Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Willie Goffney, Jr., M.D.
Docket No. A-17-67
Ruling No. 2017-5
September 15, 2017

RULING ON PETITION TO REOPEN DEPARTMENTAL APPEALS BOARD DECISION 2763

On March 23, 2017, Willie Goffney, Jr., M.D. (Petitioner) submitted a petition to reopen Board Decision No. 2763 (Jan. 23, 2017). We deny the petition because it identifies no error of fact or law in the Board's decision.

Reopening under 42 C.F.R. Part 498

Title 42 C.F.R. § 498.100 authorizes the Board, on its own motion or at the request of either party, to reopen a decision within 60 days of the date of notice of the decision. Section 498.100 does not specify circumstances in which the Board may or must reopen a decision.[1] In appeals under 45 C.F.R. Part 16, the Board may "reconsider" a decision when a party "promptly alleges a *clear error* of fact or law." 45 C.F.R. § 16.13 (italics added). The Board has held that this clear-error standard is "reasonably applied" in deciding whether to reopen a decision in an appeal brought under 42 C.F.R. Part 498. *Experts Are Us, Inc.*, DAB No. 2342, at 2 (2010). The Board has emphasized that reopening a decision is not a routine step in the administrative appeal process but, rather, an opportunity for the parties to identify "any errors that make the decision clearly wrong." *Id.*; *see also Peter McCambridge, C.F.A.*, DAB Ruling No. 2010-1, at 1 (Feb. 2, 2010); *BioniCare Medical Technologies, Inc.,* DAB Ruling No. 2011-3, at 1 (Dec. 2, 2010).

[1] Title 42 C.F.R. § 498.102, titled "Revision of reopened decision," implies that the Board may reopen its decision to consider "new evidence." However, "[t]he Board generally will not exercise the discretion to reopen based on evidence that a party could have submitted before, but did not." *Meadowwood Nursing Ctr.*, DAB Ruling No. 2014-1, at 5 (March 12, 2014). (All cited rulings are available on the Board Decisions webpage at https://www.hhs.gov/about/agencies/dab/decisions/board-decisions/board-decisions-by-year/index.html.)

Case Background

Sometime between 2005 and 2012 – precisely when is unclear – CMS deactivated Petitioner's Medicare billing privileges on the ground that he had failed to submit a Medicare payment claim for twelve consecutive months. *See* DAB No. 2763, at 2-3, 4 n.3 (discussing 2012 correspondence from CMS stating that deactivation occurred in 2008); Pet. to Reopen at 2 (asserting that CMS "deactivated Petitioner's account" in "approximately" 2005).

On August 31, 2015, seeking to reactivate his billing privileges, Petitioner filed a Medicare enrollment application, which CMS evidently treated as an "initial" application for enrollment. *See* Pet. to Reopen at 3; DAB No. 2763, at 1, 6, 7; CMS Exs. 1-2 (Civil Remedies Division (CRD) Docket No. C-16-365). CMS approved the application and granted him billing privileges effective August 31, 2015. CMS Ex. 2, at 1 (CRD Docket No. C-16-365). Petitioner appealed that decision, contending that his billing privileges had been improperly deactivated (or deactivated without adequate notice or opportunity for "rebuttal") and that CMS should therefore have granted him billing privileges retroactive to 1991. DAB No. 2763, at 2, 8. An administrative law judge (ALJ) granted summary judgment to CMS, and the Board affirmed the ALJ's decision. *Id.* at 1, 7.

The Board's Decision

Addressing Petitioner's allegation that his Medicare billing privileges had been improperly deactivated, the Board held that neither the administrative appeal regulations in 42 C.F.R. Part 498, nor the Medicare enrollment regulations in 42 C.F.R. Part 424, authorize the Board or its ALJs to review a deactivation decision by CMS or its contractors. DAB No. 2763, at 3-5. The Board further noted that, in Petitioner's circumstances, the Part 498 regulations authorized it to decide only whether CMS had correctly set the effective date based on the enrollment application he filed on August 30, 2015. *Id.* at 5. Given that limitation on the scope of review, the Board held that issues or claims arising from Petitioner's interaction or relationship with CMS and the Medicare program prior to August 30, 2015 were "not material." *Id.* at 4.

Title 42 C.F.R. § 424.520(d) states in relevant part that the "effective date for billing privileges" is "*[t]he date of filing* of a Medicare enrollment application that was subsequently approved by a Medicare contractor" (italics added). Applying that regulation, the Board held that the pertinent "date of filing" – and hence Petitioner's effective date – was August 31, 2015. DAB No. 2763, at 3-5. The Board rejected Petitioner's suggestion that he was entitled to an earlier effective date because CMS had earlier (that is, prior to August 2015) somehow misled him about his status in the Medicare program. *Id.* at 8 (noting that Petitioner did not show 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"). Finally, the Board held that it had no authority to resolve disputes relating to his eligibility for, or the denial of, Medicare payment for services he furnished during or prior to the deactivation period. *Id.* at 6.

The Petition to Reopen

Petitioner asks us to reopen the Board's January 23, 2017 decision based on "new and material evidence" that was not included in the record of that decision. Pet. to Reopen at 2. That "evidence," more accurately described as documentation of law and CMS policy governing Medicare enrollment, consists of two exhibits (A and B) attached to the petition to reopen. Exhibit A is a copy of the April 21, 2006 Final Rule, as published in the *Federal Register*, adopting the Medicare enrollment regulations in 42 C.F.R. Part 424, subpart P. As relevant to Petitioner's argument, section 424.515 of the enrollment regulations requires a provider or supplier to periodically "revalidate" – that is, "recertify the accuracy" of – its "enrollment information" on file with the Medicare program in order "[t]o maintain Medicare billing privileges." 42 C.F.R. § 424.515. That section also states that "CMS contacts each provider or supplier directly when it is time to revalidate . . . enrollment information." *Id.* § 424.515(a)(1). Exhibit B to the petition to reopen is a "Model Revalidation Letter" published in section 15.24.5 of CMS's Medicare Program Integrity Manual. The letter notifies a provider or supplier of its obligation to revalidate its enrollment information every five years and requests that it do so within 60 days of the postmarked date of the letter.

Relying on these exhibits, Petitioner contends that, prior to August 30, 2015, he "never received" notice from CMS to revalidate his enrollment. Pet. to Reopen at 6, 8. He suggests that CMS should have sent him a "notice to revalidate" in mid-2008. *Id.* at 6 n.1. Had CMS done so, says Petitioner, he would "have had the opportunity to timely revalidate his account and maintain his original 1991 effective date for billing privileges." *Id.* at 10-11. Petitioner asks the Board to "consider whether, pursuant to the regulations and policies governing the requirements for notice of CMS'[s] requirements to recertify or to re-validate an existing provider or supplier account under the new rules [promulgated in April 2006], a failure to notify the provider or supplier is a denial of due process." *Id.* at 7. Petitioner asserts – though without any supporting legal analysis – that CMS's "failure to provide notice of the requirements for revalidation . . . is an issue wholly intertwined with the effective date determined in the ALJ decision." *Id.* at 7-8.

Discussion

Elements of Petitioner's argument are speculative or unclear. For example, Petitioner fails to explain how receipt of a revalidation notice in mid-2008 would have – under then-current rules – enabled him to "maintain his original 1991 effective date" given that CMS had likely deactivated his billing privileges before then. *See* Pet. to Reopen at 3, 6 n.1 (alleging that deactivation occurred in 2005). Petitioner also has not explained why it would be legally sound to read section 424.515 as requiring CMS to send revalidation notices to physicians whose billing privileges are no longer active when, as noted, the revalidation process enables those who *have* billing privileges to "maintain" them. Nor, even if Petitioner's reading were correct, has he pointed to any connection in the regulations between a failure by CMS to send a revalidation notice and the limited appeal rights granted under the regulations. In addition, Petitioner's claim of prejudice is unconvincing. While we understand that a revalidation notice might have alerted Petitioner to inquire about, and apply to restore, his billing privileges earlier than August 2015, he does not identify any circumstances that prevented him from taking that action on his own initiative.

We need not pursue these issues further or decide the merits of Petitioner's so-called "due process" claim – which, we note, alleges no procedural defect in the underlying hearing and appeal process. The only issue before us now is whether Petitioner has identified a prejudicial legal or factual error in the Board's decision. He has not done so.

As outlined above, the result in Board Decision 2763 rested on four holdings:

- Under the applicable administrative appeal regulations in 42 C.F.R. Part 498, the Board was authorized to decide only whether CMS had properly determined the effective date for Medicare billing privileges based on Petitioner's August 31, 2015 enrollment application[2];

- Given the limited scope of review, "contentions about events and interactions other than [Petitioner's] August 31, 2015 application" were "not material" to the outcome of the appeal[3];

[2] DAB No. 2763, at 5 (stating that "[t]he only action in the reconsidered determination which is appealable [to an administrative law judge and then the Board] is thus the initial determination of the *effective date of the enrollment application* reinstating Petitioner" (italics added)); *id.* at 7 (stating that the Board's "decision resolves only when the billing privileges granted based on the application filed on August 31, 2015 became effective").

[3] DAB No. 2763, at 4.

- The law governing the appealable effective-date determination is 42 C.F.R. § 424.520(d)[4]; and

- CMS correctly determined under section 424.520(d) that August 31, 2015 was the effective date for Medicare billing privileges based on the enrollment application filed by Petitioner on August 31, 2015 and subsequently approved by CMS.[5]

Petitioner does not contend that any of these holdings is erroneous, much less clearly erroneous. He does not, for example, argue that the Board improperly described the scope of its review, made unsound relevance or materiality findings, or misconstrued or misapplied section 424.520(d); Petitioner merely makes a new purported legal claim arising from his pre-August 31, 2015 relationship with the Medicare program. Nor does Petitioner explain why he could not have made this legal argument in the prior proceeding since the regulatory changes on which he relies were effective at that time. The purpose of the reopening authority in section 16.13 is to enable the Board to correct any clear errors it makes in its decisions, not to give litigants an opportunity to make new arguments.

Like his claim that his billing privileges were improperly deactivated, Petitioner's contention that he was never notified of his obligation to revalidate his billing privileges has no bearing on the legality of the effective-date determination that he appealed to the ALJ and the Board. That determination, as the Board held, is governed by section 424.520(d), which requires that a supplier's effective date be either the "date of filing" of an enrollment application "subsequently approved" by CMS or, if applicable, "[t]he date that the supplier first began furnishing services at a new practice location." No other "date" is mentioned in section 424.520(d), and Petitioner does not argue that some other regulation or statute applies and authorizes a different effective date. As an administrative tribunal, the Board is bound by section 424.520(d) and has no authority to disregard or make exceptions to its applicability. *Vijendra Dave, M.D.*, DAB No. 2672, at 8 (2016); *see also Oaks of Mid City Nursing and Rehab. Ctr.*, DAB No. 2375, at 30-31 (2011) (stating that the Board may not fail to follow a clearly applicable regulation).

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[4] DAB No. 2763, at 7 (explaining that "[t]he governing law on how CMS (and its Medicare contractors) determine the effective date for physicians applying for Medicare billing privileges is set by" section 424.520(d)).

[5] DAB No. 2763, at 7.

Conclusion

The Petitioner having failed to identify a prejudicial error of fact or law in Board Decision 2763, we deny his March 23, 2017 petition to reopen.

/s/
Sheila Ann Hegy

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member