

DEPARTMENTAL APPEALS BOARD
Appellate Division

Judith E. Wessely, CNS
Docket No. A-18-103
Decision No. 2909
November 19, 2018

**FINAL DECISION ON REVIEW OF
ADMINISTRATIVE LAW JUDGE DECISION**

Judith E. Wessely, CNS (Petitioner) appeals the May 16, 2018 Administrative Law Judge decision, *Judith E. Wessely CNS*, DAB CR5101 (ALJ Decision). The ALJ granted summary judgment in favor of the Centers for Medicare & Medicaid Services (CMS), upholding the decision to deny Petitioner's revalidation application for enrollment in Medicare as a clinical nurse specialist (CNS). The ALJ determined that the undisputed facts established that Petitioner did not meet the CNS certification requirement at 42 C.F.R. § 410.76(b)(3) or an exception to that requirement and, consequently, CMS had a legal basis to deny Petitioner's enrollment pursuant to 42 C.F.R. § 424.530(a)(1). The ALJ also denied Petitioner's argument that she was entitled to equitable relief.

For the reasons discussed below, we affirm the ALJ Decision.

Legal Background

1. *Medicare supplier enrollment and appeals*

Medicare Part B, the Supplementary Medical Insurance program, provides payment for covered physician, non-physician practitioner and other health services. *See* Social Security Act (Act) §§ 1831, 1832, 1833.¹ CMS administers the Medicare program and delegates certain functions to Medicare administrative contractors. Act § 1816, 1842, 1874A; 42 C.F.R. § 421.5(b).²

¹ The current version of the Act can be found at http://www.socialsecurity.gov/OP_Home/ssact/ssact-toc.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross-reference table for the Act and the United States Code can be found at https://www.ssa.gov/OP_Home/comp2/G-APP-H.html.

² Unless stated otherwise, we cite to the regulations in effect on May 31, 2017, the date of Novitas Solutions' initial decision to deny Petitioner's enrollment (revalidation). CMS Ex.1, at 11-12; *cf. John P. McDonough III, Ph.D.*, DAB No. 2728, at 2 n.1 (2016) and *John M. Shimko, D.P.M.*, DAB No. 2689, at 1 n.1 (2016) (the regulations in effect on the date of the initial determination to revoke control).

Physicians, non-physician practitioners – including CNSs – and other health care “suppliers” must enroll and maintain active enrollment status in Medicare to bill the program for covered services furnished to Medicare beneficiaries.³ Act § 1866(j)(1) (requiring Secretary of Health and Human Services to issue regulations that establish a process for providers and suppliers to enroll in Medicare); 42 C.F.R. §§ 424.500, 424.505, 424.510, 424.515, 424.516.

The requirements for providers and suppliers to establish and maintain Medicare billing privileges are set out in 42 C.F.R. Part 424, subpart P. The regulations define “enrollment” as the process that Medicare uses to establish a provider’s or supplier’s eligibility to submit claims for Medicare-covered services and supplies. *Id.* § 424.502 (defining “Enroll/Enrollment”). The enrollment process includes “validating the provider or supplier’s eligibility to provide items or services to Medicare beneficiaries[.]” *Id.* To maintain Medicare billing privileges, a provider or supplier must periodically resubmit and recertify the accuracy of its enrollment information. *Id.* § 424.515. Part of the revalidation process involves the submission of an enrollment application. *Id.* § 424.515(a).

CMS may deny a supplier’s enrollment if the supplier is not in compliance “with the enrollment requirements in [42 C.F.R. Part 424] subpart P or in the enrollment application applicable for its . . . supplier type” 42 C.F.R. § 424.530(a)(1). “Deny/Denial means the enrolling provider or supplier has been determined to be ineligible to receive Medicare billing privileges for Medicare covered items or services provided to Medicare beneficiaries.” *Id.* § 424.502.

A supplier may seek reconsideration of an initial determination to deny enrollment. 42 C.F.R. §§ 498.5(l)(1), 498.22(a). A supplier may appeal an unfavorable reconsidered determination to an ALJ, and an unfavorable ALJ decision to the Board. 42 C.F.R. § 498.5(l)(2), (3); Act § 1866(j)(8) (establishing that a “provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) . . . is denied may have a hearing and judicial review of such denial”).

³ Section 400.202 of the Medicare regulations provides that, unless the context indicates otherwise, “[s]upplier means a physician or other practitioner, or an entity other than a provider that furnishes health care services under Medicare.” “Providers” include, *inter alia*, hospitals, nursing facilities, and comprehensive outpatient rehabilitation facilities. *Id.*

2. *Medicare payment for CNS services*

Beginning in 1991, Congress provided for Medicare to make separate payments for CNS services when furnished in rural areas and in collaboration with physicians. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4155, 104 Stat. 1388-86 (Coverage of Nurse Practitioners in Rural Areas). Effective for services furnished on or after January 1, 1998, Congress removed the restriction on setting, authorizing CNSs to bill Medicare Part B directly for services furnished in any location by a CNS working in collaboration with a physician, so long as no facility or other provider charges or was paid in connection with the service.⁴ Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4511, 111 Stat. 251, 442 (1997) (codified at Act § 1861(s)(2)(k)(ii)).

3. *CNS Medicare requirements*

Consistent with the legislation, in 1998 CMS issued a regulation at 42 C.F.R. § 410.76(b) setting out the qualifications for Medicare Part B coverage of a CNS's services. The regulation provides that a CNS must --

- (1) Be a registered nurse who is currently licensed to practice in the State where he or she practices and be authorized to perform the services of a clinical nurse specialist in accordance with State law;
- (2) Have a master's degree in a defined clinical area of nursing from an accredited educational institution or a Doctor of Nursing Practice (DNP) doctoral degree; and
- (3) Be certified as a clinical nurse specialist by a national certifying body that has established standards for clinical nurse specialists and that is approved by the Secretary.^[5]

The national certifying bodies approved by the Secretary are listed in the Medicare Benefit Policy Manual (MBPM), CMS Pub. 100-02, Chapter 15, Section 210, and the Medicare Program Integrity Manual (MPIM), CMS Pub. 100-08, Chapter 15, section 15.4.4.5.

⁴ Section 1861(aa)(5)(B) of the Act defines "clinical nurse specialist" to mean an individual who (1) "is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed"; and (2) "holds a master's degree in a defined clinical area of nursing from an accredited educational institution."

⁵ Subsection (3) initially provided that the CNS must be certified as a clinical nurse specialist by the American Nurses Credentialing Center. 42 C.F.R. § 410.76(b) (1999); 63 Fed. Reg. 58,814, 58,908-58,909 (Nov. 2, 1998). CMS subsequently amended the regulation to eliminate the reference to the American Nurses Credentialing Center. 42 C.F.R. § 410.76(b)(3) (2003); 67 Fed. Reg. 79,966, 80,041 (Dec. 31, 2002).

Case Background

By letter dated May 31, 2017, Novitas Solutions (Novitas), a Medicare administrative contractor, denied Petitioner's Medicare revalidation application for enrollment as a CNS, stating that Petitioner did not meet the requirements in 42 C.F.R. § 410.76 because she was "NOT CERTIFIED." CMS Ex. 1, at 11 (emphasis in original). Petitioner requested reconsideration. *Id.* at 9-10.

On October 25, 2017, Novitas issued a reconsidered determination sustaining the denial of Petitioner's enrollment as a CNS. CMS Ex. 1, at 1-2. The determination stated that the "Denial Reason" was "42 C.F.R. § 424.530(a)(1) - Not in Compliance with Medicare Requirements." *Id.* at 1. Novitas stated that, on reconsideration, it was "unable to revalidate" Petitioner "in the Medicare program as a clinical nurse specialist" because she was "not certified as a clinical nurse specialist by a recognized national certifying body," as required under section 410.76(b)(3). *Id.* at 2. Novitas further stated that Petitioner's request for reconsideration asserted that "CMS Manual System Transmittal 75, Section 210 . . . specifically exempts from the 42 CFR 410.76(b) requirements" CNSs "who were issued billing numbers prior to January 1, 1998" and that Petitioner "is exempted from the 42 CFR 410.76(b) requirement . . ." *Id.* (citing Request for Reconsideration). Novitas stated that Petitioner "was issued a billing provider number effective June 1, 1999," after the cutoff date. *Id.* Accordingly, Novitas sustained the denial of Petitioner's enrollment.

Petitioner requested an ALJ hearing to contest the reconsidered determination.

The ALJ Proceedings and Decision

On Petitioner's request for an ALJ hearing, the parties filed cross-motions for summary judgment, asserting that there was no dispute of material fact relating to Petitioner's Medicare enrollment.

The ALJ excluded from evidence Petitioner's exhibits 1 through 3, which he characterized as "letters describing the excellent mental health services Petitioner has provided in the past." ALJ Decision at 2. The ALJ stated that CMS objected to the exhibits on the grounds that Petitioner submitted them "in support of a request for equitable relief"; they were "not relevant to the issue of whether there is a basis for denial of enrollment"; and "Petitioner [had] not shown good cause for offering those exhibits for the first time before" him. *Id.*; see 42 C.F.R. § 498.56(e). The ALJ stated that his review of the case was limited to whether CMS and Novitas "had a basis to deny Petitioner's

enrollment in Medicare.” ALJ Decision at 2. The ALJ excluded Petitioner’s exhibits 1 through 3 on the ground that they were not relevant to that issue, and he concluded that it was not necessary for him “to analyze the other grounds for exclusion of the evidence cited by CMS.” *Id.*

The ALJ granted summary judgment in favor of CMS because, he concluded, there was “no genuine dispute of material fact that Petitioner failed to satisfy the [certification] requirement of 42 C.F.R. § 410.76(b)(3) and the exception to that requirement does not apply.” ALJ Decision at 6. The ALJ noted that Petitioner did not dispute that “she is not certified as a clinical nurse specialist by a ‘recognized national certifying body,’ which is required by 42 C.F.R. § 410.76(b)(3).” *Id.* at 7. Rather, Petitioner argued that she was exempt from the requirement. To support that argument, Petitioner cited MBPM, Chapter 15, Section 210, which provides in part that “CNSs who were issued billing provider numbers prior to January 1, 1998, may continue to furnish services under the CNS benefit.” *Id.* at 7. The ALJ determined that Petitioner “failed to present evidence from which [he could] infer that she was issued a billing provider number prior to January 1, 1998.” *Id.* at 6. The ALJ therefore concluded that, as a matter of law, Petitioner was “not exempt from the application of 42 C.F.R. § 410.76(b)(3) under [MBPM], CMS Pub. 100-02, chap. 15, § 210,” and “there is a basis for denial of Petitioner’s enrollment and billing privileges pursuant to 42 C.F.R. § 424.530(a)(1) for noncompliance with 42 C.F.R. § 410.76(b)(3).” *Id.* at 9.

The ALJ additionally determined that Petitioner was not entitled to equitable relief. “Petitioner’s arguments,” the ALJ explained, “may be construed to be that the government is estopped from denying Petitioner’s enrollment based on [a] prior contractor’s decision to enroll Petitioner in 2011.” *Id.* at 9. The ALJ noted that the evidence showed that in 2011, a “prior Medicare contractor” approved a corrective action plan filed by Petitioner in response to a denial of her earlier application to revalidate her enrollment. *Id.* at 8-9 (citing CMS Ex. 1, at 20-22). The ALJ stated that he accepted that the contractor notice supported a favorable inference that the contractor did not apply section 410.76(b)(3) to Petitioner at the time; however, the ALJ stated, he could not infer that the contractor chose not to apply the regulation on the ground that it found that Petitioner was enrolled in Medicare prior to January 1, 1998 and therefore excepted from the regulation. *Id.* at 9. The ALJ further explained that estoppel against the federal government, if available at all, may not be imposed absent “affirmative misconduct,” and there was no evidence suggesting misconduct on the part of the Medicare contractor. *Id.* (citations omitted). Lastly, the ALJ stated that he had no authority to grant equitable relief and was “required to follow the Act and regulations.” *Id.* (citations omitted).

Standard of Review

Whether summary judgment is appropriate is a legal issue that we address *de novo* viewing the facts in the light most favorable to Petitioner and giving her the benefit of all reasonable inferences. *1866ICPayday.com, L.L.C.*, DAB No. 2289, at 2-3 (2009) (citing *Lebanon Nursing & Rehab. Ctr.*, DAB No. 1918 (2004)). Summary judgment is appropriate when there is no genuine dispute about a fact or facts material to the outcome of the case and the moving party is entitled to judgment as a matter of law. *Id.* (citing *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986)).

The Board's standard of review on a disputed conclusion of law is whether the ALJ's decision is erroneous. *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program (Guidelines)*, accessible at <https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/enrollment/index.html>.

Analysis

On appeal to the Board, Petitioner does not contest the ALJ's conclusion that there is no genuine dispute of material fact that she did not and does not meet the certification requirement of 42 C.F.R. § 410.76(b)(3). Petitioner instead argues that: (1) she should be exempted from the requirement; and (2) the "ALJ erred in refusing to consider the unique equitable concerns in this matter" and in excluding her proposed exhibits supporting her arguments for equitable relief. Request for Review (RR) at 2-3.⁶

Below, we explain the Board's role in this matter and why we conclude that CMS had a valid legal basis to deny Petitioner's enrollment pursuant to sections 424.530(a)(1) and 410.76(b)(3). We next discuss why we reject Petitioner's argument that she should be exempted from the certification requirement. Finally, we explain why we reject Petitioner's argument that she is entitled to equitable relief.

⁶ We note that Petitioner submitted to the Board copies of her July 5, 2018 letters to two U.S. Senators and a Congressman that Petitioner says recount the history of mental health services she has provided to Medicare beneficiaries, many of whom are in "oft-neglected retirement communities" and would not have had access to such services but for her willingness to provide home-based therapy services. RR at 4 & 4 n.3. In provider and supplier enrollment appeals, the Board is barred by regulation from considering evidence not submitted at the reconsideration or ALJ levels of review. 42 C.F.R. § 498.86(a). Even if the Board could admit and consider the letters, they, like Petitioner's exhibits 1, 2, and 3 excluded by the ALJ, are irrelevant to the central issue presented here.

1. *CMS had a valid legal basis to deny Petitioner's enrollment pursuant to 42 C.F.R. § 424.530(a)(1) because the undisputed facts establish that Petitioner did not meet the CNS certification requirement at 42 C.F.R. § 410.76(b)(3).*

The central question before the ALJ, and in turn, the Board, in an appeal of a Medicare provider or supplier enrollment denial is whether CMS had a valid legal basis for the denial. “[W]here CMS is legally authorized to deny an enrollment application,” the Board has explained, “neither an ALJ nor the Board itself is empowered to substitute for CMS or its contractor in determining *how* to exercise its discretion.” *Ronald Paul Belin, DPM*, DAB No. 2629, at 5 (2015) (emphasis in decision); *cf. Jason R. Bailey, M.D., P.A.*, DAB No. 2855, at 15 (2018) (“In provider/supplier revocation cases, ALJs and the Board are limited to determining whether CMS had a basis to revoke the provider’s or supplier’s Medicare enrollment and billing privileges.”); *Care Pro Home Health, Inc.*, DAB No. 2723, at 5 (2016) (“In reviewing a revocation determination, an ALJ or the Board is limited to deciding whether CMS had a valid ‘legal basis’ for that action.”) (citations omitted).

Applying the plain language of 42 C.F.R. §§ 424.530(a)(1) and 410.76(b) to the undisputed facts in this case, we conclude that CMS lawfully denied Petitioner’s revalidation application for enrollment. As noted above, Novitas denied Petitioner’s application based on 42 C.F.R. § 424.530(a)(1), which authorizes CMS (or its contractor) to deny enrollment where the “supplier is determined to not be in compliance with the enrollment requirements in this subpart P or in the enrollment application applicable for its ... supplier type[.]” Here, it is undisputed that Petitioner did not meet all of the enrollment requirements applicable to CNSs. Specifically, Petitioner was not and is not “certified as a clinical nurse specialist by a national certifying body that has established standards for clinical nurse specialists and that is approved by the Secretary,” as required under section 410.76(b)(3). Accordingly, CMS had a valid legal basis to deny Petitioner’s enrollment pursuant to section 424.530(a)(1).

2. *We reject Petitioner's argument that she should be exempted from the certification requirement at 42 C.F.R. § 410.76(b)(3).*

Petitioner contends that she should be exempted from the certification requirement at section 410.76(b)(3). In support of this argument, Petitioner cites MBPM, Chapter 15, section 210, which provides --

Effective for services rendered after January 1, 1998, any individual who is participating under the Medicare program as a clinical nurse specialist (CNS) for the first time ever, may have his or her professional services covered if he or she meets the qualifications [at section 410.76(b)(1)-(3)]

and he or she is legally authorized to furnish CNS services in the State where the services are performed. CNSs who were issued billing provider numbers prior to January 1, 1998, may continue to furnish services under the CNS benefit.

Payment for CNS services is effective on the date of service, that is, on or after January 1, 1998, and payment is made on an assignment-related basis only.

Petitioner characterizes the manual as “set[ting] forth two distinct scenarios.” RR at 2. First, Petitioner says, “for CNS providers who had never serviced Medicare beneficiaries prior to January 1, 1998, they must comply with [the] 42 C.F.R. § 410.76(b) requirements.” *Id.* “As for those CNSs who had obtained a Medicare provider number prior to the effective date of the regulation,” Petitioner continues, “they may continue to be reimbursed by Medicare.” *Id.* Petitioner alleges that her “circumstance falls without these specific scenarios” because she “has been providing CNS services to Medicare recipients and billed for such services through various Medicare-certified facilities as early as 1997.” *Id.* Petitioner says that she “is neither participating under the Medicare program for the first time ever after January 1, 1998, nor did she obtain a provider number prior to the designated cutoff date.” *Id.* Because her “situation is unique and is not contemplated or accounted for by the regulations or MBPM,” Petitioner asserts, she “should be exempted from the 42 C.F.R. § 410.76(b)(3) certification requirements.” *Id.* at 2-3.

Petitioner’s argument does not provide a basis for reversing the denial of her enrollment. Notwithstanding Petitioner’s particular circumstances, the Board is bound by all applicable statutes and regulations. *See, e.g., Meadowmere Emergency Physicians, PLLC*, DAB No. 2881, at 12 (2018). As explained above, our role is limited to determining whether, applying the governing regulations to the undisputed material facts, CMS had a valid legal basis for denying Petitioner’s enrollment. Neither an ALJ nor the Board may substitute their discretion for that of CMS in determining whether a denial of an application for enrollment is appropriate under all of the circumstances. *Cf. Abdul Razzaque Ahmed, M.D.*, DAB No. 2261, at 19 (2009) (“[W]e may not substitute our discretion for that of CMS in determining whether revocation is appropriate under all the circumstances.”), *aff’d*, *Ahmed v. Sebelius*, 710 F. Supp. 2d 167 (D. Mass. 2010). Relevant here, section 410.76(b) plainly requires an individual to satisfy each of three distinct criteria to enroll as a CNS in Medicare. The directive of the regulation is

straightforward and does not provide any exception to those criteria. Consequently, CMS may lawfully deny the enrollment of a CNS who, like Petitioner, fails to meet the certification criterion at section 410.76(b)(3), regardless of any unique, underlying circumstances.

Furthermore, insofar as Petitioner relies on the intent of the MBPM as a basis to exempt her from the CNS certification requirement, that reliance is misplaced. The directives in the MBPM, one of several CMS manuals, constitute sub-regulatory guidance. The manuals provide “day-to-day operating instructions, policies, and procedures” for “CMS program components, providers, contractors, Medicare Advantage organizations and state survey agencies . . . to administer CMS programs.” CMS Introduction to Internet-only Manuals, available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>. “Unlike the Medicare statute and regulations, however, CMS’s instructions to contractors do not have the force and effect of law and are not binding on [ALJs or] the Board.” *Tri-Valley Family Medicine, Inc.*, DAB No. 2358, at 9 (2010) (citing *Fady Fayad, M.D.*, DAB No. 2266, at 9 n.6 (2009) (citing *Mass. Exec. Office of Health and Human Servs.*, DAB No. 2218, at 12 (2008), *aff’d, Massachusetts v. Sebelius*, 701 F. Supp. 2d 182 (D. Mass. 2010)), *aff’d, Fayad v. Sebelius*, 803 F. Supp. 2d 699 (E.D. Mich. 2011); *Foxwood Springs Living Ctr.*, DAB No. 2294, at 8-9 (2009)). Because a manual “does not have the legal authority of the statute and regulations, its instructions must give way to the statute and regulations to the extent of any conflict.” *Conn. Dep’t of Social Servs.*, DAB No. 1982, at 20 (2005). Consequently, the manual cannot be construed to authorize an ALJ or the Board to reverse a lawful determination by CMS to deny a supplier’s enrollment pursuant to 42 C.F.R. §§ 410.76(b) and 424.530(a)(1).

We also note that we cannot reasonably infer from the record evidence that Petitioner’s circumstances indeed fall outside of the first group of CNSs described in the MBPM (to which the regulatory criteria apply), as Petitioner claims. Quoted above, the MBPM provides that any individual who, for services rendered after January 1, 1998, is “*participating under the Medicare program*” as a CNS “for the first time ever” must meet each of the criteria at section 410.76(b)(1)-(3) (emphasis added). Petitioner asserts that she participated in Medicare before January 1, 1998 by providing CNS services to Medicare recipients and receiving payment for those services “as early as 1997.” RR at 2. Under the Act and regulations, however, a Medicare “participating supplier” means a supplier who “enters into an agreement with the Secretary which provides that such . . . supplier will accept payment under” Medicare Part B “on an assignment-related basis,” (that is, to accept the Medicare-approved amount as full payment for covered services), “for all items and services furnished to” Medicare beneficiaries. Act § 1842(h)(1); 42 C.F.R. §§ 400.202, 424.55. Petitioner does not allege that she entered into a Medicare

supplier participation agreement with CMS before January 1, 1998. To the contrary, she stated that before that date she “billed for [her] services through various Medicare-certified facilities,” RR at 2, and the record shows that Petitioner entered into a Medicare supplier agreement as a “new” supplier in November 1998. CMS Ex. 1, at 70.

Consequently, even if Petitioner furnished services to Medicare recipients and received Medicare payment for such services prior to January 1, 1998, we could not reasonably infer that she was “participating” in Medicare at that time, as the term is defined for purposes of administering the program.

Accordingly, we find no merit in Petitioner’s argument that she should be exempted from the certification requirement at 42 C.F.R. § 410.76(b)(3).

3. *The ALJ correctly determined that he had no authority to grant equitable relief to Petitioner; neither does the Board.*

Petitioner argues that the “ALJ erred in refusing to consider the substantial equitable concerns presented in this case” and in excluding the exhibits that she submitted to support her request for equitable relief. RR at 2-3. Petitioner contends that applying the certification requirement in section 410.76(b)(3) to her “creates a circumstance that is so inequitable and unfair that it runs afoul of a notion of justice and fair play.” *Id.* at 3.

Arguing that CMS should be estopped from denying her enrollment, Petitioner says that, because she was granted Medicare enrollment in 2011, “the only logical conclusion was that [the contractor] had assessed [her] eligibilities and concluded that the certification requirement did not apply.” *Id.* Petitioner asserts that she reasonably relied on that decision to conclude that “certification was not necessary for her continued enrollment.”

Id. She therefore “forewent her opportunity to be certified by the American Nursing Credentialing Center,” which, she asserts, is “the only approved certifying body who offered certification examination for psychiatric and mental clinical nurse specialists,” and has since “stopped offering certification examination for [Petitioner’s] discipline.”

Id. Consequently, she says, “it has become literally impossible for [her] to obtain a CNS certification to satisfy the 410.76(b)(3) requirement.” *Id.* Moreover, Petitioner argues that the “duty of consistency requires an agency to be held to the decisions made by its contractor,” and “under the rule of finality, the government is bound by the acts of its authorized officials[.]” *Id.* at 4.

In addition, Petitioner contends that equitable relief is warranted here because she has “provided valuable mental health services to many oft-neglected retirement communities.” RR at 4. “Many of these Medicare recipients would have no access to suitable mental health treatment,” she asserts, but for her “willingness to provide home-based therapy services.” *Id.* She says that the comprehensive mental health services that she provides are “uniquely beneficial to the Medicare program” and that the “denial of her Medicare enrollment will not serve the best interest of the Medicare program.” *Id.*

The ALJ did not err in denying Petitioner’s request for equitable relief or in excluding her related exhibits from the record. In an appeal of a lawful CMS determination affecting a supplier’s Medicare enrollment, neither the ALJ nor the Board has the authority to reverse CMS’s action on equitable grounds. *Donna Maneice, M.D.*, DAB No. 2826, at 7 (2017) (Neither an ALJ nor the Board has authority to reverse an authorized revocation for reasons of equity.) (citing, *inter alia*, *Patrick Brueggeman, D.P.M.*, DAB No. 2725, at 15 (2016) (The ALJ and the Board may not “restore a supplier’s billing privileges on equitable grounds.”)), *reopening denied*, Ruling 2018-1 (Apr. 3, 2018). In addition, the Board has previously explained that CMS is not “precluded by an initial enrollment decision from reviewing the basis for Petitioner’s qualifications on a subsequent revalidation application or new application.” *Marcia M. Snodgrass, APRN*, DAB No. 2646, at 11 (2015) (nurse practitioner did not show that she had a right to expect or was entitled to a guarantee that a particular certificate or degree, apparently accepted for purposes of her enrollment in 2002, would continue to be accepted going forward for revalidation or re-enrollment purposes). Thus, even if a Medicare contractor concluded in 2011 that Petitioner met – or was exempt from – the criteria to enroll in Medicare as a CNS, this would not require CMS to continue to accept that contractor’s conclusion going forward for purposes of Petitioner’s revalidation or re-enrollment.

Moreover, the ALJ correctly stated that estoppel against the federal government, if available at all, requires a showing of “affirmative misconduct” by an agent or agents of the government. ALJ Decision at 9 (citations omitted); *see also Richard Weinberger, M.D.*, and *Barbara Vizey, M.D.*, DAB No. 2823, at 18 (2017) (citing, *inter alia*, *Oaks of Mid City Nursing & Rehab. Ctr.*, DAB No. 2375 at 31 (2011) (citing *Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414, 421 (1990))). Thus, even if Petitioner had relied on the 2011 contractor’s action as a basis not to seek certification in her discipline from the American Nursing Credentialing Center, estoppel would not be warranted because there is no allegation or evidence showing that the prior determination arose from affirmative misconduct by the contractor or any other CMS agent.

Lastly, our role here is not to assess the quality or value of the health care services that Petitioner has provided over the course of her career. Rather, as explained above, the ALJ's and our authority is limited to evaluating whether CMS had a valid legal basis to deny Petitioner's revalidation application for enrollment. Where, as in this case, CMS had legal authority to deny the enrollment application, neither the ALJ nor we may substitute our discretion as to whether denial was appropriate in light of all of the circumstances presented.

Conclusion

Based on the foregoing reasons, the Board affirms the ALJ Decision.

_____/s/
Christopher S. Randolph

_____/s/
Constance B. Tobias

_____/s/
Susan S. Yim
Presiding Board Member