# Skilled nursing facility deficiencies: Provider rights and practical considerations

**By Ari J. Markenson, JD, MPH**

*Editor's note: Ari J. Markenson is Of Counsel with Benesch Friedlander Coplan & Aronoff LLP. He is experienced in counseling various health care industry clients, including providers and payers, and has specific expertise in the representation of post-acute care providers. He may be contacted by telephone in White Plains, New York at 914/682-6822 or by e-mail at amarkenson@beneschlaw.com.*

An understanding of the rights, obligations, and issues in the skilled nursing facility/nursing facility (SNF/NF) survey process is an essential tool for compliance professionals who work for providers with SNF/NF operations. This article is designed to provide a summary of the issues and can be used as a guide for future reference. What follows is an explanation of what a survey is, what a deficiency is, how a provider responds to a deficiency, how a provider can dispute a deficiency, and some practical considerations.

## Surveys

Surveys are inspections of a provider to verify whether or not it meets the standards set forth in CMS regulations (42 CFR Part §483, Subpart B Requirements for Long Term Care Facilities). SNF/NFs are subject to a survey at least once every 12 months and at other occasions, such as in response to a complaint. Surveys are conducted by a survey team employed by a state survey agency (SSA) under contract with the Centers for Medicare and Medicaid Services (CMS); although, in some cases, CMS surveyors can and do conduct surveys.

Statutory and regulatory requirements for the conduct of surveys can be found in 42 USC. §1395i-3, 42 USC§1395r, 42 CFR Part §488 and 42 CFR Part §498. Additionally, CMS policy guidance to state agency surveyors can be found in the CMS State Operations Manual (SOM) and more specifically, in Chapters 2 and 7 and Appendices P, PP, and Q of the SOM.[1]

## Deficiencies

The possible negative result of a survey is the citation of a deficiency, which is a failure of the provider to meet a regulatory requirement. If the survey team has determined that a deficiency exists, they will issue a Form CMS-2567 (or Statement of Deficiencies) within 10 days of the completion of the survey. All deficiencies are classified on the CMS-2567 by their regulatory citation, F-tag reference and a scope and severity rating. The F-tag reference corresponds to the regulatory citation and can be found in the Appendix PP of the SOM.

The scope and severity rating of a deficiency is based upon a grid that can be found in the SOM[2] and ranges from an A level to an L level. The scope of a deficiency relates to a general number of residents affected by the alleged deficient practice. Severity relates to the seriousness of the alleged deficient practice. For example, a deficiency with a scope of "Isolated" and a severity of "No actual harm with potential for minimal harm" represents the lowest level of scope and severity, level A. In contrast, a deficiency with a scope of "Widespread" and a severity of "Immediate jeopardy to resident health or safety" represents the highest level of scope and severity, level L. Deficiencies cited at levels A to C are considered so minor in nature that they do not place a provider out of substantial compliance. The deficient practice(s) identified require correction, but there is no follow up survey to verify the corrective action was taken and effective. Additionally, level A deficiencies do not require the submission of a plan of correction. Deficiencies cited at a level D or higher, do constitute a finding that a provider is not in substantial compliance and trigger the formal survey cycle process discussed below.

If a survey team determines that a deficiency exists, the team will inform the provider at an exit conference and then issue a CMS-2567 within 10 days of the team's exit from the facility. (In practice, the provider may not get the CMS-2567 exactly in that time frame and it may need to be in touch with the SSA to understand when it can expect it.) Once received, the provider's operations and compliance team should critically evaluate the deficiencies and then start the process for making decisions about how to respond. The next two sections of this article talk about those very issues.

## Evaluating a Statement of Deficiencies

The CMS-2567 is a 5-column form that is used almost universally in Medicare and Medicaid surveys. SSAs complete the form after a survey and enter the deficiency information into the Online Survey and Certification and Reporting System (OSCAR) of CMS.

Provider identifying information is in the header and the substantive deficiency information is structured across the five columns. From right to left:

- Column 1 contains the F-tag citation for the deficiency cited and the scope and severity rating.
- Column 2 contains the text of the regulation at issue and the facts and findings.
- Column 3 is where the provider identifies the F-tag corresponding to the plan of correction it places in Column 4.
- Column 4 is where the provider identifies its plan of correction for each deficiency.
- Column 5 is where the provider identifies the dates by which it will have completed its plan of correction.

When the SSA issues a CMS-2567, only the first two columns will be completed. A critical evaluation of the information is important to an understanding of what the provider must do, as well as what it may do next. Providers often anxiously await the CMS-2567, then jump into defense mode when they receive it. In order to achieve an objective evaluation of the issues, more than one member of the management team should independently read the CMS-2567. The management team should then meet to discuss their impressions, issues, conclusions, etc.

Once the team has taken the opportunity to discuss the issues, it should review of the accuracy of the facts and findings. That review should be an independent investigation and determination of the accuracy of the relationship of the facts and findings to the regulatory requirements cited. The team should speak with everyone involved in the survey and any staff member who was interviewed for the survey. This process should be undertaken efficiently by making copies of relevant documents and highlighting relevant information, because this material may become part of a submission to the SSA. This substantiation process should lead the provider to an understanding of what, if any, corrections need to be made and what, if any, disputes may exist.

### Responding to a Statement of Deficiencies

With an in-depth understanding of the issues at stake, provider staff can start responding to the CMS-2567 via a plan of correction (POC), to the extent one is required. A-level deficiencies don't require the submission of a POC. Any other level requires a POC to be submitted and approved by the SSA.[3]

Whether or not the provider believes they have a dispute for any of the deficiencies cited, a POC must be submitted to the SSA within 10 days of receiving the CMS-2567. If the provider needs more time to develop and submit a POC, it needs to contact the SSA and make sure that any agreement to extend the time is memorialized in writing.

Submitting a POC requires the facility to respond to four specific issues. A POC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the provider will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; and
- Indicate how the provider plans to monitor its performance to make sure that solutions are sustained.

Responding to each of these elements requires the provider to carefully think through how it can accomplish the corrections it is proposing. Additionally, understanding what can be done with the provider's human, operational, and financial resources is integral to developing the plan. Corrective actions should be tailored to the problem directly. Providers need to be careful to not over-promise and then be unable to deliver, particularly in cases where the SSA is sure to revisit to verify. A failure to implement the corrections that were initially proposed can prevent the provider from being placed back into compliance and can lead to additional penalties.

Providers are required to transcribe the POC on the CMS-2567 in columns 3, 4 and 5, sign it, and then return it to the SSA for review and approval. Depending upon the severity of the deficiencies, the SSA may accept the POC and place the provider back into compliance without conducting a revisit. The SSA may also reject all or a portion of the POC and ask the provider to resubmit it.

### Disputing a deficiency

When a provider believes it has a reason to dispute a deficiency, there are a number of issues to consider. Additionally, it is important to understand the paths a provider can utilize to pursue a dispute. At the outset, a decision to dispute a deficiency should take into consideration:

- the scope and severity of the deficiency,
- the consequences of the deficiency being sustained,
- if there is an argument that is supportable and appropriate,
- if the administrative and financial resources are worth it, and
- if there are future hearing or litigation consequences.

The seriousness of the deficiency is a consideration in deciding whether to dispute it. A good analogy when thinking about a low-level deficiency is the parking ticket you received for an expired meter, five minutes after it expired. Is it worth the time, energy, and effort to plead not-guilty, take a day off from work and fight with an administrative judge that may be predisposed to ignoring your argument? In

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contrast, a provider should do everything it can to develop an argument relating to serious deficiencies (at a G level or above).

Consumers, lenders, and regulators are increasingly scrutinizing provider deficiencies at a G level or above. A provider's survey performance is available on the Medicare.gov website and, in many cases, on state websites. Consumers are using this public data to make decisions about where to receive care or where to place family members for care. Serious deficiencies represent a significant marketing negative and can stain the reputation of a provider. Lenders to providers, whether for mortgages or working capital, are increasingly tightening the standards for operating performance that are memorialized in representations, warranties, and covenants in lending documents. Increasingly, these same lenders are stepping up their review of a provider's survey history and are demanding answers, requiring corrective action, and in some cases, calling loan defaults for survey deficiencies or repeated non-compliance. Providers with U.S. Department of Housing and Urban Development (HUD) insured mortgages are starting to see much more interest at HUD in a provider's operating and survey performance. A provider should take all this additional scrutiny into account when deciding whether or not to dispute a deficiency.

Any argument relating to a deficiency should have sufficient merit and warrant the resources a provider would utilize pursuing the dispute. If a deficiency is valid, providers should not challenge it because there is a novel argument or the provider didn't like the way it was cited. Providers can lose credibility with surveyors, the SSA, and CMS. One inappropriate challenge can take away from an argument relating to other deficiencies. A provider doesn't need a slam dunk before moving forward—it simply needs to be confident with a good argument. Providers should also consider that each of the processes to dispute deficiencies generally provide for a "de novo" or open review of the issues, such that the person reviewing the dispute might find additional deficiencies from the information presented.

The seriousness of a deficiency, the consequences of having it sustained, and being confident in an argument are significant issues in an analysis of whether to move forward. Other issues to consider are: (1) whether or not the resources the provider is going to put into a dispute make sense; and (2) whether or not there are any future hearing or litigation consequences. The human, operational, and financial resources the provider is going to utilize aren't always easy to quantify. The provider, however, should try. Is developing an argument, researching the law, and researching facts on a E-level deficiency going to tie up an otherwise very busy director of nursing for the next five days? Is it going to cost the provider significant dollars to hire a

life–safety code expert to give an opinion on an issue? These are just examples of questions the provider team should be asking when making a decision about moving forward with a dispute. Remember, the analogy earlier about a ticket for an expired meter?

In addition to understanding the resources utilized, a provider should consider whether or not there any future consequences in a civil hearing or litigation that relate to the facts or issues raised in the deficiency. If the "expired meter" type of a deficiency is part of issues involved in a current or potential civil litigation, the provider may need to use every avenue available to express its argument or position. Pursuing a dispute through the Informal Dispute Resolution (IDR) process, the U.S. Department of Health and Human Services Departmental Appeal Board (DAB) process, or both, may become a necessity. Additionally, the provider's position in the IDR or DAB process should be consistent with its position in any hearing or litigation context which recognizes that different standards may be used in those forums. A provider should also be attuned to whether or not it has: (1) been contacted by counsel acting on behalf of the resident or family; (2) received a summons or complaint; or (3) received a threat of litigation from family, a resident, or counsel.

After the provider has weighed the issues and practical considerations discussed above, an understanding of the two paths to dispute deficiencies is important. A provider can use the IDR process and, if it's available to it, the DAB hearing process. The IDR process is available to dispute almost any type of deficiency, although there are limitations to what can be raised at IDR. The DAB appeals process is only available in certain circumstances, such as when a "remedy" or penalty has been imposed by CMS. Each of these processes is independent of the other.

## Informal Dispute Resolution

IDR is an informal process where the provider has the opportunity to dispute deficiencies after the CMS-2567 has been issued. The federal guidelines for the process are discussed in this article, however, states can differ on how they implement the IDR process. Some states may have face-to-face meetings with providers, while others may only have a written submission process. A discussion of each state's process, however, is beyond the scope of this article.

The right to IDR is guaranteed by federal regulation, 42 CFR §488.331. A provider must be notified of its rights in the letter from the SSA enclosing the CMS-2567. The letter should explain the IDR process, who will conduct it, and that pursuing IDR will not delay the imposition of CMS penalties.

A request for IDR must be made within 10 days of receipt of the CMS-2567. If the provider needs more time to submit an IDR request, it needs to contact the SSA and make sure that any agreement to extend the time for a filing is memorialized in writing.

IDR is an opportunity to dispute the facts and findings that allegedly support a deficiency and the scope and severity of a deficiency with Substandard Quality of Care (SQC) or Immediate Jeopardy (IJ). The scope and severity of a deficiency cannot be challenged unless they are SQC or IJ. According to CMS, IDR is not a forum for disputes with respect to the survey, the IDR process, or remedies that are imposed.

Providers should evaluate whether they are going to use a staff person or a third party to complete the written IDR submission. A decision to use a consultant or outside counsel should take into consideration: (1) whether or not staff are going to have difficulty objectively evaluating the issues; (2) the resources available in house; and (3) whether or not there are significant legal and factual issues that require legal assistance to develop.

An IDR submission should set forth the entirety of the legal and factual issues relevant to the provider's position. The document should address each deficiency and how it pertains to the facts presented. Facts and findings provided by the SSA in the CMS-2567 should not be taken for granted. A review of all of the information gathered in the process of evaluating the deficiencies should be undertaken. Where necessary, staff should go back to original charts for supporting documentation.

An IDR submission should be readable, persuasive, concise, based upon the facts and applicable regulations, submitted appropriately (following SSA guidelines), and based upon an argument with sufficient merit. The submission should also point the reader to appropriate exhibits, quote exhibits where appropriate, and highlight particularly important points. Each of the arguments in the submission should explain the provider's position and be related to the facts. The submission overall should use words and information wisely. The longer the submission, the less likely it will be reviewed appropriately.

Submitting the best possible IDR request is important because providers generally only get one opportunity for IDR. Additional IDR opportunities only arise when; (1) on revisit, the deficiency still exists; (2) a new deficiency is found on revisit or cited at the original IDR; or (3) a new example of a deficiency is found on revisit or as a result of an IDR.

Once the IDR process is concluded, the provider has a right to receive written notification of the results. If successful at IDR, the

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provider has a right to an new CMS-2567, the state agency must correct information in the OSCAR system, and any enforcement action(s) imposed because of the deficiencies disputed must be rescinded.

## Federal appeals

Separate from the IDR process, a provider may have a right to a DAB appeal under certain circumstances. DAB appeals are formal hearings before an administrative law judge (ALJ) and involve formal submissions of written arguments, evidence, and witnesses.

The right to pursue a DAB appeal usually depends upon whether a provider has received deficiencies that actually resulted in the imposition of a "remedy" or penalty. Providers can't appeal specific deficiencies, per se. For example, if the provider is cited with a C-level deficiency but no CMS remedy is imposed, there is generally no right to a DAB appeal. Remedies are any of a number of sanctions that CMS has the authority to impose. Some of the remedies that can lead to an appeal include: termination, temporary management, denial of payment for new admissions, denial of payment, and civil monetary penalties (CMPs). In certain cases, providers can appeal the scope and severity of a deficiency if it would result in the change of a level of CMP or a determination of whether SQC existed.

Similar to the IDR process, all remedies, except CMPs,[4] will go into effect upon their effective date, irrespective of the provider's submission of an appeal.

Providers should be on alert for any correspondence from CMS following a survey. This correspondence is the provider's notice of the imposition of a remedy and the rights it may have to an appeal. Too often, providers mistake the correspondence as claims-related and send it off to accounting, or don't recognize the importance of the notice. A request for a hearing must be filed within 60 days of the imposition of a remedy with the DAB. In many cases, providers have had their DAB appeals dismissed summarily because of a failure to file within the 60-day time frame. Many of those cases occurred because the provider thought it had to pursue IDR first. As mentioned, IDR and a DAB appeal are two independent processes.

Distinct from IDR, providers should consult counsel to both prepare and file a DAB hearing request. There are too many procedural and substantive pitfalls in the process. If the provider believes a DAB appeal is warranted, the engagement of an attorney with experience in DAB appeals is worth the resources.

A DAB appeal request must specify the deficiencies being disputed; the facts and issues surrounding the deficiencies and the imposed remedies; and any relevant legal issues. The language of the CMS notice letter plays a large part in determining which deficiencies a provider must overcome in order to prevail at removing an imposed remedy. If the letter suggests that a remedy is imposed for more than one deficiency or due to the entire survey, a facility might be required to challenge and prevail on all the deficiencies mentioned. As a result, a provider with a weak argument on one of a number of deficiencies may choose not to devote resources to an appeal.

Once an appeal request is filed, the provider (and their counsel) will get an acknowledgement of its appeal request and an order from the ALJ. Generally, the ALJ order will require the provider's attorney to confer with CMS' attorneys. Within 60 days of the ALJ order, the provider's attorney and CMS' attorney either must jointly file readiness papers or file their own opposing papers. Readiness papers must give the ALJ a picture of the factual and legal issues at stake in the case and explain what evidence will be provided. Often, providers and CMS' counsel will attempt to settle the matter before filing readiness papers. However, similar to most litigation, settlement negotiations can go on even through the hearing process.

After submission of the readiness papers, the ALJ will hold a pre-hearing conference with attorneys for both sides. Following the pre-hearing conference and exchange of information from both sides, a hearing will be held, usually at a location convenient to the provider. At a hearing before the ALJ, both sides will introduce testimony and documentary evidence. CMS will often use the state agency surveyors as witnesses.

Following the hearing, the ALJ will render his/her written decision. If the facility is unsatisfied with the decision, it may seek to further appeal to the DHHS Departmental Appeals Board (DAB). If the provider is additionally unsatisfied with a appeal board decision, it may decide to take the matter to federal court.

## Conclusion

The SNF/NF survey process is unique compared to the survey and certification process or deemed accreditation process for other providers. An understanding of a provider's rights and obligations in the process is essential to navigating it and to assisting a provider with its compliance responsibilities. This article was designed to present a broad summary of issues for compliance professionals who assist providers after they have received a CMS-2567 with deficiencies. Understanding the issues should help compliance professionals work through regulatory obligations and business and practical considerations in the process. ■

1 A copy of the CMS State Operations Manual can be found on the web at http://www.cms.gov/Manuals/IOM/list.asp
2 CMS State Operations Manual, Section §7400E1
3 CMS State Operations Manual, Section §7400E3
4 The Patient Protection and Affordable Care Act of 2010 (or the Health Reform Bill) includes provisions that require providers to escrow CMP amounts during an appeal in certain circumstances.