**Department of Health and Human Services**
**DEPARTMENTAL APPEALS BOARD**
**Appellate Division**

Mission Hospital Regional Medical Center
Docket No. A-12-38
Decision No. 2459
May 21, 2012

# FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Mission Hospital Regional Medical Center (Mission) appealed the November 2, 2011 decision of Administrative Law Judge (ALJ) Joseph Grow, *Mission Regional Hospital Medical Center*, DAB No. CR2458 (2011) (ALJ Decision). The ALJ granted summary disposition in favor of the Centers for Medicare & Medicaid Services (CMS), upholding CMS's determination as to the effective date of Medicare enrollment for services provided at Mission's new practice location, a hospital whose assets Mission purchased on June 30, 2009. Mission billed for services provided at that location beginning July 1, 2009. The ALJ concluded that, because Mission did not assume any of the hospital's liabilities at the time of the asset purchase, Mission could not bill for the services that were provided prior to March 18, 2010, when an accrediting organization approved by CMS determined that the new location met applicable health and safety requirements. For the reasons discussed below, we uphold the ALJ's conclusion.

## Legal Background

To participate in Medicare, a provider of services must enroll in the Medicare program and enter into a provider agreement with CMS. Social Security Act (Act)[1] § 1866. As part of the enrollment process, described in 42 C.F.R. Part 424, subpart P, a provider must submit enrollment information on the applicable enrollment application. Generally, in order to enter into a provider agreement, an entity must first be surveyed by a state survey agency to ascertain whether it complies with applicable requirements for Medicare participation. *See* Act § 1864; 42 C.F.R. §§ 488.3(a), 489.2, 489.10(a), (d). CMS may "deem" some types of entities to meet federal requirements if they are properly accredited. Hospitals accredited by The Joint Commission (referred to in the regulation

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

by its former name, JCAHO) "are deemed to meet all of the Medicare conditions of participation" (with certain exceptions not relevant here). 42 C.F.R. § 488.5(a); *see also* 42 C.F.R. § 488.12 ("CMS will determine whether . . . . [a]n accredited hospital is deemed to meet the Medicare conditions of participation or is subject to full review by the State survey agency").

Section 424.520 of 42 C.F.R., captioned "Effective date of Medicare billing privileges," provides that "[i]f a provider or supplier is seeking accreditation from a CMS-approved accreditation organization, the effective date is specified in [42 C.F.R.] §489.13(d)." During the period in question here, section 489.13(d) provided in relevant part: [2]

> (d) *Accredited provider . . . requests participation in the Medicare program*—(1) *General rule*. If the provider . . . 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 . . . to meet Federal requirements, the effective date depends on whether the provider . . . is subject to requirements in addition to those included in the accrediting organization's approved program.
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> (i) *Provider . . . subject to additional requirements*. If the provider or supplier is subject to additional requirements, the effective date of the agreement or approval is the date on which the provider or supplier meets all requirements, including the additional requirements.
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> * * * * *
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> (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.

The regulations at 42 C.F.R. Part 489 also address the effect of a change of ownership on a provider agreement. In the case of corporations, "change of ownership" is defined as "[t]he merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation[.]" 42 C.F.R. § 489.18(a)(3). Section 489.18(c) states that "[w]hen there is a change of ownership . . . , the existing provider agreement will automatically be assigned to the new owner." Section 489.18(d) provides that "[a]n assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued . . . ."

[2] Section 489.13 is quoted as it appears in the 2009 Code of Federal Regulations. In 2010, that section was amended to delete subpart (d). 75 Fed. Reg. 50,042 (Aug. 16, 2010).

**Case Background**

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

Mission, an acute care hospital located in Mission Viejo, California, was accredited by The Joint Commission, a national accrediting organization approved by CMS, and had a Medicare provider agreement. On June 30, 2009, pursuant to the terms of a February 4, 2009 asset purchase agreement, Mission acquired from Adventist Health Systems/West the assets of South Coast Medical Center (South Coast), an acute care hospital located in Laguna Beach, California. CMS Ex. 2, at 89-92 (Bill of Sale and General Assignment). At the time of its acquisition, South Coast was accredited by The Joint Commission and had a Medicare provider agreement. Under the terms of the purchase, Mission did not assume any liabilities to which South Coast would have been subject under its provider agreement. CMS Ex. 2 (Bill of Sale), at 89-90; P. Ex. 9 (Affidavit of Dan Martinez), at 1.

Prior to the date of the acquisition, Mission submitted to WPS, its Medicare contractor, an enrollment application (Form CMS-855A) to add South Coast as a new practice location effective July 1, 2009. CMS Ex. 2, at 51-53, 57-58, 61-63, 81-83.[3] In addition, South Coast submitted a Form CMS-855A to WPS that reported its acquisition by Mission.[4] CMS Ex. 2, at 2, 3, 9, 10, 26, 38, 39.

WPS advised Mission by letter dated July 17, 2009 that it had completed its initial review of the application and forwarded a recommendation to the state survey agency and the CMS Regional Office. The Joint Commission notified South Coast by letter dated December 15, 2009 that, based on South Coast's "acquisition by Mission Hospital," "[w]e have extended accreditation to [the] new sites and services under Mission Hospital . . . , contingent upon their successful completion of an unannounced extension survey[.]" P. Ex. 5, at 1. A survey was conducted on or about March 2, 2009. P. Ex. 10 (Affidavit of Jan M.H. Brewer) at 2. The survey found two standard-level deficiencies under the medical records condition of participation. CMS Ex. 7, at 1, 6-9. The Joint Commission notified Mission by letter dated March 23, 2010 that, based on the submission of "evidence of standards compliance on 03/18/2010," "the areas of deficiency. . . have been removed" and "The Joint Commission is extending your organization's accreditation decision of Accredited to your new sites and services, effective 03/18/2010." CMS Ex. 7, at 1.

[3] Mission's CMS-855A was received by WPS on June 5, 2009. P. Ex. 3.

[4] South Coast's CMS-855A was signed by its CFO on June 1, 2009 (CMS Ex. 2, at 39) but the record does not show when it was received by WPS.

CMS subsequently issued a Revised Provider Tie-In Notice for Mission Hospital Regional Medical Center, Provider Number 050567, dated March 18, 2011. CMS Ex. 9, at 1. The Notice included the following "Remarks:"

> Additional campus approved for Mission Hospital Regional Medical Center effective March 18, 2010, the date of the Joint Commission survey. Voluntary termination of South Coast Medical Center effective June 30, 2009. Termination of South Coast Medical Center CCN 050193 effective 6/30/2009. The additional campus at Laguna Beach will be under CCN 050567 effective 3/18/2010.

*Id*.

Using its own provider number, Mission began billing Medicare for services provided to Medicare beneficiaries at South Coast, which Mission referred to as its Laguna Beach campus. CMS Ex. 4 (Mission letter to CMS dated 11/19/09), at 2. According to Mission, it was advised by WPS on June 18, 2009 that it would be permitted by CMS to bill for such services as of July 1, 2009 even though WPS and CMS had not yet completed their review and approval of Mission's CMS-855A. *Id.* Mission ceased billing for these services on or about September 29, 2009, when it was informed by CMS by telephone that it could not bill for the services "until either (1) the Joint Commission conducts a survey at Laguna Beach or (2) Mission Hospital agrees to take assignment of [South Coast]'s provider number, including all potential liabilities[.]" *Id*. On March 23, 2010, CMS advised Mission in writing that "the effective date of your new campus for Medicare certification and reimbursement remains March 18, 2010." P. Ex. 8, at 2. Mission requested a hearing before an ALJ on this determination in accordance with 42 C.F.R. Part 498.

**The ALJ Decision**

Before the ALJ, both parties filed a motion for summary judgment, contending that there were no genuine issues of material fact in dispute. The ALJ granted CMS's motion for summary judgment and denied the motion for summary judgment filed by Mission.

The ALJ concluded that the effective date of enrollment for Mission's Laguna Beach campus must be determined pursuant to section 489.13(d)(1)(i) (as in effect in 2009). ALJ Decision at 4. Under that regulatory provision, the effective date is the date on which the provider "meets all requirements, including the additional requirements." The ALJ concluded that the "additional requirements" to which that section refers were not met on July 1, 2009, as Mission argued. Instead, the ALJ concluded that in addition to submitting an application for a change of enrollment to include the new acquisition, Mission was "subject to the accreditation requirements that were not fulfilled until March 18, 2010." *Id*. at 5. Specifically, the ALJ found that "The Joint Commission provided accreditation to [Mission]'s newly acquired site based on a successful on-site survey

verifying compliance with applicable health and safety requirements as of March 18, 2010." *Id*. at 6; *see also id.* at 2. Accordingly, the ALJ concluded, Mission's "acquisition first met all additional federal requirements, pursuant to 42 C.F.R. § 489.13 (2009), on March 18, 2010, and its provider agreement became effective on that date." *Id*.

The ALJ also rejected Mission's argument that, even if the effective date under section 489.13(d)(1) was March 18, 2010, Mission was entitled to bill Medicare for services provided at its Laguna Beach campus beginning July 1, 2009 under the "special rule" set forth in section 489.13(d)(2). The ALJ concluded that "CMS was authorized to exercise its clear discretion not to grant retroactive certification, considering CMS had a longstanding policy not to allow retrospective billing when there was a change in ownership without assumption of the seller's provider agreement." ALJ Decision at 6.

Mission timely appealed the ALJ's decision denying its motion and granting CMS's motion for summary judgment.

**Standard of Review**

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. *1866ICPayday.com, L.L.C.*, DAB No. 2289, at 2, citing *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986). The party moving for summary judgment bears the initial burden of demonstrating that there is no genuine dispute of material fact for trial and that it is entitled to judgment as a matter of law. *Celotex*, 477 U.S. at 323. If a moving party carries its initial burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial."' *Matsushita Elec. Industrial Co. v. Zenith Radio, Ltd.*, 475 U.S. 574, at 587 (1986)(quoting Fed. R. Civ. Pro. 56(e)).[5] In order to demonstrate a genuine issue, the opposing party must do more than show that there is "some metaphysical doubt as to the material facts . . . . Where the record taken as a whole could not lead a rational trier of fact to find for the nonmoving party, there is no 'genuine issue for trial."' *Matsushita*, 475 U.S. at 586. In making this determination, 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. *See, e.g., U.S. v. Diebold, Inc.*, 369 U.S. 654, 655 (1962).

[5] The quoted language no longer appears in Rule 56, which was amended effective December 1, 2010.

Whether summary judgment is appropriate is a legal issue that we address de novo. *1866ICPayday.com, L.L.C.*, DAB No. 2289, at 2, citing *Lebanon Nursing and Rehabilitation Center*, DAB No. 1918 (2004). Our standard of review on a disputed issue of law is whether the ALJ decision is erroneous. *Guidelines — Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program*, http:// www.hhs.gov/dab/divisions/appellate/guidelines/index.html.

## Analysis

### The ALJ did not err in concluding that, under section 489.13(d)(1)(i), the effective date of billing privileges for Mission's Laguna Beach campus was March 18, 2010.

We note preliminarily that the results in this case would be different had Mission assumed South Coast's liabilities when it acquired its assets. As noted above, section 489.18(c) provides that where there is a change of ownership, the provider agreement of the facility that has been acquired is "automatically . . . assigned to the new owner." This regulatory provision allows the new owner to bill Medicare for services provided by the acquired facility as soon as the acquisition takes effect. However, one of the conditions in section 489.18(d) for assignment of the provider agreement is that the new provider agreement be "subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued[.]" Having declined to assume South Coast's outstanding liabilities, Mission was unable to comply with this condition and thereby automatically take assignment of South Coast's provider agreement. Indeed, it appears that South Coast intended to voluntarily terminate its provider agreement by submitting its CMS-855A to WPS, and Mission does not dispute the ALJ's finding that South Coast's provider agreement "did not transfer over to" Mission pursuant to section 489.18(c) (ALJ Decision at 4). Because there was no longer a provider agreement covering the Laguna Beach campus as of July 1, 2009, Mission could not obtain Medicare billing privileges for the Laguna Beach campus merely by submitting an enrollment application seeking to add it as a new practice location. Instead, Mission could bill Medicare for services provided at the Laguna Beach campus only if the Laguna Beach campus went through the survey and certification process or if it was accredited by The Joint Commission and CMS deemed that the Medicare conditions of participation were met based on that accreditation. The Laguna Beach campus did not have a state agency survey; thus, its billing privileges depended on the accreditation process.

Mission acknowledges, as it did before the ALJ, that the effective date of billing privileges for its Laguna Beach campus is governed by section 489.13(d)(1)(i), which applies to an accredited provider that is subject to additional requirements. Mission argues, however, that the ALJ incorrectly interpreted and applied that provision in determining that the effective date was March 18, 2010 rather than July 1, 2009.

According to Mission, under section 489.13(d)(1), there is a "threshold requirement" that "the provider be *currently* accredited." Request for Review (RR) at 11 (emphasis in original). Mission asserts that its Laguna Beach campus met this threshold requirement on July 1, 2009 because "The Joint Commission transferred South Coast's accreditation to the Laguna Beach Campus by virtue of the transaction on July 1, 2009" (immediately following Mission's purchase of South Coast's assets). *See* RR at 1-2, 9-11, 14. Mission argues that the only additional requirement under section 489.13(d)(1)(i) to which its Laguna Beach campus was subject was the requirement to submit an application for a change of enrollment (which the ALJ found was met prior to July 1, 2009) and that the ALJ Decision "improperly expands the 'additional requirements' of Section 489.13(d)(1)(i)" to include a requirement that the Laguna Beach campus "pass a subsequent accreditation extension survey." RR at 10. Mission reasons that because the additional requirements to which the regulation refers are "requirements in addition to those included in the accrediting organization's approved program," it is illogical to conclude that a subsequent accreditation extension survey is an additional requirement. "Put another way," Mission says, "a requirement in addition to an accreditation program cannot be . . . accreditation." RR at 13 (ellipsis in original).

We agree with Mission that, contrary to what the ALJ found, passing a subsequent accreditation extension survey was not an additional requirement within the meaning of section 489.13(d)(1)(i). However, the ALJ's error was harmless due to the very threshold requirement in section 489.13(d)(1) to which Mission points — that a provider be "currently accredited." Mission's Laguna Beach campus did not meet this threshold requirement by virtue of Mission's July 1, 2009 asset purchase because, as already discussed, Mission did not assume all of South Coast's outstanding liabilities and therefore Mission could not continue to operate the Laguna Beach campus under South Coast's provider agreement or South Coast's accreditation. Moreover, as discussed below, The Joint Commission extended Mission's accreditation to the Laguna Beach campus only as of March 18, 2010. As a consequence, until that date, the Laguna Beach campus did not meet "all requirements" within the meaning of section 489.13(d)(1)(i), i.e., the hospital conditions of participation it could be deemed to meet on the basis of accreditation. Accordingly, the effective date of billing privileges for services provided at Mission's Laguna Beach campus could not be earlier than March 18, 2010, notwithstanding the fact that the sole additional requirement under section 489.13(d)(1)(i) — submission of an enrollment application — was met even before July 1, 2009.

As noted, Mission asserts that when it acquired South Coast, South Coast's original accreditation was "transferred" to Mission's Laguna Beach campus, so that the Laguna Beach campus was accredited as of July 1, 2009. However, the record does not support that assertion. Instead, the record clearly establishes that The Joint Commission accredited the Laguna Beach campus effective March 18, 2010, as the ALJ found.[6] Mission relies on the language in the December 15, 2009 letter from The Joint Commission to South Coast stating that, based on South Coast's "acquisition by Mission Hospital," "[w]e have extended accreditation" to the "new sites and services under Mission Hospital . . . ." P. Ex. 5. This language cannot reasonably be read to mean that South Coast's accreditation was automatically transferred to Mission's Laguna Beach campus, however, because the letter goes on to describe the accreditation as "contingent upon their successful completion of an unannounced extension survey." As noted above, the March 2, 2010 survey conducted by The Joint Commission found that the Laguna Beach campus had two standard-level deficiencies. After Mission submitted evidence on March 18, 2010 that its Laguna Beach campus had corrected the two deficiencies, The Joint Commission notified Mission that it "is extending your organization's accreditation decision of Accredited to your new sites and services, effective 03/18/2010." CMS Ex. 7 (Joint Commission letter dated 3/23/10), at 1. Thus, notwithstanding any ambiguity in The Joint Commission's December 15 letter regarding the point at which Mission's Laguna Beach campus would be considered accredited, it is clear from the March 23, 2010 letter that the Laguna Beach campus was accredited only as of March 18, 2010. There is no indication in either letter that, as Mission argues (at RR at 14), the March 23 letter was simply extending South Coast's existing accreditation to Mission, rather than addressing whether new sites and services would be included in Mission's accreditation.[7]

Accordingly, we conclude that, pursuant to section 489.13(d)(1)(i), the effective date of date of billing privileges for services provided at Mission's Laguna Beach campus was March 18, 2010.

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[6] Although Mission made the same assertion in its motion for summary judgment, the parties did not identify this as a disputed issue of fact. Nevertheless, we conclude that summary judgment was appropriate because there is no legal basis on which the ALJ could have found for Mission on this issue, even viewing the evidence on which Mission relied in the light most favorable to it.

7 The December 15, 2009 letter also stated that "[a]s a result of this acquisition, your organization, and all programs under South Coast Medical Center . . ., will be listed as not accredited, effective December 31, 2009." P. Ex. 5, at 1. According to Mission, the expiration date of South Coast's original accreditation was December 31, 2009. Mission Request for Review (RR) at 6, citing P. Ex. 5, at 1. However, Mission does not argue that South Coast's original accreditation continued until that date.

This conclusion is consistent with the purpose of the Medicare participation requirements, which is to "protect the health and safety of the patients who are the intended beneficiaries of the program[.]" *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). Under Mission's reading of the regulation, an accredited hospital (or other accredited provider) could be paid for services provided at a time when there was no assurance that it met Medicare participation requirements, thus potentially endangering the health and safety of its patients.

Mission argues that its reading of section 489.13(d) is supported by the following language in the preamble to the 2010 amendments to section 489.13(d), which Mission says describes the effect of the regulation before its amendment:

> Therefore, effectively, a buyer who does not accept assignment of the seller's active provider agreement could potentially begin receiving Medicare payments immediately (assuming it meets all the requirements), but not be responsible for any existing liabilities of the provider agreement.

RR at 12, quoting 75 Fed. Reg. at 50,403. Read in its proper context, however, this language actually undercuts Mission's position. The quoted language is part of CMS's discussion of the effect of the Board's decision in *Renal CarePartners of Delray Beach, LLC*, DAB No. 2271 (2009), where the Board held that there was no basis in the regulation or policy issuances for CMS's position that CMS contractor approval is an enrollment requirement that a supplier must satisfy before the services it provides are billable to Medicare. The preamble explains that CMS was amending section 489.13(b) to clarify that contractor approval is an enrollment requirement. The language Mission quotes describes the adverse consequences of not recognizing all the "Federal requirements" to which CMS believed section 489.13 refers and does not, as Mission argues, describe the intended operation of the existing regulation.

> **The special rule in 42 C.F.R. § 489.13(d)(2) permitting a provider to bill Medicare for services provided up to one year prior to the effective date determined under section 489.13(d)(1) does not apply under the facts of this case.**

In the alternative, Mission argues that, contrary to what the ALJ found, it was entitled to bill Medicare for services that were provided at the Laguna Beach campus beginning July 1, 2009 pursuant to section 489.13(d)(2). That section provides that the effective date of a provider's Medicare billing privileges "may be retroactive for up to one year to encompass dates on which the provider . . . furnished, to a Medicare beneficiary, covered services for which it has not been paid." The Board has previously addressed the meaning of this provision, stating in relevant part:

> 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.

*Puget Sound Behavioral Health*, DAB No. 1944, at 14 (2004) (concluding that there was no basis in section 489.13(d)(2) for making the effective date of Puget Sound's certification as a psychiatric hospital retroactive because Puget Sound was accredited only as a hospital).

As in *Puget Sound*, we conclude that section 489.13(d)(2) is inapplicable because the conditions under which it was intended to apply are not present here. Specifically, there was no assurance that Mission's Laguna Beach campus was in compliance with the Medicare participation requirements at the time the services were provided both because Mission was not assigned South Coast's provider agreement due to Mission's failure to assume South Coast's liabilities and because The Joint Commission determined that the Laguna Beach campus was accredited only as of March 18, 2010.

Nonetheless, Mission argues that it is still entitled to a retroactive effective date under section 489.13(d)(2) as interpreted by the Board in *West Norman Endoscopy Center*, DAB No. 2331 (2010) . Mission argues that, unlike the ALJ in the case now before us, the Board in *West Norman* did not view the granting of a retroactive effective date under section 489.13(d)(2) as a matter within CMS's discretion. *See* RR at 15. We need not consider here whether CMS had discretion under the regulation to deny a retroactive effective date because we have found that the regulation is inapplicable here. In any case, we agree with the ALJ that *West Norman* is distinguishable from this case on its facts. In concluding that West Norman was entitled to a retroactive effective date, the Board noted that West Norman was accredited when it began providing the services and that "this assured that [West Norman] was in compliance with the conditions for coverage at the time the services were provided." DAB No. 2331, at 11. As we have found, Mission's Laguna Beach campus was not accredited when it provided the services for which Mission seeks payment from Medicare.

**Conclusion**

For the reasons stated above, we uphold the ALJ's determination that the effective date of enrollment for Mission's Laguna Beach campus is March 18, 2010.

/s/
Judith A. Ballard

/s/
Leslie A. Sussan

/s/
Stephen M. Godek
Presiding Board Member