No.

IN THE

Supreme Court of the United States

NAZARIY KMET,

Petitioner,

v.

UNITED STATES,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

APPENDIX

Nazariy Kmet
2284 Sand Trap Rd.
Jamison, PA 18929

Pro se

APPENDIX A

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

UNITED STATES OF AMERICA	:	**CRIMINAL ACTION**
Plaintiff	:	
	:	**NO. 14-319-1**
v.	:	
	:	
NAZARIY KMET.	:	
Defendant	:	

ORDER

AND NOW, this 16th day of July 2019, upon careful consideration of the *motion to vacate, set aside, or correct sentence* filed by then *pro se* Defendant Nazariy Kmet ("Defendant") pursuant to 28 U.S.C. § 2255, [ECF 153], the Government's response in opposition, [ECF 160], Defendant's counseled amended memorandum in support of his motion, [ECF 179], the Government's response in opposition, [ECF 190], the parties' post-hearing memoranda, [ECF 199, 200], the *Report and Recommendation* submitted by United States Magistrate Judge Lynne A. Sitarski, ("Magistrate Judge"), [ECF 208], Defendant's amended objections to the R&R, [ECF 221], the Government's response to the objections, [ECF 224], and Defendant's reply, [ECF 225], it is hereby **ORDERED** that:

1. The *Report and Recommendation* is **APPROVED** and **ADOPTED**;

2. The objections to the *Report and Recommendation* are **OVERULED**;[1]

---

[1] By Order dated December 6, 2017, this Court referred Defendant's § 2255 *motion to vacate, set aside, or correct sentence* to the Magistrate Judge with specific instructions to appoint counsel, conduct an evidentiary hearing on Defendant's claims of ineffective assistance of trial and appellate counsel, address the effect, if any, of *United States v. Advantage Medical Transport*, 698 F. App'x 680 (3d Cir. 2017) on Defendant's claims, and issue a Report and Recommendation ("R&R"). [ECF 167]. Consistent with said Order, the Magistrate Judge issued the 61-page R&R wherein Defendant's claims were thoroughly analyzed.

In his amended objections to the R&R, Defendant takes issue with the Magistrate Judge's finding that counsel "was not ineffective in failing to 'Research the Concept of Medical Necessity/Present a Defense Based on Physician Certificates.'" [ECF 221 at 1]. Specifically, Defendant argues that counsel was

ineffective in failing to research the operative Medicare regulations in effect at the time which would have uncovered a potentially viable defense to the two counts to which Defendant pled guilty. In his reply, Defendant further argues that "the issue before the Court is not whether Schaffer [counsel] would have given [Defendant] different legal advice had he properly researched and imparted the regulations to [Defendant] prior to the change of plea hearing. Rather, the focus is on [Defendant's] decision making process as he, not Schaffer, is the one who 'must show that there is a reasonable probability that, but for counsel's errors, he would not have pleaded guilty and would have insisted on going to trial.'" [ECF 225 at 1] (quoting *Hill v. Lockhart*, 474 U.S. 52, 59 (1985)). Defendant's objections, however, are nothing more than a disagreement with the Magistrate Judge's findings and an attempt to relitigate the various arguments raised in his motion to vacate. Those arguments were thoroughly considered and analyzed by the Magistrate Judge, who correctly concluded they were baseless.

In conducting its *de novo* review of a defendant's objections, a court may accept, reject, or modify, in whole or in part, the factual findings or legal conclusions of the magistrate judge. 28 U.S.C. § 636(b)(1). Although the review is *de novo*, the statute permits the court to rely on the recommendations of the magistrate judge to the extent it deems proper. *United States v. Raddatz*, 447 U.S. 667, 675-76 (1980); *Goney v. Clark*, 749 F.2d 5, 7 (3d Cir. 1985).

In addressing ineffective-assistance-of-counsel claims, courts must apply the familiar two-prong inquiry articulated in *Strickland v. Washington*, 466 U.S. 668 (1984). Thus, to sustain a claim for ineffective assistance of counsel, Defendant must show that counsel's performance was objectively deficient and that this deficient performance prejudiced the defense. *Id.* at 687. The *Strickland* standard "applies to challenges to guilty pleas based on ineffective assistance of counsel." *Hill*, 474 U.S. at 56. Counsel must "give a defendant enough information 'to make a reasonably informed decision whether to accept a plea offer.'" *United States v. Bui*, 795 F.3d 363, 367 (3d Cir. 2015) (citations omitted). In the plea context, to prove prejudice, "the defendant must show that there is a reasonable probability that, but for counsel's errors, he would not have pleaded guilty and would have insisted on going to trial." *Hill*, 474 U.S. at 59. "Courts should not upset a plea solely because of *post hoc* assertions from a defendant about how he would have pleaded but for his attorney's deficiencies. Judges should instead look at contemporaneous evidence to substantiate a defendant's expressed preferences." *United States v. Lee*, __ U.S. __, 137 S. Ct. 1958, 1967 (2017).

This Court has thoroughly reviewed the record, concurs with the opinions rendered, and finds that no error was committed by the Magistrate Judge in the analysis offered, the credibility assessments made, and the conclusions reached on Defendant's claims. Of note, Defendant was charged by indictment with numerous offenses; *to wit*: conspiracy to commit health care fraud in violation of 18 U.S.C. § 1349 (Count One); two counts of wire fraud, in violation of 18 U.S.C. § 1343 (Counts Two and Three); two counts of making false statements in connection with health care matters in violation of 18 U.S.C. § 1035 (Counts Four and Five); violation of the anti-kickback statute, 42 U.S.C. § 1320a-7b(b)(2)(B) (Count Seven); four counts of money laundering, including one count in violation of 18 U.S.C. § 1956 (Count Nine); and three counts in violation of 18 U.S.C. § 1957 (Counts Ten through Twelve). Represented by counsel, Defendant pled guilty to conspiracy to commit healthcare fraud and to violations of the Anti-Kickback Statute pursuant to a negotiated plea agreement, in exchange for the dismissal of the remaining counts. During the guilty-plea colloquy, Defendant admitted to this Court that he was guilty of the conspiracy to commit health care fraud and the violations of the anti-kickback statute. Specifically, he admitted in the plea agreement and reaffirmed his admission in open court that he schemed to defraud Medicare "by transporting dialysis patients in ambulances and other vehicles when those patients were able to walk and/or be transported safely by other means; billing Medicare for medically unnecessary ambulance transportation; and paying kickbacks to patients to induce them to ride with Life Support even though their transportation by ambulance was not

3. Defendant's *motion to vacate, set aside, or correct sentence* is **DENIED**;

4. Defendant's pending *pro se* motions, [ECF 163-165], are **DENIED**; and

5. A certificate of appealability is hereby issued.[2]

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medically necessary." (Plea Agreement ¶ 1). Though Defendant later attempted to withdraw his guilty plea, his motion was denied by this Court. A subsequent appeal of the denial of his motion to withdraw his guilty plea was affirmed by the United States Court of Appeals for the Third Circuit.

In the instant motion to vacate, Defendant essentially argues that he would have insisted on going to trial on all the charges he faced in the 12-count indictment had counsel advised him properly with respect to potential available defenses. Following an evidentiary hearing on Defendant's ineffective-assistance-of-counsel claim, the Magistrate Judge found that counsel testified credibly. Counsel admitted that he had not researched the Medicare regulation, but testified that had he, his advice would not have changed in light of the overwhelming evidence the Government had against Defendant. While Defendant argues it "was impossible for [Defendant] to make an informed decision to plead guilty without a full understanding of the significance the CMNs [certificates of medical necessity] had in the determination of medical necessity under the operative regulations in effect at the time of the transport," this Court finds this objection disingenuous. Defendant admitted to having been trained on the regulations and the need to document his transports. He also admitted to transporting patients that were ambulatory, did not need a stretcher, and at times rode in the front seat. Further, his lack of knowledge of the significance of the CMNs has little to no relevance to the other charges against him. Counsel negotiated the dismissal of these other charges under the plea agreement. Without the plea agreement, Defendant faced prosecution of serious felony offenses not affected by the Medicare regulation and the possible defense he now purports to assert. Counsel considered the entire exposure and ably negotiated with the Government. Based on the totality of the record, this Court agrees with the Magistrate Judge's comprehensive analysis and well-founded conclusions. Accordingly, the objections are overruled.

[2] A movant who seeks to appeal a final order of a district court must obtain a certificate of appealability for each claim he wishes to present to the Court of Appeals. 28 U.S.C. § 2253(c)(1)(B). A certificate of appealability should be granted only when jurists of reason could debate procedural or substantive dispositions of a movant's *habeas* claim. *See Slack v. McDaniel*, 529 U.S. 473, 484 (2000). A movant satisfies this "standard by demonstrating that jurists of reason could disagree with the district court's resolution of the case or that the issues presented were adequate to deserve encouragement to proceed further." *Miller-El v. Cockrell*, 537 U.S. 322, 323 (2003). The movant, however, need not demonstrate that his appeal will succeed. *Id.*

Here, reasonable jurists could debate whether Defendant received ineffective assistance of counsel, *i.e.*: whether counsel's performance was unconstitutionally deficient by failing to advise Defendant of a potential defense to one of two charges to which he pled guilty; and whether Defendant, despite the government's evidence against him, would have foregone the plea agreement and the dismissal of most of the charges against him and, instead, have gone to trial based on the potential defense to one of the twelve counts. Further, reasonable jurists have debated whether the relevant clause of the Medicare regulation in effect at the time of the underlying conduct, *i.e.*, 42 C.F.R. § 410.40(d)(2), accepted certificates of medical necessity as the only proof of medical necessity for ambulance rides, or whether this provision required additional and separate proof of the medical necessity requirements listed in § 410.40(d)(1). *See* 42 C.F.R. § 410.40(d)(2) (2012) ("Special rule for nonemergency, schedule, repetitive ambulance services. Medicare

BY THE COURT:

/s/ Nitza I. Quiñones Alejandro
NITZA I. QUIÑONES ALEJANDRO
Judge, United States District Court

covers medically necessary nonemergency, scheduled, repetitive ambulance services if the ambulance provider or supplier, before furnishing the service to the beneficiary, obtains a written order from the beneficiary's attending physician certifying that the medical necessity requirements of paragraph (d)(1) of this section are met. The physician's order must be dated no earlier than 60 days before the date the service is furnished."). Defendant's request for a certificate of appealability is, therefore, granted.

APPENDIX B

APPENDIX C

OFFICE OF THE CLERK

PATRICIA S. DODSZUWEIT

CLERK

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT
21400 UNITED STATES COURTHOUSE
601 MARKET STREET
PHILADELPHIA, PA 19106-1790
Website: www.ca3.uscourts.gov

TELEPHONE
215-597-2995

June 29, 2020

Ms. Kate Barkman
United States District Court for the Eastern District of Pennsylvania
James A. Byrne United States Courthouse
601 Market Street
Room 2609
Philadelphia, PA 19106

RE: USA v. Nazariy Kmet
Case Number: 19-2718
District Court Case Number: 2-14-cr-00319-001

Dear District Court Clerk,

Enclosed herewith is the certified judgment together with copy of the opinion or certified copy of the order in the above-captioned case(s). The certified judgment or order is issued in lieu of a formal mandate and is to be treated in all respects as a mandate.

Counsel are advised of the issuance of the mandate by copy of this letter. The certified judgment or order is also enclosed showing costs taxed, if any.

Very truly yours,
Patricia S. Dodszuweit, Clerk

By: s/Laurie
Case Manager
267-299-4936

cc: Mary E. Crawley
Nazariy Kmet

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 19-2718

UNITED STATES OF AMERICA

v.

NAZARIY KMET, a/k/a Naz,
Appellant

On Appeal from the United States District Court
for the Eastern District of Pennsylvania
(D.C. No. 2-14-cr-0319-001)
District Judge: Honorable Nitza I. Quiñones Alejandro

Submitted Under Third Circuit LAR 34.1(a)
March 26, 2020

Before: JORDAN, RESTREPO, and FUENTES, *Circuit Judges.*

JUDGMENT

This cause came to be considered on the record from the United States District Court for the Eastern District of Pennsylvania and was submitted pursuant to Third Circuit L.A.R. 34.1(a) on March 26, 2020. On consideration whereof,

It is now hereby ORDERED and ADJUDGED that the Order of the District Court entered on July 16, 2019 is hereby AFFIRMED. All of the above in accordance with the opinion of this Court.

ATTEST:

s/ Patricia S. Dodszuweit

Clerk

DATE: March 31, 2020

Certified as a true copy and issued in lieu of a formal mandate on June 29, 2020

Teste: Patricia A. Dodszuweit

Clerk, U.S. Court of Appeals for the Third Circuit

NOT PRECEDENTIAL

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 19-2718

UNITED STATES OF AMERICA

v.

NAZARIY KMET, a/k/a Naz,
Appellant

On Appeal from the United States District Court
for the Eastern District of Pennsylvania
(D.C. No. 2-14-cr-0319-001)
District Judge: Honorable Nitza I. Quiñones Alejandro

Submitted Under Third Circuit LAR 34.1(a)
March 26, 2020

Before: JORDAN, RESTREPO, and FUENTES, *Circuit Judges.*

(Filed: March 31, 2020)

OPINION*

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* This disposition is not an opinion of the full court and, pursuant to I.O.P. 5.7, does not constitute binding precedent.

JORDAN, *Circuit Judge.*

Nazariy Kmet owned Life Support Corporation ("Life Support"), a company that transported patients by ambulance and billed Medicare for those services. The government alleged that Kmet was billing Medicare for medically unnecessary trips and that he paid his patients kickbacks. He pled guilty to one count of conspiracy to commit health care fraud and one count of violating the anti-kickback statute. After sentencing, Kmet filed a motion under 28 U.S.C. § 2255. He alleged that his counsel was ineffective by failing to research a potential defense.

The District Court concluded that Kmet did not prove either that his lawyer's performance was deficient or that he had been prejudiced by it, but the Court nonetheless issued a certificate of appealability on the question of whether counsel's performance actually was constitutionally deficient for failing to advise Kmet of a potential defense. We agree with the District Court that Kmet's § 2255 motion fails, so will affirm.

I. BACKGROUND

Between May 2010 and December 2012, Kmet, along with others, provided ambulance services and billed Medicare for medically unnecessary trips, mainly for regularly scheduled, non-emergency transportation to and from dialysis. Although he had acquired from a physician certificates of medical necessity ("CMNs") for the trips, Kmet and his co-defendants paid kickbacks to patients, many of whom were fully mobile and able to take ordinary transportation.

Kmet was indicted for conspiracy to commit health care fraud, in violation of 18 U.S.C. § 1349 (Count One); two counts of wire fraud, in violation of 18 U.S.C. § 1343

(Counts Two and Three); two counts of making false statements in connection with health care matters, in violation of 18 U.S.C. § 1035 (Counts Four and Five); three counts of violating the anti-kickback statute, 42 U.S.C. § 1320a-7b(b)(2)(B) (Counts Six through Eight); and four counts of money laundering, including one count in violation of 18 U.S.C. § 1956 (Count Nine) and three counts in violation of 18 U.S.C. § 1957 (Counts Ten through Twelve). Represented by counsel, he pled guilty to conspiracy to commit health care fraud (Count One) and violation of the anti-kickback statute (Count Seven).

Prior to sentencing and represented by new counsel, Kmet filed a motion to withdraw his guilty plea. *United States v. Kmet*, 667 F. App'x 357, 358 (3d Cir. 2016). "He stated that he began researching his case after pleading guilty and concluded that he was innocent." *Id.* The District Court denied the motion and sentenced him to 72 months' imprisonment. *Id.* We affirmed. *Id.* at 358-59.

After his direct appeal, Kmet filed the § 2255 motion at the center of this appeal. He argued that his counsel "failed to conduct basic research into the law governing the charges brought against [him] and but for counsel's failures, [he] would not have consented to pleading guilty on the terms provided in the September 3, 2014 plea agreement." (App. at 42-43 (internal quotation marks and citations omitted).) More specifically, Kmet argued that, under the regulations and case law in place at the time, he had a defense that his conduct was not illegal because a CMN was sufficient to establish medical necessity for the ambulance trips.

The District Court referred the motion to a Magistrate Judge who held a hearing on the motion and recommended that the District Court deny it and not issue a certificate

of appealability. The District Court adopted the report and recommendation in part, denying the motion. The District Court did, however, issue a certificate of appealability on the question of whether counsel's performance was ineffective for failing to advise Kmet of the potential defense that he did not commit health care fraud because he had CMNs for the ambulance services that were the subject of the prosecution.

This timely appeal followed.

II. DISCUSSION[1]

In *Strickland v. Washington*, the Supreme Court established a two-part test for ineffective assistance of counsel. The first part requires "showing that counsel made errors so serious that counsel was not functioning as the 'counsel' guaranteed the defendant by the Sixth Amendment." 466 U.S. 668, 687 (1984). The second part requires showing that "there is a reasonable probability that, but for counsel's unprofessional errors, the result of the proceeding would have been different. A reasonable probability is a probability sufficient to undermine confidence in the outcome." *Id.* at 694. In the context of a guilty plea, "the defendant must show that there is a reasonable probability that, but for counsel's errors, he would not have pleaded guilty and would have insisted on going to trial." *Hill v. Lockhart*, 474 U.S. 52, 59 (1985). "When addressing a guilty plea, counsel is required to give a defendant enough information to make a reasonably informed decision whether to accept a plea offer."

---

[1] The District Court had jurisdiction under 28 U.S.C. § 2255, and we have jurisdiction under 28 U.S.C. § 2253. We review *de novo* a decision whether to grant or deny a petition under 28 U.S.C. § 2255. *United States v. Cleary*, 46 F.3d 307, 309-10 (3d Cir. 1995).

United States v. Bui, 795 F.3d 363, 367 (3d Cir. 2015) (internal quotation marks omitted). We agree with the District Court that Kmet cannot meet either prong of the *Strickland* test.

First, Kmet's lawyer was not constitutionally ineffective. At the time of Kmet's conduct, the relevant Medicare regulation, 42 C.F.R. § 410.40, provided as follows:

> (d) Medical necessity requirements—
>
> (1) General rule. Medicare covers ambulance services ... only if they are furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated. The beneficiary's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Nonemergency transportation by ambulance is appropriate if either: the beneficiary is bed-confined, and it is documented that the beneficiary's condition is such that other methods of transportation are contraindicated; or, if his or her medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required. Thus, bed confinement is not the sole criterion in determining the medical necessity of ambulance transportation. It is one factor that is considered in medical necessity determinations....
>
> (2) Special rule for nonemergency, scheduled, repetitive ambulance services. Medicare covers medically necessary nonemergency, scheduled, repetitive ambulance services if the ambulance provider or supplier, before furnishing the service to the beneficiary, obtains a written order from the beneficiary's attending physician certifying that the medical necessity requirements of paragraph (d)(1) of this section are met. The physician's order must be dated no earlier than 60 days before the date the service is furnished.

42 C.F.R. § 410.40 (2012).

When Kmet pled guilty, there was conflicting case law regarding whether a CMN alone was sufficient under the regulation to justify the kinds of trips Life Support was providing to dialysis patients. On one side, two unreported cases from the Middle District of Tennessee concluded that a CMN was sufficient. *MooreCare Ambulance*

Serv. LLC v. Dep't of Health and Human Servs., No. 09-78, 2011 WL 839502, at *3 (M.D. Tenn. Mar. 4, 2011); *First Call Ambulance Servs., Inc. v. Dep't of Health & Human Servs.*, No. 10-247, 2012 WL 769617, at *6 (M.D. Tenn. March 8, 2012). Other cases, however, including a reported case from the Fifth Circuit, concluded the opposite. *See United States v. Read*, 710 F.3d 219, 228 (5th Cir. 2012) ("Possession of a CMN—even one that is legitimately obtained—does not permit a provider to seek reimbursement for ambulance runs that are obviously not medically necessary."); *Am. Ambulance Serv. of Penn. Inc. v. Sullivan,* 761 F. Supp. 1211, 1217 (E.D. Pa. 1991), *aff'd,* 947 F.2d 934 (3d Cir. 1991) (interpreting earlier version of ambulance regulations and concluding that the "statute's language emphasizes that physician certification is a necessary, but not sufficient, predicate to reimbursement").[2]

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[2] On the day of Kmet's plea, a decision in the Eastern District of Pennsylvania rejected the argument that Kmet now raises. *See United States v. Hlushmanuk,* No. 12-327, 2014 WL 5780814, at *7 n.8 (E.D. Pa. Nov. 6, 2014) ("[Defendant] appears to suggest that he was entitled to rely on Certificates of Medical Necessity.... [W]here, as here, Hlushmanuk admitted that he knew that the transports were not medically necessary, he cannot rely on any CMNs that he may have received to establish his innocence of the charges against him and the impropriety of his guilty plea."). In 2017, we issued a split decision in an unreported opinion, with the majority citing the two decisions from the Middle District of Tennessee and agreeing that a CMN alone was sufficient to support reimbursement for an ambulance trip. *See United States v. Advantage Med. Transport, Inc.*, 698 F. App'x 680, 689 (3d Cir. 2017) ("Valid, time-appropriate certificates of medical necessity from physicians were on file for each of these three beneficiaries. Under the regulation in effect at the time and as interpreted by at least two district courts, that was all that was needed to make these transports medically necessary."). Because *Hlushmanuk* came out on the same day as Kmet's plea and *Advantage Medical Transport* came out years later, they could not have informed the advice Kmet's lawyer gave him one way or another. *Cf. Strickland*, 466 U.S. at 689 ("A fair assessment of attorney performance requires that every effort be made to eliminate the distorting effects of hindsight, to reconstruct the circumstances of counsel's challenged conduct, and to evaluate the conduct from counsel's perspective at the time.").

The Department of Health and Human Services decided an amendment to 42 C.F.R. § 410.40(d)(2) was needed to make clear that a CMN cannot justify ambulance services that are not genuinely medically necessary. *See* 77 Fed. Reg. 68892-01, 69161 (Nov. 16, 2012) ("Despite these statutory provisions and the language of the present regulation at § 410.40(d)(2) that we believe already requires both medical necessity and a [CMN], some courts have recently concluded that § 410.40(d)(2) establishes that a sufficiently detailed and timely order from a beneficiary's physician, to the exclusion of any other medical necessity requirements, conclusively demonstrates medical necessity with respect to nonemergency, scheduled, repetitive ambulance services."). The regulation was amended to add that "[t]he presence of the signed physician certification statement does not alone demonstrate that the ambulance transport was medically necessary." 42 C.F.R. § 410.40(d)(2)(ii) (2013) (current version 42 C.F.R. § 410.40(e)(2)(ii) (2020)). That amendment went into effect January 1, 2013, after Kmet's conduct but before he pled guilty.

At the time of Kmet's lawyer's advice to plead guilty, it was not at all clear that the defense Kmet now wishes he had made would have been accepted by the sentencing court, given that the only support for that defense was two unreported cases from a district court in another circuit, whereas other substantial authority, including authority from within this circuit, supported the opposite interpretation. Notably, the cases Kmet relied on involved administrative appeals regarding overbilling of Medicare, not criminal conduct, and, as the Magistrate Judge here observed, "they do not support the conclusion that a CMN provides carte blanche in a criminal context." (App. at 45.)

In addition, the Magistrate Judge made clear that she credited the testimony of Kmet's lawyer when he said that presenting an "I had a CMN" defense would have been unsuccessful because the evidence against Kmet was overwhelming. For example, there was evidence that Life Support transported patients in personal vehicles, taxis, and via public transportation; that "all but one patient could walk or safely be transported by other means;" that Life Support's ambulances did not pass state inspection and were not equipped with necessary medical equipment; and that Life Support paid patients to continue to use its services. (App. at 47.) And the defense would not have defeated several of the other charges, including the kickback charges. The decision not to pursue the CMN defense thus does not mean that counsel was ineffective, according to the standard of ineffectiveness under *Strickland*.

Second, Kmet has not shown that he was prejudiced – that is, that "there is a reasonable probability that, but for counsel's errors, he would not have pleaded guilty and would have insisted on going to trial." *Hill*, 474 U.S. at 59. First, the District Court rejected Kmet's testimony that he would not have pled guilty but for his lawyer's supposed errors. In her report and recommendation, the Magistrate Judge said that "[a]lthough Defendant testified that he would have chosen to go to trial if [counsel had] informed him of the possibility of raising a CMN defense, the Court does not credit this testimony." (App. at 53.) As the Magistrate Judge explained, a number of factors contributed to Kmet's decision to plead guilty, including that Kmet had reviewed the discovery with his lawyer, and that the lawyer had explained that the government would

dismiss counts, and that consequently, Kmet's sentencing exposure would be drastically reduced if he pled guilty.

Even if counsel had advised Kmet about the potential defense and Kmet decided to proceed to trial, it is unlikely that the defense would have been successful. As explained above, the case law at the time indicated that the District Court may well have rejected the defense, and there also was overwhelming evidence against Kmet. Additionally, the CMN defense would not have been a defense to several of the charges against Kmet, so continuing to trial would have risked conviction on all twelve counts and would likely have resulted in a longer sentence. All of this persuades us that Kmet did not suffer prejudice. *See Hill*, 474 U.S. at 59 ("[W]here the alleged error of counsel is a failure to advise the defendant of a potential affirmative defense to the crime charged, the resolution of the 'prejudice' inquiry will depend largely on whether the affirmative defense likely would have succeeded at trial.").

III. CONCLUSION

For the foregoing reasons, we will affirm the District Court's order denying Kmet's § 2255 Motion to Vacate, Set Aside, or Correct Sentence.

APPENDIX D

UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

No. 19-2718

UNITED STATES OF AMERICA

v.

NAZARIY KMET, a/k/a Naz,
Appellant

(E.D. Pa. No. 2-14-cr-00319-001)

SUR PETITION FOR REHEARING

Present: SMITH, Chief Judge, McKEE, AMBRO, CHAGARES, JORDAN, HARDIMAN, GREENAWAY, JR., SHWARTZ, KRAUSE, RESTREPO, BIBAS, PORTER, MATEY, PHIPPS, and FUENTES*, Circuit Judges

The petition for rehearing filed by appellant in the above-entitled case having been submitted to the judges who participated in the decision of this Court and to all the other available circuit judges of the circuit in regular active service, and no judge who concurred in the decision having asked for rehearing, and a majority of the judges of the circuit in regular service not having voted for rehearing, the petition for rehearing by the panel and the Court en banc, is DENIED.

BY THE COURT

s/ Kent A. Jordan
Circuit Judge

DATE: June 19, 2020
Lmr/cc: Mary E. Crawley
Nazariy Kmet

---

* *Judge Fuentes's vote is limited to panel rehearing only.

APPENDIX E

(iii) For years beginning after 2002, other procedures CMS finds appropriate for the purpose of early detection of prostate cancer, taking into account changes in technology and standards of medical practice, availability, effectiveness, costs, and other factors CMS considers appropriate.

(2) *A screening digital rectal examination* means a clinical examination of an individual's prostate for nodules or other abnormalities of the prostate.

(3) *A screening prostate-specific antigen blood test* means a test that measures the level of prostate-specific antigen in an individual's blood.

(4) A physician for purposes of this provision means a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Act) who is fully knowledgeable about the beneficiary, and who would be responsible for explaining the results of the screening examination or test.

(5) A physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife for purposes of this provision means a physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife (as defined in sections 1861(aa) and 1861(gg) of the Act) who is fully knowledgeable about the beneficiary, and who would be responsible for explaining the results of the screening examination or test.

(b) *Condition for coverage of screening digital rectal examinations.* Medicare Part B pays for a screening digital rectal examination if it is performed by the beneficiary's physician, or by the beneficiary's physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife as defined in paragraphs (a)(4) or (a)(5) of this section who is authorized to perform this service under State law.

(c) *Limitation on coverage of screening digital rectal examinations.* (1) Payment may not be made for a screening digital rectal examination performed for a man age 50 or younger.

(2) For an individual over 50 years of age, payment may be made for a screening digital rectal examination only if the man has not had such an examination paid for by Medicare during the preceding 11 months following the month in which his last Medicare-covered screening digital rectal examination was performed.

(d) *Condition for coverage of screening prostate-specific antigen blood tests.* Medicare Part B pays for a screening prostate-specific antigen blood test if it is ordered by the beneficiary's physician, or by the beneficiary's physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife as defined in paragraphs (a)(4) or (a)(5) of this section who is authorized to order this test under State law.

(e) *Limitation on coverage of screening prostate-specific antigen blood test.* (1) Payment may not be made for a screening prostate-specific antigen blood test performed for a man age 50 or younger.

(2) For an individual over 50 years of age, payment may be made for a screening prostate-specific antigen blood test only if the man has not had such an examination paid for by Medicare during the preceding 11 months following the month in which his last Medicare-covered screening prostate-specific antigen blood test was performed.

[64 FR 59440, Nov. 2, 1999, as amended at 65 FR 19331, Apr. 11, 2000]

§ 410.40 Coverage of ambulance services.

(a). *Basic rules.* Medicare Part B covers ambulance services if the following conditions are met:

(1) The supplier meets the applicable vehicle, staff, and billing and reporting requirements of § 410.41 and the service meets the medical necessity and origin and destination requirements of paragraphs (d) and (e) of this section.

(2) Medicare Part A payment is not made directly or indirectly for the services.

(b) *Levels of service.* Medicare covers the following levels of ambulance service, which are defined in § 414.605 of this chapter:

(1) Basic life support (BLS) (emergency and nonemergency).

(2) Advanced life support, level 1 (ALS1) (emergency and nonemergency).

(3) Advanced life support, level 2 (ALS2).

(4) Paramedic ALS intercept (PI).

(5) Specialty care transport (SCT).

(6) Fixed wing transport (FW).

(7) Rotary wing transport (RW).

(c) *Paramedic ALS intercept services.* Paramedic ALS intercept services must meet the following requirements:

(1) Be furnished in an area that is designated as a rural area by any law or regulation of the State or that is located in a rural census tract of a metropolitan statistical area (as determined under the most recent Goldsmith Modification). (The Goldsmith Modification is a methodology to identify small towns and rural areas within large metropolitan counties that are isolated from central areas by distance or other features.)

(2) Be furnished under contract with one or more volunteer ambulance services that meet the following conditions:

(i) Are certified to furnish ambulance services as required under §410.41.

(ii) Furnish services only at the BLS level.

(iii) Be prohibited by State law from billing for any service.

(3) Be furnished by a paramedic ALS intercept supplier that meets the following conditions:

(i) Is certified to furnish ALS services as required in §410.41(b)(2).

(ii) Bills all the recipients who receive ALS intercept services fro the entity, regardless of whether or not those recipients are Medicare beneficiaries.

(d) *Medical necessity requirements*—(1) *General rule.* Medicare covers ambulance services, including fixed wing and rotary wing ambulance services, only if they are furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated. The beneficiary's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Nonemergency transportation by ambulance is appropriate if either: the beneficiary is bed-confined, and it is documented that the beneficiary's condition is such that other methods of transportation are contraindicated; or, if his or her medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required. Thus, bed confinement is not the sole criterion in determining the medical necessity of ambulance transportation. It is one factor that is considered in medical necessity determinations. For a beneficiary to be considered bed-confined, the following criteria must be met:

(i) The beneficiary is unable to get up from bed without assistance.

(ii) The beneficiary is unable to ambulate.

(iii) The beneficiary is unable to sit in a chair or wheelchair.

(2) *Special rule for nonemergency, scheduled, repetitive ambulance services.* Medicare covers medically necessary nonemergency, scheduled, repetitive ambulance services if the ambulance provider or supplier, before furnishing the service to the beneficiary, obtains a written order from the beneficiary's attending physician certifying that the medical necessity requirements of paragraph (d)(1) of this section are met. The physician's order must be dated no earlier than 60 days before the date the service is furnished.

(3) *Special rule for nonemergency ambulance services that are either unscheduled or that are scheduled on a nonrepetitive basis.* Medicare covers medically necessary nonemergency ambulance services that are either unscheduled or that are scheduled on a nonrepetitive basis under one of the following circumstances:

(i) For a resident of a facility who is under the care of a physician if the ambulance provider or supplier obtains a written order from the beneficiary's attending physician, within 48 hours after the transport, certifying that the medical necessity requirements of paragraph (d)(1) of this section are met.

(ii) For a beneficiary residing at home or in a facility who is not under the direct care of a physician. A physician certification is not required.

(iii) If the ambulance provider or supplier is unable to obtain a signed physician certification statement from the beneficiary's attending physician, a signed certification statement must be obtained from either the physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), registered nurse (RN), or discharge planner, who has personal knowledge of the beneficiary's condition at the time the ambulance transport is ordered or the

service is furnished. This individual must be employed by the beneficiary's attending physician or by the hospital or facility where the beneficiary is being treated and from which the beneficiary is transported. Medicare regulations for PAs, NPs, and CNSs apply and all applicable State licensure laws apply; or,

(iv) If the ambulance provider or supplier is unable to obtain the required certification within 21 calendar days following the date of the service, the ambulance supplier must document its attempts to obtain the requested certification and may then submit the claim. Acceptable documentation includes a signed return receipt from the U.S. Postal Service or other similar service that evidences that the ambulance supplier attempted to obtain the required signature from the beneficiary's attending physician or other individual named in paragraph (d)(3)(iii) of this section.

(v) In all cases, the provider or supplier must keep appropriate documentation on file and, upon request, present it to the contractor. The presence of the signed certification statement or signed return receipt does not alone demonstrate that the ambulance transport was medically necessary. All other program criteria must be met in order for payment to be made.

(e) *Origin and destination requirements.* Medicare covers the following ambulance transportation:

(1) From any point of origin to the nearest hospital, CAH, or SNF that is capable of furnishing the required level and type of care for the beneficiary's illness or injury. The hospital or CAH must have available the type of physician or physician specialist needed to treat the beneficiary's condition.

(2) From a hospital, CAH, or SNF to the beneficiary's home.

(3) From a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident, including the return trip.

(4) For a beneficiary who is receiving renal dialysis for treatment of ESRD, from the beneficiary's home to the nearest facility that furnishes renal dialysis, including the return trip.

(f) *Specific limits on coverage of ambulance services outside the United States.* If services are furnished outside the United States, Medicare Part B covers ambulance transportation to a foreign hospital only in conjunction with the beneficiary's admission for medically necessary inpatient services as specified in subpart H of part 424 of this chapter.

[64 FR 3648, Jan. 25, 1999, as amended at 65 FR 13914, Mar. 15, 2000; 67 FR 9132, Feb. 27, 2002]

§ 410.41 Requirements for ambulance suppliers.

(a) *Vehicle.* A vehicle used as an ambulance must meet the following requirements:

(1) Be specially designed to respond to medical emergencies or provide acute medical care to transport the sick and injured and comply with all State and local laws governing an emergency transportation vehicle.

(2) Be equipped with emergency warning lights and sirens, as required by State or local laws.

(3) Be equipped with telecommunications equipment as required by State or local law to include, at a minimum, one two-way voice radio or wireless telephone.

(4) Be equipped with a stretcher, linens, emergency medical supplies, oxygen equipment, and other lifesaving emergency medical equipment as required by State or local laws.

(b) *Vehicle staff—(1) BLS vehicles.* A vehicle furnishing ambulance services must be staffed by at least two people, one of whom must meet the following requirements:

(i) Be certified as an emergency medical technician by the State or local authority where the services are furnished.

(ii) Be legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle.

(2) *ALS vehicles.* In addition to meeting the vehicle staff requirements of paragraph (b)(1) of this section, one of the two staff members must be certified as a paramedic or an emergency medical technician, by the State or local authority where the services are being furnished, to perform one or more ALS services.