Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: July 10, 2008
Oklahoma Heart Hospital,	
Petitioner,	Civil Remedies CR1719 App. Div. Docket No. A-08-68
- v. -	Decision No. 2183
Centers for Medicare & Medicaid Services	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Oklahoma Heart Hospital (OHH) appealed the January 4, 2008 decision by Administrative Law Judge Richard J. Smith. Oklahoma Heart Hospital, DAB No. CR1719 (2008) (ALJ Decision). The ALJ Decision upheld the determination of the Centers for Medicare & Medicaid Services (CMS) that the effective date of OHH's Medicare provider agreement is October 25, 2002.

For the reasons discussed below, we uphold the ALJ Decision. First, we determine that OHH's request for review of the ALJ Decision was timely filed. Second, we conclude that it is unnecessary to decide whether the ALJ made a procedural error by entering summary judgment in favor of CMS because any such error would be harmless in this case. Next, we explain why we uphold the ALJ's finding that CMS properly determined October 25, 2002 to be the effective date of OHH's Medicare provider agreement. Finally, we discuss our conclusion that the ALJ did not err in finding that he had no authority to provide equitable relief to OHH.

Background

The following undisputed facts are drawn from the ALJ Decision and the record below.

OHH is a hospital specializing in cardiac care. In November and December 2001, prior to commencing operations, OHH represented to its Medicare fiscal intermediary at the time, Chisholm Administrative Services (Chisholm), that it intended to be inspected for Medicare certification purposes by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)(a national accrediting organization whose program has CMS approval). ALJ Decision at 6, citing Petitioner (P.) Ex. 4; P. Brief in Support of Summary Judgment (S.J. Br.) at 6. On May 15, 2002, OHH submitted to Chisholm an application to participate in the Medicare program. ALJ Decision at 6, citing P. Ex. 4, at 1; P. S.J. Br. at 6. On July 8, 2002, Chisholm sent a letter to CMS recommending approval of OHH's application. Id. Immediately thereafter, OHH filed a request for a survey by JCAHO to establish its compliance with the federal requirements for participation in the Medicare program. ALJ Decision at 6, citing P. Ex. 4, at 1; P. S.J. Br. at 6.

On August 12, 2002, the Oklahoma State Department of Health (State agency) surveyed OHH for State licensing purposes. ALJ Decision at 7, citing P. Ex. 4, at 1; P. Ex. 8. The State agency found OHH in compliance with the State standards and issued a State license to OHH to conduct and maintain a hospital effective August 13, 2002. Id. OHH commenced operations the following day, August 14, 2002. ALJ Decision at 7, citing P. Ex. 4, at 1.

JCAHO conducted the federal Medicare accreditation survey of OHH on October 23 and 24, 2002. ALJ Decision at 7, citing P. Ex. 4, at 2. Based on that survey, JCAHO granted OHH accreditation effective October 25, 2002. P. Ex. 3, at 2.

CMS issued an initial determination on February 14, 2003, that the effective date for OHH's provider agreement and participation in the Medicare program was October 25, 2002. P. Ex. 1.

On April 14, 2003, OHH filed a request for reconsideration of CMS's action, seeking a Medicare participation effective date prior to October 25, 2002. In its request, OHH stated that it had reasonably relied on the erroneous advice of a Chisholm representative about the Medicare enrollment process. In particular, OHH submitted, Chisholm's representative repeatedly told OHH that it would be permitted to "back-bill" and receive compensation for services provided from OHH's opening date

(August 14, 2002) until the time its application for enrollment in Medicare was approved. OHH submitted that it furnished to Medicare beneficiaries over $12 million in services prior to October 25, 2002, believing that the services would be covered and that it would receive approximately $5.6 million in Medicare payments for them. P. Ex. 2.

By letter dated March 2, 2007, CMS issued its determination on OHH's request for reconsideration. P. Ex. 3. CMS determined that the governing regulation at 42 C.F.R. § 489.13 did not permit CMS to change the effective date of OHH's Medicare provider agreement from October 25, 2002 to August 14, 2002. Id.

Standard of Review

The Board reviews an ALJ's entry of summary judgment de novo. Madison Health Care, Inc., DAB No. 1927, at 4 (2004); Puget Sound Behavioral Health, DAB No. 1944, at 6 (2004), aff'd sub nom. County of Pierce v. Leavitt, 244 F.App'x 802 (9th Cir. 2007). Summary disposition without an oral hearing of appeals involving a provider's participation in the Medicare and Medicaid programs is permissible if there are no genuine issues of material fact. Puget Sound at 6-7, citing Crestview Parke Care Center, DAB No. 1836 (2002), rev'd sub nom. Crestview Parke Care Center v. Thompson, 373 F.3d 743 (6th Cir. 2004); Vandalia Park, DAB No. 1939 (2004); Everett Rehabilitation and Medical Center, DAB No. 1628, at 3 (1997), citing Travers v. Shalala, 20 F.3d 993, 998 (9th Cir. 1994).

The Board's guidelines state that "[t]he bases for modifying, reversing, or remanding an ALJ decision include the following: . . . a prejudicial error of procedure . . . was committed." Guidelines for Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs (DAB Guidelines), http://www.hhs.gov/dab/guidelines/prov.html.

Discussion

1. OHH's request for review was timely.

CMS argues that OHH's request for review of the ALJ Decision should be dismissed as untimely. CMS contends that the ALJ Decision "was issued on January 4, 2008." CMS Resp. Br. at 2. Under 42 C.F.R. § 498.82(a)(2), OHH was required to file its request for review within 60 days from its receipt of the notice

of the ALJ Decision. Sections 498.82(a)(2) and 498.22(b)(3)[1] provide that receipt is presumed to be five days after the date on the notice unless there is a showing that it was, in fact, received earlier or later. Thus, CMS argues, "[a]dding those 5 days to the date the Decision was issued would give [OHH] until Monday, March 10, to file its Request for Review." CMS Resp. Br. at 2. CMS contends that, since OHH did not file its request for review until March 14, 2008, the appeal was untimely.

Replying to CMS's argument, OHH submitted to the Board an affidavit of OHH counsel's executive legal secretary, stating that notice of the transmittal letter and the ALJ Decision were received by OHH counsel on January 15, 2008. Thus, OHH argues, it was required to submit the request for review no later than March 15, 2008, which it did.[2]

OHH's appeal was timely filed. CMS has provided no evidence or argument to dispute the affidavit of counsel's secretary stating that OHH counsel received notice of the ALJ Decision on January 15, 2008. Furthermore, the January 8, 2008 letter from the Chief of the Civil Remedies Division transmitting the ALJ Decision to the parties was sent, as indicated on the letter, via "certified mail-return receipt requested." Included in the record of this case (which was transferred from the Civil Remedies Division to the Appellate Division of the Board after the request for review of the ALJ Decision was filed) are the postal service return receipts showing the dates the parties in fact received notice of the ALJ Decision. The return receipt for the documents sent to OHH counsel shows that the documents were indeed received on January 15, 2008. Since 60 days following January 15, 2008 was

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[1] While section 498.82(b)(2) cross-references "section 498.22(c)(3)," there is no such subsection. Since the rule governing presumption of receipt is set forth at subsection 498.22(b)(3), we treat it as the intended, applicable provision.

[2] OHH argues, alternatively, that the January 8, 2008 letter transmitting the ALJ Decision was the "notice" of the Decision. Applying the five-day regulatory presumption of receipt, and taking into account that the postal service does not deliver on Sundays, OHH argues that it should be presumed to have received notice of the Decision on January 14, 2008. Both parties submitted additional pleadings relating to this argument. We do not address them, however, since the evidence conclusively establishes that OHH received the transmittal letter and the ALJ Decision on January 15, 2008.

March 15, 2008, OHH was required to file its request for review no later than March 15, 2008. 42 C.F.R. § 498.82(a)(2). Thus, OHH's request for review, which was filed on March 14, 2008, was timely.

Accordingly, we reject CMS's request that the Board dismiss OHH's request for review as untimely.

2. The ALJ did not commit a reversible procedural error by granting summary judgment in favor of CMS.

The ALJ determined that summary judgment was appropriate in this matter because there were no disputed issues of material fact. ALJ Decision, Finding of Fact and Conclusion of Law (FFCL) A.

OHH argues that the ALJ committed a prejudicial procedural error because he granted summary judgment in favor of CMS sua sponte, without providing prior notice to OHH of his intent to do so. OHH submits that CMS requested the ALJ to dismiss the appeal, not to enter summary judgment in its favor. According to OHH, Federal Rule of Civil Procedure 56(c) permits courts to grant summary judgment sua sponte in limited instances, but a court's power "is tempered by the requirement to provide prior notice." P. Br. at 10, citing Celotex Corp. v. Catrett, 477 U.S. 317, 326 (1986). In this case, OHH argues, that requirement was not met. Further, OHH argues, the Fifth Circuit Court of Appeals strictly enforces the requirement of the rule that the court notify the party against whom it intends to enter summary judgment at least ten days before doing so. P. Br. at 10-11, citing Powell v. U.S., 849 F.2d 1576, 1579 (5th Cir. 1988); Leatherman v. Tarrant County Narcotics Intelligence and Coordination Unit, 28 F.3d 1388 (5th Cir. 1994).[3]

[3] OHH also cites Horn v. City of Chicago, 860 F.2d 700, 702-04 n.6 (7th cir. 1988), to support the contention that circuit courts have held that "it is improper to convert motions to dismiss into motions for summary judgment," as the ALJ did in this case. P. Br. at 11. Horn, however, is inapposite. At the time the district court entered summary judgment in favor of plaintiffs in that case, the only motions pending were plaintiffs' motion for a preliminary injunction and defendant's motion to dismiss for failure to state a claim and on the ground that the court should abstain from exercising jurisdiction under the doctrine of Younger v. Harris, 401 U.S. 37 (1971). The district court "converted defendants' motion into one for summary judgment, and proceeded to grant summary judgment in favor of the

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The regulations at Part 498 do not include rules for determining when summary judgment is appropriate. While some ALJs have notified parties that they will apply Rule 56, the pre-hearing orders in this case did not give such notice. The Board has concluded "that an ALJ may not hold parties to the Rule 56 procedures without notice, but that the federal rule nonetheless provides helpful guidance on the standard to apply." Wade Pediatrics, DAB No. 2153, at 16 (2008), citing Thelma Walley, DAB No. 1367 (1992).

In this case, after OHH filed its request for an ALJ hearing to review CMS's reconsideration determination, each party filed a notice of issues for which it intended to seek summary judgment. Each party represented in its notice that the legal issues involved would permit the ALJ to decide the case on dispositive motions. In response to the parties' representations, the ALJ issued an Order on July 13, 2007, stating that he intended to "proceed on dispositive motions." The Order established a briefing schedule, which included the dates for OHH to file its "motion for summary judgment, with supporting brief," for CMS to file its "answer brief," for OHH to file its reply to CMS's answer, and for CMS to file a response. The parties filed their motions and briefs in accordance with the schedule, and the ALJ thereafter issued the Decision.

We conclude that we need not decide whether the ALJ committed a procedural error by entering summary judgment in favor of CMS without formal notice because even if he did, it was not reversible error. In a factually similar case, Community Home Health, DAB No. 2134 (2007), the Board recently held that an ALJ's sua sponte entry of summary judgment against the petitioner without giving prior notice and opportunity to submit additional evidence was not reversible error where: 1) the petitioner itself had moved for summary judgment against CMS on the issue on which the ALJ entered summary judgment; 2) the petitioner had submitted uncontested evidence on the issue and represented that there was no material dispute of fact precluding summary judgment in its favor; 3) the petitioner could not show that it could have presented additional evidence material to its claim; 4) the petitioner had not moved to submit new evidence on appeal (as allowed under 42 C.F.R. § 498.86) that might have shown the

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plaintiffs." Horn, 860 F.2d at 702-03. As discussed in the text, the procedural history in the present case was significantly different.

existence of a material dispute of fact; and 5) the petitioner could not point to any such evidence when directly asked during oral argument before the Board why the Board should remand to the ALJ absent the proffer of such evidence. Id. at 8-10.

In support of its decision, the Board in Community Home Health cited numerous federal court decisions in which, under procedural circumstances similar to those presented, courts declined to find error, or at least reversible error. DAB No. 2134, at 9-10, citing Goldstein v. Fidelity and Guaranty Insurance Underwriters, 86 F.3d 749 (7th Cir. 1996); Bridgeway Corp. v. Citibank, 201 F.3d 134 (2d Cir. 2000); Cool Fuel, Inc. v. Connett, 685 F.2d 309, 311-12 (9th Cir. 1982); Exxon Corp. v. St. Paul Fire and Marine Ins. Co., 129 F.3d 781, 786-87 (5th Cir. 1997). Particularly noteworthy here, in Exxon, the Fifth Circuit Court of Appeals upheld a district court's entry of summary judgment for the insured party on the insurer's motion for summary judgment even though the district court had not provided prior notice of its intent to do so. The Court of Appeals determined that the only issues remaining were questions of law, that the insurer had been offered ample opportunity to present evidence and argument, and that the insurer had indicated by its litigation choices that it had no further evidence to present or argument to make. Exxon, 129 F.3d at 786-87.

Furthermore, we note that despite its adherence to the ten-day notice rule, the Fifth Circuit Court of Appeals "recognizes a harmless error exception to [that] rule." O'Hara v. General Motors Corp. 508 F.3d 753, 764 (5th Cir. 2007), citing Leatherman v. Tarrant County Narcotics Intelligence & Coordination Unit, 28 F.3d 1388, 1398 (5th Cir. 1994); see also Nowlin v. Resolution Trust Corp., 33 F.3d 498, 504 (5th Cir. 1994). The court has held that "summary judgment will be considered harmless if the [losing party] has no additional evidence or if all of [that party's] additional evidence is reviewed by the appellate court and none of the evidence presents a genuine issue of material fact." Leatherman, 28 F.3d at 1398 (quoting Resolution Trust Corp. v. Sharif-Munir-Davidson Dev. Corp., 992 F.2d 1398, 1403 n.7).

As in Community Home Health, we conclude that the petitioner in this matter was not prejudiced by the ALJ's entry of summary judgment in favor of CMS without further advance notice. First, OHH itself moved for summary judgment on the issue on which the ALJ granted summary judgment (in this case, the effective date of OHH's Medicare participation agreement under the applicable Medicare regulations). Second, in its brief in support of summary judgment, OHH submitted that the case could be resolved

through the submission of dispositive motions. Third, while in its request for review of the ALJ Decision, OHH makes general allegations of prejudice resulting from the ALJ's deciding the case on summary judgment, it does not identify with any specificity the nature of that prejudice or point to additional material evidence that it would have submitted had it received further notice. Fourth, while OHH is permitted under 42 C.F.R. § 498.86 to move to submit new evidence on appeal to show the existence of a material dispute of fact, it has not done so.

Furthermore, given the procedural history of this case, any additional notice by the ALJ of his intent to enter summary judgment in favor of CMS would have been superfluous. As noted above, each party filed below a notice of issues for which it intended to seek summary judgment. CMS's notice stated that it believed there were no relevant and material facts in dispute and that the only outstanding issues involved the interpretation and application of the relevant regulations. CMS's notice further stated that it was "prepared to present its own Motion for Summary Judgment, or [would] respond to a Motion by [OHH], as the Court determines to be appropriate." CMS Notice of Issues for Summary Judgment at 4. The ALJ's July 13 Order establishing the briefing schedule stated that CMS's brief should be styled as an "answer brief." Thus, while CMS captioned its motion not as a cross-motion for summary judgment, but as a "Response to [OHH's] Motion for Summary Judgment, and Brief in Support," in accordance with the ALJ's Order, OHH cannot reasonably claim that it had no notice that CMS in effect sought the relief granted by the ALJ.

Indeed, while CMS asked the ALJ to deny OHH's motion for summary judgment and "dismiss [OHH's] appeal," CMS simultaneously argued in its brief that the ALJ should conclude as a matter of law that: CMS could not pay OHH claims for services furnished before OHH had a Medicare provider agreement; CMS could not grant OHH a certification date prior to the JCAHO survey; the State agency survey could not substitute for the JCAHO survey; the rule in the regulations for granting a retroactive certification date was inapplicable; and the ALJ did not have authority to grant relief based on theories of equity. In short, CMS asked the ALJ to resolve the legal questions raised by the parties as he did.

This was consistent with CMS's notice of issues for which it intended to seek summary judgment, which similarly identified the issues requiring resolution. Thus, OHH had notice and opportunity to anticipate and address the grounds on which the ALJ ultimately entered summary judgment in favor of CMS. In fact, OHH's briefs did address the legal questions resolved in the ALJ Decision. In support of its motion for summary judgment

OHH acknowledged that "[t]he parties [had] conceptually agreed in their Notices of Issues for Summary Judgment [on] . . . the . . . issues . . . subject to summary disposition," and the OHH brief addressed these issues. P. S.J. Br. at 2-3. OHH further was given an opportunity to file a reply to CMS's response brief and did file a reply in which OHH again addressed the very issues that were resolved by the ALJ Decision.

Accordingly, we conclude that even if the ALJ committed a procedural error in entering summary judgment sua sponte in favor of CMS without providing additional notice, OHH was not prejudiced by this action. Consequently, we find no basis for reversing the ALJ Decision on procedural grounds.

We do note, however, that the ALJ Decision does not state the standard of review that the ALJ applied in reaching his findings and conclusions. When evaluating whether to enter summary judgment against OHH (either sua sponte or treating CMS's pleading as a cross-motion for summary judgment), the ALJ was required (as are we) to consider the facts in the light most favorable to OHH and to draw all reasonable inferences in favor of OHH. See, e.g., Wade Pediatrics at 16-17, citing U.S. v. Diebold, Inc., 369 U.S. 654, 655 (1962); Sagan v. U.S., 342 F.3d 493, 497 (6th Cir., 2003); see also Premcor USA, Inc. v. Am. Home Assurance Co., 400 F.3d 523, 526 (7th Cir. 2005)("With cross-motions, we construe the evidence and all reasonable inferences in favor of the party against whom the motion under consideration is made."). For the reasons discussed in detail below, considering the facts in the light most favorable to OHH and drawing all reasonable inferences in favor of OHH, we conclude that the ALJ properly upheld CMS's determination that the effective date of OHH's Medicare provider agreement was October 25, 2002.

3. The ALJ did not err in concluding that CMS accurately determined October 25, 2002 as the effective date of OHH's Medicare certification. FFCL B.

To participate in Medicare, a hospital must enter into a provider agreement with CMS. Social Security Act (Act),[4] § 1866; 42

[4] The current version of the Social Security Act can be found at www.ssa.gov/OP_Home/ssact/comp-ssa.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross reference

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C.F.R. § 489.3. Before CMS will accept an agreement from a provider, the provider must meet the federal conditions of participation relevant to that provider. 42 C.F.R. §§ 488.3(a), 489.10. The conditions and standards for hospitals participating in Medicare are set forth in 42 C.F.R. Part 482.

The rules for determining the effective date of a Medicare provider agreement state:

> (a) *Applicability--(1) General rule*. Except as provided in paragraph (a)(2) of this section, this section applies to Medicare provider agreements with . . . entities that, as a basis for participation in Medicare--
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> (i) Are subject to survey and certification by CMS or the State survey agency; or
>
> (ii) Are deemed to meet Federal requirements on the basis of accreditation by an accrediting organization whose program has CMS approval at the time of [the] accreditation survey and accreditation decision.
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> * * *
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> (b) *All Federal requirements are met on the date of survey.* The agreement or approval is effective on the date the survey . . . is completed, if on that date the provider or supplier meets all applicable Federal requirements as set forth in this chapter. . . .
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> * * *
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> (d) *Accredited provider or supplier requests participation in the Medicare program--(1) General rule.* If the provider or supplier is currently accredited by a national accrediting organization whose program had CMS approval at the time of [the] accreditation survey and accreditation decision, and on the basis of accreditation, CMS has deemed the provider or supplier to meet Federal requirements, the

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table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp Table.

> effective date depends on whether the provider or supplier is subject to requirements in addition to those included in the accrediting organization's approved program.
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> * * * *
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> (ii) *Provider or supplier not subject to additional requirements.* For a provider or supplier that is not subject to additional requirements, the effective date is the date of the provider's or supplier's initial request for participation if on that date the provider or supplier met all Federal requirements.
>
> (2) *Special rule: Retroactive effective date*. If a provider or supplier meets the requirements of paragraphs (d)(1) and (d)(1)(i) or (d)(1)(ii) of this section, the effective date may be retroactive for up to one year to encompass dates on which the provider or supplier furnished, to a Medicare beneficiary, covered services for which it has not been paid.

42 C.F.R. § 489.13.

OHH argues that the ALJ erroneously determined that October 25, 2002 is the effective date of OHH's Medicare certification under the governing regulations. OHH asserts that under section 489.13, payment for services furnished to beneficiaries before "a provider's formal acceptance into the Medicare program is permitted as of the date that the prospective provider 'met all federal requirements.'" P. Br. at 12. In this case, OHH contends, it met all federal requirements as of its opening date, August 14, 2002, after it had "undergone a successful survey under the [State agency's] hospital licensing regulations [which are] substantially similar to the Medicare conditions of participation for hospitals." P. Br. at 12, citing OHH Motion for Summary Judgment at 11-13; P. Exs. 6-8. In addition, OHH submits, it "also produced evidence of the results of a successful survey . . . by Blue Cross and Blue Shield of Oklahoma, and of the standard used for such survey." P. Br. at 12, citing P. Ex. 9.

OHH acknowledges that in prior cases the Board has held that a state licensing survey is not equivalent to a survey to establish compliance with the federal Medicare requirements. P. Br. at 13,

citing Community Hospital of Long Beach, DAB No. 1938 (2004). OHH submits, however, that the facts in this case are distinguishable because here the hospital "presented undisputed evidence of a successful licensure survey and of the equivalency of the state and federal requirements." P. Br. at 13. In support of its position, OHH points to: 1) a chart that it created, which compares the Medicare conditions of participation for hospitals and the State hospital licensing requirements; 2) a letter from the Oklahoma Commissioner of Health which states that the State and federal requirements are "substantially the same," and that, to the extent they are not, the State agency "review[ed] inspections performed by other accrediting organizations, which . . . found that the facility was compliant with [the Medicare standards];" 3) the State agency notice of licensure; and 4) the results of the Blue Cross Blue Shield survey. P. Exs. 6-9; P. Br. at 12-13.

OHH's arguments are unavailing. Section 489.13 sets forth "uniform criteria for determining the effective dates of Medicare and Medicaid provider agreements . . . when the provider . . . is subject to survey and certification as a basis for determining participation in those programs." 62 Fed. Reg. 43,931 (1997). Generally, under section 489.13(a)(1)(i) and 489.13(b), a provider that is surveyed by a State survey agency on behalf of CMS to determine its compliance with the federal standards will have a provider agreement effective date as of "the date the survey . . . is completed, if on that date the provider . . . meets all applicable Federal requirements."[5]

Contrary to OHH's claim, the August 12, 2002 State agency survey of OHH is not a valid substitute for the Medicare compliance survey required under section 489.13. As the ALJ correctly observed, the State agency survey was conducted only for State licensing purposes and not for certification of the facility's compliance with the federal Medicare participation requirements. ALJ Decision at 8. Further, even if the State hospital licensing

[5] As noted in Community Hospital of Long Beach, DAB No. 1938 (2004), before 1980, the effective date of a Medicare agreement could predate the compliance survey. Medicare "permitted retroactivity, if requirements were met, to the date a facility first opened or the date on which it first requested participation." 45 Fed. Reg. 22,933 (April 4, 1980). In 1980, CMS adopted 42 C.F.R. § 489.13 to establish an effective date no earlier than the date of the survey for providers subject to survey and certification by CMS or a state survey agency. DAB No. 1938, at 9, n.5.

requirements could be viewed as "substantially similar" to the Medicare conditions and standards of participation, as OHH submits, they are not the same.

Moreover, as the Board has previously stated, the statutes and regulations setting forth the Medicare provider participation requirements are intended to "protect the health and safety of the patients who are the intended beneficiaries of the program, and this interest outweighs any interest the provider might have in program participation." Hillman Rehabilitation Center, DAB No. 1611 at 16 (1997), aff'd Hillman Rehabilitation Ctr. v. HHS, No. 98-3789 (GEB) (D.N.J. May 13, 1999). To that end, Congress established in the certification and participation requirements of the Act that an affirmative determination certifying compliance must be made for a provider to qualify. Id. at 13-14. Under the statute and regulations, that affirmative determination is premised on survey findings made by or on behalf of CMS conclusively establishing a provider's compliance with all of the federal conditions and standards set forth under the relevant regulations. Neither the statute nor the regulations contemplate or permit the determination to be based on an evaluation of the provider undertaken for State licensing purposes.

OHH alternatively argues that the ALJ erroneously determined that it did not qualify for an effective date earlier than October 25, 2002, based on section 489.13(d) of the regulations. According to OHH, the plain language of subsection 489.13(d) "permits application of a retroactive effective date for the Medicare certification of accredited providers." P. Br. at 15. OHH also argues that it qualifies for a retroactive effective date under the "special rule" of subsection 489.13(d)(2). OHH contends that the ALJ erred in adopting CMS's interpretation of the special rule, i.e., that it "does not apply unless a hospital was 'previously accredited by a CMS-approved accreditation entity'" when it sought participation in Medicare. P. Br. at 17, quoting ALJ Decision at 9.

OHH's reliance on section 489.13(d) of the regulations is misplaced. Section 1865 of the Act and 42 C.F.R. §§ 489.13(a)(ii) and 489.13(d) establish that CMS may deem a facility to meet the federal Medicare participation requirements on the basis of the facility's accreditation by an organization such as JCAHO. Subsection 489.13(d)(1) begins in the present tense, "If the provider or supplier is currently accredited . . . ." Any ambiguity in the use of the word "currently" as to the timing or sequence of the provider's accreditation and request for participation, however, is resolved by the context and history of the regulation. In particular, the

Federal Register preamble to the final rule explains that the regulation was promulgated to address situations wherein a "facility is accredited *before* it seeks participation." 62 Fed. Reg. at 43,931, 43,933 (1997)(emphasis added); see also 57 Fed. Reg. 46,362-46,363 (describing the proposed regulation as "establish[ing] rules to govern providers/suppliers that apply to participate in Medicare after they have been deemed to meet Federal requirements . . . by a [CMS]-approved accreditation organization."). Furthermore, the lead-in language of subsection 489.13(d), "Accredited provider . . . requests participation in the Medicare program," describes a provider that is already accredited at the time of its request.

Under the "general rule" of subsection 489.13(d)(1), when a provider is accredited by JCAHO, and "on the basis of accreditation, CMS has deemed the provider . . . to meet [the] Federal requirements," the effective date of the participation agreement depends on whether the facility is subject to requirements in addition to those included in JCAHO's approved program. 42 C.F.R. § 489.13(d)(1). For facilities such as OHH, which are not subject to additional requirements, the effective date is "the date of the provider's . . . initial request for participation *if on that date the provider or supplier met all Federal requirements."* 42 C.F.R. § 489.13(d)(1)(ii)(emphasis added). Since a facility that qualifies for participation in Medicare on the basis of JCAHO accreditation cannot be deemed to have met all federal requirements until the JCAHO survey is completed and the facility has received accreditation, the effective date of such a facility's provider agreement can be no earlier than the date JCAHO completed its onsite survey and issued the facility's accreditation.

Accordingly, applying the "general rule" of subsection 42 C.F.R. § 489.13(d) to the facts presented in this case, the effective date of OHH's participation agreement could be no earlier than October 25, 2002, the date that JCAHO accredited OHH based on the survey conducted on October 23-24, notwithstanding the fact that OHH submitted its application to participate in Medicare in May 2002.

OHH's reliance on the special rule of subsection 489.13(d)(2) is also unavailing. Under that provision, CMS may establish a retroactive effective date for a provider that has been deemed to meet the federal requirements based on accreditation "to encompass dates on which the provider . . . furnished, to a Medicare beneficiary, covered services for which it has not been paid." The Board previously addressed the language and meaning of the special rule in Puget Sound. In that decision, the Board

relied on the language in the preamble to the final rule that addresses public comments suggesting that the regulation should permit a facility that had been accredited before it sought participation in Medicare or Medicaid to receive payment for services furnished during the period between those dates. Id. at 13-14, citing 62 Fed. Reg. at 43,933. The Board wrote in Puget Sound:

> The language as a whole . . . support[s] CMS's position that the special rule was adopted to provide authority to make payment under special conditions that assured that the providers in question were in compliance with the participation requirements at the time the services were provided, e.g., because they were already participating in one State's Medicaid program or because they had already been accredited by an approved organization.

Id. at 14. Further, the Board held, the retroactivity provision "is in the nature of a limited exception to be construed narrowly," since there is no express authority for it in the Act and since the statute "clearly requires providers to be qualified in order to be paid." Id.

In this case, we conclude that the ALJ properly found the special rule inapplicable. The conditions that the rule was intended to address do not exist here. Specifically, OHH had not received accreditation before it sought to participate in Medicare. And, as discussed above, the State agency's survey did not provide assurance that OHH was in compliance with the federal requirements at the time the services for which OHH seeks additional reimbursement were provided. Indeed, that assurance was not made until JCAHO had completed its October 23-24, 2002 accreditation survey of OHH and determined OHH to be accredited as of October 25, 2002.

Accordingly, we affirm FFCLs B, B.1., B.2. and B.3. of the ALJ Decision, which provide:

> B. CMS accurately determined October 25, 2002 as the effective date of [OHH's] Medicare certification.
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> 1. [OHH] became eligible to participate in the Medicare program on October 25, 2002, the date of the completion of the survey conducted by the JCAHO which established that [OHH] met all Medicare participation requirements.

> 2. A State agency's survey for state licensing does not equate to a survey to certify a provider for Medicare participation.
>
> 3. [OHH] does not qualify for the "Special Rule" exception under 42 C.F.R. §§ 489.13(d)(1)(ii) and (d)(2).

4. The ALJ did not err in concluding he had no authority under equitable principles to establish an effective date for OHH's Medicare participation prior to October 25, 2002. FFCL C.

OHH argues that the ALJ incorrectly determined that he lacked authority to require CMS to establish an effective date prior to October 25, 2002 and to consider OHH's financial condition under any equitable estoppel theory. OHH states that it cited in its motion for summary judgment a number of federal court decisions supporting the application of equitable estoppel in situations involving reliance on the erroneous advice of a government agency. While the hospital acknowledges the administrative decisions cited by the ALJ to support his conclusion, OHH states that it disagrees with them and wishes to preserve for appeal its contentions that equitable principles should be applied in this case in the event that it is not granted relief through the administrative appeals process.

The Board has previously held in addressing whether a provider met relevant federal requirements:

> [T]o the extent Petitioner is seeking a remedy in the nature of damages based purely on equitable grounds, the ALJ did not have the authority to grant that remedy. In this case, the inquiry before the ALJ ends once there is a legally and factually sound determination that Petitioner did not meet the statutory and regulatory requirements for [community mental health center] certification.

Community Hospital of Long Beach at 12, quoting National Behavioral Center, Inc., DAB No. 1760, at 3-4 (2001); cf. Big Bend Hospital Corp., DAB No. 1814, at 24-25.

The ALJ and the Board are bound by the effective date provisions of 42 C.F.R. § 489.13. Consideration of equitable theories of relief is beyond the scope of our review.

Accordingly, we affirm FFCL C of the ALJ Decision that:

> [The ALJ did] not have authority under any equitable theory to require CMS to establish an effective date prior to October 25, 2002.

Conclusion

For the reasons discussed above, we sustain the ALJ's holding that the effective date of OHH's provider agreement is October 25, 2002.

/s/
Judith A. Ballard

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member