FILED: May 26, 2020

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 19-1769
(2:17-cv-02491-BHH)

CYNTHIA HOLMES, a/k/a C. Holmes, a/k/a Cynthia Holmes, M.D.

Plaintiff - Appellant

v.

THOMAS E. PRICE, Secretary of the Department of Health and Human Services (HHS)

Defendant - Appellee

ORDER

The petition for rehearing en banc was circulated to the full court. No judge requested a poll under Fed. R. App. P. 35. The court denies the petition for rehearing en banc. The court also denies the motion for abeyance.

For the Court

/s/ Patricia S. Connor, Clerk

UNPUBLISHED

UNITED STATES COURT OF APPEALS
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No. 19-1769

CYNTHIA HOLMES, a/k/a C. Holmes, a/k/a Cynthia Holmes, M.D.,

Plaintiff - Appellant,

v.

THOMAS E. PRICE, Secretary of the Department of Health and Human Services (HHS),

Defendant - Appellee.

Appeal from the United States District Court for the District of South Carolina, at Charleston. Bruce H. Hendricks, District Judge. (2:17-cv-02491-BHH)

Submitted: January 23, 2020 Decided: January 27, 2020

Before WYNN, DIAZ, and RICHARDSON, Circuit Judges.

Affirmed by unpublished per curiam opinion.

Cynthia C. Holmes, Appellant Pro Se.

Unpublished opinions are not binding precedent in this circuit.

PER CURIAM:

Cynthia Holmes appeals the district court's order accepting the recommendation of the magistrate judge and granting Defendant's motion to dismiss pursuant to Fed. R. Civ. P. 12(b)(1) and for summary judgment pursuant to Fed. R. Civ. P. 56, and a subsequent order denying reconsideration. The district court referred this case to a magistrate judge pursuant to 28 U.S.C. § 636(b)(1)(B) (2018). The magistrate judge recommended granting the motion and advised Holmes that failure to file timely specific objections to the recommendation would waive appellate review of a district court order based upon the recommendation.

The timely filing of specific objections to a magistrate judge's recommendation is necessary to preserve appellate review of the substance of that recommendation when the parties have been warned of the consequences of noncompliance. *See United States v. Midgette*, 478 F.3d 616, 621-22 (4th Cir. 2007); *see also Thomas v. Arn*, 474 U.S. 140, 154-55 (1985). Although Holmes filed objections to the magistrate judge's recommendation, she has waived appellate review because the objections were neither timely nor specific. Accordingly, we affirm the district court's orders.

We dispense with oral argument because the facts and legal contentions are adequately presented in the materials before this court and argument would not aid the decisional process.

AFFIRMED

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA

Cynthia Holmes, Plaintiff, v. Thomas E. Price, Secretary of the Dept. of Health and Human Services, Defendant.	)	Civil Action No. 2:17-2491-BHH **ORDER**

This matter is before the Court upon Plaintiff Cynthia Holmes' ("Holmes" or "Plaintiff") motion to alter or amend the summary judgment entered in favor of Defendants. In an order filed on March 26, 2019, the Court adopted the Magistrate Judge's Report because Plaintiff failed to timely file objections to that Report and because Plaintiff's objections were not sufficiently specific. In the instant motion, filed pursuant to Rule 59(e) of the Federal Rules of Civil Procedure, Plaintiff asserts that "there is no jurisdiction for the Report and Recommendation (R&R) or its adoption" and simply rehashes the arguments she raised in prior filings.

Reconsideration of a judgment pursuant to Rule 59(e) is an extraordinary remedy that should be used sparingly. *See Pac. Ins. Co. v. Am. Nat'l Fire Ins. Co.*, 148 F.3d 396, 403 (4th Cir.1998); *Exxon Shipping Co. v. Baker*, 554 U.S. 471, 485 n. 5 (2008). Ordinarily, a court may grant a motion to alter or amend pursuant to Rule 59(e) for only three reasons: (1) to comply with an intervening change in controlling law; (2) to account for new evidence not available previously; or (3) to correct a clear error of law or prevent manifest injustice. *Pac. Ins. Co.*, 148 F.3d at 403. Importantly, after review, the Court finds that Plaintiff has

failed to point to any change in controlling law, any new evidence not available previously, or any clear error of law or manifest injustice. Accordingly, the Court denies Plaintiff's motion to reconsider (ECF No. 50).

AND IT IS SO ORDERED.

/s/Bruce H. Hendricks
The Honorable Bruce Howe Hendricks

May 23, 2019
Charleston, South Carolina

NOTICE OF RIGHT TO APPEAL

The right to appeal this order is governed by Rules 3 and 4 of the Federal Rules of Appellate Procedure.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA

Cynthia Holmes, Plaintiff, v. Thomas E. Price, Secretary of the Dept. of Health and Human Services, Defendant.	)	Civil Action No. 2:17-2491-BHH **ORDER**

This matter is before the Court upon Plaintiff Cynthia Holmes' ("Holmes" or "Plaintiff") pro se complaint appealing a decision of the Medicare Appeals Council. The named Defendant is the Secretary of the United States Department of Health and Human Services. On July 5, 2018, Defendant filed a motion to dismiss pursuant to Rule 12(b)(1) of the Federal Rules of Civil Procedure and motion for summary judgment pursuant to Rule 56 of the Federal Rules of Civil Procedure. In accordance with 28 U.S.C. § 636(b)(1)(A) and (B) and Local Civil Rule 73.02(B)(2)(g) (D.S.C.), the matter was referred to a United States Magistrate Judge for preliminary review. On October 30, 2018, the Magistrate Judge issued a Report and Recommendation ("Report") outlining the issues and recommending that the Court grant Defendant's motion. Plaintiff filed objections to the Report on November 19, 2019.

STANDARDS OF REVIEW

I. The Magistrate Judge's Report

The Magistrate Judge makes only a recommendation to the Court. The recommendation has no presumptive weight, and the responsibility to make a final

determination remains with the Court. *Mathews v. Weber*, 423 U.S. 261 (1976). The Court is charged with making a *de novo* determination only of those portions of the Report to which specific objections are made, and the Court may accept, reject, or modify, in whole or in part, the recommendation of the Magistrate Judge, or recommit the matter to the Magistrate Judge with instructions. 28 U.S.C. § 636(b)(1). In the absence of specific objections, the Court reviews the matter only for clear error. *See Diamond v. Colonial Life & Accident Ins. Co.*, 416 F.3d 310, 315 (4th Cir. 2005) (stating that "in the absence of a timely filed objection, a district court need not conduct a *de novo* review, but instead must 'only satisfy itself that there is no clear error on the face of the record in order to accept the recommendation.'") (quoting Fed. R. Civ. P. 72 advisory committee's note).

II. Federal Rule of Civil Procedure 12(b)(1)

A Rule 12(b)(1) motion for lack of subject matter jurisdiction raises the fundamental question of whether a court has jurisdiction to adjudicate the matter before it. Fed. R. Civ. P. 12(b)(1). In determining whether jurisdiction exists, the court is to "regard the pleadings' allegations as mere evidence on the issue, and may consider evidence outside the pleadings without converting the proceeding to one for summary judgment." *Richmond, Fredericksburg & Potomac R.R. Co. v. United States*, 945 F.2d 765, 768 (4th Cir. 1991) (citing *Adams v. Bain*, 697 F.2d 1213, 1219 (4th Cir. 1982)). "The moving party should prevail only if the material jurisdictional facts are not in dispute and the moving party is entitled to prevail as a matter of law." *Id.* (citation omitted). The plaintiff bears the burden of proof on questions of subject matter jurisdiction. *See Evans v. B.F. Perkins Co.*, 166 F.3d 642, 647 (4th Cir. 1999).

III. Federal Rule of Civil Procedure 56

A court shall grant summary judgment if a party shows that there is no genuine dispute as to any material fact and the party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(a). The judge is not to weigh the evidence, but rather to determine if there is a genuine issue of fact. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 249 (1986). If no material factual disputes remain, then summary judgment should be granted against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which the party bears the burden of proof. *Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986). All evidence should be viewed in the light most favorable to the non-moving party. *See Perini Corp. v. Perini Constr., Inc.*, 915 F.2d 121, 123-24 (4th Cir. 1990).

ANALYSIS

As an initial matter, the Court finds that Plaintiff's objections are untimely. As previously mentioned, the Magistrate Judge filed his Report on October 30, 2018, and attached to the Report was a notice advising Plaintiff of her right to file specific, written objections to the Report within fourteen days after being served with a copy of the Report. Pursuant to Rule 5(b)(2)(C) of the Federal Rules of Civil Procedure, the date of service is the date the Report was mailed to Plaintiff, which was October 30, 2018. A party receives three additional days to file objections if served by mail or otherwise allowed under Rule 6 of the Federal Rules of Civil Procedure. Here, adding three days of mail time, Plaintiff

needed to file her objections on or before Friday, November 16, 2018.[1] However, Plaintiff did not file her objections with the Court until Monday, November 19, 2018.[2] Thus, Plaintiff's objections are untimely.

Even leaving aside the issue of untimeliness, however, the Court also finds that Plaintiff's objections are not sufficiently specific. In her 24 pages of objections, Plaintiff mentions the Report approximately four times. First, she asserts on page one that she "respectfully enters objections to the Report and Recommendation." (ECF No. 45 at 1.) Then, on page seven, she asserts that she requested disposition of this case by a district judge and "objects to the Magistrate's denial of that request and enters objections to the Report and Recommendation (R&R) in whole." (*Id.* at 7.) She contends that the Report omits materially important public issues and disputes the Report's purported facts without identifying which facts she disputes. (*Id.*) On page ten, Plaintiff states that the "R&R errs in effectively denying the intended beneficiary, the patient, the rights and protections Congress intended and granted to parties under HIPAA's Privacy Rule . . . ." (*Id.* at 10.) Finally, on page thirteen, Plaintiff again asserts that she requested disposition by a district judge; she contends "there is and was no consent for R&R" and "disputes the R&R in whole." (ECF No. 45 at 13.) The remainder of Plaintiff's objections consist of portions of her prior response in opposition to Defendant's motion, and overall, the Court finds that Plaintiff does not specifically point to any errors in the Magistrate Judge's analysis of the

[1] Pursuant to Rule 6 of the Federal Rules of Civil Procedure, the Court excludes the date of mailing, October 30, 2018, and counts every day including intermediate Saturdays and Sundays. Fed. R. Civ. P. 6. Thus, Plaintiff's fourteen days, plus three additional days allowed for service by mail, ended on Friday, November 16, 2018.

[2] The time stamp on Plaintiff's objections indicates that she filed them in person on Monday, November 19, 2018.

facts or law applicable to Plaintiff's claims. (*Cf.* ECF No. 34 at 3-12 and ECF No. 45 at 12-22.) Rather, Plaintiff simply reargues her entire case under the guise of objecting.

The United States District Court for the Western District of Virginia once reviewed objections to a Magistrate Judge's Report that were copied directly from prior pleadings and determined that this practice does not constitute the submission of specific, written objections and does not entitle a plaintiff to *de novo* review. *See Veney v. Astrue*, 539 F. Supp. 2d 841, 845 (W.D.Va. 2008). Specifically, in *Veney*, the court stated:

> A general objection such as that offered by Plaintiff fails to satisfy the requirements of Rule 72(b) and 28 U.S.C. § 636(b)(1)(C). *See United States v. Midgette*, 478 F.3d 616, 621-22 (4th Cir. 2007) ("Section 636(b)(1) does not countenance a form of generalized objection to cover all issues addressed by the magistrate judge; it contemplates that a party's objection to a magistrate judge's report be specific and particularized . . . ."); *Page v. Lee*, 337 F.3d 411, 416 n. 3 (4th Cir. 2003) ("[P]etitioner's failure to object to the magistrate judge's recommendation with the specificity required by the Rule is, standing alone, a sufficient basis upon which to affirm the judgment of the district court. . . ."). Accordingly, "[a] general objection to the entirety of the magistrate's report has the same effects as would a failure to object." *Howard v. Sec'y of Health and Human Servs.*, 932 F.2d 505, 509 (6th Cir. 1991); *see also Hyatt v. Town of Lake Lure*, 314 F. Supp. 2d 562, 580 (W.D.N.C. 2003).

539 F. Supp. 2d 841, 845 (W.D.Va. 2008); *see also Hobek v. Boeing Company*, 2017 WL 3085856, *2 (D.S.C. July 20, 2017) (quoting the same).

In *Veney*, the plaintiff's objections were "an almost verbatim copy of the 'Argument' section" of the plaintiff's brief, and the court explained that it was improper for Plaintiff "to seek re-argument and reconsideration of her entire case in the guise of objecting." *Id.* at 844; *see also Hobek v. Boeing Company*, 2017 WL 3085856, *2 (D.S.C. July 20, 2017). Indeed, the Court finds that such is the case here, and the Court agrees with *Veney* that allowing a litigant to seek *de novo* review of a case under these circumstances makes

reference to a Magistrate Judge useless. *See Veney*, 539 F. Supp. 2d at 845 (quoting *Howard*, 932 F.2d at 509) ("'The functions of the district court are effectively duplicated as both the magistrate and the district court perform identical tasks. This duplication of time and effort wastes judicial resources rather than saving them, and runs contrary to the purposes of the Magistrates Act.'"). As the Fourth Circuit explained in *Midgette*:

> To conclude otherwise would defeat the purpose of requiring objections. We would be permitting a party to appeal any issue that was before the magistrate judge, regardless of the nature and scope of objections made to the magistrate judge's report. Either the district court would then have to review every issue in the magistrate judge's proposed findings and recommendations or courts of appeals would be required to review issues that the district court never considered. In either case, judicial resources would be wasted and the district court's effectiveness based on help from magistrate judges would be undermined.

478 F.3d at 22.

Moreover, with respect to Plaintiff's assertion that she requested disposition by a district judge and did not consent to the entry of a Report and Recommendation, 28 U.S.C. § 636(b)(1)(B) specifically permits a district judge to designate a magistrate judge "to submit to a judge of the court proposed findings of fact and recommendations for the disposition, but the judge of the court, of [motions to dismiss or for summary judgment]." And the Local Civil Rules for the District of South Carolina provide for the automatic reference to a magistrate judge of "all pretrial proceedings involving litigation by individuals proceeding pro se." Local Civil Rule 73.02(B)(2)(e). Thus, Plaintiff's argument that she did not consent to the Magistrate Judge's Report is unavailing.

In all, the Court finds that Plaintiff failed to make either timely or specific objections to the Magistrate Judge's Report, and "Plaintiff will not be given the second bite of the apple [he] seeks." *Veney*, 539 F. Supp. 2d at 846. Accordingly, Plaintiff is not entitled to

de novo review, and the Court simply must satisfy itself that the Magistrate Judge has made no clear error on the face of the record. *See also Holbrooks v. Colvin*, 2015 WL 5562736, *2 (D.S.C. Sept. 21, 2015) (reviewing a Magistrate Judge's Report for clear error where the plaintiff made general and conclusory objections). After review, the Court has no difficulty in finding that the Magistrate Judge's thorough and well-reasoned Report is void of clear error. Accordingly, the Court adopts the Magistrate Judge's Report in full, incorporates it herein, and finds that Plaintiff's Attachment A claims are subject to dismissal for lack of subject matter jurisdiction, and Plaintiff's Attachment B Claims are subject to summary judgment because substantial evidence supports Defendant's determination that Plaintiff failed to submit evidence to establish that the billed services were actually rendered and were medically necessary.

CONCLUSION

Based on the foregoing, it is hereby **ORDERED** that the Magistrate Judge's Report (ECF No. 43) is adopted and specifically incorporated herein; Plaintiff's objections (ECF No. 45) are overruled; and Defendant's motion to dismiss and for summary judgment (ECF No. 30) is granted.

IT IS SO ORDERED.

/s/Bruce H. Hendricks
The Honorable Bruce H. Hendricks
United States District Judge

March 26, 2019
Charleston, South Carolina

NOTICE OF RIGHT TO APPEAL

The parties have the right to appeal this order within the time period set forth in Rules 3 and 4 of the Federal Rules of Appellate Procedure.

IN THE UNITED STATES DISTRICT COURT

DISTRICT OF SOUTH CAROLINA

Cynthia Holmes, Plaintiff, v. Thomas E. Price, Secretary of the Dept. of Health and Human Services, Defendant.	Civil Action No. 2:17-2491-BHH-BM **REPORT AND RECOMMENDATION**

This action has been filed by the Plaintiff, pro se,[1] appealing a decision of the Medicare Appeals Counsel denying her claims for reimbursement (or to avoid repayment of overpayments) for physician services Plaintiff provided to beneficiaries (patients). The named Defendant is the Secretary of the U. S. Department of Health and Human Services.

The Defendant filed a motion for summary judgment pursuant to Rule 56 Fed.R.Civ.P., on July 5, 2018. As the Plaintiff is proceeding pro se, a Roseboro Order was entered by Court on July 6, 2018, advising Plaintiff of the importance of a dispositive motion and of the need for her to file an adequate response. Plaintiff was specifically advised that if she failed to adequately respond, the Defendant's motion may be granted, thereby ending her case. Plaintiff thereafter filed

[1]It is noted that Plaintiff is a frequent filer of pro se litigation in this Court. Aloe Creme Laboratories, Inc. v. Francine Co., 425 F.2d 1295, 1296 (5th Cir. 1970)[a federal court may take judicial notice of the contents of its own records].

a response in opposition to the Defendant's motion on August 10, 2018, following which the Defendant filed a reply memorandum on August 16, 2018.

The Defendant's motion is now before the Court for disposition.[2]

Background and Evidence

In her Complaint, Plaintiff states that she is seeking Court review of the decision of the Medicare Appeals Council pursuant to § 1869(b) of the Social Security Act, 42 U.S.C. § 1395ff(b), and 42 C.F.R. § 405.1130. Plaintiff argues that the decision of the Medicare Appeals Council should be overturned because it is not supported by substantial evidence in the case record and/or because of legal error.

Plaintiff alleges that she is a physician and that she filed claims for Medicare payments or reimbursements for certain specified physician services, but that her requests for payment or reimbursement were wrongfully denied by the Defendant based on a purported failure of the Plaintiff to provide required patient information. However, Plaintiff alleges that her practice is a "non-covered" practice under HIPAA,[3] and that her patients' medical records are therefore covered by S.C. Code Ann. § 44-115-40, which provides (subject to limited exceptions) that "a physician shall not honor a request for release of copies of their medical records without the receipt of express written consent of the patient or person authorized by law to act on behalf of the patient". Plaintiff alleges in her Complaint that the "plain language" of this statute requires the *Defendant* to provide express

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[2]This case was automatically referred to the undersigned United States Magistrate Judge for all pretrial proceedings pursuant to the provisions of 28 U.S.C. § 636(b)(1)(A) and (B) and Local Rule 73.02(B)(2)(e), D.S.C. The Defendant has filed a motion for summary judgment. As this is a dispositive motion, this Report and Recommendation is entered for review by the Court.

[3]Health Insurance Portability and Accountability Act of 1996.

written consent of the patient for release of copies of their medical records. However, Plaintiff argues that an Administrative Law Judge (ALJ) dismissed her "Attachment A" claims as well as her "Attachment B" claims, all of which sought payment or reimbursement for physician services she had provided to patients, due to *Plaintiff's* failure to obtain these consents in order to provide the necessary patient information. Plaintiff also complains that she had a telephone hearing with the ALJ instead of an in-person hearing, and that she was also wrongfully denied a waiver, or, alternatively, she requests a waiver as part of this lawsuit.

Although Plaintiff's statement of her claim in her Complaint is somewhat confusing, she has attached various administrative documents and exhibits to her Complaint which provide some clarity. In an attached Notice of Order and Decision of Medicare Appeals Council (Case Docket No. M-16-2100), it is set forth that on September 14, 2015 an ALJ issued an order of dismissal of Plaintiff's claims for physician services Plaintiff purportedly provided to beneficiaries on the dates of service identified in Attachments A and B. The decision indicates that for the claims identified in Attachment A, the ALJ found that the record did not contain determinations by the prior levels of administrative review, and therefore those claims were dismissed for failure of the Plaintiff to exhaust her administrative remedies. As for the claims identified in Attachment B, the ALJ found that Plaintiff had not submitted any medical records to support that the services she had provided were medically reasonable and necessary, and therefore Plaintiff's claim for reimbursement for those services were denied. The Appeals Council order further notes that it was undisputed that the Medicare Administrative contractor requested that Plaintiff provide medical records to document the medical necessity of the services for which she had submitted claims, but that Plaintiff did not provide the requested documentation. Specifically with respect to Plaintiff's claims for

reimbursement for the services identified in Attachment B, the ALJ cited to the regulations in 42 C.F.R. § 424.5(a)(6) and found that Plaintiff was required to submit medical records or other supporting documentation to establish that the services billed for were actually rendered, and that the services were medically reasonable and necessary. Although the order indicates that the ALJ agreed with the Plaintiff that authorizations from the beneficiaries would be required to submit the documentation, the ALJ rejected Plaintiff's position that it was the contractor, not the Plaintiff, who had the responsibility for obtaining those authorizations.

Continuing further, with respect to Plaintiff's request for review of the services identified in Attachment A, the Appeals Council's order notes that before an appellant may seek review of a claim at any level of review, the prior level of review must have considered the claim and issued a determination, and that with respect to the claims identified on Attachment A, Plaintiff did not assert, and indeed the record did not show, that those claims had proceeded through the redetermination and reconsideration steps of the appeal process as required by 42 C.F.R. § 405.1000(a). The Appeals Council therefore determined that the ALJ had correctly determined that Plaintiff did not have a right to an ALJ hearing on those claims, because she had not exhausted her administrative remedies.

With respect to the claims for services identified on Attachment B, although the Appeals Council determined that the ALJ had erred procedurally by dismissing those claims rather than issuing a decision on the merits, that since the ALJ had held both a hearing and a pre-hearing conference in which the Plaintiff had participated and was afforded a full and fair opportunity to present her case (with the ALJ also allowing Plaintiff an additional opportunity to submit documentation to support her claims), the Appeals Council found that the record was fully developed

and ripe for decision, and the Appeals Council issued it own decision on the merits. Specifically, the Appeals Council found that the ALJ did not abuse his discretion by denying Plaintiff's request for an in-person hearing, as the hearing recording made clear that the ALJ had provided Plaintiff with a full and fair opportunity to present her case, nor did the ALJ abuse his discretion by not remanding Plaintiff's claims because the EOBs[4] were not in the record. The Appeals Council determined that although Plaintiff argued that she had never been notified of the reason for the denial of her claims, the record indicated that both the contractor and the QIC[5] had explained to the Plaintiff that their denials were based on a lack of supporting documentation, and that Plaintiff had not shown or explained why the EOBs were necessary (or even relevant) to adjudicating the underlying merits of her claim.[6] The Appeals Council further concluded that the ALJ had correctly found that it was the Plaintiff's responsibility to provide the documentation showing that the services for which she submitted claims were reasonable, necessary, and complied with Medicare coverage criteria, and that she had failed to do so. Moreover, with respect to the claims that were initially paid, but were later reopened and denied, the Appeals Court's order notes that Medicare contractors have the authority to request additional information, on either a prepayment or a post payment basis, to determine whether a claim submitted meets all requirements for coverage and payment, and that such reopenings are an unreviewable discretionary action on the part of a contractor. Further, once reopened, in order obtain or retain Medicare payment for her Part B claims, it was Plaintiff's

[4]Explanation of Benefits.

[5]Qualified Independent Contractor.

[6]The Appeals Council order further states that Plaintiff had herself informed the ALJ at the pre-hearing conference that her office actually had the EOBs (or corresponding remittance advices) for each claim, but had failed to submit them to either the ALJ or to the Council.

responsibility to submit medical and other supporting records when the contractor notified her that additional documentation was necessary to process her claims, and that Plaintiff had failed to do so.

Finally, the Appeals Council determined that Plaintiff's argument that it was the contractor who was required to obtain authorizations from the respective beneficiaries and provide those authorizations to the Plaintiff was without merit, noting that (as the ALJ observed) it was the Plaintiff's burden to prove entitlement to payment and to obtain any authorizations from the beneficiaries necessary to demonstrate her entitlement to Part B payment. See also 42 C.F.R. § 424.5(a)(6). As for Plaintiff's request in the alternative for a waiver, the Appeals Council noted that § 1870(b) provides that recoupment of an overpayment to a provider or supplier may be waived if the provider or supplier was without fault in receiving the overpayment, but that a supplier is not without fault if it does not submit documentation to substantiate that services billed to the program were covered. See 42 U.S.C. § 1395gg(b). Since Plaintiff did not submit any documentation to substantiate that the services she had billed to the program were covered, the Appeals Council determined that she was not without fault, and that recovery of the overpayment would not be waived. See generally, Plaintiff's Exhibit [Notice of Order and Decision of Medicare Appeals Council].

Plaintiff has also attached as an exhibit to her Complaint a copy of a letter she received from an attorney, wherein the attorney opines that Plaintiff's Ophthalmologist practice is not subject to HIPPA privacy regulations and is instead regulated under state and local medical information privacy law. [See letter from Nancy L. Perkins, Esq., dated August 25, 2015]. In a second letter from the same attorney, this attorney further opines that under both HIPPA and South Carolina law (with respect to non-covered entities under HIPPA) disclosure of medical records (with limited exceptions) is not permitted without the patient's authorization. [See letter from Nancy L. Perkins, Esq., dated

March 6, 2017].

As an attachment to the motion for summary judgment, the Defendant has submitted a copy of the Administrative Record ["AR"] involving Plaintiff's reimbursement claims, which has been filed under seal. See Court Docket Nos. 22 and 23.

Discussion

This matter arises under Title XVIII of the Social Security Act 42 U.S.C. § 1395, et seq. (the Medicare Act), a federally funded health insurance program for the elderly and disabled. See 42 U.S.C. § § 1395c, 1395j, and 1395k. More specifically, Plaintiff's claims in this matter are under Medicare Part B, which is a supplemental program that pays for physician and outpatient services. See 42 U.S.C. § 1395j, et seq.; see also 42 C.F.R. Parts 407 and 410. The Medicare part B program is administered by The Centers for Medicare & Medicaid Services (CMS) in conjunction with Medicare contractors. 42 U.S.C. § § 1395kk-1, 1395h(a), and 1395u(a). It is the responsibility of the Medicare contractors to make coverage determinations, to make payments for items and services provided by suppliers (physicians) to Medicare beneficiaries, to audit claims and determine overpayments or under payments, to adjust for any incorrect payments, and to recover for over-payments. See 42 U.S.C. § 1395kk-1(a)(4); see also 42 C.F.R. § § 421.200, 421.400 et. seq.

As authorized by the Medicare Act, contractors typically pay claims immediately upon receipt of a claim as long as the claim does not contain any obvious problems. These payments are then subject to post-payment audits in order to verify that the payments were proper. Maximum Comfort, Inc. v. Secretary of Health and Human Services, 512 F.3d 1081, 1084 (9th Cir. 2007); Gulfcoast Medical Supply, Inc. v. Secretary of Department of Health and Human Services, 468 F.3d 1347, 1349 (11th Cir. 2006). Among other things, the amounts billed by providers and suppliers must

be for services that were "reasonable and necessary" in accordance with Medicare coverage policies and program instructions, and when a post-payment audit reveals that a payment was improper, the Secretary may reopen or advise an initial determination or reconsider determination. See 42 U.S.C. § §1395ddd(a)-(b) and 1395ff(b)(1)(G); see also 42 C.F.R. § § 405.980(a) and 421.304.

In order for a supplier (such as the Plaintiff) to appeal an initial determination, they must first request a redetermination, which is then conducted by an employee of the Medicare contractor who was not involved in the initial determination. See 42 U.S.C. § 1395ff(a)(1) and (3); see also 42 C.F.R. § § 405.940, 405.948. If the supplier remains dissatisfied following the redetermination, they may then request reconsideration by a QIC within one hundred eighty days. If dissatisfied with the QIC's reconsideration decision, the supplier may then request a hearing before an ALJ within sixty days. Thereafter, the supplier may request a de novo hearing of the ALJ's decision by the Medicare Appeals Council within sixty days. The Appeals Council decision on the merits is the final decision of the Secretary. See 42 U.S.C. § 1395ff(b)(1)(A) & (B); see also 42 C.F.R. § 405. If still dissatisfied, the supplier may then seek review of the decision by filing an action in United States District Court within sixty days. See 42 U.S.C. § § 405(g), 1395ff(b)(1)(A); 1395ff(b)(2).

Upon the filing of a federal court action, judicial review of the Secretary's factual findings must be based solely on the administrative record, and is limited to determining 1) whether the record contains substantial evidence to support the ALJ's findings, and 2) whether the correct legal standards were applied. See 42 U.S.C. § § 1395ff(b), 1395w-22(g)(5); see also Byrd v. Commissioner of Social Security, 699 F.3d 337, 340 (4th Cir. 2012); Johnson v. Barnhart, 434 F.3d 650, 653 (4th Cir. 2005) ["Substantial evidence is such relevant evidence as a reasonable mind might

accept as adequate to support a conclusion"]. However, it is important to note that the supplier may seek federal judicial review of the final agency decision only after they have exhausted every step of the administrative appeals process. See 42 U.S.C. § 1395ff(b)(1)(A); see also 42 C.F.R. § 405.1136. Further, the Appeals Council review of an ALJ jurisdictional dismissal of a claim is not subject to further review, including even judicial review. See 42 C.F.R. § 405.1116.

Attachment A Claims

The record before the Court shows that Plaintiff's claims for payment or reimbursement are for various services allegedly provided to beneficiaries that were listed on two separate attachments - Attachment A and Attachment B (both indicating dates of service provided). The Medicare contractor requested that Plaintiff provide medical records to document that the services provided by her were actually rendered and were reasonable and necessary, but Plaintiff failed to provide the requested medical records. See AR,[7] pp. 4, 363, 403-583. The Medicare contractor then denied coverage for the services, either initially or (with respect to claims for which payment had previously been made) after reopening the claims. See AR, p. 4. The record reflects that Plaintiff also did not provide the requested medical records to the QIC. See AR, p. 151-182, 869-900, 917-922, 1041-1072, 1089-1094.

Significantly, the record shows that although Plaintiff sought redetermination and reconsideration of most of her Attachment B claims, there is no record that Plaintiff's Attachment A claims had either a redetermination decision by the Medicare contractor or a reconsideration determination by the QIC. The ALJ therefore dismissed Plaintiff's request with respect to her

[7]Administrative Record.

Attachment A claims for failure to exhaust. See AR, p. 5, 7, 74-76. On Appeal, the Appeals Council confirmed that the ALJ's dismissal of the Attachment A claims was proper because Plaintiff had failed to exhaust her administrative remedies as to those claims. See AR, p. 6-7. Therefore, as Plaintiff failed to exhaust her administrative remedies with respect to her Attachment A claims, she is not entitled to judicial review with respect to those claims. See 42 U.S.C. § 1395ff(b)(1)(A).

Plaintiff makes two arguments relating to her Attachment A claims. Her first argument, that her Attachment A claims are somehow exempt from the exhaustion requirement, is patently without merit. Plaintiff's second argument is that she did request a redetermination, but that the Defendant wrongfully "thwarted review and wrongfully prevented redetermination by representing that the request for review [was] not necessary". However, although it is arguable Plaintiff may have made some general assertions on this issue to the ALJ, Plaintiff failed to pursue or make any such assertion before the Appeals Council. See AR at 6-7, 57-68; see also AR at 2293, 2297, 2305. Thus, Plaintiff may not make that assertion here. See United States v. L.A. Tucker Truck Lines, Inc., 344 U.S. 33, 37 (1952) ["[A]s a general rule ... courts should not topple over administrative decisions unless the administrative body not only has erred, but has erred against objection made at the time appropriate under its practice."]; Pleasant Valley Hosp., Inc.v. Shalala, 32 F.3d 67, 70 (4th Cir. 1994) ["As a general matter, it is inappropriate for courts reviewing appeals of agency decisions to consider arguments not raised before the administrative agency involved."]; CSX Transp., Inc. v. Surface Transp. Bd., 584 F.3d 1076, 1079 (D.C. Cir. 2009) [acknowledging the "well-established doctrine of issue waiver, which permits courts to decline to hear arguments not raised before the agency where the party had notice of the issue"]; Nuclear Energy Inst. v. EPA, 373 F.3d 1251, 1290 (D.C. Cir. 2004) (per curiam) ["To preserve a legal or factual argument, ... [a]

proponent [must] have given the agency a 'fair opportunity' to entertain it in the administrative forum before raising it in the judicial one."] (*quoting* Wash. Ass'n for Television & Children v. FCC, 712 F.2d 677, 681 (D.C.Cir.1983)).[8]

As such, as Plaintiff failed to exhaust her administrative remedies with respect to the Attachment A claims, this Court is without jurisdiction to review Plaintiff's claims with respect to her Attachment A claims. See 42 U.S.C. § 1395ff(b)(1)(A); see also 42 C.F.R. § § 405.960, 405.1000(a), 405. 1002, 405.1116. Therefore, Plaintiff's claims relating to her Attachment A claims should be dismissed.

Attachment B Claims

Plaintiff did exhaust her administrative remedies with respect to her Attachment B claims. However, the record contains substantial evidence to support the decision to deny Plaintiff's reimbursement for these claims due to her own well-documented failure to provide the necessary information to justify her requested reimbursement payments.

The Medicare Act provides that "no payment may be made under Part A or Part B for any expenses incurred for items or services . . . which . . . are not reasonable and necessary for the

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[8]As an attachment to her response filed in opposition to the Defendant's motion, Plaintiff attached an affidavit in which argues that she requested a review, redetermination, and reconsideration and/or appeal for "essentially all claims" in both her Attachments A and B, and that any failure by her to exhaust her administrative remedies is due to affirmative misconduct by the Secretary and/or agents of the Secretary. However, even if Plaintiff's affidavit was proper evidence with respect to her claim, it merely reiterates her arguments in her Complaint and her response brief that the Defendant (or his agents) failed to timely process and pay her claims, required information or documentation from her that was not required by, or was even prohibited for her to provide, under federal or state law, and that she should not be punished for complying with the plain language of the applicable state statute with respect to privacy of patient information. Those arguments are all without merit, as is noted and discussed hereinabove.

diagnosis or treatment of illness or injury . . . .". See 42 U.S.C. § 1395y(a)(1)(A); see also 42 C.F.R. § 411.15(k)(1). In determining what is reasonable and necessary, the Secretary has broad discretion to determine what information to require as a condition of payment; Maximum Comfort, Inc., 512 F.3d at 1088; Community Hospital v. Thompson, 323 F.3d 782, 789 (9th Cir. 2003); and the physician submitting a claim has the burden of establishing that the medical care for which reimbursement is sought was reasonable and necessary. See 42 U.S.C. § 1395l(e); see also 42 C.F.R. § 424.5(a)(6). Moreover, if a physician fails to respond to a request for additional information "within the specified timeframes, the medical review department will likely deny the service as not reasonable and necessary based on a lack of documentation". See Medicare Claims Processing Manual (MCPM), Chapter 34, ¶ 10.3.

Here, with respect to Plaintiff's submitted claims for services provided to beneficiaries as shown on her Attachment B, the record reflects that the Medicare contractor requested that Plaintiff provide medical records to document that the services she provided were actually rendered and were reasonably necessary, but that Plaintiff refused to submit the medical records for these patient visit. See AR, pp. 4, 363, 403. As a result, the Medicare contractor denied coverage for the services, either initially or after reopening the claims. Id., p. 4. The record further reflects that Plaintiff also failed to provide these medical records to the QIC. Id., pp. 151-182, 869-900, 917-922, 1042-1072, 1089-1094. When Plaintiff sought redetermination and reconsideration for the Attachment B claims; see AR, pp. 16-17, 256-320; she argued that it was the Medicare contractor who should have obtained the necessary written authorizations from the relevant patients so that Plaintiff could produce their medical records; however, the ALJ rejected that argument, finding that it was *Plaintiff's* obligation to obtain these written authorizations from *her* patients. See AR, pp. 58-

61, 75. The ALJ therefore dismissed Plaintiff's Attachment B claims, finding that Plaintiff had failed to submit medical records sufficient to meet her burden of establishing that the services for which she had billed Medicare were actually rendered and were reasonable and necessary. Id., p. 75.

As noted , the Appeals Council found that the ALJ erred by *procedurally* dismissing all of the Attachment B claims, since those claims had, for the most part, been subjected to redetermination and reconsideration, but the Appeals Council then nevertheless rendered a decision on the merits regarding the Attachment B claims, affirming the ALJ's determination that it was Plaintiff's responsibility to provide the documentation sufficient to show that the services underlying the Attachment B claims were actually provided and were reasonable and necessary. Id., pp. 7-13. See also, Discussion, supra [reciting findings of Appeals Council order]. These findings are supported by substantial evidence in the case record. Community Hospital, 323 F.3d at 789 [Noting that the Medicare statute "specifically granted the Secretary broad discretion as to what information to require as a condition of payment to providers under the Medicare program"]; Almy v. Sebelius, 679 F.3d 297, 302-303 (4th Cir. 2012) [Finding that because the determination of what is reasonable and necessary also requires a significant degree of medical judgment, a reviewing Court must generally be at its most deferential]. Although Plaintiff argues that state privacy laws prevented her from submitting the requested medical records, that is not the issue here. Rather, the question is who had the responsibility for obtaining the necessary authorizations from Plaintiff's patients so as to allow her to then provide those records to the Medicare contractor. As noted, Plaintiff had the burden of showing entitlement to payment or reimbursement for these services, and it was therefore *her* obligation to obtain the authorizations necessary to allow her to submit the medical records needed to establish that the services underlying her Medicare claims were actually rendered and were

reasonable and necessary. See AR, p. 12, citing 42 C.F.R. § § 424.32, 424.36, MCPM, Chapter 1, at ¶ ¶ 30.3.2, 50.1.1; cf. Nephropathology Associates, PLC v. Sebelius, No.12-233, 2013 WL 3285685 at * 4 (E.D.Ark. June 27, 2013) [Finding that the Secretary's interpretation that the burden remains on the entity submitting the claim is not unreasonable]; Ojebuoboh v. Sebelius, No. 11-17, 2012 WL 1932043 at * 1 (E.D.N.C. May 29, 2012) ["In submitting a claim for payment, a provider, such as a physician, is obligated to furnish sufficient information to enable HSS to determine whether payment is due and its amount."]. Additionally, the fact that some of Plaintiff's claims may have been initially reimbursed by Medicare notwithstanding the absence of these medical records does not save Plaintiff's claim from dismissal, as (as has previously been noted) the CMS may, through its contractors, initially pay such claims subject to conducting a subsequent post payment review of the propriety of claims for reimbursement, reopen them, and, if appropriate, deny the claim. See AR, pp. 9-10.[9] Therefore, even though it was Plaintiff's burden to show entitlement to payment or reimbursement, and notwithstanding Plaintiff having been given opportunities throughout the administrative appeal process to submit the requested medical records, the record shows that she failed to do so. See AR, pp. 6-7, 12. Therefore, substantial evidence supports the decision to deny Plaintiff's reimbursement for these claims. Johnson, 434 F.3d at 653 ["Substantial evidence is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion"].

Plaintiff's separate arguments that the ALJ's decision is not supported by substantial evidence or was legally incorrect because she was not afforded an in-person hearing and because discovery was not allowed so that she could obtain EOBs are also without merit. First, Plaintiff was

[9]As previously noted, the decision on whether or not to reopen an initial determination is not itself even a determination subject to judicial review. See 42 C.F.R. § 405.926(l); 405.980(a)(5).

unable to explain during the hearing how the EOBs were even relevant to her claims. See AR, pp. 2294-2302. Moreover, the record reflects that Plaintiff already had the EOBs, but then failed to herself submit them to either the ALJ or to the Appeals Council. Id., pp. 9, 2280-2282, 2291-2294. As for Plaintiff's complaint about not having an in-person hearing, the case record reflects that the ALJ provided, and the Appeals Council found, that Plaintiff was afforded a full and fair opportunity to present her case during the telephonic hearing. Id., pp. 8, 2280, 2288-2307. Plaintiff had no "right" to an in-person hearing, as such hearings are offered in Medicare reimbursement disputes only in very exceptional circumstances (which were not present in this case). See 42 U.S.C. § 405.1000(b) [The hearing before the ALJ may be conducted "in-person, by video-conferencing, or by telephone."]; 42 U.S.C. § 405.1020(b) [an in-person hearing need be conducted only if "special or extraordinary circumstances exist."].

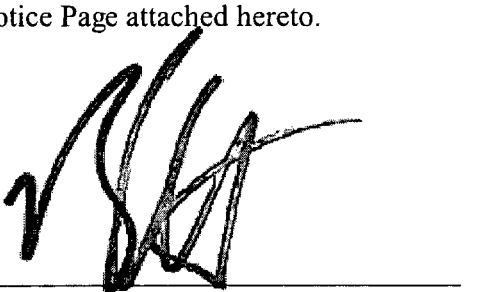
Finally, Plaintiff's assertion that she should have been allowed or granted a waiver under the facts presented is also without merit, as the administrative finding that Plaintiff was not entitled to a waiver is supported by substantial evidence in the case record. Id., pp. 12-13. Title 42 U.S.C. § 1395pp(a)(2) provides that a waiver of recovery may be provided where a supplier did not know, and could not reasonably have been expected to know, that services were not covered by Medicare, while 42 U.S.C. § 1395gg(b)(1) provides that a recoupment of a Medicare overpayment from a supplier may be waived if the supplier was without fault in receiving the overpayment. However, as a Medicare supplier, Plaintiff is deemed to have actual or constructive knowledge of non-coverage where she refused to submit the requested medical records needed to evaluate whether her services met the applicable criteria for Medicare payment. As a supplier, Plaintiff is also not deemed to be "without fault" where she fails to submit documentation to substantiate that services

billed to Medicare were covered by the program. See 42 C.F.R. § 411.406(e)(1), (e)(3). Therefore, there is no reversible error in the Appeals Council determining that a waiver was not warranted in this case. See AR, pp. 12-13.

Conclusion

Based on the foregoing, it is recommended that the Court affirm the Secretary's final decision dismissing Plaintiff's Attachment A claims for lack of subject matter jurisdiction, and Plaintiff's Attachment B claims because substantial evidence supports the Secretary's determination that Plaintiff failed to submit evidence to establish that the billed services were actually rendered and were reasonably necessary.

The parties are referred to the Notice Page attached hereto.



Bristow Marchant
United States Magistrate Judge

October 30, 2018
Charleston, South Carolina

Notice of Right to File Objections to Report and Recommendation

The parties are advised that they may file specific written objections to this Report and Recommendation with the District Judge. Objections must specifically identify the portions of the Report and Recommendation to which objections are made and the basis for such objections. "[I]n the absence of a timely filed objection, a district court need not conduct a Defendants' Exhibit novo review, but instead must 'only satisfy itself that there is no clear error on the face of the record in order to accept the recommendation.'" *Diamond v. Colonial Life & Acc. Ins. Co.*, 416 F.3d 310 (4th Cir. 2005) (quoting Fed. R. Civ. P. 72 advisory committee's note).

Specific written objections must be filed within fourteen (14) days of the date of service of this Report and Recommendation. 28 U.S.C. § 636(b)(1); Fed. R. Civ. P. 72(b); *see* Fed. R. Civ. P. 6(a), (d). Filing by mail pursuant to Federal Rule of Civil Procedure 5 may be accomplished by mailing objections to:

Robin Blume, Clerk
United States District Court
Post Office Box 835
Charleston, South Carolina 29402

Failure to timely file specific written objections to this Report and Recommendation will result in waiver of the right to appeal from a judgment of the District Court based upon such Recommendation. 28 U.S.C. § 636(b)(1); *Thomas v. Arn*, 474 U.S. 140 (1985); *Wright v. Collins*, 766 F.2d 841 (4th Cir. 1985); *United States v. Schronce*, 727 F.2d 91 (4th Cir. 1984).