Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Sreyreath Kuy, DPM
(NPI: 1407043193 / PTAN: 8F23434),
and
Quality Foot Care, PLLC
(NPI: 1508193210 / PTAN: OA5552),

Petitioners,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-17-145

Decision No. CR4875

Date: June 27, 2017

DECISION

The Medicare enrollment and billing privileges of Petitioners, Sreyreath Kuy, DPM and Quality Foot Care, PLLC, are revoked pursuant to 42 C.F.R. §§ 424.535(a)(5)(ii) and 424.535(a)(9)[1] based on a violation of 42 C.F.R. §§ 424.510(d)(1), (2) and 424.516(d)(1)(iii). The effective date of revocation is February 24, 2016, the date it was determined that Petitioners were not operating a practice location at the address listed in Petitioners' Medicare enrollment application. 42 C.F.R. § 424.535(g).

I. Procedural History and Jurisdiction

On June 6, 2016, Novitas Solutions (Novitas), a Medicare administrative contractor (MAC), notified Petitioners of its initial determination to revoke their Medicare

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[1] Citations are to the 2015 revision of the Code of Federal Regulation (C.F.R.), unless otherwise stated.

enrollment and billing privileges effective February 24, 2016, and to impose a two-year re-enrollment bar. Novitas cited 42 C.F.R. §§ 424.535(a)(5) and 424.535(a)(9) as authority for the revocation and alleged it was determined, based on an on-site review, that Petitioners were not operational and that Petitioners failed to notify the Centers for Medicare & Medicaid Services (CMS) of a change of practice location as required by 42 C.F.R. § 424.516. CMS Exhibit (Ex.) 2.[2]

Petitioners requested reconsideration by letter dated July 29, 2016. CMS Ex. 1a at 125-33. A Novitas hearing officer issued a reconsidered determination on October 6, 2016. The hearing officer upheld the revocation of Petitioners' Medicare enrollment and billing privileges. CMS Ex. 1. Petitioners requested a hearing before an administrative law judge (ALJ) on November 30, 2016 (RFH). The case was assigned to me and an Acknowledgement and Prehearing Order (Prehearing Order) was issued on December 9, 2016. Petitioners' request for hearing was timely and there is no dispute that I have jurisdiction over both parties based on the reconsidered determination. *Neb Group*, DAB No. 2573.

CMS filed a motion for summary judgment and prehearing brief on January 9, 2017 (CMS Br.) with CMS exhibits 1, 1a, 1b, 1c, 1d, 1e, and 2 through 4.[3] On February 6, 2017, Petitioners filed a prehearing brief and response in opposition to the CMS motion (P. Br.), together with Petitioners' exhibits (P. Exs.) 1 through 10. CMS failed to file a reply brief or a waiver of reply as required by Prehearing Order para. II.D.3. CMS did not object to my consideration of P. Exs. 1 through 10 and they are admitted. Petitioners objected generally to the CMS offered documents as hearsay. P. Br. at 8-10. I recognize the hearsay nature of the documents offered by CMS as evidence. To the extent that the authenticity and relevance of CMS Exs. 1, 1a, 1b, 1c, and 1e, and 2 through 4, are not disputed those documents are admissible despite the hearsay objection which impacts the

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[2] The June 6, 2016 notice of the initial determination offered as evidence by CMS is addressed only to Dr. Kuy. CMS Ex. 2. Petitioner placed in evidence a copy of the notice of initial determination to Petitioner Quality Foot Care, PLLC as P. Ex. 1 at 15-16. There is no dispute that both Petitioners were subject to the single, October 6, 2016 reconsidered determination that upheld revocation. CMS Ex. 1. My jurisdiction is based on the reconsidered determination and I conclude that both parties received proper notice and are properly before me. *Neb Group of Arizona, LLC*, DAB No. 2573 at 7 (2014).

[3] On January 9, 2017, CMS filed an exhibit and witness list related to a different case. Counsel for CMS is admonished to be more careful with filings in future cases. The absence of an accurate CMS exhibit and witness list is not prejudicial to the parties in this case.

weight to be accorded those documents but not their admissibility and those documents are admitted. 42 C.F.R. §§ 498.60(b), 498.61. Petitioners more specifically object to CMS Ex. 1d, which purports to be the report of the site visit. P. Br. at 9-10. Petitioners object that the document is clearly hearsay, but I will not exclude the document for that reason. However, Petitioners also object on grounds related to the authenticity of the document. Specifically, I note that the document is not properly executed with a signature of the purported site investigator and the form is in other ways not completely consistent with CMS policy. P. Br. at 9-10. Accordingly, I cannot conclude that the document marked CMS Ex. 1d is authentic and it cannot be admitted as evidence at this stage of the proceedings. 42 C.F.R. §§ 498.60(b), 498.61.

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 Novitas. 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.[4] Act §§ 1835(a) (42 U.S.C. § 1395n(a)), 1842(h)(1) (42 U.S.C. § 1395u(h)(1)). Petitioner Kuy is a doctor of podiatric medicine and Petitioner Quality Foot Care is his practice organization; both are suppliers under the Act. Act § 1861(d), (q), (r); 42 C.F.R. § 424.502.

The Act requires the Secretary of Health and Human Services (Secretary) to issue regulations that establish a process for enrolling providers and suppliers in Medicare, including the requirement to provide the right to a hearing and judicial review of certain enrollment determinations, such as revocation of enrollment and billing privileges. Act

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[4] 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 §§ 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.

§ 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 a MAC 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.

Pursuant to 42 C.F.R. § 424.535(a)(5), CMS may revoke a supplier's enrollment and billing privileges if CMS determines, upon on-site review, that the supplier is no longer operational to furnish Medicare-covered items or services, or has otherwise failed to satisfy any of the Medicare enrollment requirements. 42 C.F.R. § 424.535(a)(5)(i) - (ii). Pursuant to 42 C.F.R. § 424.535(a)(9), CMS may revoke a supplier's enrollment and billing privileges if the supplier did not comply with the reporting requirements specified in 42 C.F.R. § 424.516(d)(1)(ii) or (iii), which require that a physician, nonphysician practitioner or a physician or nonphysician practitioner organization report to their MAC within 30 days any adverse legal action or change in practice location.

Generally, when CMS revokes a supplier's Medicare billing privileges for not complying with enrollment requirements, the revocation is effective 30 days after CMS or its contractor mails notice of its determination to the supplier. 42 C.F.R. §§ 424.57(e)(1); 424.535(g). However, when CMS revokes a supplier's billing privileges because the supplier's "practice location" is not operational, the revocation is effective as of the date CMS determined the supplier's practice location was no longer operational. 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 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(*l*)(2). 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). 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. Issues

Whether summary judgment is appropriate; and

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

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

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

1. Summary judgment is appropriate.

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, 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 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 at 42 C.F.R. pt. 498 that establish the procedure 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. 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, para. II.D and G. The parties were given notice by my

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 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 reviewer 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 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 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. 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 Fed. App'x 181 (6th Cir. 2005).

There is no genuine dispute as to any material fact related to revocation pursuant to 42 C.F.R. § 424.535(a)(5)(ii) and (9) and the effective date of revocation. The duration of the bar to re-enrollment is not subject to my review and that issue must be resolved against Petitioner as a matter of law.

The reconsidered determination suggests that the hearing officer concluded that Petitioner was operational at an address other than the address listed in Petitioners' enrollment

applications. CMS Ex. 1 at 2. For purposes of summary judgment I accept as true that Petitioners were operational albeit at a different address than listed in their enrollment applications. Accordingly, summary judgment is not appropriate related to revocation pursuant to 42 C.F.R. § 424.535(a)(5)(i). If CMS wishes to attempt to prove Petitioners were not operational, as that term is defined in 42 C.F.R. § 424.502, as of the date of the on-site review, CMS may file a motion to reopen so that a hearing may be conducted.

2. Petitioners were required to report completely, accurately, and truthfully in their enrollment applications all information requested by the applications. 42 C.F.R. § 424.510(d)(1), (2).

3. In order to maintain active enrollment, Petitioners were required to report to the MAC any change in practice location within 30 days. 42 C.F.R. § 424.516(d)(1)(iii).

3. CMS or the MAC is authorized to revoke the Medicare enrollment and billing privileges of a provider or supplier that is found upon on-site review to fail to satisfy any Medicare enrollment requirement. 42 C.F.R. § 424.535(a)(5)(ii).

4. There is a basis to revoke Petitioners' Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(5)(ii) because Petitioners failed to meet the Medicare enrollment requirement to report their correct practice locations to CMS or the MAC. 42 C.F.R. §§ 424.510(d)(1), (2); 424.516(d)(1)(iii).

5. There is also a basis to revoke Petitioners' Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(9) because Petitioners failed to report a change of practice location to the MAC to reflect their correct practice location within 30 days as required by 42 C.F.R. § 424.516(d)(1)(iii).

6. Revocation of Petitioners' Medicare enrollment and billing privileges is effective February 24, 2016, the date it was determined by CMS that Petitioners were not operational at the practice location listed in Petitioners' Medicare enrollment applications (CMS-855I). 42 C.F.R. § 424.535(g).

7. I have no authority to review the duration of the bar to re-enrollment imposed by the MAC.

a. Undisputed Facts

The material facts are not disputed.

Petitioner Kuy filed an application (CMS-855I) to enroll in Medicare as a new enrollee in about November 2009, listing his practice as Quality Foot Care, PLLC. CMS Ex. 1a at 5-62; CMS Ex. 1b at 5-64. On about February 10, 2014, Novitas acknowledged that Petitioners had filed a change of information listing Petitioners' practice location, correspondence address, and payment address as 3130 Grants Lake Boulevard, #20117, Sugar Land, Texas. There is no dispute that 3130 Grants Lake Boulevard #20117 is a post office box in a United States Post Office located at that address. CMS Ex. 1a at 103, 127-29; CMS Ex. 1b at 105, 125-27; CMS Ex. 1e; CMS Ex. 3.

There is no dispute that the CMS-855I Petitioners completed and filed in about November 2013, was completed to indicate a change in Petitioners' practice location, payment address, and medical record storage. CMS Ex. 1e at 6. Petitioners completed the CMS-855I to reflect the correspondence address of 3130 Grants Lake Boulevard, #20117. CMS Ex. 1e at 7. The CMS-855I also listed the same address as Petitioners' practice location. CMS Ex. 1e at 18, 21. Petitioner Kuy signed the CMS-855I on November 13, 2013, agreeing to be bound by Medicare participation requirements and certifying that all information in the CMS-855I was true, correct and complete; and he committed to notify CMS of any changes as required by 42 C.F.R. § 424.516. CMS Ex. 1e at 29-30. Petitioners do not dispute that the CMS-855I specifically informed them that all locations where services are delivered must be listed as practice locations; a post office box may not be listed as a practice location; a physician that has no other office may list his or her own home address as a practice location if he or she only delivers services in patient homes; and hospitals, assisted living facilities, and long-term care facilities should be listed as practice locations if that is where services are delivered. CMS Ex. 1e at 17-20.

Petitioners do not dispute that the CMS-855I completed in November 2013 was completed to reflect that the 3130 Grants Lake Boulevard #20117 address was a "[g]roup practice office/clinic." CMS Ex. 1e at 18. Petitioners do not dispute that on about February 24, 2016, a Novitas investigator could not access Petitioners' practice at 3130 Grants Lake. CMS Ex. 1a at 127. Petitioners admit that in 2016 Petitioners had no fixed practice location but Petitioner Kuy saw patients at dialysis centers or clinics. CMS Ex. 1a at 127; P. Ex. 1 at 2, 9.

b. Analysis

In November 2013, when Petitioners filed a CMS-855I reporting a change in Petitioners' practice location, payment address, and medical record storage (CMS Ex. 1e at 6), the regulations clearly required that a complete enrollment application and supporting

documentation was to be filed with the MAC. 42 C.F.R. § 424.510(d)(1) (2013). The regulation specified that the CMS-855I must include "complete, accurate and truthful responses to all information requested in each section" of the application. 42 C.F.R. § 424.510(d)(2)(i) (2013). Further, Petitioner Kuy was required to sign the certification statement in the CMS-855I, binding Petitioners to the legal and financial requirements related to enrolling in Medicare. The regulation further provides that the signature attests that all information submitted is accurate and that the supplier is aware of and agrees to abide by all applicable statutes, regulations and program instructions. 42 C.F.R. § 424.510(d)(3) (2013). CMS specifically reserved the right to conduct on-site reviews to verify the accuracy of enrollment information. 42 C.F.R. §§ 424.510(d)(8) and 424.517(a) (2013). Pursuant to 42 C.F.R. § 424.516(d)(1)(iii) (2013), Petitioners as a physician and his practice organization were also required to accurately report their practice location, within 30 days of any change. The CMS-855I Petitioners filed in November 2013, was equally clear and Petitioners do not dispute that the form informed them that all locations where services were delivered must be listed as practice locations; a post office box could not be listed as a practice location; a physician that had no other office could list his or her own home address as a practice location if they only delivered services in patient homes; and hospitals, assisted living facilities, and long-term care facilities should be listed as practice locations if that is where services were delivered. CMS Ex. 1e at 17-20.

Petitioners bear the burden to demonstrate that they meet enrollment requirements and to produce documents demonstrating compliance. 42 C.F.R. § 424.545(c). Petitioners fail to meet their burden in this case. Petitioners do not dispute that the CMS-855I filed in about November 2013, was completed to indicate a change in Petitioners' practice location, payment address, and medical record storage. CMS Ex. 1e at 6. Petitioners do not dispute that the CMS-855I was completed in a way to reflect a practice location address of 3130 Grants Lake Boulevard, #20117, a post office box. CMS Ex. 1e at 7; CMS Ex. 13 at 18, 21. Petitioner Kuy signed the CMS-855I on November 13, 2013, agreeing to be bound by Medicare participation requirements and certifying that all information in the CMS-855I was true, correct and complete; and he committed to notify CMS of any changes as required by 42 C.F.R. § 424.516. CMS Ex. 1e at 29-30. Petitioners also do not dispute that the CMS-855I was completed to reflect its practice location was a post office box, contrary to the instructions on the CMS-855I with which Petitioners agreed to and were bound to comply. Petitioners did not list as practice locations all locations where services were delivered. CMS Ex. 1e at 17-20.

Accordingly, I conclude Petitioners violated requirements for enrolling and maintaining enrollment in Medicare and there is a basis for revocation of Petitioners' Medicare enrollment and billing privileges pursuant to 42 C.F.R. §§ 424.535(a)(5)(ii) and (9).

Having found that there is a basis for revocation, I have no authority to review the exercise of discretion by CMS to revoke Petitioners' Medicare enrollment and billing

privileges. *Dinesh Patel, M.D.*, DAB No. 2551 at 10 (2013); *Fady Fayad, M.D.*, DAB No. 2266 at 16 (2009), *aff'd*, 803 F. Supp. 2d 699 (E.D. Mich. 2011); *Abdul Razzaque Ahmed, M.D.*, DAB No. 2261 at 16-17, 19 (2009), *aff'd*, 710 F. Supp. 2d 167 (D. Mass. 2010).

Summary judgment is also appropriate as to the effective date of revocation. Pursuant to 42 C.F.R. § 424.535(g):

> (g) *Effective date of revocation.* Revocation becomes effective 30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier, except if the revocation is based on Federal exclusion or debarment, felony conviction, license suspension or revocation, **or the practice location is determined by CMS or its contractor not to be operational**. When a revocation is based on a Federal exclusion or debarment, felony conviction, license suspension or revocation, **or the practice location is determined by CMS or its contractor not to be operational**, **the revocation is effective** with the date of exclusion or debarment, felony conviction, license suspension or revocation or **the date that CMS or its contractor determined that the provider or supplier was no longer operational.**

(Emphasis added). Petitioners do not dispute that on February 24, 2016, there was no practice location at 3130 Grants Lake Boulevard #20117, Sugar Land, Texas. Petitioners concede that the address was a post office box in a U.S. Post Office. Pursuant to 42 C.F.R. § 424.535(g), CMS is authorized to establish an effective date of revocation based on the date CMS determined that Petitioners' **practice location** was no longer operational. Petitioner concedes that there was no operational practice at the 3130 Grants Lake Boulevard address on February 24, 2016. Therefore, February 24, 2016, is the correct effective date of revocation.

When a supplier's Medicare enrollment and billing privileges are revoked, the supplier is barred from re-enrolling in the Medicare program for one to 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 U.S.C. § 1395cc(j)(8)); 42 C.F.R. §§ 424.535(c), 424.545; 498.3(b), 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 not subject to ALJ review. *Vijendra Dave*, DAB No. 2672 at 10-11 (2016).

Petitioners argue that I should not consider the report of the site investigation because there has been no showing of authority to conduct the site-visit and that without the site investigation there is no evidence of a regulatory violation. RFH at 3-5; P. Ex. 1 at 3-5. The argument is without merit for as explained Petitioners have admitted to the violation by admitting to incorrectly listing a post office box as their practice location in the CMS-855I signed in November 2013, and taking no action to correct the erroneous practice location information. Furthermore, the fact that Petitioners maintained an active practice at another location or locations is no defense to Petitioners' failure to maintain compliance with enrollment requirements to accurately report a practice location. Petitioners also argue that the report of the site investigation was defective (RFH at 6; P. Ex. 1 at 6) and for that reason I have excluded the report (CMS Ex. 1d) for purposes of ruling on summary judgment. Petitioners argue that the failure to provide Petitioners a properly completed report of the site inspection amounts to a due process violation. RFH at 6-7, 12; P. Ex. 1 at 6-7, 12. In this case, both the initial and reconsidered determinations (P. Ex. 1 at 15-16, 24-28) alleged the basis for revocation sufficiently for Petitioner to mount a defense before me. I conclude that Petitioners suffered no prejudice due to the defective report which has not been considered as evidence on summary judgment. Petitioners argue that CMS is equitably estopped based on the reconsidered determination from now denying Petitioners were operational at another location. RFH at 7; P. Ex. 1 at 7. Discussion of the application of the doctrine of equitable estoppel is not necessary as I accept as true for purposes of summary judgment that Petitioners were operational at another location or locations on February 24, 2016.

To the extent that Petitioners' arguments may be construed as a request for equitable relief, I have no authority to grant such relief. *US Ultrasound*, DAB No. 2302 at 8 (2010). 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.

III. Conclusion

For the foregoing reasons, Petitioners' Medicare enrollment and billing privileges are revoked pursuant to 42 C.F.R. § 424.535(a)(5)(ii) and 424.535(a)(9). The effective date of revocation is February 24, 2016.

/s/
Keith W. Sickendick
Administrative Law Judge