Department of Health and Human Services

**DEPARTMENTAL APPEALS BOARD**

Civil Remedies Division

| In the Case of: | |
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| Manor of Wayne Skilled Nursing and Rehabilitation, (CNN: 23-5627), | Date: September 15, 2008 |
| Petitioner, | |
| - v. - | Docket No. C-07-568<br>Decision No. CR1841 |
| Centers for Medicare & Medicaid Services, | |
| Respondent. | |

## DECISION

I find that summary judgment is appropriate in this case. There is no genuine issue of material fact that would preclude entitlement to judgment as a matter of law for the Centers for Medicare & Medicaid Services (CMS) as CMS prevails against Petitioner, Manor of Wayne Skilled Nursing and Rehabilitation, on the merits. The regulations provide that the earliest date Petitioner could qualify for participation in the Medicare program is the date that surveys of the facility, which establish the facility meets all federal participation requirements, are completed. Part of the federal participation requirements is the requisite Medicare Life Safety Code (LSC) survey. That survey did not take place until April 12, 2007, and Petitioner was not in compliance with the LSC requirements until May 9, 2007. Therefore, the CMS determination that May 9, 2007 is the effective date for Petitioner's participation is affirmed.

## I. BACKGROUND

Petitioner is a skilled nursing facility located in Wayne, Michigan. Petitioner applied to be a provider of services under the Medicare program in May 2006. On June 7, 2006, the City of Wayne Fire Department conducted an inspection of the facility using the 2000 edition of the Life Safety Code, which is the same edition used by CMS. An initial state licensure survey was conducted and completed by the Michigan Department of Community Health (MDCH) on November 9, 2006. On December 19, 2006, MDCH issued a notice of licensure/certification action which indicated Petitioner was licensed by the state for 99 beds, effective November 9, 2006. CMS Ex. 13, at 2. The facility was in substantial compliance with state licensure requirements and was instructed by the state licensing officer that it could admit five to six residents. CMS Ex. 8. The admission of a sufficient number of residents, usually five, is required prior to conducting an initial federal certification survey. CMS Ex. 33.

The initial federal health survey was conducted by MDCH on December 7, 2006, which found Petitioner to be in substantial compliance with the applicable federal health requirements. P. Ex. 4. By e-mail dated January 3, 2007, MDCH issued a Notice of Licensure/Certification Action, which stated that Petitioner was in substantial compliance with federal health requirements effective December 7, 2006. CMS Ex. 14.

Under normal circumstances a LSC survey usually takes place withins 30 to 60 days following the initial health survey. CMS Ex. 33. However, in this case the LSC survey did not occur until four months after the initial health survey. CMS Ex. 19. The initial federal LSC survey was conducted on April 12, 2007. That survey identified seven deficiencies for which petitioner was cited. One of the deficiencies cited involved Petitioner's failure to close doors to resident rooms during fire drills. CMS Ex. 19. A revisit LSC survey was conducted on May 9, 2007, which found that the facility was in substantial compliance with the federal LSC requirements as of that date. CMS Exs. 24, 25. By letter dated June 5, 2007, CMS notified Petitioner that it had accepted the facility into the Medicare program with an effective date of participation of May 9, 2007. CMS Ex. 26.

By letter dated June 6, 2007, Petitioner requested that CMS reconsider the determination of Petitioner's effective date and change the effective date from May 9, 2007 to November 9, 2006. CMS Ex. 27. The facility argued that the earlier date was appropriate because it had received its Notice of Licensure/Certification dated December 19, 2006, which Indicated that Petitioner was licensed as of November 9, 2006. CMS Ex. 27. CMS

denied Petitioner's reconsideration request, citing the fact that the licensure survey which took place on November 9, 2006 was based only on state licensure requirements. Petitioner, by letter dated June 26, 2007, requested a hearing before an administrative law judge.

This case was docketed and assigned to me for hearing and decision on August 6, 2007. On December 20, 2007, CMS filed a Motion for Summary Judgment, accompanied by 33 exhibits (CMS Exs. 1 - 33). On January 21, 2008, Petitioner filed its response to CMS's motion, accompanied by seven exhibits (P. Exs. 1 - 7). CMS then filed a motion for leave to file a reply, along with a reply brief, on February 4, 2008. I hereby accept CMS's reply brief into the record.

## II. ISSUES

The issues presented in this case are:

1. Whether summary judgment is appropriate in this case; and

2. Whether Petitioner should have been certified to participate in the Medicare program on May 9, 2007, or as of an earlier date?

## III. 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 boldface italics as a separate heading and I discuss each Finding in detail.

***1. Summary judgment is appropriate under the circumstances of this case.***

CMS moved for summary judgment on a single issue: whether, under the applicable statutes and regulations, Petitioner can establish by a preponderance of the evidence that the effective date of its Medicare certification should be before May 9, 2007, the date CMS determined that Petitioner met all the requirements for Medicare participation.

Summary judgment is appropriate where the record presents no genuine dispute as to any material fact and the undisputed facts clearly demonstrate that one party is entitled to judgment as a matter of law. *White Lake Family Medicine, P.C.*, DAB No. 1951 (2004); *Lebanon Nursing and Rehabilitation Center*, DAB No. 1918 (2004). The movant, or party seeking summary judgment, bears the initial burden of showing the basis for its motion and identifying the portions of the record that it believes demonstrate the absence of a genuine factual dispute. *See Celotex Corp. V. Catrett*, 477 U.S. 317, 323 (1986).

The nonmoving party "may not rest upon the mere allegations or denials of his pleading, but . . . must set forth specific facts showing that there is a genuine issue for trial." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986) (quoting *First National Bank of Arizona v. Cities Service Co.*, 391 U.S. 253, 259 (1968)).

Here the parties agree on the essential facts of when Petitioner was surveyed, by whom, and for what purpose. Their difference lies in what legal significance, in light of the applicable law and regulations, should be attributed to those facts. With no genuine dispute as to any material fact, I find summary judgment is appropriate in this case.

***2. The earliest date Petitioner could have been certified to participate in the Medicare program was May 9, 2007.***

Section 1866 of the Social Security Act (Act) authorizes the Secretary of Health and Human Services to enter into agreements with providers of services that seek to participate in the Medicare program. Regulations at 42 C.F.R. § 489 and corresponding guidelines in the State Operations Manual (SOM) provide the requirements for participation.

Under 42 C.F.R. § 489.13, a prospective provider must meet all applicable federal requirements. CMS or a state survey agency conducts a survey in order to ascertain whether a provider complies with these applicable federal requirements. 42 U.S.C. § 1395cc. The earliest date a provider may be found to qualify for participation in the program is the date when surveys of the provider, including the LSC survey, are completed, if on that date the provider meets all federal participation requirements. 42 C.F.R. § 489.13(b). If the provider does not meet all federal requirements on the date of the survey, the effective date is the "date on which the provider meets all requirements." 42 C.F.R. § 489.13(c)(2)(i). Section 2472C of the SOM leaves the timing of the LSC survey to the discretion of the state survey agency. CMS Ex. 34, at 23. Although a state survey agency may recommend a provider be certified to participate in the Medicare program, the approving official making the final determination is CMS. 42 C.F.R. § 489.11(a).

Petitioner asserts that it is entitled to an earlier Medicare certification date of November 9, 2006, which is the date the facility was found to be in compliance with all the Medicare health requirements, and not May 9, 2007.

Petitioner argues that a June 7, 2006 fire inspection conducted by the City of Wayne Fire Department shows that the facility was in compliance with the LSC requirements as set forth in the 2000 edition of the LSC code. Petitioner maintains that, since CMS uses the same edition of the LSC in its federal surveys that was utilized by the City of Wayne,

CMS should find that the facility was in compliance with all of the federal requirements on June 7, 2006. Petitioner argues that at the time of the state licensure survey on November 9, 2006, it was therefore in compliance with all federal participation requirements. Petitioner asserts that November 9, 2006, should be the effective date because the MDCH issued a Notice of Licensure/Certification Action which indicated that Petitioner was initially certified and in compliance with Medicare program requirements. Furthermore, Petitioner asserts that the discrepancy of the date of compliance with the LSC requirements for Medicare participation is a genuine issue of material fact which would preclude granting the CMS motion for summary judgment.

Finally, Petitioner contends that it reasonably and justifiably relied on the MDCH's representation that the facility was in compliance with all Medicare program requirements. It claims that the detrimental reliance thereon resulted in deprivation of approximately $600,000 for services provided to residents of the facility over a period of 1,661 resident-days. Moreover, Petitioner argues that the four-month delay between the health survey and LSC survey was unreasonable because the LSC survey typically takes 30 to 60 days following the initial health survey.

CMS argues that Petitioner has been assigned the earliest possible certification date the law allows. CMS maintains that Medicare program participation is controlled by requirements that are separate from state inspection and licensing requirements. In order for a facility to participate in the Medicare program, the facility must be in compliance with all federal requirements. According to CMS, the ultimate authority for determining if the facility is in compliance with all federal requirements is CMS. CMS asserts that this tribunal cannot address issues of detrimental reliance and equitable estoppel. Thus, CMS maintains that I do not have the legal authority to grant the equitable relief to which Petitioner claims entitlement.

For the reasons set forth below, I find the arguments advanced by CMS that the law does not allow Medicare certification prior to the May 9, 2007 to be compelling and legally correct.

Petitioner argues that the June 7, 2006 inspection, conducted by the City of Wayne Fire Department, should serve as the initial LSC survey which demonstrated that the facility was in compliance with the requirements contained in the 2000 edition of the LSC code. This argument is without merit. CMS correctly argues that this June 2006 survey cannot serve as the initial LSC survey for certification purposes because the facility was not fully operational at that time. Petitioner began admitting patients only after the November 9, 2006 state licensure survey. Section 2008A of the SOM requires that new providers must be in operation and providing services to patients when surveyed. Furthermore, the actual federal LSC survey conducted on April 12, 2007, cited Petitioner with seven deficiencies.

CMS Br. at 11-13. One of these deficiencies related to closing doors to residents' rooms during fire drills. The City of Wayne fire inspection in June 2006 could not have determined whether the facility was in compliance with this requirement because there were no residents at the facility at that time.

It is clear that the regulations and case law establish that the approving official for purposes of determining whether a long term care facility satisfies the Medicare participation requirements is CMS, and not the local Fire Marshal. 42 C.F.R. 489.11(a); and *Ophthalmology Ltd. Eye Surgery Center*, CR 658 (2000). The Fire Marshal's June 7, 2006 inspection report was not submitted to CMS because it was not a part of the federal certification process. Therefore, CMS is not required to accept the findings of the local Fire Marshal as sufficient for federal certification purposes.

Petitioner's argument as to the four-month delay for the LSC survey is also without merit. The decision of a state agency as to when to conduct an initial survey of a prospective supplier is not an initial determination by CMS and thus is not an issue which can be appealed under the applicable regulations. *See* 42 C.F.R. § 498.3(d)(15). CMS cites Appellate Board case law which indicates that a three-month delay between the initial federal health survey and the initial LSC survey did not provide a basis for granting an earlier effective participation date for a skilled nursing home facility. *Forest Glen Skilled Nursing & Rehab. Ctr.*, DAB 1887, at 15 (2003).

Finally, I address Petitioner's argument that it reasonably and detrimentally relied upon certain statements, representations, or assurances, whether verbal or written, that Petitioner states that MDCH made with respect to the status of Petitioner's Medicare certification compliance with LSC requirements. Petitioner's brief discusses what purportedly transpired between Petitioner and MDCH personnel concerning the status of Petitioner's Medicare certification. First, as a general matter, applicants are held to a standard of responsibility for understanding what is required of them to be program participants. *See generally Cary Health and Rehabilitation Center*, DAB No. 1771 (2001). Second, regardless of whether I find the argument of reasonable reliance credible, I must agree with CMS that I do not have the legal authority to consider issues of detrimental reliance nor do I have the power to grant a party equitable relief. *See Community Hospital of Long Beach*, DAB 1118 (2003). Petitioner has identified issues of detrimental reliance and equitable relief with sufficient clarity to preserve them for review by an appellate body with jurisdiction over them should Petitioner decide to seek further review of this decision.

The regulations and case law are clear as to when a provider will be found in substantial compliance with all Medicare participation requirements. Therefore, for reasons discussed above, I find and conclude that CMS has demonstrated that there are no material facts in dispute as to the assignment of May 9, 2007 as the effective date of Petitioner's certification as a skilled nursing home in the Medicare program. Petitioner has failed to establish that there are any genuine issues of material fact which would preclude CMS from judgment as a matter of law, sustaining the decision to certify Petitioner effective May 9, 2007.

## IV. CONCLUSION

I grant CMS's motion for summary judgment. CMS's decision assigning an effective date of May 9, 2007 for Petitioner's certification as a skilled nursing home in the Medicare program is affirmed.

/s/
Alfonso J. Montano
Administrative Law Judge