Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Oklahoma Heart Hospital,	)	Date: January 4, 2008
(CCN: 37-0215),	)	
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-07-409
	)	Decision No. CR1719
Centers for Medicare & Medicaid	)	
Services.	)	
	)	

DECISION

I deny Oklahoma Heart Hospital's (Petitioner) motion for summary judgment, and uphold the initial determination of the Centers for Medicaid and Medicare Services (CMS). I find that Petitioner's effective date of participation in the Medicare program is October 25, 2002.

I. Background

Petitioner is a hospital located in Oklahoma City, Oklahoma, that specializes in cardiac care. On May 15, 2002, Petitioner submitted an application for certification to participate in the Medicare program to the Medicare Part A intermediary, Chisholm Administrative Services (Intermediary). On July 8, 2002, Petitioner was notified by the Intermediary of its recommendation to CMS for approval of Petitioner's certification application, pending a future survey determination of compliance with all federal participation requirements. Petitioner subsequently executed and submitted a Provider Agreement dated July 9, 2002.

Petitioner filed a request for a certification survey to be conducted by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) on July 10, 2002. JCAHO is an organization approved by CMS to conduct accreditation surveys and determine a facility's compliance with federal Medicare participation requirements.

On August 13, 2002, Petitioner was inspected by the Oklahoma State Department of Health (OSDH) for compliance with state licensure standards. The OSDH survey found Petitioner to be in compliance with state requirements for operating a hospital and issued a license, effective August 13, 2002. Beginning August 14, 2002, Petitioner commenced to conduct business as a fully-functioning hospital, and on that date began accepting Medicare patients.

On October 23 and 24, 2002, JCAHO conducted an on-site survey of Petitioner's facility to determine whether Petitioner met federal participation requirements. JCAHO concluded, based on the survey, that Petitioner met all requirements and recommended Petitioner for certification to CMS, effective October 25, 2002. By letter dated February 14, 2003, Petitioner was notified by CMS of acceptance of its agreement for participation in the Medicare program, effective October 25, 2002.

Petitioner filed a request for reconsideration of CMS's initial determination regarding the effective date of Petitioner's provider agreement on April 14, 2002 [sic].[1] Petitioner asserted that it had provided care to a substantial number of Medicare patients since the facility's opening on August 14, 2002. Petitioner contended that Ms. Sills, a representative for the Intermediary, indicated that it would be allowable to "back bill" for services provided to those Medicare patients from the time of the August 14 opening.

On March 2, 2007[2], CMS notified Petitioner of the denial of the request for reconsideration. CMS stated that the regulations do not allow for the change requested by Petitioner. Specifically, CMS stated that, among other things, if the requirements for accreditation are met at the time of the survey, then 42 C.F.R. § 489.13(b) determines the effective date of the provider agreement. CMS further explained that a facility cannot be deemed to be in compliance until a successful survey has determined that all federal participation requirements have been met and, in these instances, the earliest effective date an agreement may have is the date of the successful accreditation survey.

By letter dated April 30, 2007, Petitioner timely filed a request for hearing appealing CMS's determination of Petitioner's certification to participate in the Medicare program as October 25, 2002. Petitioner asserts that the effective date should be August 14, 2002.

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[1] The date on Petitioner's request for reconsideration is incorrectly written as "April 14, 200**2**." P. Ex. 2, at 1. The accurate date is "April 14, **2003**."

[2] The record before me does not illuminate the reason or reasons for the apparent four-year delay between Petitioner's request for reconsideration and CMS's determination to deny reconsideration. The nature of the reason or reasons does not, however, appear on this record to be material to the resolution of this litigation.

The case was assigned to me for hearing and decision. The parties each submitted a Notice of Issues for Which Summary Judgement Would Be Sought. A briefing schedule was established for the submission of motions and supporting briefs. Petitioner filed its initial brief in support of its Motion for Summary Judgement (P. Br.), and accompanying exhibits (P. Exs. 1-9) on August 10, 2007. CMS filed its Response to Petitioner's Motion for Summary Judgment (CMS Response) on September 13, 2007. Petitioner filed its reply brief on September 28, 2007, and CMS submitted its sur-reply brief on October 5, 2007. Without objection from CMS, I have admitted into the record P. Exs. 1-9.

II. Applicable law and regulations

In order to participate in the Medicare program, a prospective provider, such as a hospital, must enter into a provider agreement with CMS. Social Security Act (Act), section 1866. Before CMS will accept an agreement from a prospective provider, the provider must meet the conditions of participation relevant to that provider. 42 C.F.R. §§ 488.3(a)(2), 489.10(a).

The requirements for hospitals participating in Medicare are set forth at 42 C.F.R. Part 482. These requirements include both conditions and standards of participation. Conditions of participation state broad general requirements. Standards of participation set forth specific requirements related to a condition.

CMS and its agents (such as state survey agencies or a national accreditation organization) determine whether a provider is complying with applicable federal requirements pursuant to the survey and certification process set forth at 42 C.F.R. Part 488. 42 C.F.R. §§ 488.11(a), (d); 488.12; 488.26(c)(1).

42 C.F.R. § 489.13(b) establishes the general rule for determining the effective date of a provider agreement for a provider subject to survey and certification. It provides:

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

To qualify as an approved provider of Medicare services, a hospital must have an approved agreement, and in order for its agreement to be approved, the hospital must be surveyed on-site by an agency authorized by CMS to conduct such a survey, in order that its compliance with the requirements of the Medicare program can be assessed and

certified. 42 C.F.R. §§ 489.2(b)(1), 489.10(a). Until a hospital has been assessed and certified, and until its agreement has been approved based on that assessment, its status is that of a "prospective provider." 42 C.F.R. § 498.2.

When the agency has completed its on-site survey, it reports the results and its recommendation to CMS. 42 C.F.R. § 488.11(a). The agency's report may include recommendations regarding the effective date of the hospital's approved status based on the criteria set forth at 42 C.F.R. § 489.13(b). 42 C.F.R. § 488.11(d). On the basis of the agency's report and recommendation, CMS will determine whether the hospital is eligible to participate in or be covered by the Medicare program. 42 C.F.R. § 488.12(a)(1). With limited exceptions, none of which are relevant in the matter presently before me, a prospective provider may not receive reimbursement for services provided to Medicare beneficiaries prior to the effective date of its provider agreement. Act, section 1814(a).

III. Issues

The issues in this case are:

- whether a decision on summary judgment is appropriate;
- whether Petitioner became eligible to participate in the Medicare program on a date prior to October 25, 2002; and
- whether I have authority based on the principle of equitable estoppel to order CMS to certify Petitioner for participation in the Medicare program on a date prior to October 25, 2002.

IV. 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 in *italics* as a separate heading. I discuss each Finding in detail.

A. Summary judgment is appropriate in this case because there are no disputed issues of material fact.

Summary judgment is appropriate when there is no genuine issue as to any material fact and one of the parties is entitled to judgment as a matter of law. FED. R. CIV. P. 56; *see Livingston Care Center*, DAB No. 1871 (2003). If the moving party meets this burden, the onus shifts to the opposing party to establish that a genuine issue as to a material fact does exist. The opposing party will have shown that genuine issues of material fact are

present "if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248, 249 (1986). To accomplish this, the opposing party must go beyond mere allegations, and come forward with factual evidence that creates a genuine issue of material fact. All reasonable inferences are to be drawn in the opposing party's favor. *Pollock v. American Tel. & Tel. Long Lines,* 794 F.2d 860, 864 (3rd Cir. 1986).

Under Rule 56, a "material fact" is a fact which, if it exists, may affect the outcome of a case. A "genuinely disputed" material fact exists when opposing parties advance different versions of an event. The concept of a genuine dispute as to the facts is critical to understanding how summary judgment works. A fact offered by a party is not in dispute simply because the opposing party asserts that it is in dispute. In order for there to be a dispute as to the facts the opposing party must offer a version of events that differs materially from the version offered by the moving party.

Furthermore, Rule 56 draws a distinction between facts and conclusions that are based on facts. A disagreement between parties as to the meaning of facts is not an impediment to summary judgment under Rule 56. The trier of fact always has the authority to draw conclusions from facts, whether the case is disposed of by summary judgment, or after a hearing. Thus, arguments about the meaning of facts – as opposed to disputes as to what facts exist – constitute no impediment to granting summary judgment in a case.

In the case presently before me, there are no disputed issues of material fact. There are disputes as to how applicable law should be interpreted. But such disputes do not call into question the truthfulness or existence of any of the facts relied upon by either party. I conclude, therefore, that summary judgment is appropriate in this case.

B. CMS accurately determined October 25, 2002 as the effective date of Petitioner's Medicare certification.

1. Petitioner became eligible to participate in the Medicare program on October 25, 2002, the date of the completion of the survey conducted by JCAHO which established that Petitioner met all Medicare participation requirements.

Petitioner contends that the regulation at 42 C.F.R. § 489.13(b) provides a mechanism by which a provider may be reimbursed for services rendered prior to formal acceptance into the Medicare program. P. Br. at 11. The Medicare regulation, Petitioner continues, "establish[es] an 'effective date' of the provider agreement that allows for reimbursement of medical services furnished to Medicare patients prior to execution of the provider

agreement." *Id.* at 10. Petitioner states that, typically, state survey agencies conduct the initial certification survey and forward their findings and recommendations for participation to CMS for determination. *Id.*

Petitioner comments that the licensing standards utilized by OSDH are similar to those used by Medicare for participation determination. P. Br. at 11. Petitioner states that a survey was conducted by OSDH on August 12, 2002 and found Petitioner to be in compliance with the Oklahoma licensing standards. P. Ex. 8, at 2. Petitioner argues that OSDH's finding of compliance was also, "in effect," a determination of compliance with Medicare conditions of participation. P. Br. at 12.

Petitioner's interpretation of the regulations is unfounded. The regulations that govern the instant matter are set forth at 42 C.F.R. Part 489. With exceptions, a provider may not be found qualified to participate in Medicare any earlier than the date of completion of a survey finding that a provider has met all federal participation requirements. 42 C.F.R. § 489.13(b). A provider must be inspected by an entity granted authority by CMS to conduct inspections on its behalf for the purpose of certification for Medicare participation.

The undisputed facts show that:

> 1. In November 2001 and on December 10, 2001, Petitioner represented to the Intermediary its intent to be inspected by JCAHO for Medicare certification purposes. P. Ex. 4; P. Br. at 6.
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> 2. Petitioner executed and submitted its enrollment application (CMS Form 855A) to the Intermediary on May 15, 2002. P. Ex. 4, at 1.
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> 3. The Intermediary forwarded a letter to CMS recommending approval of Petitioner's enrollment application on July 8, 2002. *Id.*
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> 4. Immediately following receipt of the June 8, 2002 recommendation letter to CMS, Petitioner filed a request for inspection to JCAHO. *Id.*; P. Br. at 6.

> 5. On August 12-13, 2002, Petitioner was inspected by OSDH for state licensing purposes, was found in compliance with state licensing requirements, and was issued a state license. P. Ex. 4, at 1; P. Ex. 8, at 2.
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> 6. Petitioner began operation and commenced providing services to Medicare beneficiaries on August 14, 2002. P. Ex. 4, at 1.
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> 7. Petitioner was surveyed by JCAHO on October 23-24, 2002 and was found to be in compliance with federal Medicare participation requirements. P. Ex. 4, at 2.

The regulations at 42 C.F.R. §§ 488.4 and 488.5 provide that CMS may designate an entity to conduct certification surveys on its behalf. CMS has designated JCAHO as an entity authorized to conduct Medicare certification surveys on its behalf. A facility inspected and deemed to meet certification requirements by JCAHO has thus qualified as having been inspected and approved by a CMS-designated entity, and CMS will consider the facility as having met the criteria to participate in the Medicare program. 42 C.F.R. § 488.5; *Puget Sound Behavioral Health*, DAB CR1151, at 5 (2004). Petitioner affirms that JCAHO was the Medicare certification entity acting on behalf of CMS. An inspection was duly conducted by JCAHO, Petitioner was found compliant with Medicare requirements, and the JCAHO survey thus determined Petitioner's effective date of participation as October 25, 2002. The Board in *Community Hospital of Long Beach*, DAB No. 1938, at 9 (2004) concluded that "a provider agreement is effective the day of the survey if 'the provider . . . meets all applicable Federal requirements as set forth in this chapter [42 C.F.R. Chapter IV].'" As a matter of law, CMS cannot amend the effective date to a time prior to the date of survey completion.

> 2. A State agency's survey for state licensing does not equate to a survey to certify a provider for Medicare participation.

Petitioner asserts that the survey conducted by OSDH, and the survey subsequently conducted by Blue Cross Blue Shield of Oklahoma (BCBS), in which Petitioner was found to be fully compliant with state licensing and insurance participation requirements, should be held to fulfill the requirements for Medicare participation. P. Br. at 12-13. Petitioner contends that OSDH is an organization that sometimes performs Medicare certification surveys on behalf of CMS, and that its approval of Petitioner's facility is therefore *ipso facto* demonstrative of Petitioner's compliance with Medicare requirements. *Id.* at 13.

It is clear from the facts that the inspection conducted by OSDH was solely for state licensing certification, and not for certification of Medicare participation requirements. Petitioner has erred in its assumption that a facility that meets state licensing requirements instantaneously and *ipso jure* meets all federal requirements for Medicare participation. The Board in *Arbor Hospital of Greater Indianapolis*, DAB No. 1591, at 7-8 (1996), established that CMS cannot base Medicare certification on a state licensing survey or on the date of issuance of a state license. The regulations are clear that a provider must be inspected and found to be in compliance with participation requirements before certification will be granted. *Id.*; *see also,* 42 C.F.R. § 489.13.

3. Petitioner does not qualify for the "Special Rule" exception under 42 C.F.R. §§ 489.13(d)(1)(ii) and (d)(2).

Petitioner asserts that CMS erred in its failure to consider the provisions at section 489.13(d)(1) or (d)(2) in its consideration regarding designation of an effective date prior to that of October 25, 2002. P. Br. at 15.

Petitioner relies heavily on the language of these particular provisions. The regulation states:

> (d) *Accredited provider or supplier request participation in the Medicare program – (1) General rule.* If the provider or supplier is currently accredited by a national accrediting organization whose program had CMS approval at the time of accreditation survey and accreditation decision, and on the basis of accreditation, CMS has deemed the provider or supplier to meet Federal requirements, the effective date depends on whether the provider or supplier is subject to requirements in addition to those included in the accrediting organization's approved program.
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> (ii) *Provider or supplier not subject to additional requirements.* For a provider or supplier that is not subject to additional requirements, the effective date is the date of the provider's or supplier's initial request for participation if on that date the provider or supplier met all Federal requirements.

* * * *

> (2) *Special rule: Retroactive effective date.* If a provider or supplier meets the requirements of paragraphs (d)(1) and (d)(1)(i) or (d)(1)(ii) of this section, the effective date may be 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.

Specifically, Petitioner contends that the plain language of section 489.13(d)(1) supports a finding by CMS that the effective date should be August 14, 2002, the date on which it commenced providing services to Medicare beneficiaries. P. Br. at 15-16.

Further, Petitioner continues, the "Special Rule" at section 489.13(d)(2) gives CMS the authority to designate retroactively an alternate effective date within one year of a facility's accreditation date, for inclusion of dates for which services were provided to Medicare beneficiaries by the facility and for which reimbursement was not received. P. Br. at 16. Petitioner opines that, since the JCAHO survey found it to be in compliance with participation requirements as of October 25, 2002, a retroactive effective date of August 14, 2002 falls within the one-year window established by the regulation. *Id.*

In each instance, Petitioner's reliance on these particular provisions to support its position is ill-founded. I concur with CMS's interpretation of the law that, in order for retroactive application to take effect, a provider must have been previously accredited by a CMS-approved accreditation entity. In spite of Petitioner's unfounded belief that the survey conducted by OSDH is applicable for meeting Medicare participation certification, in actuality, Petitioner was not entitled to be considered as having met participation requirements until the on-site JCAHO survey conducted by JCAHO itself in October 2002. Therefore, there is no prior certification survey to "relate back" to in order to calculate the retroactive effective date Petitioner seeks.

Further, as CMS points out, even if section 489.13(d)(2) were applicable in this case, the rule is clearly *discretionary* on the part of CMS. The provision states that "***[i]f*** a provider . . . meets the requirements . . . " and "the effective date ***may*** be retroactive for up to one year." (Emphasis added.). There is no regulatory provision that can be understood as providing a provider or supplier an entitlement to a retroactive certification effective date. In *Puget Sound Behavioral Health*, DAB No. 1944 (2004), the Board addressed the issue of "mandatory" versus "permissive" regulatory language. The Board opined that, in instances where the bulk of the language reflects mandatory requirements and, in one instance, the language attains a permissive tone, it is reasonable to conclude that the change in the tone of the language is deliberate and intended to convey a different

meaning. *Puget Sound*, DAB No. 1944, at 16. The Board concluded that the regulatory drafters of section 489.13(d)(2) intentionally used the phrase "may be retroactive" to evidence CMS's discretion to retroactively apply the "Special Rule" when it deemed appropriate. *Id.*; *see also, Lakeside Hospital of Bastrop*, DAB CR1594 (2007). But more importantly, Petitioner plainly did not meet the necessary participation requirements until the October 2002 survey was conducted and such a determination was made by the JCAHO.

C. I do not have authority under any equitable theory to require CMS to establish an effective date prior to October 25, 2002.

My authority in the instant case is limited: The Secretary of Health and Human Services (Secretary) has delegated authority to me for hearing and decision of issues arising from the initial determinations described at 42 C.F.R. §§ 498.3 and 498.5. My authority to hear and decide a case involving CMS does not extend to awarding money damages based on principles of estoppel, or to applying principles of equity such as estoppel to decide whether CMS's interpretation of a regulation is correct or incorrect, or to otherwise deciding claims against CMS or the Secretary based on equitable estoppel.

Petitioner concedes the existence of a line of cases which support the premise that neither an Administrative Law Judge (ALJ) nor the Board "has authority to render a decision on equitable grounds." P. Br. at 18. However, Petitioner avers to its disagreement with this particular principle and has determined to make the argument nevertheless, in order to preserve the argument for a potential appeal. *Id.*

Petitioner contends that, based on the erroneous information received from, and the "egregious conduct" of, the representative of the Intermediary regarding Petitioner's ability to "bill-back" for Medicare services provided prior to the JCAHO survey, there are sufficient grounds for granting equitable relief. P. Br. at 18-22. Petitioner argues that, had it known of the material inaccuracy of the information received from Ms. Sills, the Intermediary representative, it would not have provided over $5.6 million in services, between August 14 and October 24, 2002, that it would be unable to recoup. *Id.* at 20. Moreover, Petitioner continues, after repeated notice regarding the lack of guidance provided by the Intermediary, CMS neglected to take any action to provide more distinct guidance regarding the potential for financial harm during the application process. *Id.* at 21. Petitioner concludes that CMS's failure to take any action in this regard amounts to "affirmative misconduct." *Id.*

Assuming, *arguendo*, the truthfulness of Petitioner's assertions, they are immaterial to my resolution of this matter. I do not have authority to grant the relief sought by Petitioner under any equitable theory. In *Danville HealthCare Surgery Center*, DAB CR892

(2002), ALJ Anne E. Blair was exhaustive and definitive in her treatment of the equitable estoppel argument in cases such as this one now before me. After insightful consideration of a long line of cases spanning more than 20 years (*Office of Personnel Management v. Richmond*, 496 U.S. 414 (1990); *Surgery Center of Southwest Kansas*, DAB CR619 (1999); *New Life Plus Center, CMHC*, DAB CR700 (2000); *Tenet HealthSystem Philadelphia, Inc.*, DAB CR773 (2000); *Ophthalmology Ltd. Eye Surgery*, DAB CR658 (2000)), the ALJ applied this forum's established caselaw and concluded that estoppel "does not lie against the government in these types of cases." *Danville*, DAB CR892, at 7. Specifically, the ALJ in *Danville* reasoned that "erroneous information from government employees does not rise to estoppel against the government or entitle the recipient of the incorrect information to monetary payments not otherwise permitted by law." *Id.*, (*citing Surgery Center of Southwest Kansas*, DAB CR619, at 6).

V. Conclusion

For the reasons discussed above, I deny Petitioner's motion for summary judgment, and affirm CMS's determination to certify Petitioner to participate in the Medicare program effective October 25, 2002.

/s/
Richard J. Smith
Administrative Law Judge