Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Dr. James McGuckin, Jr.,

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-703

Decision No. CR2918

Date: September 4, 2013

DECISION

I grant the Centers for Medicare & Medicaid Services' motion for summary disposition.[1] The effective date of Petitioner's reactivated enrollment remains May 1, 2012, with a 30 day retrospective billing period beginning on April 1, 2012.

I. Background

Petitioner, Dr. James McGuckin, Jr., is the founder and CEO of the Vascular Access Center of Atlanta, and Director of the Philadelphia Vascular Institute in Philadelphia, Pennsylvania. The Vascular Access Center of Atlanta provides comprehensive dialysis access maintenance and various other services relating to vascular access. Petitioner works primarily at the Philadelphia location, but travels to work at other locations of the Vascular Access Center, located nationwide, including the Vascular Access Center of Atlanta. Petitioner's Exhibit (P. Ex.) 1, at 1 ¶¶ 1, 4, 5, 6, 7. Petitioner is a supplier to the

[1] I decide this case on a summary judgment standard. *See Glenburn Home*, DAB No. 1806 (2002).

Medicare program.[2] This case addresses the deactivation of Petitioner's billing privileges and Medicare provider transaction access numbers (PTANs)[3] with respect to the Vascular Access Center of Atlanta.

On September 20, 2010, Cahaba Government Benefit Administrators, LLC (Cahaba GBA), a Medicare Administrative Contractor, issued notices informing Petitioner that his PTANs 202i940341, 202i940343, and 202i940344 were deactivated effective September 18, 2010, due to 12 consecutive months of non-billing. CMS Exhibit (CMS Ex.) 1, at 2; CMS Ex. 5. The notices were sent to the address Petitioner listed in his enrollment application and were sent through Cahaba GBA's automated deactivation notification system. CMS Ex. 1, at 2; CMS Ex. 2, at 3-4.

In September 2011, Petitioner resumed billing under PTAN 202i940344 for services provided on and after August 30, 2011 (almost a year after the deactivation became effective). CMS Ex. 7, at 2; CMS Ex. 4, at 1-2. On September 13, 2011, Cahaba GBA notified Petitioner, via the claims denial code on Electronic Remittance Advices (ERAs), that Petitioner "was not certified/eligible to be paid for this procedure/service on this date of service." CMS Exs. 7, 8.

In April 2012, Petitioner noticed that collections at the Atlanta Vascular Access Center were low and asked his staff to enquire of Cahaba GBA about the discrepancy. Petitioner states that "[b]ecause our focus was primarily on patient care and not cash receipts, the underpayments did not immediately come to our attention." Petitioner states when he discovered that his PTANs had been deactivated (in April 2012), he asked Cahaba GBA how the situation could be rectified. On April 27, 2012, Petitioner filed an application to reactivate PTAN 202i940344. CMS Ex. 4, at 2; P. Ex. 1, at 2 ¶¶ 12, 15. Cahaba GBA received the application on May 1, 2012. CMS Ex. 7. Cahaba GBA treated the application as a new enrollment application and determined Petitioner's effective date to be May 1, 2012, with a retrospective billing period beginning on April 1, 2012. Cahaba

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[2] Petitioner is considered a "supplier" for purposes of the Act and the regulations. *See* 42 U.S.C. §§ 1395x(d), 1395x(u); *see also* 42 C.F.R. § 498.2. A "supplier" furnishes services under Medicare and the term applies to physicians or other practitioners that are not included within the definition of the phrase "provider of services." 42 U.S.C. § 1395x(d).

[3] A supplier must be enrolled in the Medicare program and issued a billing number in order to have billing privileges and be able to receive payment for services rendered. Once enrolled, a supplier uses a national provider identifier (NPI), and one or more PTANs associated with that NPI, to participate in and bill the Medicare program.

GBA issued Petitioner a new PTAN, number 202i944710.[4] CMS Ex. 1; CMS Ex. 3, at 1; P. Ex. 2.

In letters dated July 12 and October 26, 2012, Petitioner requested that Cahaba GBA retroactively reactivate PTAN 202i940344 to July 2011. Petitioner asserted that he had not received notice that the PTAN had been deactivated. CMS Ex. 4. On December 18, 2012, Cahaba GBA affirmed the May 1, 2012 effective date, stating that was the date Cahaba GBA received Petitioner's enrollment application. CMS Ex. 3. On January 17, 2013, Petitioner sent a letter to Cahaba GBA stating that he was "rebut[ting] [Cahaba GBA's] December 18, 2012 letter" and asking Cahaba GBA "to investigate the denial of claims based upon a deactivation of Dr. McGuckin's billing privileges," and "reconsider the determination" because of the lack of notice to Petitioner. Specifically, Petitioner requested that Cahaba GBA "rescind the deactivation" because "there was no requisite notice to Dr. McGuckin." CMS Ex. 2. On February 27, 2013, Cahaba GBA issued a reconsideration decision upholding the May 1, 2012 effective date and noting that the effective date for retrospective billing is April 1, 2012. CMS Ex. 1; P. Ex. 2.

Petitioner filed a request for hearing on April 25, 2013. The case was assigned to me for hearing and decision on May 2, 2013. CMS filed a motion for summary disposition (CMS Br.), accompanied by eight exhibits (CMS Exs. 1 through 8) on May 22, 2013. Petitioner filed a response (P. Br.), accompanied by three exhibits (P. Exs. 1 through 3) on June 11, 2013. In the absence of objection, I admit CMS Exs. 1 through 8 and P. Exs. 1 through 3 into evidence.

II. Issues, Findings of Fact and Conclusions of Law

A. Issues

The issues in the case are as follows:

1. Whether summary judgment is appropriate;

2. Whether Petitioner has a right to appeal the deactivation of PTAN 202i940344 in this forum; and

3. Whether CMS has a legitimate basis for establishing May 1, 2012, as the effective date of Petitioner's reactivated billing privileges.

[4] This case was originally titled Dr. James McGuckin, Jr., (PTANS: 202i944710; 202i949439; 202i949437), as these PTANs were listed on Petitioner's hearing request. However, the only two PTANs at issue here are the PTAN Petitioner sought to reactivate in April 2012 (PTAN 202i940344) and the PTAN issued to Petitioner by Cahaba GBA and effective May 1, 2012 (PTAN 202i944710).

B. Findings of Fact and Conclusions of Law

I make the following findings of fact and conclusions of law, as noted in italics and bold.

1. Summary judgment is appropriate.

The Departmental Appeals Board (Board) states the standard for summary judgment:

> Summary judgment is appropriate when the record shows that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law . . . . The party moving for summary judgment bears the initial burden of showing that there are no genuine issues of material fact for trial and that it is entitled to judgment as a matter of law . . . To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact -- a fact that, if proven, would affect the outcome of he case under governing law . . . . In determining whether there are genuine issues of material fact for trial, the reviewer must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor.

Senior Rehabilitation & Skilled Nursing Center, DAB No. 2300, at 3 (2010) (citations omitted). The role of an administrative law judge (ALJ) in deciding a summary judgment motion differs from the ALJ's role in resolving a case after hearing. The ALJ should not assess credibility or evaluate the weight of conflicting evidence. *Holy Cross Village at Notre Dame*, DAB No. 2291, at 4-5 (2009).

Petitioner does not assert that he submitted claims for services under PTAN 202i940344 in the 12 months before the deactivation of this PTAN. Petitioner is not contesting whether CMS and its contractor, Cahaba GBA, had the authority to deactivate his PTAN. Petitioner is instead arguing that he did not receive any notice from Cahaba GBA deactivating his PTAN, notice that CMS asserts Cahaba GBA generated and sent to Petitioner's address on September 20, 2010, with the deactivation effective date of September 18, 2010. And Petitioner argues that because deactivation is not mandatory under 42 C.F.R. § 424.540(a)(1) [CMS *may* deactivate the Medicare billing privileges of a supplier who does not submit any Medicare claims for 12 consecutive months], Petitioner would not know his PTAN was being deactivated absent proper notice.

Petitioner acknowledges that there is no regulatory provision requiring CMS to give him notice of deactivation. CMS Ex. 2, at 1; P. Ex. 3. Petitioner argues, however, that Petitioner's assertion that he never received notice of his deactivation is a dispute of material fact that I must decide. Petitioner argues specifically that "there is a genuine issue of material fact as to whether Dr. McGuckin received notice of the deactivation of

PTAN 202i940344." P. Br. at 1. However, as explained below, whether Petitioner received notice of the deactivation or not is irrelevant, because under the regulations an ALJ does not have the authority to review a challenge to the deactivation of a PTAN. And the decision about whether or when to deactivate a PTAN is not something an ALJ has the authority to consider, as only CMS or its contractor has that authority.

Petitioner also argues that CMS is not entitled to summary judgment because CMS's refusal to reimburse Dr. McGuckin for claims between September 2010 and April 2012 is contrary to the congressional intent regarding deactivation. Petitioner's argument is an equitable argument that I am not authorized to hear, as discussed below. Thus, even if I view all the evidence in this case in the light most favorable to Petitioner, and accept Petitioner's argument that he did not receive any notice of the deactivation of PTAN 202i940344, CMS still prevails.

2. Petitioner has no right to appeal the deactivation of PTAN 202i940344.

CMS may deactivate a provider or supplier's Medicare billing privileges if the provider or supplier "does not submit any Medicare claims for 12 consecutive calendar months." 42 C.F.R § 424.540(a)(1). Deactivation is not, however, an initial determination, and an ALJ is authorized only to hear disputes involving initial determinations. 42 C.F.R. § 424.545; 42 C.F.R. § 498.3. If a provider or supplier's Medicare billing privileges are deactivated, the provider or supplier's only option is to submit a rebuttal to the contractor under 42 C.F.R. § 424.545(b), in accordance with 42 C.F.R. § 405.374.[5] Accordingly, I am not authorized to hear Petitioner's arguments with regard to the deactivation of his billing privileges, including whether or not Petitioner received notice of the deactivation.

Once a supplier's billing privileges are deactivated for non-billing, billing privileges may only be reactivated under a new billing number. The supplier must submit a CMS-855

[5] Although I cannot consider a rebuttal, it appears that Petitioner's January 17, 2013 letter served as both a rebuttal to Cahaba GBA's deactivation of its PTAN ("Dr. James McGuckin, Jr. has retained this office to rebut your December 18, 2012 letter and to investigate the denial of claims based upon a deactivation of Dr. McGuckin's billing privileges") and as a request that Cahaba GBA reconsider the effective date of PTAN 202i944710 ("We ask that you reconsider that determination as there was no requisite notice to Dr. McGuckin."). Cahaba GBA apparently treated the letter as a reconsideration of Petitioner's effective date of PTAN 202i944710 and it is Cahaba GBA's February 27, 2012 decision reconsidering the effective date that authorizes me to hear this case. CMS Ex. 1; CMS Ex. 2, at 1-2; P. Ex. 2. Petitioner does argue that the February 27, 2013 letter it received from Cahaba GBA afforded him a right to appeal the deactivation. However, the letter gave Petitioner notice of his right to appeal the effective date of his billing privileges, not the deactivation.

application, which is treated as an initial enrollment application. *Arkady B. Stern, M.D.*, DAB No. 2329, at 4 n.5 (2010); citing MPIM, Rev. 289, issued April 15, 2009, effective January 1, 2009.

3. CMS has a legitimate basis for establishing May 1, 2012, as the effective date of Petitioner's reactivated Medicare enrollment and billing privileges.

Although I do not have the authority to consider Petitioner's challenge to the deactivation of his billing privileges, I do have the authority to consider whether CMS had a legitimate basis for finding that May 1, 2012, is the effective date of Petitioner's reactivated billing privileges.

The relevant regulation states:

> The effective date for billing privileges for physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations is the later of the date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor or the date an enrolled physician or nonphysician practitioner first began furnishing services at a new practice location.

42 C.F.R. § 424.520(d). The date of filing is the date that the Medicare contractor receives a signed provider or supplier enrollment application that the Medicare contractor is able to process to approval. *Tri-Valley Family Medicine, Inc.*, DAB No. 2358 (2010). The regulation at 42 C.F.R. § 424.521 limits a supplier's retrospective billing privileges to 30 days prior to the effective date, except in circumstances not applicable here.

Cahaba GBA first received an enrollment application from Petitioner seeking reactivation of his billing privileges on May 1, 2012. The application was processed to approval, and Petitioner received the PTAN 202i944710. Under the regulations, May 1, 2012, is the earliest effective date Petitioner could receive. April 1, 2012, is the earliest date on which Petitioner could retrospectively bill for his services.

4. Petitioner is not entitled to equitable relief.

Petitioner states that from September 2011 through April 2012 he traveled to the Vascular Access Center of Atlanta to perform procedures necessary to save the legs of many patients. Many of the patients were members of minorities, said by Petitioner to have been neglected by local hospitals and treatment facilities. Petitioner states that he spent on average $8,000 from his own pocket to be certain these patients received proper treatment. Petitioner states that there are currently over $600,000 of unpaid Medicare claims for services he performed during this time period. Petitioner states that if the claims are unpaid the Vascular Center of Atlanta will be forced to close. Petitioner

asserts there are few vascular centers in the Atlanta area and that its closing would leave a heavily populated area with insufficient medical services. P. Ex. 1, at 2-3 ¶¶ 7- 20.

Petitioner argues that regardless of whether he received notice of the deactivation of his billing privileges or not, CMS is not entitled to summary judgment in this case because CMS's decision has had the "unintended and inequitable result" of punishing Petitioner by precluding payment of the claims he submitted between September 2011 and April 2012, thus resulting in Petitioner providing his services for free to patients in the Atlanta community. Petitioner asserts that this is contrary to the Congressional intent behind deactivation which is not to punish but instead to "protect the provider . . . from misuse of its billing number and to protect Medicare Trust Funds from unnecessary payments." P. Br. at 5-6; 42 C.F.R. § 424.540(c); *Horatio Aldredge, M.D., et. al.*, DAB CR2351, at 5 (2011).

Petitioner's argument is ultimately unavailing, at least in this forum, because it amounts to a claim for equitable relief which I am unable to grant. It is well-established that: (1) estoppel cannot be the basis to require payment of funds from the federal treasury; (2) estoppel cannot lie against the government, if at all, absent a showing of affirmative misconduct, such as fraud; and (3) I am not authorized to order payment contrary to law based on equitable grounds. It is well settled that those who deal with the government are expected to know the law and may not rely on the conduct of government agents contrary to law. *See*, *e.g.*, *Office of Personnel Management v. Richmond*, 496 U.S. 414 (1990); *Heckler v. Community Health Services of Crawford County, Inc.*, 467 U.S. 51 (1984); *U.S. Ultrasound*, DAB No. 2302, at 8 (2010); *Oklahoma Heart Hospital*, DAB No. 2183, at 16 (2008); *Wade Pediatrics*, DAB No. 2153, at 22 n.9 (2008), *aff'd*, 567 F.3d 1202 (10th Cir. 2009). Therefore, Petitioner's equitable estoppel argument must be rejected. And it seems important to add this observation, given the procedural history of this case: entities that would participate in Medicare as providers or suppliers are responsible for making themselves aware of, and for complying promptly and carefully with, all the myriad regulatory provisions that govern their eligibility. Such entities may choose to ignore or disregard those provisions as trivial or bothersome, but they do so at risk of that eligibility. *Manor of Wayne Skilled Nursing and Rehabilitation*, DAB No. 2249, at 11 (2009); *Cary Health and Rehabilitation Center*, DAB No. 1771, at 21 n.5 (2001); *Kids Med (Delta Medical Branch)*, DAB CR2494 (2012); *Brookside Rehabilitation and Care Center*, DAB CR1541 (2006); *The Heritage Center*, DAB CR1219 (2004).

III. Conclusion

I grant CMS's motion for summary judgment. Petitioner's effective date remains May 1, 2012, with a 30 day retrospective billing period beginning on April 1, 2012.

/s/
Richard J. Smith
Administrative Law Judge