Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Fares F. Yasin, M.D.
(NPI: 1255427472; PTANs: MI1721, MI6074001, P37170001),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-2655

Decision No. CR4425

Date: November 12, 2015

DECISION

The Medicare enrollment and billing privileges of Petitioner, Fares F. Yasin, M.D., are revoked pursuant to 42 C.F.R. § 424.535(a)(9) effective December 31, 2014.

I. Background

Wisconsin Physicians Service Insurance Corporation (WPS), the Medicare administrative contractor for the Centers for Medicare & Medicaid Services (CMS), notified Petitioner by letter dated December 1, 2014, that his Medicare enrollment and billing privileges were being revoked effective December 31, 2014. WPS cited 42 C.F.R. § 424.535(a)(9) as the basis for the revocation. WPS also notified Petitioner that he was subject to a two-year bar to re-enrollment pursuant to 42 C.F.R. § 424.535(c). CMS Exhibit (Ex.) 5.

Petitioner requested reconsideration of the revocation. CMS Ex. 7. In a reconsidered determination dated April 3, 2015, CMS upheld the revocation, again citing 42 C.F.R. § 424.535(a)(9) as the basis for revoking Petitioner's billing privileges. CMS Ex. 8.

On May 28, 2015, Petitioner timely filed a request for hearing before an administrative law judge (ALJ). On June 8, 2015, the case was assigned to me for hearing and decision, and an Acknowledgement and Prehearing Order (Prehearing Order) was issued at my direction.

On July 8, 2015, CMS filed a combined prehearing brief and motion for summary judgment (CMS Br.) with CMS Exs. 1 through 8. On August 6, 2015, Petitioner filed a combined prehearing brief and opposition to CMS's motion for summary judgment (P. Br.) with Petitioner's Exhibit (P. Ex.) 1. On September 3, 2015, CMS waived filing a reply brief. The parties have not objected to my consideration of CMS Exs. 1 through 8 and P. Ex. 1, and they are admitted as evidence.

II. Discussion

A. Applicable Law

Section 1831 of the Social Security Act (the Act) (42 U.S.C. § 1395j) establishes the supplementary medical insurance benefits program for the aged and disabled known as Medicare Part B. Administration of the Part B program is through contractors, such as WPS. Act § 1842(a) (42 U.S.C. § 1395u(a)). Payment under the program for services rendered to Medicare-eligible beneficiaries may only be made to eligible providers of services and suppliers.[1] Act §§ 1835(a) (42 U.S.C. § 1395n(a)), 1842(h)(1) (42 U.S.C. § 1395(u)(h)(1)). Petitioner, a physician, is a supplier.

The Act requires the Secretary of Health and Human Services (Secretary) to issue regulations that establish a process for the enrollment in Medicare of providers and suppliers, including the right to a hearing and judicial review of certain enrollment determinations, such as revocation of enrollment and billing privileges. Act § 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to 42 C.F.R. § 424.505, a supplier such as Petitioner

---

[1] A "supplier" furnishes services under Medicare and includes physicians or other practitioners and facilities that are not included within the definition of the phrase "provider of services." Act § 1861(d) (42 U.S.C. § 1395x(d)). A "provider of services," commonly shortened to "provider," includes hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, hospice programs, and a fund as described in sections 1814(g) (42 U.S.C. § 1395f(g)) and 1835(e) (42 U.S.C. § 1395n(e)) of the Act. Act § 1861(u) (42 U.S.C. § 1395x(u)). The distinction between providers and suppliers is important because they are treated differently under the Act for some purposes.

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.

Suppliers must submit complete, accurate, and truthful responses to all information requested in the enrollment application. 42 C.F.R. § 424.510(d)(2). Pursuant to 42 C.F.R. §§ 424.502 and 424.510(d)(3), a supplier's application to enroll in Medicare must be signed by an authorized official, i.e., one with authority to bind the provider or supplier both legally and financially. The regulation provides that the signature attests to the accuracy of information provided in the application. The signature also attests to the fact that the provider or supplier is aware of and abides by all applicable statutes, regulations, and program instructions. 42 C.F.R. § 424.510(d)(3). Suppliers must meet basic requirements depending on their type of service. 42 C.F.R. §§ 424.505, 424.516, 424.517. Suppliers are also subject to additional screening requirements depending upon the type of service they provide. 42 C.F.R. § 424.518.

The Secretary has delegated the authority to revoke enrollment and billing privileges to CMS. 42 C.F.R. § 424.535. CMS or its Medicare contractor may revoke an enrolled supplier's Medicare enrollment and billing privileges and supplier agreement for any of the reasons listed in 42 C.F.R. § 424.535. Pursuant to 42 C.F.R. § 424.535(a)(1), CMS may revoke a supplier's enrollment and billing privileges if the supplier is determined not to be in compliance with enrollment requirements. Relevant here, revocation is also authorized under 42 C.F.R. § 424.535(a)(9) when a provider or supplier fails to comply with the reporting requirements in 42 C.F.R. § 424.516(d)(1)(ii) and (iii). Those reporting requirements, as discussed in more detail hereafter, provide that physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations must report any adverse legal action or a change in practice location to their Medicare contractor within 30 days. 42 C.F.R. § 424.516(d)(1)(ii), (iii).

If CMS revokes a supplier's Medicare billing privileges, the revocation becomes effective 30 days after CMS or one of its contractors mails the revocation notice to the supplier, subject to some exceptions not applicable in this case. 42 C.F.R. § 424.535(g). After a supplier's Medicare enrollment and billing privileges are revoked, the supplier is barred from re-enrolling in the Medicare program for one to three years. 42 C.F.R. § 424.535(c).

A supplier whose enrollment and billing privileges have been revoked may request reconsideration and review as provided by 42 C.F.R. pt. 498. 42 C.F.R. § 424.545(a). A supplier submits a written request for reconsideration to CMS or its contractor. 42 C.F.R. § 498.22(a). CMS or its contractor must give notice of its reconsidered determination to the supplier, giving the reasons for its determination, specifying the conditions or requirements the supplier failed to meet, and advising of the right to an ALJ hearing. 42 C.F.R. § 498.25. If the decision on reconsideration is unfavorable to the supplier, the

supplier has the right to request a hearing by an ALJ and further review by the Departmental Appeals Board (the Board). Act § 1866(j)(8) (42 U.S.C. § 1395cc(j)(8)); 42 C.F.R. §§ 424.545, 498.3(b)(17), 498.5. A hearing on the record, also known as an oral hearing, is required under the Act. *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743, 748-51 (6th Cir. 2004). The supplier bears the burden to demonstrate that it meets enrollment requirements with documents and records. 42 C.F.R. § 424.545(c).

B. Issues

Whether summary judgment is appropriate; and

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

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

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

1. Summary judgment is appropriate.

CMS has requested summary judgment. As noted above, a supplier whose enrollment has been revoked has a right to a hearing and judicial review, and a hearing on the record is required under the Act. Act §§ 205(b), 1866 (h)(1), (j); 42 C.F.R. §§ 498.3(b)(1), (5), (6), (8), (15), (17), 498.5; *Crestview*, 373 F.3d at 748-51. A party may waive appearance at an oral hearing but must do so affirmatively in writing. 42 C.F.R. § 498.66. In this case, Petitioner has not waived the right to oral hearing or otherwise consented to a decision based only upon the documentary evidence or pleadings. Accordingly, disposition on the written record alone is not permissible, unless CMS's motion for summary judgment has merit.

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

regulate the course of proceedings and made available to the parties in the litigation of this case by my Prehearing Order. The parties were given notice by the Prehearing Order that summary judgment is an available procedural device and that the law as it has developed related to Fed. R. Civ. Pro. 56 will be applied.

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

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

There is no genuine dispute as to any material fact pertinent to revocation under 42 C.F.R. § 424.535(a)(9) or the effective date of the revocation that requires a hearing in this case. The issues in this case raised by Petitioner related to revocation under 42 C.F.R. § 424.535(a)(9) are issues of law that must be resolved against Petitioner as a

matter of law. The undisputed evidence shows that there is a basis for revocation of Petitioner's Medicare enrollment and billing privileges. Accordingly, summary judgment is appropriate.

2. There is a basis for revocation of Petitioner's billing privileges pursuant to 42 C.F.R. § 424.535(a)(9).

3. The effective date of revocation of Petitioner's Medicare enrollment and billing privileges is December 31, 2014.

a. Facts

The facts are not disputed and any inferences are drawn in favor of Petitioner.

Petitioner was enrolled in the Medicare program effective August 23, 2006, under the name "Fares F. Yasin MD/Detroit Visiting Physicians PLLC." CMS Ex. 1 at 2. On May 31, 2013, WPS sent Petitioner a request to revalidate his enrollment. The revalidation request was mailed to Petitioner at 16985 Farmington Road, Livonia, Michigan. CMS Ex. 1 at 6-8. In response to the revalidation request, Petitioner submitted a CMS-855I enrollment application dated June 1, 2013. CMS Ex. 1 at 6-36. In "Section 4: Practice Location Information" of the application, Petitioner checked the "add" box and listed 16975 Farmington Road, Livonia, Michigan as a new practice location.[2] CMS Ex. 1 at 23. On December 3, 2013, WPS notified Petitioner by letter addressed to 4634 Greenfield Road, Dearborn, Michigan that Petitioner's revalidation was approved. CMS Ex. 1 at 1-4. CMS stated in the letter that Petitioner's primary practice location was 4634 Greenfield Road, Dearborn, Michigan with an additional practice location at 16975 Farmington Road, Livonia, Michigan. CMS Ex. 1 at 2.

Petitioner submitted to WPS a CMS-855I form dated February 1, 2014. CMS Ex. 2 at 17, 27. The CMS 855I, section 1A, requires the applicant to indicate the reason for the application. Petitioner failed to select one of the options listed in 1A. CMS Ex. 2 at 4. However, in section 2B, Petitioner placed an "x" in the block indicating that the form was related to "Practice Location Information, Payment Address and Medical Record Storage Information." CMS Ex. 2 at 5. In section 4 of the CMS-855I, Petitioner placed an "x" in the block next to "ADD;" entered the effective date of February 1, 2014, and entered an address for Detroit Visiting Physicians at 4700 Greenfield Road, Dearborn, Michigan. CMS Ex. 2 at 17. The CMS-855I form has three check-boxes in Section 4 – "change,"

---

[2] Petitioner listed the practice location name as "Detroit Visiting Physicians PLLC." CMS Ex. 1 at 23.

"add," and "delete" – and it is not disputed that Petitioner checked only the "add" box and not the "change" or "delete" boxes. CMS Ex. 2 at 17. CMS approved Petitioner's change of information by letter dated April 26, 2014. CMS Ex. 2 at 1-3. CMS confirmed the additional practice location at 4700 Greenfield Road, Suite 201, Dearborn, Michigan effective February 1, 2014. CMS Ex. 2 at 2.

On July 29, 2014, and August 7, 2014, CMS inspectors attempted to conduct site verification surveys at Petitioner's 16975 Farmington Road practice location. On both occasions, the inspectors found that the office was vacant, the front door was locked, and the signage at the entrance of the building complex did not list Petitioner's name. The inspectors did not see any furniture inside the office suite and noted mail on the floor. CMS Exs. 3, 4. The inspectors took photographs to document that Petitioner's office was vacant during their attempted site visits. CMS Ex. 4. Petitioner does not deny that he was not operating at 16975 Farmington Road when the site visits were made. CMS Ex. 6 at 1; CMS Ex. 7 at 1; P. Br. at 2 -3.

By letter dated December 1, 2014, WPS notified Petitioner that his Medicare billing privileges would be revoked effective December 31, 2014, pursuant to 42 C.F.R. § 424.535(a)(9), because Petitioner failed to notify CMS within 30 days that he had changed his practice location, as required by 42 C.F.R. § 424.516. Specifically, WPS stated that on-site reviews conducted on July 29, 2014, and August 7, 2014, discovered that Petitioner's Farmington Road location was vacant. CMS Ex. 5 at 1.

Petitioner submitted a Corrective Action Plan (CAP) dated December 11, 2014. CMS Ex. 6.[3] In the CAP, Petitioner admits that the 16975 Farmington Road location "was active and operating until January or February of 2014 . . . after which it was closed" and that he did not report the change in his practice location to CMS. CMS Ex. 6. Petitioner explains that his failure to report the change was an "oversight" and an "error on [his] part." CMS Ex. 6. Petitioner also admitted in his request for reconsideration that the 16975 Farmington Road location was closed. CMS Ex. 7. In his brief, Petitioner admits, more specifically, that the 16975 Farmington Road location was closed as of February 1, 2014. P. Br. at 3.

b. Analysis

Petitioner agreed as a condition for enrolling in Medicare to notify WPS of any "change in practice location" within 30 days. 42 C.F.R. §§ 424.500, 424.505, 424.510, 424.516(d)(1)(iii). Section 4 titled "Practice Location Information" of the CMS-855I enrollment application provides boxes for providers and suppliers to check to report a

---

[3] WPS rejected Petitioner's CAP on December 19, 2014. P. Ex. 1.

change, addition, or deletion of a practice location and a space to enter the effective date for the change. CMS Ex. 1 at 23; CMS Ex. 2 at 17. There is no dispute that on or about June 1, 2013, and on or about February 1, 2014, Petitioner submitted CMS-855I applications to notify WPS that Petitioner was adding new practice locations – the 16975 Farmington Road location in June 2013 and the 4700 Greenfield Road location in February 2014. It is not disputed that when Petitioner added the Greenfield Road location Petitioner checked only the "add" box on the CMS-855I and left the "change" and "delete" boxes unchecked, with no mention that Petitioner's 16975 Farmington Road location should be deleted. CMS Ex. 2 at 17. Further, it is not disputed that Petitioner closed his 16975 Farmington Road practice location as of February 1, 2014, and that Petitioner never notified WPS within 30 days of the closure by completing a CMS-855I to alert WPS and CMS that the Farmington Road address should be deleted. Because Petitioner failed to comply with the reporting requirements of 42 C.F.R. § 424.516(d)(1)(iii), there is a basis for revocation of Petitioner's Medicare enrollment and billing privileges under 42 C.F.R. § 424.535(a)(9).

Despite conceding that he failed to notify WPS when he closed his 16975 Farmington Road practice location, Petitioner argues that he did notify CMS that the Farmington Road location was closed because he omitted that location from the CMS-855I he signed February 1, 2014. RFH at 2, 4; P. Br. at 2; CMS Ex. 2. Petitioner also argues that, though he closed the 16975 Farmington Road practice location on February 1, 2014, he continued to maintain his primary practice location and merely closed the second location and there was no "change in practice location" that required reporting. P. Br. at 4.

Even if Petitioner's 16975 Farmington Road location was only a secondary and not Petitioner's primary practice location, 42 C.F.R. § 424.516(d)(iii) makes no distinctions between primary and secondary practice locations for purposes of reporting. The regulation explicitly requires that "[a] change in practice location" be reported in 30 days. 42 C.F.R. § 424.516(d)(1)(iii). Thus, it is plain from the regulation that when a supplier closes <u>any</u> of his practice locations on file with CMS, that event constitutes a "change in practice location" that must be reported to CMS. When Petitioner ceased operations at his 16975 Farmington Road location, Petitioner was obligated to timely report the change to CMS, regardless of whether the site was a primary or secondary site.

Petitioner's suggestion that CMS should have inferred that Petitioner closed the 16975 Farmington Road location based on the fact that Petitioner did not list that location in the CMS-855I dated February 1, 2014, is also without merit. The regulations impose an affirmative duty upon enrolled providers or suppliers to report a change in practice location and do not permit or require CMS or its contractors to draw inferences based on incomplete information. Petitioner has the obligation under the regulations to affirmatively inform CMS of any change in his practice location by properly completing the CMS-855I. When Petitioner completed the CMS-855I dated February 1, 2014, he checked only the "add" box in Section 4 and did not check the "change" or "delete"

boxes. The only address Petitioner provided in Section 4 was the new practice location at 4700 Greenfield Road that he intended to add. CMS Ex. 2 at 17. When Petitioner ceased operations at his 16975 Farmington Road location, he was required to inform CMS of the closure by checking the "delete" box on the CMS-855I, furnishing the effective date of the closure, and providing the other information requested (e.g., address, telephone number, Medicare Identification Number). Petitioner failed to do so and concedes that he did not notify CMS within 30 days when he closed his Farmington Road practice location.[4]

Petitioner further argues that CMS has incorrectly interpreted 42 C.F.R. § 424.535(a)(9). Petitioner argues that under 42 C.F.R. § 424.535(a)(9), CMS has to show that Petitioner violated both subsections (ii) and (iii) of 42 C.F.R. § 424.516(d)(1) before CMS can revoke Petitioner's Medicare enrollment and billing privileges. Petitioner argues that because he only violated one of the reporting requirements, he cannot be subject to a revocation pursuant to 42 C.F.R. § 424.535(a)(9).

Petitioner's argument is without merit. CMS may revoke Medicare enrollment if "[t]he provider or supplier did not comply with the reporting requirements specified in § 424.516(d)(1)(ii) and (iii)." 42 C.F.R. § 424.535(a)(9). Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations are required to report the following events within 30 days:

> (i) A change of ownership;
> (ii) Any adverse legal action; or
> (iii) A change in practice location.

42 C.F.R. § 424.516(d)(1)(i)-(iii). Included in the final rulemaking for 42 C.F.R. § 424.516(d) is the following response from the drafters of the regulation:

> We believe that changes of ownership, adverse legal actions, and changes in practice locations can and should be reported within 30 days of the reportable event. By reporting these types of reportable events within 30 days, the Medicare program can take the necessary steps to ensure that we are paying physicians and NPPs [nonphysician practitioners]

---

[4] In the reconsidered determination dated April 3, 2015, WPS noted that as of April 2, 2015, Petitioner had not filed a change of location to remove the Farmington Road location from his file. CMS Ex. 8 at 1.

> correctly and ensure that only eligible physicians and NPPs are enrolled in the Medicare program.
>
> After reviewing public comments, we are finalizing the provision at proposed § 424.516(d) which would require physicians, NPPs or physician and NPP organizations to notify its Medicare contractor of a change of ownership, change in practice location **or** any final adverse action within 30 days of the reportable event. In addition, we believe that physician and NPP organizations' and individual practitioners' failure to comply with the reporting requirements within the time frame described above may result in the revocation of Medicare billing privileges and the imposition of a Medicare overpayment from the date of the reportable change. . . .
>
> * * * *
>
> We are finalizing the provision at proposed § 424.535(a)(9) which would specify that failure to comply with the reporting requirements specified in § 424.516(d) would be a basis for revocation.

73 Fed. Reg. 69,726, 69,780 (Nov. 19, 2008) (emphasis added). The drafters make clear that failure to report within 30 days a change of ownership, an adverse legal action, **or** a change in practice location is a basis for CMS to revoke a physician's billing privileges. 42 C.F.R. § 424.516(d)(1). Nothing in the regulatory history for 42 C.F.R. § 424.516(d)(1) supports Petitioner's position that a supplier must fail to report both an adverse legal action and a change in practice location before CMS has a basis to revoke Medicare enrollment and billing privileges. Petitioner's failure to notify CMS that its 16975 Farmington Road location should be deleted from its file within 30 days of the closing of that location was a sufficient basis for CMS to revoke his billing privileges pursuant to 42 C.F.R. § 424.535(a)(9).

Petitioner claims that WPS acted unreasonably when it refused to accept his CAP because Petitioner acted in good faith to remedy the situation. RFH; P. Br. at 6. Petitioner argues that CMS arbitrarily exercised its discretion to revoke his billing privileges.

The rejection or denial of a CAP is not an appealable initial determination under 42 C.F.R. pt. 498. 42 C.F.R. §§ 405.809, 498.3(d)(5); *Pepper Hill Nursing & Rehab. Ctr. LLC*, DAB No. 2395 at 9-10 (2011); *DMS Imaging, Inc.*, DAB No. 2313 at 5, 7-10 (2010).

I also have no authority to review the exercise of discretion by CMS or its contractor to revoke where there is a basis for revocation. *Abdul Razzaque Ahmed, M.D.*, DAB No. 2261 at 19 (2009), *aff'd*, *Ahmed v. Sebelius*, 710 F.Supp.2d 167 (D. Mass. 2010). The scope of my authority is limited to determining whether there is a legal basis for revocation of Petitioner's Medicare enrollment and billing privileges. *Id*. I have concluded that CMS established that Petitioner violated the reporting requirements of 42 C.F.R. § 424.516(d)(1). Thus, a regulatory basis for revocation exists.

To the extent that Petitioner's arguments may be construed as a request for equitable relief, I have no authority to grant equitable relief. *US Ultrasound*, DAB No. 2302 at 8 (2010) ("Neither the ALJ nor the Board is authorized to provide equitable relief by reimbursing or enrolling a supplier who does not meet statutory or regulatory requirements."). Furthermore, I am bound to follow the Act and regulations, and I have no authority to declare statutes or regulations invalid or ultra vires. *1866ICPayday.com, L.L.C.*, DAB No. 2289 at 14 (2009) (noting that "[a]n ALJ is bound by applicable laws and regulations and may not invalidate either a law or regulation on any ground.").

III. Conclusion

For the foregoing reasons, Petitioner's Medicare enrollment and billing privileges are revoked pursuant to 42 C.F.R.§ 424.535(a)(9) due to noncompliance with 42 C.F.R. § 424.516(d)(1)(iii), effective December 31, 2014.

/s/
Keith W. Sickendick
Administrative Law Judge