Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Dublin Methodist Hospital,	)	
(CCN: 36-0348),	)	Date: January 30, 2009
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-08-672
	)	Decision No. CR1894
Centers for Medicare & Medicaid	)	
Services.	)	
	)	

DECISION

This matter is before me on the Motion for Summary Disposition filed by the Centers for Medicare & Medicaid Services (CMS). CMS has submitted exhibits in support of its Motion, and Petitioner Dublin Methodist Hospital (DMH) has filed its Response and exhibits in support of its position. I have reviewed these pleadings and exhibits, and having done so, I find that no material facts remain in dispute and conclude that CMS's position is correct as a matter of well-settled law. I therefore grant CMS's Motion and thus summarily affirm CMS's determination to approve DMH's participation as a hospital under the Medicare program effective February 5, 2008, but not earlier.

I. Procedural Background

DMH is a 107-bed acute care hospital located in Dublin, Ohio. On or about August 7, 2007, DMH began the process of applying for certification to participate in the Medicare program by submitting a CMS Form 855A to the Medicare Part A fiscal intermediary for Ohio, National Government Services (NGS). Confusion and error marked the application process for several months.

The first error was DMH's: the hospital submitted its Form 855A earlier than the permitted 30 days prior to anticipated certification, and in some particulars the Form 855A had been incompletely filled out. The next error was NGS's: it returned the application on August 13, 2007 for several reasons, some valid, one in particular quite mistaken. NGS incorrectly treated the Form 855A as relating to a change in ownership at DMH, whereas in fact the Form 855A was for an entirely new, initial application enrollment.

DMH submitted its revised Form 855A on December 6, 2007, but certain required information was still missing, and DMH was still submitting additions and amendments to the Form 855A as late as December 20, 2007. In its December 6, 2007 submission, DMH stated that it was seeking accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), an alternative to direct inspection by state health department authorities. 42 C.F.R. § 488.5. JCAHO conducted a survey of DMH's facility and notified DMH on January 25, 2008, that it had received JCAHO's accreditation effective the next day, January 26, 2008.

A certain amount of controversy surrounds the period between late December 2007 and early February 2008. DMH contends with some correctness that NGS's actions – or lack of actions – delayed the final approval of its application once the JCAHO accreditation was complete. CMS appeared at the time to concede that the delay was "unfortunate." DMH also argues, but with substantially less correctness, that NGS erred in returning the incomplete Form 855A submitted by DMH in early August 2007, and that the overall time elapsed between its August 7, 2007 submission of the incomplete Form 855A and NGS's final approval of the much-revised Form 855A on February 5, 2008, violated CMS guidelines set out in the Medicare Program Integrity Manual (PIM) by three days.[1] I note

[1] With reference to DMH's reliance on the PIM's 180-day goal for processing applications, there are several points to be made, and at least two of them do little credit to DMH's posture in these proceedings. First, the explicit language of PIM § 10.2.1.1 directs that the fiscal intermediary "[s]hall . . . process 99 percent of paper CMS-855 initial applications within 180 calendar days of receipt." The section makes no reference whatsoever to an individual time limit for any individual case. DMH has scrupulously avoided quoting the section *in haec verba*, but merely – and quite wrongly – asserts that it established a firm deadline for NGS's processing of its application. Second, DMH departs from candor in a singularly regrettable way when it claims that NGS took 183 days to process its application. The PIM section could not be clearer in setting the benchmark for processing time to begin at the fiscal intermediary's *receipt* of the application, which in this case is rather unmistakably shown to have been August 10, 2007. CMS. Ex. 1. By that standard, NGS's action on February 5, 2008, was timely, if

these arguments by way of acknowledging them, and by observing that CMS makes no attempt to elucidate NGS's activities over the 10-day period between January 26, 2008 and February 5, 2008, but I must observe that those matters require nothing further of me because they are, under the established and widely-understood rules of this forum, immaterial to the resolution of the legal issues before me.

What is material is the uncontested fact that, at the time of the JCAHO survey, NGS had not yet approved DMH's Form 855A. That review and approval of the Form 855A was not substantially complete until February 5, 2008, when NGS wrote to DMH and announced its approval of the Form 855A. CMS determined to make DMH's provider agreement effective on February 5, 2008.

This determination was conveyed to DMH by CMS on April 14, 2008. DMH objected to February 5, 2008 as the effective date of its agreement, and in its May 22, 2008 letter to CMS, asked that its provider agreement be made effective as of January 26, 2008, the day its JCAHO accreditation became effective. CMS declined to alter the date, and affirmed the February 5, 2008 date in a letter to DMH on June 19, 2008.

On August 13, 2008, DMH timely filed a request for hearing contesting CMS's determination to certify DMH eligible to participate in the Medicare program effective February 5, 2008. As it has below, DMH asserts here that the effective date should be January 26, 2008.

II. Issue

The legal issue before me is narrow. It is simply whether DMH is entitled to approval or certification as a Medicare provider effective as of any date prior to February 5, 2008.

This legal issue has been addressed in a variety of factual settings by several other ALJs, by appellate panels of the Departmental Appeals Board (Board), and by me, most recently in *University Behavioral Health of El Paso, LLC*, DAB CR1880 (2009) and *Physicians Medical Center of Santa Fé, LLC*, DAB CR1790 (2008). Although some of those cases have differed slightly from the present one in certain factual details, none have differed in such a way as to establish an exception to this forum's well-settled rule that requires me to

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only barely. But finally, I share the view of Administrative Law Judge (ALJ) Keith W. Sickendick, who has observed that "[t]he PIM is not a statute or a regulation and one may question that Complainants enjoy any enforceable rights based on that policy document." *In re CMS LCD Complaint: Intravenous Immunoglobulin*, DAB CR1426, at 15 (2006), *aff'd,* DAB No. 2059 (2007).

find that DMH is not entitled to approval or certification as a Medicare provider on any date prior to February 5, 2008.

III. Controlling Statutes and Regulations

In order to participate in the Medicare program, a prospective provider such as a hospital must apply for and be granted an approved provider agreement with CMS. The general framework of the application process is set out at section 1866 of the Social Security Act (Act), 42 U.S.C. § 1395cc. Before CMS will approve a provider agreement and certify that a prospective provider is eligible, the provider must meet all of the requirements of participation relevant to that provider. 42 C.F.R. §§ 488.3(a)(2); 489.10(a).

One requirement hospitals wishing to participate in Medicare must meet addresses the identity, qualifications, and character of the hospital's *operating entity*. The eligibility of the *operating entity* must be assessed according to the criteria established at 42 C.F.R. §§ 489.10 and 489.12 for transparency of ownership, reliability, financial soundness, and compliance with important civil rights standards. CMS may decline to approve a provider agreement if the hospital's *operating entity* does not meet the criteria listed at 42 C.F.R. §§ 489.10; 489.12.

Another such requirement is that the hospital's *facility* must be surveyed on-site by an agency authorized by CMS to do so, 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). JCAHO is authorized to conduct certification surveys. 42 C.F.R. § 488.5. When the surveying agency has completed its on-site survey, it reports the results and its recommendations to CMS. 42 C.F.R. § 488.11(a). On the basis of the agency's report and recommendations, CMS will determine whether the hospital's *facility* is eligible to participate in the Medicare program. 42 C.F.R. § 488.12(a)(1).

Generally, the earliest date on which a hospital may be certified by CMS to participate in Medicare is established by 42 C.F.R. § 489.13. If a hospital's *operating entity* has satisfied all other requirements and the survey of that provider's *facility* is the final step in the review sequence, then 42 C.F.R. § 489.13(b) controls:

> (b) *All Federal requirements are met on the date of 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.

In practice, the survey is usually the last step in the process. But, significantly, 42 C.F.R. § 489.13(c) provides for situations in which the *facility* survey may be completed before the *operating entity* has been approved:

> (c) *All Federal requirements are not met on the date of survey*. If on the date the survey is completed the provider or supplier fails to meet any of the requirements specified in paragraph (b) of this section, the following rules apply:
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> * * * *
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> (2) For an agreement with, or an approval of, any other provider . . . the effective date is . . . :
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> (i) The date on which the provider or supplier meets all requirements.

Until a hospital's *operating entity's* eligibility has been assessed and verified, and until the hospital *facility* has been surveyed and certified, its agreement cannot be approved. Until its agreement has been approved based on those assessments, its status is that of a *prospective provider*. 42 C.F.R. § 498.2. With limited exceptions, none of which are relevant in the matter presently before me, a *prospective provider*, such as a hospital, may not receive reimbursement for services provided to Medicare beneficiaries prior to the effective date of its provider agreement. Act § 1814(a) (42 U.S.C. § 1395f(a)).

IV. Findings of Fact and Conclusions of Law

I find and conclude as follows:

1. Because NGS had not yet approved its Form 855A, Petitioner DMH did not meet all applicable federal requirements for participation in the Medicare program when it gained JCAHO accreditation on January 26, 2008.

2. Petitioner DMH did not meet all applicable federal requirements for participation in the Medicare program at any time between January 26, 2008 and February 5, 2008.

3. Petitioner DMH first met all applicable federal requirements for participation in the Medicare program on February 5, 2008, when NGS approved its Form 855A.

4. Petitioner DMH is entitled to approval or certification as a Medicare provider effective February 5, 2008, but not earlier.

5. There are no disputed issues of material fact and summary disposition is appropriate in this matter. I have viewed the facts and the inferences reasonably to be drawn from the facts in the light most favorable to the nonmoving party. *See Pollock v. American Tel. & Tel. Long Lines*, 794 F.2d 860, 864 (3rd. Cir. 1986); *Brightview Care Center*, DAB No. 2132 (2007); *Madison Health Care, Inc*., DAB No. 1927, at 5-7 (2004).

V. Discussion

Although DMH argues vigorously that many of them do not apply to this controversy, the decisions of this forum and of the Board that govern its resolution are not in doubt, either as to their meaning or as to their application in this appeal. They may be simply summarized: a hospital is not entitled to certification as a Medicare provider, and CMS may not certify it as a Medicare provider, until the hospital meets all applicable federal requirements for participation in the Medicare program.

There is no dispute as to the material facts surrounding the sequence of steps leading to NGS's February 5, 2008 letter to DMH. JCAHO accredited DMH effective January 26, 2008, based on its survey of DMH's *facility*. Dilatory or not, NGS completed its assessment of DMH's Form 855A on February 5, 2008, and found the facility then in compliance with all *remaining* Medicare requirements. This sequence is something of a reversal of the usual sequence in which the facility survey is not undertaken until the fiscal intermediary has approved the operating entity. Most, but by no means all, of the recorded litigation in this forum has been based on an "entity-approval first, facility-survey next" model. But two significant exceptions to that model provide clear precedent for the result I announce here.

The first significant exception to the usual sequence appears in *SRA, Inc., D/B/A St. Mary Parish Dialysis Center*, DAB CR341 (1994), a case in which an end-stage renal disease treatment center (ESRD) sought certification of its Medicare provider agreement. The ESRD successfully "passed" a state agency survey of its facility, but certain aspects of the ESRD's management, supervisory, and professional arrangements were not then in compliance with Medicare requirements. Eventually those operating arrangements were corrected and approved by CMS's predecessor agency, the Health Care Financing Administration (HCFA). The ESRD claimed that it was entitled to certification as of the date of the successful survey, but HCFA insisted that the ESRD had not met all requirements until its operating arrangements were finally approved. In upholding HCFA's position, ALJ S.T. Kessel announced the rule that controls this case:

> The regulations provide plainly that, where a provider or supplier fails to meet certification requirements at the date of the inspection, it will be found to satisfy those requirements either on the date when it actually meets the

> requirements or on the date that it submits a plan of correction acceptable to HCFA, whichever comes first. 42 C.F.R. 489.13(a) and (b). Thus, a provider or supplier cannot be certified effective the date of survey where: (1) deficiencies are found to exist as of the survey date, and (2) the deficiencies are not corrected (or an acceptable plan of correction is not submitted by the provider or supplier) until a subsequent date.

SRA, DAB CR341, at 20.

In a more recent case, to which I have referred briefly above, a hospital had "passed" a state survey, but had simply not yet met "all requirements" for certification until its operating entity had been assessed and approved by the fiscal intermediary. On the principles ALJ Kessel explained in *SRA*, I concluded that the hospital could not "be certified effective the date of survey" as it had asked because unresolved questions about its operating entity existed on that date. *Physicians Medical Center of Santa Fé, LLC*, DAB CR1790.

There are no exceptions to these rules based on delays in the administrative process of reviewing the hospital's satisfaction of the participation requirements, and there are no exceptions based on a hospital's claimed reliance on allegedly-erroneous representations it complains were made to it by representatives of CMS, a state agency, or a fiscal intermediary. "The governing regulations are essentially unforgiving." *Tenet HealthSystem Philadelphia, Inc.*, DAB CR663, at 7 (2000). Thus, the argument over what DMH may have said or done in August 2007 or December 2007 is irrelevant, and, to the extent that facts in that argument remain unresolved, those facts are immaterial to the application of the rules that govern the disposition of this case.

Because DMH's briefing depends so heavily on its asserted injury as the result of incorrect actions by NGS, or by actions by NGS and by CMS that DMH characterizes as arbitrary and capricious, it seems important to emphasize why those claims are immaterial and require no resolution of the factual disputes behind them. DMH's theory is straightforward enough, even if it coyly stops just short of its ultimate statement. It is based on the doctrine of equitable estoppel, and it implies that its right to that equitable remedy is of constitutional dimension. Now, equitable estoppel, particularly in cases involving the effective dates of Medicare provider agreements, is specifically beyond my authority to consider. *Oklahoma Heart Hospital*, DAB CR1719, at 10-11 (2008), *aff'd*, DAB No. 2183, at 16-17 (2008); *Maher A. A. Azer (Florence Dialysis Center, Inc.)*, DAB CR994 (2003); *Danville HealthCare Surgery Center*, DAB CR892 (2002); *Everett Rehabilitation and Medical Center*, DAB CR455 (1997), *aff'd,* DAB No. 1628 (1997). Constitutional challenges to the validity of the regulations governing these proceedings are by settled precedent similarly beyond my jurisdiction and authority. While the issues

and arguments noted above may be suitable for discussion and debate in other forums, they are not legitimate subjects for litigation in this one. *Wisteria Care Center*, DAB No. 1892 (2003); *Hermina Traeye Memorial Nursing Home,* DAB No. 1810 (2002); *Sentinel Medical Laboratories, Inc.,* DAB No. 1762 (2001). I need not resolve DMH's factual assertions because they raise questions of fact that have no bearing on the issues I may properly consider. They are immaterial questions of fact and represent no bar to summary disposition.

VI. Conclusion

For the reasons discussed above, I grant CMS's Motion for Summary Disposition, and affirm CMS's determination to certify DMH to participate in the Medicare program as a Medicare provider effective February 5, 2008, but not earlier.

/s/
Richard J. Smith
Administrative Law Judge