Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Kearney Regional Medical Center, LLC
(CCN: 28-0134),[1]

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-1016

Decision No. CR3362

Date: September 10, 2014

DECISION

The Centers for Medicare & Medicaid Services (CMS) denied the request of Kearney Regional Medical Center, LLC (Petitioner) to participate in the Medicare program as a hospital because it was not primarily engaged in providing care to inpatients during an accreditation survey. Petitioner disputes this determination and requested a hearing before an administrative law judge. Both parties moved for summary judgment. Because the application of the law to the undisputed facts in this case supports CMS's denial of Petitioner's participation in the Medicare program, I grant CMS's motion for summary judgment and affirm CMS's reconsidered determination.

I. Background and Procedural History

Petitioner is a new hospital in Kearney, Nebraska. Petitioner Exhibit (P. Ex.) 1 ¶ 1. Petitioner's facility took four years to build and equip at a total cost of $38 million.

[1] The caption on the April 3, 2014 Acknowledgement and Pre-hearing Order in this case did not include Petitioner's Centers for Medicare & Medicaid Services Certification Number (CCN) because Petitioner did not have a CCN until June 3, 2014. *See* Petitioner Exhibit 5. I amend the caption in this case to include the CCN.

P. Ex. 1 ¶ 5. Petitioner's facility includes various medical equipment as well as "over forty licensed patient beds." P. Ex. 1¶ 4. Petitioner obtained a Certificate of Occupancy from the local government on September 27, 2013, and a state license to operate on December 9, 2013. P. Ex. 1 ¶¶ 6, 8. Since December 9, 2013, Petitioner has maintained full nursing staff to care for inpatients at the hospital. P. Ex. 1 ¶ 9. From December 9, 2013, through December 30, 2013, Petitioner admitted 21 inpatients. P. Ex. 1 ¶ 11.

On December 18, 2013, Petitioner filed an application for the American Osteopathic Association, Healthcare Facilities Accreditation Program (AOA) "to assist with its Medicare Certification." P. Ex. 1 ¶¶ 13-15. An AOA team conducted an accreditation survey of Petitioner's facility from January 13-15, 2014. CMS Ex. 1, at 2; P. Ex. 1 ¶¶ 17, 19. Although Petitioner was capable of admitting inpatients at the time of the accreditation survey, it did not do so because Petitioner would not be able to bill Medicare or other health insurers for the patients until CMS granted Petitioner's request to participate in the Medicare program. P. Ex. 1 ¶¶ 16, 17. The head of the AOA survey team told Petitioner's staff that admitting inpatients was unnecessary. P. Ex. 1 ¶¶ 20, 21. The AOA surveyors relied on a review of the inpatients admitted to Petitioner's facility in December 2013. P. Ex. 1 ¶¶ 21, 23.

On January 24, 2014, AOA determined that Petitioner had a number of deficiencies. CMS Ex. 1, at 5-12. However, Petitioner submitted an acceptable plan of correction and, on February 7, 2014, AOA "granted Full Accreditation" to Petitioner and recommended that CMS "approve deemed status" for Petitioner. CMS Ex. 1, at 1-4. AOA's notice informed Petitioner that CMS had to review the survey findings and determine if Petitioner met all CMS requirements. CMS Ex. 1, at 1.

On April 9, 2014, CMS issued an initial determination in which it denied Petitioner's participation in the Medicare program because Petitioner failed to meet the statutory definition of a hospital, i.e., "there were no inpatients at the time of the initial certification survey and the last inpatient discharge prior to the survey occurred on December 30, 2013." CMS Ex. 2. Petitioner requested reconsideration asserting that it met the statutory definition of a hospital because it was fully staffed and had cared for 21 inpatients in December 2013, as well as 67 inpatients from February 10-April 10, 2014. CMS Ex. 3. Further, Petitioner stated that the AOA survey team leader indicated that Petitioner did not need to admit patients for the January 13-15, 2014 survey, even though Petitioner had been able and willing to do so. CMS Ex. 3, at 2.

On April 17, 2014, CMS issued a reconsidered determination in which it affirmed the initial determination because Petitioner did not have any inpatients during the AOA survey or "for a period of time prior to that survey." CMS Ex. 4, at 1. AOA then terminated its previous accreditation of Petitioner. CMS Ex. 5.

On April 22, 2014, Petitioner, through counsel, requested a hearing before an administrative law judge with the Departmental Appeals Board (DAB). I issued an Acknowledgment and Pre-hearing Order (Order) on April 30, 2014. In response, CMS filed a motion for summary judgment and memorandum in support of that motion (CMS Motion), and 6 exhibits (CMS Exs. 1-6). Petitioner filed a memorandum in opposition to CMS's summary judgment motion (P. Opposition) and five exhibits (P. Exs. 1-5). Petitioner subsequently filed a motion for summary judgment and memorandum in support of that motion (P. Motion), and 1 exhibit (P. Ex. 6). CMS did not respond to Petitioner's motion.

II. Summary Judgment

The parties have filed cross motions for summary judgment. When appropriate, administrative law judges may decide a case arising under 42 C.F.R. pt. 498 by summary judgment. *See* Civil Remedies Division Procedures § 7; *Livingston Care Ctr. v. U.S. Dep't of Health & Human Servs.*, 388 F.3d 168, 172 (6th Cir. 2004) (citing *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743 (6th Cir. 2004). Summary judgment is appropriate and an in-person hearing is not required if the record shows that there is no genuine dispute of any material fact and the moving party is entitled to judgment as a matter of law. *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 3 (2010).[2] To determine whether there are genuine issues of material fact for an in-person hearing, the administrative law judge must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. *Id*.

The material facts on which this case turns are not in dispute. P. Opposition at 2-4. Because Petitioner has asserted a number of material facts to which CMS has not responded, I consider those facts in the light most favorable to Petitioner. P. Opposition at 5-12; P. Motion at 3-10. I note that Petitioner's facts are supported by P. Exs. 1-6.

III. Issue

Whether CMS had a legitimate basis for denying Petitioner's participation in the Medicare program as a provider (hospital) because Petitioner did not have any inpatients at the time of its accreditation survey.[3]

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[2] DAB decisions cited in this decision are accessible on the Department of Health and Human Services' website at: http://www.hhs.gov/dab/decisions/index.html

[3] AOA conducted a second survey of Petitioner's facility on April 28-30, 2014. P. Ex. 4. On May 14, 2014, AOA again granted Petitioner full accreditation, effective May 8, 2014, and recommended CMS approval of deemed status. P. Ex. 4. On June 3, 2014, CMS informed Petitioner that "[y]our agreement for participation as a deemed status acute care hospital under the Medicare program has been accepted by [CMS]," and that

IV. Jurisdiction

I have jurisdiction to decide whether Petitioner qualifies as a provider for the Medicare program. 42 U.S.C. § 1395cc(h)(1); 42 C.F.R. §§ 498.3(b)(1), 498.5(a)(2).

V. Findings of Fact, Conclusions of Law, and Analysis[4]

Petitioner sought to participate in the Medicare program as a hospital. Hospitals are "providers" for Medicare program purposes. 42 C.F.R. §§ 400.202 (definition of *Provider*), 488.1 (definition of *Provider of services* or *provider*). A hospital may request to participate in the Medicare program, but must meet the conditions of participation in the regulations. *Id*. § 489.10(a). To determine compliance with the conditions of participation, a survey of the hospital may be conducted by CMS, a state survey agency, or a CMS approved accreditation organization. *Id*. § 489.13(a)(1). AOA is a CMS approved accreditation organization and hospitals surveyed and accredited by AOA are deemed to meet all of the conditions of participation. *Id*. § 488.5(a). However, CMS may use information from AOA's survey to determine that a hospital does not meet the conditions of participation. *Id*. § 488.5(c)(2).

1. From December 9, 2013, until December 30, 2013, Petitioner cared for 21 inpatients, and from February 10, 2014, to May 7, 2014, Petitioner cared for 51 inpatients; however, during the AOA accreditation survey from January 13, 2014, to January 15, 2014, Petitioner did not have any inpatients at its facility.

Petitioner received a state license to operate as a hospital on December 9, 2013, and from that date until December 30, 2013, Petitioner cared for inpatients that had been admitted to Petitioner's facility. P. Ex. 1 ¶¶ 8, 11. Because Petitioner was not yet a provider in the Medicare program and could not bill commercial health care payers, Petitioner decided not to admit any inpatients until Petitioner was accepted into the Medicare program. P. Ex. 1 ¶¶ 12, 16. Petitioner informed the AOA survey team that it did not have any inpatients, but could admit some patients if necessary; however, the head of the survey team indicated that admitting patients for the survey was not necessary. P. Ex. 1 ¶¶ 20-

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May 8, 2014, is Petitioner's effective date of Medicare participation. P. Ex. 5. CMS's subsequent determination to permit Petitioner to participate in the Medicare program is not an issue in this case. My jurisdiction over this case is based on Petitioner's request for hearing related to CMS's April 17, 2014 reconsidered determination, *see Denise A. Hardy, D.P.M*, DAB No. 2464, at 4 (2012), and my review is limited to the matters addressed on reconsideration. *Neb Group of Arizona LLC*, DAB No. 2573, at 7 (2014).

[4] My findings of fact and conclusions of law are set forth in italics and bold font.

21. Following AOA's notice that it fully accredited Petitioner, Petitioner cared for 51 inpatients from February 10 to May 7, 2014. P. Ex. 1 ¶¶ 25, 29.

2. CMS had a legitimate basis to deny Petitioner's participation in the Medicare program because Petitioner was not primarily engaged in providing care to inpatients during the AOA January 2014 survey, as required by 42 U.S.C. § 1395x(e)(1).

For purposes of the Medicare program, a hospital must be:

> primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

42 U.S.C. § 1395x(e)(1). The regulations, under the heading "conditions of participation," state that a prospective provider must meet the applicable statutory definition for its provider type in order for a prospective provider to be approved for participation in the Medicare program. 42 C.F.R. § 488.3(a). This is consistent with the statute, which authorizes CMS to refuse to approve a provider agreement when it "has determined that the provider fails substantially to meet the applicable provisions of section 1395x." 42 U.S.C. § 1395cc(b)(2). Therefore, Petitioner must be able to show that it was "primarily engaged" in providing care to inpatients or else CMS could justifiably deny participation in the Medicare program. *See Arizona Surgical Hospital LLC*, DAB No. 1890 (2003).

Petitioner asserts that it met the requirement of being primarily engaged in providing care to inpatients because it had inpatients in December 2013 and from February to May 2014. Further, Petitioner avers that at all times since December 9, 2013, it has had full nursing staff present at the facility, and thus was ready and able to treat inpatients. P. Opposition at 16-20; P. Motion at 12-16. CMS's position is that AOA could not perform a proper survey of Petitioner's facility without the presence of inpatients. CMS Motion at 7-8. CMS relies on the State Operations Manual.

As explained below, I disagree with Petitioner's argument. Further, CMS's argument provides a justification for denial of Petitioner's participation that does not appear in the reconsidered determination. Therefore, I reject that argument. *Neb Group of Arizona LLC*, DAB No. 2573, at 7.

CMS determined that Petitioner did not satisfy the statutory requirement that it be "primarily engaged" in providing inpatient care. Based on the DAB's decision quoted

below, I conclude that CMS permissibly made its determination because the statutory requirement that a hospital be "primarily engaged" in providing inpatient care has been narrowly interpreted.

> Petitioner's resort to the dictionary definition of "primarily" to show a dispute requiring evidentiary proceedings overlooks the common meaning of the word that "primarily" modifies in [42 U.S.C. § 1395x(e)(1)]: "engaged." "Engage" and "engaged" have myriad definitions; those obviously applicable here include, as a verb, "to involve oneself or become occupied; participate," and as an adjective, "employed, occupied, or busy." The American Heritage Dictionary of the English Language, 4th ed., accessed via dictionary.com. At the time of the March survey and the termination, Petitioner was under a state sanction that prevented it from accepting inpatients. Petitioner did not dispute CMS's findings that it had no inpatients and was not engaged in providing inpatient services as of the dates of the two Medicare complaint validation [surveys]. As of those surveys, then, Petitioner was not employed, occupied, busy, involved in or participating in providing services to inpatients. We fail to see how Petitioner could have been "primarily engaged" in providing services to inpatients when it was not "engaged" in providing those services in the first place . . . . The length of Petitioner's failure to engage in providing services to inpatients, which included the March survey and CMS's notice of termination, supports the ALJ's conclusion that Petitioner failed substantially to meet the provisions of [42 U.S.C. § 1395x(e)].
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> Petitioner offered evidence only to show that its policies, history and business model indicated an intent to operate as a hospital.

Arizona Surgical Hospital, DAB No. 1890. In applying *Arizona Surgical Hospital LLC*, to another case, the DAB stated:

> It was undisputed that the hospital in question had not been engaged in providing inpatient services in the 39-day period between two Medicare complaint surveys. We concluded that the "length of Petitioner's failure to engage in providing

> services to inpatients . . . support[ed] the ALJ's conclusion that Petitioner failed substantially to meet the provisions of [42 U.S.C. § 1395x(e)]."

United Medical Home Care, Inc., DAB No. 2194, at 10 (2008) (internal citations omitted).

In the present case, Petitioner admits that it did not have any inpatients from December 30, 2013, until February 10, 2014, which is 42 days.[5] Further, unlike *Arizona Surgical Hospital*, Petitioner had no previous history of serving inpatients prior to December 9, 2013. *See Arizona Surgical Hospital*, DAB No. 1890 ("Petitioner stated that it had functioned as a hospital, providing care to inpatients and outpatients, for more than 30 years, with the treatment of inpatients at all times its objective and practice"). Therefore, I conclude that while Petitioner intended to operate as a hospital by having the capability to accept inpatients, it was not actually "primarily engaged" in care for inpatients immediately prior to or following the survey that took place in January 2014.

Petitioner relies on *Boone County Hospital*, DAB CR2526 (2012), for the proposition that, considering the facts in this matter as a whole, Petitioner was plainly primarily engaged in providing services to inpatients. P. Opposition at 2; P. Motion at 2. However, as CMS argues, *Boone County Hospital* involved a provider who had already initially demonstrated compliance with the conditions of participation based on an initial survey, whereas this case involves Petitioner's initial survey. CMS Motion at 9. Further, *Boone County Hospital* appears to have considered the termination in *Arizona Surgical Hospital* to have turned on the four-month period of state license suspension, and that this was a long period of time in which no inpatients were admitted. DAB CR2526, at 18. However, as quoted above, the DAB considered the 39 days when no inpatients were admitted between two surveys at the Arizona Surgical Hospital as sufficient time to conclude that it was no longer primarily engaged in providing care to inpatients. *United Medical Home Care, Inc*., DAB No. 2194, at 10. That time frame is relevant to this matter because Petitioner admits to a 42-day gap in the admission of patients.

Petitioner also argues that it could have admitted inpatients at the time of the survey; however, Petitioner relied on the statement of the head of AOA's survey team that no

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[5] The affidavit that Petitioner submitted with its motion for summary judgment states that Petitioner "also engaged in the care of patients in January 2014 by treating a patient admitted on January 22, 2014, and following up with that patient by phone on January 24, 2014, to assess the patient's condition." P. Ex. 6 ¶ 8. However, in its motion, Petitioner did not rely on or refer to this statement to show compliance with 42 U.S.C. § 1395x(e)(1). In any event, this vague statement of a single admission, for no more than one night to Petitioner's facility, could not show that Petitioner was primarily engaged in inpatient care.

such action was necessary. P. Opposition at 8-9; P. Motion at 7. Petitioner asserts that CMS ought to be estopped from arguing that inpatients should have been required during the survey. P. Opposition at 19 n. 5; P. Motion at 15 n.5. However, even if the statements of an AOA employee could be considered those of a CMS agent, it is well settled that such statements cannot be used to estop the government. *See, e.g.*, *Office of Personnel Mgmt. v. Richmond*, 496 U.S. 414 (1990); *Heckler v. Cmty. Health Servs. of Crawford County, Inc.*, 467 U.S. 51 (1984); *Oklahoma Heart Hosp.*, DAB No. 2183, at 16 (2008); *Wade Pediatrics*, DAB No. 2153, at 22 n.9 (2008), *aff'd*, 567 F.3d 1202 (10th Cir. 2009); *U.S. Ultrasound*, DAB No. 2302, at 8 (2010). Therefore, I must reject Petitioner's equitable estoppel argument.

VI. Conclusion

For the reasons stated above, I deny Petitioner's motion for summary judgment, grant CMS's motion summary judgment, and affirm CMS's determination to deny Petitioner's request to participate in the Medicare program.

/s/
Scott Anderson
Administrative Law Judge