UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

THE AMERICAN HOSPITAL ASSOCIATION, *et al*, Plaintiffs, v. KATHLEEN SEBELIUS, in her official capacity as Secretary of Health and Human Services, Defendant.	Case No. 12-1770 (CKK)

PLAINTIFFS' SUPPLEMENTAL BRIEF

INTRODUCTION

This Court has requested supplemental briefing on two issues: first, "why [Plaintiffs'] claims . . . are not moot," in light of the issuance of CMS's final rule replacing Ruling 1455-R, and second, "the status of the claims for payment under Medicare Part B that Plaintiffs have presented to the agency." Feb. 25 Order at 2-3. This brief responds to that request.

1. Plaintiffs' claims are not moot because Plaintiffs challenge a policy—CMS's application of a time limit to rebill for Medicare Part B payment after a RAC denial—that CMS itself agrees was in place since before interim Ruling 1455-R, and remains in place after the final rule. Ruling 1455-R made a narrow exception to that limitation on the right to rebill, but it did not alter the general rule prohibiting Part B payment if requested more than one year after the care was provided. Indeed, as the Ruling stated, and as both parties have argued, Ruling 1455-R did not even *apply* to claims like the ones on which Plaintiffs seek payment. *See* Gov't MTD 12 ("The Ruling by its own terms did 'not apply to Part A hospital inpatient claim denials for which the timeframe to appeal expired prior to the effective date of the Ruling' ") (quoting Ruling 1455-R); Pl. Opp. to MTD 2 ("CMS made its ruling applicable only to RAC denials that are still live on appeal or for which the time to appeal has not run[.]"). Thus, Ruling 1455-R's only impact on Plaintiffs was its repudiation of the unlawful Payment Denial Policy, which triggered Plaintiffs' requests for Part B payment for claims denied by RACs before the Ruling took effect.

2. Plaintiffs set forth in detail below the status of their claims for payment. In short, some of those claims have not been paid, have no prospect of being paid, and have reached a dead end in the administrative process. That fact underscores why the exhaustion requirement applicable to CMS litigation should be deemed waived in this case.

I. PLAINTIFFS' CLAIMS ARE NOT MOOT BECAUSE THEY NEVER DEPENDED ON RULING 1455-R.

On August 5, 2013, CMS issued a final rule, *Medicare Program: Payment Policies Related to Patient Status*, 78 Fed. Reg. 50,496, 50,906 (Aug. 19, 2013) ("Final Rule"). The Final Rule adopts, with few changes, the policies CMS had put forth in its proposed rule, 78 Fed. Reg. 16,632 (Mar. 18, 2013) ("Proposed Rule"). In her supplemental brief dated October 28, 2013, the Secretary argued that the Final Rule rendered Plaintiffs' case moot *to the extent it constituted a challenge to interim Ruling 1455-R*. Gov't Supp. Brief at 4-6.

That argument fails for the precise reason articulated in the Secretary's own brief: Plaintiffs' case does *not* merely challenge Ruling 1455-R. It challenges CMS's decision to apply the time limit to circumstances when a hospital rebills a claim under Part B after a RAC denial—a policy that leaves providers with no way to obtain payment for medically necessary care to beneficiaries because of the delinquent timing of RAC clawbacks. Ruling 1455-R made an *exception* to that policy where the RAC denial was still live on appeal. But that interim ruling neither created nor abrogated the time limit policy. As the Secretary explained, "Ruling 1455-R did not say that hospitals 'cannot rebill'; rather, it announced a limited category of claims that hospitals could rebill. *It had no effect on Plaintiffs' expired claims, as to which it left the status quo in place*." Gov't Supp. Br. 5 (emphasis added). Thus it was CMS's unlawful application of "preexisting statutory and regulatory timely filing requirements" in RAC rebilling cases—not Ruling 1455-R—"that . . . stood in the way of [plaintiffs'] attempts to revive their claims" through rebilling. *Id.* at 6. That application of the time limit on rebilling remains subject to challenge here.

Indeed, the Ruling itself stated, and the parties have recognized, that Ruling 1455-R does not even apply to claims like those which Plaintiffs seek payment—namely, claims in which the

RAC denial is not live on appeal. The Ruling stated that it did "not apply to Part A hospital inpatient claim denials for which the timeframe to appeal expired prior to the effective date of the Ruling." Ruling 1455-R, 78 Fed. Reg. 16,614, 16,616 (Mar. 18, 2013). The Secretary quoted that language in her motion to dismiss, Govt. MTD 12, and stated that the time limit was applicable to hospitals' attempts to rebill after a RAC denial even before Ruling 1455-R, *id.* at 6-7. Plaintiffs, too, argued that "CMS *made its ruling applicable* only to RAC denials that are still live on appeal or for which the time to appeal has not run[.]" Pl. Opp. to MTD 2 (emphasis added). The fact that the interim ruling has been superseded cannot render Plaintiffs' claims moot when the interim ruling did not apply to their claims in the first place.

To be sure, Ruling 1455-R rearticulated the policy Plaintiffs challenge, which is why Plaintiffs refer to the Ruling in their complaint and opposition brief. The Ruling also provided an additional reason why that policy was arbitrary and capricious: Allowing hospitals recently wronged by CMS's now-repudiated Payment Denial Policy to obtain payment while the rulemaking was pending, but leaving hospitals with less recent injuries out in the cold, was a distinction that could not be defended. *See* Pl. Supp. Br. 5. But that additional point merely supported the broader challenges in Plaintiffs' suit: First, it is arbitrary to make hospitals submit "new" Part B claims when they could instead amend or supplement their existing claims. *See* Second Am. Cmplt ¶¶ 148-153. Second, it is arbitrary to apply a waivable time limit to a circumstance where the agency knows the requirement cannot be met. *See id.* ¶¶ 98, 112, 122, 154-159. Nothing about those theories turns on the scope of the exception created by Ruling 1455-R.[1]

[1] Ruling 1455-R did form the basis for Count VI of Plaintiffs' complaint. Plaintiffs are willing, with the Court's permission, voluntarily to dismiss Count VI.

In any event, the Final Rule did not alter CMS's policy that severely limits the time in which a RAC denial can be rebilled. After the Final Rule—just as before the Final Rule, and just as before Ruling 1455-R—CMS takes the position that it will apply the time limit to attempts to rebill after a Part A denial, even though in almost every case the time limit will already have expired by the time the RAC denial issues. *See* 78 Fed. Reg. at 50,922; Gov't Supp. Brief 5-6. The D.C. Circuit has recognized that the issuance of a final rule does not necessarily moot a challenge to a provisional rule, particularly where the final rule does not alter, or relies on, the challenged policy. *See, e.g.*, *Union of Concerned Scientists v. Nuclear Regulatory Comm'n*, 711 F.2d 370, 377 (D.C. Cir. 1983) (holding that promulgation of a final rule does not moot challenge to interim rule where interim rule made a safety determination upon which the final rule is partially predicated). In this case, CMS's Final Rule hews to the very policy Plaintiffs already had been challenging.

Plaintiffs thus challenge a policy that has been in place since before Ruling 1455-R and remains in place after the Final Rule. For these reasons, Plaintiffs have not moved for leave to file a Third Amended Complaint and do not believe it is necessary to do so. However, if the Court concludes that an amendment is required, Plaintiffs are prepared to seek leave to so move.

II. SOME OF PLAINTIFFS' CLAIMS HAVE NOT BEEN PAID AND ARE STALLED IN THE ADMINISTRATIVE PROCESS.

Below are updates on the status of Plaintiffs' claims for payment before the agency.[2]

A. Missouri Baptist Sullivan Hospital

Cardiac Care Claim. In 2011, Missouri Baptist Sullivan sought reimbursement under Part A for treatment provided to a 76-year-old Medicare beneficiary during an overnight stay.

[2] Because Plaintiffs agree to dismiss Count VI, *see supra* at 3 n.1, Plaintiffs are providing updates on only the claims relevant to Counts I-V. Should the Court so desire, Plaintiffs will provide updates on the two claims relevant to Count VI.

Second Am. Cmplt. ¶ 73. More than a year later, the RAC later clawed back the entire payment, claiming the care should have been provided on an outpatient basis. *Id.* ¶ 74.

After CMS repudiated the Payment Denial Policy, Missouri Baptist requested Part B payment for the items and services provided. *Id.* ¶ 77. The first attempt to submit the request was rejected, so on April 23, 2013, Missouri Baptist re-submitted the request using another method. Decl. of Amber Haring ¶ 11. That request was placed in "Return to Provider" status in the Medicare claims processing system, meaning that it could not be processed. *Id.* After CMS released new instructions in May 2013 for submitting requests for Part B payment, Missouri Baptist supplemented and re-submitted the request for Part B reimbursement. The last submission was rejected on the (inappropriate) basis that it was duplicative of Missouri Baptist's original Part A claim. *Id.* ¶¶ 12-13. As of March 7, 2014, the request for Part B payment still has not been paid.

B. Munson Medical Center

Esophageal Tear Claim. In 2011, Munson Medical Center sought Part A reimbursement for treatment provided to an 89-year-old Medicare beneficiary with an esophageal tear. Second Am. Cmplt. ¶ 84. More than a year later, the RAC took back the entire Part A payment, asserting that the care should have been provided on an outpatient basis. *Id.* ¶ 85.

On April 16, 2013, Munson sought reimbursement under Part B. *Id.* ¶ 87. That request was rejected. Decl. of Jill Robinson ¶ 10. After several conversations with the Medicare contractor and two re-submissions, the request was placed in "Return to Provider" status. *Id.* ¶¶ 11-13. Despite two more conversations with the Medicare contractor and additional attempts to add or alter information to show that the request for Part B payment was being made after a RAC Part A denial, *id.* ¶14, as of March 7, 2014, the claim still has not been processed.

Hernia Procedures Claim. In 2010, Munson received reimbursement under Part A for treatment provided to a Medicare beneficiary for inguinal and femoral hernia procedures. The RAC later clawed back that payment in its entirety, claiming the care should have been provided on an outpatient basis. Second Am. Cmplt. ¶ 89; Decl. of Jill Robinson ¶¶ 16-17.

On April 16, 2013, Munson sought reimbursement under Part B. On June 6, 2013, Munson re-submitted the request to follow the modified instructions released by CMS in May 2013. In violation of CMS's stated policy, the claim was paid in the amount of $1,718.24 on June 20, 2013. Decl. of Jill Robinson ¶¶ 16-17. As of March 7, 2013, CMS has not yet recouped this payment.

C. Lancaster General Hospital

Cardiac Catheterization Claim. In 2008, Lancaster General received Part A reimbursement for a cardiac catheterization performed on a 79-year-old Medicare beneficiary. Second Am. Cmplt. ¶ 96. Three years later, the RAC clawed back the entire payment. *Id*. ¶ 98.

On April 19, 2013, after CMS repudiated the unlawful Payment Denial Policy, Lancaster General manually filed a Part B claim. *Id.* ¶ 100. The Medicare contractor placed the request in "Return to Provider" status. Decl. of Lorelie Lauer ¶ 12. For weeks thereafter, Lancaster General was forced to fix a variety of technical discrepancies and roadblocks and had to re-submit the request several times. *Id.* ¶ 13. As of March 7, 2014, the Medicare contractor has paid Lancaster General for the Part B items and services provided, taken back the reimbursement, and paid Lancaster General again.

Congestive Heart Failure Claim. In 2008, Lancaster General received reimbursement under Part A for treating an 82-year-old Medicare beneficiary with congestive heart failure. *Id.* ¶

8. In December 2011—more than three years after Lancaster General cared for this patient—the RAC clawed back the entire payment. *Id.* ¶ 9.

On April 19, 2013, after CMS repudiated the Payment Denial Policy, Lancaster General electronically submitted a Part B claim. The Medicare contractor placed the request in "Return to Provider" status. *Id.* ¶ 12. As with the claim described above, Lancaster General was forced to fix a variety of technical discrepancies and roadblocks and had to re-submit the request several times. *Id.* ¶ 13. As of March 7, 2014, the Medicare contractor has paid Lancaster General for the Part B items and services provided, taken back the reimbursement, and paid Lancaster General again.

D. Trinity Health

Coronary Atherosclerosis Claim. In 2008, St. Joseph Mercy Oakland hospital, a Trinity Health hospital, received Part A reimbursement for treatment provided to 60-year-old disabled Medicare beneficiary for coronary atherosclerosis. Second Am. Cmplt. ¶¶ 111-13. Approximately three years later, the RAC concluded that the disabled patient should have been treated as an outpatient and demanded that the hospital repay the entire reimbursement, which it did. *Id.*

After CMS repudiated the Payment Denial Policy, the hospital manually filed a Part B claim for all of the other reasonable and necessary services provided in this case. *Id.* ¶ 114. It first presented the request using one billing format, but the bill could not be processed. It then tried again using a different billing format but the Medicare contractor did not upload the payment request into the electronic Medicare claims processing system. Decl. of Vivian Mallari ¶ 15. After CMS issued modified instructions, St. Joseph again re-submitted the request on June 26, 2013. *Id.* ¶ 16. That request for payment was never processed.

Chest Pain Claim.[3] In 2009, St. Mary Mercy Livonia hospital received Part A reimbursement for treating a 55-year-old disabled Medicare beneficiary with chest pain. *Id.* ¶¶ 6-7. More than a year later, in 2011, the RAC demanded that the hospital repay the entire reimbursement, which it did. *Id.*

After CMS repudiated the Payment Denial Policy, the hospital twice attempted to request payment under Medicare Part B for the items and services provided. However, the limits imposed by the Medicare claims processing system precluded the hospital from successfully submitting the requests. *Id.* ¶ 11. After CMS released new instructions in May 2013 for submitting Part B requests, the hospital again submitted its claim, using the two different billing formats identified in CMS's instructions. *Id.* ¶ 12. In September 2013, CMS's contractor refused to process the request for Part B payment because the claim was filed after the time limit expired. The request for Part B payment was never processed.

Other Beneficiaries. Trinity Health also has requested Part B payment for three other cases in which the RAC determined that Medicare beneficiaries should have been treated in the outpatient rather than inpatient setting. *Id.* ¶ 18. Trinity Health first presented its requests for Part B reimbursement by facsimile, using one type of billing format, on April 18, 2013. After CMS issued its revised instructions in May 2013, Trinity Health also submitted payment requests electronically on July 26, 2013, using the two different billing formats identified in CMS's instructions. *Id.* None of these requests was ever processed. One was rejected on the

[3] As explained in Plaintiffs' opposition brief, the Second Amended Complaint incorrectly recounted several background facts about one Trinity Health Medicare beneficiary. *See* Pl. Opp. to MTD 13 n.5. Plaintiffs thus rely on only the claims described here. Plaintiffs do not rely on the claim described in paragraphs 106-107 of the Second Amended Complaint. Plaintiffs remain willing to amend the Complaint to reflect this clarification should the Court so desire.

(inappropriate) basis that it was duplicative of the original Part A claim, and the other two were placed in "Return to Provider" status for other reasons.

E. Dignity Health

Pacemaker Implant Claim. In 2008, St. John's Regional Medical Center, a Dignity Health Hospital received Part A reimbursement for procedures performed to implant a pacemaker in an 80-year-old Medicare beneficiary. Second Am. Cmplt. ¶ 121. Approximately three years later, the RAC demanded that the hospital return the entire payment and the hospital did so. *Id.* ¶ 122.

On April 4, 2013, after CMS repudiated the Payment Denial Policy, St. John's filed a Part B claim. That very same day, the Medicare contractor inappropriately denied the request, because in its view, the services should have been bundled into the inpatient stay and paid as part of the Part A payment. Decl. of Le Anne Trachok ¶ 10. After CMS released new instructions in May 2013 for submitting Part B claims, St. John's supplemented its payment request, and on June 13, 2013, re-submitted its request for Part B reimbursement. *Id.* ¶ 11. The Medicare contractor made the Part B payment for these services on June 28, 2013. As of March 7, 2014, CMS has not yet recouped this payment.

Other Medicare Beneficiaries. Dignity Health also submitted requests for Part B payment on behalf of several of its hospitals for the care provided to five other Medicare beneficiaries that the RAC determined should have been provided on an outpatient basis. Decl. of Le Anne Trachok ¶ 13. Those requests initially were submitted to each hospital's respective Medicare contractor, using two different billing formats, on or around April 4, 2013. *Id.* ¶ 14. Two of the requests were rejected out of hand because the Medicare contractor viewed the

requests as duplicates of the original Part A claims. The Medicare contractors suspended the other three requests for manual review. *Id.*

On June 17, 2013, after CMS released new instructions for submitting requests for Part B payment, Dignity Health amended and re-submitted the five requests. *Id.* ¶ 15. As of March 7, 2014, one of the claims—involving care provided to a Medicare beneficiary with rheumatoid arthritis—has been rejected because the claim was filed after the time limit expired. The other four requests for Part B payment were paid, even though the Medicare contractor should not have made those payments under the time limit policy. CMS has not yet recouped the payment for any of the four paid claims.

In sum, CMS has denied requests for payment due to the time limit policy, meaning the Plaintiff hospitals have been injured by that policy. (And in cases where CMS's contractors have erroneously paid, the payments remain subject to potential clawback.) Moreover, CMS's contractors have erected insuperable roadblocks to processing many Part B rebilling requests in the first place—a circumstance that demands waiver of the statutory exhaustion requirement.

III. REQUEST FOR ORAL ARGUMENT

As the foregoing discussion shows, this lawsuit is both procedurally and factually complex. For this reason, Plaintiffs renew their request for oral argument on the Secretary's Motion to Dismiss.

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Respectfully submitted,

/s/ Catherine E. Stetson

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CERTIFICATE OF SERVICE

I hereby certify that on the 7th day of March 2014, I caused the foregoing document to be served on Defendant's counsel of record electronically by means of the Court's CM/ECF system.

/s/ Catherine E. Stetson
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