Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

AMT Ambulance, Inc.
(NPI: 1295007904),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-1477

Decision No. CR4559

Date: March 28, 2016

DECISION

The Medicare billing privileges of Petitioner, AMT Ambulance, Inc., are revoked pursuant to 42 C.F.R. § 424.535(a)(1)[1] because Petitioner was not in compliance with Medicare enrollment requirements for a supplier of ambulance services. The effective date of the revocation is March 5, 2014, 30 days after a Medicare administrative contractor acting on behalf of the Centers for Medicare & Medicaid Services (CMS) notified Petitioner of the revocation. 42 C.F.R. § 424.535(g). CMS established a two year bar to Petitioner's re-enrollment in the Medicare program. 42 C.F.R. § 424.545(c).

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[1] Citations are to the 2013 revision of the Code of Federal Regulations (C.F.R.), unless otherwise indicated.

I. Background

Petitioner was enrolled in the Medicare program as a supplier[2] of ambulance services, and operated only in Los Angeles County, California. Palmetto GBA, a Medicare administrative contractor, notified Petitioner on July 16, 2013, that Petitioner's Medicare billing privileges were retroactively deactivated as of January 31, 2012. Petitioner (P.) Exhibit (Ex.) 4. On February 3, 2014, Noridian Healthcare Solutions (Noridian), the Medicare administrative contractor that replaced Palmetto GBA for certain functions, notified Petitioner that its Medicare billing privileges were retroactively revoked as of January 31, 2012. CMS Ex. 1 at 9. Noridian determined that Petitioner was "[n]ot in compliance with Medicare requirements," citing 42 C.F.R. § 424.535(a)(1) as the basis for revocation. Noridian found that Petitioner was "not permitted to operate in the county of Los Angeles as of January 31, 2012" and subject to an order to cease and desist ambulance operations that was issued by the Los Angeles County Emergency Medical Services (EMS) Agency and effective July 12, 2013. CMS Ex. 1 at 9.

On April 4, 2014, Petitioner submitted a request for reconsideration to Noridian. CMS Ex. 1 at 4-8. Petitioner did not directly dispute the underlying basis for the revocation, but argued that reinstatement of Petitioner's billing privileges would help correct what it considered to be erroneous overpayment notices that CMS began sending to Petitioner for services that Petitioner provided between January 31, 2012 and July 12, 2013. CMS Ex. 1 at 6. According to Petitioner, the Los Angeles County EMS Agency clarified that Petitioner was allowed to operate as an ambulance service in Los Angeles County until July 12, 2013, meaning that any deactivation or revocation of Petitioner's Medicare billing privileges prior to that date would be improper. CMS Ex. 1 at 4-6. On May 13, 2014, Noridian Provider Enrollment issued a reconsidered determination upholding the revocation pursuant to 42 C.F.R. § 424.535(a)(1). The reconsidered determination states that Petitioner "did not submit an application as required by the Los Angeles County Code causing [Petitioner] to not be authorized to continue operation in Los Angeles County after January 30, 2012." CMS Ex. 1 at 1.

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[2] 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.

On July 10, 2014, Petitioner filed a request for hearing (RFH) before an administrative law judge (ALJ). On July 24, 2014, the case was assigned to me for hearing and decision, and an Acknowledgement and Prehearing Order (Prehearing Order) was issued at my direction.

CMS filed a motion for summary judgment and supporting brief. Petitioner opposed CMS's motion. In a ruling dated October 22, 2014, I denied the CMS motion for summary judgment and notified the parties that I would convene a hearing by video teleconference (VTC). I convened a VTC hearing on May 27, 2015. A transcript (Tr.) of the proceedings was prepared and is part of the record of this case. During the hearing, CMS offered CMS Exs. 1, and 3 through 7.[3] Tr. 25. CMS Ex. 1 was admitted without objection. Tr. 25. Petitioner objected to CMS Exs. 3 through 7 and they were not admitted as evidence. Tr. 49, 54, 64. Petitioner offered P. Exs. 1 through 4. Tr. 64. P. Exs. 2 through 4 were admitted without objection. Tr. 67-68. CMS objected to P. Ex. 1 as being unauthenticated. Tr. 65. Petitioner authenticated the exhibit through witness testimony and P. Ex. 1 was admitted. Tr. 112. CMS did not call any witnesses. Petitioner called as witnesses: Eugene Brusilovsky, the former Acting Vice President of Petitioner, and Zina Kagan, the former Vice President of Petitioner. Following the hearing, CMS filed a motion to remand this case pursuant to 42 C.F.R. § 498.78 (CMS Mot. to Remand), but Petitioner opposed (P. Opp. to Remand). I subsequently issued a ruling deferring a final ruling on the motion to remand until a decision on the merits. The parties filed post-hearing briefs (CMS Br. and P. Br.) and post-hearing reply briefs (CMS Reply and P. Reply).

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 Palmetto GBA and 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. Act §§ 1834(j)(1) (42 U.S.C. § 1395m(j)(1)); 1835(a) (42 U.S.C. § 1395n(a)); 1842(h)(1) (42 U.S.C. § 1395u(h)(1)). Petitioner is a supplier of ambulance services. 42 C.F.R. § 410.41.

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[3] CMS did not offer CMS Ex. 2. Tr. 23.

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 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 an 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. Subsection 424.510(d)(3) 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. Suppliers of ambulance services are subject to the additional requirements of 42 C.F.R. §§ 410.40-410.41.

The Secretary has delegated authority to CMS or its Medicare contractor to revoke an enrolled supplier's Medicare enrollment and billing privileges and any 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 CMS determines that the supplier is not in compliance "with the enrollment requirements described in this section or in the enrollment application applicable for its provider or supplier type." 42 C.F.R. § 424.535(a)(1).

If CMS revokes a supplier's Medicare billing privileges for not complying with enrollment requirements, then the revocation becomes effective 30 days after CMS or its contractor mails notice of its determination to the supplier. 42 C.F.R. § 424.535(g). After a supplier's Medicare enrollment and billing privileges are revoked, the supplier is barred from reenrolling in the Medicare program for a minimum of one, but no more than 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. 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 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 statement of pertinent facts and my analysis. I have carefully considered all the evidence and the arguments of both parties, although not all may be specifically discussed in this decision. I discuss the credible evidence given the greatest weight in my decision-making.[4] I also discuss any evidence that I find is not credible or worthy of weight. The fact that evidence is not specifically discussed should not be considered sufficient to rebut the presumption that I considered all the evidence and assigned such weight or probative value to the credible evidence that I determined appropriate within my discretion as an ALJ. There is no requirement for me to discuss the weight given every piece of evidence considered in this case, nor would it be consistent with notions of judicial economy to do so. Charles H. Koch, Jr., *Admin. L. & Prac.* § 5:64 (3d ed. 2013).

1. The CMS motion to remand is denied as remand is not in the interest of judicial economy.

On July 20, 2015, CMS filed a motion to remand this case to CMS pursuant to 42 C.F.R. § 498.78, "to allow CMS to adjust the effective date of revocation of the Medicare enrollment of [Petitioner] from January 31, 2012 to March 5, 2014." CMS Mot. to Remand at 1. In a response filed August 10, 2015, Petitioner opposed remand, arguing that remanding the case to adjust the date of revocation would not result in a satisfactory outcome for Petitioner but instead result in additional "costly litigation." P. Opp. to

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[4] "Credible evidence" is evidence worthy of belief. *Black's Law Dictionary* 596 (8th ed. 2004). The "weight of evidence" is the persuasiveness of some evidence compared to other evidence. *Id.* at 1625.

Remand at 1. Petitioner states that it seeks a "global resolution" of the revocation and deactivation determinations, but remand may only serve to correct CMS's revocation determination, thus leading to further litigation. P. Opp. to Remand at 3.

Petitioner has made clear in its opposition to remand and in its post-hearing briefing that resolving the effective date of revocation would not be a satisfactory conclusion to this case. P. Opp. to Remand at 3; P. Br. at 4-7. If this case was remanded to CMS to correct the effective date of the revocation of Petitioner's Medicare billing privileges, it is likely that the case would be re-litigated through the administrative process, *i.e.*, before an ALJ in this forum. Re-litigating this case means additional time and resources of the parties and this forum. This litigation, which has lasted close to two years already, has reached a point where stopping and turning back for a remand to CMS would only serve to delay a final conclusion for the parties. Moreover, an ALJ has the authority to correct the effective date of the revocation of billing privileges. 42 C.F.R. §§ 424.535(g), 498.3(b)(17), 498.5(*l*)(1)-(2). Therefore, there are no issues that CMS stated it will address on remand that I cannot resolve. Based on the current posture of the case and the parties' positions, remanding this case to CMS will most likely be ineffectual, unproductive, and not in the interest of judicial economy. Accordingly, CMS's motion to remand this case pursuant to 42 C.F.R. § 498.78 is denied.

2. **Petitioner does not deny that it failed to obtain a license required for ambulance operators in Los Angeles County, California, a violation of the requirement for continuing compliance with state licensure requirements. 42 C.F.R. § 424.516(a)(2).**

3. **There is a basis to revoke Petitioner's Medicare billing privileges pursuant to 42 C.F.R. § 424.535(a)(1) because Petitioner failed to obtain a Los Angeles County ambulance operator's business license and therefore did not continue to comply with all of the enrollment requirements for a supplier of ambulance services.**

   a. Facts

The parties stipulated that prior to January 31, 2012, Petitioner was enrolled in Medicare as a supplier of ambulance services. Tr. 38-39. The parties agree that on July 28, 2011, the Los Angeles County Board of Supervisors changed certain provisions of the local ordinances to require ambulance operators intending to operate in incorporated and unincorporated areas of Los Angeles County to obtain a Los Angeles County business

license. Tr. 39-41; P. Br. at 2; CMS Br. at 2; Los Angeles Cnty. Code § 7.16.030.[5] Prior to that time, Los Angeles County only required a license for ambulance operators that operated in unincorporated areas of the county. Each incorporated area within Los Angeles County had its own requirements for ambulances. Tr. 94. Los Angeles County gave ambulance operators until January 30, 2012, to apply for the newly required county-wide license. Tr. 41; CMS Ex. 1 at 10.

Petitioner presented credible testimony that it submitted an application for a Los Angeles County business license in 2010. Adult Medical Transportation, a sister corporation to Petitioner, was granted a license but not Petitioner. Petitioner does not deny that as of July 12, 2013, it did not have the necessary license to operate as an ambulance service in both incorporated and unincorporated areas of Los Angeles County. Petitioner agrees that it was never issued the Los Angeles County license. Tr. 43-44, 95, 101-02, 107. On July 8, 2013, the Los Angeles County EMS Agency sent Petitioner a cease and desist letter, stating that Petitioner had not submitted an application for the required business license and that Petitioner was therefore not permitted to operate an ambulance service in Los Angeles County beginning January 31, 2012. CMS Ex. 1 at 10. Petitioner has not operated as a supplier of ambulance services in Los Angeles County since the cease and desist letter was received. Tr. 137, 150-51.

Petitioner argues that, contrary to what the cease and desist letter states, it was permitted to operate as an ambulance service throughout Los Angeles County from January 31, 2012 to July 8, 2013, the date of the cease and desist letter because it had filed an application for the required business license. P. Br. at 2, 9-10; Tr. 95; P. Ex. 2. Consistent with Petitioner's argument, on October 24, 2013, the Los Angeles County EMS Agency issued an amended cease and desist letter, clarifying that it had not received a "complete and proper" application from Petitioner, and that the cease and desist order was effective July 12, 2013, and not January 31, 2012, as stated in the prior cease and desist letter. CMS Ex. 1 at 63. Petitioner argues that the October 24, 2013 amended cease and desist letter is evidence that it was permitted to operate in Los Angeles County

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[5] The revised provision of the Los Angeles County Code reads:

> 7.16.030 - Licenses—Required.
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> Every ambulance operator shall procure and maintain a license and pay an annual license fee in the amount set forth in Section 7.14.010 of this code under the appropriate heading in order to operate in any incorporated city or unincorporated area of the county.

until July 12, 2013. P. Br. at 3. I agree and CMS has not presented evidence to the contrary. However, the fact that Petitioner was allowed to operate as an ambulance service in Los Angeles County from January 31, 2012 until July 12, 2013, is not relevant to decide the issue before me, which is whether there was a basis for revocation at the time CMS revoked Petitioner's billing privileges on February 3, 2014.[6] 73 Fed. Reg. 36,448, 36,452 (June 27, 2008) ("[A]ppeal rights are limited to provider or supplier eligibility at the time the Medicare contractor made the adverse determination."). The evidence is undisputed, and I find as fact, that after July 12, 2013, Petitioner did not have the license required by section 7.16.030 of the Los Angeles County Code and the cease and desist letter rendered Petitioner unable to operate as an ambulance supplier in Los Angeles County as of the date of that letter. CMS Ex. 1 at 63; Tr. 107. Petitioner does not dispute that it never actually obtained the required business license and it clearly did not have the required license on February 3, 2014, the date Noridian issued the initial determination to revoke Petitioner's enrollment. P. Br. at 24; CMS Ex. 1 at 9; Tr. 102, 107. I further find as fact, that the Los Angeles County EMS Agency's cease and desist letter, as subsequently amended, was de facto a denial of any pending business license application from Petitioner. CMS Ex. 1 at 10, 63. Former Acting Vice President Brusilovsky confirmed that Petitioner, in fact, stopped operating as a supplier of ambulance services following receipt of the July 12, 2013 cease and desist letter.[7] Tr. 128.

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[6] As discussed hereafter, Noridian improperly revoked Petitioner's billing privileges retroactively rather than prospectively (CMS Ex. 1 at 9), in violation of 42 C.F.R. § 424.535(g). If CMS or its contractor had authority under the Act or regulations to revoke Petitioner's billing privileges retroactively, the date Petitioner was allowed to operate as an ambulance service in Los Angeles County would be relevant to determine the effective date of revocation. But CMS and its contractor have identified no such authority in this case. Because the correct effective date of revocation may only be prospective in this case as a matter of regulation, *i.e.*, 30 days after the date of the initial determination as provided by 42 C.F.R. § 424.535(g), the fact that Petitioner was not barred from operating an ambulance service throughout Los Angeles County between January 31, 2012 and July 8, 2013, is not relevant to my decision.

[7] Petitioner argues that multiple CMS overpayment actions caused Petitioner to cease operations and the fact that Petitioner ceased operations is what prevented it from obtaining the necessary license. Petitioner suggests that CMS effectively put Petitioner out of business. P. Br. at 1; P. Reply at 5-6. The evidence, however, does not support Petitioner's argument. Petitioner's own witness testified that the Los Angeles County EMS Agency's cease and desist letter is what prompted Petitioner to cease operations. Tr. 128. CMS began its overpayment actions against Petitioner after the Los Angeles County EMS Agency's cease and desist letter directing Petitioner to stop operating as an

(Continued next page.)

b. Analysis

The reconsidered determination states that Petitioner was not permitted to operate as an ambulance service in Los Angeles County as of January 31, 2012. The factual determination that Petitioner was not permitted to operate as of January 31, 2012, was clearly erroneous. The amended cease and desist letter dated October 24, 2013, clearly shows that the bar to operating an ambulance service in Los Angeles County was imposed upon Petitioner effective July 12, 2013. CMS Ex. 1 at 63. The reconsidered determination upheld the initial determination revoking Petitioner's billing privileges citing 42 C.F.R. § 424.535(a)(1). The regulation provides that CMS may revoke the Medicare billing privileges of a provider or supplier if:

> (1) *Noncompliance*. The provider or supplier is determined not to be in compliance with the enrollment requirements described in this section, or in the enrollment application applicable for its provider or supplier type, and has not submitted a plan of corrective action as outlined in part 488 of this chapter . . . . All providers and suppliers are granted an opportunity to correct the deficient compliance requirement before a final determination to revoke billing privileges, except for those imposed under paragraphs (a)(2), (a)(3), or (a)(5) of this section . . . .

42 C.F.R. § 424.535(a)(1).

The Board has determined that the "enrollment requirements" referred to in section 424.535(a)(1) extend to those in 42 C.F.R. § 424.516 as well as the specific requirements for each provider and supplier type to be eligible to receive Medicare Part B payments. *Akram A. Ismail, M.D.*, DAB No. 2429 at 6 (2011); *Peter McCambridge, C.F.A.*, DAB No. 2290 at 4 (2009). Indeed, a provider or supplier that is ineligible to receive payment for services it provides to Medicare beneficiaries cannot reasonably obtain or maintain enrollment in the Medicare program. *McCambridge*, DAB No. 2290 at 4. Pursuant to 42 C.F.R. § 424.516, CMS must verify and a provider or supplier must certify that it continues to be in compliance with federal and state requirements. The regulation provides in relevant part:

(Continued from preceding page.)

ambulance supplier. CMS Ex. 1 at 12. Because the alleged overpayments are not properly before me, I render no opinion about the validity of the overpayment claims of CMS.

> (a) *Certifying compliance.* CMS enrolls and maintains an active enrollment status for a provider or supplier when that provider or supplier certifies that it meets, **and continues to meet,** and CMS verifies that it meets, and continues to meet, all of the following requirements:
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> > (1) Compliance with title XVIII of the Act and applicable Medicare regulations.
> >
> > (2) Compliance with Federal and **State licensure, certification, and regulatory requirements**, as required, based on the type of services or supplies the provider or supplier type will furnish and bill Medicare . . . .

42 C.F.R. § 424.516(a)(1)-(2) (emphasis added).

As a supplier of ambulance services in Los Angeles County, Petitioner was required to obtain a county business license after January 30, 2012, due to the change in the county code. Los Angeles Cnty. Code § 16.7.030. Petitioner did not obtain the required license to operate as an ambulance service in Los Angeles County. Petitioner does not deny that it could not operate as a supplier of ambulance services after July 12, 2013. Tr. 107; CMS Ex. 10 at 63. Therefore, after July 12, 2013, Petitioner did not meet and could not certify that it continued to meet the requirement that it maintain compliance with "Federal and State licensure, certification, and regulatory requirements, as required, based on the type of services or supplies the provider or supplier type will furnish and bill Medicare." 42 C.F.R. § 424.516(a)(2). The regulation's reference to "State licensure" equally applies to Petitioner's Los Angeles County licensure requirement because Petitioner only operated in Los Angeles County and there is no evidence that it operated elsewhere in California. Tr. 120-21; P. Br. at 1. Petitioner was not in compliance "with the enrollment requirements described in this section, or in the enrollment application applicable for its provider or supplier type . . . ." 42 C.F.R. § 424.535(a)(1). Petitioner was no longer eligible to provide ambulance services and no longer eligible to continue to be enrolled to receive Medicare Part B payments as a supplier of ambulance services. Thus, there is a legal basis pursuant to 42 C.F.R. § 424.535(a)(1) for CMS to revoke Petitioner's Medicare billing privileges.

Petitioner argues that CMS erred procedurally by not providing it with an opportunity to correct its noncompliance as required by 42 C.F.R. § 424.535(a)(1), before CMS revoked Petitioner's billing privileges. P. Reply at 10. However, the plain language of the initial determination notice belies this argument. Noridian notified Petitioner in the February 3, 2014 initial determination letter that Petitioner could submit a corrective action plan

(CAP) if Petitioner believed it could demonstrate eligibility to participate in the Medicare program. CMS Ex. 1 at 9. There is no evidence that Petitioner submitted a CAP to Noridian. Instead, Petitioner requested reconsideration. CMS Ex. 1 at 4-8. Providing the opportunity to submit a CAP is sufficient for CMS or its contractor to meet the requirement of 42 C.F.R. § 424.535(a)(1) that an affected party be given an opportunity to correct its noncompliance. *Conchita Jackson, M.D.*, DAB No. 2495 at 7-8 (2013). Noridian provided that opportunity in this case, and there was no procedural error.

4. The effective date of revocation of Petitioner's Medicare billing privileges pursuant to 42 C.F.R. § 424.535(a)(1) is determined pursuant to 42 C.F.R. § 424.535(g), and is March 5, 2014, which is 30 days after the initial determination notice was mailed to Petitioner.[8]

a. Facts

The initial determination by Noridian revoking Petitioner's Medicare billing privileges was dated February 3, 2014. CMS Ex. 1 at 9. The thirtieth day after February 3, 2014, was March 5, 2014.

b. Analysis

Revocation is effect 30 days after CMS or its contractor mails notice of its determination to the supplier, except in four specific types of cases listed in the regulation. 42 C.F.R. § 424.535(g). CMS concedes that the effective date of revocation in this case should be March 5, 2014, pursuant to 42 C.F.R. § 424.535(g). CMS Br. at 2, 4-5; CMS Reply at 2.

There is no evidence that any of the four exceptions stated in 42 C.F.R. § 424.535(g) apply in this case. Therefore, as a matter of law, the effective date of revocation based on

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[8] There is no dispute that Petitioner did not have the license required by Los Angeles County as of July 12, 2013, and Petitioner concedes it was no longer operating as an ambulance service after that date. Therefore, Petitioner was both legally and factually no longer operational after about July 12, 2013. A determination by CMS or its contractor based on an onsite review, or arguably where there is a concession that a provider or supplier is no longer operation, is an independent basis for revocation of enrollment pursuant to 42 C.F.R. § 424.535(a)(5). Revocation pursuant to 42 C.F.R. § 424.535(a)(8) is effective retroactively to the date the supplier or provider is found to be no longer operational. 42 C.F.R. § 424.535(g). However, this basis was not cited in the reconsidered determination and is not before me for review under 42 C.F.R. § 498.5(*l*)(2). CMS Ex. 1 at 1-3.

Petitioner's failure to comply with enrollment requirements must be 30 days after the date of the Noridian initial determination to revoke. In this case, Noridian's notice of revocation was dated February 3, 2014. CMS Ex. 1 at 9. Thirty days after February 3, 2014, was March 5, 2014. Accordingly, pursuant to 42 C.F.R. § 424.535(g), the effective date of Petitioner's revocation is March 5, 2014.

5. I have no jurisdiction to review the erroneous deactivation of Petitioner's billing privileges, the alleged overpayments based on the deactivation, or to grant Petitioner equitable relief.

On July 16, 2013, Palmetto GBA notified Petitioner that its Medicare billing privileges were deactivated retroactively to January 31, 2012. P. Ex. 4. The notice letter explained:

> We were made aware of the fact that you did not submit an application for an Ambulance Operator Business License by January 30, 2012 and therefore, have been prohibited from operating in any incorporated city or unincorporated area of Los Angeles County effective January 31, 2012. Our records show the only geographic area submitted to Medicare on the CMS 855B enrollment application was Los Angeles, CA, therefore you are no longer in compliance with the enrollment requirements. Any payments made after January 31, 2012 will be recouped, as those services are considered ineligible for payment due to non-compliance.

P. Ex. 4. The notice letter did not cite any regulatory basis for the deactivation. Soon after the July 16, 2013 deactivation notice, Petitioner received multiple overpayment notices from CMS seeking recovery of the payment for services that Petitioner provided between January 31, 2012 and July 16, 2013. CMS Ex. 1 at 12-62. Throughout this case Petitioner has strenuously argued that the deactivation of its billing privileges was erroneous and CMS has used the deactivation as an excuse to recover millions of dollars in alleged overpayments. Petitioner also argues it is subject to constant telephone calls from the U.S. Department of the Treasury attempting to collect debts for claims during the period of the deactivation that CMS improperly referred for collection. Petitioner argues that I must consider this erroneous agency action because it is "inextricably intertwined" with the erroneous deactivation and the revocation actions. P. Br. at 4-7.

It is difficult to disagree with Petitioner's position. The notice of deactivation is clearly based on the faulty factual determination that Petitioner was not authorized to operate as an ambulance supplier in Los Angeles County between January 31, 2012 and July 12, 2013. Further the deactivation in this case is contrary to the plain language of the regulation authorizing deactivations. The deactivation of billing privileges is governed

by 42 C.F.R. § 424.540. Pursuant to that section, there are only three situations in which CMS or its contractor may deactivate billing privileges:

> (a) *Reasons for deactivation.* CMS may deactivate the Medicare billing privileges of a provider or supplier for any of the following reasons:
>
> > (1) The provider or supplier does not submit any Medicare claims for 12 consecutive calendar months. The 12 month period will begin the 1st day of the 1st month without a claims submission through the last day of the 12th month without a submitted claim.
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> > (2) The provider or supplier does not report a change to the information supplied on the enrollment application within 90 calendar days of when the change occurred. Changes that must be reported include, but are not limited to, a change in practice location, a change of any managing employee, and a change in billing services. A change in ownership or control must be reported within 30 calendar days as specified in §§ 424.520(b) and 424.550(b).
> >
> > (3) The provider or supplier does not furnish complete and accurate information and all supporting documentation within 90 calendar days of receipt of notification from CMS to submit an enrollment application and supporting documentation, or resubmit and certify to the accuracy of its enrollment information.

42 C.F.R. § 424.540(a). The drafters of the regulation explained that when a supplier's billing number is deactivated, billing privileges are suspended but can be restored by submission of updated or recertified information. The drafters described deactivation as a "temporary action to protect the provider or supplier from misuse of their billing number and to also protect the Medicare Trust Funds from unnecessary overpayments." 71 Fed. Reg. 20,754, 20,762 (April 21, 2006). The drafters also specified that "deactivation of a billing number would not have any effect on a provider or supplier's participation agreement or conditions of participation." *Id*.

There is no regulatory language authorizing deactivation of billing privileges based solely on a supplier's alleged noncompliance with an enrollment requirement, other than the requirement to timely submit information upon a change or request of CMS. Furthermore, there is no regulatory authority for CMS or its contractor to deactivate

billing privileges retroactively. The regulatory authority for revocation of billing privileges permits retroactive revocation in four limited circumstances. 42 C.F.R. § 424.535(a)(1), (g). But the Secretary's delegation of authority to CMS to deactivate billing privilege includes no similar provisions permitting retroactive deactivation. 42 C.F.R. § 424.540(a). Thus, any retroactive deactivation of a supplier's Medicare billing privileges based on that supplier's noncompliance is clearly contrary to the controlling regulation. Any alleged overpayment of Medicare benefits based on such an erroneous deactivation is also arguably contrary to law.

However persuasive Petitioner's argument may be on the issues related to deactivation and the resulting allegations of overpayments, the regulations do not allow for me to review a deactivation. By regulation, I may hear and decide cases where a party has requested a hearing from a "reconsidered determination." 42 C.F.R. § 498.5(*l*)(2); *Denise A. Hardy, D.P.M.*, DAB No. 2464 at 5 (2012). A party may request reconsideration only in cases where CMS or its contractor has issued an "initial determination." 42 C.F.R. § 498.5(*l*)(1). The list of "initial determinations" does not include the deactivation of billing privileges. 42 C.F.R. § 498.3(b). Also, the regulation authorizing deactivation of billing privileges does not provide for any further administrative review. 42 C.F.R. § 424.540. Therefore, there is no right for a reconsidered determination or subsequent ALJ review of the deactivation of a provider's or supplier's Medicare billing privileges. Suspension and recoupment of payments to providers and suppliers and the collection and compromise of overpayments is regulated by 42 C.F.R. pt. 405, subpt. C. The evidence before me does not reflect that the detailed procedures for collecting overpayments were followed in this case and Petitioner alleges it was deprived of due process in this regard. However, the review of the alleged overpayments is not a matter within my jurisdiction. Review of alleged overpayments and their collection is governed by 42 C.F.R. pt. 405. subpts. H and I. Accordingly, I have not attempted to further develop the record regarding whether the declaration of the overpayments or their collection was in accordance with the law. Petitioner will need to seek review of the overpayments in another administrative or judicial forum.

To the extent 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) ("[n]either 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."). 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 (2009) ("[a]n ALJ is bound by applicable laws and regulations and may not invalidate either a law or regulation on any ground.").

III. Conclusion

Petitioner's Medicare billing privileges are revoked effective March 5, 2014, pursuant to 42 C.F.R. § 424.535(a)(1) and (g), because Petitioner was not in compliance with the requirement to have all required state licenses.

/s/
Keith W. Sickendick
Administrative Law Judge