Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Plaza Surgical Center,	)	Date: December 3, 2007
(CCN 05-C0001680),	)	
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-05-185
	)	Decision No. CR1705
Centers for Medicare & Medicaid	)	
Services.	)	
	)	

DECISION

I enter summary judgement in favor of the Centers for Medicare & Medicaid Services (CMS) and against Plaza Surgical Center (Petitioner). I find that Petitioner's effective date of participation in the Medicare program is September 28, 2004.

I. Background

Petitioner is a ambulatory surgical center (ASC) located in Monterey Park, California, that sought certification for initial participation in the Medicare Program. Petitioner was surveyed by the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) on June 11, 2004, and Petitioner subsequently submitted an application for Medicare enrollment in September 2004. The application was processed and Petitioner was notified by CMS on November 4, 2004, that it had been certified for initial participation in the Medicare Program effective September 28, 2004.

On November 22, 2004, Petitioner requested reconsideration of the effective date of certification arguing that it had provided care to Medicare beneficiaries as of February 9, 2004. Petitioner further indicated that it understood that it was able to back bill to the original date it filed its application for enrollment. Petitioner maintained that it had filed a CMS Form 855B (Medicare enrollment application for ASCs) prior to September 2004 and it had not been appropriately processed by the Medicare carrier.

CMS informed Petitioner by letter dated December 3, 2004, that Petitioner's request for reconsideration had been denied. CMS explained that while Petitioner had been surveyed by an accrediting organization and had "deemed status" as of June 11, 2004, it was subject to additional requirements that had to be met before a determination as to an effective date or approval could be made pursuant to 42 C.F.R. § 489.13(d)(1)(i). CMS further informed Petitioner that it had not received CMS Form 855B from Petitioner, which is a requirement for participation in the Medicare program. CMS maintained that the correct effective date of participation was September 28, 2004, the day that CMS approved Form 855B which was also the date that Petitioner met all federal requirements of participation.

By letter dated January 27, 2005, Petitioned filed a request for hearing with CMS appealing the determination by CMS that Petitioner was certified to participate in the Medicare Program effective September 28, 2004. Petitioner maintains that CMS should have certified it to participate in the Medicare program effective June 11, 2004.

The case was assigned to me for hearing and decision. The parties conferred and agreed that they each would submit motions for summary judgement. A briefing schedule was proposed by the parties for the submission of their respective motions. CMS filed its initial brief in support of its Motion for Summary Judgment (CMS Br.). Petitioner also filed an initial brief in support of its Motion for Summary Judgment (P. Br.). Both CMS and Petitioner filed reply briefs. (CMS R. Br.), (P. R. Br.). CMS submitted three (3) attachments with its initial brief, which for the purposes of this decision I will refer to as proposed CMS Exhibits 1-3 (CMS Exs. 1-3). Along with its initial brief, Petitioner submitted five (5) proposed exhibits (P. Exs. 1-5). Without objection from the parties, I receive into evidence the exhibits tendered by each party.

II. Applicable Law

Title XVIII of the Social Security Act (Act) provides for payment of part or all of the cost of covered services furnished to eligible individuals by qualified providers of services and suppliers. The Act includes as Part B coverages under section 1832(a)(2)(f) services furnished in connection with surgical procedures specified by the Secretary at an ASC which meets health, safety and other standards specified by the Secretary and has entered into an agreement with the Secretary to participate and accept payment as an ASC. The act of meeting all applicable standards is referred to as "certification."

The regulations at 42 C.F.R. Part 416 contain the requirements for ASC participation agreements and the substantive health, safety, and other conditions for coverage specified by the Secretary. An entity may qualify for a participation agreement if CMS finds the entity in compliance based on a survey of the facility by a State survey agency. 42 C.F.R.

§ 416.26(b). In the alternative, an entity may qualify for a participation agreement based on accreditation "by a national accrediting body . . . that CMS determines provides reasonable assurance that the conditions are met." 42 C.F.R. § 416.26(a). The second process is referred to as "deemed status."

The effective date for a participation agreement is subject to the requirements of 42 C.F.R. § 489.13. For a facility (other than a federally qualified health center, or a community mental health center) that is surveyed by federal or state surveyors and meets all federal requirements, the effective date of the provider or supplier participation agreement is "the date the survey (including the Life Safety Code survey, if applicable) is completed, if on that date the provider or supplier meets all applicable Federal requirements as set forth in this chapter." 42 C.F.R. § 489.13(b). If a facility (other than a skilled nursing facility) fails to meet any of the specified requirements on the date the survey is completed, the effective date is the earlier of the following:

> (i) The date on which the provider or supplier meets all requirements.
> (ii) The date on which a provider or supplier is found to meet all conditions of participation or coverage, but has lower level deficiencies, and CMS or the State survey agency receives an acceptable plan of correction for the lower level deficiencies, or an approvable waiver request, or both. (The date of receipt is the effective date regardless of when CMS approves the plan of correction or the waiver request, or both.)

42 C.F.R. § 489.13(c)(2).

A different rule applies under 42 C.F.R. § 489.13(d)(1) to determine the effective date for a provider or supplier "currently accredited by a national accrediting organization whose program had CMS approval at the time of the accreditation survey and accreditation, and on the basis of accreditation, CMS has deemed the provider or supplier to meet Federal requirements." Under these circumstances the effective date depends on whether the provider or supplier is subject to requirements in addition to those included in the accreditation organization's approval program. If there are additional requirements to which the entity is subject, then the effective date "is the date on which the provider or supplier meets all requirements, including the additional requirements." 42 C.F.R. § 489.13(d)(1)(i). If at the time of the initial request to participate, the entity "is not subject to additional requirements," then the effective date is the date of the "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).

A retroactive effective date for a participation agreement is available pursuant to 42 C.F.R. § 489.13(d)(2). The section permits an effective date that is 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."

III. Issues, findings of fact and conclusions of law

A. Issues

The issues in this case are:

1. Whether summary judgment is appropriate; and

2. Whether the effective date of Petitioner's participation is September 28, 2004 or an earlier date.

B. Findings of fact and conclusions of law

I make findings of fact and conclusions of law (Findings) to support my decision in this case. I set forth each Finding below as a separate heading. I discuss each Finding in detail.

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

An administrative law judge (ALJ) may decide a case on summary judgment, without an evidentiary hearing, if the case presents no genuine issue of material fact. *Crestview Parke Care Center v. Thompson,* 373 F.3d 743, 750 (6th Cir. 2004); *Livingston Care Center v. Dep't. of Health & Human Services,* No. 03-3489, 2004 WL 1922168, at 3 (6th Cir. Aug. 24, 2004). By interpretive rule, this tribunal has established 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,* No. 03-3489, 2004 WL 1922168, at 4, citing *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). The nonmoving 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*, No. 03-3489, 2004 WL 1922168, at 4, quoting *Anderson v. Liberty Lobby,* 477 U.S. 242*,* at 249-250 (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).

This case is appropriate for summary judgment. The parties conferred and agreed that the case could be resolved through cross motions for summary judgment. The parties agree that there are no material issues of facts in dispute in this case. Thus, the only issues before me are legal, and can be decided based on written submissions, without the need for an in-person hearing. The central legal issue in this case is whether CMS correctly certified Petitioner to participate in Medicare on September 28, 2004. In evaluating the parties submissions, I find that even if I construe the entire record in the light most favorable to Petitioner, as discussed below, I find that CMS correctly certified Petitioner to participate in Medicare on September 28, 2004.

2. The effective date of Petitioner's participation in Medicare is September 28, 2004.

Petitioner raises several arguments, the first of which is its assertion that it is entitled to an effective certification date of June 11, 2004. Petitioner maintains that it should have been "deemed" to have been certified effective June 11, 2004, based on an accreditation that it received from the AAAHC. P. Br. at 1-2. Petitioner maintains that this accreditation ought to have been accepted by CMS because the AAAHC is an organization whose accreditation of a provider of services or a supplier of items is accepted under applicable regulations as sufficient to deem that provider as having met Medicare participation requirements. P. Br. at 2-3.

There is no dispute that Petitioner had AAAHC accreditation as of June 11, 2004. CMS maintains that in order to participate in the Medicare Program as an ASC, the provider must, in addition to the survey by the Federal or State surveyors or another national accrediting organization with a program approved by CMS, complete and submit a Provider/Supplier Enrollment Application Form (Form 855B), (CMS Ex. 2). CMS contends that Form 855B must be reviewed and approved by CMS before Petitioner can participate in the Medicare Program. CMS Br. at 2. CMS maintains that participation is limited to facilities that "have in effect an agreement obtained in accordance with this subpart." 42 C.F.R. § 416.25(b). According to CMS, Petitioner's Form 855B was

reviewed and approved on September 28, 2004, and on that same day Petitioner also met all federal requirements in accordance with 42 C.F.R. 489.13(d)(1)(i). CMS Br. at 8. Thus, CMS maintains the effective date of September 28, 2004 is the correct date of certification which should be sustained by this forum.

Petitioner argues that the submission of Form 855B is not an additional requirement with which it had to comply before it was certified. Petitioner maintains that if Form 855B is always an additional requirement, as CMS contends, then there would be no point in distinguishing 42 C.F.R. § 489.13(d)(1)(i) - *Provider or supplier subject to additional requirements* from 42 C.F.R. § 489.13(d)(1)(ii) - *Provider or supplier not subject to additional requirements*. P. Br. at 3-4. Following this logic, Petitioner contends Form 855B would always be an "additional requirement" and therefore there would be no purpose for the alternative effective dates, and no provider or supplier accredited as compliant with federal requirements may have an effective date other than that corresponding to the submission of form 855B.

I do not agree with Petitioner. The regulations at 42 C.F.R. § 489.2, set forth which providers are subject to Part 489 regulations. Section 489.2(b) states in part:

> The following providers are subject to the provisions of this part:
> (1) Hospitals.
> (2) Skilled nursing facilities (SNFs)
> (3) Home health agencies (HHAs)
> (4) Clinics, rehabilitation agencies, and public health agencies
> . . . .

42 C.F.R. § 489.2(b).

Thus 489.13(d)(1)(i) and (ii) is a more general regulation which applies to hospitals, SNFs, etc. Part 416 - Ambulatory Surgical Services is a more specific regulation which applies to ASCs. Therefore, the more general regulation 42 C.F.R. § 489.13(d)(1)(i) and (ii) simply does not apply to Petitioner as an ASC. The more specific regulation which applies to Petitioner lies at 42 C.F.R. § 416.26(c). 42 C.F.R. Part 416 gives CMS the authority to set ASC requirements for provider participation in the Medicare program. 42 C.F.R. § 416.26 (c) specifically states that:

> . . . If CMS determines, after reviewing the survey agency recommendation and other evidence relating to the qualification of the ASC, that the facility meets the requirements of this part . . . .

CMS maintains that the "other evidence relating to the qualification of the ASC" is CMS Form 855B which must be submitted and approved prior to any issuance of a provider agreement, or an effective date.

The importance of the information provided in Form 855B, according to CMS, is not a mere formality as Petitioner suggests, but an integral part of CMS's review process. The general instructions to Form 855B, also known as the Medicare Federal Health Care Provider/Supplier Enrollment Application, are very clear about the importance of completing the form and the significance of the information provided. Indeed the instructions state that the:

> [a]pplication has been designed by CMS to assist in the administration of the Medicare program and to ensure that the Medicare program is in compliance with all regulatory requirements. The information collected in this application will be used to ensure that payments made from the Medicare trust fund are paid only to qualified health care suppliers, and that the amounts of the payments are correct.

CMS Ex. 2.

Indeed the application requires information such as the qualifications of the health care supplier, where and how the supplier intends to render services, persons having ownership interest, etc. These are certainly legitimate questions for CMS to ask and consider before making a determination as to whether to accept or reject a potential Medicare provider applicant.

Petitioner further argues that an approved CMS Form 855B is not an "additional requirement" for effective date determination, because the regulations do not specifically indicate that Form 855B is a requirement for Medicare participation. Petitioner reasons that if the legislature wanted Form 855B to be a requirement for Medicare participation, it would have been specifically delineated in this part. Petitioner points out that 42 C.F. R. § 489.10 provides specific examples of these "additional requirements," such as bond requirements, advance directives requirements, and capitalization requirements which are express provisions of the type of additional requirements necessary for some kinds of providers or suppliers. Therefore, Petitioner maintains that failure to mention Form 855B as an "additional requirement" under 42 C.F.R. § 489.10 indicates Form 855B is not a necessary part of all provider requirements.

Petitioner is incorrect. The absence of Form 855B as a requirement in the regulations is not determinative. 42 C.F.R. Part 416 gives CMS the authority to set requirements for provider participation in the Medicare program. It would be impracticable, indeed impossible, for law makers to publish any and all possible provisions of a regulation. An ASC applying for Medicare participation is considered a "prospective supplier." A prospective supplier has a right to a hearing before an ALJ on the issue of whether it "meets the conditions for coverage of its services as those conditions are set forth elsewhere in this chapter." 42 C.F.R. § 498.3(b)(4). The "conditions for coverage of its services" are not contained in the "deeming" language of 42 C.F.R. § 416.26(a), but are set forth in subpart C of 42 C.F.R. Part 416. That subpart is specifically incorporated in 42 C.F.R. § 416.26(c), which addresses the requirements for acceptance of the ASC as qualified to furnish ambulatory surgical services.

The regulations at 42 C.F.R. § 416.26(c) dictates that a provider agreement will not be approved nor an effective date granted until after CMS has reviewed a survey *and other evidence* relating to the qualifications of the ASC. As previously noted, the other evidence relating to the qualification of the ASC in this case refers to CMS's review of Form 855B.

Petitioner further argues that even if submission of Form 855B is required, the form was submitted on four different occasions and the prior submissions provide a basis for granting the June 11, 2004 effective date.[1] However, Petitioner has advanced no objective evidence that it submitted completed forms on previous occasions. Petitioner may well have submitted Form 855B previously; however, the regulations require that the form be submitted and approved prior to CMS setting an effective certification date. 42 C.F.R. § 416.26 (c) and (e). A Departmental Appeals Board ALJ has held that a provider does not have an interest in the Medicare program until CMS acts independently to approve a provider's application for provider status. *Mariner Health Home Care of Metro West*, DAB CR980 (2002). CMS acted in accordance with the regulations and its own policies and procedures in determining that Petitioner did not meet all federal requirements until Petitioner had been accredited and had an approved CMS Form 855B. Thus, I find that CMS correctly certified Petitioner's effective date of participation in Medicare as September 28, 2007.

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[1]. Guadalupe M. Ojeda, director of nursing for Petitioner, declared that she submitted several Medicare Provider/Supplier Enrollment Applications beginning as early as February 9, 2004. P. Ex. 2. However, due to an incorrect form submission and/or delivery mishaps, none of the applications were processed by CMS' carrier, National Heritage Insurance Company (NHIC) until September 2004.

Finally, CMS maintains that this tribunal does not have the authority to award an earlier date of certification in this case or compel CMS to award an earlier certification date. CMS argues that the regulations and case law establish that retroactive certification is permitted but not required. *Oak Lawn Endoscopy,* DAB No. 1952 (2004).

A retroactive effective date for a participation agreement is available pursuant to 42 C.F.R. § 489.13(d)(2). This "Special rule" permits an effective date that is 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(d)(2).

According to CMS, there is no support in the regulations, statute or preamble which establish the proposition that this tribunal can require or compel CMS to use its discretion to certify a retroactive effective date. Furthermore, CMS maintains that case law has established that neither the doctrine of estoppel nor any other equitable remedy would entitle Petitioner to claim an earlier effective date. *Maher A.A. Azer (Florence Dialysis Center, Inc.),* DAB CR994, at 5 (2003) quoting *Arbor Hospital of Greater Indianapolis,* DAB No. 1591 (1996) and *SRA d/b/a St. May Parish Dialysis Center,* DAB CR341 (1994).

Petitioner argues that the "Special rule" for retroactivity is not required in this case to give effect to the June 11, 2004 date, and the AAAHC approval was all that is required to certify Plaza as complying with all federal requirements. Petitioner maintains that since CMS Form 855B is not a federal requirement, and it was found to meet all federal requirements, that the AAAHC certification date of June 11, 2004 should be accepted by CMS. However, Petitioner also asserts that the preamble to 42 C.F.R. § 489.13 confirms that "retroactivity should be applied in narrow circumstances such as in a situation where a facility was certified by an approved accrediting organization but did not immediately apply for Medicare certification." P. Br. at 9. Petitioner asserts that the circumstance described in the preamble where retroactivity is applicable is precisely the same circumstance in this case.

CMS maintains that Petitioner's interpretation of the "Special rule" is incorrect and unavailing. The regulation itself, CMS asserts, as construed by the DAB, clearly confers discretion on CMS to decide whether or not to grant retroactivity based on the facts of each individual case. CMS R. Br. at 6. *See Oak Lawn Endoscopy,* DAB No. 1952, at 14 n.7 (2004).

I find the arguments advanced by CMS relative to the issue of retroactivity to be persuasive and supported by case law. I find that I do not have the authority to compel CMS to use its discretion to certify a retroactive effective date. The discretion to grant or deny retroactivity as to a certification date clearly lies with CMS.

IV. Conclusion

I find that Petitioner's effective date of participation in the Medicare program is September 28, 2004, the date it met all federal requirements. Therefore, I enter summary judgment in favor of CMS and against Plaza Surgical Center .

/s/
Alfonso J. Montano
Administrative Law Judge