Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of: KGV Easy Leasing, d/b/a Privilege Diagnostics, (PIN: TD052), Petitioner, v. Centers for Medicare & Medicaid Services.	Date: August 6, 2008 Docket No. C-08-93 (On Remand) Decision No. CR1828

DECISION

The Medicare billing privileges of Petitioner, KGV Easy Leasing, d/b/a Privilege Diagnostics, are revoked effective January 3, 2008.

I. Background

The National Heritage Insurance Company (NHIC)[1] notified Petitioner by letter dated April 6, 2006, that Petitioner's Medicare Provider Identification Number (PIN) was being revoked effective April 21, 2006. NHIC advised Petitioner that the revocation was based upon NHIC's "possession of information which establishes that [Petitioner] submitted false or fraudulent claims to Medicare." CMS Exhibit (CMS Ex.) 2, at 1. The NHIC notice listed the allegedly false and fraudulent claims. NHIC further alleged in its notice

[1] NHIC was the regional Medicare Part B Carrier at the time of the notice. SafeGuard Services subsequently became the Medicare Part B Carrier for the region. Pursuant to sections 1834(a)(12) and 1842(a) of the Social Security Act (Act) (42 U.S.C. § 1395m(a)(12) and 1395u), the administration of Medicare Part B is through Medicare administrative contractors, and the Secretary of Health and Human Services (Secretary) may designate one carrier for one or more regions to process claims for items covered by Medicare Part B. CMS administers the contracting program, which includes both intermediaries and carriers, pursuant to 42 C.F.R. Part 421.

that Petitioner "violated the terms of [Petitioner's] participation in Medicare" and Petitioner no longer met the requirements for Medicare billing privileges and those privileges were being revoked effective April 21, 2006. The notice advised Petitioner of the right to request a hearing before a carrier hearing officer or, in the alternative, to submit a corrective action plan. CMS Ex. 2, at 3.

Petitioner requested hearing by a carrier hearing officer. A hearing was held on July 28, 2006, and a decision was issued that day. The hearing officer found that Petitioner signed an application to participate in Medicare on May 15, 2001, and thereby agreed not to "knowingly" present false or fraudulent claims to Medicare for payment. The hearing officer concluded that Petitioner's evidence did not overcome the allegations of the NHIC notice dated April 6, 2006. The hearing officer mentions no evidence submitted by NHIC or CMS to show why NHIC or CMS believed that the claims listed in the NHIC notice dated April 6, 2006, were either false or fraudulent. The hearing officer apparently concluded that Petitioner submitted false or fraudulent claims in violation of the covenant not to in its May 15, 2001 application. The hearing officer advised Petitioner of the right to review by an administrative law judge (ALJ). Request for Hearing (RFH) Ex. A; CMS Ex. 5.

On September 25, 2006, Petitioner requested a hearing before an ALJ. This case was docketed as C-06-686 and assigned to me for hearing and decision on September 28, 2006. On November 15, 2006, I convened a telephonic prehearing conference, the substance of which is memorialized in my Order dated November 20, 2006. Counsel for CMS agreed that the hearing procedures of 42 C.F.R. Part 498 are applicable to this case. CMS asserted during the conference that the basis for revocation of Petitioner's PIN was 42 C.F.R. § 424.535(a)(4), which permits revocation based upon false or misleading information in connection with application or reapplication for enrollment in Medicare. However, counsel for CMS requested the opportunity to move for dismissal on grounds that the request for hearing was moot on the theory that Petitioner had voluntarily ended its participation in Medicare before revocation of the PIN by NHIC. Because the issue raised by CMS was potentially jurisdictional, I issued a briefing schedule in my Order of November 20, 2006, rather than ordering development of the case for hearing.

CMS filed its motion to dismiss on November 29, 2006, with CMS Exs. 1 through 3. Petitioner filed its opposition to the motion on December 15, 2006, with Petitioner's exhibits (P. Exs.) 1 through 5.[2] CMS requested leave to file a reply with CMS Ex. 4, and

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[2] The parties did not comply with the Civil Remedies Procedures in marking and submitting documentary evidence for my consideration, and documents appropriate for consideration were not marked or were incorrectly numbered. To facilitate any review on (continued...)

Petitioner requested leave to file a sur-reply and for oral argument. The CMS reply and Petitioner's sur-reply were accepted, but the request for oral argument was denied.

On March 6, 2007, I issued a ruling granting the CMS motion to dismiss the request for hearing in this case. On May 3, 2007, Petitioner moved that I vacate and reconsider my March 6, 2007 ruling, with P. Ex. 6 attached. CMS opposed the motion on May 23, 2007. Petitioner replied to the CMS opposition on June 5, 2007, with P. Exs. 7 through 9 attached. On June 25, 2007, I issued a ruling denying Petitioner's request that I reconsider my March 6, 2007 ruling. On November 6, 2007, an appellate panel of the Departmental Appeals Board (the Board) issued a decision vacating my ruling dismissing the request for hearing and remanding the case to me for further action specified in the decision. *KGV Easy Leasing, dba Privilege Diagnostics*, DAB No. 2130 (2007) (Board Decision). The case was received on remand and assigned docket number C-08-93.

Counsel for CMS advised me by letter dated November 21, 2007, that CMS had received the remand order from the Board and that CMS intended to renew the motion to dismiss. On December 3, 2007, I ordered that CMS address specified issues raised by the remand decision and produce specified documents, if such documents existed. I also permitted Petitioner an opportunity to respond. CMS filed its response to my December 3 Order on December 11, 2007. Petitioner filed its response to the December 3 Order on December 20, 2007, with P. Exs. 10 and 11 attached. On January 29, 2008, the parties filed a joint status report in which they set forth their respective positions, and Petitioner requested a "special evidentiary hearing"for me inquire into alleged misrepresentations by CMS and sanctions.[3]

On February 5, 2008, I issued a ruling denying CMS's motion to dismiss Petitioner's request for hearing and a scheduling order to guide and direct the parties in preparing this case for a hearing. In a letter dated March 5, 2008, counsel for CMS acknowledged receipt of my February 5, 2008 Ruling Denying Respondent's Motion to Dismiss and Scheduling Order. CMS asserted in its letter that the action to revoke Petitioner's billing privileges was rescinded. CMS also asserted that due to the recision there is "no longer a live case or controversy before" me and that "CMS does not intend to make any further filings in this matter." Petitioner responded by letter dated March 7, 2008, and requested that judgment be entered in its favor. On March 17, 2008, I issued an order for CMS to produce certain documents and a ruling denying Petitioner's motion for judgment. On

[2](...continued)
appeal, I have remarked the exhibits that I believe the parties intended for me to consider on the merits and compiled an exhibit list for each party that is at the end of this decision.

[3] I have reviewed the many pleadings and items of correspondence in this case and find no grounds to inquire further or to consider sanctioning either party.

April 10, 2008, CMS responded to my order to produce, filing CMS Exs. 5 through 10. CMS also asserted in its cover letter that, pursuant to the remand order, it is entitled to file a dispositive motion and receive a ruling. On April 15, 2008, CMS filed CMS Ex. 11, pursuant to my order to produce. On April 17, 2008, Petitioner moved to strike CMS Ex. 11 (originally marked CMS Ex. 10). On April 18, 2008, CMS filed CMS Ex. 12, pursuant to my order to produce.

On April 28, 2008, I issued a ruling denying the CMS request in its April 10, 2008 cover letter that CMS be permitted to file a dispositive motion. I treated the CMS request as a request that I reconsider my February 5, 2008 ruling denying the CMS motion to dismiss. The CMS motion to dismiss filed November 29, 2006 was pending before me after the remand due to the Board having vacated my prior ruling granting the motion. Thus, after remand it was not necessary for CMS to file another dispositive motion arguing the same grounds. In my April 28 ruling, I also modified the prehearing schedule and notified the parties of the issues for hearing.

Petitioner waived an oral hearing by letter dated May 1, 2008, presented its arguments and requested a judgment on the existing record. CMS filed a brief on May 27, 2008. Petitioner responded to the CMS brief by letter dated June 1, 2008. Pursuant to the CMS request, I issued a ruling on June 4, 2008, establishing the date by which CMS could file a reply brief. By letter dated June 23, 2008, CMS advised that "all relevant matters having been exhaustively briefed by the parties, this matter is now ripe for decision. Accordingly, respondent respectfully requests that the hearing request be dismissed forthwith."

CMS has filed no objection to any of the documents offered as evidence by Petitioner, and Petitioner's Exs. 1 through 11, as marked and described in the attached table, are admitted. Petitioner objected to the admission of CMS Ex. 11 (originally marked CMS Ex. 10) on grounds that it was produced late, is not relevant, and is of no probative value. Petitioner's Letter dated April 17, 2008. I agree with Petitioner that CMS Ex. 11 is not relevant to the specific issue of whether Petitioner ceased doing business as alleged by CMS. However, CMS Ex. 11 does provide information related to additional actions by CMS and its contractors concerning Petitioner for the period in issue and I find it is at least minimally relevant for that reason. Petitioner's objections to CMS Ex. 11 are overruled, and CMS Exs. 1 through 12, as marked and described on the attached table, are admitted.[4]

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[4] Prior to my ruling granting the CMS motion to dismiss, Petitioner filed affidavits or declarations allegedly related to the original NHIC allegations of false or fraudulent claims. However, those affidavits or declarations are not relevant because CMS has

(continued...)

Upon consideration of the responses of CMS, I find that it is not necessary to receive supplemental briefing upon the CMS motion to dismiss. The motion must be denied and this matter developed for hearing.

II. Discussion

A. Findings of Fact

The following findings of fact are based upon the parties' joint stipulation, the undisputed allegations of fact from their pleadings, and the exhibits admitted. Citations to evidence may be found in the analysis section of this decision if not indicated here.

1. NHIC notified Petitioner by letter dated April 6, 2006, that Petitioner's Medicare billing privileges were being revoked effective April 21, 2006, based on information Petitioner had submitted false or fraudulent claims.

2. Petitioner ceased operations as an Independent Diagnostic Testing Facility (IDTF) on April 6, 2006.

3. On November 29, 2006, CMS, by its counsel, nullified or rescinded the NHIC action to revoke Petitioner's billing privileges based upon the alleged submission of false or fraudulent claims by Petitioner and withdrew its assertion of such basis in the case before me.

4. Between November 29, 2006 and December 4, 2007, there was no evidence of any action by CMS to revoke Petitioner's billing privileges or Petitioner's participation in Medicare.

5. CMS rescinded the April 6, 2006 NHIC notice of revocation by letter December 4, 2007. CMS Ex. 6.

6. The CMS notice of December 4, 2007, was a notice of revocation of Petitioner's billing privileges based on Petitioner's cessation of operations as an IDTF. CMS Ex. 6.

7. Petitioner's Medicare billing privileges were revoked effective January 3, 2008.

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[4](...continued)
abandoned all allegations of false or fraudulent claims as a basis for revocation of Petitioner's billing privileges in this proceeding. Thus, I have not marked the affidavits or declarations as Petitioner's exhibits, or considered them as evidence in this case.

B. Conclusions of Law

1. Petitioner has a right to a hearing before an ALJ based upon the revocation of his billing privileges.

2. I have jurisdiction to hear and decide this case.

3. CMS rescinded the April 6, 2006 action of its contractor NHIC to revoke Petitioner's billing privileges based upon allegations of false or fraudulent claims and CMS, through counsel, withdrew from any allegations of false or fraudulent claims by Petitioner in the case before me.

4. The April 6, 2006 action of NHIC to revoke Petitioner's Medicare billing privileges was rescinded and nullified by CMS, and was of no force or effect.

5. Among the requirements for enrollment in Medicare is the requirement that the supplier must be operational to furnish Medicare covered items or services before being granted billing privileges. 42 C.F.R. § 424.510(d)(6).

6. Following enrollment, a supplier must report to CMS any changes to the information furnished on its enrollment application (42 C.F.R. § 424.520(b)), including any change in its operational status and ability to deliver Medicare items or services.

7. CMS may revoke a supplier's Medicare billing privileges, after an opportunity to correct, because the supplier is not in compliance with enrollment requirements, which include the requirement to be operational. 42 C.F.R. § 424.535(a)(1).

8. CMS may revoke billing privileges without an opportunity for the supplier to correct when CMS determines, based on an on-site review, that the supplier is no longer operational to furnish Medicare items or services or does not meet the enrollment requirement to provide Medicare-covered items or services. 42 C.F.R. § 424.535(a)(5).

9. Petitioner was subject to revocation for no longer being operational after April 6, 2006, under either 42 C.F.R. § 424.535(a)(1) or (5), with or without an opportunity to correct.

10. Petitioner was not prejudiced in this case because CMS failed to conduct an on-site review as Petitioner admitted it was no longer operational after April 6, 2006.

11. The December 4, 2007 CMS notice was deficient under the regulations because it did not advise Petitioner of a right to appeal or provide an address where any appeal should be sent.

12. Petitioner was not prejudiced by the defective CMS notice dated December 4, 2007, as Petitioner's appeal was already pending before me.

13. Pursuant to 42 C.F.R. § 424.535(f), a revocation becomes effective within 30 days of the initial revocation notification. *See also* 73 Fed. Reg. 36,448, 36,461 (June 27, 2008) to be codified as 42 C.F.R. § 405.874(b)(2), effective August 26, 2008.

14. The revocation of Petitioner's billing privileges was effective January 3, 2008, 30 days after the December 4, 2007 CMS notice of revocation.

C. Applicable Law

The hearing officer decision reflects that on May 15, 2001, Petitioner completed an application to participate in the Medicare Part B program. After the application was approved, Petitioner could deliver services to Medicare-eligible beneficiaries and file claims with Medicare for reimbursement for covered services. RFH, Ex. A; CMS Ex. 5. Petitioner is an IDTF and provides mobile diagnostic services to Medicare-eligible beneficiaries pursuant to physician orders. P. Ex. 5.

Section 1831 of the Act (42 U.S.C. § 1395j) establishes the supplementary medical insurance benefits program for the aged and disabled known as Medicare Part B. Payment under the program for services rendered to Medicare eligible beneficiaries may only be made to eligible providers of services and suppliers.[5] Act, §§ 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395u(h)(1)). Administration of the Part B program is through contractors. Act, § 1842(a) (42 U.S.C. § 1395u(a)). The Act requires that the Secretary issue regulations that establish a process for the enrollment of providers and

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[5] A "supplier" furnishes services under Medicare and includes physicians or other practitioners and facilities that are not a "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, or are subject to section 1814(g) and section 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.

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. § 424.505, a provider or supplier 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.[6]

CMS may deny a supplier's enrollment application if a supplier is not in compliance with Medicare enrollment requirements. 42 C.F.R. § 424.530(a)(1). A supplier enrollment is considered denied when a supplier is determined to be "ineligible to receive Medicare billing privileges for Medicare covered items or services provided to Medicare beneficiaries" for one or more of the reasons listed in 42 C.F.R. § 424.530. 42 C.F.R. § 424.502. CMS's contractor notifies a supplier in writing when it denies enrollment and explains the reasons for the determination and information regarding the supplier's right to appeal. 42 C.F.R. § 498.20(a); MPIM Ch. 10, §§ 6.2, 13.2. The supplier may submit a written request for reconsideration to CMS. 42 C.F.R. § 498.22(a). CMS 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. 42 C.F.R. § 498.25. If the CMS decision on reconsideration is unfavorable to the supplier, the Act provides for a hearing by an ALJ and judicial review. Act § 1866(j); *see also* 73 Fed. Reg. 36,448, 36,461.

If a provider or supplier is accepted for enrollment and granted billing privileges, the enrollee is subject to revalidation every five years. Every five years, the enrollee is required to resubmit and recertify the accuracy of its enrollment information, and the information is reverified by the CMS contractor. CMS is also permitted to conduct "off-cycle" revalidations, which may be conducted at any time and which may be triggered by random checks, adverse information, national initiatives, complaints, or other reasons that cause CMS to question whether the provider or supplier continues to meet enrollment requirements. 42 C.F.R. § 424.515.

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[6] Currently, if enrollment is approved, a supplier is issued a National Provider Identifier (NPI) to use for billing Medicare and a Provider Transaction Access Number (PTAN), an identifier for the supplier for inquiries. Medicare Program Integrity Manual (MPIM), Chapter 10 – Healthcare Provider/Supplier Enrollment, § 6.1.1. In this case it is sufficient to understand that Petitioner's billing number and related billing privileges were revoked.

CMS may revoke an enrolled provider's or supplier's Medicare billing privileges and any provider or supplier agreement for any of the reasons listed in 42 C.F.R. § 424.535. Section 1866(j)(2) of the Act does not specify that a supplier has a right to a hearing or judicial review if its billing privileges are revoked, but mentions only that such rights exist for denial of an application or nonrenewal of enrollment. However, the Secretary recently amended 42 C.F.R. § 424.545(a) to provide a supplier a hearing if its enrollment is revoked. 73 Fed. Reg. 36,448, 36,461 (June 27, 2008), amending 42 C.F.R. §§ 424.545(a) and 498.1(g) (section 1866(j) of the Act provides for hearing and judicial review for provider or supplier whose billing privileges are revoked). Although the revision of the regulations is not effective until August 26, 2008, CMS agreed during the first prehearing conference that a supplier may request an ALJ hearing when its billing privileges are revoked. Nevertheless, CMS has consistently argued in this case since the first prehearing conference, that this Petitioner has no right to a hearing because it voluntarily ceased participation in Medicare rather than having its billing privileges revoked.

D. Issues

> Whether there is a basis for revocation of Petitioner's billing privileges.
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> Whether, if there is a basis for revocation of Petitioner's billing privileges, a revocation occurred in this case and the effective date of the revocation.

E. Analysis

The evidence presented provides insight into Petitioner's rocky relationship with CMS and its contractors.

Petitioner was notified by letter dated March 27, 2006 from Medicare contractor Electronic Data Systems Corporation (EDS) that its claims for services were selected for prepayment review. The notice explains that under prepayment review Petitioner needed to submit documents with its claims showing that the services provided were medically necessary and reasonable; and that the claims and supporting documents would be reviewed by a medical advisor before they would be paid. The notice advised Petitioner that prepayment review would continue from three months to a year. P. Ex. 2. Petitioner was previously on prepayment review that ended on May 24, 2004. P. Ex. 1.

Petitioner was notified by letter dated April 6, 2006 from the Medicare contractor EDS, that its Medicare payments were suspended based upon a decision of the CMS Regional Office in San Francisco. EDS advised Petitioner that the CMS decision was based on reliable information that an overpayment existed, that fraud or willful misrepresentation existed, and that payments made to Petitioner may not be correct, based upon a post payment review or audit by EDS. EDS included a list of patients for which Petitioner filed claims but allegedly could not have provided the services for which compensation was claimed. EDS advised Petitioner that a suspension is generally limited to 180 days, but the suspension could be extended upon CMS approval. EDS also advised Petitioner that suspension is not punitive and Petitioner could continue to provide services and submit claims for payment to Medicare, the claims would be reviewed, Petitioner could appeal denied claims, but payment would be withheld during the period of the suspension. CMS Ex. 7.

On July 14, 2006, Petitioner filed a complaint for damages and injunctive relief (compliant) against the Secretary, NHIC, and EDS in the United States District Court for the Central District of California. Petitioner stated in its complaint that due to repeated denial of its claims it was unable to financially sustain operations and it stopped providing services and went out of business in or about February 2006. CMS Ex. 1, at 17. Petitioner alleged that NHIC and EDS forced Petitioner to stop providing services and to go out of business. CMS Ex. 1, at 24. Petitioner sought: judicial review of claims denied by the Secretary through the Medicare Appeals Council; that the court declare Petitioner entitled to be reimbursed for certain claims; a writ directing the Secretary to reopen and review certain of Petitioner's claims; and damages. CMS Ex. 1, at 18-29. On September 15, 2006, the complaint was dismissed without prejudice. CMS Ex. 3.

Petitioner was notified by letter dated October 23, 2006, from the Medicare contractor EDS, that the period of suspension of payment was being extended for an additional 180 days with approval by CMS. CMS Ex. 8.

On November 7, 2006, the Medicare contractor EDS requested by letter that Petitioner provide specified records for a list of patients and dates of services. EDS required that Petitioner respond in 15 days, but no list of patients was attached to the EDS letter. P. Ex. 3. The list of 65 patients was attached to a letter from EDS to Petitioner dated November 13, 2006. EDS extended the time for Petitioner to respond with the specified records to December 4, 2006. P. Ex. 4.

Petitioner was notified by letter dated March 27, 2007, that CMS approved a further extension of the payment suspension, but no period for the extension was specified. EDS indicates that the reason for the extension was Petitioner's failure to provide requested documentation so that EDS could complete its review. CMS Ex. 9.

CMS Medicare contractor SafeGuard Services (SafeGuard) advised Petitioner by letter dated April 9, 2008, that the post payment audit or review for the period January 1, 2005 to February 28, 2006 was completed. CMS Ex. 11. The contractor stated that it reviewed 2,037 claims totaling $1,715,100.00; $1,284,895.89 in claims were allowed; and $1,023,855.65 in claims were previously paid. The notice indicates that Petitioner was placed on prepayment review on March 27, 2006. The notice clarifies that the suspension of payments was effective March 22, 2006, although I note that the effective date of the suspension is not mentioned in the EDS letter of April 6, 2006 (CMS Ex. 7). The notice indicates that Petitioner was sent a preliminary overpayment letter dated January 30, 2007, that alleged that Petitioner had been overpaid in the amount of $953,535.94. The contractor reveals that its medical consultant completed review of records submitted by Petitioner on April 19, 2007. CMS Ex. 11, at 1-3. The contractor discussed in its letter the results of its review, concluded that Petitioner was overpaid in the amount of $953,535.94, and advised Petitioner that it would receive a demand for overpayment from another Medicare contractor, NHIC, and that the demand would explain Petitioner's appeal rights. CMS Ex. 11, at 12-13.

Petitioner received a second letter from SafeGuard dated April 9, 2008. SafeGuard advised Petitioner that CMS had directed termination of payment suspension. The contractor advised that payment suspension would end when NHIC issued the demand for overpayment referenced in SafeGuard's April 10, 2008 letter. CMS Ex. 11. I note that the reference to an April 10 letter is in error, as the letter described is actually the letter discussed above dated April 9, 2008.

In addition to being placed on prepayment review on March 27, 2006 (P. Ex. 2) and suspension of payments on April 6, 2006 (CMS Ex. 7), Petitioner was notified on April 6, 2006, that its Medicare Billing Privileges were being revoked on April 21, 2006. CMS Ex. 2. The April 6, 2006 notice-letter was issued by NHIC. The letter advised Petitioner that NHIC possessed information "which establishes that [Petitioner] . . . submitted false or fraudulent claims to Medicare" for services Petitioner did not provide. CMS Ex. 2, at 1.

1. Issues within my jurisdiction or authority.

Of all the actions by CMS and its contractors described above, only the last, the April 6, 2006 notice of revocation, is subject to my jurisdiction. CMS agreed during the initial prehearing conference that I have authority to review and decide whether there was a basis for revocation as upheld by the hearing officer's unfavorable decision on July 28,

2006 (CMS Ex. 5). The CMS consent to my jurisdiction is consistent with recent revisions to the Secretary's regulations. As part of such review, it is necessary for me to determine whether there is a basis for the CMS revocation action. In its April 6, 2006 notice of revocation, the CMS contractor alleged that it had evidence that Petitioner had submitted false or fraudulent claims as the basis for revocation. In the context of such allegations, it would be necessary for me to review individual claims that were allegedly false or fraudulent. However, as discussed in detail hereafter, CMS has now withdrawn from the allegations that the revocation was based upon individual claims and no such allegations are before me for review.

I am aware of no statutory or regulatory provision, and Petitioner points to no authority, that accords Petitioner a right to challenge or have reviewed the CMS decisions to impose prepayment review or to suspend payments to Petitioner.

I have no authority to review Petitioner's individual claims for reimbursement for services allegedly provided to Medicare eligible beneficiaries. Authority to review such claims has been delegated by the Secretary to ALJs assigned to the Office of Medicare Hearings and Appeals (OMHA). *See* Act, § 1869(a), (b), (d); 42 C.F.R. § 405.855. I also have no authority to review or decide any claims by CMS to recoup overpayments. *See* Act, §§ 1870(a), 1879; 42 C.F.R. Part 405, Subpart C.

2. The March 6, 2007 Ruling granting the CMS motion to dismiss.

Petitioner requested a hearing on September 25, 2006, after receiving the July 28, 2006 unfavorable hearing officer decision. On November 29, 2006, CMS moved to dismiss the request for hearing. On March 6, 2007, I issued a ruling granting the CMS motion to dismiss the request for hearing in this case. I made one finding of fact,[7] i.e., that CMS had declared the April 6, 2006 revocation of Petitioner's billing privileges by NHIC a nullity. I did not inquire into or address the basis for the judicial declaration and admission of the Office of General Counsel, which represents CMS in this matter, that the revocation action was a nullity,[8] i.e., the argument that Petitioner had previously voluntarily terminated its participation in the program. The initial determination for

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[7] The Board correctly noted in its remand decision that I failed to specifically denominate my finding of fact and conclusion of law as such. The regulations require that a decision contain separately numbered findings of fact and conclusions of law (42 C.F.R. § 498.74(a), although I note that that requirement is often not observed, at least as to findings of fact.

[8] "Nullify" means to make void or to render invalid. "Nullification" is the act of making something void or may mean the state or condition of being void. "Nullity" means legally void. *Black's Law Dictionary* 1098 (8th ed. 2004).

which a hearing was requested was the "involuntary" termination of Petitioner's PIN by the CMS contractor NHIC based upon allegedly false or fraudulent claims. After CMS withdrew from those allegations as a basis for revocation and declared the revocation a nullity, I had no evidence of any adverse action by CMS within my jurisdiction affecting Petitioner's billing privileges. I have no authority to issue advisory opinions on matters not before me. I made one conclusion of law, i.e., because there was no revocation of Petitioner's PIN or billing privileges, Petitioner had no right to a hearing and dismissal was appropriate.

On June 25, 2007, I issued a ruling denying Petitioner's request that I reconsider my March 6, 2007 ruling. I denied the request because the parties presented no new facts that would cause me to reopen and revise my earlier ruling, i.e., the parties had presented no evidence that there was an involuntary termination by a CMS contractor, CMS, or the Secretary.[9] I did not provide an advisory opinion regarding the CMS argument that there may have been a voluntary termination by Petitioner or the issue of my jurisdiction to review such a termination. I also avoided suggesting a possible course of action by CMS.

While my finding, based upon the concession of counsel for the Secretary and CMS, that no revocation of Petitioner's PIN occurred seemed to be wholly favorable to Petitioner, Petitioner nevertheless requested review by the Board.

3. The November 6, 2007 Board remand decision.

On November 6, 2007, the Board issued a decision vacating my ruling dismissing the request for hearing and remanding the case to me for further action specified in the decision. *KGV Easy Leasing, dba Privilege Diagnostics*, DAB No. 2130 (2007).

Despite my failure to specifically denominate my finding of fact and conclusion of law, the Board correctly identified my factual finding that a revocation did not occur on April 6, 2006, and my conclusion of law that because there was no revocation, there was no right to a hearing. Board Decision at 4. In the remaining four pages of its discussion the Board appears to have fallen victim to the parties' speculations and convoluted arguments about the basis for my ruling dismissing the request for hearing, rather than accepting the simple answer provided by the ruling itself. *See, e.g.,* Board Decision at 5-6, n.5. The Board recognized that

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[9] In its remand decision the Board suggests that I may have failed to consider the evidence submitted by Petitioner in connection with the request for reconsideration. Board Decision at 4. To the contrary, I specifically mentioned that the parties had not presented new facts that would cause me to reopen and revise. *Ruling Denying Request for Reconsideration* at 1 (June 25, 2007). There is no requirement that I actually summarize or specifically discuss evidence to demonstrate that it was considered.

> [T]he appealability [sic] of a voluntary termination finding is not at issue here because there is no evidence that a CMS official with proper authority actually made such a finding. Moreover, nowhere in its motion to dismiss did CMS assert that it had made a finding of voluntary termination.

Board Decision at 6. Nevertheless, the Board directed that on remand, if CMS renews its motion to dismiss, I am to determine:

> [W]hether KGV voluntarily terminated its Medicare enrollment and billing privileges prior to April 2006.

Board Decision at 8. Depending upon the results of that inquiry, the Board directed that I reconsider the motion to dismiss. If, on the other hand, CMS does not renew the motion to dismiss, the Board specified that I am to promptly conduct a hearing on the merits, of what, is not specified by the Board.

The Board in its remand decision expressed concern that there was no evidence that one with proper authority at CMS declared the involuntary revocation of Petitioner's PIN, evidenced by the April 6, 2006 notice, a nullity. Indeed, the Board rejected with virtually no discussion the notion that counsel from the Office of General Counsel (OGC) assigned to represent CMS in this case had authority to declare the April 6, 2006 revocation a nullity and withdraw the allegation that revocation of Petitioner's billing number was based upon false or fraudulent claims. The CMS responses to my December 3, 2007 Order clearly demonstrate that counsel from OGC who represent CMS before me had full authority to act for and bind CMS and the Secretary.[10] CMS *Response to December 3, 2007 Order*, dated December 11, 2007. It is not necessary in this case to determine with more certainty the scope of the authority of counsel for CMS to declare the April 6, 2006 notice of NHIC rescinded as on December 4, 2007, a CMS official took action and rescinded the NHIC notice. CMS Ex. 6. I note, however, that I have no doubt that counsel for CMS acted within his authority when advising Petitioner and me that the government would no longer proceed on the theory that Petitioner's billing privileges were revoked due to evidence of false or fraudulent claims.

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[10] CMS cites to Part A, Chapter AG (Office of the General Counsel), Section AG20(3), Statement of Organization, Functions and Delegations of Authority, U.S. Department of Health and Human Services (OGC attorneys authorized to represent the Department in litigation before the Board); M. Graham, Federal Practice and Procedure: *Evidence* §§ 7023 (Interim Ed. 2007) (discussing Rule 801(d)(2)(D) and application to attorneys representing clients in proceedings); and *U.S. v. Kattar*, 840 F.2d 118, 130-31 (1st Cir. 1988) (government attorney in proceeding establishes the position of the United States by his or her assertions). *See also United States v. Bisset-Berman Corp.*, 481 F.2d 764, 768-69 (9th Cir. 1973); Fed.R.Civ.Pro. 11(b).

The Board was also concerned that there was no evidence that one with proper authority at CMS made a finding that Petitioner had voluntarily terminated its participation in Medicare. This concern was well founded and validates my conclusion that when the April 6, 2006 revocation was nullified, there was no adverse CMS action pending against Petitioner's billing privileges. CMS also recognized a vacuum had been created. CMS thus produced the December 4, 2007 letter from CMS to Petitioner, which declared that Petitioner's participation in Medicare was terminated on February 28, 2006, on grounds that Petitioner allegedly ceased providing services and went out of business as an IDTF on that date. CMS Ex. 6. Therefore, there is now evidence that CMS declared Petitioner's participation in Medicare terminated, whether voluntarily or involuntarily, based upon Petitioner's cessation of business and providing services.[11]

4. The renewed CMS motion to dismiss following remand.

CMS advised me of its intent to renew its motion to dismiss on November 21, 2007. CMS reminded me at the end of its filing in response to my December 3, 2007 Order, that it renewed the motion to dismiss and requested an opportunity to submit further supporting argument and evidence should I determine that the record was insufficient to sustain the motion. I concluded that further argument or supplementation of the record was unnecessary. The positions of both parties on the motion to dismiss were well-documented in their numerous pleadings. CMS did not elaborate upon what other evidence it might offer in support of its motion, and I found the promise of additional unspecified evidence an insufficient reason to further delay ruling, particularly as the evidence before me made the ruling clear.

The evidence shows that CMS rescinded the action to revoke Petitioner's PIN based upon allegations of fraud and false claims. The evidence shows one with authority acting on behalf of CMS rescinded the revocation action based on false claims or fraud. The evidence shows that CMS on December 4, 2007, declared Petitioner's enrollment and PIN revoked effective February 28, 2006, based upon Petitioner's cessation of operation as an IDTF on or about that date.

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[11] The Board directs me to address on remand whether claims listed in the NHIC notice on April 6, 2006 are or were subject to review, I presume by OMHA and the Medicare Appeals Council who have jurisdiction to review individual claims. Board Decision at 8. However, whether those claims are pending review or not is not relevant to the issues before me, as CMS has withdrawn its allegation that revocation was based upon those allegedly false or fraudulent claims.

CMS requested dismissal of the request for hearing pursuant to 42 C.F.R. § 498.70(b). The cited regulation provides that an ALJ may dismiss a request for a hearing either entirely or as to any issue if the petitioner has no right to a hearing or is not a proper party. The CMS theory is that the Petitioner in this case has no right to a hearing because Petitioner "voluntarily terminated" its participation in Medicare pursuant to 42 C.F.R. § 489.52, despite Petitioner's protestations to the contrary. CMS argues that voluntary termination is not one of the initial determinations listed in 42 C.F.R. § 498.3(b) over which ALJs may exercise jurisdiction under 42 C.F.R. Part 498. CMS Motion to Dismiss at 3-7. CMS pursues a similar argument in its brief on the merits. Respondent's Prehearing Brief (CMS Brief) at 4-8. However, the Board correctly noted in the remand decision that 42 C.F.R. § 489.52, the regulatory provision that is the lynch-pin for the CMS argument, has no application in this case as 42 C.F.R. §§ 489.52, 489.53, 489.54, 489.55, and 489.57 govern termination of "provider agreements" by the provider, CMS, or OIG, and reinstatement of a "provider agreement" after termination.[12] The Board correctly found that Petitioner is a supplier and not a provider, and suppliers do not have provider agreements that they can voluntarily terminate. Board Decision at 7; *see* Act, § 1861(d) (supplier is a physician or other practitioner, a facility, or other entity (other than a provider of services), that furnishes items or services under the Act).

Revocation of a supplier's enrollment in Medicare and the revocation of the supplier's billing privileges is governed by 42 C.F.R. § 424.535, which lists specific grounds for the revocation of a supplier's enrollment and billing privileges. Part 424 of 42 C.F.R. does not appear to include specific provisions similar to 42 C.F.R. § 489.52, nor language making that regulatory provision applicable to suppliers.

Section 1866(j)(2) of the Act provides that a provider of services or supplier whose application to enroll is denied or not renewed is entitled to a hearing and judicial review. Provider and supplier appeal rights are set forth in the Secretary's regulations at 42 C.F.R. § 424.545. Counsel for CMS agreed during the prehearing conference on November 15, 2006 (Order dated November 20, 2006), that the current version of the regulation was undergoing revision and that pending such revision, CMS agrees that the hearing and appeal procedures established by 42 C.F.R. Part 498 should be applied in this case. The regulations provide that "(a)ny supplier dissatisfied with an **initial** determination that the services subject to the determination no longer meet the conditions for coverage, is entitled to a hearing before an ALJ." 42 C.F.R. § 498.5(e) (emphasis added). Initial determinations by CMS listed at 42 C.F.R. § 498.3(b) include "[w]hether the services of a supplier continue to meet the conditions for coverage . . . ." 42 C.F.R. § 498.3(b)(6). CMS determined in this case, evidenced by the December 4, 2007 letter (CMS Ex. 6),

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[12] Contrary to what the title to 42 C.F.R. Part 489 indicates, its application is limited to providers and provider agreements. *See* 42 C.F.R. § 489.2. IDTFs, such as Petitioner, are not listed as subject to the provisions of the part. 42 C.F.R. § 489.2(b).

that Petitioner no longer met conditions for coverage, an initial determination. Accordingly, I concluded that Petitioner was entitled to a hearing by an ALJ and the CMS motion to dismiss was denied. Ruling Denying CMS Motion to Dismiss and Scheduling Order dated February 5, 2008.

On April 10, 2008, CMS submitted a letter that I treated as a motion to reconsider my February 5, 2008 ruling denying its motion to dismiss. Because CMS had filed additional evidence in response to my order to produce, I reconsidered my February 5, 2008 ruling and again denied the CMS motion to dismiss. Additional rationale to that stated in my ruling of February 5, 2008, was my observation that the evidence submitted by CMS confirmed the presence of a case and controversy for me to adjudicate. Contrary to the suggestion of CMS in its April 10, 2008 letter, it did file a dispositive motion in the form of its motion to dismiss. I granted that motion and dismissed the request for hearing. The Board vacated the dismissal and remanded the case for me for further proceedings. Vacation of my Ruling dismissing the case resulted in the CMS motion being unresolved and pending before me. By letter dated November 21, 2007, CMS renewed its motion to dismiss. On December 11, 2007, CMS responded to my Order of December 3, 2007. CMS responded to the issues specified in my December 3, 2007 Order, and included two and one-half pages arguing in support of its motion to dismiss. On January 29, 2008, CMS filed the parties' status report, which included an approximate three-page statement of CMS, again arguing in support of its motion to dismiss. The arguments advanced by CMS in both pleadings were similar to that advanced in its original briefing on the motion. In my ruling dated February 5, 2008, I noted at page 4 that after reviewing the CMS response to my order dated December 3, 2007, I found it unnecessary to receive supplemental briefing upon the CMS motion to dismiss.[13] Thus, the CMS arguments that this case should have been dismissed have been fully considered on more than one occasion and found to be meritless.

Even if I accepted the CMS argument that "voluntary termination" pursuant to 42 C.F.R. § 489.52 or similar provision was applicable to suppliers[14], I would nevertheless find it appropriate to deny the motion to dismiss. Considering the pleadings of the parties, I

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[13] On June 3, 2008, CMS requested by email that a date be set for CMS to file a reply brief on the merits of the case. On June 4, 2008, I issued an Order granting CMS until June 23, 2008, to file a reply. The CMS one-page reply consisted of the assertion that the matter was fully briefed and that the request for hearing should be dismissed.

[14] CMS argues that the SOM extends the application of 42 C.F.R. § 489.52 to suppliers. CMS Brief at 7-8. The SOM does not have the force and effect of law. *State of Indiana by the Indiana Department of Public Welfare v. Sullivan*, 934 F.2d 853 (7th Cir. 1991); *Northwest Tissue Center v. Shalala*, 1 F.3d 522 (7th Cir. 1993). CMS is the proponent of 42 C.F.R. Part 489 and has the option to modify the regulations which are legally enforceable against Petitioner.

conclude that CMS has mischaracterized the nature of the termination in this case as a "voluntary termination" and that CMS has, in fact, involuntarily terminated Petitioner's enrollment and billing privileges. CMS has cited no authority for the proposition that I am bound by its characterization of the termination action as voluntary even though the facts show that the termination was involuntary. Key to my conclusion that Petitioner did not voluntarily terminate is the fact that Petitioner did not give the notice of termination to CMS and the public as would be required by 42 C.F.R. § 489.52(a) and (c). *Cresent Healthcare*, DAB No. 1888, 2003 WL 21801701 (HHS) (July 11, 2003). Another important fact is that it was CMS who issued the notice of termination on December 4, 2007 (CMS Ex. 6) in this case rather than Petitioner. Finally, it is significant that Petitioner presented some argument and evidence to support its argument that it had, in fact, continued in business and to provide services after February 28, 2006.

Accordingly, I concluded that Petitioner was entitled to a hearing and decision on the issue of whether CMS had a basis to revoke Petitioner's billing privileges. Petitioner waived an oral hearing by letter dated May 1, 2008, presented its arguments, and requested a judgment on the existing record.

5. Petitioner ceased providing services on or about April 6, 2006.

In its July 2006 complaint in the U.S. District Court, Central District of California, Petitioner clearly stated that due to repeated denial of its claims it was unable to financially sustain operations and it stopped providing services and went out of business in or about February 2006. CMS Ex. 1, at 17. In his December 15, 2006 declaration, Petitioner's principal[15] and representative in this proceeding, Gregory Davidov, stated that:

> In March of 2006, . . . [EDS] of which NHIC is a wholly-owned subsiderary again placed KGV on a prepayment review. Unable to operate without being paid for its services, in February of 2006, KGV stopped providing further services but continued to proceed with the administrative review of its 2002-2003 claims as well as its 2005-2006 claims.

P. Ex. 5, at 2-3. I construe the claims to which Petitioner refers, to be claims for Medicare reimbursement. In a declaration dated May 3, 2007, Mr. Davidov declared that Petitioner never intended to surrender its billing privileges, that he hoped to resume operations after receiving payment on his claims, and that Petitioner was effectively

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[15] Gregory Davidov was the President and owner of KGV Easy Leasing Incorporated, doing business as Privilege Diagnostics, the Petitioner. P. Exs. 5, 6, 7.

driven out-of-business and ceased providing services on April 6, 2006, when NHIC notified Petitioner that its billing privileges were revoked. He further declares that Petitioner continued to provide services to patients between February 2006 and April 2006, although Petitioner's operations were greatly reduced. P. Ex. 6.

In response to my order to produce, CMS filed CMS Ex. 10, a listing of Fully Denied Claims submitted by Petitioner. The list shows claims with dates of service (column title "FDOS") in January, February, and March 2006. The latest date of service listed is March 29, 2006 on four claims. Petitioner also filed 12 claims with date of service of March 28, 2006. CMS Ex. 10. Petitioner also submitted for my consideration, copies of test results for tests done on April 6, 2006. P. Ex. 9. CMS argues that its records show that no claims for services were filed by Petitioner after March 28, 2006 (CMS Brief at 10), however CMS Ex. 10 shows claims filed on March 29, 2006. CMS argues that Mr. Davidov's attestation is self-serving and not entitled to credence. CMS Ex. 9-10. CMS does not address P. Ex. 9, but, no doubt, CMS does not believe that evidence credible either. CMS argues that it does not matter if Petitioner ceased providing services in February 2006, March 2006, or April 6, 2006. Rather, CMS asserts that the key consideration is whether Petitioner ceased providing services prior to April 21, 2006, the effective date of the rescinded revocation by NHIC. CMS Brief at 10-11.

For purposes of this decision, out of an abundance of caution, I accept as credible Mr. Davidov's representation that Petitioner ceased providing services as an IDTF on April 6, 2006. Although CMS questions Mr. Davidov's credibility, the date is supported by CMS records showing that claims for dates of service of March 29, 2006 were denied by the CMS contractor and by records of testing submitted by Mr. Davidov. Further, CMS now takes the position that the precise date is of no consequence so long as it was before April 21, 2006.

Accordingly, I conclude that Petitioner ceased providing services as an IDTF on April 6, 2006. Whether Petitioner voluntarily ceased providing service as CMS asserts or Petitioner was forced out of business by CMS contractors is a matter of opinion and perspective. Whether voluntary or involuntary, I concluded that Petitioner was entitled to a hearing and decision and he has received same.

6. Petitioner's billing privileges are revoked effective January 3, 2008.

Because I have concluded that Petitioner ceased providing services as an IDTF on April 6, 2006, it is necessary to examine the regulatory scheme for supplier eligibility to participate in Medicare and whether cessation of operation has any effect on Petitioner's continuing eligibility for continued participation thereafter.

A supplier must be enrolled in Medicare to receive payment for Medicare items or services from either Medicare or a Medicare beneficiary. An enrolled supplier is granted billing privileges evidenced by a valid billing number. 42 C.F.R. § 424.505. Among the requirements for enrollment in Medicare is the requirement that the supplier must be operational to furnish Medicare covered items or services before being granted billing privileges. 42 C.F.R. § 424.510(d)(6). Pursuant to 42 C.F.R. § 424.510(d)(8)(ii), CMS reserves the right to review that Medicare Part B suppliers continue to be operational including the right to do an on-site review. Following enrollment, a supplier must report to CMS any changes to the information furnished on its enrollment application (42 C.F.R. § 424.520(b)), which I construe to include any change in its operational status and ability to deliver Medicare items or services. CMS may revoke a supplier's Medicare billing privileges, after an opportunity to correct, because the supplier is not complying with enrollment requirements, which include the requirement to be operational. 42 C.F.R. § 424.535(a)(1). CMS may also revoke billing privileges without an opportunity for the supplier to correct when CMS determines, based on an on-site review, that the supplier is no longer operational to furnish Medicare items or services or does not meet the enrollment requirement to provide Medicare covered items or services. 42 C.F.R. § 424.535(a)(5). Pursuant to 42 C.F.R. § 424.502,

> *Operational* means the provider or supplier has a qualified physical practice location, is open to the public for the purpose of providing health care related services, is prepared to submit valid Medicare claims, and is properly staffed, equipped, and stocked (as applicable, based on the type of facility or organization, provider or supplier specialty, or the services or items being rendered), to furnish these items or services.

In this case, Petitioner does not deny that it stopped providing services on April 6, 2006. Thus, after April 6, 2006, Petitioner was not operational and no longer met the enrollment requirements. Petitioner was subject to revocation for no longer being operational after April 6, 2006, under either 42 C.F.R. § 424.535(a)(1) or (5), with or without an opportunity to correct. CMS did not conduct an on-site review in this case. However, given Petitioner's July 2006 admission in the U.S. District Court that it stopped providing services, an on-site review would have been a needless and unnecessary act.

CMS, or its contractor, did not give Petitioner any notice that revocation of its billing privileges was based upon Petitioner's failure to continue to meet enrollment requirements because it ceased to be operational, until the CMS letter dated December 4, 2007 (CMS Ex. 6). The requirement for notice is not provided for in 42 C.F.R. Part 424. Pursuant to 42 C.F.R. § 424.545(a), a supplier was granted the right to appeal a revocation pursuant to 42 C.F.R. Part 405, subpart H. The notice of revocation must be sent by certified mail, and inform the supplier of the reason for revocation, the date by which an appeal must be filed, and the address to where an appeal should be sent in writing. 42 C.F.R. § 405.874(b). In this case, CMS agreed that the provisions of 42

C.F.R. Part 498 should be applied to this appeal. Pursuant to 42 C.F.R. § 498.20(a)(1), a notice of initial determination must be mailed by CMS, and set forth the basis or reasons for the determination, the effect of the determination, and the party's right to reconsideration, if applicable, or to a hearing. The notice requirements for a reconsidered determination are similar to those for an initial determination. 42 C.F.R. § 498.25(a). Under the revision to the regulations, effective August 26, 2008, the notice provisions are in a revised 42 C.F.R. § 405.874(b), and include that notice of revocation must be sent to the supplier by certified mail, state the reason for the revocation in sufficient detail for the supplier to understand the nature of the deficiencies, the right to appeal in accordance with 42 C.F.R. Part 498, and the address to which the appeal must be mailed. 73 Fed. Reg. 36,448, 36,460. My review of the December 4, 2007 CMS notice reveals that it states that Petitioner ceased providing services and went out of business as the basis for the termination of Petitioner's participation in the Medicare program, and that no payments would be made after the termination. The notice reflects it was sent by an express delivery service. The notice did not advise Petitioner of a right to appeal or an address to where the appeal should be sent. Though the notice was defective for not providing notice as to a right to appeal, which is required under the existing and future regulations, I conclude that error was not prejudicial as Petitioner already had this appeal pending.

The December 4, 2007 notice (CMS Ex. 6) advised Petitioner that the revocation was effective February 28, 2006, prior to the date of the notice. This was clearly in error. Pursuant to 42 C.F.R. § 424.535(f), a revocation becomes effective within 30 days of the initial revocation notification. The revision to the regulations provides that a revocation is effective 30 days after the date the notice is mailed. 42 C.F.R. § 405.874(b)(2); 73 Fed. Reg. 36,448, 36,460. I conclude, based upon the regulatory requirements, that the CMS revocation of which Petitioner was notified by the letter dated December 4, 2007, was not effective for 30 days or January 3, 2008. If the documents produced by CMS are correct, Petitioner's last claim was for services provided on March 31, 2006. Accordingly, the delayed effective date causes no prejudice to the Medicare program.

Petitioner's representative argues throughout his many correspondences that CMS forced him to cease providing services and to go out of business. Neither CMS nor its contractors have authority to require a supplier to cease operations or its business. CMS and its contractors approve a supplier for participation upon finding the supplier eligible. CMS and its contractors are tasked by the Act and the Secretary with reviewing and approving claims for services or supplies furnished by eligible suppliers to eligible beneficiaries. I have received and reviewed evidence and arguments that show Petitioner, when an eligible supplier, had much difficulty receiving payment from CMS and its contractors. I have no jurisdiction to review Petitioner's problem with obtaining payment for its claims. I note, however, that Petitioner's decision to participate in Medicare was a business decision. Apparently, Petitioner's business became so dependent upon Medicare claims that Petitioner could not continue to maintain operations after April 6, 2006, in the

face of its difficulty obtaining payment on its Medicare claims. Any decision by Petitioner to rely upon Medicare claims as its primary business was a business decision. Finally, Petitioner's decision that it could no longer continue operations after April 6, 2006, was a business decision. I find Petitioner's arguments to be without merit.

To the extent that Petitioner's arguments might be construed to be an argument that CMS should be estopped from revoking Petitioner's billing privileges, I find such argument to be without merit. I recognize that my jurisdiction in cases involving CMS is limited to hearing and deciding those issues which the Secretary has delegated authority for me to hear and decide in his regulations. The regulations authorize me only to hear and decide cases involving specified initial determinations by CMS. I have no authority to determine that CMS's actions would violate public policy and no authority to award damages or fashion extraordinary relief. I also have no authority to hear and decide claims of equitable estoppel against the Secretary. I note, however, that while the Supreme Court has not ruled that estoppel will never lie against the government, the decisions of the Court make clear that equitable estoppel will not lie against the government in cases involving benefits to be paid from the Treasury, particularly in the complicated area of Medicare. *See Office of Personnel Management v. Richmond*, 496 U.S. 414 (1990); *Heckler v. Community Health Services of Crawford County, Inc.,* 467 U.S. 51 (1984). If I had authority to rule upon an estoppel defense, I see no evidence that CMS made any representations or statements to Petitioner upon which Petitioner detrimentally relied.

I conclude that there was a basis for the revocation of Petitioner's billing privileges, i.e., Petitioner was no longer operational and no longer met enrollment requirements after April 6, 2006. The revocation of Petitioner's billing privileges was effective January 3, 2008, 30 days after the December 4, 2007 CMS notice of revocation.[16]

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[16] Pursuant to 42 C.F.R. § 424.535(c) of the current regulation, a supplier may seek to re-enroll in Medicare by completing a new application for validation by CMS. Under the revision to 42 C.F.R. § 424.535(c) effective August 26, 2008, a provider or supplier is barred from re-enrollment for a minimum of one year but not more than three years. 73 Fed. Reg. 36,448, 36,461.

III. Conclusion

For the foregoing reasons, Petitioner's billing privileges are revoked effective January 3, 2008.

/s/
Keith W. Sickendick
Administrative Law Judge

08-093 KGV Easy Leasing – Exhibit Lists

CMS Exhibits

Ex. No.	Description	Offered	Attached To	Comment
1	Complaint for Damages & Injunctive Relief, Filed 7/14/2006, U.S. Dist. Ct., Central Dist. Calif.	11/29/2006	CMS Memo. in Support of Motion to Dismiss (MTD)	
2	CMS/NHIC Ltr. Dtd. 4/6/2006, Re: Notice of Revocation of Billing Privileges	11/29/2006	CMS Memo. in Support of MTD	
3	Judgment of Dismissal, Filed 9/15/2007, U.S. Dist. Ct., Central Dist. Calif.	11/29/2006	CMS Memo. in Support of MTD	
4	Notice of Final Action and Order of Remand of Medicare Appeals Council	12/29/2006	CMS Reply to P. Opp. to MTD	
5	CMS/NHIC Ltr. Dtd. 7/28/2006	4/10/2008	CMS Production	Marked by CMS as Ex. 4
6	CMS Ltr. Dtd. 12/4/2007 Ho to P.	4/10/2008	CMS Production	Marked by CMS as Ex. 5
7	CMS/EDS Ltr. Dtd. 4/6/2006	4/10/2008	CMS Production	Marked by CMS as Ex. 6
8	CMS/EDS Ltr. Dtd. 10/23/2006	4/10/2008	CMS Production	Marked by CMS as Ex. 7
9	CMS/EDS Ltr. Dtd. 3/27/2007	4/10/2008	CMS Production	Marked by CMS as Ex. 8
10	Medicare Part B Billing Provider Detail – Fully Denied Claims, 3/1/2006 -- 2/29/2008	4/10/2008	CMS Production	Marked by CMS as Ex. 9
11	CMS/SafeGuard Services, Ltr. Dtd. 4/9/2008, Final Notice of Post Payment Audit	4/15/2008	Ltr. Submitting Exhibit	Marked by CMS as Ex. 10
12	CMS/SafeGuard Services, Ltr. Dtd. 4/9/2008, Termination of Payment Suspension	4/18/2008	Ltr. Submitting Exhibit	Marked by CMS as Ex. 11

Petitioner's Exhibits

Ex. No.	Description (Based on first page)	Date Offered	Attached To	Comment
1	CMS/NHIC Ltr. Dtd. 5/24/2004	12/15/2006	Petitioner's Opp. To CMS MTD (P. Opp.)	
2	CMS/EDS Ltr. Dtd. 3/27/2006	12/15/2006	P. Opp.	
3	CMS/EDS Ltr. Dtd. 11/7/2006	12/15/2006	P. Opp.	
4	CMS/EDS Ltr. Dtd. 11/13/2006	12/15/2006	P. Opp.	
5	Declaration, Gregory Davidov, Dtd. 12/15/2006	12/15/2006	P. Opp.	Not marked by Petitioner
6	Declaration, Gregory Davidov, Dtd. 5/2/2007 with Exhibit A	5/3/2007	P. Motion to Vacate and Reconsideration	Not marked by Petitioner
7	Declaration, Gregory Davidov, Dtd. 6/6/2007	6/5/2007	P. Reply to CMS Opp. to Reconsideration	Marked by P. as Ex. 1 to pleading
8	Declaration, Gary Berkovich, Esq.	6/5/2007	P. Reply to CMS Opp. to Reconsideration	Marked by P. as Ex. 2 to pleading
9	Neuro-Electro Diagnostic Tests, Physician Order Form, Dtd. 4/6/2006	6/5/2007	P. Reply to CMS Opp. to Reconsideration	Marked by P. as Ex. 3 to pleading
10	CMS Ltr. Dtd 12/4/2007, Ho to P.	12/20/2007	P. Response to 12/3/2007 Order	Marked by P. as Ex. 1 to pleading
11	Misc. Communication between CMS counsel and Davidov	12/20/2007	P. Response to 12/3/2007 Order	Marked by P. as Ex. 2 to pleading