Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Med-Caire, Inc.,
(Supplier No.: 0545010005; NPI: 1336420975),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-227

Decision No. CR3826

Date: May 1, 2015

DECISION

The Medicare enrollment and billing privileges of Petitioner, Med-Caire, Inc. are revoked pursuant to 42 C.F.R. § 424.57(e) and 424.535(a)(1),[1] effective August 8, 2014, based on noncompliance with 42 C.F.R. § 424.57(c)(1) (Supplier Standard 1).

I. Procedural History and Jurisdiction

Petitioner, Med-Caire, Inc., was a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) participating in Medicare. The National Supplier Clearinghouse (NSC), operated by Palmetto GBA (Palmetto), notified Petitioner by letter dated July 9, 2014, that Petitioner's Medicare enrollment was revoked effective May 21, 2014. Centers for Medicare & Medicaid Services (CMS) exhibit (CMS Ex.) 1 at 7-10, 12-15. NSC cited 42 C.F.R. §§ 405.800, 424.57(e), 424.535(a)(1), 424.535(a)(5)(ii), and 424.535(g) as the legal authority for the revocation based on noncompliance with 42 C.F.R. §§ 424.57(c)(1) (Supplier Standard 1 – failure to comply with federal and state

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[1] Citations are to the 2013 revision of the Code of Federal Regulations (C.F.R.), unless otherwise indicated.

licensure and regulatory requirements), 424.57(c)(7) (Supplier Standard 7 – failure to maintain a physical facility on an appropriate site), 424.57(c)(10) (Supplier Standard 10 – failure to have a current liability insurance policy), and 424.57(c)(22) (Supplier Standard 22 – failure to be accredited by a CMS-approved accreditation organization). NSC notified Petitioner that it was subject to a two-year bar to re-enrollment pursuant to 42 C.F.R. § 424.535(c). NSC also advised Petitioner that the effective date of revocation was retroactive to May 21, 2014, the date on which CMS determined that Petitioner's practice location was no longer operational. CMS Ex. 1 at 7, 12.

On August 18, 2014, Petitioner requested reconsideration of the initial determination. CMS Ex. 1 at 11. On September 25, 2014, a reconsideration hearing officer upheld the revocation, concluding that Petitioner was non-compliant with Supplier Standards 1, 7, 10, and 22. CMS Ex. 1 at 1-6.[2]

Petitioner requested a hearing before an administrative law judge (ALJ) on October 28, 2014 (RFH). The case was assigned to me for hearing and decision on November 14, 2014, and an Acknowledgment and Prehearing Order (Prehearing Order) was issued at my direction. No issue has been raised as to the timeliness of Petitioner's request for hearing, the parties do not challenge my authority to decide this case, and I conclude that I have jurisdiction.

On December 15, 2014, CMS filed a motion for summary judgment (CMS Br.) with CMS Exs. 1 through 3. On January 21, 2015, I ordered Petitioner to show good cause why its request for hearing should not be dismissed for abandonment or as a sanction for violation of my Prehearing Order because Petitioner had failed to file its exchange, including a response to the CMS motion and Petitioner's exhibits. Petitioner responded to the order to show cause on January 28, 2015 (P. Response). Petitioner also submitted two documents for my consideration, neither of which was properly marked as an exhibit. CMS filed a reply to Petitioner's response to the order to show cause (CMS OSC Reply). On February 6, 2015, I ruled that Petitioner had not abandoned its request for hearing and no sanction would be imposed. On February 19, 2015, CMS filed another reply to Petitioner's response, which addressed Petitioner's contentions (CMS Reply). Petitioner also filed a reply (P. Reply) to the CMS motion for summary judgment on February 19, 2015.

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[2] The copy of the reconsideration determination CMS submitted as CMS Ex. 1 at 1-6 is missing the second page, which contains the hearing officer's discussion of Supplier Standard number 1 under the section of the determination titled "RATIONALE." A complete copy of the reconsidered determination was filed by Petitioner with its request for hearing. Departmental Appeals Board Electronic Filing System (DAB E-File) Item # 1, "Originating Case Decision" (DAB E-File #1).

Petitioner did not object to my consideration of CMS Exs. 1 through 3 and they are admitted as evidence. CMS objected to my consideration of the documents Petitioner submitted on grounds that Petitioner failed to submit the documents at reconsideration and also because the documents are not relevant to any issue that I may decide. CMS OSC Reply at 1-2. One of the documents is a lease agreement dated August 22, 2013, for 2,000 square feet at 1793 N.W. Maynard Road, Cary, North Carolina, for the period September 1, 2013 through September 30, 2016. CMS offered a copy of the same lease agreement but the copy submitted by CMS (CMS Ex. 1 at 30-46) was unexecuted and did not include the hand-written notes and interlineation contained on the copy Petitioner submitted, which appears to be the executed document. Thus, contrary to the assertion of CMS, Petitioner did submit the lease document at reconsideration, albeit a copy that was incomplete. I conclude that it is appropriate to ensure that the complete document offered by Petitioner is included in the record. I also conclude that the document is relevant to the extent it shows that Petitioner may have established a new location for its DMEPOS location as alleged by Petitioner. Accordingly, the lease agreement offered by Petitioner is admitted and treated as if marked Petitioner's exhibit (P. Ex.) 1. The other document includes copies of Employer's Quarterly Tax and Wage Reports for the State of North Carolina, for the last quarter of 2013 and the first three quarters of 2014. The fact that Petitioner paid payroll taxes to the State of North Carolina is not disputed by CMS. However, the fact that Petitioner paid payroll taxes in North Carolina is not a fact that helps me resolve any issue in dispute in this case. *E.g.*, Fed. R. Evid. 401(b). Accordingly, I conclude that the North Carolina tax records submitted by Petitioner are not relevant and may not be admitted. However, the documents remain with the record and are available for further review if necessary.

II. Discussion

A. Applicable Law

Section 1831 of the Social Security Act (the Act) (42 U.S.C. § 1395j) establishes the supplementary medical insurance benefits program for the aged and disabled known as Medicare Part B. Administration of the Part B program is through contractors, such as Palmetto. Act § 1842(a) (42 U.S.C. § 1395u(a)). Payment under the program for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of services and suppliers.[3] Act §§ 1834(j)(1) (42 U.S.C. § 1395m(j)(1));

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[3] A "supplier" furnishes services and supplies under Medicare. The term supplier applies to physicians or other practitioners and facilities that are not included within the 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
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1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395(u)(h)(1)). Petitioner is a DMEPOS supplier.

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

Pursuant to 42 C.F.R. §§ 424.57 and 424.505, a DMEPOS supplier such as Petitioner must be enrolled in the Medicare program to be reimbursed for durable medical equipment, prosthetics, orthotics, or supplies sold or rented to Medicare beneficiaries. The regulations establish detailed requirements that suppliers must meet and maintain to enroll in Medicare and to receive and maintain Medicare billing privileges. 42 C.F.R. pt. 424, subpt. P. DMEPOS suppliers have additional requirements imposed by 42 C.F.R. § 424.57(b) and (c). To receive direct-billing privileges, a DMEPOS supplier must meet and maintain the Medicare application certification standards set forth in 42 C.F.R. § 424.57(c). Among other requirements, a DMEPOS supplier must maintain a physical facility on an appropriate site. 42 C.F.R. § 424.57(c)(7). An appropriate site for the physical facility must meet certain criteria, including that the practice location be a location accessible to the public, Medicare beneficiaries, and CMS and its agents, and that the practice location must be accessible and staffed during posted hours of operation. 42 C.F.R. § 424.57(c)(7)(i)(B), (C). A DMEPOS supplier must operate and furnish Medicare-covered items in compliance with all applicable federal and state licensure and regulatory requirements. 42 C.F.R. § 424.57(c)(1). A DMEPOS supplier is required to submit completed application and enrollment forms for each separate physical location it uses to furnish DMEPOS, with the exception of warehouses or repair facilities. 42 C.F.R. § 424.57(b)(1). A DMEPOS supplier must provide complete and accurate information in response to questions on its application for Medicare billing privileges and must report to CMS any changes in information supplied on the application within 30 days of the change. 42 C.F.R. §§ 424.57(c)(2); 424.516(c). Additionally, a DMEPOS supplier must permit CMS or its agent to conduct on-site inspections to ascertain supplier compliance with the Medicare enrollment standards. 42 C.F.R. § 424.57(c)(8). Finally, a DMEPOS supplier must at all times be "operational," which means it "has a qualified physical practice location, is open to the public for the purpose of providing health care

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

related services, is prepared to submit valid Medicare claims, and is properly staffed, equipped, and stocked . . . to furnish these items or services." 42 C.F.R. § 424.502.

The Secretary has delegated authority to CMS or its Medicare contractor to revoke an enrolled supplier's Medicare enrollment and billing privileges and any supplier agreement for any of the reasons listed in 42 C.F.R. § 424.535. Noncompliance with enrollment requirements, such as those established by 42 C.F.R. § 424.57(b) and (c) for DMEPOS suppliers, is also a basis for revocation of billing privileges and enrollment in Medicare. 42 C.F.R. §§ 424.57(e); 424.535(a)(1). After a supplier's Medicare enrollment and billing privileges are revoked, the supplier is barred from reenrolling in the Medicare program for one to three years. 42 C.F.R. § 424.535(c).

A supplier whose enrollment and billing privileges have been revoked may request reconsideration and review as provided by 42 C.F.R. pt. 498. A supplier submits a written request for reconsideration to CMS or its contractor. 42 C.F.R. § 498.22(a). CMS or its contractor must give notice of its reconsidered determination to the supplier, giving the reasons for its determination and specifying the conditions or requirements the supplier failed to meet, and advising the supplier of its right to an ALJ hearing. 42 C.F.R. § 498.25. If the decision on reconsideration is unfavorable to the supplier, the supplier has the right to request a hearing by an ALJ and further review by the Departmental Appeals Board (the Board). Act § 1866(j)(8) (42 U.S.C. § 1395cc(j)(8)); 42 C.F.R. §§ 424.545, 498.3(b)(17), 498.5. A hearing on the record, also known as an oral hearing, is required under the Act. *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743, 748-51 (6th Cir. 2004). The supplier bears the burden to demonstrate that it meets enrollment requirements with documents and records. 42 C.F.R. § 424.545(c).

B. Issue

Whether summary judgment is appropriate; and

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

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

My conclusions of law are set forth in bold text followed by my findings of fact and analysis.

1. Summary judgment is appropriate.

CMS has requested summary judgment. A provider or supplier denied enrollment in Medicare or whose enrollment has been revoked has a right to a hearing and judicial review pursuant to section 1866(h)(1) and (j) of the Act and 42 C.F.R. §§ 498.3(b)(1),

(5), (6), (8), (15), (17); 498.5. A hearing on the record, also known as an oral hearing, is required under the Act. Act §§ 205(b), 1866 (h)(1) and (j)(8); *Crestview*, 373 F.3d at 748-51. A party may waive appearance at an oral hearing, but must do so affirmatively in writing. 42 C.F.R. § 498.66. In this case, Petitioner has not waived the right to oral hearing or otherwise consented to a decision based only upon the documentary evidence or pleadings. Accordingly, disposition on the written record alone is not permissible, unless the CMS motion for summary judgment has merit.

Summary judgment is not automatic upon request but is limited to certain specific conditions. The Secretary's regulations that establish the procedure to be followed in adjudicating Petitioner's case are at 42 C.F.R. pt. 498. 42 C.F.R. §§ 405.800, 405.803(a); 424.545(a), 498.3(b)(5), (6), (15), (17). The regulations do not establish a summary judgment procedure or recognize such a procedure. However, the Board has long accepted that summary judgment is an acceptable procedural device in cases adjudicated pursuant to 42 C.F.R. pt. 498. *See, e.g.*, *Ill. Knights Templar Home*, DAB No. 2274 at 3-4 (2009); *Garden City Med. Clinic*, DAB No. 1763 (2001); *Everett Rehab. & Med. Ctr.*, DAB No. 1628 at 3 (1997). The Board also has recognized that the Federal Rules of Civil Procedure (Fed. R. Civ. Pro.) do not apply in administrative adjudications such as this, but the Board has accepted that Fed. R. Civ. Pro. 56 and related cases provide useful guidance for determining whether summary judgment is appropriate. Furthermore, a summary judgment procedure was adopted as a matter of judicial economy within my authority to regulate the course of proceedings and made available to the parties in the litigation of this case by my Prehearing Order. The parties were given notice by the Prehearing Order that summary judgment is an available procedural device and that the law as it has developed related to Fed. R. Civ. Pro. 56 will be applied.

Summary judgment is appropriate when there is no genuine dispute as to any issue of material fact for adjudication and/or the moving party is entitled to judgment as a matter of law. The party requesting summary judgment bears the burden of showing that there are no genuine issues of material fact for trial and/or that it is entitled to judgment as a matter of law. In determining whether there are genuine issues of material fact for trial, the reviewer must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. Generally, the non-movant may not defeat an adequately supported summary judgment motion by relying upon the denials in its pleadings or briefs but must furnish evidence of a dispute concerning a material fact, i.e., a fact that would affect the outcome of the case if proven. *Mission Hosp. Reg'l Med. Ctr.*, DAB No. 2459 at 4 (2012) (and cases cited therein); *Experts Are Us, Inc.*, DAB No. 2452 at 4 (2012) (and cases cited therein); *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 at 3 (2010) (and cases cited therein); *see also Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986).

The standard for deciding a case on summary judgment and an ALJ's decision-making in deciding a summary judgment motion differs from that used in resolving a case after a

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

In this case, I conclude that there is no genuine dispute as to any material fact pertinent to revocation under 42 C.F.R. §§ 424.57(e) and 424.535(a)(1) based on Petitioner's noncompliance with 42 C.F.R. § 424.57(c)(1) (Supplier Standard 1) that requires a trial. Petitioner has conceded its noncompliance with Supplier Standard 1, in that, Petitioner admits that it moved to another location and failed to notify CMS of its new address. Petitioner admits that it did not file the required Form CMS-855S to report its change of address. RFH; P. Response; P. Reply. Accordingly, summary judgment based on the violation of 42 C.F.R. § 424.57(c)(1) is appropriate.

Summary judgment is not appropriate for a revocation based on the alleged violations of 42 C.F.R. §§ 424.57(c)(7) (Supplier Standard 7); 424.57(c)(10) (Supplier Standard 10); and 424.57(c)(22) (Supplier Standard 22). Petitioner's submitted evidence in support of its request for reconsideration (CMS Ex. 1 at 11, 16-46) and P. Ex. 1. If all favorable inferences are drawn in favor of Petitioner, as required in ruling on summary judgment, I conclude that there are genuine disputes of material fact related to revocation for noncompliance with 42 C.F.R. §§ 424.57(c)(7) and (10) that would require a trial. Drawing all favorable inferences for Petitioner, I conclude that there is a genuine dispute as to whether Petitioner had a fully operational site, open and accessible to the public and CMS, and that satisfied other requirements of 42 C.F.R. § 424.57(c)(7) on May 21, 2014, at about 11:20 a.m. when the site visit occurred, albeit at a location other than that on file with CMS. P. Ex. 1; CMS Ex. 1 at 16-27, 30-46. Petitioner's evidence submitted on reconsideration also shows a genuine dispute because the evidence supports an inference that Petitioner had the insurance required by 42 C.F.R. § 424.57(c)(10) with no lapse in coverage. CMS Ex. 1 at 28-29, 74.

The alleged noncompliance with 42 C.F.R. § 424.57(c)(22) (Supplier Standard 22) poses a different problem. CMS records show that Petitioner was accredited by the Community Health Accreditation Program for its location on 2617 Rowland Road, Suite 104,

Raleigh, North Carolina effective through June 2, 2016. CMS Ex. 1 at 57-58; CMS Exs. 2, 3. NSC advised Petitioner in the initial determination dated July 9, 2014, that according to CMS records, Petitioner was not accredited for "multiple products and services" that Petitioner disclosed to NSC. CMS Ex. 1 at 9, 14. Petitioner presented no evidence reflecting its accreditation status when it requested a reconsidered determination. CMS Ex. 1 at 11. On reconsideration the hearing officer concluded that revocation was appropriate for noncompliance with 42 C.F.R. § 424.57(c)(22). The hearing officer mentioned that Petitioner was not accredited for multiple products. The hearing officer failed to address whether or not Petitioner was properly accredited at its new address, 1793 N.W. Maynard Road, Cary, North Carolina, even though Petitioner clearly informed the hearing officer of the move to the new location. CMS Ex. 1 at 4-5, 30-46; P. Ex. 1. Pursuant to 42 C.F.R. § 424.57(c)(23), Petitioner was required to notify its accreditation organization when Petitioner opened a new location and the accreditation organization could accredit the new location for three months without conducting a new site visit. There is no evidence that Petitioner gave its accreditation organization the required notice, whether Petitioner was subject to the three-month interim accreditation, or what products or services were accredited for the new location. Petitioner did not mention the accreditation issue in its request for hearing. In its Reply, Petitioner's Chief Executive Officer asserts that Petitioner maintained all required accreditations. Petitioner failed, however, to present any evidence of its accreditation for my consideration. Based on the evidence and the absence of any mention in the NSC notices of the issue of whether or not Petitioner was properly accredited to operate at its new location at 1793 N.W. Maynard Road, Cary, North Carolina, remand to CMS pursuant to 42 C.F.R. § 498.56(d) for consideration of that new issue would be appropriate. However, I conclude that remand is unnecessary because there is a basis for revocation for noncompliance with 42 C.F.R. § 424.57(c)(1).

The facts related to Petitioner's noncompliance with Supplier Standard 1 are not disputed. Accordingly, there is a basis for revocation of Petitioner's Medicare enrollment and billing privileges. It is well established that even a single violation of a single supplier standard is an adequate basis for revocation of billing privileges and enrollment. *1866ICPayday.com*, DAB No. 2289 at 13 (2009).

2. Petitioner was not in compliance with 42 C.F.R. § 424.57(c)(1) (Supplier Standard 1).

3. The effective date of revocation of Petitioner's enrollment and billing privileges is determined pursuant to 42 C.F.R. § 424.57(e), and is August 8, 2014, which is 30 days after the date on which Petitioner was sent the July 9, 2014 notice of initial determination to revoke.

a. Facts

The material facts that establish noncompliance with Supplier Standard 1 are not disputed. On May 21, 2014, a NSC investigator attempted to inspect Petitioner's facility at Petitioner's address on file with CMS – 2617 Rowland Road 104, Raleigh, North Carolina 27615. CMS Ex. 1 at 47-53, 59. The investigator found that Petitioner was no longer at that location. The investigator found that the location was occupied by another business, and a representative for that business advised the investigator that the business had been at that location since October 2013. CMS Ex. 1 at 52-53. Petitioner admits that at the time of the attempted site visit, it was not at the 2617 Rowland Road address because it had moved to another location. Petitioner admits that it failed to notify CMS of its new address by filing a Form CMS-855S. RFH; P. Response; P. Reply.

b. Analysis

On reconsideration, the hearing officer upheld the revocation of Petitioner's Medicare enrollment and billing privileges based on noncompliance with 42 C.F.R. § 424.57(c)(1) (Supplier Standard 1), among other regulatory requirements. The hearing officer found that the site investigator was unable to conduct an inspection because Petitioner was not at the location on file with CMS. DAB E-File #1 at 2. The hearing officer concluded that Petitioner's documentation did "not verify that the supplier submitted the required CMS-855S change of information application to the NSC in the required time frame of 30 days from the change." CMS Ex. 1 at 4; DAB E-File #1 at 4.

The regulation requires that a DMEPOS supplier operate and furnish Medicare-covered items in compliance with all applicable federal and state licensure and regulatory requirements. 42 C.F.R. § 424.57(c)(1). A DMEPOS supplier must submit completed application and enrollment forms for each separate physical location it uses to furnish DMEPOS, with the exception of warehouses or repair facilities. 42 C.F.R. § 424.57(b)(1). The supplier must provide complete and accurate information on its application and must report any changes in information on the application within 30 days of the change. 42 C.F.R. §§ 424.57(c)(2); 424.516(c). All suppliers are required to provide CMS notice of the address of practice locations using an enrollment application. 42 C.F.R. § 424.510(d)(2)(iii). All suppliers are required to report any changes on the applicable enrollment application. 42 C.F.R. §§ 424.510, 424.515(a)(1).

Accordingly, once it was enrolled in the Medicare program as a DMEPOS supplier, Petitioner was required to notify NSC of any changes in its enrollment information within 30 days of the change. 42 C.F.R. §§ 424.57(c)(2), 424.516(c). Petitioner was required to report such changes by filing Form CMS-855S. 42 C.F.R. § 424.510(a).

Petitioner admits that it moved its business from 2617 Rowland Road, Raleigh, North Carolina, the address listed in CMS records at the time of the attempted site investigation. RFH; P. Response; P. Reply; CMS Ex. 1 at 47-48, 52, 71. Petitioner concedes that it failed to notify CMS that it had relocated its business to another address. In its request for reconsideration dated August 18, 2004, Petitioner states "[w]e do recognize the mistake of not changing our address with CMS, this is a task that was overlooked and not followed through on." CMS Ex. 1 at 11. In its October 28, 2014 request for hearing, Petitioner states, "[w]e ask that we are granted mercy in the fact that we did not complete our change of address information in a timely manner." RFH. In its reply, Petitioner specifically refers to its failure to submit the Form CMS-855S, stating "[t]he only standard in question and admitted to was that [Petitioner] did not fill out a change of address form with Medicare . . . . it was one update that was not made in our 855S, and that is the change of address." P. Reply.

Based on Petitioner's admitted failure to notify NSC of its address change within 30 days, I conclude that Petitioner was not in compliance with all federal regulatory requirements. Therefore, Petitioner was not in compliance with 42 C.F.R. § 424.57(c)(1) (Supplier Standard 1). Accordingly, I conclude that there is a basis for the revocation of Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. §§ 424.57(e) and 424.535(a)(1).

The July 9, 2014 initial determination stated that the effective date of revocation was retroactive to May 21, 2014, the date CMS determined that Petitioner's practice location was no longer operational. CMS Ex. 1 at 7, 12. A retroactive effective date for revocation is only authorized under 42 C.F.R. § 424.535(g) in limited circumstances, one of which is a determination by CMS or its contractor that a location is not operational. The hearing officer on reconsideration concluded that Petitioner was noncompliant with Supplier Standards 1, 7, 10, and 22. The hearing officer did not make any factual findings or conclude as an additional basis for revocation that Petitioner was no longer operational within the meaning of 42 C.F.R. §§ 424.502 and 424.535(a)(5).

Revocation in this case is authorized under 42 C.F.R. §§ 424.57(e) and 424.535(a)(1). Pursuant to 42 C.F.R. § 424.57(e), revocation for noncompliance with the supplier standards established by 42 C.F.R. § 424.57(b) and (c), is effective 30 days after the supplier is sent notice of the revocation. Therefore, the correct effective date for revocation of Petitioner's Medicare enrollment and billing privileges based on a violation of 42 C.F.R. § 424.57(c)(1) (Supplier Standard 1) is 30 days after the notice of the revocation was issued. *Neb Group of Arizona*, DAB No. 2573 at 7-8 (2014). Accordingly, I conclude that the effective date of the revocation of Petitioner's Medicare enrollment and billing privileges was August 8, 2014, which is 30 days after the July 9, 2014 notice of the revocation was issued.

Petitioner states that it has been in business for over 33 years and has been a committed provider to its patients' needs. Petitioner states that its current customers were aware of its move and that its sales orders reflected the change in address. Petitioner asks that I give it favorable consideration and allow it to continue to serve its patients. P. Reply. Even if I accept Petitioner's assertions as true for purposes of summary judgment, these facts have no impact on the outcome of this case as those facts are not material to the issue of whether Petitioner violated Supplier Standard 1. Furthermore, to the extent that Petitioner's arguments may be construed as a request for equitable relief, I have no authority to grant equitable relief. *US Ultrasound*, DAB No. 2302 at 8 (2010) ("[n]either the ALJ nor the Board is authorized to provide equitable relief by reimbursing or enrolling a supplier who does not meet statutory or regulatory requirements."). I am also required to follow the Act and regulations and have no authority to declare statutes or regulations invalid. *1866ICPayday.com, L.L.C.*, DAB No. 2289 at 14 ("[a]n ALJ is bound by applicable laws and regulations and may not invalidate either a law or regulation on any ground.").

III. Conclusion

For the foregoing reasons, I conclude that Petitioner's Medicare enrollment and billing privileges were properly revoked effective August 8, 2014, due to noncompliance with 42 C.F.R. § 424.57(c)(1).

/s/
Keith W. Sickendick
Administrative Law Judge