Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	
Transitional Hospitals Corporation -- Las Vegas,	DATE: January 6, 1995
Petitioner,	
- v. -	Docket No. C-94-413 Decision No. CR350
Health Care Financing Administration.	

DECISION

On March 28, 1994, the Health Care Financing Administration (HCFA) notified Petitioner that it had approved its participation in Medicare as an acute care hospital effective February 10, 1994. Petitioner requested that HCFA reconsider this determination. Petitioner contended that HCFA should have approved its participation in Medicare effective January 20, 1994. HCFA denied Petitioner's request for reconsideration. Petitioner requested a hearing. The case was assigned to me for a hearing and a decision.

HCFA moved for disposition of this case without an in-person hearing, asserting that it was entitled to a decision sustaining its determination based on the undisputed material facts and the law. Petitioner opposed the motion. Petitioner argued that there exist disputed material facts such that an in-person hearing is necessary to resolve the case.

I conclude that there is no need for an in-person hearing in this case.[1] I find that HCFA is entitled to a decision sustaining its determination to approve Petitioner's participation in Medicare effective February 10, 1994.

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[1] In order to decide this case, I have accepted as true all facts asserted by Petitioner to be material. I discuss these facts below.

I. Issues, findings of fact, and conclusions of law

The issue in this case is whether HCFA correctly certified Petitioner to participate in Medicare as an acute care hospital effective February 10, 1994. In deciding that HCFA correctly certified Petitioner's participation effective February 10, 1994, I make specific findings of fact and conclusions of law. After each finding or conclusion, I cite to the page or pages of the decision at which I discuss the finding or conclusion.

1. A provider's participation in Medicare will become effective as of the date that an onsite survey of the provider is completed by or on behalf of HCFA if, on that date, the provider meets all federal health and safety requirements for participation and any other requirements imposed by HCFA. Page 4.

2. If a provider does not meet all requirements for participation as of the date that an onsite survey is completed, then the provider's participation in Medicare will become effective on the earlier of the following dates:

a. The date on which the provider meets all requirements for participation; or

b. The date on which the provider submits a correction plan acceptable to HCFA, or an approvable waiver request, or both.

Page 4.

3. HCFA may not certify a provider to participate in Medicare where that provider has not met all requirements for participation, submitted a plan of correction acceptable to HCFA, or submitted an approvable waiver request. Pages 4, 8 - 11.

4. Petitioner did not meet all requirements for participation in Medicare as of January 20, 1994, the date when an onsite survey of Petitioner was completed. Pages 5 - 7.

5. The earliest date that Petitioner met all requirements for participation in Medicare was February 10, 1994, the date that Petitioner submitted a plan of correction acceptable to HCFA. Pages 7, 12 - 13.

6. Petitioner is not entitled to be certified for participation in Medicare earlier than February 10, 1994, due to the fact that the individuals who surveyed Petitioner advised Petitioner's representatives on

January 20, 1994, that Petitioner met all conditions for certification as a Medicare provider. Pages 5 - 6, 11 - 12.

7. Petitioner is not entitled to be certified for participation in Medicare earlier than February 10, 1994, due to the fact that the individuals who surveyed Petitioner did not tell Petitioner's representatives on January 20, 1994, that Petitioner must correct outstanding deficiencies before being certified as a Medicare provider. Pages 6, 11 - 12.

8. Petitioner is not entitled to be certified for participation in Medicare earlier than February 10, 1994, even if the individuals who surveyed Petitioner failed to follow the requirements of the operating manual governing surveys of providers by State agency surveyors. Pages 6, 12.

II. Discussion

A. Governing law

1. Criteria for participation in Medicare

The statutory criteria for a hospital's participation in Medicare are contained in section 1861(e) of the Social Security Act (Act). Regulations which implement these criteria, and which set forth additional requirements for participation by a hospital, are contained in 42 C.F.R. Part 482.

The purpose of both the Act and the regulations is to establish criteria for a hospital's participation in Medicare which promote and protect the health and safety of Medicare beneficiaries. The criteria for participation contained in the Act are, on their face, intended to achieve this purpose. Act, section 1861(e)(1) - (9).[2] The criteria contained in the regulations are intended also to achieve this purpose. 42 C.F.R. §§ 482.1 - 482.66.

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[2] These criteria include the requirement that a hospital: maintain clinical records on all patients; have bylaws to govern its physician staff; require that all of its patients be under the care of a physician; provide 24-hour nursing services rendered or supervised by a registered professional nurse; have in effect a hospital utilization review plan; and meet applicable State or local licensing standards. Act, section 1861(e)(2) - (7).

Regulations governing acute care hospitals' participation in Medicare establish the conditions under which hospitals may participate. A condition is generally set forth at the beginning of each regulation governing participation, in the form of a broadly stated prerequisite to participation. The conditions of participation established by these regulations generally express conditions stated in the Act. For example, the regulation which establishes medical staff requirements for participating hospitals states, as a condition of participation, staffing requirements that are contained in the Act (although in somewhat broader language than the statutory language). 42 C.F.R. § 482.22; see Act, section 1861(e)(3).

These regulations establish also standards of participation, which are criteria intended to elaborate and to flesh out the conditions of participation. In turn, these standards contain subdivisions (elements). For example, the medical staff condition of participation provides as a standard under that condition that a participating hospital must have a medical staff that is "composed of doctors of medicine or osteopathy . . . ." 42 C.F.R. § 482.22(a). One element of this standard is that the medical staff must conduct periodic appraisals of its members. 42 C.F.R. § 482.22(a)(1).

2. The circumstances under which HCFA may approve a provider's participation in Medicare

The circumstances under which HCFA may approve a provider's participation in Medicare are established by regulation. 42 C.F.R. § 489.10. An agreement between a provider and HCFA becomes effective on the date that HCFA completes an onsite survey of the provider if, on that date, the provider meets all conditions of participation and any other requirements imposed by HCFA. 42 C.F.R. § 489.13(a). As of the effective date of the agreement, the provider will be eligible to receive Medicare reimbursement for its services.

If the provider fails to meet any of the requirements established by HCFA for certification on the date that the survey is completed, then the agreement becomes effective, and the provider becomes eligible to receive Medicare reimbursement for its services, on the earlier of two dates. These are: 1) the date on which the provider meets all HCFA requirements; or 2) the date on which the provider submits a plan of correction to HCFA which HCFA accepts, or an approvable waiver request, or both. 42 C.F.R. § 489.13(b)(1), (2).

B. Material facts

The following material facts are not disputed. Petitioner is an acute care hospital in Las Vegas, Nevada, which began operating in late December 1993. Petitioner applied to participate as a provider in Medicare. In January 1994, Petitioner was surveyed on behalf of HCFA by surveyors from the Bureau of Licensure and Certification of the Health Division of the Nevada Department of Human Resources (Nevada State agency). Two surveys were performed, consisting of a Medicare survey and a Life Safety Code survey. These surveys were completed, respectively, on January 19 and 20, 1994.

In both surveys, the surveyors identified deficiencies in Petitioner's operations. The deficiencies identified by the surveyors included failures to comply with participation standards established by regulation, and with elements of those standards. HCFA Ex. 1, 2.[3] By letters of January 25 and 26, 1994, the Nevada State agency gave Petitioner written notice of the deficiencies. Id.; P. Ex. 4; HCFA Ex. 3. On February 10, 1994, Petitioner submitted to the Nevada State agency its plans of correction. HCFA Ex. 1, 2.[4] On March 28, 1994, HCFA advised Petitioner that it had accepted its agreement to participate in Medicare as an acute care hospital, effective February 10, 1994. HCFA Ex. 4.

Petitioner asserts the presence of additional facts. For purposes of this Decision, I accept the following fact contentions made by Petitioner. On January 20, 1994, at the completion of the two surveys, the Nevada State agency surveyors gave Petitioner's representatives a verbal report of their findings. The surveyors advised

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[3] HCFA submitted six exhibits (HCFA Ex. 1 - 6). Petitioner submitted four exhibits (P. Ex. 1 - 4). Neither party has objected to the admission into evidence of the other's exhibits. I admit all of the exhibits into evidence, although, strictly speaking, it is not necessary for me to do so, inasmuch as many of them are evidence of facts which are not in dispute.

[4] The documents in which the deficiencies are identified are each captioned "Statement of Deficiencies and Plan of Correction." HCFA Ex. 1, 2. Petitioner was instructed to prepare written plans of correction to resolve the deficiencies and to describe the proposed corrections in the right-hand columns of the statements of deficiencies. HCFA Ex. 3; P. Ex. 4. The statements of deficiencies which are in evidence as HCFA Ex. 1 and 2 contain also Petitioner's plans of correction.

Petitioner's representatives that Petitioner met all Medicare conditions of participation. However, they told Petitioner's representatives also that they had identified some deficiencies in Petitioner's operations. P. Ex. 1, page 3; P. Ex. 2, page 2. The surveyors did not provide Petitioner's representatives with a written statement of the deficiencies that they found. P. Ex. 1, pages 2 - 3; P. Ex. 2, page 2. The surveyors told Petitioner's representatives that they would take their survey results back to their office, compile their findings, and mail the written results to Petitioner. P. Ex. 1, page 3.

The surveyors did not tell Petitioner's representatives that the date when Petitioner would be certified to participate in Medicare would depend on Petitioner's response to the written statement of deficiencies that the surveyors would be preparing. P. Ex. 1, page 3; P. Ex. 2, page 2. The surveyors did not tell Petitioner's representatives when Petitioner would be certified to participate in Medicare. P. Ex. 2, page 2.

Petitioner does not contend that the surveyors told its representatives at the completion of the surveys that Petitioner would be certified to participate in Medicare as of the surveys' completion date (January 20, 1994). Nor does Petitioner contend that the surveyors told Petitioner's representatives that Petitioner would be excused from the obligation to submit a plan of correction of deficiencies as a prerequisite to becoming certified to participate in Medicare.

For purposes of this Decision, I accept also Petitioner's assertion that the surveyors did not conduct their exit conference with Petitioner's representatives in full compliance with the requirements of the State Operations Manual (SOM). The SOM consists of HCFA's instructions to State agencies which, in part, govern the manner in which surveys of providers are to be conducted. I accept Petitioner's representation that the SOM required the surveyors to notify Petitioner that the effective date of its participation in Medicare would be determined according to the date that Petitioner submitted its plan of correction of the deficiencies identified by the surveyors, and that the surveyors failed to comply with this requirement. Petitioner's Brief at 14 - 15.

C. Analysis of the parties' arguments

Relying on the language of 42 C.F.R. § 489.13, HCFA argues that Petitioner could not be certified to participate in Medicare on January 20, 1994, inasmuch as Petitioner did not meet all of HCFA's participation requirements on that date. HCFA asserts that the

earliest date that Petitioner qualified for certification was February 10, 1994, the date on which Petitioner submitted plans of correction to HCFA which HCFA determined to be acceptable.

Petitioner does not deny that there were deficiencies in its operations as of January 20, 1994. Nor does Petitioner deny that the deficiencies constituted failures to comply with HCFA's certification requirements. Petitioner does not assert that it corrected any of these deficiencies prior to February 10, 1994, the date on which it submitted its plans of correction. Thus, Petitioner acknowledges that, under 42 C.F.R. § 489.13, Petitioner was not in compliance with all of HCFA's requirements on January 20, 1994, and that it did not come into compliance with those requirements prior to February 10, 1994, the date on which it submitted acceptable plans of correction.[5]

Petitioner argues that the requirements contained in 42 C.F.R. § 489.13 are not applicable here. It contends that, through no fault of its own, it was misled by Nevada State agency surveyors into believing that it did not have to correct deficiencies as a prerequisite to certification. Petitioner asserts that, had it known that it had to correct deficiencies identified by the surveyors as a prerequisite to certification, it would have corrected them prior to February 10, 1994. Therefore, according to Petitioner, it relied to its detriment on misleading statements made by Nevada State agency surveyors. It argues also that the surveyors' failure to tell it, in contravention of SOM requirements, that it would be certified as of the date it submitted acceptable plans of correction, should estop HCFA from denying certification as of the date of the completion of the surveys. According to Petitioner, the reasonable remedy would be for me to order that it be certified as a Medicare provider, effective January 20, 1994.

As I explain below, I do not find that Petitioner can assert reasonably that it was misled into believing that it would be certified before it corrected the deficiencies that the surveyors identified. However, I would find that Petitioner is not entitled to be certified prior to February 10, 1994, even if I were to find that Petitioner had been misled as it contends. That is so because I find no legal basis for Petitioner's estoppel argument.

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[5] Petitioner did not request a waiver from participation requirements.

Central to my conclusion is that Petitioner's estoppel argument relies on a fundamental misconstruction of HCFA's obligations under the Act and implementing regulations. The Act and regulations do not impose on HCFA the duty to pay Medicare reimbursement to providers who are not in compliance with participation requirements. No such duty exists even where HCFA might arguably mislead a provider into believing that it would be certified to participate when, in fact, the provider had not met participation requirements. The Act and the regulations impose on HCFA the duty to protect the welfare of Medicare beneficiaries. Where HCFA's agents conduct a survey of an applicant for participation in Medicare and find deficiencies, HCFA's obligation is to refrain from certifying the applicant until the deficiencies are corrected.

A provider's duty is to understand the implications of a finding that deficiencies exist and to do whatever is necessary to bring its operations into compliance with the legal requirements for certification. A provider may not rely on errors or omissions by HCFA's agents to obtain certification in advance of the date when it complies fully with certification requirements.

I analyze the relevant law and facts in this case as follows.

o The provider certification regulations do not permit HCFA to certify a provider to participate in Medicare where that provider has not complied with all certification requirements. The equitable principle of estoppel does not supersede or supplant the requirements of the regulations.

The regulation governing the date when a provider becomes certified states plainly, and without exception, that a provider must meet <u>all</u> federal requirements before being certified. 42 C.F.R. § 489.13(a), (b). The regulation does not permit a deficient provider to be certified prior to correcting its deficiencies. This is true even where the provider is aware of deficiencies, but concludes incorrectly that it need not correct those deficiencies as a prerequisite to certification. This is true even if the provider has been misled by State agency surveyors into believing that it need not correct deficiencies prior to becoming certified.

Petitioner argues that, notwithstanding the plain language of the regulations, the doctrine of estoppel may be invoked to bar HCFA from denying certification to a provider where HCFA misleads a provider into believing that it will be certified prior to correcting deficiencies. Petitioner cites <u>Livingston Care Center,</u>

Inc., OHA Appeals Docket No. 000-51-7010 (1989), as precedent for this argument.[6] In Livingston, a Social Security Administration Office of Hearings and Appeals administrative law judge held that HCFA had not established a legitimate basis to terminate the participation in Medicare of a skilled nursing facility. Id. at 63 - 64. The administrative law judge based his decision, in part, on his finding that the State agency that surveyed the provider failed to comply with the requirements contained in the SOM governing the information which State agency surveyors were obligated to impart to the provider as part of the inspection process.[7]

I am not persuaded by the Livingston decision that HCFA may be estopped from denying certification to Petitioner at a date earlier than the date when Petitioner complied with participation requirements. First, the Livingston decision does not operate as precedent and I am not required to accept it.

Second, the legal principle which governed the judge's decision in Livingston does not operate here. Livingston is a decision which upholds a provider's rights under the Act. In Livingston, the administrative law judge found that the provider had a statutory right to continue as a Medicare provider while it was given a reasonable opportunity to correct deficiencies. Id. The State agency's surveyors' failure to impart necessary information to the provider concerning the deficiencies they found was held to deprive the provider of the opportunity to correct its deficiencies.

Here, there are no statutory rights at issue. There is no statutory right for a provider-applicant to be certified as a Medicare provider while it attempts to correct deficiencies.

My interpretation of the provider certification regulations is similar to the analysis I made of the same regulations in SRA, Inc., D/B/A St. Mary Parish Dialysis Center, DAB CR341 at 18 - 19 (1994). In SRA, as in this case, I held that the regulations which govern

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[6] The Livingston decision is included in the record of this case as Attachment A to Petitioner's November 21, 1994 Brief.

[7] Below, I explain why the failure of Nevada State agency surveyors in this case to comply with the requirements of an SOM does not entitle Petitioner to be certified at a date earlier than the date it complied with Medicare participation requirements.

certification of a provider to participate in Medicare do not permit a provider to be certified until it complies with all requirements for participation. Id.

Petitioner argues that the SRA decision is not applicable here. Although the facts of SRA are somewhat different from the facts of this case, the law on which that decision is based is applicable also in this case.

In SRA, State agency surveyors conducted several surveys and a complaint investigation of the petitioner which identified deficiencies. The State agency provided the petitioner with notices of these deficiencies. The petitioner argued that the State agency did not provide it with timely notice of the deficiencies. It argued also that it had complied "substantially" with certification requirements. It asserted that it ought to have been certified at a date earlier than the certification date established by HCFA, due to its "substantial" compliance with certification requirements and the alleged failure of the State agency and HCFA to give it timely notice of deficiencies.

I held that the petitioner in SRA did not prove its compliance with certification requirements at any date prior to the certification date established by HCFA. I held also that the requirement that the petitioner comply with certification requirements was not vitiated by alleged failures by the State agency or HCFA to provide the petitioner with timely notice of deficiencies (although I held also that the notices that were sent to the petitioner were not untimely).

o The regulations are consistent with congressional intent. The purpose of both the Act and the regulations is to protect the welfare of Medicare beneficiaries by assuring that only providers who comply with all applicable criteria governing the delivery of services are reimbursed for those services. SRA, at 19. It would not be consistent with the purpose of the Act or the regulations to permit a provider to claim reimbursement for its services where that provider is not complying with certification requirements.

Indeed, when the competing equities of Petitioner and those Medicare beneficiaries who are served by Petitioner are measured against this congressional intent, it is apparent that Petitioner cannot prevail. Congress has decided that Medicare beneficiaries have an interest in being provided health care consistent with appropriate health and safety requirements which is superior to providers' interest in being reimbursed for services to Medicare beneficiaries. Thus, Congress has decided that

providers who fail to meet certification requirements must not be certified to provide services to beneficiaries.

o Based on the facts contended by Petitioner, Petitioner has not proved that it was misled by Nevada State agency surveyors into believing that it need not correct deficiencies in its operations as a prerequisite to being certified. The surveyors made no affirmative statements which were misleading. Furthermore, Petitioner cannot assert, reasonably, that it was misled by what the surveyors did not say.[8]

The surveyors said nothing affirmatively misleading to Petitioner's representatives. The surveyors did not tell Petitioner's representatives that Petitioner would be certified at any date earlier than the date when Petitioner corrected the deficiencies identified by the surveyors. The record establishes only that the surveyors told Petitioner's representatives that: 1) there were deficiencies in Petitioner's operations; and 2) they would be providing Petitioner with written notification of the deficiencies.[9]

Petitioner cannot assert credibly that it was misled into believing, from statements that the surveyors did not make to Petitioner's representatives, that it would be certified prior to correcting the deficiencies that were identified by the surveyors. It is within the realm of possibility that a provider who is totally ignorant of the survey and certification process might conclude from the surveyors' failure to state that certification would be contingent on correction of deficiencies that it would be certified to participate in HCFA before deficiencies were corrected. But neither Petitioner nor other applicants to become providers may rely on ignorance of the certification process to assert that HCFA should be estopped by its agents' failure to assertively link certification to correction of deficiencies.

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[8] Nor is there any evidence to show that the Nevada State agency was dilatory in notifying Petitioner in writing about the deficiencies which were identified at the January 19 and 20, 1994 surveys. The Nevada State agency sent written notification and a request for plans of correction to Petitioner on January 25 and 26, 1994, three and four working days from January 20, 1994.

[9] For the reasons which I discuss above, I would not find in favor of Petitioner even if Petitioner were able to prove that the Nevada State agency surveyors had told its representatives that it need not correct deficiencies as a prerequisite to becoming certified.

An applicant for certification as a Medicare provider has a duty to understand and comply with the requirements of the applicable law and regulations. If Petitioner did not know that it had to correct its deficiencies before being certified, it had a duty to find that out. The prerequisite that Petitioner correct deficiencies before becoming certified would have been apparent to Petitioner had it simply read the relevant regulation.

The statements made to Petitioner's representatives by the Nevada State agency surveyors would not have misled anyone familiar with the regulations governing certification. Had Petitioner considered these statements in the context of 42 C.F.R. § 489.13, it would have known immediately that it would not be certified until it corrected the deficiencies identified by the surveyors.

o The failure by Nevada State agency surveyors to comply with SOM requirements does not entitle Petitioner to participate in Medicare at a date earlier than February 10, 1994. The SOM establishes guidelines to be followed by surveyors in the conduct of surveys. It does not constitute a statement by the Secretary which supersedes regulations. There is nothing to suggest that the Secretary has directed that the SOM be distributed to providers as an interpretation of the Act, or as a statement of their rights in the survey and certification process. In no respect does the SOM establish rights which inure to the benefit of providers. Thus, the controlling law and policy here remains the requirement in the regulations that providers not be certified until they comply with all requirements for participation.

Moreover, Petitioner does not allege that it relied on the SOM to its detriment. Petitioner does not contend that its representatives assumed that Petitioner would be certified effective January 20, 1994, based on their understanding of the SOM.

III. Conclusion

I conclude that summary disposition is appropriate in this case and that there is no need for an in-person hearing. Based on the undisputed material facts (including those facts alleged by Petitioner which I have accepted for purposes of this decision) and the law, HCFA correctly certified Petitioner as a Medicare provider on February 10, 1994, the date when Petitioner submitted its

plans of correction. There is no basis for me to order that Petitioner be certified at any date prior to February 10, 1994.

/s/

Steven T. Kessel
Administrative Law Judge