Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Wesley Medical Center, LLC, d/b/a Galichia Heart Hospital
(CCN: 170202),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-956

Decision No. CR3033

Date: December 13, 2013

DECISION

Petitioner, Wesley Medical Center, LLC, d/b/a Galichia Heart Hospital, challenges the effective date of its participation in the Medicare program. Initially and on reconsideration, the Centers for Medicare & Medicaid Services (CMS) determined that the hospital first met Medicare program requirements on April 20, 2012. CMS therefore approved the hospital's program participation effective that date. Petitioner appeals, arguing that it is entitled to an earlier effective date. The parties have filed cross-motions for summary judgment.

For the reasons set forth below, I grant CMS's motion and deny Petitioner's.

Background

Under the Medicare statute, a hospital is defined as an institution that is primarily engaged in providing diagnostic, therapeutic and rehabilitation services to inpatients, under the supervision of physicians, and meets other specified requirements. Social Security Act (Act) § 1861(e). It may participate in the Medicare program as a provider of services, if it meets the statutory definition and complies with regulatory requirements called conditions of participation. Act § 1866; 42 C.F.R. §§ 488.3(a); 489.10(a). A "condition of participation" represents a broad category of services. Each condition is

contained in a single regulation, which is divided into subparts called standards. 42 C.F.R. Part 482.

To determine whether certain prospective providers (such as hospitals) qualify for Medicare certification, CMS authorizes certain accreditation organizations to survey and accredit the applicants and recommend Medicare certification. Institutions accredited by approved accreditation bodies are generally "deemed" to meet Medicare conditions of participation. Act § 1865; 42 C.F.R. § 488.5. However, if CMS finds that the prospective provider has significant deficiencies, it will be deemed not to meet those conditions. Act § 1865(c). Ultimately, CMS makes that call, and its decision to reject the accreditation body's survey and recommendations based on that survey is not reviewable. *See* 42 C.F.R. § 498.3, and discussion, below.[1]

Here, prior to February 1, 2012, Wesley Medical Center, LLC, was a Medicare-certified acute care hospital, located in Wichita, Kansas. On February 1, 2012, it acquired the assets of Galichia Heart Hospital, also located in Wichita. Prior to this change of ownership, Galichia had been a Medicare-certified provider; however, Petitioner did not accept assignment of Galichia's provider agreement. It therefore acquired a non-certified entity, which would be treated the same way as any new applicant to the program. CMS Survey & Certification Letter 09-08 (October 17, 2008).

Det Norske Veritas Healthcare (DNV Healthcare) is a national accrediting organization, approved by CMS to accredit prospective providers and recommend Medicare certification. Petitioner contracted with DNV Healthcare to survey Galichia for accreditation. On February 1, 2012, a three-person survey team visited the facility and conducted a one-day (8:30 a.m. to 4:30 p.m.) accreditation survey. CMS Exhibit (Ex.) 4. In a letter dated March 28, 2012, DNV Healthcare told Petitioner that it would recommend certification, effective February 1, 2012. CMS Ex. 2 at 1; P. Ex. 4. However, because the surveyors cited deficiencies that had to be corrected, DNV Healthcare subsequently changed the recommended effective date to February 17, 2012, the date the hospital submitted an acceptable plan of correction. P. Exs. 2, 3, 5.

Thereafter, however, CMS determined that DNV Healthcare had conducted an inadequate survey, and, by letter dated April 16, 2012, CAPT Cindy R. Melanson, the health evaluation officer for CMS's Office of Clinical Standards and Quality, advised the accrediting organization that its survey did not comply with CMS requirements for a full, standard survey. CMS Ex. 8 at 4 (Melanson Decl. ¶ 6). DNV Healthcare agreed to conduct promptly a more adequate survey. CMS Ex. 8 at 4 (Melanson Decl. ¶ 7).

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[1] Whether a prospective provider qualifies as a provider is, of course, reviewable (42 C.F.R. § 498.3(b)(1), but that issue is separate from CMS's administrative determination as to the adequacy of the accrediting organization's survey performance.

Surveyors from DNV Healthcare returned to the hospital and, from April 17 through 19, 2012, conducted another survey, again finding deficiencies, which did not rise to condition-level. The hospital submitted a written plan of correction, which DNV Healthcare accepted on April 20, 2012. P. Ex. 6. By letter dated May 11, 2012, CMS advised Petitioner that, based on the survey findings and the hospital's acceptable plan of correction, the hospital met the applicable requirements for Medicare participation, effective April 20, 2012. P. Ex. 7.

Petitioner challenges this effective date, arguing that it should have been certified effective February 17, 2012. The parties have submitted memoranda in support of their respective motions for summary judgment (CMS MSJ; P. MSJ). CMS has submitted a reply (CMS Reply) and Petitioner a response (P. Response). CMS has submitted 12 exhibits (CMS Exs. 1-12) and Petitioner has submitted 10 exhibits (P. Ex. 1-10).[2]

Discussion

1. ***CMS properly determined the April 20, 2012 effective date for Petitioner's Medicare enrollment, because the undisputed evidence establishes that the hospital failed to meet program requirements prior to that date.*** [3]

[2] I note that Petitioner objects to my admitting CMS Exs. 9-12, which were filed late.

Petitioner also asked that I issue a subpoena compelling the production of a wide but ill-defined array of documents ("all communications between DNV and CMS regarding the Galichia . . . survey"; "all internal communications regarding the Galichia survey"; "all documents and communications regarding the April 3, 2012 call between DNV and CMS . . ."; "all documents . . . that define the time period that must pass after a CHOW before the survey can occur"; "all documents related to surveys that were initiated the first day that the new owner was responsible for the operation of the hospital . . ."; and "all CMS guidance provided directly to DNV and other accreditation organizations defining the requirements for post-CHOW surveys."). I deny the subpoena request. Petitioner has not specifically identified the documents it seeks, has not *specified* the pertinent facts it expects to establish by the documents, and has not indicated why it could not establish those facts without the use of a subpoena, as required by 42 C.F.R. § 498.58(c)(3). I find insufficient to satisfy the requirements of the regulation Petitioner's very general claims that it "cannot obtain this information" or "does not have access to this information." I note also that much of the information sought is privileged. Petitioner is not entitled to discover the agency's internal deliberative documents.

[3] My findings of fact/conclusions of law are set forth, in italics and bold, in the discussion captions of this decision.

The parties spend a lot of time arguing issues that are peripheral to the dispositive question here: when did the hospital demonstrate that it met Medicare certification requirements. As noted above, to be certified, CMS must determine that the prospective provider meets Medicare conditions of participation. Act § 1866; 42 C.F.R. §§ 488.3(a); 489.10(a). If a provider is deficient with respect to one or more of the standards within the conditions of participation, it may participate in the program only if, within a reasonable period of time, it submits an acceptable plan of correction. 42 C.F.R. §§ 488.28(a); 489.13(c)(2)(ii)(A); *Cmty. Hosp. of Long Beach*, DAB No. 1938 (2004).

The parties agree that the hospital did not meet Medicare requirements as of the April 19, 2012 survey. CMS MSJ at 3; P. MSJ at 4; P. Exs. 6, 7. At that time, the surveyors cited deficiencies under surgical services (42 C.F.R. § 482.51(b)(6)), medical records (42 C.F.R. § 482.24(c)(1)), and physical environment/life safety management (42 C.F.R. § 482.41(b)(1)(i)). The hospital submitted a plan of correction, which DNV Healthcare accepted on April 20, 2012. CMS Ex. 7 at 4 (Friedrich Decl. ¶ 11). Thus, because the hospital did not meet program requirements prior to April 20, 2012, it could not have been certified before that date.

2. I have no authority to review CMS's refusal to accept as adequate DNV Healthcare's February 1, 2012 survey.

According to Petitioner, under section 1865(a)(1)(A) of the Act, CMS has no discretion, but must accept the conclusions of a hospital accrediting organization unless CMS finds that the hospital has significant deficiencies. P. MSJ at 1. This argument fails for two reasons: first, this is not what the statute says; second, even if CMS arguably exceeded its authority (which it assuredly did not), I have no authority to review its refusal to accept the adequacy of an accrediting organization's survey and recommendations based on that survey.

Petitioner misreads the statute. The statute says that CMS accepts the accreditation *if* it finds that the accreditation "demonstrates that all of the applicable conditions or requirements" are met. Here, CMS did not make that finding with respect to the February survey. It found that the accrediting body conducted an inadequate and unreliable survey, so could not demonstrate that all requirements were met.[4] CMS Ex. 3;

[4] That the surveyors found standard-level deficiencies when they finally conducted an acceptable survey in April buttresses CMS's determination that the February visit had been inadequate. Moreover, this case illustrates why CMS oversight and approval is so critical to protecting the integrity of the certification process. Here, Petitioner selected DNV Healthcare to survey and accredit the hospital. In January 2012, a DNV Healthcare official told the surveyors that they should not "feel compelled to visit all areas of the hospital" and that the hospital "should concur with legitimacy of [any] finding." CMS Ex. 5.

CMS Ex. 7 at 3-4 (Friedrich Decl. ¶ 9); CMS Ex. 8 at 2-4 (Melanson Decl. ¶¶ 4, 5); *see* 42 C.F.R. § 488.6(c)(2) (authorizing CMS to determine that a provider does not meet Medicare conditions based on its own investigation of the accreditation survey "or any other information related to the survey.").

In any event, I have no authority to review CMS's rejection of the February survey. A provider's hearing rights are established by federal regulations: 42 C.F.R. Part 498. A provider dissatisfied with an initial determination is entitled to further review, but administrative actions that are not initial determinations are not subject to appeal. 42 C.F.R. § 498.3(a); *Florida Health Sciences Ctr., Inc., d/b/a/ Tampa General Hosp.*, DAB No. 2263 at 4 (2009). The regulations specify which actions are "initial determinations" and set forth examples of actions that are not. Insisting that an accrediting organization's survey comply with minimal federal requirements, as CMS did here, is not an initial determination under 42 C.F.R. § 498.3(b) and therefore not reviewable.[5]

Conclusion

CMS is entitled to summary judgment because the parties agree -- and undisputed evidence establishes -- that the hospital failed to meet program requirements prior to the April 20, 2012 effective date. As a matter of law, CMS was authorized to reject the adequacy of the February survey, and to order a valid one, and I have no authority to review its decision to do so. I therefore grant CMS's motion for summary judgment, and deny Petitioner's motion.

/s/
Carolyn Cozad Hughes
Administrative Law Judge

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[5] Instead of allowing DNV Healthcare to conduct an adequate survey, CMS could have directed the state survey agency to conduct a validation survey under 42 C.F.R. § 488.7(a), and its decision to do so would not have been reviewable. *See Apollo Behavioral Health Hosp. LLC,* DAB CR2908 (2013).