Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Ridgeview Hospital
(CCN: 36-4047)
Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-142

Decision No. CR3183

Date: March 31, 2014

DECISION

Petitioner, Ridgeview Hospital, is challenging the effective date of its participation in the Medicare program. Initially and on reconsideration, the Centers for Medicare & Medicaid Services (CMS) determined that the hospital first met all the requirements for enrollment as a provider of services in the Medicare program on September 21, 2012 and approved the hospital's program participation effective from that date, the same date on which the hospital became accredited. Petitioner appealed and claimed that it is entitled to an effective date starting on the date of its exit survey, which was 64 days earlier. The parties have filed cross-motions for summary judgment.

For the reasons set forth below, I grant CMS's motion and affirm its determination of Petitioner's effective date, deny Petitioner's motion, and find that Petitioner would not be entitled to an effective enrollment date prior to its accreditation.

Background

Petitioner is a psychiatric hospital located in Middle Point, Ohio. On July 19, 2012, The Joint Commission (TJC), an accrediting organization that CMS approved, completed an initial accreditation survey and cited Petitioner with standard-level deficiencies in several

areas. None of these deficiencies rose to the level of a violation of a condition of participation. Petitioner submitted a plan of correction, also known as "evidence of standards compliance." On September 21, 2012, TJC received Petitioner's plan of correction, determined it was acceptable, and issued a positive accreditation decision. On October 16, 2012, CMS issued its notice granting Petitioner's request to enroll in the Medicare program as a psychiatric hospital effective September 21, 2012. CMS Exs. 2-3; P. Ex. 8. Petitioner appealed, requesting an effective date of July 19, 2012, the date that TJC completed its accreditation survey and found no violations of conditions of participation. CMS Ex. 4. On October 25, 2012, CMS issued an unfavorable determination upholding the September 21, 2012 effective date of enrollment. CMS Ex. 1.

On November 16, 2012, Petitioner requested a hearing before an administrative law judge (ALJ). The case was assigned to me for hearing and decision. The parties submitted memoranda in support of their respective motions for summary judgment (CMS Br.; P. Br.). CMS submitted a reply (CMS Reply). CMS submitted seven exhibits (CMS Exs. 1-7) and Petitioner submitted 10 exhibits (P. Ex. 1-10).

Petitioner also filed a motion for oral argument on the cross-motions for summary judgment, a prehearing conference, and other relief. CMS filed an opposition. Petitioner is not entitled to oral argument on the summary judgment motions here. Instead, I am authorized to grant summary judgment without holding an in-person hearing to resolve these matters without undue expenditures. As detailed in this decision, I find that a full evidentiary hearing in this matter is not needed, and this case is appropriate for summary judgment. Accordingly, I deny Petitioner's motions.

Findings of Fact and Conclusions of Law

1. Summary judgment in favor of CMS is appropriate.

Summary judgment is appropriate when a case presents no issue of material fact, and its resolution turns on questions of law. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-48 (1986); *Livingston Care Ctr. v. U.S. Dep't of Health & Human Servs.*, 388 F.3d 168, 173 (6th Cir. 2004); *see also Ill. Knights Templar Home*, DAB No. 2274, at 3-4 (2009) (*citing Kingsville Nursing Ctr.*, DAB No. 2234, at 3-4 (2009)). 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 Ctr.*, 388 F.3d at 173 (quoting *Celotex Corp. v. Catrett*, 477 U.S. 317, 323-24 (1986)).

To avoid summary judgment, the non-moving 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 & Rehab. Ctr.*, DAB No. 1918 (2004).

To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs but must furnish evidence of a dispute concerning a material fact. *Ill. Knights Templar*, DAB No. 2274, at 4; *Livingston Care Ctr.*, DAB No. 1871, at 5 (2003). In examining the evidence to determine the appropriateness of summary judgment, I must draw all reasonable inferences in the light most favorable to the non-moving party. *See Brightview Care Ctr.*, DAB No. 2132, at 2, 9 (2007); *Livingston Care Ctr.*, 388 F.3d at 168, 172; *Guardian Health Care Ctr.*, DAB No. 1943, at 8 (2004); *but see Cedar Lake Nursing Home*, DAB No. 2344, at 7 (2010); *Brightview*, DAB No. 2132, at 10 (noting entry of summary judgment upheld where inferences and views of non-moving party are not reasonable). Also, the role of an ALJ in deciding a summary judgment motion differs from the ALJ's role in resolving a case after a hearing. On summary judgment, an ALJ should not assess credibility or evaluate the weight of conflicting evidence. *Holy Cross Vill. at Notre Dame*, DAB No. 2291, at 4-5 (2009).

Here, there is no dispute as to the material facts. CMS and Petitioner agree that on the date of its exit survey, July 19, 2012, Petitioner had no condition-level deficiencies, but it did have several standard-level deficiencies. Further, they agree that TJC did not accept the resolution of those standard-level deficiencies until it received a plan of correction from Petitioner on September 21, 2012. The parties' contentions relate to a matter of law regarding whether CMS properly denied the date of July 19, 2012, versus September 21, 2012, as Petitioner's effective date for Medicare enrollment and billing privileges.

Petitioner, however, does contend there is a disputed fact about whether CMS has previously granted an accredited provider an initial Medicare enrollment date that was effective before the effective date of the provider's accreditation. P. Br. at 4-5, 20-21. Nonetheless, as detailed subsequently in my findings, whether CMS may have improperly granted other providers enrollment dates prior to accreditation is not material and will not defeat CMS's motion.

2. The undisputed evidence establishes TJC found Petitioner had several lower-level standard deficiencies as of the completion of its survey on July 19, 2012.

Upon completion of its survey of Petitioner on July 19, 2012, TJC, the CMS-approved accreditation organization, determined that the hospital had seven lower-level deficiencies:

1. Compliance with Federal, State, and local laws (42 C.F.R. § 482.11);

2. Governing Body (42 C.F.R. § 482.12);

3. Patient's Rights (42 C.F.R. § 482.13);

4. Medical Record Services (42 C.F.R. § 482.24);

5. Food and Dietetic Services (42 C.F.R. § 482.28);

6. Physical Environment (42 C.F.R. § 482.41); and

7. Special Medical Record Requirements for Psychiatric Hospitals (42 C.F.R. § 482.61).

P. Ex. 7. Petitioner does not contest the existence of these standard-level deficiencies and did not come forward with any affidavits of its own employees or experts to dispute them. P. Br. 5, 12.

3. The undisputed evidence establishes that Petitioner did not submit an acceptable plan of correction to remedy its lower-level standard deficiencies prior to September 21, 2012.

Petitioner submitted a plan of correction (termed "evidence of standards compliance" by the accreditation organization) for its lower-level deficiencies that TJC received on September 21, 2012. TJC thereafter accepted Petitioner's plan.

Petitioner's plan of correction was essential to TJC's determination to grant the hospital accreditation and to their determination to recommend the facility for Medicare certification. TJC's letter explains:

> Based upon the submission of your evidence of standards compliance on September 21, 2012, the areas of deficiency listed below have been removed. [TJC] is granting your organization an accreditation decision of Accredited with an effective date of September 21, 2012. . . .
>
> * * *
>
> [TJC] is also recommending your organization for Medicare certification effective September 21, 2012.

P. Ex. 7. Based upon Petitioner's plan of correction, the accreditation organization found Petitioner no longer deficient in those seven areas. TJC then approved Petitioner for accreditation and recommended CMS's certification for Medicare enrollment. P. Ex. 7 at 1; CMS Br. at 2-3.

4. The receipt of Petitioner's acceptable plan of correction, which effectively addressed its standard-level deficiencies, necessarily determines the earliest date that CMS can enroll Petitioner as a provider in Medicare.

The Social Security Act (Act) defines a psychiatric hospital as an institution that "is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons." Act § 1861(f) (42 U.S.C. § 1395x(f)). It must also meet criteria for general hospitals (section 1861(e)(3)-(9) (42 U.S.C. § 1395x(e)(3)-(9))), maintain clinical records on all its patients, and meet staffing requirements set by the Secretary. Act § 1861(f)(2)-(4) (42 U.S.C. § 1395x(f)(2)-(4). It may participate in the Medicare program as a provider of services, if it meets this statutory definition and complies with regulatory requirements of applicable conditions. Act §§ 1861(f), 1871 (42 U.S.C. §§ 1395x(f), 1395hh); 42 C.F.R. §§ 482.60 -.62, 488.3.

To determine whether certain prospective providers (such as psychiatric hospitals) qualify for Medicare certification, CMS authorizes certain accreditation organizations to survey and accredit the applicants and recommend Medicare certification. Institutions accredited by approved accreditation bodies are generally "deemed" to meet Medicare conditions of participation. Act § 1865 (42 U.S.C. § 1395bb); 42 C.F.R. § 488.5. However, if CMS finds that the prospective provider has significant deficiencies, it will not deem it to meet the conditions of participation. Act § 1865(c) (42 U.S.C. § 1395bb(c)). CMS may "refuse to enter into an agreement" with a provider that fails to meet even one condition of participation. Act §§ 1866(b)(2)(B), 1861(f) (42 U.S.C. §§ 1395cc(b)(2)(B), 1395x(f)); *see* 42 C.F.R. § 488.3(a).

A "condition of participation" represents a broad category of services. Each condition is contained in a single regulation, which is divided into subparts called standards. 42 C.F.R. Part 482. Compliance with a condition of participation is determined by the manner and degree to which the provider satisfies the standards within the condition. 42 C.F.R. § 488.26(b). The provider may meet all conditions of participation but still be cited with lower standard-level deficiencies that do not rise to a violation of a condition of participation. In those circumstances, CMS may approve the enrollment application, however, the effective date of that agreement is not until the accrediting organization receives an acceptable plan of correction for the lower-level deficiencies and issues a positive accreditation decision. 42 C.F.R. §§ 488.28(a), 489.13(c)(2)(ii)(A); *Apollo Behavioral Health Hosp*., L.L.C., DAB No. 2561, at 9-10 (2014); *Cmty. Hosp. of Long*

Beach, DAB No. 1938 (2004) (sustaining an ALJ's conclusion that CMS lacked authority to give a hospital a Medicare provider effective date before determining from a plan of correction whether it met applicable federal requirements, which included standard-level deficiencies). Accordingly, the earliest date here that Petitioner could enroll as a Medicare provider was September 21, 2012, the date TJC received Petitioner's plan of correction that effectively addressed its standard-level deficiencies.

5. Petitioner's proposed interpretation of the applicable effective date regulation is unreasonable because it would grant Medicare enrollment before Petitioner met all federal requirements including applicable health and safety standards.

It is undisputed that TJC cited Petitioner with a number of deficiencies. Petitioner argues that its deficiencies were standard-level deficiencies that do not qualify as condition-level deficiencies, which undisputedly Petitioner had complied with by the time of its exit survey. Petitioner argues therefore these types of deficiencies would not affect its effective date when applying the language of 42 C.F.R. § 489.13(c)(2) and that CMS's reliance on the language of 42 C.F.R. § 489.13(c)(2)(ii) is incorrect. P. Br. at 12-19. I find unreasonable, however, Petitioner's argument that the facility's lower-level deficiencies were irrelevant to determining its effective date.

Specifically, Petitioner argues that the regulation is ambiguous. P. Br. at 12-14, 17-19. The subsection states, in pertinent part:

> (c) *All health and safety standards are not met on the date of survey*. If, on the date the survey is completed, the provider or supplier has failed to meet any one of the applicable health and safety standards, the following rules apply for determining the effective date of the provider agreement or supplier approval, assuming that no other Federal requirements remain to be satisfied. However, if other Federal requirements remain to be satisfied, notwithstanding the provisions of paragraphs (c)(1) through (c)(3) of this section, the effective date of the agreement or approval may not be earlier than the latest of the dates on which CMS determines that each applicable Federal requirement is met.
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> * * *
>
> (2) For an agreement with, or an approval of, any other provider or supplier, (except in a situation that does not apply here), the effective date is the earlier of the following:

> (i) The date on which the provider or supplier meets all applicable conditions of participation, conditions for coverage, or conditions for certification; or, if applicable, the date of a CMS-approved accreditation organization program's positive accreditation decision, issued after the accreditation organization has determined that the provider or supplier meets all applicable conditions.
>
> (ii) The date on which a provider or supplier is found to meet all conditions of participation, conditions for coverage, or conditions for certification, **but has lower-level deficiencies**, and —
>
> (A) CMS or the State survey agency receives an acceptable plan of correction for the lower-level deficiencies (the date of receipt is the effective date regardless of when the plan of correction is approved); or, if applicable, a CMS-approved accreditation organization program issues a positive accreditation decision after it receives an acceptable plan of correction for the lower-level deficiencies; or
>
> (B) CMS receives an approvable waiver request . . . .

42 C.F.R. § 489.13 (c) (emphasis added). The regulation provides for the situation where, if the prospective provider meets all applicable conditions but has lower-level deficiencies, its effective date for participation is the date that "a CMS-approved accreditation organization program issues a positive accreditation decision after it receives an acceptable plan of correction for the lower-level deficiencies." 42 C.F.R. § 489.13(c)(2)(ii)(A). To find a provider eligible with existing standard-level deficiencies would allow a provider to bill Medicare before it was accredited and before it met all applicable health and safety standards, a result that I do not believe was intended and which would be simply irresponsible.

6. I cannot estop CMS from following the effective date regulation even if it may have incorrectly granted an earlier effective date in another situation.

Petitioner argues that the only material fact in dispute is whether CMS, in other cases, issued a provider an effective date of enrollment that pre-dated the provider's accreditation. To help provide support for its assertion, Petitioner requests that I order

CMS to produce documents and declarations, or that I issue subpoenas to compel testimony and documentation from each Associate Regional Administrator for Survey and Certification located at the CMS regional offices. P. Br. at 4-5, 10-11; *see* P. Ex. 2. I deny these requests.

Whether CMS improperly issued other facilities effective dates prior to their accreditation is collateral and irrelevant to this proceeding. Even assuming that CMS may have enrolled another institution prior to the institution's compliance with all requirements, the Secretary is not estopped from changing a position based upon a mistaken legal interpretation. *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 517-18 (1994); *cf. also United Hosp. v. Thompson*, 383 F.3d 728, 733 (8th Cir. 2004) (holding that erroneous overpayments to other hospitals do not entitle plaintiff to the same overpayments: "The Secretary's refusal to compound the error was not irrational or discriminatory."). Therefore, I also deny Petitioner's motion for summary judgment finding no issue of material fact.

Compliance with the federal requirement of accreditation is required prior to the time that the entity may bill for services. 75 Fed. Reg. 50042, 50400 (Aug. 16, 2010) (final rule amending 42 C.F.R. § 489.13 and clarifying that prospective providers must comply with all federal requirements including all applicable health and safety standards). In *Mission Hospital Reg'l Med. Ctr.*, DAB No. 2459 (2012), the Board rejected pre-accreditation enrollment because it could endanger the health and safety of patients if a hospital or other provider were to be paid for services provided at a time when there was no assurance that it met Medicare participation requirements. *Mission Hospital Reg'l Med. Ctr.*, DAB No. 2459, at 9. Although Petitioner attempts to distinguish *Mission Hospital* because the Board examined subsection (d) of 42 C.F.R. § 489.13 rather than subsection (c), the broader intention to protect patient safety still remains applicable and analogous here.

Conclusion

I grant summary judgment in favor of CMS because the undisputed evidence establishes that Petitioner still had lower-level standard deficiencies at the time of its accreditation survey. It was not until September 21, 2012, that the CMS-approved accreditation organization program, TJC, received a plan of correction from Petitioner to remedy its

standard-level deficiencies, which TJC accepted. Accordingly, CMS was authorized to grant Petitioner a Medicare enrollment effective date of September 21, 2012, the date that TJC received Petitioner's acceptable plan of correction, which is also the date TJC first accredited Petitioner.

/s/
Joseph Grow
Administrative Law Judge