Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Sherye Epps
d/b/a Sunshine Shoes,
(NPI: 1154518033),

Petitioner

v.

Centers for Medicare & Medicaid Services.

Docket No. C-10-521

Decision No. CR2215

Date: August 13, 2010

DECISION

After a full review of the record before me, I uphold the revocation of the Medicare billing privileges and supplier number of Sherye Epps d/b/a Sunshine Shoes (Petitioner) by the Centers for Medicare & Medicaid Services (CMS) based on Petitioner's failure to comply with two specific standards applicable to suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

I. Background

Petitioner enrolled in the Medicare program in August of 2007. CMS Ex. 1. CMS required Petitioner to present evidence of accreditation by October 1, 2009 and of a valid surety bond by October 2, 2009, in order to continue to participate in the Medicare program as a supplier of durable medical equipment. The CMS contractor, Palmetto GBA National Supplier Clearinghouse (NSC), revoked Petitioner's Medicare supplier number by notice dated October 9, 2009. CMS Ex. 6. The letter provided the following "Reasons for Revocation of Your Supplier Number:"

> *In accordance with 42 C.F.R. §§ 424.57(c)(22) and 424.57(d), the NSC has not received proof of accreditation as required by October 1, 2009. In addition, in accordance with 42 C.F.R. § 424.57(c)(26) and 424.57(d), "All existing DMEPOS suppliers subject to the bonding requirement shall submit a copy of the required surety bond to the NSC no later than October 2, 2009." You failed to submit the surety bond to the NSC as required.*

Id. at 1 (emphasis in original).[1] The letter stated that the revocation was effective 30 days from the date of postmark and that Petitioner was barred from re-enrolling in the Medicare program for one year from the effective date of the revocation. CMS Ex. 6, at 1; *see* 42 C.F.R. § 405.874(b)(2) (revocation effective 30 days after CMS or the CMS contractor mails the notice of its determination). The letter informed Petitioner that she could appeal the decision by requesting reconsideration within 60 days of the date of postmark, and/or submit a corrective action plan within 30 days. CMS Ex. 6, at 2.

Petitioner requested reconsideration in a letter dated October 27, 2009. CMS Ex. 10. An unfavorable reconsideration decision was issued on December 30, 2009. CMS Ex. 9.

On March 2, 2010, Petitioner filed a hearing request (HR) pursuant to section 1866(j)(2) of the Social Security Act (Act), 42 U.S.C. § 1395cc(j)(2) and 42 C.F.R. Part 498 *et seq.*, accompanied by several supporting documents. The attached documents included the December 30, 2009 reconsideration decision; an October 19, 2009 letter from Sharon T. Nesbitt; a letter requesting reconsideration dated October 27, 2009; a different surety bond dated November 1, 2009; a power of attorney from Bond Safeguard Insurance Company dated February 26, 2010; a certificate of accreditation; and a DMEPOS Accreditation Addendum.[2]

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[1] The language in quotations is from CMS's Medicare Program Integrity Manual (MPIM), chapter 10, § 21.7.

[2] The regulations governing provider and supplier enrollment appeals require "good cause" for a petitioner to submit "new documentary evidence . . . for the first time at the ALJ level." 42 C.F.R. § 498.56(e). CMS did not challenge Petitioner's documentary evidence, and Petitioner did not explain whether these documents had been submitted at the reconsideration level or whether good cause justified their late submission. It is clear that some of the documents now submitted are dated after the December 30, 2009 reconsideration decision. However, I do not further explore whether the documentary evidence is new or its submission justified, since CMS did not object and since the documents do not demonstrate any dispute over facts material to the outcome of this appeal. Since Petitioner later submitted these documents in the form of exhibits identified below, I need not number or refer to the attachments to her hearing request.

This case was originally assigned to Administrative Law Judge (ALJ) Steven T. Kessel. It was reassigned to me for hearing and decision pursuant to 42 C.F.R. § 498.44, which permits designation of a member of the Departmental Appeals Board (Board) to hear appeals taken under part 498. On March 23, 2010, ALJ Kessel issued an acknowledgment and pre-hearing order (PHO) setting procedures for this case.

CMS submitted a Motion for Summary Disposition (CMS Br.) and its exhibits (CMS Exs. 1-13) on April 22, 2010. CMS argues that Petitioner did not present evidence of appropriate accreditation by October 1, 2009, or of compliance with certain surety bond requirements by October 2, 2009. CMS Br. at 1-2. CMS also argues that Petitioner did not voluntarily terminate her enrollment prior to the respective requirement dates, which would have preserved her opportunity to re-enroll in Medicare once she met the participation requirements without facing a reenrollment bar for one year. CMS Br. at 2.

Petitioner opposed CMS's motion (P. Br.) and filed exhibits (P. Exs. 1-5). Petitioner's exhibits included multiple documents, as follows: marked as P. Ex. 1 is a letter from NSC dated November 19, 2007; marked as P. Ex. 2 is CMS Medicare DMEPOS supplier standards; marked as P. Ex. 3 is a letter and an email from Ms. Sharon T. Nesbitt dated October 19, 2009; marked as P. Ex. 4 is a CMS 855S form dated September 15, 2009; and marked as P. Ex. 5 are a letter to the NSC dated April 19, 2010; sections of a completed CMS-855S form dated November 1, 2009; a surety bond from Bond Safeguard Insurance Company dated November 1, 2009; a power of attorney from Bond Safeguard Insurance Company dated April 16, 2010; a letter dated February 15, 2010 from the Accreditation Commission for Health Care, Inc. approving Sherye Epps for accreditation for medical supply provider services effective February 12, 2010; a letter from the Accreditation Commission for Health Care, Inc dated October 19, 2009; an invoice dated October 26, 2009; and an order receipt dated September 22, 2009.[3] Neither party objected to any exhibit, and I admit all exhibits into the record.

On July 26, 2010, I issued an Order in which I pointed out that Petitioner had failed to submit any witness list or written direct testimony, that CMS had listed and submitted testimony for one witness (an NSC employee), and that Petitioner had not sought to cross-examine that witness. Under the procedures set out in the PHO, an in-person hearing would only be necessary if one party has presented admissible testimony and the opposing party sought an opportunity to cross-examine. I concluded that neither condition existed and that, unless I heard to the contrary by a set date, I would presume

[3] I note that Petitioner submitted renumbered exhibits to this office via facsimile transmission of June 11, 2010, which also indicated that the original exhibits 4 and 5 were "mix up." However, the fax did not include all of the documents received with Petitioner's official submission via UPS to this office. To avoid confusion, all references to Petitioner's exhibits will be to the exhibits received with Petitioner's official submission as numbered therein.

that Petitioner waived an in-person evidentiary hearing and consented to decision on the merits on the written record.

In a telephone conversation with my staff attorney, memorialized in an email communication dated July 29, 2010, Petitioner inquired only whether she was *required* to resend her material in notarized form and was told that she was not required to do so. She did not therefore object to proceeding to decision on the written record. CMS stated by email on the same date that it had no objection to that procedure.

II. Applicable Law and Regulations

CMS revoked Petitioner's billing privileges for failure to have complied with requirements that a supplier be accredited by a CMS-approved accrediting organization and provide a surety bond. Those requirements are as follows.

Section 1834(a)(16)(B) of Act states that the Secretary of Health and Human Services (Secretary) "shall not provide for the issuance (or renewal) of a provider number for a supplier of durable medical equipment for purposes of payment . . . for durable medical equipment furnished by the supplier unless the supplier provides the Secretary on a continuing basis . . . with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000." Section 1834(a)(20)(F)(i) states that the Secretary "shall require suppliers . . . on or after October 1, 2009 . . . to have submitted to the Secretary evidence of accreditation by an accreditation organization designated . . . as meeting applicable quality standards . . . ."

CMS's regulations implement these requirements among the "supplier standards" at 42 C.F.R. § 424.57(c) that DMEPOS suppliers (42 C.F.R. § 424.57(a)) must meet to maintain Medicare billing privileges. As relevant here, section 424.57(c) provides:

> (c) *Application certification standards.* The supplier must meet and must certify in its application for billing privileges that it meets and will continue to meet the following standards.
>
> * * * *
>
> (22) All suppliers of DMEPOS and other items and services must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment for those specific products and services. [supplier standard 22]
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> * * * *

> (26) [The supplier must] meet the surety bond requirements specified in paragraph (d) of this section. [supplier standard 26]

The surety bond requirements at 42 C.F.R. § 424.57(d) referenced in supplier standard 26 state, as relevant here, that "beginning October 2, 2009, each Medicare-enrolled DMEPOS supplier must meet the requirements of paragraph (d)," which include "a bond that is continuous," which "must meet the minimum requirements of liability coverage ($50,000)" and which provides that "[t]he surety is liable for unpaid claims, CMPs [civil money penalties], or assessments that occur during the term of the bond." 42 C.F.R. § 424.57(d)(1)(ii), (4), (5). "The term of the initial surety bond must be effective on the date that the application is submitted to the NSC." 42 C.F.R. § 424.57(d)(2). CMS may at any time require a DMEPOS supplier to show compliance with the surety bond requirement. 42 C.F.R. § 424.57(d)(12).

The regulations provide that failure to submit a surety bond as required is grounds for revocation of a supplier's billing privileges, specifying that --

> CMS requires a supplier to submit a bond that on its face reflects the requirements of this section. CMS revokes or denies a DMEPOS supplier's billing privileges based upon the submission of a bond that does not reflect the requirements of paragraph (d) of this section [42 C.F.R. § 424.57].

42 C.F.R. § 424.57(d)(4)(ii)(B); *see also* 42 C.F.R. § 424.57(d)(11) ("CMS revokes the DMEPOS supplier's billing privileges if an enrolled supplier fails to obtain, file timely, or maintain a surety bond as specified in this subpart and CMS instructions."). The regulations also provide more generally that CMS "will revoke a supplier's billing privileges if it is found not to meet" the supplier standards or other requirements in section 424.57(c). 42 C.F.R. § 424.57(e) (formerly § 424.57(d)).[4]

A supplier that has had its billing privileges revoked is "barred from participating in the Medicare program from the effective date of the revocation until the end of the re-enrollment bar. The re-enrollment bar is a minimum of 1 year, but not greater than 3 years depending on the severity of the basis for revocation." 42 C.F.R. § 424.535(c).

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[4] Paragraph (e) of section 424.57 was previously designated paragraph (d) and was redesignated by the rulemaking that imposed the surety bond requirements at paragraph (d); however, the redesignations have not yet been incorporated in the Code of Federal Regulations. *See* 42 C.F.R. Ch. IV § 424.57, Editorial Note (Oct. 1, 2009). References are to the regulation as redesignated.

III. Issues, Findings of Fact, Conclusions of Law

A. Issues

The issues in this case are as follows:

1. whether CMS is entitled to summary disposition on the ground that the undisputed facts demonstrate that the revocation of Petitioner's Medicare billing privileges was legally authorized;

2. whether CMS is authorized to revoke Petitioner's Medicare billing privileges for the stated reasons; and

3. whether Petitioner successfully submitted a timely voluntary termination of billing privileges, making revocation and the application of a re-enrollment bar inappropriate.

B. Applicable Standards

CMS has moved for summary disposition in the nature of summary judgment. The Board stated the standard for summary judgment as follows:

> Summary judgment is appropriate when the record shows that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. . . . The party moving for summary judgment bears the initial burden of showing that there are no genuine issues of material fact for trial and that it is entitled to judgment as a matter of law. . . . To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact – a fact that, if proven, would affect the outcome of the case under governing law. . . . In determining whether there are genuine issues of material fact for trial, the reviewer must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor.

Senior Rehab. & Skilled Nursing Ctr., DAB No. 2300, at 3 (2010) (citations omitted). The role of an ALJ in deciding a summary judgment motion differs from the ALJ's role in resolving a case after a hearing. The ALJ should not assess credibility or evaluate the weight of conflicting evidence. *Holy Cross Vill. at Notre Dame, Inc.*, DAB No. 2291, at 5 (2009).

In deciding a case on the written record, by contrast, the factfinder must evaluate conflicting assertions and determine the appropriate weight to be assigned to the party's evidence in the same manner as after an in-person hearing. The facts so found must then be considered in light of the applicable law to determine the legal conclusion.

C. Analysis

My findings and conclusions are in the italicized headings supported by the subsequent discussions below.

1. CMS is not entitled to summary judgment.

The essence of CMS's argument for summary judgment is that Petitioner does not deny that she failed to comply with the surety bond and accreditation requirements. CMS Br. at 2; CMS Ex. 6. CMS recognizes that Petitioner alleges that she sent in a voluntary termination form, but points out that she "did not certify her alleged mailing" or otherwise document it, and asserts that NSC had not received it as of October 3, 2009,[5] whereupon the revocation notice was issued. *Id.*, citing CMS Ex. 5. Furthermore, CMS argues that the supporting letter from a postal worker proffered by Petitioner is "unauthenticated" and only states that she mailed "some important documents . . . sometime in September." *Id.* CMS concludes that Petitioner failed to successfully submit a voluntary termination form and thus forfeited the opportunity to re-enroll in the Medicare program without application of a re-enrollment bar of one year imposed in the revocation notice. CMS Br. at 7.

CMS's arguments do not address Petitioner's position that, if a voluntary termination were perfected during the requisite time, the revocation would not go into effect and no re-enrollment bar would apply. CMS's arguments, instead, amount to contentions that Petitioner has failed to prove adequately the factual premise of her position, i.e., that she timely and correctly mailed a voluntary termination form to NSC. These contentions go to the weight I should give to Petitioner's assertions and supporting letter and to the inferences I should draw from them. In the summary judgment context, however, I am to determine only whether a dispute of material fact exists as to whether Petitioner properly acted to voluntarily terminate her participation in Medicare. I am not to consider whether her evidence on that point is persuasive. A reasonable finder-of-fact, taking her assertions as true and construing all evidence in her favor, could infer that she mailed this important document (the voluntary termination form) in September and that NSC should therefore have received it prior to the deadline.

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[5] October 3, 2009 is the relevant date because the last date on which Petitioner could have achieved compliance with the surety bond and accreditation requirements, or avoided their application by voluntary termination, was October 2, 2009. CMS Ex. 6, at 1.

Given that Petitioner has thus raised a dispute of material fact, I cannot resolve the matter in CMS's favor on summary judgment. I turn next to what facts I find and conclusions I draw in reviewing the entire written record of this case.

2. CMS was authorized to revoke Petitioner's billing privileges based on undisputed evidence that Petitioner was not accredited as required by 42 C.F.R. § 424.57(c)(22) or bonded as required by 42 C.F.R. § 424.57(c)(26) and (d).

CMS contends that on October 8, 2009, the NSC received a form from Petitioner purporting to show compliance with the accreditation and surety bond requirements. CMS Br. at 3; CMS Ex. 7. According to CMS, however, the information was received after the deadline and did not show timely compliance with the respective requirements. CMS Br. at 3. In a letter dated October 23, 2009, NSC informed Petitioner that her change of information form received on October 8, 2009 could not be processed. CMS Ex. 8. CMS further states that, in any case, the information Petitioner provided did not show compliance because the accreditation could not be verified by the accrediting organization listed and Petitioner had not provided a copy of the surety bond. CMS Br. at 3; CMS Ex. 5.

CMS asserts that NSC did not receive any subsequent evidence that would show compliance with the accreditation and surety bond requirement, so Petitioner's Medicare billing privileges were revoked effective November 8, 2009. CMS Br. at 3.

On reconsideration, the NSC hearing officer determined that Petitioner's billing privileges were properly revoked due to Petitioner's failure to comply with both supplier standard 22 and supplier standard 26. CMS Ex. 9. The hearing officer concluded that Petitioner "has not provided evidence to show they have fully complied with the standard for which they were non-compliant . . . ." CMS Ex. 9, at 2. The decision also relied on the following language from CMS's MPIM:

> In reviewing an initial enrollment decision or a revocation, a Medicare contractor… should limit the scope of its review to the contractor's reason for imposing a denial or revocation at the time it issued the action and whether the contractor made the correct decision (i.e., denial/revocation). If a provider or supplier provides evidence that demonstrates or proves that they met or maintained compliance **after** the date of denial or revocation, the contractor shall exclude this information from the scope of its review.

Id., *quoting* MPIM, ch. 10, § 19.A (emphasis added).

As noted, one of the bases relied on in the revocation notice and on reconsideration was that Petitioner failed to meet the accreditation requirement on time. Petitioner has been less than clear in presenting her position on this question, but it appears that she alleges that she became accredited **after** the revocation. Petitioner states in a letter dated October 27, 2009 that she was "in the process of my accreatication [sic] . . . spending over 4,100.00 trying to become certified . . . ." CMS Ex. 10. Petitioner also has submitted various documents to prove that she subsequently became accredited. *See, e.g.,* CMS Ex. 11. However, Petitioner presents no argument or documentary evidence indicating that she obtained appropriate accreditation by the statutory deadline or as of the date of revocation. Indeed, she asserts that a site visit required for accreditation did not take place until February 2010. P. Br. at 1.

A showing of compliance subsequent to the revocation is not a ground to reverse the revocation. The regulations require that a supplier "must meet and must certify in its application for billing privileges that it meets and will continue to meet" the supplier standards. 42 C.F.R. § 424.57(c). The preamble to the regulations implementing the reconsideration and appeals process for suppliers whose billing privileges are revoked explains:

> When a Medicare contractor makes an adverse enrollment determination (for example, enrollment denial or revocation of billing privileges) . . . appeal rights are limited to provider or supplier eligibility at the time the Medicare contractor made the adverse determination. . . . Accordingly, a provider or supplier is required to furnish the evidence that demonstrates that the Medicare contractor made an error at the time an adverse determination was made, not that the provider or supplier is now in compliance.

73 Fed. Reg. 36,448, 36,452 (June 27, 2008). This rulemaking also amended the enrollment regulations to provide that "suppliers have the opportunity to submit evidence related to the enrollment action" and "must, at the time of their request [for reconsideration], submit all evidence that they want to be considered." 42 C.F.R. § 405.874(c)(3); *1866ICPayday.com, L.L.C.*, DAB No. 2289, at 8-9 (2009). The MPIM provision that the hearing officer cited, stating that "evidence that demonstrates or proves that [the supplier or provider] met or maintained compliance after the date of denial or revocation" must be excluded from the hearing officer's review, is consistent with the preamble language. CMS Ex. 9, at 2; MPIM, ch. 10, § 19.A.

Thus, Petitioner's allegation that she became accredited after the fact shows no error in the revocation on November 8, 2009, or in the reconsideration decision on December 30, 2009. The certificate of accreditation that Petitioner submitted on appeal, which does not show accreditation at the time of revocation, is not material. Given Petitioner's concession that she was not accredited at the time of revocation and the absence of any

contrary evidence, CMS had a basis to revoke for failure to comply with supplier standard 22.

As far as her compliance with supplier standard 26, the surety bond requirement, Petitioner similarly takes the position that she is presently in compliance. *See* HR, P. Br. In support of that assertion, Petitioner submitted a copy of a surety bond. P. Ex. 5. CMS contends that Petitioner did not submit a surety bond by October 2, 2009 and that Petitioner's failure to obtain a compliant surety bond by that deadline justifies the revocation of Petitioner's billing privileges pursuant to 42 C.F.R. § 424.57(d)(11)(i) and (e). CMS Br. at 9. CMS thus argues that the hearing officer correctly concluded that Petitioner failed to comply with supplier standard 26. *Id*.

Even the latest version of the surety bond submitted to me on appeal fails to demonstrate Petitioner's compliance with supplier standard 26. The bond states on its face that it is effective November 1, 2009. P. Ex. 5. That date is beyond the October 2, 2009 date upon which each Medicare-enrolled DMEPOS supplier was required to submit a compliant bond. 42 C.F.R. § 424.57(d)(1)(ii); *see* 73 Fed. Reg. at 36,452; MPIM, ch. 10, § 19.A. The undisputed facts thus demonstrate that CMS had a basis to revoke because Petitioner was not in compliance with supplier standard 26.

3. Petitioner did not timely submit a voluntary termination form.

CMS advised suppliers, however, that they had the option of voluntarily terminating her enrollment in the Medicare program before the new requirements took effect. CMS Ex. 2, at 2-3 (CMS information letter). The information made clear that, if Petitioner voluntarily terminated her enrollment prior to October 1, 2009, Petitioner would preserve her right to re-enroll in Medicare once she met the participation requirements. *Id.* CMS also made clear that, if she did not obtain appropriate accreditation and meet certain surety bond requirements *and* failed to voluntarily terminate her enrollment, her Medicare billing privileges would be revoked. *Id.*

The hearing officer considered Petitioner's argument that she sent a voluntary termination form to NSC in September of 2009 and concluded that –

> it is not possible to determine from the documentation when the information was mailed. There is no verifiable mailing documentation to establish when the said information was received by the NSC, therefore this does not express compliance with the procedure regarding voluntary termination of their supplier number prior to the allotted timeframe. Consequently, the NSC appropriately revoked the billing privileges of Sherye Epps dba: Sunshine Shoes.

CMS Ex. 9, at 2.

Petitioner alleges before me that she mailed a voluntary termination form with a proposed termination date of September 15, 2009. HR; CMS Ex. 3. Indeed, in her hearing request, Petitioner asserts that her "objection was never to indicate I was accredited and surety bond by Oct. 1, 2009." P. Br. at 1. Petitioner contends instead that she sent in the form to terminate her privileges voluntarily sometime in the "third week of Sept 2009." CMS Ex. 10. In support of her contention that she mailed the voluntary termination form timely, Petitioner submits a letter from a Sharon T. Nesbitt, who appears to work for the United States Postal Service, stating that Petitioner "mailed separately a manilla 8 x 10 envelope that contained some important documents." CMS Ex. 4. Ms. Nesbitt further wrote that –

> Ms. Epps came back to the PO to inquire about a scheduled delivery time of her mail because she called your company for the status of her mailings and to her surprise you had not received them. Those documents were mailed from our office sometime in September.

Id. CMS submits a statement from an NSC employee asserting that NSC did not receive a voluntary termination form. CMS Ex. 5 (Declaration of Tanya Mattingly). The NSC hearing officer considered Petitioner's argument that she sent a voluntary termination form to NSC in September of 2009 and concluded that there was not verifiable mailing documentation that could establish when NSC received the voluntary termination form allegedly mailed in September of 2009. CMS Ex. 9, at 2. Thus, the hearing officer determined that Petitioner did not comply with the procedure regarding voluntary termination of her supplier number within the allotted timeframe. *Id.*

Apart from her own assertions in briefing, Petitioner's only evidence to prove that NSC received a voluntary termination form in September of 2009 is the letter from the postal employee. As I noted, Petitioner's representations are not provided in a form subject to perjury and hence are less reliable than testimony. They also lack specificity about the date and circumstances of her preparation and mailing of a voluntary termination form. The postal employee's letter is, as CMS noted, unauthenticated. The claims in the letter are extremely vague. The signatory does not purport to know the contents of the 8 x 11 manilla envelope or even to what entity the envelope was addressed. Since NSC did receive a mailing from Petitioner on October 8, 2009, which did not contain a voluntary termination form, a reasonable inference is that the postal employee remembers Petitioner's mailing of the purported documentation of accreditation and bonding which certainly qualified as "important documents." This documentation did not, as I have explained above, succeed in demonstrating compliance.

In addition, in her brief, Petitioner indicates that she called and spoke to someone at NCS in October of 2009 who stated "that they haven't receive my voluntarily terminate but they are back up 3 week of mail." P. Br. at 2. In addition, in her October 27, 2009 reconsideration request, Petitioner states that she "sent my forms but didn't certified it

because it was the third week of Sept 2009." CMS Ex. 10. Petitioner also states that she "went to the Post Office where I mail off my envelope, checking too see if some how it was miss place after speaking to a NSC representative." *Id*. These statements by Petitioner amount to a recognition that NSC may not have received Petitioner's voluntary termination form prior to October 1, 2009 and that Petitioner could have taken measures within her own control to establish the date of receipt of her voluntary termination form (such as using certified mailing) and simply failed to do so.

Thus, I am not persuaded that Petitioner sent, and NSC received, a timely voluntary termination form.

IV. Conclusion

For the reasons explained above, I conclude that Petitioner was not in compliance with applicable requirements and did not timely terminate her enrollment on a voluntary basis. I therefore uphold the revocation of Petitioner's Medicare billing privileges and supplier number and the application of the one-year re-enrollment bar.

/s/
Leslie A. Sussan
Board Member