Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Willie Goffney, Jr., M.D.
Docket No. A-16-121
Decision No. 2763
January 23, 2017

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Willie Goffney, Jr., M.D. (Petitioner) timely appealed the decision of an Administrative Law Judge (ALJ) upholding the determination of the Centers for Medicaid & Medicare Services (CMS) that the effective date for reactivation of Petitioner's Medicare billing privileges was August 31, 2015. *Willie Goffney, Jr., M.D.*, DAB CR4619 (2016) (ALJ Decision). The ALJ concluded that no material facts relevant to the correctness of the effective date were in dispute, and that those facts which Petitioner did contest related only to the deactivation of his billing privileges – an action which the ALJ determined was not within his jurisdiction. Accordingly, the ALJ granted summary judgment in favor of CMS upholding the effective date.

For the reasons explained below, we conclude that CMS determined the effective date as required by the applicable law and that the ALJ correctly determined that the other issues which Petitioner sought to inject cannot properly be addressed in this proceeding. We therefore uphold the ALJ Decision.

Background

Before the ALJ, CMS sought summary judgment on the ground that the following facts established as a matter of law that August 31, 2015 was the earliest possible effective date for Petitioner's reactivation:

> On October 31, 2012, a Medicare contractor notified Petitioner that his provider transaction access number (PTAN) was deactivated on the ground that Petitioner had not filed Medicare reimbursement claims since 2008. P. Ex. 5; *see* Ex. 3 to Petitioner's Hearing Request; *see* CMS Ex. 4.
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> On August 31, 2015, a Medicare contractor received an initial Medicare enrollment application from Petitioner. The contractor treated this application as an application by Petitioner to reactivate his billing privileges and PTAN. CMS Ex. 1.

> On October 2, 2015, the contractor advised Petitioner that his application was approved and that he was assigned an effective billing date of August 31, 2015. CMS Ex. 2.

ALJ Decision at 2. Petitioner sought reconsideration by the contractor and received an unfavorable reconsidered determination on December 18, 2015. CMS Exs. 3-4.

Petitioner's core contention is that either he was not, or at any rate should not have been, deactivated because he never went 12 months without submitting a claim (although apparently he has not been able to receive reimbursement since at least 2008). Therefore, he contends, nothing should have "disrupt[ed] the flow of Petitioner's constant enrollment in Medicare since 1991." Petitioner's Request for Review (RR) at 4. On that theory, he argues that his "earliest effective enrollment date should be September 6, 1991." *Id*. According to Petitioner, his claims were rejected beginning in 2005 for reasons he does not understand. *Id*. at 1; *see also* CMS Ex. 1 (August 28, 2015 letter from Petitioner to CMS asking for expedited handling of his revalidation application because his "status with Medicare was inexplicably changed many years ago" and he had not been paid for provided services). Moreover, he states that repeated inquiries to the contractor yielded various conflicting explanations, mostly relating to glitches in the transition to an electronic claims system. RR at 1-2, citing P. Exs. 8-9, 11-13. He asserts that, even after issuance of the deactivation letter in 2012, various contractor staff assured him that he had not been deactivated. *Id*.

The Board has previously explained the deactivation process as follows:

> Deactivation of a provider's or supplier's billing privileges is to be distinguished from denial of enrollment of a provider or supplier. "Deactivate" is defined to mean that "the provider or supplier's billing privileges were stopped, but can be restored upon the submission of updated information." *Id.* § 424.502. Medicare may deactivate an enrolled provider's or supplier's billing privileges for the reasons cited in 42 C.F.R. § 424.540(a), one of which is that the provider or supplier has not submitted any Medicare claims for 12 consecutive months, from "the 1st day of the 1st month without a claims submission through the last day of the 12th month without a submitted claim." *Id*. § 424.540(a)(1). "Deactivation of Medicare billing privileges is considered an action to protect the provider or supplier from misuse of its billing number and to protect the Medicare Trust Funds from unnecessary overpayments." *Id.* § 424.540(c); *see also* Final Rule, 77 Fed. Reg. 29,002, 29,010 (May 16, 2012) (explaining that the purpose of deactivating a provider's or supplier's

> billing privileges for non-submission of claims for 12 consecutive months in accordance with section 424.540(a)(1) is "to prevent situations in which unused, idle Medicare billing numbers could be accessed by individuals and entities to submit false claims").
>
> The regulations also permit CMS to ask a provider or supplier . . . to periodically "resubmit and recertify the accuracy of its enrollment information" in order to maintain billing privileges. 42 C.F.R. § 424.515. A provider or supplier whose billing privileges were deactivated for non-submission of a claim for 12 consecutive months is "required to recertify that the enrollment information currently on file with Medicare is correct and furnish any missing information as appropriate . . . [and] must meet all current Medicare requirements in place at the time of reactivation, and be prepared to submit a valid Medicare claim." *Id*. § 424.540(b)(2). *See also* 77 Fed. Reg. at 29,010 (stating that, in general, the recertification process entails "the submission of a completed CMS-855 enrollment application").

Deann Worthington, N.P., DAB No. 2661, at 2-3 (2015). Deactivation also differs from revocation in several ways, particularly in that revocation terminates a Medicare provider or supplier agreement and requires imposition of a re-enrollment bar of at least one year, neither of which occurs with deactivation. *Compare* 42 C.F.R. § 424.535(a), (b), (c) with § 424.540(c).

The provisions on supplier appeal rights also distinguish between denial or revocation of enrollment, which may be appealed under 42 C.F.R Part 498, and deactivation, for which the supplier "may file a rebuttal in accordance with § 405.374." 42 C.F.R. § 424.545(a), (b). Section 405.374 simply permits the supplier "to submit any statement (to include any pertinent information) as to why [the deactivation] should not be put into effect on the date specified in the notice" to the contractor, generally within 15 days or less. *Id.* § 405.374(a).

Analysis

A. *Deactivation is not appealable and is not reviewable in this proceeding.*

Petitioner has not denied, before the ALJ or on appeal, that he received the letter notifying him of deactivation in 2012.[1] Nor does he assert that he sought to file a rebuttal

[1] The contractor sent this October 31, 2012 letter (P. Ex. 5) in response to a September 27, 2012 inquiry from Petitioner (P. Ex. 4) about why Medicare "continues to deny payment" for his claims. The contractor explained that Petitioner's PTAN number "has been deactivated for non-billing since 2008." P. Ex. 5. Petitioner argues that the letter was wrong but not that he did not receive the letter.

in response to that notice.[2] He contends, instead, that he is not trying to challenge the validity of a deactivation action but rather offering evidence to establish that his PTAN was never actually deactivated, or at any rate not properly deactivated for the reasons set out in the deactivation letter. RR at 1. He relies on these contentions to suggest that somehow the effective date of the action on his 2015 enrollment application should relate back to his original enrollment in Medicare. *Id.* at 3-4.

He bases his contentions about his deactivation on an account of his interactions with various individuals at the Medicare contractor in the years since 2005 when he asserts he stopped receiving payment for claims submitted to Medicare despite having been enrolled since 1991. *See* Petitioner's Affidavit (P. Aff.) at 2-5, and exhibits cited therein. He also provides a letter he wrote to the contractor in January 2006 saying he had learned of a "hold" on his account. P. Ex. 3. His affidavit refers to other "correspondence . . . by mail, email and phone" with the contractors after that, but he provides no examples or details of other communications before the inquiry that triggered the October 31, 2012 deactivation notice. P. Aff. at 2. Given this spotty record, and multiple inconsistencies in those documents provided,[3] it is not possible to discern exactly when and why Petitioner's claims first began to be denied. It is also unnecessary that we do so.

Petitioner's contentions about events and interactions other than his August 31, 2015 application to reactivate his Medicare billing privileges are not material to this case. As the ALJ explained, the regulations do not provide a right to ALJ review of deactivation of billing privileges. Before an ALJ (or the Board) may review the correctness of an effective date determination, the provider must have sought, and the contractor must have issued, a reconsideration decision. That decision sets the parameters of the issues before the ALJ (and the Board) which are reviewable under the regulations. *Cf. Vijendra Dave, M.D.*, DAB No. 2672, at 8 n.10 (2016) (holding, in an appeal challenging a Medicare enrollment revocation, that the Board is "limited to reviewing the basis for revocation articulated in the unfavorable reconsidered determination issued by CMS or its contractor").

[2] The record contains a letter dated September 23, 2013 in which Petitioner says that he believes there has been an error in his deactivation for nonbilling and asks for information. P. Ex. 6. He has not indicated that this submission in fact constituted a rebuttal, which would have been due 15 days after the deactivation notice, although at times he suggests that he should be viewed as having done what he could to respond to the notice which he came to believe was erroneous. *See* P. Reply at 5-6.

[3] For example, Petitioner has variously asserted that he began receiving Medicare payments in 1989 and 1991 (compare P. Ex. 1, at 1 and RR at 4 with P. Ex. 4) and that he ceased receiving them in 2005 or 2006 (compare P. Ex. 3 with Feb. 18, 2016 Req. for Hearing). The October 31, 2012 notice indicates that he was deactivated in 2008 as a result of nonbilling but does not indicate when the period of nonbilling began or whether any billing was attempted thereafter.

The regulations provide for appeal rights to an ALJ and then Board review only from certain specified "initial determinations" by CMS. 42 C.F.R. § 498.3(b). These appealable determinations include unfavorable reconsiderations as to:

> (15) The effective date of a Medicare provider agreement or supplier approval.
>
> * * *
>
> (17) Whether to deny or revoke a provider or supplier's Medicare enrollment in accordance with §424.530 or §424.535 of this chapter.

Id. The reconsidered determination on which our jurisdiction is based does not deny or revoke Petitioner's enrollment. CMS Ex. 4. The only action in the reconsidered determination which is appealable is thus the initial determination of the effective date of the enrollment application reinstating Petitioner.

Our conclusion in this regard is reinforced by a review of 42 C.F.R. § 424.545, which, as we have noted, spells out the appeal right of Medicare suppliers. Section 424.545(a) explains that a prospective supplier denied enrollment or an existing supplier whose enrollment has been revoked may appeal under the provisions of 42 C.F.R. Part 498. Section 424.545(b), by contrast, states only that a "supplier whose billing privileges are deactivated may file a rebuttal." A rebuttal is not itself an appeal. *See* 42 C.F.R. § 405.374 (defining "Opportunity for rebuttal" as "an opportunity to submit a statement . . ."). Moreover, neither section 424.545(b) nor any other regulation provides appeal rights from the contractor's deactivation determination or any rebuttal determination. *See also Arkady B. Stern, M.D.*, DAB No. 2417, at 3 n.4 (2011) (Petitioner argues on appeal that deactivation was improper, but Board "does not have authority to review" deactivation under circumstances of this case, citing 42 C.F.R. §§ 424.545(b) and 498.3(b)); *Andrew J. Elliott, M.D.*, DAB No. 2334, at 4 n.4 (2010) (Board "does not have authority to review" a deactivation).

Moreover, despite his claims to the contrary, much of Petitioner's argument is indeed a challenge to the validity of his deactivation given his assertion that the October 31, 2012 letter provides a reason for deactivating that is "false and inapplicable" because he denies that he ever went twelve months without submitting a claim. RR at 2. Petitioner reasons that the flaws he sees in the deactivation letter demonstrate that the letter was issued "in error" and that his PTAN was therefore not deactivated. *Id*. Whether the letter was issued due to some kind of error or was based on some misunderstanding regarding the status of Petitioner's PTAN or Petitioner's claiming practices does not alter either the letter's effect in providing notice of the deactivation of Petitioner's billing privileges, or the fact that deactivation is not an appealable initial determination.

B. *We do not have authority to review retrospectively the status of Petitioner's billing privileges or of Medicare claims from prior years that were either denied or never submitted.*

Even assuming Petitioner is not attempting to obtain a belated and unauthorized appeal of the 2012 deactivation letter, we still could not give Petitioner any of the review he seeks. Petitioner asserts a number of factual issues that appear to be designed to have the Board opine on the state of Petitioner's Medicare billing privileges. The Board has no authority to do this apart from reviewing the effective date set in the appealable determination (i.e., the December 18, 2015 reconsidered determination) on the August 31, 2015 enrollment application. In any event, determining the effective date of Petitioner's billing privileges based on the approval of this application does not determine whether he previously participated in Medicare or previously had a valid PTAN. Those questions, however important they may be to Petitioner, are not within our jurisdiction.

Beyond that, Petitioner's apparent underlying concern is that he wishes to receive reimbursement for services provided in prior years for which he either did not submit claims or for which his claims were denied. It is certainly true that he may not receive payment for claims for services during any period when his billing privileges were deactivated. Section 424.555(b) provides:

> No payment may be made for otherwise Medicare covered items or services furnished to a Medicare beneficiary by a provider or supplier if the billing privileges of the provider or supplier are deactivated, denied, or revoked. The Medicare beneficiary has no financial responsibility for expenses, and the provider or supplier must refund on a timely basis to the Medicare beneficiary any amounts collected from the Medicare beneficiary for these otherwise Medicare covered items or services.

42 C.F.R. § 424.535(b). Disputes about Medicare claim reimbursement are not cognizable in this forum, however. Denial of Medicare reimbursement may be appealed only after submitting a claim and only through the process set out in 42 C.F.R. Part 405. *See Vijendra Dave, M.D.* at 12.

Petitioner asserts that "the overwhelming evidence suggests that [the contractor] did not deactivate Petitioner's PTAN, but rather denied his claims because of an internal error." RR at 4. As with the question of whether the deactivation took place or was well-founded, the questions of if and why any of Petitioner's claims were denied is beyond the scope of this proceeding, however consequential they may be to Petitioner.

Petitioner contends that the ALJ erred by resolving this case on summary judgment when "outcome-determinative questions of material fact" remained in dispute. P. Reply Br. at 4. None of the facts to which Petitioner refers, however, are material to the sole issue

before the ALJ. For example, Petitioner contends that CMS relied on the deactivation as the reason that September 9, 1991 "is no longer" a valid effective billing date. *Id.* But we need not, and cannot, make conclusions as to whether Petitioner was deactivated properly or when, or as to whether his billing privileges first became effective on September 9, 1991. As we have explained, this decision resolves only when the billing privileges granted based on the application filed on August 31, 2015 became effective.

C. *The effective date set in the reconsideration decision is correct.*

Only facts relevant to the effective date resulting from the August 31, 2015 application were material to the ALJ Decision. The governing law on how CMS (and its Medicare contractors) determine the effective date for physicians applying for Medicare billing privileges is set by regulation as follows:

> The effective date for billing privileges for physicians . . . is the later of . . . [t]he date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor; or . . . [t]he date that [an enrolled physician] . . . first began furnishing services at a new practice location.

42 C.F.R. § 424.520(d). The date on which the approved application was filed was August 31, 2015, and Petitioner asserts he had long been providing services at the same practice location. *See* RR at 3-4. Therefore, as the ALJ correctly concluded, the only date on which billing privileges arising from the approved application could become effective is August 31, 2015.

We therefore find no error in the ALJ's decision to proceed by summary judgment.

D. *Petitioner's other legal arguments have no merit.*

We note that several arguments made in Petitioner's reply brief were not clearly articulated in his prior submissions. Generally, the Board will not consider issues which were not raised in the request for review or which could have been presented to the ALJ but were not. *See Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program,* "Completion of the Review Process" (available at https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/enrollment/index.html); *John M. Shimko, D.P.M.*, DAB No. 2689, at 11 (2016). Because Petitioner's contentions throughout have been less than entirely clear and have reflected confusion about the scope of the proceeding, we will nevertheless briefly explain why these

arguments, even as they are now phrased, have no merit.[4] Petitioner now acknowledges that deactivation is not an initial determination giving rise to appeal rights, but suggests that, if the effective date here is upheld, his deactivation becomes "permanent" and somehow converts into an appealable revocation. P. Reply at 8. Moreover, he argues that, if CMS did deactivate his PTAN, it did so in violation of various regulations that he reads as requiring sufficient notice and opportunity to submit a rebuttal, or else the deactivation should become appealable as a revocation. *Id*. at 6-7. In support of these concepts, Petitioner cites only the 2011 decision of another ALJ in *Horatio Aldredge, M.D., et al.*, DAB CR2351 (2011), which was never appealed to the Board. The ALJ in *Aldredge* dismissed the hearing requests because the petitioners had no right to a hearing on their deactivation. *Id*. at 1. In dicta, however, the ALJ opined as follows:

> Although I dismiss this case, it is my hope that the contractor will properly address Petitioners' concerns about an improper deactivation through the rebuttal process. If CMS does not properly address Petitioners deactivations through the regulatory process, Petitioners may file a request to vacate this dismissal within 60 days, pursuant 42 C.F.R. § 498.72. I will then consider the issue of whether CMS has, in effect, improperly revoked Petitioners' billing privileges as opposed to deactivating them.

Id. at 5-6. There is no record of whether any of the petitioners in *Aldredge* did file rebuttals or of what action CMS took, but we find no indication that the dismissal was ever in fact vacated. Moreover, we find no authority in the regulations for treating a deactivation as if it were a revocation. An ALJ decision is not itself precedent or binding on the Board, and the ALJ decision which Petitioner cites merely suggests that the ALJ issuing it might consider such an argument in the event the matter returned to him in a motion to vacate his dismissal.

Finally, we reject Petitioner's claims that the ALJ could or should have offered him some form of equitable relief. The ALJ concluded that, to the extent that Petitioner's complaints about the contractor amounted to a request for equitable relief, he did not have authority to consider such a request. ALJ Decision at 4, citing *US Ultrasound*, DAB No. 2302, at 8 (2010). Petitioner argues that the information he claims to have received from contractor employees was so misleading as to constitute misconduct (RR at 6), relying on cases in which the Board (and courts) have said that the equitable remedy of estoppel could lie against the government, if at all, only in the situation of affirmative governmental misconduct. *See, e.g., Illinois Dep't of Children & Family Servs.*, DAB No. 2734, at 8 (2016) (government cannot be estopped "absent, at a minimum, a showing

[4] We also note that, while we have not responded to every formulation of Petitioner's contentions, we have fully considered all arguments that appear to be raised on appeal, regardless of whether our decision contains a detailed written analysis of each.

that the traditional requirements for estoppel are present . . . and that the government's employees or agents engaged in 'affirmative misconduct"') citing *Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414, 421 (1990). Petitioner has not shown that the ALJ or the Board has any authority to alter an effective date for equitable reasons, even had he shown that affirmative misconduct occurred, which he has not on this record.

Conclusion

For the reasons fully explained above, we sustain the ALJ Decision and uphold the effective date as determined by CMS.

/s/
Sheila Ann Hegy

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member