Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Day Op of North Nassau, Inc.
Docket No. A-17-54
Decision No. 2818
September 15, 2017

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Day Op of North Nassau, Inc. (Day Op), a provider of ambulatory surgical center (ASC) services, appeals the ruling of an administrative law judge (ALJ) dismissing Day Op's request for a hearing on the Centers for Medicare & Medicaid Services' (CMS) termination of Day Op's participation in the Medicare program. *Day Op of North Nassau, Inc*., ALJ Ruling No. 2017-7 (January 6, 2017). The ALJ dismissed the hearing request after concluding it was not filed within the time limit provided in 42 C.F.R. § 498.40(a)(2) and Day Op had not shown good cause for the late filing. Day Op does not deny that the filing was late but claims the ALJ erred in finding it had not demonstrated good cause for the late filing.

For the reasons explained below, we affirm the ruling and dismissal.

Legal Background

Federal regulations define an ASC as "any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission." 42 C.F.R. § 416.2. An ASC meeting that definition may participate in the Medicare program under an agreement with the Secretary of Health and Human Services (Secretary) provided the ASC meets certain conditions and requirements. *Id*.; 42 U.S.C. §§ 1395k(a)(2)(F)(i), 1395*l*(a)(1). Specifically, the ASC must meet the general conditions and requirements specified at 42 C.F.R. Part 416, Subpart B, as well as specific conditions for coverage at 42 C.F.R. Part 416, Subpart C. 42 C.F.R. § 488.3(a)(1)(2). Absent deemed compliance with the conditions for coverage (where CMS accepts an accrediting agency's assurances that the ASC meets the conditions), the State survey agency must survey the ASC to ascertain its compliance with those conditions and report its findings to CMS. 42 C.F.R. § 416.26(a), (b).

CMS may terminate an ASC's Medicare agreement for cause if it determines that the ASC no longer meets the ASC conditions for coverage or is not in substantial compliance with the provisions of its agreement or applicable regulations, or any applicable provisions of the Medicare Act. 42 C.F.R. § 416.35(b). CMS sends a notice of termination to the ASC at least 15 days before the effective date of termination stated in the notice, and provides prompt notice of the termination to the public through publication in local newspapers. 42 C.F.R. § 416.35(b)(2) and (d).

An ASC may appeal the termination of its Medicare agreement in accordance with the provisions set forth in 42 C.F.R. Part 498. 42 C.F.R. §§ 416.35(b)(3), 416.26(f). A party has 60 days from receipt of CMS' notice of initial determination to file a request for a hearing with an ALJ, unless the period for filing is extended by the ALJ. 42 C.F.R. § 498.40(a)(2). If a request for an ALJ hearing is not filed within 60 days, the affected party, or its legal representative or other authorized official, may file with the ALJ a written request for extension of time stating the reasons why the request was not filed timely, and "[f]or good cause shown, the ALJ may extend the time for filing the request for hearing." 42 C.F.R. § 498.40(c). An ALJ may dismiss a hearing request if the affected party did not file a hearing request timely and the time for filing has not been extended. 42 C.F.R. § 498.70(c).

Factual Background[1]

The Survey and Termination

Prior to the termination at issue in this appeal, Day Op participated in the Medicare program as an ASC. On September 10, 2014 and September 12, 2014, surveyors from the New York State Department of Health, Bureau of Hospitals and Diagnostic & Treatment Centers (NYSDOH), conducted a recertification survey of Day Op (September survey). *See* CMS Exhibit (Ex.) 22, Declaration (Decl.) of Teresa Nolan, R.N., at 2, ¶ 2; CMS Ex. 23, Decl. of Mary Walters-Franco, R.N., at 1, ¶ 2. On September 26, 2014, NYSDOH notified Day Op that the surveyors had found Day Op not in substantial compliance with Medicare conditions for coverage. ALJ Decision at 1; CMS Ex. 3. The September 26 notice identified the condition at 42 C.F.R. § 416.44 (Environment) as unmet and stated that if Day Op did not submit an acceptable plan of correction resulting in verified correction during a follow-up on-site visit, NYSDOH "will be required to

[1] The facts stated here are taken from the ALJ Decision and the record before the ALJ; we make no new findings of fact. The facts stated here are undisputed unless otherwise indicated.

recommend to CMS that the facility be terminated from the Medicare Program."[2] CMS Ex. 3, at 1. NYSDOH enclosed with the letter a Statement of Deficiencies discussing the noncompliance. *Id*. at 2; CMS Ex. 1.

On October 2, 2014, CMS sent Day Op a letter advising that Day Op's Medicare participation would be terminated effective December 31, 2014. ALJ Decision at 2, citing CMS Ex. 4. The October 2 letter also informed Petitioner that it could submit a plan for correcting its deficiencies and that it had a right to request a hearing before an ALJ "[i]f your Medicare agreement is terminated and you do not believe this termination decision is correct[.]" *Id*., citing CMS Ex. 4, at 1-2; CMS Ex. 4, at 2. On January 12, 2015, CMS sent Day Op a second letter confirming it had terminated Day Op's Medicare participation with an adjusted termination date of January 4, 2015.[3] ALJ Decision at 2, citing CMS Ex. 5. Also, the January 12 letter again informed Day Op of its right to request a hearing before an ALJ in accordance with 42 C.F.R. § 498.40, and stated that the request must be filed within 60 days after receiving the letter. *Id*., citing CMS Ex. 5, at 1-2; CMS Ex. 5, at 1.

CMS never received a plan of correction from Day Op. ALJ Decision at 2, citing CMS Ex. 22 (Nolan Decl. at 4, ¶ 8); *see also* CMS Ex. 5, at 1. Day Op did not file a hearing request, but on April 29, 2016 (approximately 15 months after CMS's January 4, 2015 letter), filed a request for an extension of time to file a hearing request.[4] ALJ Decision at 2, citing CMS Ex. 19.

[2] The "Environment" condition requires facilities to have "a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients."

[3] CMS adjusted the effective date of the termination to allow for publication of the required notice of termination. *Id*.; *see* 42 C.F.R. § 416.35(d).

[4] As CMS Exhibit 19 shows, Day Op erroneously sent its April 29, 2016 extension request to CMS's Associate Regional Administrator who, as CMS Exhibit 20 shows, wrote Day Op on May 10, 2016 to advise that only an ALJ may grant an extension. Day Op did not actually file its extension request with the ALJ until June 16, 2016. *See* Civil Remedies Division Docket Item 1. However, the ALJ accepted April 29, 2016 as the filing date. Although CMS notes Day Op's error and refers to the extension request as having been filed on June 16, 2016, *see* The Centers for Medicare & Medicaid Services' Response to Petitioner's Request for Review (CMS Response) at 9, 13, CMS does not attribute any material significance to this issue, and we find none.

The ALJ Decision

The ALJ found that Day Op had not filed a timely hearing request.

> There is no doubt that [Day Op] failed to file a timely hearing request. Petitioner had 60 days within which to request a hearing from CMS's notification to it of its determination to terminate Petitioner's participation in Medicare. It did not request an extension of the time within which to request a hearing until April 2016, well over a year from the date when CMS effectuated termination of participation.

Id. The ALJ further found that Day Op had not established good cause for the late filing. Before the ALJ, as here, Day Op's "good cause" argument was based on what it asserted was negligent and malicious conduct by a third party, a company called "Freifeld Associates Consulting" and Scott Freifeld, the owner and operator of that company.[5] *Id*. The ALJ accepted Day Op's "assertion that it was the victim of Freifeld's negligent or, perhaps, malicious acts." *Id*. at 3. However, the ALJ found that this did not constitute "good cause" for the late filing of Day Op's hearing request because, the ALJ concluded, "Freifeld was Petitioner's agent and Petitioner bore full responsibility for whatever it was that Freifeld did or did not do." *Id.* Finding no "good cause" to extend the date for filing a hearing request, the ALJ dismissed the untimely hearing request under 42 C.F.R. § 498.70(c).[6]

Standard of Review

"The standard of review for an ALJ's exercise of discretion to dismiss a hearing request where such dismissal is committed by regulation to the discretion of the ALJ is whether the discretion has been abused." *St. George Health Care Ctr*., DAB No. 2645, at 3 (2015), citing *High Tech Home Health, Inc*., DAB No. 2105, at 7-8 (2007), *aff'd, High Tech Home Health, Inc. v. Leavitt*, Civ. No. 0780940 (S.D. Fla. Aug. 15, 2008).

[5] The ALJ referred to the company and its owner collectively as "Freifeld." As we discuss later, it is undisputed that Scott Freifeld was also Day Op's acting administrator at the time of the survey and termination, and our decision uses the term "Freifeld" in that context as well.

[6] The ALJ did not address CMS' additional argument in its motion to dismiss that the hearing request should be dismissed under section 498.70(b) (no right to a hearing) because Day Op acknowledged it did not meet all Medicare conditions of coverage at the time of the survey and was not entitled to an opportunity to correct. *See* CMS Response at 19, n.7. We need not address this issue since we uphold the ALJ Dismissal under section 498.70(c).

Discussion

Under section 498.40(a)(2), Day Op had 60 days after receiving CMS's termination notice to file a request for a hearing. CMS sent two termination notices to Day Op – the October 2, 2014 notice of the impending termination and the January 12, 2015 notice stating that the termination had occurred on January 4 – each of which informed Day Op of its right to request a hearing and explained how to file a request and the time limit for doing so. The first notice also advised Day Op it could file a corrective action plan which could avoid the termination, if CMS accepted the plan and verified its implementation. Although Day Op contends its acting administrator (Freifeld) did not make it aware of these notices, it does not dispute that CMS sent them to Day Op at its address of record or that the acting administrator received them, and the record shows that CMS sent the notices and that they were not returned to CMS. *See* CMS Ex. 21, Decl. of Sherry Mohamed, at 2, 3, ¶¶ 4, 10. Nor does Day Op dispute that it did not file a timely hearing request. Indeed, Day Op effectively conceded it never filed a hearing request by filing the request for an extension of time to file such a request that is the subject of this appeal.[7]

On appeal, as below, Day Op attempts to show "good cause" by attributing the failure to timely file a hearing request (and to submit a corrective action plan) to the alleged negligence or malicious conduct of Freifeld who, Day Op claims, was an independent contractor over whom it had no control.[8] *See* Petitioner's Reply and Opposition to

[7] In any event, under the regulations, receipt of CMS' initial determination notices 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. 42 C.F.R. §§ 498.40(a)(2), 498.22(b)(3); *see also Hiva Vakil*, DAB No. 2460, at 4, n.2 (2012) (five-day receipt presumption applied where neither party showed an earlier or later receipt date). Day Op has made no attempt to rebut the presumption that the notices arrived at its offices no later than five days after the date on each notice).

[8] On December 7, 2016, Day Op sued Freifeld in state court in New York for alleged breach of contract and tortious conduct. RR at 2; Petitioner (P.) Ex. 28. Day Op claims it did not learn of the termination until February 2016 when it received a letter from the Medicare contractor, and that its unawareness of the termination that it attributes to Freifeld "was compounded by Medicare's continued payment of claims filed by Day Op" until February 2016. *See* RR at 3-4; P. Ex. 27, Decl. of Jay Merker, M.D., at 3-4, ¶¶ 11, 14); P. Ex. 26, at 2, Decl. of Stewart Robbins, M.D., at 2, ¶ 9); *see also* CMS Ex. 18 (CMS contractor January 27, 2016 letter). The record does not show why these payments continued beyond the termination date, and Day Op says it subsequently repaid them. As we discuss later, Day Op is responsible for Freifeld's actions and failures to act with respect to its Medicare participation regardless of whether it knew about them. Accordingly, it is not material to our decision whether the erroneously continued payments contributed to Day Op's alleged unawareness of the termination. However, we note that even after Day Op says it first learned of the termination, it did not file its request for an extension of time to file a hearing request for approximately another four months.

Motion to Dismiss at 2, 4-5; Request for Review (RR) at 3-4. The ALJ, as noted above, accepted the assertions about Friefeld's conduct as true but found that this was not "good cause" because --

> Freifeld was [Day Op's] agent and Petitioner bore full responsibility for whatever it was that Freifeld did or did not do. Consequently, Petitioner cannot excuse its failure to file a hearing request timely on the ground that Freifeld failed to act appropriately. For purposes of interacting with Medicare, Freifeld was Petitioner and whatever he did bore Petitioner's imprimatur.

ALJ Decision at 3. Nothing Day Op has argued on appeal causes us to question the ALJ's finding, much less persuades us that he abused his discretion. The Board has held that under an "abuse of discretion" standard, "the reviewer may not simply substitute his or her judgment for that of the person exercising discretion." *Sunview Care & Rehab Center LLC*, DAB No. 2713, at 9 (2016), citing *Vincent Baratta, M.D.*, DAB 1172, at 9, n.5 (1990). "Instead, the reviewing body – here the Board – will consider only whether the decision maker has articulated a reasonable basis for the decision under review, not whether it was the only reasonable decision." *Id.*, citing *River East Econ. Revitalization Corp.*, DAB No. 2087, at 9 (2007). As explained below, we conclude that the ALJ's conclusion that Freifeld's alleged negligence or malicious misconduct was not "good cause" is more than reasonable.

Day Op asserts that while "good cause" is not defined in the regulations governing this proceeding, the Board has defined that term as whether the failure to timely file a hearing request was due to circumstances beyond the control of the party seeking the hearing. RR at 2-3, citing *Hillcrest Healthcare, LLC*, DAB No. 1879 (2003).[9] Day Op misstates Board precedent on this issue. In *Hillcrest*, the ALJ, in the absence of a definition of "good cause" in the Part 498 appeal regulations, had found no good cause by applying a definition of that term that appears in regulations governing hearings before ALJs in cases involving Social Security disability and Supplemental Security Income claims, a definition that, in part, uses the "circumstances beyond the party's ability to control" standard. DAB No. 1879, at 3. On appeal, the Board stated that it "has never attempted to provide an authoritative or complete definition of the term 'good cause' in section 49.40(c)(2)." *Id.* at 4, citing *Glen Rose Medical Ctr. Nursing Ctr.*, DAB No. 1852, at 7, n.5 (2002). The Board then concluded that it did "not need to decide whether the ALJ's definition is appropriate because the ALJ's factual findings support his good cause

[9] Day Op notes the ALJ's statement that the term "good cause" "has generally and universally been held to constitute a situation beyond a party's control." RR at 3; *see* ALJ Decision at 3. The ALJ, however, did not state that the Board has limited the definition to such circumstances, and, as we discussed above, it has not.

determination under any reasonable definition of that term, and because Hillcrest's asserted reasons for failing to file a timely hearing request do not – under our prior decisions – warrant an extension of the filing deadline." DAB No. 1879, at 4. In subsequent decisions, the Board has maintained its holding that it need not provide an authoritative or complete definition of "good cause." *See, e.g.*, *Meridian Nursing & Rehab at Shrewsbury*, DAB No. 2504, at 8 (2013) (reiterating that the Board has not adopted an authoritative or complete definition of "good cause" and concluding it need not define "good cause" in *Meridian* because the Board agreed with the ALJ that "no reasonable definition of 'good cause' encompasses the lapses" for which Meridian (or its representatives) is responsible), *aff'd*, *Meridian Nursing & Rehab at Shrewsbury v. Ctrs. for Medicare & Medicaid Servs.*, 555 Fed. Appx. 177 (3d Cir. 2014); *Kids Med (Delta Medical Branch)*, DAB No. 2471, at 6, 8 (2012) (again stating that the Board has not adopted an authoritative or complete definition of "good cause" and need not do so because Kids Med made no showing of good cause under "any reasonable definition of that term" (internal quotation marks omitted)).

Here yet again, we conclude that the undisputed facts do not show "good cause," under any reasonable definition of that term, for Day Op's belated attempt to file a hearing request. As the ALJ noted, Day Op "concedes [that] Freifeld was Petitioner's agent for purposes of dealing with the Medicare program." ALJ Decision at 3; *see also* P. Ex. 26, Decl. of Stewart Robbins, M.D., at 1, ¶ 4 ("In or about 2013, Day Op retained Freifeld's administrative services for, among other things, supervising Day Op's compliance with applicable Medicare participation conditions. Freifeld worked one to two days per week at Day Op's facility in Great Neck, New York."). Day Op contended before the ALJ, as it does here, that cases such as *Jackson Manor*, DAB CR545, at 5 (1998), where an ALJ held that the "negligence or misfeasance of a party's employee that causes a hearing request to be untimely filed is not good cause," are inapplicable because Freifeld was an independent contractor, not an employee. Petitioner's Reply and Opposition to Motion to Dismiss at 5; RR at 3-4. The ALJ rejected Day Op's attempt to distinguish between an employee and an agent for purposes of the conduct of Medicare providers, and any consequences thereof, with respect to Medicare participation. The ALJ stated,

> I discern no difference in this case between the acts of an employee or those of an agent. Whether an employee or an agent, the person charged with responsibility for dealing with the Medicare program acts on behalf of the entity that retains his or her services for that purpose and is under the entity's control. A facility is equally responsible for the acts of its agents as it is for those of its employees.

ALJ Decision at 3.

Like the ALJ, we find no material significance in the fact that Freifeld may have been acting as an agent or independent contractor rather than an employee when he failed to timely file Day Op's hearing request since there is no dispute that either way he was acting on behalf of Day Op with regard to its dealings with Medicare. Although Day Op's briefing to us avoids this fact, the record clearly shows that Freifeld was Day Op's acting administrator at the time of the survey and termination. *See* CMS Exs. 3; 7; 8, at 2; 15; 16, at 23; 17; 23, at 2, ¶ 7. As such, his actions or inactions with regard to Medicare were on behalf of Day Op regardless of whether he held his position by way of having been hired or contracted.

We reject Day Op's suggestion that the ALJ should have followed common law "principles of general liability" when addressing Day Op's proposed distinction between an employee and an independent contractor. RR at 4 (citing New York cases holding that a principal generally cannot be held responsible for the acts of an independent contractor because, unlike in a master-servant relationship, the principal cannot control how the contractor performs). Federal law – the Medicare statutes and regulations in particular – govern this proceeding, not state law or common law principles. Indeed, in *Kindred Transitional Care and Rehab-Greenfield*, DAB No 2792, at 11-14 (2017), the Board specifically declined to apply common law liability principles, in that case the doctrine of respondeat superior. Although the specific issue in that case was whether the provider, a nursing facility, could avoid liability for the resident abuse committed by an employee (the Board held it could not avoid liability), the Board made it clear that a Medicare provider was also liable for prohibited conduct (or misconduct or inaction) of its agents. *Id*. at 12 ("The statute acts to impose responsibility on facilities for the misconduct of their staff and agents in violation of federal participation standards, even that of which facility owners or management may not be aware, to the full extent of their employment or agency, rather than to restrict liability to the terms of an imported tort concept." (emphasis added)).[10] The Board noted that it "has routinely rejected attempts to import tort principles into federal administrative proceedings involving long-term care facilities that receive federal funding for participating in Medicare and Medicaid." *Id*. at 12 (citations omitted). Although Day Op is an ASC rather than a long-term care facility, we see no reason why the Board's rejection of attempts to import tort law principles would not be equally applicable. In both instances, the provider's participation in the Medicare program – and any appeal rights accorded for adverse initial determinations addressing that participation – is governed by federal statutes and regulations. *Cf. Royal Manor*, DAB No. 1990, at 12 (2005) ("It is the facility that executes a provider agreement and undertakes to provide services . . . mandated by the participation requirements.")

[10] The "statute" referenced was section 1128A(*l*) of the Medicare Act, which provides"[a] principal is liable for penalties, assessments, and an exclusion under this section for the actions of the principal's agent acting within the scope of the agency." The Board rejected the provider's argument that in enacting that statute, Congress "expressly incorporated the doctrine of respondeat superior in the laws authorizing CMS to issue penalties for noncompliance." DAB No. 2792, at 11.

Conclusion

For the reasons stated above, we find no abuse of discretion and affirm the dismissal.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Sheila Ann Hegy
Presiding Board Member