Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	Date: February 19, 2009
Presbyterian Hospital of Rockwall, (CCN: 67-0044),	)	
	)	Docket No. C-08-558
Petitioner,	)	Decision No. CR1904
v.	)	
Centers for Medicare & Medicaid Services.	)	

DECISION

Petitioner, Presbyterian Hospital of Rockwall, did not meet the requirements for participation in the Medicare program before April 4, 2008, the effective date of its provider agreement to participate in the Medicare program. Summary judgment is entered for the Centers for Medicare & Medicaid Services (CMS) and the hearing scheduled for March 10 through 12, 2009, in Dallas, Texas is cancelled.

I. Background

Petitioner is a hospital located in Rockwall, Texas. On September 17, 2007, Petitioner submitted an enrollment application to participate in the Medicare program to the Medicare contractor, Trailblazer Health Enterprises, LLC (the contractor). The contractor acknowledged that Petitioner's application was received on September 21, 2007. Joint Stipulation of Undisputed Facts (Jt. Stip.) ¶¶ 1-2. CMS notified Petitioner by letter dated April 30, 2008, that Petitioner was accepted for participation in Medicare and that the effective date of its provider agreement was April 4, 2008. Petitioner requested reconsideration on May 9, 2008. CMS denied Petitioner's request that the effective date of its provider agreement be changed from April 4, 2008 to March 4, 2008. Jt. Stip. ¶¶ 6-7; Request for Hearing. Petitioner requested a hearing before an administrative law judge (ALJ) by letter dated June 16, 2008. The case was assigned to me for hearing and decision on July 14, 2008, and a Notice of Case Assignment and Prehearing Case Development Order (Prehearing Order) was issued at my direction on that date. On September 30, 2008, I notified the parties that a hearing was scheduled to be convened in

this case on March 10, 2009. CMS submitted CMS Exhibits (CMS Exs.) 1 through 3, and 5 through 6. Petitioner has not objected, and CMS Exs. 1 through 3 and 5 through 6 are admitted. On September 26, 2008, CMS filed a motion for summary judgement (CMS Brief). Petitioner filed a response to the CMS motion for summary judgment on October 16, 2008 (P. Brief). Petitioner submitted Petitioner's Exhibits (P. Exs.) 1 through 39. CMS has not objected, and P. Exs. 1 through 39 are admitted.

II. Discussion

A. Applicable Law

Section 1811 of the Social Security Act (the Act) (42 U.S.C. § 1395c) describes the hospital insurance benefits program for the aged and disabled known as Medicare Part A. Payment under the program may only be made to providers of services who are determined eligible to participate pursuant to section 1866 of the Act. Act § 1814(a) (42 U.S.C. § 1395f(a)). Medicare Part A is administered by CMS through Medicare contractors. Act § 1816 (42 U.S.C. § 1395(h)).

A "hospital" within the meaning of section 1861(e) of the Act (42 U.S.C. § 1395x), is a "provider of services" pursuant to section 1861(u) of the Act. A provider of services is qualified to participate in the Medicare program, and eligible for payment from the program for its services to Medicare eligible beneficiaries, if it files with the Secretary of Health and Human Services (Secretary) an agreement that meets the requirements of section 1866(a)(1) of the Act (42 U.S.C. § 1395cc). The Secretary may refuse to enter into a contract[1] with a provider of services if the Secretary determines the provider fails to comply substantially with the provisions of the provider agreement, the Act, or the regulations; the provider was previously excluded from participation; or the provider was convicted of a felony offense that the Secretary determines is detrimental to the best interests of the program or its beneficiaries. Act § 1866(b)(2). An institution or agency dissatisfied with the Secretary's determination not to enter into a provider agreement pursuant to section 1866(b)(2), is entitled to a hearing and judicial review. Act §§ 1866(h)(1) and (j)(2). The Act requires that the Secretary issue regulations that establish a process for the enrollment of providers and suppliers, including deadlines for actions on applications for enrollment, with monitoring of the performance of Medicare contractors in meeting the deadlines. Act § 1866(j)(1).

---

[1] These contracts between the Secretary and providers of services are commonly referred to as provider agreements.

The Secretary's regulations for provider and supplier enrollment are found at 42 C.F.R. Part 489; the conditions for participation of hospitals are found at 42 C.F.R. Part 482; the basic requirements for participation as a provider are set forth at 42 C.F.R. § 489.10; and the procedures for application to participate in Medicare as a provider or supplier are set forth in 42 C.F.R. Part 424. The regulations require that a state survey agency determine whether a provider meets the conditions for participation and make a recommendation to CMS. 42 C.F.R. § 489.10(d). However, the regulation also allows a provider to be deemed to meet participation requirements based upon accreditation by an approved accrediting organization. 42 C.F.R. § 489.13(a)(ii). If CMS determines that a provider meets the requirements for participation, CMS notifies the provider and includes two copies of the provider agreement that the provider must sign and return. CMS then returns one copy of the provider agreement with a notice to the provider of the acceptance and effective date of the agreement. 42 C.F.R. § 489.11. The effective date of the provider agreement and the date on which a provider is eligible to have its services to a Medicare eligible beneficiary paid by Medicare is determined pursuant to 42 C.F.R. § 489.13.

The hearing to which an institution or agency that is denied a provider agreement is entitled pursuant to section 1866(h)(1) and (j)(2) of the Act, is described in section 205(b) of the Act and is before an ALJ. The prospective provider who is denied enrollment may obtain review of the CMS decision in accordance with 42 C.F.R. Part 498. 42 C.F.R. §§ 424.545(a); 498.3(b)(1) and (17); 498.5(a)(2). The hearing before an ALJ is a *de novo* proceeding. *Anesthesiologists Affiliated, et al*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991); *Emerald Oaks*, DAB No. 1800, at 11 (2001); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Cal Turner Extended Care*, DAB No. 2030 (2006); *The Residence at Salem Woods*, DAB No. 2052 (2006). The Board has previously ruled upon the allocation of the burden of persuasion and the burden of coming forward with the evidence in cases subject to 42 C.F.R. Part 498. The Board has held that CMS must make a prima facie showing of the basis for its action. "Prima facie" means that the evidence is "(s)ufficient to establish a fact or raise a presumption unless disproved or rebutted." *Black's Law Dictionary* 1228 (8th ed. 2004); s*ee also Hillman Rehabilitation Center*, DAB No. 1611, at 8 (1997), *aff'd Hillman Rehabilitation Center v. U.S. Dept. of Health and Human Services*, No. 98-3789 (GEB), slip op. at 25 (D.N.J. May 13, 1999). To prevail, a petitioner must overcome CMS's showing by a preponderance of the evidence. *Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004); *Batavia Nursing and Convalescent Inn*, DAB No. 1911 (2004) *aff'd*, *Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 Fed. Appx. 181 (6th Cir. 2005); *Emerald Oaks*, DAB No. 1800 (2001); *Cross Creek Health Care Center*, DAB No. 1665 (1998); *Hillman Rehabilitation Center*, DAB No. 1611.

B. Issues

The issues in this case are:

Whether summary judgment is appropriate, and, if so,

Whether the effective date of Petitioner's provider agreement and participation in Medicare may or should be changed from April 4, 2008 to March 4, 2008.

C. Analysis

My conclusions of law are set forth in bold followed by my findings of fact and analysis.

1. Summary judgment is appropriate in this case because there are no disputed issues of material fact.

An ALJ may decide a case on summary judgment, without an oral evidentiary hearing, if the case presents no genuine issues of material fact. *Crestview Parke Care Center v. Thompson,* 373 F.3d 743, 750 (6th Cir. 2004); *Livingston Care Center v. Dept. of Health and Human Services,* 388 F.3d 168 (6th Cir. 2004). The Departmental Appeals Board (the Board) has previously approved the use of a summary judgment procedure "akin to the summary judgment standard contained in Federal Rule of Civil Procedure 56." *Crestview Parke Care Center*, 373 F.3d 743, 750. Under that rule, the moving party may show the absence of a genuine factual dispute by presenting evidence so one-sided that it must prevail as a matter of law, or by showing that the non-moving party has presented no evidence "sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial." *Livingston Care Center,* 388 F.3d at 173*, citing Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). The non-moving party must then act affirmatively by tendering evidence of specific facts showing that a dispute exists. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586, n.11 (1986); *see also Vandalia Park,* DAB No. 1939 (2004); *Lebanon Nursing and Rehabilitation Center*, DAB No. 1918 (2004). A mere scintilla of supporting evidence is not sufficient. "If the evidence is merely colorable or is not significantly probative summary judgment may be granted." *Livingston Care Center*, 388 F.3d, 173, *quoting Anderson v. Liberty Lobby,* 477 U.S. 242*,* at 249-50 (1986). In deciding a summary judgment motion an ALJ may not make credibility determinations or weigh conflicting evidence but must instead view the entire record in the light most favorable to the non-moving party, all reasonable inferences drawn from the evidence in that party's favor. *Innsbruck HealthCare Center,* DAB No. 1948 (2004); *Madison Health Care, Inc.,* DAB No. 1927 (2004).

The Prehearing Order advised the parties that the Federal Rules of Civil Procedure and the Federal Rules of Evidence do not apply to proceedings before ALJs assigned to the Departmental Appeals Board, Civil Remedies Division. However, the Prehearing Order also advised the parties that both the Federal Rules of Evidence and the Federal Rules of Civil Procedure would be consulted as guides for resolution of issues due to the fact that further review in this case would be by the federal courts. Both parties addressed summary judgment standards consistent with those established by Fed. R. Evid. 56 and related cases. CMS Brief at 6-7; P. Brief at 9-10; *Wade Pediatrics*, DAB No. 2153, at 15-17 (2008). This case is appropriate for summary judgment. There is no genuine dispute as to any material fact and a decision may be made by application of law to the undisputed facts.

2. Pursuant to 42 C.F.R. § 489.13(b), the effective date of Petitioner's provider agreement and participation in Medicare is the date on which Petitioner met all federal requirements.

3. The effective date of Petitioner's provider agreement and participation in Medicare is April 4, 2008, the date it was determined to meet all federal requirements.

a. Undisputed Material Facts

The parties stipulated that Petitioner sent its enrollment application to the contractor on September 17, 2007. On October 5, 2007, the contractor acknowledged that it received Petitioner's application on September 21, 2007. Petitioner was licensed by the State of Texas as a general hospital on December 6, 2007. Petitioner was surveyed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), using the Comprehensive Accreditation Manual for Hospitals, and granted accreditation with an effective date of March 4, 2008. Jt. Stip. ¶¶ 1, 2, 4, 5. JCAHO granted Petitioner accreditation for three years effective March 4, 2008, the date the survey of Petitioner was completed. CMS Brief at 2. On March 20, 2008, March 21, 2008, and April 3, 2008, the Medicare contractor requested that Petitioner make corrections to its application or asked for additional information to support its application. P. Exs. 11, 13, and 20. CMS notified Petitioner by letter dated April 30, 2008, that the Secretary accepted Petitioner's participation agreement effective April 4, 2008. P. Ex. 29.

b. Analysis

The Secretary has specified in 42 C.F.R. § 489.13 how the effective date of a provider's agreement is determined. The regulation applies to, among others, Medicare provider agreements with providers that "[a]re deemed to meet Federal requirements on the basis of accreditation by an accrediting organization whose program has CMS approval at the

time of accreditation survey and accreditation decision." 42 C.F.R. § 489.13(a)(1)(ii). There is no question that JCAHO was an approved accreditation organization when it completed its survey and granted Petitioner accreditation on March 4, 2008, and CMS did not require another survey prior to approving Petitioner's agreement and participation in Medicare. Thus, Petitioner may be deemed to have met the federal requirements that were subject to or that required survey and certification on March 4, 2008, the date of its accreditation. Section 489.13(b) of Title 42 provides that a provider agreement is effective the date the required survey is completed, or in this case, the accreditation, if on that date the provider or supplier meets all applicable federal requirements set forth in 42 C.F.R. Chapter IV.

CMS argues that Petitioner was not qualified to participate in Medicare until April 4, 2008, because it did not meet all federal requirements prior to that date. The CMS argument is based upon the undisputed fact that the Medicare contractor did not approve Petitioner's application (Form CMS-855A) until April 4, 2008. CMS Brief at 7-8. CMS argues that Petitioner did not meet the requirement that its application be approved by the Medicare contractor prior to April 4, 2008. CMS cites 42 C.F.R. § 424.510(a) as the source of the requirement that the Medicare contractor must approve the provider's application before the provider agreement can be effective. The regulation states:

> (a) Providers and suppliers must submit enrollment information on the applicable enrollment application. Once the provider or supplier successfully completes the enrollment process, including, if applicable, a State survey and certification or accreditation process, CMS enrolls the provider or supplier into the Medicare program. To be enrolled, a provider or supplier must meet enrollment requirements specified in paragraph (c) of this section.

42 C.F.R. § 424.510(a). The reference to "paragraph (c)" in the subsection appears to be in error, as the list of enrollment requirements are set forth in 42 C.F.R. § 424.510(d).

I agree with Petitioner that, contrary to the CMS argument, neither 42 C.F.R. § 424.510(a) nor (d) establish "Medicare contractor approval" as a federal requirement for participation in Medicare. However, the regulation at 42 C.F.R. § 424.510(d)(1) does clearly establish the federal requirement that:

> (1) *Submittal of the enrollment application*. A provider or supplier must submit a complete enrollment application and supporting documentation to the designated Medicare fee-for-service contractor.

Petitioner does not dispute that on April 3, 2008, the Medicare contractor requested additional information from Petitioner because its application (Form CMS-855A) was missing information or supporting documentation. P. Ex. 20, at 2. According to P. Ex. 22, at 1, and Petitioner does not dispute this, Petitioner sent the missing documents to the Medicare contractor on Friday, April 4, 2008. Accordingly, I conclude that Petitioner did not submit a complete enrollment application and supporting documentation to the Medicare contractor until April 4, 2008, and Petitioner did not meet all federal requirements for participation until that date. I further conclude that CMS committed no error by establishing April 4, 2008 as the effective date of Petitioner's provider agreement and participation in Medicare.

Petitioner asserts that there are material facts in dispute. P. Brief at 15. I disagree. Petitioner argues that the date on which the Medicare contractor received Petitioner's application is a material fact in dispute. I accept Petitioner's assertion that the contractor received the application on September 21, 2007. However, in this case, the date Petitioner's application was received is not a material fact, as it does not affect my decision. Petitioner asserts that whether it met all federal requirements in the Medicare program on March 4, 2008 is a material fact in dispute. This is a mixed question of law and fact. The federal requirements, including the requirement to submit a complete application, are established by the regulations. Whether Petitioner met all the federal requirements established by law is, in this case, a question of fact. Petitioner is deemed to have met all federal requirements covered by the JCAHO survey because Petitioner was accredited by JCAHO. However, the regulatory requirement to submit a complete enrollment application and supporting documentation is not subject to the JCAHO survey and Petitioner is not entitled to have its application "deemed" complete. Petitioner does not dispute and, in fact, Petitioner submitted evidence which shows that on April 3, 2008, the Medicare contractor requested additional information to complete Petitioner's application and that Petitioner submitted all required information and/or supporting documents to complete its application on April 4, 2008. Therefore, as a matter of law, Petitioner did not meet all federal requirements until it submitted its complete application on April 4, 2008. Petitioner asserts that a material fact in dispute is whether CMS appropriately applied relevant sections of the regulation; however, this is an issue of law not fact. Similarly, whether a contractor's approval of an application is a federal requirement is an issue of law, and an issue that I have resolved in Petitioner's favor. Whether a provider may schedule its survey prior to approval of the enrollment application is a legal issue that does not require resolution in this case.

Petitioner acknowledges that it "must submit an enrollment application including certain information and documentation . . . and that such application ultimately must be approved by CMS" in order for Petitioner to participate in Medicare. P. Brief at 13. Petitioner incorrectly asserts that it submitted a complete enrollment application and all of the

required information and documents by March 4, 2008. P. Brief at 13. The undisputed evidence shows that the contractor requested information to complete or correct the application on March 20, 2008, March 21, 2008, and April 3, 2008, and Petitioner submitted the last of the information requested on April 4, 2008. P. Exs. 11, 13, and 20. Petitioner does not assert that the documents and information requested were not necessary to complete its application, nor does Petitioner point to any evidence that the information and documents requested duplicated prior submissions in support of its application. Rather, Petitioner argues that it was the fault of CMS and its contractor for not having more staff to process Petitioner's application more expeditiously. While I recognize Petitioner's frustration that it took more than 180 days for the Medicare contractor and CMS to act upon its application for enrollment, Petitioner cites no authority for the proposition that it is entitled to any relief or remedy on that basis.

III. Conclusion

For the foregoing reasons, the CMS motion for summary judgment is granted and the hearing scheduled for March 10 through 12, 2009, in Dallas, Texas is cancelled.

/s/
Keith W. Sickendick
Administrative Law Judge