Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Physicians Medical Center of Santa Fé, LLC (CCN: 32-0087),	)	Date: May 13, 2008
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-07-679
	)	Decision No. CR1790
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

This matter is before me on the Motion for Summary Judgment filed by the Centers for Medicare & Medicaid Services (CMS). CMS has submitted memoranda and exhibits in support of its Motion, and Petitioner, Physicians Medical Center of Santa Fé, LLC (PMCSF), has done likewise. I have reviewed these pleadings and exhibits carefully, and have done so with particular attention to PMCSF's presentation of its case under the circumstances noted below. Having done so, I find that no material facts remain in dispute and conclude that CMS's position is correct as a matter of law. I therefore grant CMS's Motion and thus summarily affirm CMS's determination to approve PMCSF's participation as a hospital under the Medicare program effective June 13, 2007, but not earlier.

I. Procedural Background

PMCSF owns and operates a 12-bed hospital located in Santa Fé, New Mexico. On or about December 15, 2006, PMCSF began the process of applying for certification to participate in the Medicare program by submitting a CMS Form 855A to the Medicare Part A fiscal intermediary, TrailBlazer Health Enterprises (FI). Confusion and error attended the application process for several months: the FI's records reflect that the FI repeatedly asked PMCSF to clarify, correct, complete, and update the information it had

provided on the form. PMCSF was still submitting corrections to the Form 855A as late as June 11, 2007.

PMCSF applied to the New Mexico Department of Health (NMDH) for a state license to operate its hospital on March 23, 2007. NMDH conducted a survey of PMCSF's facility on April 5, 2007, for purposes of determining whether it satisfied state standards and state licensing requirements. NMDH found the facility to be in satisfaction of those state standards and requirements, and issued PMCSF a state license effective April 16, 2007. PMCSF's hospital opened for business on April 23, 2007.

While the FI's review of PMCSF's Form 855A remained incomplete, on May 3 and 4, 2007, NMDH undertook another survey of the PMCSF facility, this one purportedly for assessing its compliance with Medicare requirements. This second survey by NMDH revealed no deficiencies in PMCSF's compliance with those Medicare requirements.

The circumstances that led to this second survey by NMDH are unclear. PMCSF asserts that an official at NMDH said that the FI had, in writing, authorized NMDH to conduct the Medicare survey. CMS denies that the FI gave any such authorization, written or otherwise. PMCSF's assertion that the FI gave NMDH written authorization for the survey has never been corroborated by the production of such a written instrument, and CMS's denial that such written authorization ever existed remains uncontradicted in this record and in the FI's files. But the existence of such a written authorization is immaterial to the issue before me, just as the nature and content of any statement the NMDH official may have made to PMCSF is immaterial. What is material is the uncontested fact that, at the time of the second NMDH survey, the FI had not yet completed its review of PMCSF's Form 855A.

That review and approval of the Form 855A was not substantially complete until June 13, 2007. On that date, the FI wrote to NMDH recommending approval of PMCSF's application and authorizing the survey of PMCSF's facility, although some documentation in its application was, in fact, still incomplete. Since the second NMDH survey had already occurred — in advance of the FI's letter of June 13, 2007 — CMS determined to treat FMCSF's provider agreement as effective on June 13, 2007.

This determination was conveyed to PMCSF by CMS on August 9, 2007. PMCSF objected to June 13, 2007 as the effective date of its agreement, and in an August 10, 2007 letter to CMS, asked that its provider agreement be made effective as of May 5, 2007, the day after the second NMDH survey. CMS declined to alter the date, and affirmed the June 13, 2007 date in a letter to PMCSF on August 15, 2007.

On August 17, 2007, PMCSF's Chief Executive Officer, Lloyd W. Scarrow, timely filed a request for hearing contesting CMS's determination to certify PMCSF eligible to participate in the Medicare program effective June 13, 2007. PMCSF asserts that the effective date should be May 4, 2007.

In compliance with paragraph 2(c) of the docketing Order of September 7, 2007, CMS filed its Notice of Issues for Summary Judgment on November 6, 2007. That Notice, presented "by agreement with Petitioner, Physician's Medical Center of Santa Fe," stated CMS's intention to seek summary disposition of the case and its request that I establish a schedule for motion practice on the issue. PMCSF did not file a separate pleading in response to the docketing Order. By letter of November 16, 2007, I established a schedule for CMS's motion and for a full cycle of briefing on it.

CMS filed its Motion for Summary Judgment and Brief in Support on December 17, 2007, accompanied by proffered CMS Exhibits A through O (CMS Exs. A-O). PMCSF's Response Brief was due by January 17, 2008, but when nothing was timely filed by PMCSF, I issued my Order to Show Cause, dated January 30, 2008, requiring PMCSF to explain and justify its failure to do so by February 12, 2008.

On Saturday, February 2, 2008, Mr. Scarrow transmitted an e-mail to the Civil Remedies Division. The content of that e-mail message suggested that Mr. Scarrow, who is not an attorney, did not fully appreciate the nature of the adversary process or the nature of motion practice in the context of summary disposition, and illuminated the need for a conference with the parties. I conducted that conference by telephone on Thursday, February 7, 2008. The details of Mr. Scarrow's e-mail, the discussions held during the conference, and the actions taken as a result of it appear in my Order of February 7, 2008.

Mr. Scarrow filed PMCSF's Answer Brief on March 4, 2008, in compliance with that Order. PMCSF's Answer Brief bore two attachments, which I will treat as proffered Petitioner's Exhibits A and B (P. Exs. A, B). CMS sought and was granted leave to reply, and its Reply was filed on March 11, 2008.

Mr. Scarrow ceased to represent PMCSF before its Response Brief was due, and, under the circumstances reflected in correspondence dated April 14, 2008 and April 29, 2008, that Response Brief was filed on May 2, 2008, by Scott B. Clark, Esquire, General Counsel to PMCSF's parent company, National Surgical Hospitals.

II. Issue

The legal issue before me is narrow. It is simply whether PMCSF is entitled to approval or certification as a Medicare provider effective as of any date prior to June 13, 2007.

This legal issue has been addressed in a variety of factual settings by several other Administrative Law Judges (ALJs), by appellate panels of the Departmental Appeals Board (Board), and by me. Although some of those factual settings have differed slightly from the present one in certain details, none have differed in such a way as to establish an exception to this forum's well-settled rule that requires me to find that PMCSF is not entitled to approval or certification as a Medicare provider on any date prior to June 13, 2007.

III. Controlling Statutes and Regulations

In order to participate in the Medicare program, a prospective provider such as a hospital must apply for and be granted an approved provider agreement with CMS. The general framework of the application process is set out at section 1866 of the Social Security Act (Act), 42 U.S.C. § 1395cc. Before CMS will approve a provider agreement and certify that a prospective provider is eligible, the provider must meet all of the requirements of participation relevant to that provider. 42 C.F.R. §§ 488.3(a)(2), 489.10(a). The administrative and operational requirements for hospitals participating in Medicare are set out at 42 C.F.R. Part 482. These requirements include both conditions and standards of participation. Conditions of participation state broad general requirements. Standards of participation set forth specific requirements related to a condition.

In addition, providers wishing to participate in Medicare must meet other requirements. One requirement addresses the identity, qualifications, and character of the hospital's *operating entity*. The eligibility of the *operating entity* must be assessed according to the criteria established at 42 C.F.R. §§ 489.10 and 489.12 for transparency of ownership, reliability, financial soundness, and compliance with important civil rights standards. CMS may decline to approve a provider agreement if the hospital's *operating entity* does not meet the criteria listed at 42 C.F.R. §§ 489.10 and 489.12.

Another such requirement is that the hospital's *facility* must be surveyed on-site by an agency authorized by CMS to do so, in order that its compliance with the requirements of the Medicare program can be assessed and certified. 42 C.F.R. §§ 489.2(b)(1) and 489.10(a). When the surveying agency has completed its on-site survey, it reports the results and its recommendations to CMS. 42 C.F.R. § 488.11(a). On the basis of the agency's report and recommendations, CMS will determine whether the hospital's *facility* is eligible to participate in the Medicare program. 42 C.F.R. § 488.12(a)(1).

Generally, the earliest date on which a provider may be certified by CMS to participate in Medicare is established by 42 C.F.R. § 489.13. If a prospective provider's *operating entity* has satisfied all other requirements and the survey of that provider's *facility* is the final step in the review sequence, then 42 C.F.R. § 489.13(b) controls:

> (b) *All federal requirements are met on the date of the survey*. The agreement or approval is effective on the date the survey . . . is completed, if on that date the provider or supplier meets all applicable Federal requirements as set forth in this chapter.

In most cases, the survey is the last step in the process. But, significantly, 42 C.F.R. § 489.13(c) provides for situations in which the *facility* survey may be completed before the *operating entity* has been approved:

> (c) *All Federal requirements are not met on the date of survey*. If on the date the survey is completed the provider or supplier fails to meet any of the requirements specified in paragraph (b) of this section, the following rules apply:
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> * * * *
>
> (2) For an agreement with, or an approval of, any other provider . . . the effective date is . . . :
>
> (i) The date on which the provider or supplier meets all requirements.

Until a hospital's *operating entity*'s eligibility has been assessed and verified, and until the hospital *facility* has been assessed and certified, its agreement cannot be approved. Until its agreement has been approved based on those assessments, its status is that of a *prospective provider*. 42 C.F.R. § 498.2. With limited exceptions, none of which are relevant in the matter presently before me, a *prospective provider*, such as a hospital, may not receive reimbursement for services provided to Medicare beneficiaries prior to the effective date of its provider agreement. Act, section 1814(a) (42 U.S.C. § 1395f(a)).

IV. Findings of Fact and Conclusions of Law

I find and conclude as follows:

1. Petitioner PMCSF did not meet all applicable federal requirements for participation in the Medicare program when the NMDH survey of its facility was completed on May 4, 2007.

2. Petitioner PMCSF did not meet all applicable federal requirements for participation in the Medicare program at any time between May 4, 2007 and June 13, 2007.

3. Petitioner PMCSF first met all applicable federal requirements for participation in the Medicare program on June 13, 2007.

4. Petitioner PMCSF is entitled to approval or certification as a Medicare provider effective June 13, 2007, but not sooner.

5. There are no disputed issues of material fact and summary disposition is appropriate in this matter.

V. Discussion

Although the source and history of this controversy are marked by a certain amount of confusion, the rules governing its resolution are not. They may be simply stated: a hospital is not entitled to certification as a Medicare provider, and CMS may not certify it as a Medicare provider, until the hospital meets all applicable federal requirements for participation in the Medicare program.

There is no dispute as to the material facts surrounding the sequence of steps leading to the FI's June 13, 2007 letter. NMDH completed its survey of PMCSF's facility on May 4, 2007, and found the facility in compliance with Medicare requirements. The FI completed its review of PMCSF's operating entity on June 13, 2007, and found the operating entity in compliance with Medicare requirements. It may very well be that this sequence is, in substance, a reversal of the usual sequence in which the facility survey is not undertaken until the FI has approved the operating entity; with only one significant exception, recorded litigation in this forum seems to be based on an "entity-approval first, facility-inspection next" model for that sequence. But that significant exception provides conclusive authority for the result I announce here.

That significant exception to the usual sequence appears in *SRA, Inc., D/B/A/ St. Mary Parish Dialysis Center*, DAB CR341 (1994), a case in which an end-stage renal disease treatment center (ESRD) sought certification of its Medicare provider agreement. The ESRD successfully "passed" a state agency survey of its facility, but certain aspects of the ESRD's management, supervisory, and professional arrangements were not then in compliance with Medicare requirements. Eventually those operating arrangements were corrected and approved by CMS's predecessor agency, the Health Care Financing Administration (HCFA). The ESRD claimed that it was entitled to certification as of the date of the successful survey, but HCFA insisted that the ESRD had not met all requirements until its operating arrangements were finally approved. In upholding

HCFA's position, Administrative Law Judge (ALJ) S.T. Kessel announced the rule that controls this case:

> The regulations provide plainly that, where a provider or supplier fails to meet certification requirements at the date of the inspection, it will be found to satisfy those requirements either on the date when it actually meets the requirements or on the date that it submits a plan of correction acceptable to HCFA, whichever comes first. 42 C.F.R. 489.13(a) and (b). Thus, a provider or supplier cannot be certified effective the date of survey where: (1) deficiencies are found to exist as of the survey date, and (2) the deficiencies are not corrected (or an acceptable plan of correction is not submitted by the provider or supplier) until a subsequent date.

SRA, DAB CR341, at 33, 34.

In this case, PMCSF simply did not meet "all requirements" for certification until its operating entity had been assessed and approved by the FI on June 13, 2007. On the principles ALJ Kessel explained in *SRA*, PMCSF could not "be certified effective the date of survey" because uncorrected deficiencies in its operating entity existed on that date.

There are no exceptions to these rules based on delays in the administrative process of reviewing the hospital's satisfaction of the participation requirements, and there are no exceptions based on a hospital's claimed reliance on allegedly-erroneous representations it complains were made to it by representatives of CMS, a state agency, or a fiscal intermediary. Thus, the argument over what the FI may have said to NMDH — and what an official at NMDH is alleged have said to PMCSF's Mr. Scarrow — in connection with NMDH's May 4, 2007 survey of the PMCSF facility is irrelevant, and, to the extent that facts in that argument remain unresolved, those facts are immaterial to the application of the rules that govern the disposition of this case.

Because the briefing submitted on behalf of PMCSF depends so heavily on Mr. Scarrow's asserted reliance on incorrect information allegedly given to him by the NMDH official and the FI, it may be helpful to emphasize why those claims are immaterial and require no resolution of the factual disputes behind them. PMCSF's theory is straightforward enough: it is that PMCSF was misled to its detriment by false assurances given to it by NMDH and the FI, and that CMS should not be permitted to renege on those assurances. Such a theory, if supported by the facts precisely as Mr. Scarrow has alleged them, would represent the purest form of equitable estoppel. And equitable estoppel, particularly in cases involving the effective dates of Medicare provider agreements, is specifically beyond my authority to consider. *Oklahoma Heart Hospital*, DAB CR1719, at 10-11 (2008); *Maher A. A. Azer (Florence Dialysis Center, Inc.)*, DAB CR994 (2003); *Danville*

HealthCare Surgery Center, DAB CR892 (2002); *Everett Rehabilitation and Medical Center*, DAB CR455 (1997), *aff'd* DAB No. 1628 (1997). In short, *whether* PMCSF was told anything by NMDH or the FI, and, if so, *what* it was told, are questions of fact that have no bearing on the issues I may properly consider. They are immaterial questions of fact, and, unresolved or not, represent no bar to summary disposition.

VI. Conclusion

For the reasons discussed above, I grant CMS's Motion for Summary Judgment, and affirm CMS's determination to certify PMCSF to participate in the Medicare program as a Medicare provider effective June 13, 2007, but not sooner.

/s/
Richard J. Smith
Administrative Law Judge