpersuasively, that the deactivation of its billing privileges was contrary to 42 C.F.R. § 424.540(c) because the regulation states that deactivation "does not have any effect on a provider or supplier's participation agreement or any conditions of participation." P. Br. at 8. As relevant here, a physician or supplier's participation agreement is triggered by the *physician or supplier's submission* of a Form CMS-460. By submitting a Form CMS-460, a physician or supplier agrees to be a "participant" in the Medicare program and "to accept assignment of the Medicare Part B payment for all services for which the participant is eligible to accept assignment under the Medicare law and regulations . . . " Form CMS-460. In agreeing to participate in the Medicare program, the physician or supplier also agrees that it "shall not collect from the

beneficiary or other person or organization for covered services more than the applicable deductible and coinsurance." Form CMS-460. Contrary to Petitioner's interpretation of a physician or supplier agreement, nothing in the language on the face of a Form CMS-460 binds CMS or its contractors to reimburse the physician or supplier for every service provided to a Medicare beneficiary.[8] In fact, neither CMS nor the contractor is a signatory to a participation agreement. It is quite logical why the deactivation of billing privileges would not impact a participation agreement, in that a lapse in billing privileges would not be determinative of whether a physician or supplier would nonetheless desire to continue as a participant in the Medicare program and abide by its terms once its enrollment and billing privileges are reactivated.

To the extent that it appears that Petitioner argues that CMS should be required to prove that Petitioner actually received the December 9, 2015 and April 5, 2016 letters, it is mistaken. *See* P. Br. at 15. Petitioner contends that it did not receive either of the December 9, 2015 or April 5, 2016 letters. *See* P. Ex. 9. Based on the presumption of regularity, I presume that employees of CMS's Medicare administrative contractor have performed their ministerial duties. *See, e.g.*, *Miley v. Principi*, 366 F. 3d 1343, 1347 (Fed. Cir. 2004) (holding, in a case involving the mailing of a decision to a claimant for benefits, that the presumption of regularity "provides that, in the absence of clear evidence to the contrary, the court will presume that public officers have properly discharged their official duties"); *U.S. Postal Serv. v. Gregory*, 534 U.S. 1, 10 (2001) (discussing that the presumption of regularity attaches to actions of government agencies); *U.S. v. Chemical Foundation, Inc.*, 272 U.S. 1, 14-15 (1926) (creating presumption that government officials and agents have properly discharged duties in the absence of "clear evidence to the contrary"). Petitioner's allegations that it has been unable to locate either letter are insufficient to rebut the presumption that Novitas mailed each letter to the address listed on the letter.

Petitioner also contends that CMS contractors "routinely approve an effective date for the new PTAN that is 30 days prior the date the application that had been processed was received," and that Novitas should have granted an effective date of March 29, 2016, for its reactivated billing privileges based on the application of 42 C.F.R. § 424.521(a)(1). P. Br. at 14. Petitioner is correct that although an effective date is set in accordance with 42 C.F.R. § 424.520(d), CMS or its contractor *may* permit retrospective billing for 30 days prior to the effective date if "circumstances precluded enrollment in advance of providing services to Medicare beneficiaries." 42 C.F.R. § 424.521(a)(1). Petitioner has made no assertion in its brief that any circumstance *precluded* it from reactivating its enrollment in advance of providing services to Medicare beneficiaries. As Petitioner has

[8] Petitioner has not submitted a copy of its participation agreement, and therefore, I rely on a generic Form CMS-460 to discuss the content of a participation agreement. *See https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS460.pdf* (last visited June 14, 2017).

not asserted that it was precluded from submitting the updated enrollment application prior to rendering services in the six months following the death of one of its owners, I see no basis to consider whether CMS or its contractor should have exercised discretion to grant a 30-day retrospective billing period in accordance with section 424.521(a)(1).[9]

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

In the absence of any basis to grant an earlier date for the reactivation of billing privileges, the April 28, 2016 effective date for the reactivation of Petitioner's billing privileges must stand.

V. Conclusion

I uphold the April 28, 2016 effective date of the reactivation of Petitioner's Medicare billing privileges.

/s/
Leslie C. Rogall
Administrative Law Judge

[9] In fact, regardless of the contractor's request that Petitioner update its enrollment information following the death of Dr. Berger, Petitioner was required to update its enrollment information to report its change of ownership and did not timely do so. *See* 42 C.F.R. §§ 424.516(d), 424.535(a)(9). While Petitioner sustained a "nearly one million dollar loss" as a result of the relatively short gap in its billing privileges (P. Br. at 7), CMS and its contractor exercised restraint by not revoking Petitioner's enrollment and billing privileges and imposing a re-enrollment bar.