Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Humble Surgical Hospital, LLC,
(CCN: 67-0074),

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-11-805

Decision No. CR2862

Date: July 18, 2013

DECISION

Petitioner, Humble Surgical Hospital, LLC, was not in substantial compliance with program participation requirements due to violation of 42 C.F.R. § 482.43,[1] as determined by a survey completed on August 24, 2011. There is a basis for the termination of Petitioner's provider agreement and participation in Medicare effective September 23, 2011.

I. Background

Petitioner is located in Houston, Texas, and participated in Medicare as a hospital. On July 22, 2011, Petitioner was surveyed by the Texas Department of State Health Services (state agency). On August 2, 2011, the Centers for Medicare and Medicaid Services (CMS) notified Petitioner that it no longer met the requirements to participate in Medicare due to deficiencies that posed an immediate and serious threat to patient health and safety. CMS advised Petitioner that its provider agreement would be terminated on

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[1] References are to the 2010 revision of the Code of Federal Regulations (C.F.R.) in effect at the time of the survey, unless otherwise stated.

August 26, 2011. On August 26, 2011, CMS changed the termination date to September 23, 2011, to permit the state agency to conduct a revisit survey. The state agency completed a revisit survey on August 24, 2011, and found that Petitioner remained out of substantial compliance and that Petitioner did not meet the conditions for Medicare participation. On September 6, 2011, CMS notified Petitioner that its provider agreement would be terminated on September 23, 2011. Joint Statement of Undisputed Facts. Petitioner's provider agreement and participation in Medicare was terminated effective September 23, 2011. Transcript (Tr.) 25.

Petitioner requested a hearing before an administrative law judge (ALJ) on September 20, 2011. The case was assigned to me for hearing and decision on September 28, 2011, and an Acknowledgement and Prehearing Order was issued at my direction. The case was set for hearing on April 24 through 27, 2012, in Houston, Texas, but that hearing was postponed upon request of the parties. On July 24 and 25, 2012, a hearing was convened in Houston, Texas, and a transcript of the proceedings was prepared. CMS offered CMS exhibits (CMS Ex.) 1 through 17. CMS Exs. 3 through 17 were admitted as evidence. Tr. 18-27, 443-51. Petitioner offered Petitioner exhibits (P. Ex.) 1 through 17 and 19 through 39. Petitioner withdrew P. Ex. 18. P. Exs. 1 through 17 and 19 through 39 were admitted into evidence. Tr. 28-32, 292-300. CMS called Surveyor Carol Hall, RN, as a witness. Petitioner called the following witnesses: Jakob Kohl, Vice President, Humble Surgical Hospital; Shakeel Uddin, M.D., Petitioner's Medical Director; and Debbie Cormier, RN, BSN, MHA, Petitioner's Chief Nursing Officer and Administrator. The parties filed post-hearing briefs and post-hearing reply briefs (CMS Br. and CMS Reply and P. Br. and P. Reply, respectively).

On September 28, 2012, Petitioner offered as a post-hearing exhibit, a document which purports to be copies of pages 142 through 144 and 175 through 189 from chapter 8 of *The Lippincott Manual of Nursing Practice* (6th ed. 1996).[2] The document was not marked in accordance with the Prehearing Order or the Civil Remedies Division Procedures. I have marked the document P. Ex. 40, pages 1 through 19. CMS filed an objection on October 18, 2012. CMS does not challenge the authenticity of the document but argues that it is "belated" and an improper offer of substantive evidence under Fed. R. Evid. 803(18). The Federal Rules of Evidence are not applicable to this proceeding except to the extent they provide guidance. CMS does not challenge the authenticity of P. Ex. 40, and it is relevant as evidence of the standard of practice adopted by Petitioner

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[2] This is not the most current edition of the treatise, but there was no objection on that basis. The proffer of this document is accepted as counsel's representation that this is the edition of the treatise used by Petitioner, or that provisions of the treatise offered are the same as those used by Petitioner. *See* Fed. R. Civ. Pro. 11(b).

at least for purposes of evaluating the competency of its nursing staff. Accordingly, P. Ex. 40 is admitted as evidence.

II. Discussion

A. Issue

Whether there is a basis for the termination of Petitioner's provider agreement and participation in Medicare.

B. Applicable Law

The statutory and regulatory requirements for participation of a hospital in Medicare are found at section 1861(e) of the Social Security Act (Act) and at 42 C.F.R. pt. 482.

A hospital is an institution that, among other requirements, primarily engages in providing to inpatients, "by or under the supervision of physicians," (A) diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled or sick persons, or (B) rehabilitation services for injured, disabled, or sick persons. Act § 1861(e)(1). A hospital 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 § 1861(e); 42 C.F.R. pt. 482; 42 C.F.R. § 488.3. CMS, acting pursuant to delegated authority of the Secretary of Health and Human Services (the Secretary), may terminate a provider agreement based on the provider's failure to comply substantially with the provisions of section 1861 of the Act or the regulations governing hospital program participation at 42 C.F.R. pt. 482. Act § 1866(b)(2); 42 C.F.R. § 489.53(a)(1) and (3).

The conditions of participation for hospitals are set forth in the Secretary's regulations at 42 C.F.R. pt. 482 and most of the conditions list one or more standards. Survey, certification, and enforcement procedures are set forth at 42 C.F.R. pt. 488. Provider agreements, including their approval and termination, are the subject of 42 C.F.R. pt. 489. The determination of whether a hospital meets a condition of participation "depends upon the manner and degree to which the provider . . . satisfies the various standards within each condition." 42 C.F.R. § 488.26(b); *Profound Health Care*, DAB No. 2371 (2011); *Aspen Grove Home Health*, DAB No. 2275 (2009); *CSM Home Health Services*, DAB No. 1622, at 6-7 (1997). A state survey agency conducts a survey pursuant to an agreement with the Secretary, and subject to the Secretary's regulations, to determine whether a hospital is in compliance with the conditions of participation set forth in 42 C.F.R. pt. 482. 42 C.F.R. §§ 482.1(b), 488.10, 488.11, 488.20, 488.24, 488.26. After completing its survey, the state survey agency certifies its findings to CMS and the certification survey by the state survey agency is treated as a recommendation to CMS. 42 C.F.R. §§ 488.11, 488.12, 488.24, 488.27. A state survey agency certification to CMS

that a provider no longer is in compliance with one or more conditions of participation supersedes a state's prior certification of compliance. 42 C.F.R. § 488.20(c). The regulations require that a state survey agency certify noncompliance when "the deficiencies are of such character as to substantially limit the provider's . . . capacity to furnish adequate care or which adversely affect the health and safety of patients." 42 C.F.R. § 488.24(b).

CMS may terminate a provider's agreement if CMS determines that the provider no longer meets one or more of the statutory or regulatory conditions for participation. 42 C.F.R. § 489.53(a)(1) and (3). CMS must give notice of its decision to terminate a provider agreement not less than 15 days prior to the effective date of the termination, with certain exceptions for hospitals with emergency departments and skilled nursing facilities. The notice must state the reason for and effective date of the termination and the extent to which services may continue after the termination. 42 C.F.R. § 489.53(d).

A provider has the right to have the CMS decision to terminate its provider agreement reviewed in accordance with the provisions of 42 C.F.R. pt. 498. 42 C.F.R. §§ 488.24(c), 489.53(e). The provider's right to appeal includes rights to notice and a *de novo* hearing by an Administrative Law Judge (ALJ) and judicial review. Act § 1866(h)(1); 42 C.F.R. §§ 498.3(b)(8), 498.5(b). The hearing before an ALJ pursuant to 42 C.F.R. pt. 498, is a *de novo* proceeding. *The Residence at Salem Woods*, DAB No. 2052 (2006); *Cal Turner Extended Care*, DAB No. 2030 (2006); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Emerald Oaks*, DAB No. 1800, at 11 (2001); *Anesthesiologists Affiliated*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991). The standard of proof, or quantum of evidence required, is a preponderance of the evidence. CMS has the burden of coming forward with the evidence and making a prima facie showing of a basis for termination. The Departmental Appeals Board has stated that CMS must come forward with "evidence related to disputed findings that is sufficient (together with any undisputed findings and relevant legal authority) to establish a prima facie case of noncompliance with a regulatory requirement." *Evergreene Nursing Care Ctr.*, DAB No. 2069, at 7 (2007); *Batavia Nursing and Convalescent Ctr.*, DAB No 1904. "Prima facie" means generally 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). In *Hillman Rehab. Ctr.*, the Board described the elements of the CMS prima facie case in general terms as follows:

> HCFA [now known as CMS] must identify the legal criteria to which it seeks to hold a provider. Moreover, to the extent that a provider challenges HCFA's findings, HCFA must come forward with evidence of the basis for its determination, including the factual findings on which HCFA is relying and, if HCFA has determined that a condition of participation was

> not met, HCFA's evaluation that the deficiencies found meet the regulatory standard for a condition-level deficiency.

DAB No. 1611, at 8 (1997). CMS makes a prima facie showing if the credible evidence CMS relies on is sufficient to support a decision in its favor absent an effective rebuttal. The Act or regulations give Petitioner notice of the criteria or elements it must meet to comply with the conditions of participation established by the regulations. 5 U.S.C. §§ 551(4), 552(a)(1).

The Board has long held that Petitioner bears the burden of persuasion to show by a preponderance of the evidence that it was in compliance with the condition of participation or any affirmative defense. *Batavia Nursing & Convalescent Inn*, DAB No. 1911 (2004); *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 F. App'x 181 (6th Cir. 2005); *Emerald Oaks*, DAB No. 1800; *Cross Creek Health Care Ctr.*, DAB No. 1665 (1998); *Hillman Rehab. Ctr.*, DAB No. 1611 (1997), *aff'd, Hillman Rehab. Ctr. v. United States*, No. 98-3789 (GEB), 1999 WL 34813783 (D.N.J. May 13, 1999). However, only when CMS makes a prima facie showing of noncompliance, is the facility burdened to show, by a preponderance of the evidence on the record as a whole, that it was in substantial compliance or had an affirmative defense. *Evergreene Nursing Care Ctr.*, DAB No. 2069, at 4. A facility can overcome CMS's prima facie case either by rebutting the evidence upon which that case rests, or by proving facts that affirmatively show compliance. "An effective rebuttal of CMS's prima facie case would mean that at the close of the evidence the provider had shown that the facts on which its case depended (that is, for which it had the burden of proof) were supported by a preponderance of the evidence." *Id.*, at 7-8 (citations omitted).

C. Findings of Fact, Conclusions of Law, and Analysis

My conclusions of law are set forth in bold text followed by my findings of fact and analysis. I have carefully considered all the evidence and the arguments of both parties, although not all may be specifically discussed in this decision. I discuss the credible evidence given the greatest weight in my decision-making.[3] I also discuss any evidence that I find is not credible or worthy of weight. The fact that evidence is not specifically discussed should not be considered sufficient to rebut the presumption that I considered all the evidence and assigned such weight or probative value to the credible evidence that

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[3] "Credible evidence" is evidence that is worthy of belief. *Black's Law Dictionary* 596 (8th ed. 2004). The "weight of evidence" is the persuasiveness of some evidence compared to other evidence. *Id*. at 1625.

I determined appropriate within my discretion as an ALJ. There is no requirement for me to discuss the weight given every piece of evidence considered in this case, nor would it be consistent with notions of judicial economy to do so.

The parties stipulated that the termination of Petitioner's provider agreement was based only upon the survey completed August 24, 2011, and the only matters at issue before me relate to that survey. Tr. 22-23. The Statement of Deficiencies (SOD) for the survey completed on August 24, 2011, reflects that the survey was an unannounced full survey to determine Petitioner's compliance with the conditions for participation established by 42 C.F.R. pt. 482. The SOD alleges the following condition-level violations: 42 C.F.R. §§ 482.12 (Tag A0043[4]); 482.13 (Tag A0115); 482.21 (Tag A0263); 482.23 (Tag A0385); 482.28 (Tag A0618); 482.43 (Tag A0799); and 482.57 (Tag A1151). CMS Ex. 7, at 2, 11, 18, 21, 31, 38, 39. CMS notified Petitioner by letter dated September 6, 2011, that CMS was terminating Petitioner's provider agreement and participation in Medicare effective September 23, 2011, based on the condition-level violations cited in the SOD. CMS Ex. 6, at 1. In its post-hearing brief, CMS asserts that it made a prima facie showing of condition-level noncompliance based on violations of 42 C.F.R. §§ 482.21 (Tag A0263); 482.23 (Tag A0385); 482.43 (Tag A0799); and 482.57 (Tag A1151). CMS Br. at 2-3. I construe the CMS statement to be a concession that it did not make a prima facie showing as to the remaining alleged deficiencies, and I conclude that the deficiencies for which CMS conceded it did not make a prima facie showing provide no basis for termination of Petitioner's provider agreement. Pursuant to 42 C.F.R. § 489.53(3), a provider's failure to meet a single condition of participation is a sufficient basis for termination. In this case, I conclude that Petitioner was not in compliance with the discharge planning requirements established by 42 C.F.R. § 482.43 (Tag A0799); Petitioner's noncompliance with 42 C.F.R. § 482.43 was at the condition-level; Petitioner's condition-level noncompliance with 42 C.F.R. § 482.43 is a basis for

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[4] This is a "Tag" designation as used in CMS Publication 100-07, State Operations Manual (SOM), app. A – "Survey Protocol, Regulations and Interpretive Guidelines for Hospitals" available at http://www.cms.hhs.gov/Manuals/IOM/list.asp. The "Tag" refers to the specific regulatory provision allegedly violated and CMS's policy guidance to surveyors. The SOM does not have the force and effect of law, but the provisions of the Act and regulations interpreted clearly do have such force and effect. *Ind. Dep't. of Pub. Welfare v. Sullivan*, 934 F.2d 853 (7th Cir. 1991); *Northwest Tissue Ctr. v. Shalala*, 1 F.3d 522 (7th Cir. 1993). Thus, while the Secretary may not seek to enforce the provisions of the SOM, she may seek to enforce the provisions of the Act or regulations as interpreted by the SOM.

termination of Petitioner's provider agreement pursuant to 42 C.F.R. § 489.53(a)(3); and, therefore, it is unnecessary to discuss the three remaining citations of noncompliance.[5]

> **1. Petitioner was not in compliance with the condition for participation at 42 C.F.R. § 482.43, which establishes discharge planning requirements.**
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> **2. Petitioner's noncompliance with 42 C.F.R. § 482.43 was at the condition-level as the noncompliance substantially limited Petitioner's capacity to furnish adequate care and adversely affected the health and safety of patients. 42 C.F.R. § 488.24, 488.26, 488.28.**
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> **3. Petitioner's noncompliance with the condition for participation related to discharge planning established by 42 C.F.R. § 482.43 is a basis for termination of Petitioner's provider agreement and participation in Medicare pursuant to 42 C.F.R. §§ 424.535(a)(1) and 489.53(a)(1) and (3).**

It is necessary to clarify, as a preliminary matter, what law that establishes discharge planning requirements CMS seeks to enforce in this proceeding. The Act defines the term "hospital" in section 1861(e) and, thereby, establishes certain requirements for a provider to qualify to participate in Medicare as a hospital. Failure to comply with the requirement of Title XVIII of the Act, which includes section 1861(e), is an authorized basis for termination of a provider agreement. 42 C.F.R. § 489.53(a)(1). The surveyors did not cite Petitioner for noncompliance with any provision of Title XVIII of the Act and CMS did not give Petitioner notice that it was being terminated for such a violation. CMS Exs. 6, 7.

CMS argues in its post-hearing brief that Petitioner admitted at hearing that "its discharge plan did not require its staff to identify, at an early stage, patients who could suffer

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[5] In its September 20, 2011 request for hearing at page 4, Petitioner asserts that it preserves legal challenges to issues beyond my authority and that of the Board to adjudicate, specifically: (1) the regulations on which the findings of noncompliance are based are unconstitutionally vague; (2) the forms, methods, procedures, and guidelines used to conduct the survey are illegal and deprived Petitioner of due process because they were not promulgated in accordance with the Administrative Procedures Act, 5 U.S.C. § 553 et. seq. Petitioner does not seek my opinion on these issues and none is offered. I note however, that I do not find that Petitioner was deprived of due process under current regulations and policies of the Secretary promulgated pursuant to authority of the Act.

adverse health consequences if there is inadequate discharge planning." CMS Br. at 2, 8-13; CMS Reply at 5-6. CMS correctly argues that a hospital as defined by section 1861(e) must have the discharge planning process required by section 1861(ee) that does identify at an early stage, patients who could suffer adverse health consequences if discharge planning is inadequate. Section 1861(ee)(1) provides that discharge planning is sufficient if it meets the guidelines and standards established by the Secretary under section 1861(ee)(2). Section 1861(ee) requires that the Secretary develop guidelines and standards for the discharge planning process to ensure "timely and smooth transition to the most appropriate type of and setting for post-hospital or rehabilitative care." Congress specified that the Secretary include certain guidelines and standards as follows:

> (2) The Secretary shall develop guidelines and standards for the discharge planning process in order to ensure a timely and smooth transition to the most appropriate type of and setting for post-hospital or rehabilitative care. The guidelines and standards shall include the following:
>
> (A) The hospital must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning.
>
> (B) Hospitals must provide a discharge planning evaluation for patients identified under subparagraph (A) and for other patients upon the request of the patient, patient's representative, or patient's physician.
>
> (C) Any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-hospital care will be made before discharge and to avoid unnecessary delays in discharge.
>
> (D) A discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-hospital services, including hospice care and post-hospital extended care services and the availability of those services, including the availability of home health services through individuals and entities that participate in the program under this title and that serve the area in which the patient resides and that request to be listed by the hospital as available and, in the case of individuals who are likely to need post-hospital extended care services, the availability of such services

> through facilities that participate in the program under this title and that serve the area in which the patient resides.
>
> (E) The discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative).
>
> (F) Upon the request of a patient's physician, the hospital must arrange for the development and initial implementation of a discharge plan for the patient.
>
> (G) Any discharge planning evaluation or discharge plan required under this paragraph must be developed by, or under the supervision of, a registered professional nurse, social worker, or other appropriately qualified personnel.
>
> (H) Consistent with section 1802, the discharge plan shall—
>
> > (i) not specify or otherwise limit the qualified provider which may provide post-hospital home health services, and
> >
> > (ii) identify (in a form and manner specified by the Secretary) any entity to whom the individual is referred in which the hospital has a disclosable financial interest (as specified by the Secretary consistent with section 1866(a)(1)(S)) or which has such an interest in the hospital.

Act § 1861(ee)(2).

The Secretary promulgated 42 C.F.R. § 482.43, which establishes guidelines and standards as required by Congress as follows:

> The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing.
>
> (a) Standard: Identification of patients in need of discharge planning.

The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning.

(b) Standard: Discharge planning evaluation.

(1) The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician.

(2) A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, the evaluation.

(3) The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services.

(4) The discharge planning evaluation must include an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital.

(5) The hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge.

(6) The hospital must include the discharge planning evaluation in the patient's medical record for use in establishing an appropriate discharge plan and must discuss the results of the evaluation with the patient or individual acting on his or her behalf.

(c) Standard: Discharge plan.

(1) A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, a discharge plan if the

discharge planning evaluation indicates a need for a discharge plan.

(2) In the absence of a finding by the hospital that a patient needs a discharge plan, the patient's physician may request a discharge plan. In such a case, the hospital must develop a discharge plan for the patient.

(3) The hospital must arrange for the initial implementation of the patient's discharge plan.

(4) The hospital must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.

(5) As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care.

(6) The hospital must include in the discharge plan a list of HHAs or SNFs that are available to the patient, that are participating in the Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF, in the geographic area requested by the patient. HHAs must request to be listed by the hospital as available.

(i) This list must only be presented to patients for whom home health care or post-hospital extended care services are indicated and appropriate as determined by the discharge planning evaluation.
(ii) For patients enrolled in managed care organizations, the hospital must indicate the availability of home health and post-hospital extended care services through individuals and entities that have a contract with the managed care organizations.
(iii) The hospital must document in the patient's medical record that the list was presented to the patient or to the individual acting on the patient's behalf.

(7) The hospital, as part of the discharge planning process, must inform the patient or the patient's family of their freedom to choose among participating Medicare

> providers of posthospital care services and must, when possible, respect patient and family preferences when they are expressed. The hospital must not specify or otherwise limit the qualified providers that are available to the patient.
>
> (8) The discharge plan must identify any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest, as specified by the Secretary, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare. Financial interests that are disclosable under Medicare are determined in accordance with the provisions of Part 420, Subpart C, of this chapter.
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> (d) Standard: Transfer or referral.
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> The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for followup or ancillary care.
>
> (e) Standard: Reassessment.
>
> The hospital must reassess its discharge planning process on an on-going basis. The reassessment must include a review of discharge plans to ensure that they are responsive to discharge needs.

42 C.F.R. § 482.43.

The surveyors cited noncompliance with 42 C.F.R. § 482.43 and CMS notified Petitioner that noncompliance with the condition of participation established by 42 C.F.R. § 482.43 was a basis for termination. The standards and guidelines that the Secretary promulgated are those that Congress intended that a hospital must fulfill. Act §§ 1861(e)(6)(B), 1861(ee)(2). The plain language of section 1861(ee)(1) reflects the intent of Congress that a hospital's discharge planning process meet the guidelines and standards established by the Secretary. The plain language of section 1861(ee)(2) shows that that provision of the Act was Congressional direction to the Secretary, not the standard to which Petitioner should be held. If Congress had intended otherwise, section 1861(ee)(2) could have been simply rephrased to specify that the discharge planning of a participating hospital must meet the specified requirement. Whether or not Petitioner was noncompliant with the discharge planning requirements established by 42 C.F.R. § 482.43, is properly at issue

before me as alleged in the SOD, not whether Petitioner was in compliance with section 1861(ee) of the Act. P. Reply at 2-6.

a. Facts

Petitioner opened its surgical hospital in August 2010. Tr. 347. Petitioner's facility includes five inpatient beds for the medical/surgical inpatient unit; one emergency room bed; six operating room suites, one of which is used as the catheterization laboratory; two procedure rooms; six preoperative beds; and nine post-anesthesia care unit (PACU) recovery room beds. Tr. 270-71.

The surveyors cited examples of three residents, Patients 25, 22, and 23, as the basis for the alleged violation of 42 C.F.R. § 482.43 (Tag A0799). CMS Ex. 7, at 38-39; Tr. 45. There is no dispute about what happened to Patient 25 and the following facts are gleaned from Petitioner's clinical records for Patient 25 placed in evidence by CMS as CMS Exs. 3, 4, 10, and 11.

On June 22, 2011, Patient 25, who was 73 years old, was admitted to Petitioner by her surgeon Robert Berwind, M.D., for exploration and evaluation of a large cyst on her left kidney. She complained of a three-year history of back and left flank pain that had worsened during the preceding six months. Her history and physical shows that she had a history of hypertension but no complaints of shortness of breath, chest pain, or swelling of her lower extremities. CMS Ex. 3, at 2-4, 7. Dr. Berwind performed surgery on June 22, 2011 and removed a left renal mass with part of the left kidney and a renal cyst. CMS Ex. 3, at 9-10. Following surgery, Patient 25 was left on supplemental oxygen. She complained of left flank pressure or pain, and had some nausea that was treated. Attempts to wean her off supplemental oxygen were not successful as her blood oxygen would drop when the supplemental oxygen was removed. Normal oxygen saturation is 95 to 100 percent at sea level and Petitioner's records show that Patient 25's oxygen saturation dropped as low as 82 percent on one occasion when oxygen was removed. Tr. 59; CMS Ex. 3, at 53-90.

On June 25, 2011 at about 11:30 p.m., a nurse noted that Patient 25's abdomen was distended and tender and she complained of discomfort. Dr. Berwind was notified. CMS Ex. 3, at 74. Patient 25's complaints of abdominal discomfort continued with staff noting abdominal distention that was firm, constipation, flatulence, and belching. CMS Ex. 3, at 77-88.

A nurse's note dated June 27, 2011 at 7:00 a.m. states that Patient 25 was sitting up with oxygen on; she had pale yellowish complexion; she had audible wheezing; her breath sounds were diminished in both lungs; her abdomen remained distended and sore to palpitation; she complained of pain with movement; and breathing treatment with Albuterol (a bronchodilator) had been started as ordered. CMS Ex. 3, at 89. A nurse's

note on June 27, 2011 at 9:30 a.m. states that Dr. Berwind visited with Patient 25 and her daughter. Dr. Berwind issued discharge orders for Patient 25 to go home on oxygen; with a leg bag for her Foley catheter; and direction to see him the next day. A note at 10:00 a.m. states that when the oxygen was removed to give Patient 25 a shower, she became short of breath and she was returned to bed and oxygen was applied. A note at 10:45 a.m. states "Rocephin hung." Rocephin is an antibiotic. A note at 11:30 a.m. states that Patient 25's daughter was instructed on how to empty Patient 25's urine bag and she was given a copy of the discharge instruction. The note also states that the daughter was encouraged to take Patient 25 to the emergency room for complications, difficulty breathing, and signs of an uncontrolled infection near the incision site. A note at 11:45 a.m. states that Patient 25 was discharged to the care of her daughter. CMS Ex. 3, at 89-90, 114; CMS Ex. 10, at 112. Medication records show that Patient 25 had been given Rocephin intravenously on June 22, 23, 25, and 26, 2011, and she was given the antibiotic Ceftin by mouth on June 24, 2011. CMS Ex. 3, at 96-101.

Following the discharge of Patient 25 on June 27, 2011, Patient 25's daughter took her to Petitioner's emergency room where Patient 25 was assessed beginning at 12:22 p.m. for a complaint of shortness of breath for four days. She was assessed as having a fever of 100.3 degrees, shortness of breath, wheezing, decreased breath sounds in the left lung, and a productive cough. Her abdomen was assessed as distended and rigid with increased bowel sounds. CMS Ex. 4, at 5; CMS Ex. 10, at 5. A chest x-ray on June 27, 2011, showed that she had a left pleural effusion. CMS Ex. 10, at 11-12. A note at 5:42 p.m. on June 27, 2011, indicates that Patient 25 was being transferred to Kingwood Medical Center. A note at 6:07 p.m. states that Patient 25 was transferred.[6] CMS Ex. 4, at 13-14.

Petitioner offered as evidence its written Discharge Planning policy (P. Ex. 34) and a copy of its Medical Staff Bylaws which discusses discharge of patients in section 1.6 (P. Ex. 4, at 39-40). Neither document is dated or signed, but the unrebutted testimony of Petitioner's witness, Jakob Kohl, is that both documents were approved and adopted by the hospital board prior to the August 2011 survey. Tr. 453, 491-96, 499-503; P. Ex. 3, at 12, 26. The fact that the surveyors were not provided copies of the policy or bylaws during the survey (Tr. 67-68, 445-48), does not cause me to find that Mr. Kohl's testimony was not credible. I find that Petitioner had a written discharge planning policy that had been approved for implementation prior to the survey of August 2011.

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[6] Patient 25's subsequent treatment at Kingwood Medical Center is not relevant to my decision. However, readers may be interested to know that as of her discharge from Kingwood on July 11, 2011, Patient 25 was recovering following surgery to correct a perforation of her colon and treatment of the resulting peritonitis. CMS Ex. 4, at 42-43; CMS Ex. 11.

b. Analysis

On July 25, 2012, after CMS concluded its case-in-chief, Petitioner filed a written motion for a judgment on partial findings, pursuant to Fed. R. Civ. Pro. 52(c), and both parties were permitted to offer oral argument at hearing. Tr. 224-48. The Federal Rules of Civil Procedure do not control this proceeding but are often used as guidance. For example, Fed. R. Civ. Pro. 56, which establishes a summary judgment procedure for the federal courts and decisions of the federal courts related to the rule are often referred to and applied when a motion for summary judgment is filed in a case pending before an ALJ. Fed. R. Civ. Pro. 52(c) provides that a federal court in a nonjury trial may enter a judgment against a party that has been fully heard on an issue if the party can maintain its claim or defense only upon a favorable ruling upon the issue. The Board has long held that CMS must make a prima facie showing of the basis for its action. Therefore, if at the conclusion of the CMS case-in-chief, the evidence does not establish all the elements of the CMS prima facie case, a motion in the nature of a motion for judgment on partial findings pursuant to Fed. R. Civ. Pro. 52(c) is appropriate. If such a motion has merit, judgment could appropriately be entered against CMS. Fed. R. Civ. Pro. 52(c) provides that a judge may decline to enter any judgment until the close of the evidence, as I have done in this case. Although Petitioner has properly characterized its motion, the motion must be denied as I conclude that CMS has made a prima facie showing of noncompliance with the condition-level requirement established by 42 C.F.R. § 482.43.

I further conclude that Petitioner has failed to meet its burden to rebut the CMS prima facie case or to establish an affirmative defense.

Congress provided in section 1866(a) of the Act that any provider of services, except specifically designated funds, are qualified to participate in the health insurance program for the aged and disabled under Title XVIII of the Act, known as Medicare, if the provider files with the Secretary an agreement with the terms in that section. In section 1866(b)(2), Congress specified when the Secretary may refuse to enter or renew or terminate a contract. Four grounds are specified: (1) failure to substantially comply with the terms of the agreement, the provisions of Title XVIII, the regulations, or required corrective action under section 1886(f)(2)(B); (2) failure to meet the requirements of section 1861; (3) exclusion by the Inspector General pursuant to sections 1128 or 1128A; or (4) conviction of a felony that the Secretary determines is detrimental to the best interest of the program or program beneficiaries.

The Secretary delegated authority to CMS to revoke a currently enrolled provider or supplier's Medicare billing privileges and any related provider or supplier agreement for any of the ten reasons listed at 42 C.F.R. § 424.535(a). The reason for revocation implicated in this case is 42 C.F.R. § 424.535(a)(1), failure to maintain compliance with enrollment requirements after notice of the noncompliance and failure to correct the

noncompliance. The required terms for provider agreements are set forth in 42 C.F.R. pt. 489, which also establishes procedures for termination. Sixteen reasons that CMS may terminate a provider agreement are established by 42 C.F.R. § 489.53. The two reasons for termination implicated in this case are: (1) failure to comply with Title XVIII of the Act, the applicable regulations, or the terms of the agreement; and (3) failure to meet the conditions of participation established by the regulation.

The conditions for participation for hospitals are established by 42 C.F.R. Part 482. It is a condition of participation that a hospital have in effect a written discharge planning process that applies to all patients. 42 C.F.R. § 482.43. The regulation has two requirements: (1) the discharge planning process must be in writing; and (2) the discharge planning process must be in effect. The determination by the state agency and CMS as to whether Petitioner was in compliance with this condition of participation "depends upon the manner and degree to which [Petitioner] satisfies the various standards within" the condition. 42 C.F.R. § 488.26. If a survey finds that a provider is not in compliance with one or more standards, the provider is granted a reasonable time to achieve compliance. 42 C.F.R. § 488.28. However, the state survey agency must certify to CMS that a provider is not in compliance with a condition of participation, "where the deficiencies are of such character as to substantially limit the provider's or supplier's capacity to furnish adequate care or which adversely affect the health and safety of patients." 42 C.F.R. § 488.24(b). If CMS agrees that a provider is noncompliant with a condition for participation, CMS terminates the provider's participation in Medicare (billing privileges and provider agreement) using the procedures of 42 C.F.R. pt. 498 and the provider has a right to review as provided by 42 C.F.R. pt. 498. 42 C.F.R. § 488.24(c). My *de novo* review under 42 C.F.R. pt. 498 is guided by the same principles and considerations applicable to the state survey agency and CMS determinations. Therefore, in order to make a prima facie showing of noncompliance that will support termination of Petitioner's participation in Medicare, CMS must show that: (1) Petitioner violated 42 C.F.R. § 482.43; and (2) the violation rose to the condition-level because the violation either substantially limited Petitioner's capacity to furnish adequate care or adversely affected the health and safety of Petitioner's patients.

i. Petitioner's Discharge Planning Policy

The surveyors concluded that Petitioner had no discharge planning policy as none was provided during the survey, and the surveyors cited Petitioner for a condition-level violation of 42 C.F.R. § 482.43, in part, for that reason. Tr. 66-70, 141; CMS Ex. 7, at 38. The CMS evidence, if unrebutted, is sufficient to meet the CMS burden to make a prima facie showing of a condition-level violation of 42 C.F.R. § 482.43. Petitioner has offered evidence and I have found that Petitioner had a written discharge planning policy.

P. Ex. 34.[7] However, whether or not the policy met the regulatory requirements and whether or not the policy was in effect are specific issues that require resolution.[8]

The requirements for a discharge planning process are specified by the standards listed in 42 C.F.R. § 482.43. Whether or not Petitioner's discharge policy met the requirements of the condition for participation under 42 C.F.R. § 482.43, requires comparison of the standard-level requirements of the regulation to Petitioner's policy. To comply with the regulation, Petitioner's written discharge planning process must provide for the following: (a) identification of patients who need discharge planning; (b) evaluation for discharge planning; (c) development of the discharge plan if required; (d) transfer or referral as necessary; and (e) review and reassessment of the discharge plan on an on-going basis to ensure that the plan is responsive. 42 C.F.R. § 482.43(a)-(e). Each of the standards list specific requirements to satisfy the standard.

Petitioner's discharge planning policy (P. Ex. 34) satisfies 42 C.F.R. § 482.43(a) by specifying that discharge planning begins early with a preadmission telephone call; it applies to all patients; and it requires the identification of patients who may require discharge planning.

Petitioner's policy provides, consistent with 42 C.F.R. § 482.43(b)(1)-(6) that: a registered nurse, social worker, or physician must develop or supervise the development of the discharge planning evaluation; the evaluation must assess the likelihood of a patient's need for post-hospital services and their availability; the patient's capacity for self-care and the possibility for care in the environment from which the patient entered the hospital must be evaluated; the evaluation must be completed in an expedient manner; and the evaluation must be included in the medical record, the physician progress notes; and the nursing admission assessment. However, the policy does not meet the requirement of 42 C.F.R. § 482.43(b)(1) that a discharge planning evaluation must also

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[7] The Medical Staff Bylaws, § 1.6 (P. Ex. 4, at 39-40), imposes requirements on the attending physician regarding discharge. The section does not establish a policy or procedure for discharge planning except to the extent that it requires the attending physician to document plans for discharge and post-hospital care and requires that the attending physician and staff inform the patient or family of certain information that should be in a discharge plan.

[8] Any complaint by Petitioner that it was not notified of these specific issues by the SOD or otherwise, should not be credited. Petitioner offered its policy document for consideration arguing that it had the required policy and, by so doing Petitioner knew or should have known that the policy and its application in this case would be carefully scrutinized for compliance with 42 C.F.R. § 482.43.

be provided to patients upon their request or the request of a person acting on their behalf, or at the request of a physician.

Petitioner's policy does not specifically state who must develop the discharge plan contrary to the requirement of 42 C.F.R. § 482.43(c)(1), which requires that a registered nurse, social worker, or other appropriately qualified personnel "develop, or supervise the development of, a discharge plan if the discharge planning evaluation indicates a need for a discharge plan." Petitioner's policy does not require the preparation of a discharge plan if requested by a physician, even when the evaluation does not indicate a need for such a plan, a violation of 42 C.F.R. § 482.43(c)(2). Petitioner's policy does not require that the discharge plan include the information required by 42 C.F.R. § 482.43(c)(6), (7), and (8).

Petitioner's policy does not address transfers and referrals as required by 42 C.F.R. § 482.43(d).

Petitioner's policy requires "re-assessment . . . throughout the hospital stay, until final discharge." P. Ex. 34, at 1. But the policy does not require reassessment of the discharge planning process as required by 42 C.F.R. § 482.43(e).

I conclude that Petitioner's "Discharge Planning" policy violates standards established by 42 C.F.R. § 482.43(b), (c), (d) and (e). I further conclude that violation of four of five standards of the condition established by 42 C.F.R. § 482.43, amounts to a condition-level violation of 42 C.F.R. § 482.43 because the standard-level violations render Petitioner's discharge planning policy ineffective and, therefore, are "of such character as to substantially limit [Petitioner's] capacity to furnish adequate care or . . . adversely affect the health and safety of patients." 42 C.F.R. § 488.24(b).

ii. Discharge Planning for Patient 25

In considering the alleged noncompliance in the context of what happened in the case of Patient 25, it is important to recognize that 42 C.F.R. § 482.43 establishes five standards that may be characterized generally as: (a) identification of patients who need discharge planning, including those who have requested or for whom a request for discharge planning has been made; (b) evaluation of patients identified for discharge planning; (c) development of the discharge plan for patients identified and evaluated; (d) development of plans for transfer or referral for follow-up and ancillary care; and (e) reassessment on a continuing basis of the discharge plans developed for patients to ensure they meet discharge needs. 42 C.F.R. § 482.43(a)-(e).

The surveyors allege in the SOD that there was a condition-level violation of 42 C.F.R. § 482.43 because there was no documented discharge plan for Patient 25 that gave direction for how to obtain home oxygen; and Patient 25's oxygen was removed at the time of discharge and she was simply walked down the hall from Petitioner's PACU to

Petitioner's emergency room and from there she transferred to another hospital for further treatment. CMS Ex. 7, at 38-39. Surveyor Hall testified that she reviewed the inpatient records for Patient 25. She testified that a discharge plan, whether simple or complex, should be in the medical record. She testified that she found nothing in the medical record that reflected a plan for discharge until Patient 25 was discharged. She testified that she found no documentation that a discharge evaluation had been conducted; she found no documented discharge plan; and she found no evidence of reassessment. She testified that she concluded that Patient 25 was at risk because she required oxygen but was given no instruction for how to obtain it if discharged home as her attending physician ordered. Tr. 66-70, 174-77, 179-80. CMS Exs. 3 and 10 and the testimony of Surveyor Hall satisfy the CMS burden to make a showing of condition-level noncompliance with 42 C.F.R. § 482.43. Whether or not Petitioner rebutted the CMS prima facie case or established an affirmative defense requires review of the evidence in light of the standards of 42 C.F.R. § 482.43.

Petitioner is required to identify patients in need of discharge planning early in their hospitalization. 42 C.F.R. § 482.43(a). The regulation does not require documentation of the identification.[9] However, documentation in some form is advisable to permit a hospital to later show that the required identification was accomplished. Petitioner's discharge planning policy specifies that it applies to all patients; requires that all patients receive a preadmission telephone call; and requires that patients who may require discharge planning be identified. P. Ex. 34. There is no allegation in this case that Petitioner failed to make the initial preadmission call or that it incorrectly determined prior to surgery that Patient 25 was unlikely to require a discharge plan. The evidence shows that Patient 25 received her preoperative call on June 14, 2011. P. Ex. 7, at 24, 26. Patient 25 was also assessed on June 22, 2011, prior to surgery. P. Ex. 7, at 25. I note that none of the forms refer to discharge planning except an entry on the Preoperative Nursing History/Assessment form that required that the interviewer inquire as to whether the patient would have someone to drive her home after surgery. P. Ex. 7, at 24. A history and physical completed by the physician prior to surgery does not mention discharge planning. P. Ex. 7, at 55.

Petitioner's obligation to identify that Patient 25 might require discharge planning did not end after the initial telephone call and review of her case prior to surgery. The regulation

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[9] In fact, the drafters of the regulation specifically rejected a suggestion that they include the requirement for a writing to document that a patient was determined not to require a discharge plan. The drafters responded that they believed it not necessary to dictate how a hospital may establish compliance. The drafters also declined for the same reason to adopt a standard form. 59 Fed. Reg. 64,152 (Dec. 13, 1994).

requires that Petitioner identify "all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning." 42 C.F.R. § 482.43(a). The regulation does not limit the obligation to a single review early in the hospitalization of a patient. The plain language of the regulation requires that the hospital identify the need for discharge planning as early as possible in the patient's hospitalization. Therefore, Petitioner did not satisfy the standard of participation established by 42 C.F.R. § 482.43(a) by conducting a single review of Patient 25 early in her hospitalization. Rather, Petitioner was obliged to identify Patient 25 as needing a discharge plan at anytime during her hospitalization when her condition suggested that she was likely to suffer adverse health consequences if discharged without an adequate discharge plan. There is no dispute that following kidney surgery on June 22, 2011, Patient 25 could not be weaned off oxygen; when oxygen was removed, she experienced shortness of breath; her abdomen became distended, tender, and firm; she complained of abdominal pain, constipation, flatulence, and belching; she required continued antibiotic therapy; and she continued to require a urinary catheter. Petitioner has not presented evidence that it complied with 42 C.F.R. § 482.43(a) by identifying that Patient 25 needed a discharge plan. Petitioner has also failed to present credible evidence that Patient 25 did not require a discharge evaluation or discharge plan despite her post-surgical symptoms.

Petitioner has also failed to present any evidence that it complied with the standard of participation established by 42 C.F.R. § 482.43(b), which requires a discharge planning evaluation for those patients identified to need a discharge plan or when such an evaluation is requested by the patient, the patient's representative, or a physician. 42 C.F.R. § 482.43(b)(1). There is no evidence that a discharge evaluation was requested by Patient 25, or her daughter, or her physician. However, due to Patient 25's post-surgical complications and her continuing need for oxygen and a urinary catheter, she should have been identified as requiring follow-up care or referral and, therefore, a discharge plan. Petitioner has not presented evidence that an evaluation was done or developed by a qualified individual; that the evaluation considered the likelihood that Patient 25 would require post-hospital services and their availability; and that the evaluation considered the likelihood of Patient 25 caring for herself or the possibility of her returning to the environment from which she entered the hospital. 42 C.F.R. § 482.43(b)(2)-(4). Because there is no evidence that an evaluation was done, there is no evidence that it was performed timely. 42 C.F.R. § 482.43(b)(5). The regulation requires that the evaluation be documented, though no form is specified; that it be in the patient's medical record; and that the results of the evaluation be discussed with the patient or the patient's representative. The clinical records placed in evidence by CMS and Petitioner do not include a specific document that reports the results of a discharge planning evaluation or that reflects discussion of the results with Patient 25 or her daughter, and Petitioner points to no such document.

I conclude that Petitioner failed to show that it complied with the standard established by

42 C.F.R. § 482.43(c). The clinical records show that on June 27, 2011, Dr. Berwind decided that it was time to discharge Patient 25 and he gave orders that she be discharged that day with a walker, access to nasal oxygen, with her urinary catheter in place and draining to a leg bag, medications including an antibiotic and Vicodin; and with the instruction for her to come to his office the next day. The evidence shows that Petitioner provided Patient 25 a form containing discharge instructions. P. Ex. 7, at 67, 118-20, 123; CMS Ex. 3, at 89; CMS Ex. 10, at 112. Nurse's notes entries at 11:30 a.m. on June 27, 2011, record that Patient 25 was fitted for a catheter bag; the patient and her daughter were taught how to empty the catheter bag; discharge instructions were given; discharge prescriptions were provided; and the daughter was encouraged to take her mother to the emergency room for complications including difficulty breathing, uncontrolled pain, and signs of infection of the incision. The nurse's note states that at 11:45 a.m. Patient 25 was discharged home in the care of her daughter with a walker. P. Ex. 7, at 119-20; CMS Ex. 3, at 89-90. The nurse's notes do not mention the physician's order for access to nasal oxygen or what arrangements, if any, were made for Patient 25 to access oxygen if she elected not to go to the emergency room. The evidence shows that Petitioner's staff implemented Dr. Berwind's orders to a limited extent and did provide instruction for post-hospital care to Patient 25 and her daughter. 42 C.F.R. § 482.43(c)(3) and (5). Although Dr. Berwind's orders reflect his plan for sending Patient 25 home on June 27, 2011, Dr. Berwind's "discharge plan" was not developed by Petitioner as required by 42 C.F.R. § 482.43(c)(1) and (2).[10] Because there was no discharge plan developed by Petitioner as soon as the need for such a plan became apparent after surgery, there is no evidence that the plan was reassessed as required by 42 C.F.R. § 482.43(c)(4).

Petitioner discharged Patient 25 to go home in the care of her daughter, though the undisputed evidence is that staff encouraged the daughter to immediately take her mother to Petitioner's emergency room for care. Petitioner did not transfer Patient 25 for necessary care. It is arguable under the common meaning for the term "referral" that the recommendation that Patient 25's daughter take Patient 25 to Petitioner's emergency room, amounted to a "referral" within the meaning of 42 C.F.R. § 482.43(d). However, the evidence does not show that the appropriate medical information was provided to Patient 25, her daughter, or the emergency room, as required by 42 C.F.R. § 482.43(d). Accordingly, I conclude that Petitioner has failed to show that it was in compliance with the standard for transfer or referral established by 42 C.F.R. § 482.43(d).

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[10] Petitioner complains about Dr. Berwind and his care of Patient 25. However, Dr. Berwind's care of his patient does not establish a defense for Petitioner's failure to do the required discharge evaluation and plan for Patient 25. Timely discharge evaluation and planning involving staff and Dr. Berwind may have avoided the problems about which Petitioner complains.

The testimony of Petitioner's witnesses supports my findings. Debbie Cormier, Petitioner's Chief Nursing Officer and Administrator, testified that she did not find Petitioner's discharge plan in Patient 25's records. Tr. 331-37. Dr. Shakeel Uddin, Petitioner's Medical Director at the time of hearing but not in June 2011, reviewed Patient 25's chart. Dr. Uddin testified as an expert witness in internal medicine. Tr. 346. He testified that there was no discharge planning evaluation documented for Patient 25 at any time, June 22 through her discharge on June 27, 2011, and there was no documented discharge plan for Patient 25. Tr. 392-95.

Petitioner stresses that Dr. Berwind's failure to accept Petitioner's recommendations that Patient 25 should be transferred to another hospital for additional care was the real impediment. Petitioner claims that the hospital staff never planned to discharge Patient 25 to her home as ordered by Dr. Berwind. Petitioner argues that the discharge plan was to remove Patient 25 from Dr. Berwind's care by discharging her, immediately readmitting her through Petitioner's emergency room, and then transferring Patient 25 to another hospital for necessary care. P. Br. at 22; P. Reply Br. at 21, 27. Surveyor Hall agreed that transferring Patient 25 to another hospital so that she could be given a higher level of care was necessary and the correct course of action. Tr. at 144. Petitioner alleges that "[i]t is obvious from reading the patient's chart that the staff planned, prior to discharge, for her to go directly to the ER for transfer to another facility . . . staff knew that the patient was not going directly home following discharge so there was no point in setting up home oxygen for her." P. Br. at 27. Petitioner's post hoc rationalizations neither rebut the CMS prima facie showing nor establish an affirmative defense. Petitioner has not shown how the plan devised by some creative nurses, in contravention of specific treating physician orders, met the requirements of 42 C.F.R. § 482.43, or excused Petitioner's failure to comply with the regulation. The undisputed fact that Patient 25's physician was apparently uncooperative is no defense to Petitioner's failure to perform discharge planning.

I conclude Petitioner failed to rebut the CMS prima facie case. I conclude that the evidence shows that Petitioner violated the standards established by 42 C.F.R. § 482.43(a), (b), (c), and (d) in the case of Patient 25. I further conclude that violation of four of five standards of the condition established by 42 C.F.R. § 482.43, amounted to a condition-level violation of 42 C.F.R. § 482.43 because the standard-level violations were "of such character as to . . . adversely affect the health and safety of" Patient 25 who could not maintain a viable oxygen saturation level without supplemental oxygen. 42 C.F.R. § 488.24(b). The evidence does not show that Petitioner conducted a discharge planning evaluation or prepared a discharge plan for Patient 25 when she should have been identified as requiring a discharge plan following surgery on June 22, 2011. Petitioner has also failed to rebut the evidence that the absence of proper discharge planning had an adverse effect upon Patient 25's health and safety. There is no dispute that when Patient 25 was discharged from Petitioner's PACU, Patient 25 was taken to Petitioner's emergency room where she was assessed as experiencing shortness of breath,

an elevated temperature, wheezing, decreased breath sounds in the left lung with a pleural effusion and a productive cough, and her abdomen was assessed as distended and rigid with increased bowel sounds. CMS Ex. 4, at 5; CMS Ex. 10, at 5. Petitioner 25 had to be transferred to Kingwood Medical Center for a higher level of care than could be provided by Petitioner's emergency room where she was stabilized before transfer. CMS Ex. 4, at 13-14, 142. Petitioner's argument that Patient 25's health and safety were not adversely affected is without merit. P. Br. at 13; P. Reply at 8. Petitioner argues that Patient 25 was stable when she was discharged from the inpatient department and had stable vital signs. P. Br. at 19. However, Petitioner does not dispute that upon arrival in the emergency room Patient 25 was immediately put back on oxygen due to shortness of breath. It is a matter of common knowledge that insufficient oxygen may result in serious injury or death. Patient 25 did not have to suffer actual injury or death to establish that Petitioner was not in compliance with discharge planning requirements.

Accordingly, I conclude that Petitioner was not in compliance with the condition for participation under 42 C.F.R. § 482.43 and the noncompliance is a basis for termination of Petitioner's provider agreement and participation in Medicare pursuant to 42 C.F.R. § 483.53(a)(1).[11]

III. Conclusion

For the foregoing reasons, I conclude that Petitioner was not in compliance with 42 C.F.R. § 482.43 at the condition-level. Accordingly, I conclude that there was a basis for termination of Petitioner's provider agreement and participation in the Medicare program and termination was effective September 23, 2011.

/s/
Keith W. Sickendick
Administrative Law Judge

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[11] Petitioner also argues that the determination of immediate jeopardy was in error. Petitioner argues that the erroneous declaration of immediate jeopardy resulted in speedier termination and fewer days for Petitioner to correct alleged deficiencies and return to substantial compliance. P. Br. at 9. Even if Petitioner is correct that the determination of immediate jeopardy caused termination to occur on an expedited basis, Petitioner has not cited any authority to show that I have authority to review the immediate jeopardy determination. The regulation grants Petitioner the right to review of the termination of its provider agreement, not the speed with which termination is accomplished. 42 C.F.R. § 489.53(e).