Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Blair & Associates,
A Professional Psychological Corporation,
(NPI: 1700030582 / PTAN: BO782A),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-17-48

Decision No. CR4833

Date: April 26, 2017

DECISION

The Medicare enrollment and billing privileges of Petitioner, Blair & Associates, A Professional Psychological Corporation, are revoked pursuant to 42 C.F.R. §§ 424.535(a)(5)(ii) and 424.535(a)(9)[1] based on a violation of 42 C.F.R. § 424.516(d)(1)(iii). The effective date of revocation is January 14, 2016, the date it was determined that Petitioner was not operating a practice location at the address Petitioner had reported as a practice location. 42 C.F.R. § 424.535(g).

I. Procedural History and Jurisdiction

On April 28, 2016, Noridian Healthcare Solutions (Noridian), a Medicare administrative contractor (MAC), notified Petitioner of its initial determination to revoke Petitioner's Medicare enrollment and billing privileges effective January 14, 2016, and to impose a two-year re-enrollment bar. Noridian cited 42 C.F.R. §§ 424.535(a)(5) and 424.535(a)(9)

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

as authority for the revocation and alleged it was determined, based on an on-site review, that Petitioner was not operational and that Petitioner failed to notify the Centers for Medicare & Medicaid Services (CMS) of a change of practice location as required by 42 C.F.R. § 424.516. CMS Exhibit (Ex.) 1 at 25-29.

Petitioner requested reconsideration by letter dated June 2, 2016. CMS Ex. 1 at 10-24. A Noridian hearing officer issued a reconsidered determination on August 18, 2016. The hearing officer upheld the revocation of Petitioner's Medicare enrollment and billing privileges. The hearing officer found, based on a site visit conducted on January 14, 2016, that Petitioner was not operating its practice at the address on file as its practice location. The hearing officer found no evidence that Petitioner had notified CMS of a change of practice location. The hearing officer upheld revocation pursuant to 42 C.F.R. §§ 424.535(a)(5) and (9). CMS Ex. 1 at 1-4.

Petitioner requested a hearing before an administrative law judge (ALJ) on October 17, 2016 (RFH). The case was assigned to me and an Acknowledgement and Prehearing Order (Prehearing Order) was issued on October 28, 2016. There is no dispute that Petitioner's request for hearing was timely and I have jurisdiction.

CMS filed a motion for summary judgment and prehearing brief on November 21, 2016 (CMS Br.) with CMS exhibits 1 through 4. On December 27, 2016, Petitioner filed a prehearing brief, motion for a favorable decision on the record, and response in opposition to the CMS motion (P. Br.), together with Petitioner's exhibits (P. Exs.) 1 through 3. CMS filed a reply brief on January 10, 2017 (CMS Reply). Petitioner did not object to my consideration of CMS Exs. 1 through 4 and they are admitted as evidence. CMS objected to my consideration of P. Exs. 1 through 3 on grounds that they are not relevant to any issue I may resolve. CMS is correct that only relevant and material evidence is considered. 5 U.S.C. § 556(d); 42 C.F.R. § 498.60(b). P. Ex. 1 is a "Medicare ID Report" printed from the CMS Provider Enrollment, Chain, and Ownership System (PECOS) on May 4, 2016. CMS does not dispute the authenticity of the information reflected in P. Ex. 1 or that the document was generated from a CMS controlled system of records. CMS also does not deny the truth and accuracy of the information contained in P. Ex. 1. Noridian based revocation in this case on 42 C.F.R. §§ 424.516(d) and 424.535(a)(5) and (9) and the application of these regulations in this case involves the issue of whether or not Petitioner gave notice of a change of practice location or other change. CMS does not dispute that P. Ex. 1 accurately shows various practice locations for Petitioner and the effective dates. Therefore, P. Ex. 1 is clearly relevant to an issue I must decide and the CMS objection is overruled. P. Ex. 1 is admitted. P. Exs. 2 and 3 are CMS publications that either state CMS policy or interpret

CMS policy. Whether or not the documents are current CMS policy is not apparent from the face of the documents, but CMS does not deny they set forth the current CMS policy on the topics discussed. Both documents are highly relevant to Petitioner's case and they are admitted as evidence.[2]

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 Noridian. 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.[3] Act §§ 1835(a) (42 U.S.C. § 1395n(a)), 1842(h)(1) (42 U.S.C. § 1395u(h)(1)). Petitioner, a nonphysician practitioner organization, is a supplier. Act §§ 1842(b)(18)(C), 1848(k)(3)(B); 42 C.F.R. § 424.502.

The Act requires that the Secretary issue regulations to establish a process for enrolling providers and suppliers in Medicare, including the requirement to provide 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, suppliers such as Petitioner must be enrolled in the Medicare

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[2] Generally, I would not require the parties to mark as evidence a published policy of the Secretary of Health and Human Services (Secretary) or CMS for the same reason it is not necessary to mark a copy of a statute or regulation as evidence. However, because CMS policy frequently changes, it is a good practice to provide a copy of any policy a party wants me to consider that was in effect at the time of an action or event in issue.

[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.

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 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)(5), CMS may revoke a supplier's enrollment and billing privileges if CMS determines, upon on-site review, that the supplier is no longer operational to furnish Medicare-covered items or services, or has otherwise failed to satisfy any of the Medicare enrollment requirements. 42 C.F.R. § 424.535(a)(5)(i) - (ii). Pursuant to 42 C.F.R. §424.535(a)(9), CMS may revoke a supplier's enrollment and billing privileges if the supplier did not comply with the reporting requirements specified in 42 C.F.R. § 424.516(d)(1)(iii), which requires a nonphysician practitioner organization such as Petitioner to report to their Medicare contractor within 30 days any change in practice location.

Generally, when CMS revokes a supplier's Medicare billing privileges for not complying with enrollment requirements, the revocation is effective 30 days after CMS or its contractor mails notice of its determination to the supplier. 42 C.F.R. § 424.535(g). However, when CMS revokes a supplier's billing privileges because the supplier's "practice location" is not operational, the revocation is effective the date the practice location was no longer operational as determined by CMS. 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. 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 and specifying the conditions or requirements the supplier failed to meet, and advising the supplier of its 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(*l*)(2). CMS is also granted the right to request ALJ review of a reconsidered determination with which it is dissatisfied. 42 C.F.R. § 498.5(*l*)(2). 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 Medicare enrollment.

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.

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. Petitioner styled its pleading as its "Pre-Hearing Exchange, Motion for a Favorable Decision on the Record, and Response to CMS' Motion for Summary Judgment." Petitioner moves for a favorable decision on the record but opposes summary judgment. P. Br. at 1, 17-18. It is not clear that Petitioner intends to waive its right to an oral hearing by requesting a favorable decision on the record. The regulation requires a specific written waiver of the right to appear and present evidence and Petitioner's pleading is not clear as to its intent. 42 C.F.R. § 498.66(a). Accordingly, I conclude that Petitioner has not waived the right to appear at an oral hearing to present evidence. However, Petitioner submitted a declaration with its pleading as one generally does with a motion or cross-motion for summary judgment. Therefore, I treat Petitioner's motion for a favorable decision on the record as a cross-motion for summary judgment. Because I conclude Petitioner has not waived the right to oral hearing, disposition on the written record alone is not permissible unless summary judgment is appropriate in favor of either party.

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, para. II.D and G. The parties were given notice by my 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 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 in this case related to whether Petitioner properly notified CMS or Noridian or its actual practice location as required by 42 C.F.R. § 424.516(d)(1)(iii). Summary judgment is appropriate as to revocation pursuant to 42 C.F.R. § 424.525(a)(5)(ii) and (9), for failure to comply with 42 C.F.R. § 424.516(d)(1)(iii), and the effective date of revocation. The issues in this case that require resolution related to revocation on these bases, are issues of law related to the interpretation and application of the regulations that govern enrollment and billing privileges in the Medicare program and application of the law to the undisputed facts of this case.

There are genuine disputes of material fact related to whether or not Petitioner was operational at another location at the time of the on-site review based on the declaration of Petitioner's president (CMS Ex. 1 at 13-14). On summary judgment all inferences must be drawn in favor of the non-movant. CMS is not entitled to judgment as a matter of law for revocation pursuant to 42 C.F.R. § 424.535(a)(5)(i). Therefore, summary judgment is not appropriate for revocation pursuant to 42 C.F.R. § 424.535(a)(5)(i). If CMS wishes to attempt to prove Petitioner was not operational, as that term is defined in 42 C.F.R. § 424.502, as of the date of the on-site review, CMS may file a motion to reopen.

2. It is a requirement to maintain enrollment in Medicare that a nonphysician practitioner or nonphysician practitioner organization report to their Medicare contractor within 30 days a change in practice location. 42 C.F.R. § 424.516(d)(1)(iii).

3. CMS or its contractor is authorized to revoke the Medicare enrollment and billing privileges of a provider or supplier that is found upon on-site review to fail to satisfy any Medicare enrollment requirement. 42 C.F.R. § 424.535(a)(5)(ii).

4. There is a basis to revoke Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(5)(ii) because Petitioner failed to report to its Medicare contractor using a CMS-855I its correct practice location as required by 42 C.F.R. § 424.516(d)(1)(iii).

5. There is also a basis to revoke Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. § 424.535(a)(9) because Petitioner, a nonphysician practitioner organization, failed to report its correct practice location to the Medicare contractor using a CMS-855I within 30 days as required by 42 C.F.R. § 424.516(d)(1)(iii).

6. Revocation of Petitioner's Medicare enrollment and billing privileges is effective January 14, 2016, the date Petitioner was determined not to be operating at the practice location listed in Petitioner's Medicare enrollment application (CMS-855I). 42 C.F.R. § 424.535(g).

a. Facts

The material facts are not disputed.

It is alleged in the reconsidered determination that Noridian received a revalidation application for Petitioner on August 30, 2013. It is alleged that the address of Petitioner's practice location on file on August 30, 2013 was 12021 Wilshire Boulevard, Suite 430, Los Angeles, California (12021 Wilshire). It is also alleged that the revalidation application did not reflect any change in practice location. CMS Ex. 1 at 1-2. I specifically advised the parties in the Prehearing Order that a fact alleged and not specifically denied may be accepted as true for purposes of considering summary judgment. Prehearing Order ¶ II.G. Petitioner has not disputed the truth of these facts from the reconsidered determination, and I accept them as true. My finding is consistent with and supported by P. Ex. 1 which listed the practice location for Petitioner as 12021 Wilshire from December 16, 2008 through Petitioner's termination on January 14, 2016. P. Ex. 1. Petitioner also had practice locations at 9454 Wilshire Boulevard, Beverly Hills, California (9454 Wilshire) Provider Transaction Number (PTAN) BO782B and 415 W Route 66, Suite 202, Glendora, California (Route 66) PTAN BO782C, effective December 1, 2009, but Petitioner's evidence shows that those practice locations were terminated January 1, 2010 by Petitioner. P. Ex. 1; P. Br. at 5. Petitioner does not dispute that CMS records show that its practices at 9454 Wilshire, PTAN BO782B, and Route 66, PTAN BO782C, were withdrawn from Medicare effective January 1, 2010. CMS Ex. 2 at 1. Petitioner does not dispute that after January 1, 2010, only 12021 Wilshire, PTAN BO782A, was listed as Petitioner's practice location. P. Ex. 1, CMS Ex. 2 at 2.

Cassidy Blair, a licensed psychologist, is the president of Petitioner. She executed a declaration dated June 1, 2016, that was submitted in support of the request for reconsideration. Ms. Blair states in her declaration that the 9454 Wilshire location has always been Petitioner's "physical location," at least the last eight years without interruption. CMS Ex. 1 at 13. She states that 9454 Wilshire is where outpatient services are provided but that she had not seen any Medicare patients as outpatients since 2008. She states that her Medicare practice has been hospital based. She testified that 9454 Wilshire is the address on Petitioner's business tax certificate and the location insured by Petitioner. She attests that 12021 Wilshire has never been Petitioner's practice location and that address is only a mailing address. She states that during the preceding three years Petitioner revalidated its enrollment information without any issue or comment

from Noridian or CMS. CMS Ex. 1 at 13-14. I accept as true Ms. Blair's statements for purposes of summary judgment. Petitioner filed copies of its business tax certificate and insurance policy on reconsideration, and those documents show 9454 Wilshire as Petitioner's business location and 12021 Wilshire as a mailing address. CMS Ex. 1 at 20-22. Petitioner submitted a letter from its landlord at 9454 Wilshire stating that Petitioner has been a tenant since 2008 or 2009. CMS Ex. 1 at 23. I accept these facts as true for purposes of summary judgment.

Petitioner does not allege and has not submitted any evidence that it reported 9454 Wilshire as its practice location or 12021 Wilshire as only a correspondence address after 9454 Wilshire was withdrawn as a practice location effective January 1, 2010. Request for Reconsideration (CMS Ex. 1 at 10-14); RFH.

On January 14, 2016, a CMS inspector conducted an on-site inspection at the 12021 Wilshire location. The inspector indicates in his report that the location was a post office box but the photographs submitted with the report reflect that the location was a commercial mailbox business. The inspector concluded that Petitioner did not operate a practice at 12021 Wilshire. CMS Ex. 1 at 5-6. Petitioner did not specifically object to my consideration of the unsigned report or deny the truth of the matter asserted in the report. Petitioner does not deny that it did not operate a practice at 12021 Wilshire and Petitioner's president admits it never did. CMS Ex. 1 at 13.

b. Analysis

There is no dispute that Petitioner was enrolled as a supplier in Medicare from at least December 16, 2008. P. Ex. 1; CMS Ex. 2. There is also no dispute that from December 16, 2008 through January 14, 2016, 12021 Wilshire was listed in CMS records as a practice location for Petitioner for purposes of Medicare. Petitioner's practice locations at 9454 Wilshire and Route 66 were withdrawn from Medicare by Petitioner effective January 1, 2010. P. Ex. 1.

Petitioner is obliged to submit a complete Medicare enrollment application with accurate and truthful responses to all information requested and to ensure that its enrollment information is updated to remain complete, accurate, and truthful. 42 C.F.R. §§ 424.510(d), 424.515, 424.516. In order to maintain an active enrollment status in Medicare, Petitioner had to comply with 42 C.F.R. § 424.516. Pursuant to 42 C.F.R. § 424.516(d)(1)(iii), Petitioner was required to report a change of practice location to the Medicare contractor within 30 days. The regulations require the use of the appropriate enrollment application (CMS-855) or PECOS to report changes in enrollment information such as a change of practice location. 42 C.F.R. §§ 424.502, 424.515. CMS has the right to perform on-site inspections to verify information and confirm that a provider or supplier continues to meet enrollment requirements. 42 C.F.R. §§ 424.510(d)(8), 424.517. Petitioner bears the burden to demonstrate that it meets

enrollment requirements and to produce documents demonstrating compliance with all program participation requirements. 42 C.F.R. § 424.545(c).

Petitioner argues that Noridian sent its site investigator to the wrong location in violation of CMS policy. P. Br. at 1. However, Petitioner's own evidence shows that 12021 Wilshire was listed as Petitioner's only practice location at the time of the site inspection. The investigator attempted to visit the only practice location listed for Petitioner as the 9454 Wilshire and Route 66 locations were removed as practice locations in 2010 and no longer subject to survey. Therefore, the investigator did not go to the wrong location. Indeed, by attempting to inspect 12021 Wilshire the investigator discovered Petitioner's noncompliance with reporting requirements.

Petitioner argues it was operational at a location other than 12021 Wilshire at the time of the site inspection but not for purposes of delivery of care and services to Medicare beneficiaries. P. Br. at 4, 7-12. I am not granting summary judgment on grounds that Petitioner was not operational. Therefore, further discussion of whether or not Petitioner was operational at the time of the site inspection is unnecessary.

Petitioner does not dispute that CMS records listed 12021 Wilshire as Petitioner's only practice location from January 1, 2010 through January 14, 2016. P. Ex. 1. Petitioner asserts that there was confusion about how to report Petitioner's practice location, a fact I accept as true for purposes of summary judgment. Petitioner does not assert any confusion about the fact that 12021 Wilshire was only Petitioner's mailbox and not its practice location. Petitioner does not deny knowledge of the reporting of 12021 Wilshire as a practice location. Petitioner does not allege that there was an attempt to file a new report to correct the information on file with Noridian and CMS. Petitioner does not allege that there was an attempt to obtain clarification of program participation requirements regarding practice location requirements and reporting from CMS or Noridian. Petitioner argues that because Ms. Blair only delivered services to Medicare beneficiaries in a hospital setting (a fact accepted as true for summary judgment) she did not have an office location to be reported as a practice location. P. Br. at 4-5. Petitioner asserts as fact that there was confusion about regulatory and policy guidance about what locations must be reported as practice locations, specifically when the location is not open for Medicare beneficiaries to visit. P. Br. at 5. Whether or not Petitioner is correct in its interpretation of the regulation related to reporting practice locations, I need not resolve. The undisputed facts are that Petitioner's practice location on file was 12021 Wilshire but Petitioner did not have a practice at that location, only a mailbox. Petitioner does not explain how any of its various arguments constitute a defense to having incorrectly reported and then failed to report accurately that 12021 Wilshire was not a practice location but, rather, just its correspondence address.

Petitioner argues that the site visit was invalid because it was requested by Novitas Solutions, Inc. rather than Noridian. Petitioner points to no statute, regulations, or policy that specifies that CMS or a MAC must be listed as the requesting authority for a site

survey or inspection. I am aware of none. Petitioner does not dispute that Noridian issued the initial determination to revoke. Petitioner does not dispute that Noridian had jurisdiction to issue the initial determination revoking Petitioner's enrollment and billing privileges. P. Br. at 14.

Petitioner argues that the site investigation report is not signed and the pictures do not bear time and date stamps (CMS Ex. 1 at 5-6). However, Petitioner did not object to my consideration of CMS Ex. 1 or any of its pages, which it was obliged to do under the Prehearing Order paragraph II.G. P. Br. at 14-15. More significant is the fact that Petitioner does not dispute the findings in the investigator's report. Even if I excluded the report and photos, there is no dispute that: a site inspection was attempted at 12021 Wilshire; that site was never a practice location for Petitioner (CMS Ex. 1 at 13), but P. Ex. 1 clearly shows that CMS listed 12021 as a practice location for Petitioner at the time of the failed inspection. The regulation provides for a determination that a supplier does not satisfy an enrollment requirement based on either on-site review or other reliable evidence. 42 C.F.R. § 424.535(a)(5). In this case the exclusion of CMS Ex. 1 at 5-6 would have no impact upon the decision, and erroneously admitting those documents as evidence would amount to harmless error.

I conclude that Petitioner has failed to show that it met and continued to meet enrollment requirements or to establish any affirmative defense. The 12021 Wilshire location was listed as Petitioner's only practice location from January 1, 2010 to January 14, 2016. P. Ex. 1. Petitioner did not file a CMS-855I to correct its enrollment record to show that 12021 Wilshire was not a practice location but only a correspondence address. Accordingly, I conclude that there is a basis for revocation of Petitioner's Medicare enrollment and billing privileges pursuant to 42 C.F.R. §§ 424.535(a)(5)(ii) and (9) for violation of 42 C.F.R. § 424.516(d)(1)(iii).

Having found that there is a basis for revocation, I have no authority to review the exercise of discretion by CMS to revoke Petitioners' Medicare enrollment and billing privileges. *Dinesh Patel, M.D.*, DAB No. 2551 at 10 (2013); *Fady Fayad, M.D.*, DAB No. 2266 at 16 (2009), aff'd, 803 F. Supp. 2d 699 (E.D. Mich. 2011); *Abdul Razzaque Ahmed, M.D.*, DAB No. 2261 at 16-17, 19 (2009), aff'd, 710 F. Supp. 2d 167 (D. Mass. 2010).

Summary judgment is also appropriate as to the effective date of revocation. Pursuant to 42 C.F.R. § 424.535(g):

> (g) *Effective date of revocation.* Revocation becomes effective 30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier, except if the revocation is based on Federal exclusion or debarment, felony conviction, license suspension or revocation, **or the practice location is determined by CMS or its contractor not to be operational**. When a revocation is based on a Federal exclusion or debarment, felony conviction, license suspension or revocation, **or the practice location is determined by CMS or its contractor not to be operational**, **the revocation is effective** with the date of exclusion or debarment, felony conviction, license suspension or revocation or **the date that CMS or its contractor determined that the provider or supplier was no longer operational.**

(Emphasis added). Petitioner does not dispute that at the time of the site visit there was no practice location at 12021 Wilshire. Pursuant to 42 C.F.R. § 424.535(g), CMS is authorized to establish an effective date of revocation which is the date Petitioner's **practice location** was no longer operational, as determined by CMS. The Noridian investigator found that Petitioner did not have an operational practice at 12021 Wilshire on January 14, 2016. Therefore, January 14, 2016, is the correct effective date of revocation.

Petitioner argues that CMS failed to follow its rules by not issuing the notice of revocation timely and the three-month delay in issuing the notice caused an arbitrary and capricious revocation effective date. P. Br. at 1, 4. Petitioner argues that pursuant to CMS policy, CMS or Noridian had only seven calendar days from determining that Petitioner was not operational to issue the notice of revocation. The site visit occurred on January 14, 2016. Petitioner calculates that Noridian had until January 21, 2016 to issue the notice of revocation but did not do so until April 28, 2016, more than three months later. P. Br. at 15-16. There are two errors in Petitioner's reasoning. First, the CMS policy cited by Petitioner, Medicare Program Integrity Manual, CMS pub. 100-08, chap. 15, § 15.20.1.E, is very specific that revocation must be effected and notice given within seven calendar days of the determination by CMS or Noridian that Petitioner was not operational at 12021 Wilshire. It is the determination of CMS or Noridian that triggers the seven days under the policy not the date of the site visit. In this case, the Noridian notice of the initial determination to revoke is April 28, 2016. I accept the date of the notice as the date of the determination. There is no evidence that the Noridian determination that Petitioner was not operational at 12021 Wilshire was made on any

other date. Second, Petitioner is in error because 42 C.F.R. § 424.535(g) is clear that the effective date of revocation is the date it is determined that a provider's or supplier's practice location is not operational, not the date the determination is made. 42 C.F.R. § 424.535(g).

When 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). There is no statutory or regulatory language establishing a right to review of the duration of the re-enrollment bar CMS imposes. Act § 1866(j)(8) (42 U.S.C. § 1395cc(j)(8)); 42 C.F.R. §§ 424.535(c), 424.545; 498.3(b), 498.5. The Board has held that the duration of a revoked supplier's re-enrollment bar is not an appealable initial determination listed in 42 C.F.R. § 498.3(b) and not subject to ALJ review. *Vijendra Dave*, DAB No. 2672 at 10-11 (2016).

To the extent that Petitioner's arguments may be construed as a request for equitable relief, I have no authority to grant such 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, Petitioner's Medicare enrollment and billing privileges are revoked pursuant to 42 C.F.R. § 424.535(a)(5)(ii) and 424.535(a)(9). The effective date of revocation is January 14, 2016.

/s/
Keith W. Sickendick
Administrative Law Judge