Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Steadfast Homecare Health Services, Inc.
(NPI: 1174856363 / PTAN: 14-8173)

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-16-757

Decision No. CR4779

Date: January 30, 2017

DECISION

The Medicare enrollment and billing privileges of Petitioner, Steadfast Homecare Health Services, Inc., are revoked pursuant to 42 C.F.R. § 424.535(a)(10)[1] for noncompliance with 42 C.F.R. § 424.516(f).

I. Procedural History and Jurisdiction

Petitioner was enrolled in Medicare as a home health agency. Palmetto GBA (Palmetto), a Medicare administrative contractor, notified Petitioner by letter dated February 18, 2016, that Petitioner's Medicare enrollment and billing privileges were revoked and its provider agreement terminated effective March 20, 2016. Palmetto cited 42 C.F.R. § 424.535(a)(10) as the authority for revocation based on the fact that Petitioner failed to provide documents requested by CMS. Palmetto imposed a re-enrollment bar of one year. Centers for Medicare & Medicaid Services (CMS) Exhibit (Ex.) 1 at 9-12.

---

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

Petitioner requested reconsideration by letters dated February 29 and March 3, 2016. CMS Ex. 1 at 6-8. Palmetto notified Petitioner by letter dated May 26, 2016, that the revocation of its enrollment and billing privileges was upheld on reconsideration. CMS Ex. 1 at 1-5.

Petitioner requested a hearing before an administrative law judge (ALJ) on July 25, 2016 by letter dated July 22, 2016 (RFH). On August 3, 2016, the case was assigned to me for hearing and decision and an Acknowledgement and Prehearing Order (Prehearing Order) was issued at my direction. Petitioner's request for hearing was timely; the parties have not challenged my authority to decide this case; and I have jurisdiction.

On September 2, 2016, CMS filed a motion for summary judgment and prehearing brief, with CMS Exs. 1 through 25. Petitioner responded on October 25, 2016, by submitting a copy of the request for hearing; a copy of the August 3, 2016 Acknowledgment and Prehearing Order; a copy of the May 26, 2016 reconsidered determination by CMS; and a copy of the February 18, 2016 initial determination by Palmetto, including Enclosure A to that determination, which I treat collectively as Petitioner's response to the motion for summary judgment (P. Br.). Petitioner did not offer any exhibits or a list of witnesses. On November 1, 2016, CMS filed a reply, albeit styled as a waiver of a reply. Petitioner did not object to my consideration of CMS Exs. 1 through 25 and all are admitted as evidence.

II. Discussion

A. Applicable Law

Sections 1811 through 1821 of the Social Security Act (the Act) (42 U.S.C. §§ 1395c-1395i-5) establish the hospital insurance benefits program for the aged and disabled known as Medicare Part A. 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.[2] Administration of both the Part A and B programs is through contractors, such as Palmetto. Act §§ 1816, 1842(a) (42 U.S.C. §§ 1395h, 1395u(a)). Payment under the programs for services rendered to Medicare-eligible beneficiaries may

---

[2] In the case of Medicare-eligible beneficiaries not enrolled in Medicare Part B, home health services are paid under Part A subject to the limitations specified in section 1812(a)(3) of the Act. Home health services are also covered under Medicare Part B for those enrolled. Act § 1832(a)(2)(A). Thus, home health agencies, which are defined as providers by section 1861(u) of the Act, may be reimbursed under Part A or Part B depending upon the facts of the particular case.

only be made to eligible providers of services and suppliers.[3] Act §§ 1815, 1817, 1834(j)(1) (42 U.S.C. §§ 1395g, 1395i, 1395m(j)(1)); 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395u(h)(1)). Petitioner, a home health agency, is a provider.

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. §§ 424.500 and 424.505, a provider such as Petitioner must be enrolled in the Medicare program and be issued a billing number to have billing privileges and to be eligible to receive payment for services rendered to a Medicare-eligible beneficiary. The Act sets forth requirements for home health agencies participating in the Medicare and Medicaid programs, and authorizes the Secretary to promulgate regulations implementing the statutory provisions. Act §§ 1861(m) and (o), and 1891 (42 U.S.C. §§ 1395x(m) and (o), and 1395bbb).

The Secretary has delegated authority to CMS or its Medicare contractor to revoke an enrolled provider's Medicare enrollment and billing privileges and any provider agreement for any of the reasons listed in 42 C.F.R. § 424.535. The provider bears the burden to demonstrate that it meets enrollment requirements with documents and records. 42 C.F.R. § 424.545(c). If CMS revokes a provider's Medicare billing privileges for not complying with enrollment requirements, then the revocation is effective 30 days after CMS or its contractor mails notice of its determination to the provider. 42 C.F.R. § 424.535(g).

The Secretary has issued regulations that establish the right to a hearing and judicial review of certain enrollment determinations. Act § 1866(j) (42 U.S.C. § 1395cc(j)). Pursuant to section 1866(h)(1) and (j)(8), a provider or supplier whose enrollment application or renewal application is denied or whose Medicare enrollment is revoked and corresponding agreement, if any, is terminated is entitled to a hearing before an ALJ

———————

[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," 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.

and Board review, followed by judicial review. Pursuant to 42 C.F.R. § 424.545(a), a provider or supplier denied enrollment in Medicare or whose Medicare enrollment and billing privileges are revoked has the right to administrative and judicial review in accordance with 42 C.F.R. pt. 498. Appeal and review rights are specified by 42 C.F.R. § 498.5.

B. Issues

Whether summary judgment is appropriate; and

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

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

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

1. Summary judgment is appropriate.

CMS filed a motion for summary judgment.

A provider or supplier denied enrollment in Medicare or whose enrollment has been revoked has a right to a hearing and judicial review pursuant to section 1866(h)(1) and (j) of the Act and 42 C.F.R. §§ 498.3(b)(1), (5), (6), (8), (15), (17); 498.5. A hearing on the record, also known as an oral hearing, is required under the Act. Act §§ 205(b), 1866 (h)(1) and (j)(8); *Crestview*, 373 F.3d at 748-51. A party may waive appearance at an oral hearing, but must do so affirmatively in writing. 42 C.F.R. § 498.66. In this case, 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 the CMS motion for summary judgment has merit.

Summary judgment is not automatic upon request but is limited to certain specific conditions. The Secretary's regulations that establish the procedure to be followed in adjudicating Petitioner's case are at 42 C.F.R. pt. 498. 42 C.F.R. §§ 405.800, 405.803(a); 424.545(a), 498.3(b)(5), (6), (15), (17). The regulations do not establish a summary judgment procedure or recognize such a procedure. However, the Departmental Appeals Board (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 (Fed. R. Civ. Pro.) 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. 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. 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. 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 differs from that used in resolving a case on the merits after a hearing or when hearing is waived. 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 & Conv. Ctr.*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Conv. Ctr. v. Thompson*, 129 Fed. App'x 181 (6th Cir. 2005).

In this case, I conclude that there is no genuine dispute as to any material fact pertinent to revocation pursuant to 42 C.F.R. § 424.535(a)(10) based on a violation of 42 C.F.R. § 424.516(f) that requires a trial. There is no dispute that Petitioner failed to provide CMS adequate documents related to certification of home health services for at least one Medicare beneficiary. Resolution of this case turns upon application of the law to the undisputed facts. Accordingly, summary judgment is appropriate.

2. Petitioner violated 42 C.F.R. § 424.516(f) by failing to provide documents requested by CMS that Petitioner was required to have, retain, and produce on request by CMS or a Medicare contractor.

3. There is a basis for revocation of Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(10) for noncompliance with the requirement of 42 C.F.R. § 424.516(f) to provide documents requested by CMS.

a. Facts

The material facts are not disputed and any inferences are drawn in Petitioner's favor on summary judgment.

There is no dispute that prior to revocation Petitioner was enrolled in Medicare as a provider of home health services. CMS has provided the declaration of Elizabeth Lindner, Director, Division of Field Operations – North, Investigations and Audits Group for the Centers for Program Integrity of CMS. CMS Ex. 2. According to Ms. Lindner, Petitioner became a target for investigation by CMS because Medicare program data show that Petitioner had submitted a high number of claims for reimbursement of services provided to beneficiaries whose referring physician had no prior relationship to the beneficiaries. Therefore, a team of three CMS investigators, including Ms. Lindner, conducted an unannounced site inspection of Petitioner's facility on June 24, 2015. CMS Ex. 2 at 2. Basil Ohakosim, Petitioner's Administrator, states in the request for hearing that the investigators were at Petitioner's facility on July 8, 2015 (RFH at 1; P. Br. at 1), but he offers no declaration of an employee or any other evidence to dispute that the investigators conducted the on-site inspection on June 24, 2015 as stated by Ms. Lindner. Ms. Lindner states the investigators gave Petitioner's representative in the office a written request for the patient records of 17 beneficiaries. A copy of the request for records has been admitted as evidence marked as CMS Ex. 5 with no objection by Petitioner. CMS Ex. 2 at 2-3. The parties were specifically advised by the Prehearing Order that a fact alleged and not specifically denied, may be accepted as true on summary judgment. The parties were also advised that any evidence offered will be considered admissible and true, unless a specific objection is made to admissibility or accuracy. Prehearing Order ¶II.G. Petitioner does not dispute the admissibility of Ms. Linder's declaration

(CMS Ex. 2) or that it is true. Petitioner also has not disputed the admissibility or accuracy of CMS Ex. 5. Accordingly, both CMS Ex. 2 and 5 are accepted as admissible and accurate.

CMS Ex. 5 reflects on its face that the investigators were seeking records in Petitioner's possession for all 17 beneficiaries listed. None of the three categories of records listed on CMS Ex. 5 were checked or otherwise marked to indicate that the request for records was limited to those types of records. Nor is there any indication on the face of CMS Ex. 5 to indicate that the requested records were for a specific period of time. CMS Ex. 2 at 2-3; CMS Ex. 5. Mr. Ohakosim asserts in the request for hearing that the requested records were limited to dates of service between May 1, 2014 and July 4, 2014. RFH at 1; P. Br. at 1. However, again he failed to submit an affidavit, declaration, or other evidence to show a disputed issue of fact that the request for records (CMS Ex. 5) was limited to the dates of service he asserts. Nothing on the face of CMS Ex. 5 establishes a dispute as to whether the requested records were for a limited period of dates of service as asserted by Mr. Ohakosim.

It is not disputed that during the on-site inspection an employee of Petitioner prepared copies of records for the beneficiaries listed on CMS Ex. 5 and gave them to the investigators who left without discussing the records with Petitioner's employee. RFH at 1; P. Br. at 1; CMS Ex. 2 at 3. There is no dispute that the records provided to the investigators are those offered and admitted as CMS Exs. 6 through 22. CMS Ex. 2 at 3.

Subsequently the records provided by Petitioner were reviewed by a member of the Investigations and Audits Group and it was determined that some records were missing for 16 of the 17 beneficiaries. A spreadsheet was created listing the beneficiaries and the missing records for each which has been offered and admitted as CMS Ex. 1 at 11-12. CMS Ex. 2 at 5. The spreadsheet was attached to the February 18, 2016 notice of the initial determination to revoke issued by Palmetto and the missing documents listed on the spreadsheet were referred to as the factual basis for the revocation. CMS Ex. 1 at 9. The notice of initial determination states that "[o]n July 8, 2015, CMS requested medical records for 17 beneficiaries [for] whom [Petitioner] submitted claims for dates of service from May 1, 2014 through July 4, 2014." CMS Ex. 1 at 9. The facts asserted in the initial determination regarding the date of the on-site inspection and the limitation to dates of service from May 1 through July 4, 2014 are clearly at odds with the declaration of Ms. Lindner. Whether Palmetto or Ms. Lindner is in error is not for me to determine on summary judgment. Rather, the facts asserted by Palmetto in the initial determination are consistent with the assertions of Petitioner. Therefore, for purposes of summary judgment I draw all favorable inferences for Petitioner and accept as true for summary judgment that the investigation occurred on July 8, 2014, and that records requested were for beneficiaries for whom Petitioner filed claims for dates of service from May 1, 2014 through July 4, 2014.

Petitioner timely requested reconsideration of the initial determination to revoke its Medicare enrollment and billing privileges and its provider agreement. CMS Ex. 1 at 6-8. Petitioner asserted in its letter dated February 29, 2016, signed by Ejehi Awenlimobor, that all the documents alleged in the spreadsheet to be missing "ARE substantively present." CMS Ex. 1 at 6. Petitioner asserts in its reconsideration request that all the documents were provided to the investigators during the July 8, 2015 on-site inspection. Petitioner submitted with its request for reconsideration beneficiary records marked CMS Ex. 1 at 13-166. Ms. Lindner disputes that records marked CMS Ex. 1 at 13-166 were received by the investigators at the time of the on-site investigation. CMS Ex. 1 at 6, 7, 14-166; CMS Ex. 2 at 5-6 ¶ 22. For purposes of summary judgment, I again accept as true the assertion that the documents marked CMS Ex. 1 at 13-166 that were submitted by Petitioner at reconsideration, were in the initial collection of copies given to the investigators.

The hearing officer on reconsideration determined that Palmetto failed to timely provide medical records requested by CMS and failed to provide proper documentation. Specifically, the hearing office concluded that revocation was appropriate citing 42 C.F.R. §§ 424.535(a)(10), 424.516(f), and 424.22(a)(1)(v), because Petitioner "failed to properly document several requested plans of care and face-to-face patient encounters and did not meet the requirements for providing home health services to Medicare beneficiaries." CMS Ex. 1 at 3. The hearing officer provides no clue in her reconsidered determination as to what specific errors she found.[4]

Before me on summary judgment, CMS argues that Petitioner failed to produce records it was required to keep and produce upon request for 3 of the 17 beneficiaries listed on the spreadsheet marked as CMS Ex. 1 at 11-12. Specifically:

---

[4] Because the hearing officer cites to no facts she found to support her conclusion that there are errors that provide a basis for revocation, remand would be appropriate. However, remand would not be in the interest of either judicial economy or due process for CMS or Petitioner. Petitioner is accorded its right to a de novo review by me without the additional delay and what could be a fruitless effort to cause the hearing officer to make proper findings of fact and conclusions of law. I note that neither Petitioner nor CMS suggest remand for a new reconsidered determination.

PATIENT #[5]	DOCUMENT PETITIONER FAILED TO PRODUCE
1	Plan of Care, Certification Period July 9 through September 6, 2014
2	Plan of Care, Certification Period May 17 through July 15, 2014
3	Face-to-Face Encounter Record for Start of Care September 24, 2013

CMS Br. at 7, 9-12. The certification period July 9 through September 6, 2014 for Patient 1 is outside the window for claims for dates of service from May 1, 2014 through July 4, 2014, that was accepted by Palmetto in the initial determination as the period for which records were requested. CMS Ex. 1 at 9; CMS Ex. 22. Although CMS may well prove that the period reflected in initial determination is error based on testimony of Ms. Lindner, for purposes of summary judgment I find myself limited by the initial determination findings which appear to be consistent with Petitioner's assertion and trigger a favorable inference for Petitioner. Similarly for Patient 3, the record of a face-to-face encounter for a start of care of September 24, 2013, relates to a 60-day period for home health services considerably before and unlikely related to claims submitted by Petitioner for dates of service between May 1 and July 4, 2014. CMS Ex. 22. Accordingly, for purposes of summary judgment only, I do not consider further the examples of Patients 1 and 3.

The case of Patient 2 is significantly different however. CMS alleges that Petitioner failed to produce a proper physician certification for home health services for the period May 17 through July 15, 2014. The certification period mostly coincides with the period May 1, 2014 through July 4, 2014, the period of dates of service that Palmetto determined was pertinent. CMS Ex. 1 at 9. Therefore, if CMS is correct that Petitioner failed to produce the certification for the period May 17 through July 15, 2014, that document would relate to claims submitted by Petitioner for dates of service between May 1, 2014 and July 4, 2014 for Patient 2. Petitioner does not deny that CMS Ex. 25 shows that claims were submitted for Patient 2 for dates of service from May 17, 2014 through July 15, 2014. CMS Ex. 2 at 2. CMS Ex. 7 and CMS Ex. 1 at 121-32 are the records for Patient 2 produced by Petitioner. CMS Ex. 7 at 1 shows a start of care for Patient 2 of

---

[5] Patient names are omitted from this decision for privacy reasons. Patient names are listed in the Centers for Medicare & Medicaid Services Motion for Summary Disposition Patient Identification Key dated September 2, 2016 (Departmental Appeals Board Electronic Filing System (DAB E-File) Item # 7). Records for Patient 1 are located in CMS Ex. 6; for Patient 2 in CMS Ex. 7, and for Patient 3 in CMS Ex. 8.

May 17, 2014. However, there is no "Home Health Certification and Plan of Care" with a certification period of May 17 through July 15, 2014, included among the documents in CMS Ex. 7. CMS Ex. 1 at 121-132. The spreadsheet issued with the initial determination clearly listed the missing plan of care for May 17, 2014 through July 15, 2014. CMS Ex. 1 at 12 (first patient listed). Petitioner submitted a "Home Health Certification and Plan of Care" form completed for a certification period of May 17 through July 15, 2014, but that document was not certified and signed by the attending physician. CMS Ex. 1 at 129-32.

b. Analysis

Section 1891(a) of the Act (42 U.S.C. § 1395bbb) establishes conditions of participation that a home health agency must meet. Pursuant to section 1891(a)(4) of the Act, a home health agency must include the plan of care required by section 1861(m) of the Act as part of its clinical records for a Medicare beneficiary receiving home health services. Section 1861(o) of the Act defines the term home health agency. Section 1861(o)(3) of the Act requires that a home health agency maintain clinical records on all patients. Section 1861 of the Act defines the term home health services. Section 1861(m) requires that home health services be delivered according to a plan of care established and periodically reviewed by a physician.

The regulations at 42 C.F.R. pt. 484 establish the conditions of participation and standards a home health agency must meet to participate in the Medicare program. Pursuant to 42 C.F.R. § 484.18, home health services must be delivered according to "a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine" at least once every 60 days.

Home health agencies must also satisfy the requirements of 42 C.F.R. §§ 409.40-.50 and 424.22, which provide among other things that Medicare Part A or Part B only pay for home health services if properly certified and recertified by a physician. The physician certification of need for home health service must be obtained at the time the plan of care is established or as soon thereafter as possible and must be signed and dated by the physician who establishes the plan of care. 42 C.F.R. §§ 424.22(a)(v)(B)(1), 409.43(c). Providers or suppliers, including home health agencies, that furnish covered items of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), clinical laboratory services, imaging services, or home health services are required to maintain documents for seven years from the date of service and to give CMS or a Medicare contractor access to that documentation, including written and electronic documents, upon request. 42 C.F.R. § 424.516(f)(1). The regulations specifically provide that failure to permit CMS access to documentation required to be maintained by 42 C.F.R. § 424.516(f) is a basis for revocation. 42 C.F.R. § 424.535(a)(10).

It is undisputed that CMS investigators requested records from Petitioner that were not more than seven years old. It is undisputed that Petitioner was required to have a home health certification and plan of care for Patient 2 for the certification period May 17, 2014 to July 15, 2014, that was signed and dated by the attending physician. Petitioner has failed, despite multiple opportunities, to produce a home health certification and plan of care for Patient 2 for the period May 17, 2014 to July 15, 2014. Accordingly, I conclude that Petitioner violated 42 C.F.R. § 424.516(f) and that violation is a basis for revocation of Petitioner's Medicare enrollment and billing privileges and termination of Petitioner's provider argument under 42 C.F.R. § 424.535(a)(10) and (b). The re-enrollment bar of one year is the minimum authorized by 42 C.F.R. § 424.535(c).

To the extent that any of Petitioner's arguments may be construed to be a request for equitable relief, I have no authority to grant equitable relief. *US Ultrasound*, DAB No. 2302 at 8 (2010). I am also required to follow the Act and regulations and have no authority to declare statutes or regulations invalid. *1866ICPayday.com, L.L.C.*, DAB No. 2289 at 14.

III. Conclusion

For the foregoing reasons, I conclude that Petitioner's Medicare enrollment and billing privileges are revoked pursuant to 42 C.F.R. § 424.535(a)(10) for failure to comply with the documentation requirements at 42 C.F.R. § 424.516(f).

/s/
Keith W. Sickendick
Administrative Law Judge