Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	Date: November 14, 2008
Abdul Razzaque Ahmed, M.D.	)	
(PTANS: J08437, SX0554, M20993),	)	
Petitioner,	)	Docket No. C-08-452
	)	Decision No. CR1864
v.	)	
	)	
Centers for Medicare & Medicaid Services.	)	

DECISION

The Medicare supplier numbers and billing privileges of Petitioner, Abdul Razzaque Ahmed, M.D., were properly revoked, effective November 5, 2007.

I. Background

The Medicare contractor for the Centers for Medicare & Medicaid Services (CMS), National Heritage Insurance Company (NHIC), notified Petitioner by letter dated November 8, 2007, that his Medicare Provider Transaction Access Numbers (PTANs)[1] were being revoked on December 9, 2007, with an effective date of November 5, 2007. The regulatory authority cited for the revocation was 42 C.F.R. § 424.535(a)(3)(i)(B) based upon Petitioner's felony conviction of "a single count of obstruction." CMS Exhibit (CMS Ex.) 2; Petitioner's Exhibit (P. Ex.) 9. Petitioner requested reconsideration by a contractor hearing officer who issued a decision on March 12, 2008. The hearing officer sustained the revocation pursuant to 42 C.F.R. § 424.535(a)(3)(i)(B) based upon Petitioner's felony conviction. CMS Ex. 1.

Petitioner requested a hearing before an administrative law judge (ALJ) by letter dated May 9, 2008. The case was assigned to me for hearing and decision on May 15, 2008. On June 3, 2008, I convened a prehearing conference by telephone, the substance of

[1] At the time, a PTAN represented the billing privileges of the supplier and revocation of the PTAN was revocation of billing privileges.

which is memorialized in my Order and Schedule for Filing Briefs and Documentary Evidence dated June 4, 2008. During the prehearing conference, CMS agreed that proceedings in this case are subject to 42 C.F.R. Part 498.[2] Petitioner did not waive his right to a hearing but CMS requested the opportunity to file a motion for summary judgment before further case development. With the agreement of the parties, I established a briefing schedule. CMS filed its opening brief (CMS Brief) and exhibits 1 through 8 on July 3, 2008. Petitioner filed an opposing brief and a cross-motion for summary judgment (P. Brief) with exhibits 1 through 15 on August 1, 2008. CMS filed its reply on August 29, 2008. The parties have not objected to my consideration of the offered exhibits. Therefore, CMS Exs. 1 through 8 and P. Exs. 1 through 15 are admitted.

II. Discussion

A. Findings of Fact

These findings are based upon the undisputed statements of fact in the parties' pleadings and the documentary evidence admitted.

1. Petitioner admitted to creating false documents, letters and immunopathology reports, and adding them to patient records in order to obstruct the government's investigation into his prior billings for possible Medicare fraud. P. Brief at 5; P. Ex. 8.

2. On November 5, 2007, Petitioner pled guilty to and was convicted of one felony count of obstruction of a criminal investigation of health care offenses, in violation of 18 U.S.C. § 1518, in the United States District Court, District of Massachusetts. P. Brief at 6; P. Ex. 8; CMS Ex. 5.

3. Petitioner's conviction occurred within the 10 years preceding revalidation of his enrollment in Medicare.

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[2] CMS proposed regulatory changes on October 25, 1999 (64 Fed. Reg. 57,431) and again on March 2, 2007 (72 Fed. Reg. 9,479) to extend appeal rights to suppliers like Petitioner, including the right to hearing by an ALJ, review by the Departmental Appeals Board (the Board), and judicial review. The final rule amending 42 C.F.R. Parts 405, 424, and 498 was not issued until June 27, 2008, and the changes were not effective until August 26, 2008. 73 Fed. Reg. 36,448. Prior to issuance of the final rule and its effective date, CMS consented to hearing by ALJ and review by the Board in supplier cases involving denial of enrollment or revocation of billing privileges.

B. Conclusions of Law

1. I have jurisdiction.

2. The Secretary of Health and Human Services (Secretary) has determined and provided by regulation that financial crimes or similar crimes are detrimental to the Medicare program or its beneficiaries. 42 C.F.R. § 424.535(a)(3)(i)(B).

3. Petitioner was convicted of obstruction of a criminal investigation of health care fraud offenses which, on the facts of this case, is a financial crime similar to the financial crimes that the Secretary has found are detrimental to the Medicare program or its beneficiaries.

4. Petitioner pled guilty to and was convicted of a financial crime within the meaning of 42 C.F.R. § 424.535(a)(3)(i)(B).

5. There is a basis for revocation of Petitioner's enrollment in Medicare and his billing privileges.

6. CMS or its contractor is not required to conduct a revalidation of enrollment before revoking a provider's or supplier's billing privileges pursuant to 42 C.F.R. § 424.535(a)(3).

7. The issue for hearing and decision is whether there is a basis for revocation of Petitioner's billing privileges and jurisdiction does not extend to review of whether CMS properly exercised its discretion to revoke Petitioner's Medicare enrollment and billing privileges.

8. Petitioner's enrollment in Medicare and his billing privileges were properly revoked, effective November 5, 2007.

C. 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. Payment under the program for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of services and suppliers.[3] Act

[3] 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,"

§§ 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395(u)(h)(1)). Administration of the Part B program is through contractors. Act § 1842(a) (42 U.S.C. § 1395u(a)). The Act requires the Secretary to issue regulations that establish a process for the enrollment of providers and suppliers, including the right to a hearing and judicial review in the event of denial or non-renewal. Act § 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to 42 C.F.R. § 424.505, 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. If enrollment is approved, a supplier is issued a National Provider Identifier (NPI) to use for billing Medicare and a PTAN, an identifier for the supplier for inquiries. Medicare Program Integrity Manual (MPIM), Chapter 10, Healthcare Provider/Supplier Enrollment, § 6.1.1.

Qualified physician services are covered by the program for those enrolled, subject to some limitations. Act §§ 1832(a) (42 U.S.C. § 1395k(a)); 1861(s)(1) (42 U.S.C. § 1395x(s)(1)). "Physician's Services" means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls (with certain exceptions). Act § 1861(q) (42 U.S.C. § 1395x(q)). The term "physician," when used in connection with the performance of any function or action, means, in part, a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she performs such function or action. Act § 1861(r) (42 U.S.C. § 1395x(r)); 42 C.F.R. § 410.20(b). The Medicare program authorizes Medicare Part B payments for services provided by physicians. 42 C.F.R. § 410.20. A physician who wants to bill Medicare or its beneficiaries for Medicare-covered services or supplies must enroll in the Medicare program. 42 C.F.R. § 424.505. Medicare pays a supplier directly for covered services if the beneficiary assigns the claim to the supplier and the supplier accepts it. Medicare may pay a supplier's employer if the supplier is required, as a condition of employment, to turn over the fees for the supplier's services. Medicare will also pay an entity billing for a supplier's services if the entity is enrolled in Medicare and there is a contractual arrangement between the entity and the supplier. Act § 1842(b)(6); 42 C.F.R. §§ 424.55(a), 424.80(a) and (b).

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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 sections 1814(g) and 1835(e) of the Act. Act § 1861(u) (42 U.S.C. § 1395x(u)). The distinction between providers and suppliers is important because they are treated differently under the Act for some purposes.

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)(2).

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" revalidation that 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.

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. Pursuant to 42 C.F.R. § 424.535(a)(3), if a provider or supplier or the owner of a provider or supplier is convicted of a federal or state felony that CMS has determined is detrimental to the program or its beneficiaries, CMS may revoke billing privileges. *See* Act § 1866(b)(2)(D) (42 U.S.C. § 1395cc(b)(2)(D)). The regulation specifies that the conviction must have occurred within the 10 years preceding enrollment or revalidation of enrollment in Medicare. Offenses that CMS has found detrimental to the program or its beneficiaries include financial crimes such as income tax evasion, insurance fraud, and similar crimes. 42 C.F.R. § 424.535(a)(3)(i)(B). The Act provides for a hearing by an ALJ and judicial review of the determination to deny enrollment or re-enrollment. Act § 1866(j)(2).

D. Issue

Whether there was a basis for revocation of Petitioner's supplier numbers and his billing privileges.

E. Analysis

1. Summary judgment is appropriate.

CMS moved for summary judgment and Petitioner filed a cross-motion for summary judgment. There are no genuine issues of material fact in dispute in this case and summary judgment is appropriate. Petitioner does not deny that on November 5, 2007, he pled guilty in the United States District Court, District of Massachusetts, to one count of obstruction of criminal investigations of health care offenses in violation of 18 U.S.C. § 1518, a felony. P. Brief at 1; P. Ex. 8.

Summary judgment is appropriate and no hearing is required where either: there are no disputed issues of material fact and the only questions that must be decided involve application of law to the undisputed facts; or, the moving party must prevail as a matter of law even if all disputed facts are resolved in favor of the party against whom the motion is made. *See White Lake Family Medicine, P.C.,* DAB No. 1951 (2004); *Lebanon Nursing and Rehabilitation Center*, DAB No. 1918 (2004). A party opposing summary judgment must allege facts which, if true, would refute the facts relied upon by the moving party. *See, e.g.*, Fed. R. Civ. P. 56(c); *Garden City Medical Clinic*, DAB No. 1763 (2001); *Everett Rehabilitation and Medical Center*, DAB No. 1628, at 3 (1997) (in-person hearing required where non-movant shows there are material facts in dispute that require testimony); *Thelma Walley*, DAB No. 1367 (1992); *see also New Millennium CMHC, Inc.*, DAB CR672 (2000); *New Life Plus Center, CMHC,* DAB CR700 (2000).

This case requires an application of the law to the undisputed facts. The issues in this case turn on the legal interpretation of the regulation 42 C.F.R. § 424.535 and other regulatory provisions that govern revocation of billing privileges as discussed hereafter. Petitioner does not dispute that he was convicted of a felony. Petitioner opposes summary judgment and asserts that judgment should be entered for him as a matter of law on three theories:

> The CMS contractor had no legal authority to revoke Petitioner's billing privileges because it did not first conduct an enrollment or revalidation process as required by the regulation, resulting in deprivation of Petitioner's right to be heard;
>
> The crime of which Petitioner was convicted was not a financial crime and not a proper basis for exclusion pursuant to 42 C.F.R. § 424.535(a)(3)(i)(B); and

> The CMS contractor abused its discretion by failing to consider mitigating factors prior to revocation of Petitioner's billing privileges.

P. Brief at 1-2.

Neither party asserts that there is a genuine dispute as to a material fact and the evidence does not show such a dispute. Interpretation of the regulations and application of the regulations to the undisputed facts are required to resolve this case. Accordingly, summary judgment is appropriate.

2. CMS or its contractor is not required to conduct a revalidation of enrollment before revoking a provider's or supplier's billing privileges pursuant to 42 C.F.R. § 424.535(a)(3).

Revocation of enrollment and billing privileges is governed by 42 C.F.R. § 424.535. In this case, Petitioner's enrollment and billing privileges were revoked pursuant to 42 C.F.R. § 424.535(a)(3)(i)(B). There is no dispute that Petitioner was enrolled in Medicare and had billing privileges on November 5, 2007, when he was convicted, and on November 8, 2007, when NHIC gave notice that it was revoking his billing privileges on December 9, 2007, with an effective date of November 5, 2007. There is no dispute that NHIC did not give Petitioner notice that it was doing a revalidation of his enrollment eligibility or request any input from him prior to issuing the November 8, 2007 notice.

The authorized reasons or bases for revocation of enrollment and billing privileges are listed in 42 C.F.R. § 424.535(a) and include: (1) noncompliance with enrollment requirements; (2) provider or supplier conduct resulting in exclusion or debarment or suspension; (3) conviction of a felony detrimental to the best interests of the program or beneficiaries or that would result in mandatory exclusion pursuant to section 1128(a) of the Act; (4) certification of false or misleading information as true on the enrollment application; (5) determination that the provider or supplier is not operational or not meeting program enrollment requirements based on on-site review; (6) failure to furnish complete and accurate information on reverification; and (7) misuse of a billing number. The revocation in this case was based upon 42 C.F.R. § 424.535(a)(3)(i)(B), which provides:

> (3) *Felonies.* The provider, supplier, or any owner of the provider or supplier, within the 10 years preceding enrollment or revalidation of enrollment, was convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries.

> (i) Offenses include –
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> * * * *
>
> (B) Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions.

Petitioner argues, based upon the foregoing language of the regulation, that CMS had no authority to revoke Petitioner's billing privileges without first giving Petitioner notice and conducting a revalidation of his enrollment. Petitioner misconstrues the regulation and his argument is without merit.

In *Robert F. Tzeng, M.D.*, DAB No. 2169 (2008), an appellate panel of the Board took the approach that, even if one read the regulation as does Petitioner in the case before me, the regulation does not require a specific revalidation procedure and a revalidation may occur when CMS obtains information related to a conviction and then considers whether a provider or supplier continues to meet enrollment criteria. *Id*. at 11-12. Applying the rationale in *Tzeng* to the case before me, a revalidation of enrollment occurred when the CMS contractor obtained information that Petitioner was convicted and then determined that revocation of enrollment and billing privileges was required, negating Petitioner's complaint that no revalidation occurred.[4]

However, application of the regulation does not require definition of the term revalidation. The regulation plainly provides that a felony conviction within the 10 years preceding enrollment or revalidation of enrollment is a basis for revocation if the conviction is for an offense that CMS finds detrimental. Pursuant to 42 C.F.R. § 424.515, a provider or supplier must resubmit and recertify the accuracy of its enrollment information every five years in order to maintain its billing privileges. CMS reserved the right to do off-cycle revalidations in addition to the regular five-year revalidations, for any reason that causes CMS to question the compliance of the provider or supplier with enrollment requirements. 42 C.F.R. § 424.515(d)(1). Due to the five-year revalidation requirement, the conviction of a provider, supplier, or an owner of a provider or supplier of a felony offense after initial enrollment in Medicare, will necessarily have occurred

[4] The Board's characterization of revalidation appears to be at odds with revalidation procedures established by CMS in its MPIM, Ch. 10, § 9.

less than ten years prior to the next revalidation.[5] Thus, even if I accept Petitioner's assertion that no revalidation occurred in November 2007, Petitioner cannot deny that a revalidation would have occurred in five years or less and his conviction would not have occurred more than ten years prior to the revalidation.

Furthermore, the plain language of 42 C.F.R. § 424.535(a) is inconsistent with Petitioner's theory that CMS or its contractor must engage in a revalidation procedure that permits Petitioner's participation prior to revocation. P. Brief at 11. The regulation lists the reasons for revocation and it does not purport to establish the procedure for revocation. Read in its correct context, 42 C.F.R. § 424.535(a)(3) does not establish a procedure for revocation, but rather describes or lists the criteria for a conviction that may be the basis for revocation, i.e., the conviction may be no more than ten years old, the conviction must have been in a state or federal court, the conviction must be of a felony offense, and the offense must be one that CMS determines detrimental to the program or its beneficiaries. The list of specific offenses that CMS has found detrimental is at 42 C.F.R. § 424.535(a)(3)(i), and the list includes financial crimes with examples (42 C.F.R. § 424.535(a)(3)(i)(B)). The language of 42 C.F.R. § 424.535(a)(3) that Petitioner asserts requires CMS to initiate a revalidation process prior to revocation, i.e., "within the 10 years preceding enrollment or revalidation of enrollment," simply provides the method for calculating the age of the conviction rather than triggering a procedure.

The only process due Petitioner prior to revocation of enrollment and billing privileges is that required by the Act and provided by the regulations. The regulations in effect at the time Petitioner was notified of the revocation, when the reconsideration determination was issued, and when Petitioner requested a hearing, required notice of the revocation of supplier billing privileges and reconsideration by a fair hearing officer. 42 C.F.R. §§ 405.874, 424.535(f).[6] In this case, Petitioner was given notice on November 8, 2007 that his billing privileges would be revoked on December 9, 2007, with an effective date of November 5, 2007. The November 8, 2007 notice advised Petitioner of the right to request reconsideration within 60 days. CMS Ex. 2. Petitioner exercised his right to request reconsideration on December 13, 2007 (CMS Ex. 1, at 2; P. Ex. 10), after the revocation occurred. Reconsideration occurred as evidenced by the hearing officer decision dated March 12, 2008, which advised Petitioner of the right to request a hearing

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[5] CMS also reserved the right to shorten or extend the normal five-year revalidation requirement. 42 C.F.R. § 424.515(d)(2). There is no evidence and no assertion by Petitioner that CMS extended the revalidation period for Petitioner beyond five years.

[6] The new regulations effective August 26, 2008, include more detailed provisions regarding notice and appeals in supplier enrollment and billing privilege revocations. 42 C.F.R. §§ 405.874(b)-(g), 424.545. 73 Fed. Reg. 36,448, 36,460-61 (June 27, 2008).

by an ALJ. CMS Ex. 1; P. Ex. 13. Petitioner has now had the opportunity to present his case to me and receive my decision, which is also subject to review by the Board and then the appropriate court. Petitioner has received all the process due him under the Act and regulations.

3. Petitioner pled guilty to and was convicted of a financial crime within the meaning of 42 C.F.R. § 424.535(a)(3)(i)(B).

Petitioner argues that CMS erred when it determined that Petitioner was convicted of a financial crime. P. Brief at 6, 12-15. The list of financial crimes under 42 C.F.R. § 424.535(a)(3)(i)(B) is not exhaustive as is clearly indicated by the language at the end of that subsection, "and other similar crimes." 42 C.F.R. § 424.535(a)(3)(i)(B). Based on the facts of this case, I have no difficulty finding that Petitioner's crime was similar to the crime of insurance fraud listed in the regulation.

The transcript of the plea colloquy is in evidence without objection as CMS Ex. 5. Petitioner agreed that the government's evidence would have shown that he was a licensed physician authorized to participate in Medicare. During the pertinent period from 1997 through 2001, his practice focused on the treatment of autoimmune blistering skin diseases, including two different diseases, one known as pemphigus and another known as pemphigoid. Petitioner used intravenous immunoglobulin (IVIg) to treat patients suffering from both pemphigus and pemphigoid. During the period from 1997 through 2001, Medicare reimbursed physicians for IVIg treatment for pemphigus in qualified beneficiaries. However, Medicare coverage did not extend to IVIg treatments of qualified beneficiaries for other autoimmune blistering skin diseases such as pemphigoid. In early 2000, Medicare focused on Petitioner because it was observed that he was being reimbursed millions of dollars for IVIg treatment of beneficiaries diagnosed with both pemphigus and pemphigoid. A fraud investigation was initiated and Petitioner's records for patients treated with IVIg were subpoenaed. In October 2000, Petitioner produced records for patients he treated with IVIg, many of whom were Medicare beneficiaries. Petitioner admitted that he placed backdated documents, including letters and false immunopathology reports, in the files of the Medicare beneficiaries indicating that they had been diagnosed with pemphigus in order to qualify them for Medicare coverage for their IVIg treatments. CMS Ex. 5, at 20-26. Although Petitioner was also charged with fraud, those charges were dismissed pursuant to his plea agreement. CMS Ex. 4; P. Brief at 6. Petitioner nevertheless admits before me that he "placed false letters and immunopathology reports into his patients' files to bolster the reimbursements he received from Medicare." P. Brief at 14. Thus, Petitioner admits that he knew that he was not entitled to reimbursement from Medicare unless he provided IVIg treatment based on a diagnosis of pemphigus. Petitioner nevertheless claimed reimbursement for IVIg treatment for patients as if they had a diagnosis of pemphigus, even though he did not have a documented diagnosis of pemphigus when the claims were made to Medicare.

When investigators subpoenaed his records, he created documents to show a diagnosis of pemphigus and, thus, obstructed the investigation and covered or bolstered his prior false claims. Given these facts I have no trouble concluding that Petitioner's offense was a financial crime within the meaning of 42 C.F.R. § 424.535(a)(3)(i)(B), even though the offense of which he was convicted included no specific financial element. Falsifying records as Petitioner did to support his billing for treatments that were not subject to reimbursement by Medicare is significantly similar to insurance fraud, even though that was not the specific charge of which Petitioner was convicted. Further, Petitioner's undisputed conduct is exactly the sort of behavior that must be detected and prevented to protect the program and its beneficiaries, even though the crime of which he was convicted was obstruction of a fraud investigation rather than the offense of fraud.

4. The issue for hearing and decision is whether there is a basis for revocation of Petitioner's billing privileges and my jurisdiction does not extend to review of whether CMS properly exercised its discretion to revoke Petitioner's Medicare enrollment and billing privileges.

Petitioner argues that the CMS contractor abused its discretion and acted without a rational basis when it revoked Petitioner's billing privileges without considering mitigating factors and the impact of its decision, including the effect of the revocation upon Petitioner's patients, and the impact upon Petitioner's practice. P. Brief at 16-18. Petitioner cites no provision of the Act or the regulations that requires CMS or its contractors to consider mitigating or other factors when deciding to revoke billing privileges.[7] In his brief, at 16, Petitioner quotes language from the preamble for the final

[7] Petitioner refers to 42 C.F.R. § 1001.301, which applies to exclusions of entities and individuals from participation in Medicare, Medicaid, and all federal healthcare programs by the Inspector General. P. Brief at 16. Part 1001 of 42 C.F.R. has no application to enrollment and billing privilege revocations by CMS or its contractors. However, 42 C.F.R. § 1001.301 does provide an example of the type of specific regulatory authority that is absent in revocation cases. I note that, unlike the regulations applicable in revocation cases, the exclusion regulations specifically provide for ALJ and Board review of the mitigating and aggravating factors that might be applicable in a given case. *See, e.g.*, 42 C.F.R. §§ 1001.2007 and 1005.15. However, even in exclusion cases, review of mitigating factors is limited to only those cases where the I.G. considered aggravating factors. *See* 42 C.F.R. §§ 1001.102; 1001.2007. Furthermore, in permissive exclusion cases to which Petitioner refers, the regulations specifically prohibit the ALJ from reviewing the I.G. exercise of discretion to exclude if there exists a basis for exclusion. 42 C.F.R. § 1005.4(c)(5).

rule amending 42 C.F.R. Parts 420, 424, 489, and 498, promulgating requirements for providers and suppliers to establish and maintain Medicare enrollment, effective June 20, 2006. 71 Fed. Reg. 20,753 (April 21, 2006). CMS said in the preamble:

> In considering whether to revoke enrollment and billing privileges in the Medicare program, we would consider the severity of the offenses, mitigating circumstances, program and beneficiary risk if enrollment was to continue, possibility of corrective action plans, beneficiary access to care, and any other pertinent factors.

Id. at 20,761. CMS has not, however, promulgated regulations that require consideration of such factors before revocation or permitted my review of the CMS exercise of discretion to revoke if a basis for revocation exists.

There is a basis for revocation of Petitioner's billing privileges and my jurisdiction does not extend to review of whether CMS or its contractor properly exercised its discretion when deciding to proceed with revocation.

III. Conclusion

Petitioner's supplier numbers and his billing privileges were properly revoked.

/s/
Keith W. Sickendick
Administrative Law Judge