Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Innovative Pain Treatment Surgery Center of Temecula, Inc.,	)	Date: March 24, 2009
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-08-666
	)	Decision No. CR1932
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

I enter summary judgment in favor of the Centers for Medicare & Medicaid Services (CMS). I find the effective date of Petitioner's participation in the Medicare program is October 8, 2007.[1]

I. Background

The following facts are undisputed. Petitioner is an ambulatory surgical center (ASC) located in Temecula, California, that received certification for initial participation in the Medicare program but disputes the effective date of its approval. Petitioner received a six-month term of accreditation from the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) or "deemed compliance" status on June 21, 2007 after a two day survey. Neither party disputes that Petitioner subsequently submitted an application for Medicare enrollment, CMS Form 855B, in August 2007, which NHIC, the CMS Contractor for Medicare Provider Enrollment, received on August 27, 2007. P. Brief at 2;

[1] CMS submitted a motion for summary judgment together with a brief, which I refer to as CMS Brief, with 19 exhibits, CMS Exhibits (Exs.) 1-19, and a Reply. Petitioner submitted a brief in response, P. Brief, and 12 exhibits, P. Exs. 1-12. Neither party objected to the other's exhibits and the exhibits are admitted into the record.

CMS Brief at 3; CMS Ex. 1. By letter dated October 8, 2007, NHIC indicated that Petitioner's application for provider enrollment had been approved. CMS Ex. 4; CMS Ex. 19, at 13. Even though Petitioner had received notice that its application had been approved, Petitioner submitted a second application to NHIC which was rejected because it contained photocopied signatures rather than original signatures as required. Petitioner submitted a third application which was rejected because it did not contain certain required documents. CMS Ex. 19. But on March 20, 2008, CMS sent notice to Petitioner that CMS accepted Petitioner's agreement to participate in the Medicare program and had countersigned the Health Insurance Benefits Agreement. CMS Ex. 19, at 20. CMS indicated that Petitioner's participation for coverage was effective as of December 19, 2007. *Id*. Petitioner made a request to CMS for a retroactive effective date of June 21, 2007, the date of its AAAHC accreditation. On June 10, 2008, CMS denied Petitioner's request, but did revise its original date of December 19, 2007 and granted Petitioner an effective date of October 8, 2007. CMS Ex. 19, at 7. CMS indicated that the October 8, 2007 date is the date NHIC had determined that Petitioner's application was complete and was approved. *Id.*

Petitioner timely appealed CMS's initial determination of the effective date of Petitioner's Medicare approval. 42 C.F.R. § 498.3(b)(15).

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. Section 1832(a)(2)(F) of the Act includes under Part B coverage for 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. (Meeting applicable standards is referred to as "certification.")

The regulations at 42 C.F.R. Part 416 contain the requirements for ASC participation agreements as a supplier of reimbursable Medicare services and the substantive health, safety, and other conditions for coverage as an ASC supplier specified by the Secretary. The provisions of 42 C.F.R. § 416.26 provide the steps necessary for an ASC to qualify for and to have its agreement to be a supplier accepted and approved by CMS. An entity may qualify for a participation agreement after all of the following steps have been taken–

- It has "deemed compliance" with the conditions for participation in Subpart C of Part 416, meaning it is accredited by a national accrediting body or licensed by a state agency that CMS determines provides reasonable assurance that the conditions are met. 42. C.F.R. § 416.26(a).

- If the ASC does not have "deemed compliance," it must be surveyed by the State survey agency for compliance with the conditions of Subpart C. 42. C.F.R. § 416.26(b).

- CMS must review the recommendation and other evidence relating to the qualification of the ASC and if the facility meets the requirements of Subpart B of Part 416, CMS will send the ASC written notice of its determination and two copies of the ASC agreement. 42 C.F.R. § 416.26.(c).

- If the ASC wishes to participate in the program, it must have both copies of the agreement signed by its authorized representative and file both with CMS. 42 C.F.R. § 416.26(d).

- If CMS accepts the agreement filed by the ASC, it returns to the ASC one of the copies of the agreement together with a notice of acceptance specifying the effective date of the ASC's participation for coverage in the Medicare program. 42 C.F.R. § 416.26(e).

The effective date for such a participation agreement is subject also to the general requirements of 42 C.F.R. § 489.13.[2] Under 42 C.F.R. 489.13(d)(1), there is a separate rule for 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." In that instance, the effective date depends on whether the provider or supplier is subject to requirements in addition to those included in the accreditation organization's approved program. If the entity is subject to requirements in addition to the accreditation, then the effective date "is the date on which the provider or supplier meets all requirements, including the additional

[2] Subpart A of Part 489 largely implements section 1866 of the Act, which specifies the terms of provider agreements. However, 42 C.F.R. § 489.1(d) specifically provides that the effective date rules in this part are also made applicable to the approval of suppliers that meet the requirements specified in § 489.13.

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 special rule for retroactive effective date for a participation agreement is available pursuant to 42 C.F.R. § 489.13(d)(2) if a provider meets the requirements of paragraphs (d)(1). That 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 Petitioner became eligible for participation on a date prior to October 8, 2007.

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 and the only question to be decided involves the application of law to the undisputed facts.

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. Petitioner opposes CMS's motion and argues that summary judgement is not appropriate because 42 C.F.R. § 416.26(c) does not explicitly state that CMS Form 855B must be submitted and approved in order to grant an effective date. However, the issue of the effective date of the participation agreement is a legal issue and not a dispute of material fact for which an in-person hearing and testimony might be useful. Rather, where the only issues before me are legal, those issues appropriately 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 October 8, 2007 and not June 21, 2007, the effective date of AAAHC's deemed six-month accreditation of Petitioner. 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 October 8, 2007.

2. The effective date of Petitioner's participation in Medicare is October 8, 2007.

There is no dispute that Petitioner had AAAHC accreditation as of June 21, 2007. CMS maintains that in order to participate in the Medicare Program as an ASC, the supplier must, in addition to the survey by AAAHC under the Early Option Survey Program for Medicare deemed status, complete and submit a Provider/Supplier Enrollment Application Form (CMS Form 855B). CMS states that under the applicable

regulations the earliest effective date of participation for Petitioner would be October 8, 2007, the date the contractor informed Petitioner that it had reviewed its application and found it acceptable.

Petitioner argues that it is entitled to an effective certification date of June 21, 2007, the date that the AAAHC awarded Petitioner a six-month accreditation or "deemed compliance" status. P. Ex. 1; P. Br. at 1-2. Petitioner essentially argues that it detrimentally relied on information provided to it on the telephone by NHIC, the CMS contractor. Petitioner had a question concerning whether if it began treating Medicare patients, it would be able to bill for those services. P. Br. at 2. Therefore, on July 3, 2007, its business manager contacted NHIC. He was apparently informed that Petitioner's Medicare application, once approved, would be retroactively effective to the date of its deemed status. Petitioner argues that it assumed this was the case and began to treat Medicare patients. P. Br. at 2; P. Ex. 4. What Petitioner neglects to add here is that it did not submit its Medicare Enrollment Application, CMS Form 855B, until after the AAAHC survey, sometime in late August 2007. P. Br. at 6. Petitioner does not dispute that NHIC received the Medicare Enrollment Application, CMS Form 855B, on August 27, 2007. Petitioner instead contends that CMS Form 855B was a mere formality and was not a prerequisite to Medicare certification. P. Br. at 6 and 7. It also contends that neither the regulations nor the statute explicitly state that CMS Form 855B must be submitted and approved as an additional requirement to an ASC's approval as a supplier.

I disagree. Every ASC which wishes to enroll as a Medicare supplier must complete and submit CMS Form 855B. The information in this form is used in part to ensure that no payments are made to suppliers who are excluded from participation in the Medicare program pursuant to section 1128 of the Act or who are prohibited from providing services to the federal government under section 2455 of the Federal Acquisition Streamlining Act of 1994, 31 U.S.C. § 6101. *See* State Operations Manual (SOM), section 2005 ["Suppliers should be informed of the enrollment process so that they do not expect instant Medicare effective dates"]. Thus, the provided information is an important aspect of the Department's efforts to effectively prevent supplier fraud and abuse and to ensure that Medicare does business with only trustworthy and qualified providers and suppliers. The information that is required to be provided in this form is what 42 C.F.R. § 416.26(c) refers to as "other evidence relating to the qualification of the ASC" which CMS must review in order to determine whether to accept the ASC. If the ASC has not provided this information prior to its accreditation survey, thereby giving the contractor and CMS time to verify the information, then that form is considered an additional requirement under the terms of 42 C.F.R. §489.(d)(1)(i). Thus, under the applicable regulation at 42 C.F.R. 489.13(d)(1)(i), the effective date of the approval is the date that it meets all the additional requirements. Here, the contractor reviewed the information

contained in CMS Form 855B and determined on October 8, 2007, that Petitioner had submitted all the required additional information and that the enrollment application (CMS Form 855b) was approved.

The absence of specifying CMS Form 855B as an "additional requirement" in the regulations is not determinative. 42 C.F.R. Part 416 gives CMS the authority to set requirements for an ASC's participation in the Medicare program. And Part 416 specifically provides that CMS will review whatever other evidence relating to the qualification of the ASC for enrollment. 42 C.F.R. §416.26(c). It would be impracticable, indeed impossible, to specify all forms and information requirements necessary in the regulation.

I find Petitioner's argument disingenuous considering that by its submission of Form 855B, Petitioner obviously knew it was required to submit it in order to apply for Medicare program enrollment. Moreover, the form itself specifies on the first page that an ASC must complete this application and submit it to initiate the enrollment process. Thus, since 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 AAAHC's award of six-month accreditation to Petitioner *and other evidence* relating to the qualifications of the ASC, I conclude that *the other evidence* relating to the qualification of the ASC in this case refers to CMS's review of Form 855B. As for Petitioner's contention that it had relied on the oral assurances from the contractor regarding the effective date, the applicable regulations, which I am bound to apply, provide that an ASC does not qualify for acceptance for participation in the Medicare program until CMS returns a countersigned copy of the Health Insurance Benefits Agreement and informs the ASC with a notice of acceptance specifying the effective date for the ASC's participation. 42 C.F.R. § 416.26(e). CMS did so and specified first an effective date of December 19, 2007 which it revised upon reconsideration to October 8, 2007, the date the contractor indicated it had completed its review of Petitioner's Form 855B and found that Petitioner met all of the requirements for participation.

Finally, the provisions of 42 C.F.R. § 489.13(d)(2) do confer discretion on CMS to decide whether to grant a retroactive effective date. Here, CMS determined not to do so. CMS based its decision on the fact that Petitioner did not meet all the requirements for participation until October 8, 2007, the date the contractor determined that Petitioner's application was complete and was approved. The regulations and case law establish that retroactive certification is permitted but is not required. The regulations, as construed by the Departmental Appeals Board, clearly confer discretion on CMS to decide whether or not to grant retroactivity on the facts of an individual case. *Oak Lawn Endoscopy*, DAB No. 1952, at 11-12 (2004). 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. Thus, I do not have the authority to award an earlier date of certification or compel CMS to use its discretion to certify a retroactive effective date. The discretion and the exercise of the discretion to grant or deny retroactivity as to a certification date clearly lies exclusively with CMS.

IV. Conclusion

I find that Petitioner's effective date of participation in the Medicare program is October 8, 2007, the date it met all federal requirements. Therefore, I enter summary judgment in favor of CMS.

/s/
Alfonso J. Montano
Administrative Law Judge