CONTENTS OF APPENDIX

APPENDIX A

Case: 17-2165 Document 48-1 Filed 10/03/2018

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT
100 EAST FIFTH STREET, ROOM 540
POTTER STEWART U.S. COURTHOUSE
CINCINNATI, OHIO 45202-3988

Deborah S. Hunt
Clerk

Tel. (513) 561-7000
www.ca6.uscourts.gov

Filed: October 03, 2018

Mr. George F. Indest III
Mr. Lance O'Neal Leider
Health Law Firm
1101 Douglas Avenue
Altamonte Springs, FL 32714

Ms. Alisa B. Klein
Ms. Thais-Lyn Trayer
U.S. Department of Justice
950 Pennsylvania Avenue, NW
7712
Washington, DC 20530

Re: Case No. 17-2165, *New Vision Home Health Care, Inc., et al. v. Anthem, Inc., et al.*
Originating Case No.: 2:16-cv-13173

Dear Counsel,

The Court issued the enclosed opinion today in this case.

Sincerely Yours,

S/Cathryn Lovely
Opinions Deputy

cc: Mr. David J. Weaver

Enclosure

Mandate to issue

NOT RECOMMENDED FOR FULL-TEXT PUBLICATION
File Name: 18a0493n.06

Case No. 17-2165

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

NEW VISION HOME HEALTH CARE, INC.; SALEEM BIN SHAKOOR,	) Filed Oct 03, 2018
Plaintiffs-Appellants,	) ON APPEAL FROM) THE UNITED) STATES DISTRICT
v.	) COURT FOR THE) EASTERN
ANTHEM, INC.; TRUSTSOLUTIONS, LLC; NATIONAL GOVERNMENT SERVICES, INC.,	) DISTRICT OF) MICHIGAN
Defendants-Appellees.	)

BEFORE: SUHRHEINRICH, MOORE, and BUSH, Circuit Judges.

JOHN K. BUSH, Circuit Judge. In this Medicare reimbursement dispute, appellants New Vision Home Health Care, Inc., and Saleem Bin Shakoor (collectively, "New Vision") appeal the district

court's dismissal of their claims against appellees Anthem, Inc. ("Anthem"), TrustSolutions LLC ("TrustSolutions"), and National Government Services, Inc. ("NGS") (collectively, "Contractors") for lack of subject matter jurisdiction.

On Counts I and II of the complaint, which sought a writ of mandamus ordering an Administrative Law Judge ("ALJ") to enforce its 2013 order, the district court held that it did not have jurisdiction because New Vision had failed to satisfy administrative exhaustion and presentment requirements. *See New Vision Home Health Care, Inc., et al. v. Anthem, Inc., et al.*, No. 16-13173, 2017 WL 3704379, at *1, *6 (E.D. Mich. Aug. 28, 2017). In addition, the court found that the ALJ's order did not subject appellees to an enforceable, "clear nondiscretionary duty," required for mandamus. *Id.* at *6.

On Counts III–VIII, the court found that New Vision had failed to exhaust its administrative remedies and was therefore barred from suing on claims "arising under" the
Medicare statute. *Id.* at *6–7.

For the reasons that follow, we AFFIRM the district court's decision on all Counts.

I. FACTS

Appellant New Vision is a home healthcare provider that is reimbursed by Medicare for qualifying

services provided to patients. Appellee TrustSolutions is a Medicare "Program Safeguard Contractor" (PSC). Appellee NGS is a Medicare "Administrative Contractor" responsible for making initial determinations on providers' claims for reimbursement. Appellee Anthem is a for-profit healthcare insurer with an interest in the resolution of this case because of its transactions with TrustSolutions.

This dispute began in 2007, when TrustSolutions conducted an audit of Medicare payments made to New Vision between 2003 and 2006 and determined that some of the services previously reimbursed had not, in fact, qualified for Medicare coverage. Based on this determination, TrustSolutions took a sample of the claims and entered the data in a formula to extrapolate an estimated total amount that New Vision had been overpaid. The extrapolated amount was over $4 million.

New Vision appealed that determination through the Medicare appeals process and obtained a favorable decision from an ALJ in 2011.[1] *See New Vision Home Health Care Inc.,* 1-737870647 (ALJ Appeal No.), Docket Number: M-12-388, 2012 WL 891098, at *1 (H.H.S. Feb. 8, 2012). The ALJ found that the formula used by TrustSolutions to extrapolate the overpayment was faulty and therefore the amount

[1] This was not the first ALJ hearing in this dispute, but the first one and its procedural history are not relevant to this appeal.

calculated was not valid. *Id.* at *4.

Contractors appealed the ALJ's decision to the Medicare Appeals Council, which remanded for another ALJ hearing. That hearing resulted in the 2013 decision at issue in this case. The ALJ agreed with Contractors that some of the disputed claims previously submitted by New Vision between 2003 and 2006 had not been eligible for reimbursement (as TrustSolutions had already determined); however, many more of those claims had been eligible. The "actual overpayment amount" determined by the ALJ was $35,872.28, far less than the $4 million-plus extrapolated by TrustSolutions. The ALJ ordered Contractors "to process the claims and claim lines at issue in accordance with this decision" and ordered that "[a]ny amounts recouped or otherwise recovered from the Provider based upon the invalid overpayment demands herein shall be returned to [New Vision]."

After the ALJ issued the 2013 decision, Contractors made an interest calculation and added it to the "actual overpayment amount;" they then deducted amounts already repaid by New Vision and determined that New Vision owed Contractors $41,675.65. Contractors sent New Vision a request for reimbursement of this amount, but New Vision never paid. In addition, according to New Vision's allegations, beginning after 2006[2] Contractors

[2] In its brief, New Vision states that the withholdings began after 2006, but its Second Amended Complaint stated that they began in 2010. The district court used the 2006 date because New

withheld from New Vision all payments on reimbursements for approved claims. New Vision asserted that Contractors had a policy of withholding future payments to recoup past overpayments and that because Contractors "never provided any notice to [New Vision] that they were subject to any other audits, the, withholding . . . has no reasonable explanation other than as an attempt" to recoup. However, according to New Vision, Contractors have withheld over $200,000 in payments since 2006—approximately five times the $41,675.65 that New Vision was due to reimburse Contractors under the ALJ's 2013 decision.

II. PROCEDURAL BACKGROUND

In 2016, New Vision brought this action in the district court seeking a writ of mandamus for enforcement of the 2013 ALJ decision (Counts I and II) and asserting the following claims for monetary relief: Count III (negligence under Michigan law), Count IV (gross negligence under Michigan law), Count V (tortious interference with business relationships under Michigan law), and Count VI (violation of procedural due process rights under the federal Constitution and the Michigan constitution).

In addition, New Vision sought a declaratory judgment under 28 U.S.C. § 2201 (Count VII) and an

---

Vision also used that date in some of its other filings. We will use the 2006 date as well, but the exact date is not relevant to the jurisdictional questions raised by this appeal.

injunction under Federal Rule of Civil Procedure 65, ordering Contractors to comply with the ALJ's 2013 order, among other requirements (Count VIII).

In support of its request for mandamus, New Vision alleged that (1) Contractors' withholding of over $200,000 in payments since 2006 violated the portion of the ALJ's 2013 decision that required Contractors to "release . . . all improperly retained funds owed to" New Vision and that (2) Contractors improperly retained the post-2006 payments in an attempt to recoup overpayment amounts based on TrustSolutions's initial determination of over $4 million, which had been invalidated by the ALJ. New Vision argued that the ALJ's order created a "clear legal duty" for Contractors to make the payments withheld on post-2006 claims. The existence of this clear duty, New Vision claimed, gave the district court jurisdiction to issue a writ of mandamus.

Contractors filed a motion to dismiss, which the district court initially denied. Contractors then filed a motion to reconsider, which the district court granted. On reconsideration, the district court agreed with Contractors that it did not have subject matter jurisdiction over New Vision's claims, and it granted Contractors' motion. The district court found it lacked jurisdiction over Counts I and II (seeking mandamus relief) because, first, New Vision had not satisfied the exhaustion and presentment requirements of the administrative appeals process with regard to its post-2006 claims, and, second, the ALJ's 2013 order did not create a "clear nondiscretionary duty" in Contractors.

See New Vision, 2017 WL 3704379, at *6. Finally, the district court also found it lacked jurisdiction over Counts III–VIII of the complaint because New Vision had not exhausted its administrative remedies on those claims. *See id.* at *6–7.

New Vision appealed.

III. STANDARD OF REVIEW

We review a district court's dismissal for lack of subject matter jurisdiction de novo. *Cathedral Rock of N. Coll. Hill, Inc. v. Shalala*, 223 F.3d 354, 358 (6th Cir. 2000). We may affirm the district court's dismissal on any ground and are "not restricted to ruling on the district court's reasoning . . . ." *In re Comshare Inc. Sec. Litig.*, 183 F.3d 542, 548 (6th Cir. 1999); *see also Bright v. Gallia Cty., Ohio*, 753 F.3d 639, 652 (6th Cir. 2014).

IV. STATUTORY BACKGROUND

The Medicare statute describes a four-step process by which Medicare service providers may appeal administrative determinations. 42 U.S.C. § 1395ff. First, if the provider is not satisfied with the initial determination of the Medicare Administrative Contractor, it may ask the contractor to conduct a "redetermination." *Id.* § 1395ff(a)(3). The second step is to seek "reconsideration" with a Qualified Independent Contractor ("QIC"). *Id.* § 1395ff(b)–(c). Third, the provider may appeal to an ALJ. *Id.* § 1395ff(d)(1). The ALJ may make a decision or remand

to the QIC. *Id.* § 1395ff(b). "The decision of the ALJ or attorney adjudicator on a request for hearing is binding on all parties unless" one of five exceptions applies, including an exception for claims appealed to the Medicare Appeals Council ("Council"). 42 C.F.R. § 405.1048. Fourth, and finally, the provider may appeal to the Council, which may enter a final decision or remand to the ALJ. 42 U.S.C. § 1395ff(d)(2); 42 C.F.R. § 405.1100(c). "The Council's decision is final and binding on all parties unless a Federal district court issues a decision modifying the Council's decision or" if another exception, not at issue here, applies. 42 C.F.R. § 405.1130.

After going through this process, a provider may still seek relief in a United States district court if it satisfies certain strict requirements. The parties dispute whether New Vision has satisfied the jurisdictional requirements of 42 U.S.C. § 405(g), which provides:

> Any individual, after any final decision[3] of the [Secretary of Health and Human Services][4] made after a hearing to which he was a party . . . may obtain a review of such decision by a civil action . . . . The

---

[3] This court has made clear that, for purposes of the four-step Medicare appeals process and the judicial review provisions in 42 U.S.C. § 405(g) and (h), the decision of the Council "is considered the final decision of the Secretary." *S. Rehab. Grp., P.L.L.C. v. Sec'y of Health & Human Servs.*, 732 F.3d 670, 673 (6th Cir. 2013).

> court shall have power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the [Secretary] . . . .

In addition, access to judicial review on claims "arising under" the statute is available only to those who follow the prescribed process:

> The findings and decision of the [Secretary] after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the [Secretary] shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the [Secretary], or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

42 U.S.C. § 405(h) (incorporated into the Medicare statute at 42 U.S.C. § 1395ii).

V.DISCUSSION

As a preliminary matter, we note that if a motion to dismiss for lack of subject matter jurisdiction "attack[s] the claim of jurisdiction on its face . . . all allegations of the plaintiff must be considered as true

. . . ." *DLX, Inc. v. Kentucky*, 381 F.3d 511, 516 (6th Cir. 2004). Here, New Vision argues that the district court applied the wrong legal standard in granting Contractors' motion because it considered affidavits and other evidence outside the pleadings. However, although the district court did cite authority indicating it believed it could consider evidence outside the pleadings, its resolution of the motion to dismiss turned only on whether New Vision had exhausted the Medicare appeals process-a determination for which the underlying facts were not disputed. New Vision and Contractors agree on how many steps New Vision completed in the Medicare appeals process; the question is whether those steps amounted to exhaustion as a matter of law. The district court's ruling that it lacked subject matter jurisdiction, therefore, did not go beyond the pleadings.

We now turn to the jurisdictional question. To satisfy the Supreme Court's test for mandamus jurisdiction under 28 U.S.C. § 1361, New Vision must show both that it has "exhausted all other avenues of relief" and that Contractors "owe[] [New Vision] a clear nondiscretionary duty." *Heckler v. Ringer*, 466 U.S. 602, 616 (1984); *accord BP Care, Inc. v. Thompson*, 398 F.3d 503, 514-15 (6th Cir. 2005).

The district court correctly determined that New Vision has not exhausted all other avenues of relief. Instructive in this regard is *BP Care*, in which we rejected a Medicare claimant's request for a mandamus writ and determined that the exhaustion analysis for mandamus jurisdiction in administrative

cases duplicates the exhaustion analysis for determining whether a district court has federal-question jurisdiction:

> Both the Supreme Court and this circuit have avoided deciding whether § 405(h) bars mandamus jurisdiction under 28 U.S.C. § 1361, in the same way that it bars jurisdiction under §§ 1331 and 1346. The Supreme Court has, however, muted the importance of the question by holding in Ringer that a litigant who has a remedy available under § 405 has not met the exhaustion of remedies requirement for mandamus. Thus, the Ringer decision has an effect similar to that of placing mandamus within § 405(h)'s jurisdictional bar. The conclusion that the district court lacked jurisdiction over BP Care's claims under § 1331, because of BP Care's failure to present its claims to the agency and to exhaust administrative remedies, therefore applies equally to bar mandamus jurisdiction.

398 F.3d at 515 (citations omitted). Following *BP Care*, we apply the exhaustion analysis for federal-question claims and conclude that because New Vision has not exhausted its administrative remedies, it has not satisfied the exhaustion requirement for mandamus jurisdiction.

We begin our exhaustion analysis with *Southern Rehabilitation Group, P.L.L.C. v. Secretary of Health and Human Services*, 732 F.3d 670, 678 (6th Cir. 2013). In that case, we held that plaintiffs who "seek[] judicial review of the Secretary's final decision" must satisfy three requirements under 42 U.S.C. § 405(g) and (h): they must "present[] their claims to the Secretary;" they must "exhaust their administrative remedies resulting in a final decision;" and they may not "rais[e] federal question claims that are inextricably intertwined with their claim for benefits." S. Rehab., 732 F.3d at 678 (internal quotation marks omitted).[5]

As this formulation makes clear, the Medicare statute's exhaustion requirement calls for a "final decision" from the Secretary. 42 U.S.C. § 405(g). The district court acknowledged this requirement and found that New Vision had not met it. This determination was correct. Although New Vision describes the 2013 ALJ order as "final and binding" under 42 C.F.R. § 405.1048, this regulation simply states that "[t]he decision of the ALJ . . . on a request for hearing is binding on all parties," with a number of exceptions that do not apply here. 42 C.F.R. § 405.1048(a). This section does not address "finality" for purposes of judicial review of agency action. Instead,

---

[5] Although Southern Rehabilitation addressed a matter of benefit determinations, Medicare providers are subject to the same jurisdictional requirements. See, e.g., Randall D. Wolcott, M.D., P.A. v. Sebelius, 635 F.3d 757 (5th Cir. 2011); Bodimetric Health Servs., Inc. v. Aetna Life & Cas., 903 F.2d 480 (7th Cir. 1990).

the statute and regulations, as well as our case law, demonstrate that the Council's decisions, not the ALJ's, are the final decisions of the Secretary and satisfy the jurisdictional prerequisite. See 42 C.F.R. § 405.1100(c) ("When the Council reviews an ALJ's . . . decision," it "issues a final decision or dismissal order or remands a case to the ALJ . . . ."); *id.* § 405.1130 (describing the Council's decision as "final and binding"); *S. Rehab.*, 732 F.3d at 673 (stating that when "the ALJ denies the claim," the Council's "decision is considered the final decision of the Secretary"); cf. 42 C.F.R. § 405.904(a)(1) (beneficiaries seeking review of agency determinations may sue after obtaining a decision from the Council). Thus, because it has not obtained a decision from the Council regarding any adverse aspects of the ALJ's 2013 decision, New Vision has obtained no final agency decision and has not exhausted its remedies.

Assuming that New Vision had obtained a final decision affirming the ALJ's 2013 decision, the district court still would have been correct in denying mandamus relief because the terms of the ALJ's 2013 decision do not place Contractors under a clear duty to pay New Vision for post-2006 claims. If the terms of the ALJ's 2013 decision are clear at all, it is clear that they reference only claims on which New Vision had been overpaid between 2003 and 2006. The order says to "process the claims and claim lines at issue," and the claims at issue were those included in TrustSolutions' audit: claims for which New Vision had already been paid and about which the dispute was simply how much New Vision had been overpaid.

But New Vision wants relief beyond the scope of the ALJ's 2013 decision. What New Vision seeks is a remedy that not only takes into account reimbursement of the pre-2006 overpayment but also compels payment for post- 2006 claims. This latter component is not contemplated by the ALJ's 2013 decision.

Moreover, even if the ALJ's 2013 decision was meant to address post-2006 claims, that intention is not clear enough to support a writ of mandamus because it does not sufficiently define an amount owed. In this regard, *Maczko v. Joyce*, 814 F.2d 308, 310 (6th Cir. 1987) is analogous. There, we found the duty was not sufficiently well defined where the parties disagreed about the amount of backpay owed to the claimant pursuant to an EEOC decision. The EEOC decision in that case ordered that "the Complainant be reinstated with reasonable accommodation; be awarded backpay, seniority and benefits that may have accrued since the effective date of the denial of the Complainant's request for light duty deducting any duplicative award the Complainant may have received prior to the issuance of this decision." *Id.* at 309. We found that this order's terms were not "readily ascertainable" and therefore did not support mandamus jurisdiction. *Id.* at 310. "We conclude[d] that when a duty is disputed or subject to various interpretations, for instance when unliquidated damages are involved, the duty is not 'owed' in that the obligation to do a particular act cannot be said to be clear, peremptory, defined or ministerial within the meaning of section 1361." *Id.* (citations omitted).

As in *Maczko*, so here, the agency order at issue does not contain instructions regarding an amount owed. The ALJ's 2013 decision does not quantify any sum for post-2006 claims. In short, the duty New Vision seeks to have enforced is not "clear, peremptory, defined or ministerial" in the ALJ's 2013 decision. *Id.* Rather, that decision left it to Contractors to determine what "amounts recouped" should be returned to New Vision and contains no directive with regard to payment of post-2006 claims.[6] Although Contractors may have behaved poorly in not making reimbursements after 2006, their actions are not in conflict with the ALJ's 2013 decision. That decision, therefore, is not a clear enough basis to support mandamus jurisdiction.

---

[6] Asserting that the district court "read a temporal requirement into the order which was simply not there," New Vision argues that the ALJ's instruction to Contractors to return "amounts recouped" refers to all amounts wrongly recouped or withheld, past, present, and future. We, by contrast, agree with the district court that the wording suggests the ALJ's 2013 decision contemplated only funds withheld prior to the date of the decision. That there is room for dispute about the future application of the order supports our conclusion that Contractors were not under a clear nondiscretionary duty. On that point, it is worth noting that we found no clearly defined duty in Maczko, despite the EEOC order's placing temporal boundaries on the calculation. See 814 F.2d at 309 (discussing the EEOC order, which required that the plaintiff "be awarded backpay, seniority and benefits that may have accrued since the effective date of the denial of the Complainant's request for light duty deducting any duplicative award the Complainant may have received prior to the issuance of this decision" (emphasis added))

New Vision nevertheless argues that this case is comparable to *Randall D. Wolcott, M.D., P.A. v. Sebelius*, 635 F.3d 757, 770 (5th Cir. 2011), in which the Fifth Circuit found the district court did have mandamus jurisdiction even though the administrative order did not specify an amount to be paid. The facts here, however, do not align with *Wolcott*. There, the plaintiff provider sought administrative review of denied claims for Medicare reimbursement. The ALJ reversed the denial of claims and found that the plaintiff was "entitled" to payment on them. *Id.* at 761. The Fifth Circuit found that the district court had mandamus jurisdiction because the defendant had a "non-discretionary duty to pay a successfully appealed claim." *Id.* at 770.

This case is different. New Vision has not sought any administrative review of any withheld payments for post-2006 claims. There is no ALJ order finding New Vision entitled to anything for those claims. Nor is there any determination that any amount has been withheld that is owed for those claims. By contrast, in Wolcott, the Fifth Circuit found there was subject matter jurisdiction because the plaintiff "ask[ed] the district court to compel the defendants to process and pay claims in accordance with binding final administrative decisions ordering payment of these claims." *Id.* at 766. This language from *Wolcott*, rather than supporting New Vision's position, suggests that New Vision's route to relief should be to challenge Contractors' nonpayment through the administrative process and obtain an order requiring payment.

Because New Vision has not demonstrated that Contractors were under a clear nondiscretionary duty to make payments on New Vision's post-2006 reimbursement claims, the district court correctly found that it lacked subject matter jurisdiction to grant mandamus relief on those claims based on the ALJ's 2013 decision. Therefore, the district court properly dismissed Counts I and II of New Vision's complaint.

We now turn to Counts III-VIII. The district court also dismissed each of these for lack of subject matter jurisdiction, finding that New Vision was required to exhaust its administrative remedies and had not done so. *See New Vision*, 2017 WL 3704379, at *6-7. In reaching this conclusion, the court applied the same exhaustion analysis it applied to New Vision's mandamus claims. Thus, it held that New Vision was required to pursue its tort and constitutional claims through the four-step Medicare appeals process. Under this court's precedent, the district court reached the correct result.

As discussed above, the exhaustion requirement comes from the jurisdictional limitations in 42 U.S.C. § 405(g) and (h). *S. Rehab.*, 732 F.3d at 678. Section 405(g) prescribes a process for review of administrative decisions. Section 405(h) limits the power of federal courts to hear claims related to those decisions: "No action against the United States, the [Secretary], or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim

arising under this subchapter."

In *Southern Rehabilitation*, this court said that state-law claims are subject to the same analysis as federal claims for purposes of § 405(h). 732 F.3d at 677 n.6. We also applied the same analysis to all of the plaintiffs' assertions of jurisdiction over their federal claims, including under 28 U.S.C. § 2201 (the declaratory judgment statute). *See* 732 F.3d at 674, 680. Under *Southern Rehabilitation*, therefore, New Vision was required to exhaust its administrative remedies with regard to all of its claims in Counts III-VIII arising under the Medicare statute.

New Vision objects that because Contractors are not "the United States, the [Secretary], or any officer or employee thereof," the jurisdictional limitation does not apply to this lawsuit. But in *Southern Rehabilitation*, we read the Medicare Act as a whole and determined that Medicare contractors, acting within the scope of their authority, were "agents" of the United States government and therefore enjoyed § 405(h) immunity to the same extent as the United States. 732 F.3d at 680 n.7.

New Vision also contends that its claims do not "arise under" the Medicare statute. Thanks to *Southern Rehabilitation*, this assertion fails too. In that case, we affirmed dismissal of the plaintiffs' state-law claims for breach of contract, fraud, and negligence (among others) as well as its federal constitutional claims for failure to satisfy the presentment requirement of § 405(g) and (h). 732 F.3d

at 674, 680. In so doing, we found that the state-law and federal constitutional claims were "inextricably intertwined with the claim for review of the Secretary's decision" and must, like claims for review, "be presented to the agency . . . ." *Id.* at 679.

Here, the district court dismissed New Vision's claims for failure to exhaust, rather than failure to present. Because (as discussed above) New Vision did not obtain a final decision from the Council on any of its claims, the district court appears to have made the correct decision. However, we need not determine whether New Vision exhausted its administrative remedies on the state-law and federal constitutional claims because New Vision failed to present its claims to the agency as required by *Southern Rehabilitation*. In that case, we found that because plaintiffs "d[id] not allege they ever presented their federal or state law claims to the agency," it did not matter that they claimed to have "exhausted the administrative review channels[] and properly progressed through the administrative review process." *Id.* at 679-80 (internal quotation marks omitted).

New Vision does claim to have presented its theories of relief to the agency, but its argument to that effect mirrors that of the *Southern Rehabilitation* plaintiffs in simply reiterating that it exhausted its administrative remedies. This strategy, we have held, will not avail. *See id.*

The closest New Vision gets to a meritorious argument that it presented its claims is by contending

that it "raised the facts underlying the tort and due process causes of action to the ALJ." New Vision asserts that statements in the ALJ's 2013 order show that the ALJ heard and considered these facts. In particular, the ALJ chastised Contractors for failing to use due care and for making serious errors, among other misdeeds, in calculating the amount they thought New Vision had been overpaid. However, the district court found, and we agree, that whatever the ALJ may have determined about Contractors' actions, those determinations did not affect the substance of its order. *See New Vision*, 2017 WL 3704379, at *7. The ALJ order simply found Contractors had made calculation mistakes and had overestimated the overpayments to New Vision. This conclusion would have been the same regardless of whether Contractors had acted from sterling motives or had been grossly negligent. There is no evidence the ALJ considered Contractors' behavior as a separate or additional ground for relief, especially since New Vision was not seeking a remedy for Contractors' behavior but was seeking reversal of their amount determination. Not until its district court filing did New Vision seek relief (in the form of damages and an injunction) for alleged violations of its rights, and extensively detail why Contractors' actions should entitle it to relief on those claims.

But New Vision argues that *Bodimetric Health Services, Inc. v. Aetna Life & Casualty*, 903 F.2d 480, 486 (7th Cir. 1990) supports its claim that it can satisfy presentment requirements by simply airing its "theories" of tortious and constitutional harms before

the ALJ. *Bodimetric* does not provide an obviously available hook for New Vision to hang its hat on, though, given that the Seventh Circuit found it did not have federal subject matter jurisdiction over the plaintiff's claims. *Id.* at 487. To be sure, the Seventh Circuit acknowledged (as New Vision stresses) that "no provision in the regulations prohibit[ed] [Bodimetric] from introducing the facts underlying its claims during the administrative hearings" and that "Bodimetric can seek review of Aetna's denials through Medicare's administrative process . . . [and] the ALJ can provide relief . . . through the reversal of denied claims." Id. at 486. But the court made these statements while distinguishing *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), which had found an exception to the § 405(h) jurisdictional requirements for plaintiffs who had no possibility of review at all in the administrative process because their challenges were to the validity of underlying regulations. *See Bodimetric*, 903 F.2d at 486 (citing Mich. Acad., 476 U.S. at 676 n.6).

The Seventh Circuit thus distinguished *Michigan Academy*, pointing out that Bodimetric did have an administrative avenue for relief, and found judicial review precluded by § 405(g) and (h): the opposite of the result New Vision desires here. *Bodimetric*, 903 F.2d at 487, 489-90; see also id. at 486 (Bodimetric's state-law tort claims and RICO claims, which it based on its travails in the administrative process, were, "at bottom, a challenge to Aetna's approach to processing claims. Judicial review of such a challenge seems to be foreclosed by [Supreme Court

precedent]."). Nowhere did the *Bodimetric* court indicate that Bodimetric's presentation to the ALJ of facts that would also support state or federal claims for damages satisfied the jurisdictional hurdle in § 405(g) and (h). As the Seventh Circuit did in *Bodimetric*, we hold that New Vision's state-law and federal constitutional claims for relief "arise under" the Medicare statute and must be dismissed because New Vision failed to satisfy the statute's jurisdictional requirements. *See* 903 F.2d at 489-90.

In sum, the district court correctly concluded that it did not have subject matter jurisdiction over Counts III-VIII because New Vision did not satisfy the presentment and exhaustion requirements of 42 U.S.C. § 405(g) and (h) on those claims. Therefore, the dismissal for lack of subject matter jurisdiction was proper.

VI. CONCLUSION

Because we find that the district court correctly dismissed New Vision's claims for lack of subject matter jurisdiction, we AFFIRM the holding of the district court on all Counts.

APPENDIX B

2:16-cv-13173-VAR-RSW Doc # 38 Filed 08/28/17

UNITED STATES DISTRICT COURT EASTERN DISTRICT OF MICHIGAN SOUTHERN DIVISION

NEW VISION HOME HEALTH CARE, INC., et al.,

Plaintiffs,

v. Case No.: 16-13173

ANTHEM, INC., et al.,

Defendants.
_____/

OPINION AND ORDER GRANTING DEFENDANTS' MOTION FOR RECONSIDERATION (Doc. # 32) and GRANTING DEFENDANTS' MOTION TO DISMISS (Doc. # 20)

This matter is before the Court on Defendants' Motion for Reconsideration. The Court finds there was a palpable defect by which it and the parties were misled in issuing its first Order. By addressing it, a different outcome is warranted. Loe. Civ. R. 701(h)(3). Accordingly, the Court GRANTS Defendant's Motion for Reconsideration and GRANTS Defendants' Motion to Dismiss. This revised order addresses the issues raised by both defense motions.

I. STATEMENT OF FACTS

New Vision Home Health Care, Inc., and Saleem Shakoor, the owner of New Vision (collectively, "New Vision"), filed suit against National Government, Inc., TrustSolutions, LLC, and Anthem, Inc. (collectively "Defendants"). New Vision's Second Amended Complaint ("SAC") contains eight claims: Count I - writ of mandamus for enforcement of the ALJ's September 4, 2013 decision (Contractors Within Course and Scope); Count II - writ of mandamus for enforcement of the ALJ's September 4, 2013 decision (Contractors Outside of Course and Scope and Failed to Exercise Due Care); Count III - negligence; Count IV - gross negligence; Count V - tortious interference with business relationships and expectancies; Count VI - violation of right to procedural due process; Count VII - declaratory judgment; and, Count VIII - injunction.

Defendants are government contractors for the Medicare program administered by the U.S. Department of Health and Human Services ("HHS"). New Vision submits Medicare claims to Defendants; they determine how much Medicare must pay New Vision for home health care services.

In 2007, Defendants initiated an audit of New Vision's Medicare claims for dates of service from May 8, 2003 through October 3, 2006. Defendants paid these disputed claims, from January 1, 2004 to December 10, 2006. Subsequently - through an audit sample - Defendants concluded that it overpaid New Vision $672,493.57 for claims for dates of service May

8, 2003 through October 6, 2006. Defendants then used a statistical extrapolation formula to calculate an estimated total overpayment to New Vision of $4,155,239.00 ("Disputed Amount") for that period.

In its Second Amended Complaint, New Vision says from October 2010 to the present, Defendants have not paid any claims New Vision has submitted, and that Defendants have withheld payments in order to recoup the Disputed Amount. (SAC 42 and 43). However, in papers filed in connection with Defendants' motions, New Vision says Defendants have withheld payments since 2006 (Doc. # 36; Pg ID 1145). For purposes of this Opinion, the Court will use the 2006 date.

In 2008, New Vision filed a claim through the Medicare Appeal Process over the Disputed Amount for 2003-2006. The Administrative Law Judge ("ALJ") ruled in its favor. Defendants appealed the decision through the Medicare Appeals Council ("MAC"). The MAC remanded for a new ALJ hearing. On June 7, 2012, the ALJ conducted a hearing. New Vision presented arguments contesting the validity of the methodology the Defendants used to determine the estimated overpayment. It also presented reports from a statistical expert who analyzed Defendants' data and methodology. Defendants' evidence included medical records and an analysis of each medical claim submitted by New Vision between 2003 and 2006.

In his decision, the ALJ set forth the issue before him: "whether New Vision received and

retained the total overpayment amount identified by [Defendants] … , and if so, whether [New Vision] is liable for return of the amount the [Defendants] calculated by extrapolation based upon its findings from its medical reviews of the claims in a statistical sample it had drawn." [Doc. 18-1; Pg ID 451]. To resolve this issue, the ALJ went through each of the 228 claims at issue and listed the amount of overpayment amount, if any, for that claim.

The ALJ entered a decision on September 4, 2013 that was partially favorable to New Vision; instead of being required to pay the entire Disputed Amount, the ALJ concluded that New Vision was overpaid only $35,872.28; this is the amount New Vision had to return to Defendants.

The ALJ stated these conclusions of law:

1. Some of the claims New Vision submitted to Defendants met the Medicare coverage criteria.

2. The reimbursements Defendants made for those claims to New Visions were appropriate and did not constitute overpayments.

3. Other home care services New Vision provided did not meet Medicare coverage criteria and/or condition for payment, and New Vision was overpaid for those claims.

4. The statistical sampling and methodology Defendants used to calculate the overpayment had numerous defects, which diminished the reliability and probative value of the evidence.

5. Because the sample was not valid, the resulting amount of the overpayment, calculated by extrapolation for the universe of claims, was not valid.

6. The overpayment amount subject to recovery was limited to the actual overpayment amounts based upon the ALJ's dispositions after conducting individual reviews of the medical records related to the episode claims in the sample and the claim lines there.

[Doc. #18-1; Pg ID 739].

The ALJ made no findings of fact or conclusions of law pertaining to the amounts Defendant withheld after 2006. Nor were there findings concerning the claims made by New Vision in Counts III-VIII.

The decision ended with this order:

"The Medicare contractors are hereby DIRECTED to process the claims and claim lines at issue in accordance with this decision. Any amounts recouped or otherwise recovered from the Provider

> based upon the invalid overpayment demands herein shall be returned to the Appellant."

[Doc. #18-1; Pg ID 740].

This order required Defendants to return to New Vision any amounts it had "recouped" from New Vision based on the Disputed Amount.

Neither party appealed the ALJ's decision to the MAC.

After the ALJ decision issued, Defendants sent New Vision a letter demanding $41,676.65. Defendants calculated that amount by reducing the $35,872.28 to $29,989.11 (reflecting New Vision earlier payments), and adding $11,686.54 interest. New Vision has not paid anything in response to Defendants' letter.

Since 2006, New Vision says it has not received any reimbursements for services from Defendants. New Vision claims Defendants did not pay reimbursements on new claims New Vision submitted, because Defendants were still attempting to collect on the Disputed Amount, most of which the ALJ said New Vision did not owe. New Vision relies on the ALJ's language in his one paragraph order to argue that the ALJ directed Defendants to pay New Vision amounts they withheld beginning in 2006.

On the other hand, Defendants say they did not recoup or recover any amount from New Vision post

2006 that had anything to do with the Disputed Amount. And, Defendants say they still have not received the $41,675.65 they demanded in 2013.

The Court finds:

1. New Vision cannot seek a writ of mandamus with respect to Counts I and II; it failed to exhaust administrative remedies on its lawsuit allegations that the amounts Defendants withheld beginning in 2006 were related to 2003-2006 claims and were intended to collect on the Disputed Amount;

2. The ALJ did not impose a clear nondiscretionary duty on Defendants to pay New Vision funds that it withheld beginning in 2006; and

3. New Vision failed to exhaust administrative remedies on claims set forth in Counts III-VIII.

II. STANDARD OF REVIEW

a. Motion to Dismiss 12(b)(1)

The Defendants move to dismiss all counts of New Vision's Second Amended Complaint, pursuant to Rules 12(b)(1). They say the Court lacks subject matter jurisdiction because New Vision failed to exhaust administrative remedies for claims arising under the Medicare Act, before filing suit; exhaustion is required

for any civil action brought under 42 U.S.C. § 405(2).

"A motion to dismiss an action under Rule 12(b)(1) raises the question of the federal court's subject matter jurisdiction over the action." 5A Charles Alan Wright & Arthur R. Miller, Federal Practice and Procedure § 1350, at 194 (2d ed.1990). The Plaintiff bears the burden to prove jurisdiction. See generally *RMI Titanium Co. v. Westinghouse Elec. Corp.*, 78 F.3d 1125, 1134-35 (6th Cir.1996); see also Rogers v. Stratton Indus., 798 F.2d 913, 915 (6th Cir.1986). "When considering a motion to dismiss for lack of subject matter jurisdiction, this Court may look beyond jurisdictional allegations in the complaint and the Court may consider whatever evidence the parties submit." *Fairport Int'l. Exploration, Inc. v. Shipwrecked Vessel Known as THE CAPTAIN LAWRENCE*, 105 F.3d 1078, 1081 (6th Cir.1997), vacated on other grounds. 523 U.S. 1091, 118 S.Ct. 1558, 140 L.Ed.2d 790 (1998).

Under 28 U.S.C. § 1331, federal district courts "have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States." 28 U.S.C. § 1331. The jurisdiction conferred on federal courts by this statute is commonly referred to as "federal question" jurisdiction.

In cases such as this - where there is a challenge to the allocation of costs under Medicare - Congress prescribed a specific and exclusive method for judicial review of disputes arising under the Medicare program. See *Michigan Ass'n of Homes and Services*

For Aging v. Shalala, 127 F.3d 496, 497 (6th Cir.1997); *Michigan Ass'n of Indep. Clinical Labs. v. Shalala*, 52 F.3d 1340, 1344-46 (6th Cir.1994). In particular, Congress limited federal court jurisdiction by expressly incorporating 42 U.S.C. § 405(h) of the Social Security Act into the Medicare Act. See 42 U.S.C. § 1395ii. This section provides: "No finding of fact or decision of the ... [Secretary] shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the ... [Secretary], or any officer or employee thereof shall be brought under Section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter." 42 U.S.C. § 405(h).

b. Administrative Process

Before federal courts can exercise subject matter jurisdiction over Medicare claims, a plaintiff must fully exhaust administrative remedies and obtain a final decision from HHS. See 42 U.S.C. § 1395ff(b)(1)(A) (limiting judicial review to reconsideration of the Secretary's "final decision," reached at the conclusion of the administrative review process); see also *Weinberger v. Salfi*, 422 U.S. 749, 764-766 (1975) (holding a "final decision" is "central to the requisite grant of ... jurisdiction" and therefore is a "statutorily specified jurisdictional prerequisite" to suit).

A plaintiff must follow a five-step process to fully exhaust administrative remedies: (1) After a party receives a denial of its claim, the first level of appeal is invoked by requesting a redetermination by

the fiscal intermediary carriers. 42 U.S.C. § 1395ff(a)(3); 42 C.F.R. § 405.940; (2) A party who is not satisfied with the redetermination can seek reconsideration by a Qualified Independent Contractor. 42 U.S.C. § 1395ff(b)(1)(A); 42 C.F.R. § 405.960; (3) A party not satisfied with the decision of the Qualified Independent Contractor may request a hearing before an Administrative Law Judge. The ALJ conducts a hearing and issues a decision. The ALJ's decision is final and binding on all parties unless a party requests further review by the MAC within sixty days of the ALJ's decision; 42 C.F.R. §§ 405.1000; (4) If a party requests review by the MAC, the MAC will review the case and issue a final agency decision; 42 U.S.C. § 1395ff(d)(2); and (5) any party may file a civil suit in federal district court once the Secretary of HHS renders a final decision. 42 U.S.C. § 1395ff(b)(1)(A); 42 C.F.R. §§ 405.1002, 405.1006, 405.1014(b).

c. Writ of Mandamus

To seek a writ of mandamus New Vision must show it "has exhausted all other avenues of relief" and the Defendants owe New Vision "a clear nondiscretionary duty." *BP Care, Inc. v. Thompson*, 398 F.3d 503, 515 (6th Cir. 2005) citing *Heckler v. Ringer*, 466 U.S. 602, 616 (1984).

III. DISCUSSION

A. COUNTS I AND II

1. New Vision did not fully exhaust administrative remedies.

New Vision seeks a writ of mandamus under 28 U.S.C. §1361 to enforce the ALJ's 2013 decision, which neither party appealed to the MAC.

Defendants first argue that the Court does not have subject matter jurisdiction over Counts I and II because New Vision failed to exhaust administrative remedies when it did not appeal the ALJ's 2013 decision. New Vision argues it had no obligation to appeal what it calls a decision in its favor and for which it only seeks enforcement. But, what is the decision that New Vision wants enforced? Certainly it is not the decision that it owes Defendants $35,872.28. Instead, New Vision wants this Court to order Defendants to pay New Vision amounts withheld beginning in 2006 because New Vision says this is what the ALJ ordered Defendants to do. New Vision says Defendants are still trying to recover the Disputed Amount through these withholdings.

Defendants say there is no final decision from the MAC that requires them to pay New Vision withholdings beginning in 2006. Further, Defendants say these withholdings had nothing to do with the 2003 through 2006 Disputed Amount.

New Vision's argument is without merit. There were no findings of fact or conclusions of law that pertain to the funds Defendants withheld from New Vision beginning in 2006, nor was there a finding that Defendants withheld funds beginning in 2006 to continue to collect on the Disputed Amount. Furthermore, the ALJ made no finding that Defendants had to pay New Vision a specific amount (or a finding that there was *any* amount).

Since neither party requested review by the MAC, and since the MAC never issued a final decision on whether Defendants withheld funds starting in 2006 to collect on the Disputed Amount, neither party can take advantage of the last step in the statutorily mandated process, which is to file a claim in federal district court.

New Vision relies on *Wolcott v. Sebelius*, 635 F.3d 757 (5th Cir. 2011). In *Wolcott*, the ALJ found that the plaintiff was entitled to Medicare payments for services rendered. The ALJ ordered defendants to process plaintiff's claims. The defendants did not pay the plaintiff for services rendered nor did they process new claims. The plaintiff, a health care provider, sued defendants, the Secretary of HHS and a Medicare carrier, asserting five claims for mandamus because the defendants failed to process and pay claims, only some of which were successfully appealed at the administrative level. The defendants filed a motion to dismiss for lack of subject matter jurisdiction, claiming the plaintiff did not exhaust administrative remedies as required by 42 U.S.C. §405.

On appeal, the Fifth Circuit found that the ALJ's decisions favorable to the plaintiff's claims were final because the "plaintiff does not seek a redetermination of administrative decisions concerning its right to benefits, but rather the enforcement of these administrative decisions." *Wolcott*, 635 F.3d 757, 764.

First and foremost, the Court in *Wolcott* only asserted mandamus jurisdiction over claims in which it found defendants owed a "clear non-discretionary duty to act" after a "fully favorable" ALJ decision. *Wolcott* at 768. As the Court discusses below, Defendants here do not have a clear nondiscretionary duty to pay New Vision anything. Additionally, the Sixth Circuit rejected the *Wolcott* rationale several years before the *Wolcott* decision, in BP Care, 398 F.3d 503, 514-15 (6th Cir. 2005).

New Vision also relies on *Pritchett v. Comm'r of Soc. Sec.*, 2005 U.S. Dist. LEXIS 46965 (E.D. Mich. 2005). In *Pritchett*, the plaintiff sought enforcement of the Social Security Appeals Council's decision to reinstate her benefits. The Court found that mandamus jurisdiction was not precluded as a matter of law by 42 U.S.C. § 405(g), when a plaintiff obtains favorable ALJ and Appeals Council's decisions, and a defendant has a clear obligation to pay back benefits. The Court stated: "the [Social Security] Act does not preclude the exercise of mandamus jurisdiction," finding that "the actions of the Secretary of Health and Human Services challenged . . . constitute such a complete abnegation [sic] of the Secretary's statutory

responsibilities that issuance of the writ is warranted." *Pritchett*, 2005 U.S. Dist. LEXIS 46965, op. at 12, quoting *Ganem v. Heckler*, 746 F.2d 844, 845-846 (D.C. Cir. 1984).

Pritchett is not on point. The plaintiff in I did exhaust administrative remedies through the MAC; the MAC rendered a final agency decision, which gave the plaintiff authority to file a claim in federal district court. In contrast, New Vision has not exhausted administrative remedies.

Defendants rely on *BP Care, Inc. v. Thompson* to argue that Sixth Circuit precedent disallows mandamus jurisdiction when a party has not met exhaustion requirements.

In *BP Care*, the plaintiff "contested the Department of Health and Human Services' policy of imposing successor liability for money penalties incurred because of a violation of a Medicare provider agreement." *BP Care, Inc.*, 398 F.3d at 506. The successor owner abandoned the administrative process which ended when the ALJ dismissed the previous owner's challenge without a hearing. The successor filed suit in federal court claiming that the ALJ's dismissal without a hearing "removed any available administrative remedies." . at 506.

The Sixth Circuit held that the plaintiff failed to exhaust administrative remedies, therefore barring mandamus jurisdiction; it concluded that the successor owner had failed to complete the administrative

process and failed to exhaust "all other avenues of relief." I. at 514-15.

As the statutes and case law make clear, a party seeking mandamus relief must first demonstrate exhaustion. Neither the ALJ nor MAC rendered a final agency decision on whether Defendants withheld funds beginning in 2006 to collect on the Disputed Amount, and whether Defendants were required to reimburse New Vision.

Because the Court finds New Vision did not fully exhaust administrative remedies for Counts I and II, it does not meet the first requirement for a writ of mandamus.

2. Defendants do not owe New Vision a clear nondiscretionary duty.

The ALJ never concluded that Defendants had a duty to pay New Vision a specific amount of money. Defendants rely on *Maczko v. Joyce*, 814 F.2d 308 (6th Cir. 1987) to argue Sixth Circuit precedent dictates that mandamus jurisdiction is not proper because New Vision did not meet the clear duty requirement for mandamus relief.

In *Maczko*, the plaintiff sought enforcement of an Equal Employment Opportunity Commission ("EEOC") decision in her favor. Maczko, 814 F.2d at 309. The Sixth Circuit held that even though the plaintiff fully exhausted administrative remedies, the

district court lacked subject matter jurisdiction and the plaintiff was not entitled to mandamus relief, because the EEOC did not clearly state what relief the defendant owed the plaintiff. *Id.* at 310-11.

The EEOC ordered: "the Complainant be reinstated with reasonable accommodation; be awarded back pay, seniority and benefits that may have accrued since the effective date of the denial of the Complainant's request for light duty deducting any duplicative award the Complainant may have received prior to the issuance of this decision." *Id.* at 309.

The Sixth Circuit reasoned that the terms of the EEOC order were not "readily ascertainable" because the parties disagreed over its meaning, and did not seek clarification from the EEOC. *Id.* In addition, the EEOC did not order the defendants to pay a specific amount to the plaintiffs for back pay.

Maczko is on point. New Vision and Defendants dispute the meaning of the ALJ's order, and the ALJ did not issue a decision that made it clear to the Defendants that they have a clear, nondiscretionary duty to reimburse New Vision for monies recouped beginning in 2006.

New Vision fails to meet the second requirement for a writ of mandamus: it does not demonstrate that Defendants had a clear, nondiscretionary duty to pay New Vision for amounts withheld beginning in 2006.

In sum, the Court lacks subject matter jurisdiction over Counts I and II.

B. COUNTS III THROUGH VIII

1. New Vision did not fully exhaust administrative remedies.

In Counts III through VIII, New Vision seeks compensatory and consequential damages based on negligence, gross negligence, tortious interference with business relationships, and due process violations. It also seeks declaratory and injunctive relief. New Vision argues it presented evidence to the ALJ of the Defendants' negligence, lack of due care, and violations of New Vision's due process rights, and it says the ALJ commented on Defendants' violations in his decision. Defendants argue that New Vision did not raise state law tort claims during the administrative process. Hence, Defendants argue that the Court does not have subject matter jurisdiction over these counts because New Vision failed to exhaust administrative remedies. The Court agrees.

For these claims, New Vision must show that it fully exhausted administrative remedies by following the five-step process described above. To enforce at step five, New Vision must seek enforcement of a final decision. See 42 U.S.C. § 1395ff(b)(1)(A).

The ALJ's final decision in 2013 only upheld New Vision's position that it had not been overpaid

over four million dollars for its claims from May 8, 2003, through October 3, 2006. This was the only issue before the ALJ: "whether New Vision received and retained the total overpayment amount identified by [Defendants]…, and if so, whether [New Vision] is liable for return of the amount the [Defendants] calculated by extrapolation based upon its findings from its medical reviews of the claims in a statistical sample it had drawn." [Doc. 18-1; Pg ID 451].

The ALJ final decision was not based on negligence, gross negligence, tortious interference with business relationships, or due process violations.

New Vision argues several comments in the ALJ's findings show he found the Defendants lacked due care and they violated New Vision's right to due process of law. These comments included:

> "TrustSolutions' letter **failed to include** at least five of the mandatory elements. . . . TrustSolutions **failed to comply** with the above MPIM requirements and **exhibited disregard** for the CMS instructions to auditors."

(Dkt. 18-1, ALJ Decision, PgID 705. Emphasis added.)

> TrustSolutions did not use care in defining the sampling unit that served as the basis for its statistical sampling.

(Dkt. 18-1, ALJ Decision, PgID 708. Emphasis added.)

> [T]he PSC **did not demonstrate even substantial compliance** with the instructions set forth in chapter 3 of the MPIM.

(Dkt. 18-1, ALJ Decision, PgID 716. Emphasis added.)

> As with most rights, the right to recover Medicare overpayment is not without responsibilities. **Those duties attendant to the right to recover overpayments, especially the necessity of protection of due process, have not been faithfully executed.**

(Dkt. 18-1, ALJ Decision, PgID 729. Emphasis added.)

The comments, at best, were dicta, and not part of or the basis for the final decision. New Vision did not direct the Court to any part of the ALJ's findings of fact or conclusions of law that addressed negligence, gross negligence, tortious interference with business relationships, declaratory or injunctive relief. The ALJ did not render a final decision or order specific to the claims in Counts III-VIII.

Because New Vision did not fully exhaust administrative remedies for Counts III- VIII inasmuch as it did not follow the five-step process set forth in 42 U.S.C. § 1395ff, the Court lacks subject matter jurisdiction over Counts III-VIII.

IV. CONCLUSION

The Court **GRANTS** Defendant's Motion for Reconsideration and **GRANTS** Defendants' Motion to Dismiss Counts I-VIII.

IT IS ORDERED.

/s/ Victoria A. Roberts
Victoria A. Roberts
United States District Judge

Dated: 8/28/17

APPENDIX C

2:16-cv-13173-VAR-RSW Doc # 30 Filed 07/12/17

UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF MICHIGAN SOUTHERN DIVISION

NEW VISION HOME HEALTH CARE, INC., et al.,

Plaintiffs, Case No: 16-13173
Honorable Victoria A. Roberts

v.

NATIONAL GOVERNMENT, INC., et al.,

Defendants.
_____/

ORDER DENYING DEFENDANTS' MOTION TO DISMISS [Doc. 20]

I. INTRODUCTION

New Vision Home Health Care, Inc., and Saleem Shakoor, the owner of New Vision (collectively, "New Vision"), filed suit against National Government, Inc., TrustSolutions, LLC, and Anthem Inc. (collectively "Defendants"). Defendants are government contractors for the Medicare program administered by the U.S. Department of Health and Human Services ("HHS"). New Vision submits Medicare claims to

Defendants; they determine how much Medicare must pay New Vision for home health care services. New Vision claims Defendants did not sufficiently reimburse it for services rendered.

In 2008, New Vision filed a claim through the Medicare Appeal Process. The Administrative Law Judge ("ALJ") ruled in its favor. Defendants appealed the decision through the Medicare Appeals Council ("MAC"). The MAC remanded for a new ALJ hearing. At the conclusion of that hearing in 2013, the ALJ partially found in favor of New Vision.

New Vision asks the Court to order Defendants to pay what the ALJ says is owed. Defendants do not deny New Vision's allegations, but say this Court lacks subject matter jurisdiction because New Vision failed to exhaust administrative remedies. This Court disagrees with Defendants; New Vision fully exhausted administrative remedies for claims on which the ALJ found in its favor.

This Court **DENIES** Defendants' motion to dismiss.

II. STANDARD OF REVIEW

The Defendants move to dismiss pursuant to Rules 12(b)(1). "A motion to dismiss an action under Rule 12(b)(1) raises the question of the federal court's subject matter jurisdiction over the action." 5A Charles Alan Wright & Arthur R. Miller, Federal Practice and Procedure § 1350, at 194 (2d ed. 1990). In

this type of motion the plaintiff bears the burden to prove lack of jurisdiction. See generally *RMI Titanium Co. v. Westinghouse Elec. Corp.*, 78 F.3d 1125, 1134-35 (6th Cir. 1996); see also *Rogers v. Stratton Indus.*, 798 F.2d 913, 915 (6th Cir. 1986). "When considering a motion to dismiss for lack of subject matter jurisdiction, this Court may look beyond jurisdictional allegations in the complaint and the Court may consider whatever evidence the parties submit." *Fairpoint Int'l Exploration, Inc. v. Shipwrecked Vessel Known as THE CAPTAIN LAWRENCE*, 105 F.3d 1078, 1081 (6th Cir. 1997), vacated on other grounds. 523 U.S. 1091, 118 S.Ct. 1558, 140 L.Ed.2d 190 (1998).

Under 28 U.S.C. § 1331, federal district courts "have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States." The jurisdiction conferred on federal courts by this statute is commonly referred to as "federal question" jurisdiction.

In cases such as this - where there is a challenge to the allocation of costs under Medicare - Congress prescribed a specific and exclusive method for judicial review of any disputes arising under the Medicare program. See *Michigan Ass'n of Homes and Services for Aging v. Shalala*, 127 F.3d 496, 497 (6th Cir. 1997); *Michigan Ass'n of Indep. Clinical Labs v. Shalala*, 52 F.3d 1340, 1344-46 (6th Cir. 1994). In particular, Congress limited federal court jurisdiction by expressly incorporating 42 U.S.C. § 405(h) of the Social Security Act into the Medicare Act. See 42 U.S.C. § 1395ii. This section provides: "No finding of fact or decision of

the ... [Secretary] shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the ... [Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter." 42 U.S.C. § 405(h).

Before federal courts can exercise subject matter jurisdiction over Medicare claims, a plaintiff must fully exhaust administrative remedies and obtain a final decision from HHS. See 42 U.S.C. § 1395ff(b)(1)(A) (limiting judicial review to reconsideration of the Secretary's "final decision," reached at the conclusion of the administrative review process); see also *Weinberger v. Salfi*, 422 U.S. 749, 764-766 (1975) (holding a "final decision" is "central to the requisite grant of ... jurisdiction" and therefore is a "statutorily specified jurisdictional prerequisite" to suit).

A plaintiff must follow a five-step process to fully exhaust administrative remedies: (1) After a claim denial is received by a party the first level of appeal is invoked by requesting a redetermination by the fiscal intermediary carriers. 42 U.S.C. § 1395ff(a)(3); 42 C.F.R. § 405.940; (2) A party who is not satisfied with the redetermination can seek reconsideration by a Qualified Independent Contractor. 42 U.S.C. § 1395ff(b)(1)(A); 42 C.F.R. § 405.960; (3) A party not satisfied with the decision fo the Qualified Independent Contractor may request a hearing before an Administrative Law Judge. The ALJ conducts a hearing and issues a decision. The

ALJ's decision is final and binding on all parties unless a party requests further review by the MAC within sixty days of the ALJ's decision; 42 U.S.C. §§ 405.1000; (4) if a party requests review by the MAC, the MAC will review the case and issue a final agency decision; 42 U.S.C. § 1395ff(d)(2) and, (5) any party may file a civil suit in federal district court once a final decision is rendered. 42 U.S.C. § 1395ff(b)(1)(A); 42 C.F.R. §§ 405.1002, 405.1006, 405.1014(b).

III. DISCUSSION

Exhaustion of Administrative Remedies

Defendants say the Court does not have subject matter jurisdiction because New Vision failed to exhaust administrative remedies when it did not appeal the ALJ's second decision. New Vision says it had no obligation to appeal a favorable decision for which it only seeks enforcement.

The question presented is whether "exhaustion" requires a party who partially prevail, to appeal that victory before it seeks enforcement. This Court finds that the law does not burden prevailing parties to engage in such a meaningless process, and that New Vision can properly seek enforcement of the ALJ's decision.

New Vision relies on *Wolcott v. Sebelius*, 635 F.3d 757 (5th Cir. 2011). In Wolcott, the ALJ found plaintiff was entitled to Medicare payments for services rendered. The ALJ ordered defendants to

process plaintiff's claims. Id did not, nor did it process new claims. The plaintiff, a health care provider, sued defendants, the Secretary of HHS and a Medicare carrier, asserting five claims for mandamus because defendants failed to process and pay claims, only some of which were successfully appealed at the administrative level.

Defendants filed a motion to dismiss for lack of subject matter jurisdiction; they claimed plaintiff did not exhaust administrative remedies through 42 U.S.C. §405. On appeal, the Fifth Circuit found that the ALJ's decision for the claims favorable to plaintiff were final because the "plaintiff does not seek a redetermination of administrative decisions concerning its right to benefits, but rather the enforcement of these administrative decision." *Wolcott*, 635 F.3d 757, 764. See also, *Fields v. Astrue*, No. 1:08-CV-264, 2012 WL 7807611, at *1 (E.D. Tenn. Dec. 3, 2012), report and recommendation adopted, No. 1:08-CV-264, 2013 WL 1249585 (E.D. Tenn. Mar. 27, 2013) ("The Administrative Law Judge... issued a decision which was partially favorable and which claimant did not administratively appeal. Therefore, the ALJ's June 8, 2010, decision is the Agency's final decision for purposes of this Court's review").

Similarly, New Vision does not seek a redetermination of the ALJ's decision concerning its right to payment; rather, it seeks only enforcement of the ALJ's decision. Defendants say *Wolcott* is not controlling because in *Wolcott*, the ALJ's decision was fully favorable to plaintiffs as opposed to partially

favorable. Defendants misstate the facts of *Wolcott*. The ALJ "reversed the denial of ninety-five debridement claims on services rendered." *Wolcott*, 635 F.3d 757, 767. This amounted to only a ninety-two percent success rate by Wolcott; this is not fully successful.

However, it does not matter if the plaintiff was partially or fully successful; what matters is whether a final decision was rendered in the administrative process on the claims plaintiff brings to the court for enforcement purposes only. Here, the ALJ reached a final decision that Defendants owed New Vision; New Vision only seeks enforcement of the final decision by the ALJ.

Through their briefing, the parties agree that New Vision must exhaust on claims between 2010 and 2016, which were never considered by the ALJ. This enforcement suit is limited to the ALJ's decision concerning claims between 2006-2010.

IV. CONCLUSION

This Court has subject matter jurisdiction over New Vision's claims between 2006-2010. The Court finds that New Vision fully exhausted administrative remedies for the claims the ALJ found in its favor.

The Court **DENIES** Defendants' motion to dismiss New Vision's claims for 2006-2010.

IT IS ORDERED

/s/ Victoria A. Roberts
Victoria A. Roberts
United States District Judge

Dated: 7/12/17

APPENDIX D

Department of Health and Human Services
OFFICE OF MEDICARE HEARINGS AND APPEALS
Midwestern Field Office
Cleveland, Ohio

Appeal of: **New Vision Home Health Care, Inc.**

Beneficiary: **Multiple** (See Appendix A)[1]

HICN: **Multiple** (See Appendix A)

ALI Appeal No.: **1-909525621**

---

[1] The identification of a total amount for the overpayments at issue is based upon a Medicare contrc1ctor's audit and its medical reviews of a sample of claims that related to the HHA services provided to 186 Medicare beneficiaries during 228 h0me health episodes of care. (Exhs. l-3) The Provider's appeal at tbe ALJ level relates specifically to services provided to 161 of those Beneficiaries. (Exh. 20)

To protect the confidentiality of the personally identifiable information related to individual Beneficiaries and the privacy of their medical records, the Beneficiaries' names and IDC numbers do not appear in the body of this decision. For the purpose of effectuation of this decision by Medicare, the names and HIC numbers are listed on Appendix A.

Medicare Part A[2]
with demand for return of overpayment amount calculated \)y extrapolation from overpayments found in PSC audit of statistical sample of claims

Before: James S. O'Leary
U.S. Administrative Law Judge

DECISION

After carefully considering the evidence and the arguments presented in the record and at hearings, the undersigned Administrative Law Judge (ALJ) hereby enters this decision, which is PARTIALLY FAVORABLE to the Appellant for the reasons discussed below.

Procedural History

By and through counsel, New Vision Home Health Care, Inc., a Home Health Agency (HHA.) located in Southfield, Michigan, (Appellant or Provider) filed this appeal regarding the Medicare identification of

---

[2] Some of the overpayments at issue related to reimbursements made under Medicare Part and others relate to payments to the Provider issued under Medicare Part B. However, Medicare reviewers below have not distinguished between the two sources of funds or between the statutory and regulatory authorities - governing coverage and payments.

overpayments made to the Provider, the calculation of a total overpayment ount by extrapolation, and Medicare demands for return of the total amount of the overpayment the Provider received upon the claims at issue (Eili 20) The HHA services at issue include the following disciplines or modalities: skilled nursing (SN) services; medical social worker (MSW) services; personal care services provided by Home Health Aides; and skilled therapy services, such as physical therapy (PT), occupational therapy (OT), and speech...language pathology (SLP) services. Id.

* * *

Conclusions of Law

Some of the home health services furnished by the

Provider to the 161 Beneficiaries herein during the 228 episodes of care represented by the claims in the statistical sample met the Medicare coverage criteria, as shown in Appendix A. The reimbursements made to the Provider upon those claims were appropriate and did not constitute overpayments. Because those services qualified for Medicare coverage, the provisions of section 1879 of the Act do not apply to the Provider or Beneficiaries as to the related claims.

Other home health services provided to the 161 Beneficiaries during the 228 episodes of care did not meet Medicare coverage criteria and/or conditions for payment, as also shown on Appendix A. As to those individual claims, the Provider did receive and retain overpayments. The Provider is not without fault with regard to the overpayments received and retained upon the episode claims and claim lines in the sample that were submitted for noncovered services.

Some of the claim lines included in the sample are for services provided after October 3, 2006 and are therefore outside the universe that had been described by the PSO. Those claim lines, which are identified in Appendix A, should be removed from the sample..The corresponding dollar amounts of any overpayments identified as to those claim lines must be removed from the amount of actual overpayments identified on the claims and claim lines in the sample.

The PSC statistical sampling documentation was initially withheld from the Appellant. When the PSC documentation was provided fo the Appellant and to

the ALJ, numerous defects were found that greatly diminished the reliability and probative value of the evidence as to the calculation of the total overpayment amount at issue. The most reliable evidence in this appeal supports the finding that the PSC sample was not a valid sample; therefore it could not s e as the basis for an accurate extrapolation of the total overpayment amount for the PSC universe of claims.

The PSC did not submit sufficient reliable evidence to make a prima facie case for the accuracy of the extrapolated total overpayment amount demanded from the Appellant. The Appellant submitted substantial reliable, credible, and probative evidence to rebut the validity of the statistical sampling procedures herein. Because the sample is not valid the resulting amount of the overpayment calculated by extrapolation for the universe of claims is not valid. The overpayment amount that is subject to recovery is therefore limited to the actual overpayment amounts based upon the ALJ' s dispositions after conducting individual reviews of the medical records related to the episode claims in the sample and the claim lines therein.

ORDER

The Medicare contractors are hereby **DIRECTED** to process the claims and claim lines at issue in accordance with this decision. Any amounts recouped or otherwise recovered from the Provider based upon the invalid overpayment demands herein shall be

returned to the Appellant.

SO ORDERED.

Dated: Sep 4 2013

/s/

James S. O'Leary
U.S. Administrative Law Judge

Enclosures: Form OMHA-56
List of Exhibits

* * *

APPENDIX C
ALJ Appeal No. 1-9095 25621

Chronology
PSC Audit and Related Appeals

PSC AUDIT LEVEL,
during which Provider filed a lawsuit in federal court seeking injunction

PSC: TrustSolutlons, LLC (TrustSolutions)

7/31/07	PSC letter to Provider with notice of audit and request for me local records RE: PSC to conduct medical review of claims it selected for statistical sample; re Provider must submit medical records for Beneficiaries and DOS on PSC list	Exh. 13 (998-99)
1/19/08	Letters from Provider's attorney (Elizabeth Zink Pearson) to DHHS Secretary Michael Leavitt and to DHHS OGC Chief Counsel Donna Morros Weinstein RE: Provider's complaints regarding past prepayment audits and current postpayment audit, reclaims that PSC conducted "wrongful investigation," using inappropriate medical	Exh. 13 (980-81)

	review personnel and failing to follow proper procedures	
4/22/08	**Complaint filed by Provider in U.S. District Court (E.D. Mich.) challenging audit at issue** Provider sought injunction against further postpayment review in Case Number: 08-11704 *New Vision Home Health Care, Inc., and Saleem Bin Shakoor* v. *Michael Leavit, Secretary of DHHS; Kerry Weems, CMS Administrator; NGS; and Linda Mann, Manager of Benefit Integrity Investigations for TrustSolutions, LLC*	
4/08	New Vision Brief in Support (28 pp. Plus 14 exhibits)	Exh. 13 (978-1047
5/21/08	Motion to dismiss for lack	

	of subject matter jurisdiction filed by Defendants	
6/10/08	Oral argument	
10/2/08	**Order Granting Defendants' Motion to Dismiss and Dismissing Case**	

8/14/08	PSC TrustSolutions partial spreadsheet (85 pp.)	Exh. 1 (1-85)
8/14/08	PSC TrustSolutions partial spreadsheet (45 pp.)	Exh. 2 (86-130)
12/30/09	**PSC letter to Provider wiht identifification of orverpayment** RE: PSC reproting overpayment to NGS Total Overpayment Amount for universe of claims: **$4,155,239.00**	Exh. 3 (131-143)

REDETERMINATION LEVEL

RHHI: National Government Services, Inc. (NGS)

12/31/09	**NGS letter to Provider with initial Overpayment Demand**	Exh. 4 (144-155)
1/24/10	**Appellant Requests for Redetermination** submitted with:	Exhs. 5 & 6
	Appellant letter to NGS RE: appeal request	Exh. 6 (157-160)
	Appellant letter RE: transmittal of Beneficiaries' medical records	Exh. 5 (156)
2/11/10	Appellant cover letter RE: transmittal of Letters of Medical Necessity	Exh. 9 (165)
3/2/10	Appointment of Representative form executed by Appellant and counsel RE: Appointment of The Health Law Partners attorneys as Appellant's representative	Exh. 18 (2247)

3/2/10	Appellant letter to PSC with FOIA Request for information	Exh. 20 (2351-52) or Exh. 13 (1108-09)
3/17/10	**NGS PARTIALLY FAVORABLE REDETERMINATION DECISION (234 pp.)**	**Exh. 10 (166-400)**
3/26/10	PSC letter to Appellant RE: recalculation of total overpayment Enclosure: 2nd SVRS Worksheet (1130-31) Based upon NGS redetermination dispositions, revised total overpayment amount: **$4,142,594.00**	Exh. 13 (1130-33)
3/31/10	NGS letter to Appellant with second Overpayment Demand RE: demand for return of funds, stating revised total overpayment amount	Exh. 11 (401-11)

3/31/10	PSC letter to Appellant RE: response to 3/2/10 FOIA Request RE: Records responsive to FOIA Request "not within [PSC] authority to release" FOIA Request being forwarded this .d. ate to JoAnn Passarelli at CMS	Exh. 13 (1125)
5/12/10	Appellant letter to JoAnn Passarelli at CMS with FOIA Request	Exh. 13 (1111-12)

1st QIC RECONSIDERATION LEVEL APPEAL
QIC case no. 1-6103 16221

QIC: Maximus Federal Services (Maximus)

5/24/10	**Appellant Requests for Reconsideration** Cover letter with numerous tabbed attachments (Tabs A-N), including: Chart summarizing ALJ decisions favorable to Appellant, some in appeals related to services provided to the same beneficiaries as those in the sample herein, and copies of decisions (Tab M, 605-974)	Exh. 13 (412-1397)
5/24/10	Director Shakoor submission of letters of medical necessity (See individual Beneficiary flies)	Exh. 12
6/3/10	Maximus acknowledgment letter sent to Appellant	Exh. 14 (1398-1403)
7/1/10	PSC transmittal of Statistical Sampling Worksheet	Exh. 16 (1416-21)
7/19/10	Appellant letter to NGS with FOIA Request	Exh. 20 (2347-48)

7/19/10	Appellant letter to JoAnn Passarelli at CMS with FOIA Request	Exh. 20 (2345-46)
7/19/10	**Appellant Supplement to Reconsideration Request** Cover letter with Statement of Position (2248-53) and attachments, including: -Appellant's spreadsheet (Tab O) showing all claims at issue with episode DOS. dates of initial determinations, and dispositions. (2228-45) Additional columns indicate whether "Revision Regulations Violated" or "PWF Applies." (18 pp. in vertical orientation)	Exh. 18 (2228-53)
7/23/10	**QIC 1st Partially Favorable Reconsideration Decision** (213 pp.)	Exh. 17
7/23/10	QIC Statistical Review Form signed by Daniel Teitelbaum, PhD {10 pp.)	Exh. 17 (2113-18)

7/30/10	**QIC CORRECTED 1st PARTIALLY FAVORABLE RECONSIDERATION DECISION**	Exh. 17 (2119-2227)
	QIC medical review panel documentation	Exh. 17 (1424-2112)
8/5/10	NGS letter to Appellant RE: response to FOIA Request dated 7/19/10, states NGS has no records responsive to Appellant's FOIA Request	Exh. 20 (2344)
8/11/10	Appellant letter to TrustSolutions with FOIA Request	Exh. 20 (2342-43)
8/11/10	Appellant letter to NGS with post-redetermination FOIA Request	Exh. 20 (2338-39)
8/11/10	Appellant letter to Maximus with post-redetermination FOIA Request	Exh. 20 (2336-37)
8/11/10	Appellant letter to CMS (JoAnn Passarelli) with FOIA Request	Exh. 20 (2340-41)

8/13/10	Appellant letter to Maximus with FOIA Request for QIC "complete audit file"	Exh. 20 (2334-35)
8/13/10	CMS letter to Appellant from Charla Jordan {FOIA Request Coordinator) RE: acknowledgment of receipt of FOIA Request dated 7/19/10; re CMS procedures and fees for responses to FOIA Requests; and re option to request expedited processing of FOIA Request for cause	Exh. 20 (2332-33)
8/19/10	Appellant Request for Expedited Processing of FOlA Request	Exh. 20 (2330-31)
9/3/10	QIC (Maddy Gruber) letters (two) to Appellant RE: transmittal of CD(s) with audit documentation	Exh. 20 (2412-13)

1st APPEAL to ALJ LEVEL
ALJ STEVEN STERNER
ALJ Appeal No.1-6662 72615

9/14/10	**Appellant's 1st Request for ALJ hearing filed** Cover letter dated 9/13/10 (appeal filed as of OMHA receipt) with the following tabbed enclosures: A. Appointment of Representative form executed on 3/2/10 B. Reconsideration decision dated 7/23/10 C. Appellant FOIA requests and responses thereto received as of 8/19/10	Exh. 20 (2330-2466)
9/14/10	Appellant letter to QIC RE: problems with 7 CDs from QIC, renewed request for PSC documentation as to statistical sampling and extrapolation	Exh. 21 (2470-71)

9/29/10	Appellant letter to QIC Attorney Gruber RE: request for complete file re statistical information in this appeal, including documents QIC cited in reconsideration decision that were not CDs previously provided by Maximus to Appellant (2406-08; per MAS numbering)	Exh. 22
10/6/10	QIC letter to Appellant RE: QIC cannot send information on CDs because file sent to OMHA	Exh. 22 (2472-73)
10/26/10	ALJ Notice of Hearing (set for 11/22/10)	Exh. 23
10/29/10	Appellant letter to OMHA (prior to learning ALJ name) RE: request for audit file documents re PSC methodology for statistical sampling and extrapolation (2402-04, per MAS numbering)	Exh. 24

11/1/10	ALJ staff transmittal (Master Exhibit List & list of beneficiaries) to Appellant	Exh. 25 (2489-98)
11/1/10	Appellant request to ALJ for hearing continuance in order to arrange for statistical experts	Exh. 26 (2501-04)
11/2/10	ALJ Order denying Appellant's request for continuance of hearing	Exh. 27 (2505-07)
11/4/10	ALJ staff transmittal of CD to Appellant	Exh. 28 (2508)
11/8/10	Dr. Haller draft or memo (4 pp.) re problems with PSC extrapolation	
11/9/10	ALJ staff transmittal of three CDs with Beneficiaries' medical records	Exh. 29
11/9/10	ALJ order: Appellant must submit list of services remaining at issue	Exh. 29 (2509-11)

11/12/10	Appellant submission in response to 11/9/10 ALJ Order, including - Pre-Hearing Position Paper (2651-62) - Statement of Harold S. Haller, PhD and Patricia Maykuth, PhD (42 pp. including 7 Appendices)	Exh. 30 (2512-2720)
11/15/10	Appellant fax transmittal to ALJ in response to ALJ Order RE: spreadsheet re claims at issue (2264-79, per MAS numbering)	Exh. 30
11/16/10	**ALJ STERNER ORDER OF REMAND TO QIC** for clarification of reconsideration decision	Exh. 31 (2721-33)
11/24/10	PSC letter to Appellant responding to 10/29/10 FOIA Request RE: transmittal of jump drive with information requested	Exh. 48

2nd QIC RECONSIDERATION LEVEL APPEAL
(QIC re-opened appeal after ALJ Sterner issued Order of Remand to QIC.)

QIC Case No. 1-7030 31941

12/30/10	**QIC 2nd PARTIALLY FAVORABLE RECONSIDERATION DECISION**	**Exh. 32 (2734-3053)**

2nd APPEAL at ALJ LEVEL
1st Iteration, prior to MAC remand to ALJ

ALJ JAMES S. O'LEARY
ALJ Appeal No.1-7378 70647

2/9/11	**2nd Request for ALJ hearing received/filed**	Exh. 33 (3054-2316)
2/14/11	Statement of Patricia Maykuth, PhD (37 pp.)	Exh. 38 (1091-96)

2/16/11	QIC letter to Appellant with password for encrypted file information and with QIC Case File Attestation dated 2/16/11	Exh. 34 (3217) Exh. 35 (3218)
2/23/11	ALJ Notice of Prehearing Conference (set for 4/7/11)	Exh. 36 (3219-22)
2/26/11	QIC memorandum and transmittal of CD to ALJ containing statistical information the PSC provided to the QIC	Exh. 35
3/8/11	Dr. Haller memorandum (1O pp.) RE: Case Review of Overpayment Extrapolation from TrustSolutions Audit	Exh. 38
3/8/11	Appellant Pre-Hearing Position Paper and re-submission of documents previously submitted to ALJ Sterner 11/12/10 (admitted as Exh. 30): -11/12/10 Position Paper -11/12/1O Statement from statistical experts	Exh. 37
3/23/11	ALJ Notice of Prehearing Conference (set for 5/25/11)	Exh. 39 (3243-45)

6/1/11	ALJ Notice of Hearing (set for 7/28/11)	Exh. 39 (3240-42)
6/1/11	ALJ Notice of Supplemental Hearing (set for 8/4/11)	Exh. 39 (3235-37)
7/28/11	**ALJ Hearing**	7/28/11 Hearing CD
9/26/11	Email from ALJ staff (Rebecca Corradi) to Appellant (cited in MAC Remand Order) RE: request that Appellant resend any/all materials related to Dr. Haller's statistical review (Document not in Exhibits, but cited In MAC Remand Order at page 11)	
10/18/11	**ALJ FAVORABLE DECISION**	Exh. 40

DEPARTMENTAL APPEALS BOARD (DAB)
MEDICARE APPEAL COUNCIL (MAC) LEVEL
Case No. M-12-388

12/14/11	AdQIC Q2A sent letters to Appellant and counsel RE: referral of 10/18/11 ALJ decision to DAB MAC "for possible review on the Council's own motion"	Exh. 41
12/16/11	CMS Referral for Own Motion Review by DAB/MAC (54 pp.)	Exh. 41
1/4/12	Appellant's Position Paper stating exceptions to CMS Referral	Exh. 42
2/8/12	**MAC ORDER REMANDING CASE TO ALJ**	Exh. 43

2nd APPEAL at ALJ LEVEL
2nd Iteration, after MAC remand to ALJ

ALJ JAMES S. O'LEARY
ALJ Appeal No. 1-9095 25621

4/12/12	ALJ Notice of Pre-Hearing Conference (set for 5/14/12) Cover letter with Agenda sent to Appellant's counsel, TrustSolutions, and NGS	Exh. 44
5/14/12	ALJ Pre-Hearing Conference	Pre-Hearing CD
5/17/12	ALJ Order re outcome of Pre-Hearing and clarifications as to appeal record	Exh. 44
5/17/12	ALJ Notice of Hearing (set for 5/29/12) sent to Appellant, Appellant's counsel, TrustSolutions, and Maximus	Exh. 44
5/29/12	ALJ Notice of Rescheduled Hearing (set for 6/7/12) sent to Appellant, Appellant's counsel, TrustSolutions, and Maximus	Exh. 44
6/6/12	Appellant Pre-Hearing Submission with cover	

	letter to ALJ Attachment 1: Appointment of Representative document, signed on 1/4/12 Enclosed documents include: - Statement of Dr. Haller dated 6/1/12, with appendices (Tab A) - Statement of Dr. Maykuth dated 6/1/12, with appendices (Tab B) - Appellant's Spreadsheet re claims at issue with citation to authorities (Tab C) (13 pp. Table in horizontal orientation)* - DAB MAC decision (6/22/10), reversing statistical extrapolation in unrelated case	
6/7/12	**ALJ Hearing**	6/7/12 Hearing CD

*This 13-page version of Appellant's line-by-line spreadsheet is the document cited in the Summary of Claims Analyses in this ALJ Decision. Earlier in the appeal process, the Appellant had submitted other versions of its line- by-line

spreadsheets listing claims at issue.

One spreadsheet (18 page table in vertical orientation) was submitted to Maximus on July 19, 2010 as Tab O in the Supplement to Request for Reconsideration. (Exh. 18, pages 2228-45) The Appellant submitted another version (14-page table in horizontal orientation) to ALJ Sterner by fax on November 15, 2010. (Exh. 30)

APPENDIX D

STATISTICAL INFORMATION TIMELINE

Transmittals to Appellant indicated by boldface italics, Appellant's statisticians' reports shown in boxes.

Date	Documents and transmittals
12/30/09	TrustSolutions letter to Appellant RE: Audit Findings Enclosed: 1st TS Statistical Sampling Worksheet Attributes: 2-page document with no date, no signature, no name of preparer
3/2/10	Appellant letter to PSC with FOIA Request for information
3/26/10	TrustSolutions letter to Appellant RE: recalculated overpayment amount

	Enclosed: **2nd TS Statistical Sampling Worksheet** Attributes: 2-page document dated 3/25/10, electronically signed by Sara Brielmaier and signed as approved by Eric Vasiloff. No indications of the signers' positions, employers, titles, or credentials appear on the document.
3/31/10	PSC letter to Appellant RE: response to 3/2/10 FOIA Request: RE: Records responsive to FOIA Request "not within [PSC] authority to release" and FOIA Request being forwarded this date to JoAnn Passarelli at CMS
5/11/10	**Statement of Dr. Maykuth for submission with Request for Reconsideration**
5/12/10	Appellant letter to JoAnn Passarelli at CMS with FOlA Request
7/12/10	PSC submitted CD to Maximus for reconsideration review in response to QIC's request
7/19/10	Appellant letter to NGS with FOIA Request

	Appellant letter to JoAnn Passarelli at CMS with FOIA Request
7/23/10	Report of review of statistical information by Maximus statistician The QIC decision issued on this date relied upon this report and quoted extensively from It, but Maximus did not identify its statistician or supply his report to the Appellant with the decision. Attributes: Teitelbaum Report (6 pp.) was submitted to Maximus on its 10-page "QIC Part A Statistical Review Form."
7/30/10	Maximus issued its corrected reconsideration decision. which also relied upon the Maximus statistician's report and quoted extensively from it. However, the QIC did not identify the statistician or supply Appellant with his report with this version of the reconsideration.
8/5/10	NGS letter to Appellant RE: response to FOIA Request dated 7119/10, states NGS has no records responsive to Appellant's FOIA Request
8/11/10	Appellant letter to TrustSolutions with FOIA Request
8/11/10	Appellant letter to NGS with post-

	redetermination FOIA Request
8/11/10	Appellant letter to Maximus with post-redetermination FOIA request
8/11/10	Appellant letter to CMS (JoAnn Passarelli) with FOIA Request
8/13/10	Appellant letter to Maximus with FOIA Request for QIC "comp1ete audit file"
8/13/10	CMS letter to Appellant from Charla Jordan (FOIA Request Coordinator, CMS Region 5) RE: acknowledge receipt of FOIA Request dated 7/19/1O; re CMS procedures and fees for responses to FOIA Requests, and re option to request expedited processing for cause
8/19/10	Appellant Request for Expedited Processing of FOIA Request submitted to CMS
9/3/10	*Maximus letters RE: transmittal of CDs with TrustSolutions audit files* Project Director Maddy Gruber
9/14/10	Appellant letter to Maximus Project Director Gruber RE: CD problems, request for all PSC documents re statistical sampling and extrapolation
9/29/10	Appellant letter to Maximus Project

	Director Gruber RE: request for complete file re statistical audit information in this appeal, including documents cited in reconsideration, which were not previously provided to Appellant
10/6/10	Maximus letter to Appellant lj RE: QIC cannot send information on CDs because file sent to OMHA
10/29/10	Appellant letter to OMHA (prior to learning ALJ name) RE: request for audit file re PSC methodology for statistical sampling and extrapolation
11/4/10	*ALJ Sterner staff transmittal of CD to Appellant*
11/9/101	*ALJ Sterner staff transmittal of three CDs with Beneficiaries' medical records*
11/8/10	Dr. Haller draft or memorandum to client and/or client's attorney (4 pp.) RE: problems with PSC extrapolation
11/12/10	Joint Statement of Dr. Haller and Dr. Maykuth
11/24/10	*PSC transmittal of jump drive with information requested* Letter to Appellant in response to FOIA Request dated 10/29/10

2/14/11	Statement of Dr. Maykuth
2/16/11	*QIC letter to Appellant with password for encrypted file information*
3/8/11	Dr. Haller memorandum (10 pp.) RE: Case Review of Overpayment Extrapolation from TrustSolutions Audit

* * *

APPENDIX E

Case: 17-2165 Document: 53-1 Filed: 12/06/2018

No. 17-2165

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

NEW VISION HOME HEALTH CARE ,INC.; SALEEM BIN SHAKOOR,	)	[Filed Dec. 06, 2018]
Plaintiffs-Appellants,	)	ORDER
v.	)	
ANTHEM, INC.; TRUSTSOLUTIONS, LLC; NATIONAL GOVERNMENT SERVICES, INC.,	)	
Defendants-Appellees.	)	

BEFORE: SUHRHEINRICH, MOORE, and BUSH, Circuit Judges.

The court received a petition for rehearing en banc. The original panel has reviewed the petition for rehearing and concludes that the issues raised in the petition were fully considered upon the original submission and decision of the case. The petition then

was circulated to the full court. No judge has requested a vote on the suggestion for rehearing en banc.

Therefore, the petition is denied.

ENTERED BY ORDER OF THE COURT

/s/
Deborah S. Hunt, Clerk

APPENDIX F

2:16-cv-13173-VAR-RSW Doc # 18 Filed 03/11/17

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF MICHIGAN SOUTHERN DIVISION

NEW VISION HOME HEALTH CARE, INC., etc., et al.,

Plaintiffs,

vs.

ANTHEM, INC., etc., et al.,

Defendants.

Case No.: 2:16-cv-13173-VAR-RSW
Hon. Victoria A. Roberts
Mag. Judge R. Steven Whalen

GEORGE F. INDEST III, J.D., M.P.A., LL.M.
CAROLE C. SCHRIEFER, R.N., J.D.
THE HEALTH LAW FIRM
1101 Douglas Avenue
Altamonte Springs, Florida 32714
Phone: (407) 331-6620
Fax: (407) 331-3030
E-mail: GIndest@TheHealthLawFirm.com
Second: CourtFilings@TheHealthLawFirm.com
Attorneys for Plaintiffs

SECOND AMENDED COMPLAINT

Plaintiffs New Vision Home Health Care, Inc., and Saleem Shakoor hereby file their Second Amended Complaint suing Defendants TrustSolutions, LLC (TrustSolutions), Anthem, Inc. (f/k/a WellPoint, Inc.), and National Government Services, Inc. (NGS), (collectively Defendants), referring back in time to the filing of their original Complaint, stating:

PARTIES AND JURISDICTION

1. At all relevant times hereto, Plaintiff New Vision Home Health Care, Inc. (New Vision), was a Michigan corporation with its principal place of business located in Southfield, Michigan.

2. At all relevant times hereto, Plaintiff Saleem Shakoor was an individual residing in the City of West Bloomfield, County of Oakland, Michigan. At all relevant times hereto Plaintiff Shakoor was and remains the owner, director, sole shareholder and successor in interest to New Vision. Plaintiff Shakoor's interests and Plaintiff New Vision's interests in this matter are one and the same.

3. Defendant TrustSolutions, LLC (TrustSolutions), is a foreign corporation incorporated in Wisconsin. It has its principal place of business located at 120 Monument Circle, Indianapolis, Indiana.

4. On information and belief, TrustSolutions, LLC, is a wholly owned subsidiary of Defendant Anthem, Inc. (f/k/a WellPoint, Inc.) (Anthem), and is completely controlled and operated by Anthem.

5. Anthem is a foreign corporation incorporated in Indiana with its principal place of business located at 120 Monument Circle, Indianapolis, Indiana.

6. On information and belief, at all relevant times, TrustSolutions is and was the alter ego of Anthem. Anthem used TrustSolutions as a mere instrumentality in its abuse of The Centers for Medicare & Medicaid Services' (CMS), Program Safeguard Contractor (PSC) program.

7. Furthermore, Anthem is the successor to TrustSolutions.

8. National Government Services, Inc. (NGS), is a foreign corporation incorporated in Indiana with its principal place of business located at 8115 Knue Road, Indianapolis, Indiana 46250. At all relevant times hereto, NGS was the Medicare Administrative Contractor (MAC) for the Medicare Program for the state of Michigan and for the Plaintiffs.

9. On information and belief, at all relevant times, NGS is and was a wholly owned subsidiary of Anthem, completely controlled and operated by

Anthem and was the alter ego of Anthem. Anthem used NGS as a mere instrumentality in its wrongful and unlawful acts as stated herein, including its abuse of the Medicare Appeals Process (MAP) and the Medicare Integrity Program (MIP), to increase Anthem's income.

10. Maximus Federal Services, Inc. (Maximus), is a Virginia corporation with its principal place of business at 1891 Metro Center Drive, Reston, Virginia 20190. At all relevant times hereto, Maximus was the Qualified Independent Contractor (QIC), pursuant to 42 U.S.C. § 1395ff(c), which was the CMS contractor responsible for the second level of appeal (the "request for reconsideration" or "reconsideration") in the Medicare Appeals Process. While Maximus is not a named party to this complaint, it was involved in the administrative proceedings below and discussed by the Administrative Law Judge (ALJ) in his Decision, Exhibit "1."

11. This Court has mandamus jurisdiction pursuant to 28 U.S.C. § 1361. The Court also has jurisdiction pursuant to 28 U.S.C. § 1332, by virtue of diversity of citizenship, and 28 U.S.C. § 1331, federal question jurisdiction. For those Counts seeking monetary damages, the amount in controversy exceeds $75,000 exclusive of costs, interest and attorney's fees. The Court has jurisdiction pursuant to 28 U.S.C. § 2201 for declaratory relief.

12. Venue is proper in the Eastern District of Michigan, in accordance with 28 U.S.C. §§ 1391(b)(2)

and 1391(e)(1)(B), because a substantial part of the events, acts and omissions of the Defendants giving rise to this action occurred in this judicial district and the harm to the Plaintiffs caused by the Defendants took place in this judicial district. Venue is also proper in this district, pursuant to 28 U.S.C. § 1391(e)(1)(C), because Plaintiffs reside in this district. In the alternative, venue is also proper in this district under 28 U.S.C. § 1391(b)(3) because the Defendants are each subject to the court's personal jurisdiction with respect to the Plaintiffs' claims in this district.

GENERAL ALLEGATIONS COMMON TO ALL COUNTS

A. Plaintiff New Vision

13. At all relevant times hereto, New Vision was a home health agency and provider of Medicare home health services within the meaning of 42 U.S.C. § 1395d(a), providing services paid for under Part A of the Medicare Program. New Vision furnishes home health services to homebound patients, among others.

14. New Vision was a Medicare participating provider. Virtually all of its patients were Medicare beneficiaries. Therefore, New Vision billed Medicare for payment for its services and relied almost exclusively on reimbursement from Medicare.

B. CMS and NGS

15. The Centers for Medicare and Medicaid

Services (CMS) is a division within the U.S. Department of Health and Human Services (HHS), a federal agency. It is responsible for the administration and operation of the Medicare program, including contracting with private business entities and insurance companies to assist in carrying out its functions.

16. At all relevant times hereto, NGS was the Medicare Administrative Contractor (MAC) for the State of Michigan, having been contracted by CMS to process Medicare claims.

17. After rendering services to Medicare beneficiaries, New Vision would submit its claims for payment under Medicare to NGS.

18. As a MAC, NGS was responsible for "[d]etermining the amount of payments to be made to providers for covered services furnished to Medicare beneficiaries" and "[m]aking the payments." 42 C.F.R. § 421.100(a).

19. At all relevant times in this matter, NGS held a contract with CMS pursuant to the Medicare Integrity Program. 42 U.S.C. § 1395ddd.

C. TrustSolutions and Anthem

20. At all relevant times, TrustSolutions was

a Medicare Program Safeguard Contractor ("PSC").[1] In this role it contracted with CMS to perform program integrity functions such as detecting and deterring potential waste, fraud and abuse in the Medicare program.

21. At all relevant times in this matter, TrustSolutions held a contract with CMS pursuant to the Medicare Integrity Program. 42 U.S.C. § 1395ddd.

22. On information and belief, Anthem is the largest for-profit managed health care company in the Blue Cross Blue Shield Association.

23. Anthem acquired WellPoint Health Networks, Inc., with the combined company adopting the name WellPoint, Inc., on November 30, 2004. Effective December 2, 2014, WellPoint changed its corporate name to Anthem, Inc.

24. On information and belief, during the time period in which New Vision's claims arise, Anthem used TrustSolutions for its own benefit as a mere instrumentality.

---

[1] In 2012 the name used for Program Safeguard Contractors was changed to Zone Program Integrity Contractors (ZPICs). At all times relevant hereto TrustSolutions was the PSC or ZPIC acting against the Plaintiffs. The purpose of the PSC or ZPIC is to detect and recover for fraudulent claims billed to Medicare. They are financially rewarded by CMS based on the amount of allegedly fraudulent claims they identify. *See* n. 8, *infra*.

25. In doing so, Anthem failed to observe corporate formalities such that there was no distinction between the two entities due to Anthem's control over TrustSolutions' execution of its day-to-day operations.

26. On information and belief, Anthem exercised direct control over the management, directors, and officers of TrustSolutions to advance its own interests and policies.

27. TrustSolutions functioned as the alter ego of Anthem for purposes of pursuing Anthem's unlawful objectives through the PSC program.

28. All profits and benefits obtained by TrustSolutions through its actions as stated herein actually accrued to and were retained by Anthem.

29. Anthem was an interested party in the Plaintiffs' case having a substantial financial interest in the outcome, along with TrustSolutions, in violation of the independence standards required by 42 U.S.C. §§ 1395ff(g)(2) and (5), at all times that New Vision was being reviewed by TrustSolutions.

30. Anthem was an interested party in the Plaintiffs' case, having a substantial financial interest in the outcome, along with NGS, in violation of the independence standards required by 42 U.S.C. §§ 1395ff(g)(2) and (5), at all times that New Vision was being reviewed by NGS.

D. The Medicare Appeals Process

31. **First Step.** If a claim submitted by a Medicare provider is denied (in whole or in part), the Medicare provider may appeal the denial to the Medicare Administrative Contractor (MAC) (in this case, for New Vision it was NGS). The first appeal is called a "request for redetermination." The request for redetermination is submitted to the MAC that originally denied the claim or demanded the refund of the alleged overpayment amount.

32. **Second Step.** If a claim is denied (in whole or in part) by the MAC upon its redetermination, the Medicare provider may then appeal the decision to a Qualified Independent Contractor (QIC) (in this case, for New Vision it was Maximus), which is supposed to be a separate, independent entity contracted by CMS for that purpose. This second appeal is called a "request for reconsideration."

33. **Third Step**. If the claim is denied (in whole or in part) by the QIC upon the reconsideration, the Medicare provider may then appeal the decision further by requesting a formal administrative hearing before an administrative law judge (ALJ) of the U.S. Department of Health and Human Services' (HHS) Office of Medicare Hearings and Appeals (OMHA).[2]

---

[2] Because of the numerous abbreviations and acronyms for the different organizations and processes involved in this complex matter, many of which change over time and some of which are the same as others (e.g., "MAC"

The ALJ's decision is final unless any party requests further review by the Medicare Appeals Council within sixty (60) days. 42 C.F.R. § 405.1048.

34. **Fourth Step**. If any party to the ALJ hearing is dissatisfied with the decision of the ALJ that is issued after the hearing, then that party may appeal the case to the Medicare Appeals Council within sixty (60) days. After this period of time has passed with no appeal, the ALJ's decision becomes final. 42 C.F.R. § 405.1048. An organization called the Departmental Appeals Board (or DAB) manages and acts for the Medicare Appeals Council.

35. **Fifth Step**. Review by the federal district court.[3]

E. New Vision's Audits and Appeals

---

for "Medicare Administrative Contractor" and "MAC" for Medicare Appeals Council), Plaintiff will attempt to limit use of such abbreviations in favor of the full names.

[3] See 42 U.S.C. § 1395ff and 42 C.F.R. §§ 405.900 to 405.1140. See generally *PrimeSource Healthcare of Ohio, Inc. v. Sebelius*, 2014 U.S. Dist. LEXIS 93293, 2014 WL 3368194 (N.D. Ill. Jul. 9, 2014). However, in this case, since there was no appeal to the Medicare Appeals Council after the ALJ Decision of September 4, 2013, the last step actually exercised in the administrative appeal process at issue herein was the ALJ hearing, for which the resulting decision was favorable to the Plaintiffs and was not further appealed. It is Exhibit "1" to this Second Amended Complaint.

36. On July 31, 2007, TrustSolutions initiated a post-payment review or audit for New Vision's Medicare claims for dates of service from May 8, 2003, through October 3, 2006. These were claims paid by NGS from January 1, 2004 to December 10, 2006. Exhibit "1."[4]

37. There were claims for 228 episodes of home health care provided to 186 Medicare beneficiaries in this audit. (Exhibit "1," pp. 2-3 & 271-273.)

38. On August 14, 2008, TrustSolutions denied approximately ninety percent (90%) of the claims reviewed (which had previously been paid). (Exhibit "1," pg. 3.) It found that New Vision had received a total of $672,493.57 in actual overpayments for only those claims in the audit sample it reviewed.

39. TrustSolutions then used a statistical extrapolation formula to calculate an estimated total overpayment by Medicare to New Vision of $4,155,239.00, during the period covered by the audit (May 8, 2003, through December 10, 2006). (Exhibit "1," pp. 4 & 20).

---

[4] The Decision of U.S. Administrative Law Judge James S. O'Leary, dated September 4, 2013, in HHS Office of Medicare Hearings and Appeals, Case No. 1-909525621, is attached with certain patient information redacted from it so as to protect privacy of the Medicare beneficiaries. The redacted information is not directly relevant to this litigation.

40. New Vision timely appealed the denied claims through the Medicare Appeals Process, ultimately having the decision reversed for more than ninety-nine percent (99%) of the denied claims.

41. However, in October 2010, while New Vision was still in the Medicare Appeals Process, NGS began recoupment on the alleged overpayment of $4,155,239.00 from New Vision.

42. From October 2010 through the present time, NGS has not paid any claims, including back claims, or refunded any amount owed by Medicare to New Vision.

43. New Vision timely and properly utilized the Medicare Appeals Process. New Vision eventually obtained the current Administrative Law Judge Decision in its favor on September 4, 2013, thus completely exhausting its administrative remedies. Exhibit "1."[5]

---

[5] The procedural history of these claims through the Medicare Appeals Process is extremely complex and convoluted. It involved multiple appeals, remands and ALJ hearings. The original ALJ decision dated October 18, 2011, favorable to New Vision, was appealed to the Medicare Appeals Council (note: the Departmental Appeals Board or "DAB" operates the Medicare Appeals Council or MAC) by the Administrative Qualified Independent Contractor. (Exhibit "1," pg. 12.) The Medicare Appeals Council/DAB remanded the case to the ALJ for a new hearing. (Exhibit "1," pg. 12.) The ALJ held another hearing and issued the decision for which enforcement is being sought herein on September 4, 2013, finding that more than ninety-nine percent

F. The Administrative Law Judge's Decision of September 4, 2013

44. In the present case, New Vision went through every step in the Medicare Appeals Process. It received an ALJ decision that was in its favor on ninety-nine percent (99%) of the denied claims it appealed to the ALJ. Exhibit "1."

45. In the decision dated September 4, 2013, Exhibit "1," Administrative Law Judge James S. O'Leary overturned TrustSolutions' statistical sampling as invalid. (Exhibit "1," pp. 14, 268, 294-299, 300-305).

46. The ALJ's decision was entered on September 4, 2013. Exhibit "1." The ALJ's Decision was not appealed to the Medicare Appeals Council. Therefore, on November 3, 2013, the ALJ's decision, Exhibit "1," became final. 42 C.F.R. § 405.1048;[6] Medicare Claims Processing Manual, Ch. 29, § 340.[7]

(99%) of the denied claims were valid and ordering the contractors to pay all of New Vision's claims that had been denied or recouped. No party requested further review of the ALJ Decision of September 4, 2013. Thus it became final on November 3, 2013. 42 C.F.R. § 405.1048. A detailed chronology of the case is provided by the ALJ as Appendix C to Exhibit "1."

[6] *See also*, CMS, Medicare Financial Management Manual, CMS Pub. 100-06, Ch. 3.

[7] CMS, Medicare Claims Processing Manual, CMS Pub. 100-04, Ch. 29, § 340.

47. The final paragraph of Judge James S. O'Leary's Decision states in part:

ORDER

> The Medicare contractors [sic] are hereby **DIRECTED** [sic] to process the claims and claim lines at issue in accordance with this decision. Any amounts recouped or otherwise recovered from the Provider [New Vision] based upon the invalid overpayment demands herein shall be returned to the [a]ppellant.

Exhibit "1," pg. 305 (emphasis in original).

48. The ALJ's Decision was forwarded by the Administrative Qualified Independent Contractor (AdQIC) to both NGS and CMS for compliance with it as shown by subsequent correspondence between NGS, CMS and the Plaintiffs.

49. As of the date of this Second Amended Complaint, none of the Defendant contractors nor CMS has complied with the ALJ's Decision of September 4, 2013, Exhibit "1."

50. As of the date of this Second Amended Complaint, the Defendants continue to not pay claims submitted by Plaintiffs claiming they are recouping funds overpaid.

51. As of the date of this Second Amended

Complaint, none of the Defendant contractors nor CMS has repaid New Vision the amount of the wrongfully denied claims as calculated by the ALJ in his Decision of September 4, 2013 (Exhibit "1," pp. 4 & 305.)

52. As of the date of this Second Amended Complaint, none of the payments or recouped amounts that were the subject of the ALJ hearing have been refunded to Plaintiffs by Defendants.

G. ALJ's Findings Incorporated Herein

53. The ALJ's Decision of September 4, 2013, Exhibit "1" and all of its findings and conclusions are adopted herein by reference. The chronology attached to the ALJ's Decision, Appendix C of Exhibit "1," is incorporated herein and provides a more detailed factual basis giving the background of this matter.

54. As stated in 42 C.F.R. § 405.1048, "the decision of the ALJ is binding on all parties. . . ."

H. Conditions Precedent Satisfied

55. All conditions precedent to bringing this litigation have been fulfilled, complied with or waived.

56. Plaintiffs have fully and completely exhausted all administrative remedies connected with their allegations made herein, including but not limited to, fully completing all steps required of them in the Medicare Appeals Process.

57. No exception stated in 42 C.F.R. § 405.1048 applies in this case.

58. Furthermore, Plaintiffs have no other remedy available to them to obtain relief in this matter, other than as stated herein.

I. Entitlement to Interest, Attorney's Fees and Costs

59. Plaintiffs are entitled to interest on all claims amounts owed to it as calculated in the ALJ's Decision, pursuant to 42 U.S.C. § 1395g(d); the Medicare Financial Management Manual, Pub. 100-06, Ch. 3; and the Medicare Claims Processing Manual, Ch. 29, § 330.6. Id.

60. Plaintiffs are entitled to their attorney's fees, costs and expenses pursuant to 28 U.S.C. § 2412(a)(1) and 5 U.S.C. § 504.

COUNT I
PETITION FOR WRIT OF MANDAMUS FOR ENFORCEMENT OF ALJ'S DECISION OF SEPTEMBER 4, 2013
(Contractors Within Course and Scope)

61. This is a cause of action for a writ of mandamus by the Plaintiffs against all three (3) Defendants to enforce the Administrative Law Judge's Decision of September 4, 2013, Exhibit "1."

62. This Count is pleaded in the alternative

to and in addition to all other Counts in this Complaint.

63. Paragraphs 1 through 60 above are incorporated herein by reference.

64. Both Plaintiffs have an interest that is required to be protected by the action requested herein.

65. For purposes of this Count and this Count alone, Plaintiffs allege that at all times relevant hereto, the Defendants were acting lawfully and within the course and scope of their duties as contractors and agents of the government, notwithstanding the findings in the ALJ's Decision.

66. For purposes of this Count and this Count alone, Plaintiffs allege that at all times relevant hereto, the Defendants were carrying out the terms of their contracts and were exercising due care, notwithstanding the findings in the ALJ's Decision.

67. As of this date, the Defendants have failed to comply with the ALJ's Decision.

68. Furthermore, since October 2010, pursuant to the instructions of Defendant TrustSolutions, Defendant NGS has paid none of the claims submitted for payment by the Plaintiffs and has continued to illegally recoup the $4,155,239.00 alleged overpayment (that was reversed by the ALJ) from the money it owes Plaintiffs, despite a statutory obligation

to do so.

69. This Court has mandamus jurisdiction to enforce such decisions under 28 U.S.C. § 1361. *Farkas v. Blue Cross Blue Shield of Mich.*, 24 F.3d 853 (6th Cir. 1994); *PrimeSource Healthcare of Ohio, Inc. v. Sebelius*, 2014 U.S. Dist. LEXIS 93293, 2014 WL 3368194 (N.D. Ill. Jul. 9, 2014).

70. Plaintiffs have a clear legally and judicially protected right to the relief sought from the Defendants.

71. The Defendants owe the Plaintiffs performance of the legal duty sought to be compelled that is so plainly prescribed as to be free from doubt.

72. The Defendants have a clear legal duty to perform.

73. At this point, the act for which mandamus is sought is a specific, plain ministerial act devoid of exercise of judgment or discretion.

74. The duty owed by the Defendants to the Plaintiffs is mandatory and not discretionary.

75. Plaintiffs have no other adequate legal or equitable remedy available to obtain relief.

WHEREFORE, for the purposes of this Count, Plaintiffs request the Court:

A. Issue a writ of mandamus against the Defendants ordering their immediate compliance with the Administrative Law Judge's decision of September 4, 2013, Exhibit "1."

B. Alternatively, the Defendants should be required to take whatever action may be necessary in their role as government contractors to have the government make all payments that are due to the Plaintiffs pursuant to the Administrative Law Judge's decision of September 4, 2013.

C. In addition, Plaintiffs request the Court to include an assessment of interest, attorney's fees, costs and expenses against the Defendants in accordance with the authority cited in paragraphs 54 and 55 above from October 2010 until paid in full.

COUNT II
PETITION FOR WRIT OF MANDAMUS FOR ENFORCEMENT OF ALJ'S DECISION OF SEPTEMBER 4, 2013
(Contractors Outside of Course and Scope and Failed to Exercise Due Care)

76. This is a cause of action for a writ of mandamus by the Plaintiffs against all three (3) Defendants to enforce the Administrative Law Judge's

decision of September 4, 2013, Exhibit "1."

77. This Count is pleaded in the alternative to and in addition to all other Counts in this Complaint.

78. Paragraphs 1 through 60 above are incorporated herein by reference.

79. Plaintiffs have an interest that is required to be protected by the action requested herein.

80. For purposes of this Count Plaintiffs allege that at all times relevant hereto the Defendants were acting outside the course and scope of their duties as contractors and agents of the government and without due care.

81. For purposes of this Count Plaintiffs allege that at all times relevant hereto the Defendants violated the terms of their contracts with the government and failed to exercise due care in the performance of their duties.

82. Plaintiffs further incorporate the allegations made in paragraphs 67 through 75 above.

WHEREFORE, for the purposes of this Count, Plaintiffs request the Court:

A. Issue a writ of mandamus against the Defendants ordering their immediate

compliance with the Administrative Law Judge's decision of September 4, 2013, Exhibit "1."

B. Alternatively, the Court should find the Defendants liable in accordance with the ALJ's determination of the amounts wrongfully withheld from the Plaintiffs jointly, severally and individually.

C. In addition, Plaintiffs request the Court to include an assessment of interest, attorney's fees, costs and expenses against the Defendants in accordance with the authority cited in paragraphs 54 and 55 above from October 2010 until paid in full.

COUNT III
NEGLIGENCE
(Against All Defendants)

83. This is a cause of action for damages for the negligence of all three (3) Defendants, arising under Michigan law, within the jurisdiction of this Court.

84. This Count is pleaded in the alternative to and in addition to all other Counts in this Complaint.

85. Paragraphs 1 through 60 above are incorporated herein by reference.

86. At all times relevant hereto Defendants were acting outside the course and scope of their contracts with CMS, were not acting with due care, and were knowingly violating applicable laws and regulations.

87. Plaintiffs presented the claims stated in this Count to the relevant government agency and to the Defendants named herein and such claims were administratively litigated to finality as shown, in part by Exhibit "1." Plaintiffs have exhausted their administrative remedies for the claims stated in this Count.

88. Alternatively, it is alleged that the wrongful actions taken by the Defendants as stated herein and the claims made by the Plaintiffs in this Count did not arise under the Medicare Act, 42 U.S.C. § 1395, et seq.

A. Hidden Purpose Motivating Defendants' Actions; Bonuses Paid to Contractors for Denied Claims; and Conflicts of Interest

89. At all times relevant hereto, PSC/ZPIC contractors such as TrustSolutions received an incentive bonus (or "awards payment") based on the amount of claims of Medicare providers it determined to be false, fraudulent or otherwise overpayments.[8]

---

[8] See Wheeler, et al., "Meet the Fraud Busters: Program Safeguard Contractors and Zone Program Integrity Contractors,"

90. During the period at issue, TrustSolutions working with NGS, routinely improperly denied 100% of the Medicare claims that had been paid to home health providers to increase its overpayment rates for the purpose of receiving awards payments (incentive bonuses) from CMS.

91. On information and belief, at all relevant times hereto Anthem promulgated and advanced a corporate policy of using its Program Safeguard Contractor subsidiaries, such as TrustSolutions, to audit New Vision in violation of Medicare policies and procedures.

92. Anthem's intent in doing this was to artificially increase the alleged overpayments it identified as having been paid to Medicare providers, including the Plaintiffs, so as to maintain and gain additional contracts with CMS. Such contracts included those for Recovery Audit Contractors (RACs) and Zone Program Integrity Contractors (ZPICs).

93. Anthem did this to wrongfully increase its

---

4 J. Health & Life Sci. L. 1 at 5, No. 2, (Feb 2011); and U.S. GAO, "Medicare Program Integrity: Contractors Reported Generating Savings, but CMS Could Improve its Oversight," (Oct. 2013) (GAO-14-111), at 12-13, which reports, in part: "Each ZPIC contract includes award fee provisions, which give contractors the opportunity to earn all or some of the award fee. . . . CMS paid the six operating ZPICs . . . in calendar year 2012 . . .about $1.3 million in award fees for <u>each</u> ZPIC's most recent contract year evaluation. . . . [Emphasis added.]

profits, since ZPICs, RACs and PSCs receive contingent bonuses based on their recoveries of overpayments from Medicare providers such as New Vision, which would then accrue to Anthem, their owner. Fees paid by CMS to its contractors, including TrustSolutions and NGS, accrued to their owner, Anthem.

94. Additionally, by owning both the Medicare Administrative Contractor (MAC), NGS, and the Zone Program Integrity Contractor (ZPIC), TrustSolutions, two organizations which should have been independent of each other and both of which had jurisdiction over New Vision, Anthem created a conflict of interest by its common ownership and control.

95. The foregoing constitutes a hidden purpose and an improper motive for the actions taken by the Defendants.

B. Failure to Act with Due Care; Lack of Immunity

96. For purposes of this Count, Plaintiffs allege that at all times relevant hereto, the Defendants were acting outside of the course and scope of their duties as contractors and agents of the government and were acting unlawfully, in direct violation of federal laws, federal regulations, and mandatory Medicare procedures and guidelines.

97. The Defendants did not exercise due care, failed to comply with CMS guidelines in its relations with New Vision, and did not follow CMS directives

from the Medicare Program Integrity Manual. Thus the Defendants, by federal law, are not entitled to immunity for the wrongs alleged in this Count.

98. Defendants are not immune from liability for the cause of action stated in this Count. 42 U.S.C. §§ 1395ddd(e) & 1320c-6(b); & 42 C.F.R. § 421.316(a).[9]

---

[9] The federal statute which created the Medicare Integrity Program (MIP) states at 42 U.S.C. § 1395ddd(e):

> **(e) Limitation on contractor liability.**
> The Secretary [of the Department of Health and Human Services] shall by regulation provide for the limitation of a contractor's liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1320c–6 of this title.

42 U.S.C. § 1320c-6 states:

> **(b) Employees and fiduciaries of organizations having contracts with Secretary.**
> No organization having a contract with the Secretary under this part and no person who is employed by, or who has a fiduciary relationship with, any such organization or who furnishes professional services to such organization, shall be held by reason of the performance of any duty, function, or activity required or authorized pursuant to this part or to a valid contract entered into under this part, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political

> subdivision thereof) **provided due care was exercised in the performance of such duty, function, or activity**. [Emphasis added.]

It should be noted that in establishing the immunity provisions contained in the Medicare Integrity Program regulations, the Centers for Medicare and Medicaid Services, Department of Health and Human Services, stated at 72 Fed. Reg. 48869, 48878 (Aug. 24, 2007):

> In drafting §421.316(a), we considered employing a standard for the limitation of liability other than the due care standard. For example, we considered whether it would be appropriate to provide that a contractor would not be criminally or civilly liable by reason of the performance of any duty, function, or activity under its contract provided the contractor was not grossly negligent in that performance. However, section 1893(e) of the Act requires that we employ the same or comparable standards and provisions as are contained in section 1157 of the Act. **We do not believe that it would be appropriate to expand the scope of immunity to a standard of gross negligence, as it would not be a comparable standard to that set forth in section 1157(b) of the Act.** [Emphasis added.]

CMS went on to further clarify this stating at 72 Fed Reg. 48869, 48879 (Aug. 24, 2007):

> . . . We believe that the due care standard specified in §421.316(a) is the only standard consistent with the statutory mandate of the Act. Section 1893(e) of the Act requires us to limit a contractor's liability by employing the same or comparable standards that are set forth in section

C. Concert of Action

99. The three (3) Defendants each acted in concert with each other and pursuant to a common design.

100. Defendants each aided and abetted the other in carrying out the activities stated herein.

101. Defendants each were engaged in tortious conduct.

102. Defendants are each liable for all of the tortious, wrongful conduct alleged herein and are each liable for the damages set forth herein.

D. Negligence Acts and Omissions

103. Defendants committed a number of negligent and wrongful acts and omissions and failed to exercise due care as set forth herein.

1157 of the Act. Section 1157 of the Act limits a contractor's liability under a due care standard. We believe that applying this standard to MIP contractors strikes a reasonable balance between the concerns of the contractors and those subject to the contractors' review. We believe MIP contractors operate with due care to avoid liability, and **those being reviewed [e.g., Plaintiffs in this case] have the assurance that they have legal recourse if a contractor acts negligently.** [Emphasis added.]

104. Defendants violated a number of federal statutes and regulations as set forth herein, including but not limited to:

a. Defendants committed wrongful acts in initiating the post-payment audit and statistically extrapolating the audit findings given the nearly fully favorable pre-payment review results in favor of New Vision and that there was not a sustained or high level of payment error or showing that documented educational intervention failed to correct the payment error, in violation of 42 U.S.C. § 1395ddd(f)(3).

b. Defendants committed wrongful acts by failing to comply with the Medicare Program Integrity Manual and Medicare Financial Management Manual, both having the force of regulations.

c. Defendants' post-payment audit, statistical extrapolation and review on appeal were undertaken in violation of the Social Security Act, federal regulations and controlling CMS guidelines, as stated above.

d. Violating 42 U.S.C. §1395ddd(f)(7) (Title XVIII §1893(f)(7) of the Social Security Act or the "Act"), which requires Medicare contractors to provide a supplier or provider audited through a post-payment audit with written notice of the contractor's intent to conduct an audit and to present a full review and explanation of the findings of the audit upon its

completion.

e. Violating 42 U.S.C. § 1395ddd(f)(3) (§1893(f)(3) of the Act), which prohibits use of extrapolation to determine overpayment amounts unless the Secretary determines that "(A) there is a sustained or high level of payment error; or (B) documented educational intervention has failed to correct the payment error." *Id.*

f. Violating the Medicare Financial Management Manual, which requires Medicare audits to comply with Government Auditing Standards. (CMS, Medicare Financial Management Manual, CMS Pub. 100-06, Ch. 8, § 80.)

g. Violating the Medicare Program Integrity Manual[10] provides mandatory directives Medicare contractors must follow when conducting post-payment audits and statistical sampling and extrapolation. (CMS, Medicare Program Integrity Manual, Ch. 3.)

h. Violating 42 U.S.C. §§ 1395ddd(f) & (7) (§§ 1893(f)(3) and (7) of the Act) by failing to comply with CMS guidelines in initiating and conducting the post-payment audit and statistical extrapolation of New Vision's billed services.

---

[10] CMS, Medicare Program Integrity Manual, SMS Pub. 100-08,

i. Additionally, Anthem and TrustSolutions violated the independence standards required by 42 U.S.C. §§ 1395ff(g)(2) and (5), at all times that New Vision was being reviewed by TrustSolutions, because Anthem was an interested party in the Plaintiffs' case having a substantial financial interest in the outcome, along with TrustSolutions.

105. Under Michigan law, the violation of statutes or regulations give rise to a presumption of negligence on the part of the Defendants.

106. Additionally, Defendants, in their reviews and audits, failed to comply with generally accepted government auditing standards and generally accepted statistical practice and procedures, as set forth in greater detail above and in the ALJ Decision attached as Exhibit "1".

107. Defendants had a duty or duties to the Plaintiffs as set forth, in part, in the statutes and regulations governing the Medicare Program and the Medicare Appeals Process (MAP).

108. Defendants breached their duty or duties to the Plaintiffs in one or more ways as set forth herein.

109. Plaintiffs were harmed as a direct result of their breaches.

E. New Vision's Growth and Business and Its Decline

110. New Vision became an enrolled Medicare provider of home health services with CMS in February of 2002.

111. As a result of its hard work and provision of quality services, New Vision flourished and grew as a home health provider.

112. New Vision grew from one (1) office in 2002 to three (3) offices in 2006, because of its reputation and quality of services.

113. New Vision had an average of approximately 150 to 170 active Medicare patients in 2006.

114. New Vision's income grew to approximately $3,000,000 by 2006.

F. Plaintiffs' Damages

115. As of 2010, New Vision had fewer than 50 referring providers, which exists through this date.

116. As a result of the post-payment audit, in or about December 2010, New Vision had terminated nearly all of its employees as it no longer had the financial ability to maintain payroll, New Vision had lost nearly all of its patients and customers, and New Vision had lost the overwhelming majority of its

referring providers.

117. In or about 2011, New Vision lost the majority of its patients so that it had only seven (7) active patients. As of this date, New Vision has had to close all of its offices except for the one (1) office it has remaining.

118. In 2013, New Vision's annual income had dropped to $2,604.46. Its income for the years from 2014 through the present has been similar or less.

119. Physicians and hospitals ceased referring patients to New Vision.

120. As a direct result of the Defendants' acts as set forth in this Count, Plaintiffs suffered the following noninclusive damages:

a. Closure of offices;

b. Loss of referral sources;

c. Loss of its patients and clients;

d. Loss past of income and profit;

e. Loss of their professional reputation;

f. Loss of future income and profits; and

g. Loss of opportunities for growth and expansion.

121. Plaintiffs estimate that they have lost in excess of $20,000,000.00 in past and future lost business profits alone.

122. As a result of Defendants' wrongful acts, New Vision lost essentially all of its business, suffered in excess of $20,000,000.00 in lost business profits and incurred over $400,000.00 in legal and expert fees challenging the wrongful post-payment audit findings.

123. Defendants' wrongful and improper actions as stated above directly caused or resulted in Plaintiffs' damages as set forth in detail in Paragraphs115 through 122 above, incorporated herein by reference.

WHEREFORE, for the purposes of this Count, Plaintiffs request the Court enter judgment in their favor against the Defendants, jointly, severally and in individually for:

A. Pre-judgment interest on all liquidated amounts.

B. Monetary damages for all past and future losses.

C. Their attorney's fees and costs.

D. Post-judgment interest.

E. Any other relief the Court finds to be fair and equitable.

COUNT IV
GROSS NEGLIGENCE

124. This is a cause of action for damages for gross negligence against all three (3) Defendants for violating statutes and regulations, arising under Michigan law, within the jurisdiction of this Court.

125. This Count is pleaded in the alternative to and in addition to all other Counts in this Complaint.

126. Paragraphs 1 through 60 and 89 through 113 above are incorporated herein by reference.

127. At all times relevant hereto Defendants were acting outside the course and scope of their contracts with CMS, were not acting with due care, and were knowingly violating applicable laws and regulations.

128. Plaintiffs presented the claims stated in this Count to the relevant government agency and to the Defendants named herein and such claims were administratively litigated to finality as shown, in part by Exhibit "1." Plaintiffs have exhausted their administrative remedies for the claims stated in this Count.

129. Alternatively, it is alleged that the wrongful actions taken by the Defendants as stated herein and the claims made by the Plaintiffs in this Count did not arise under the Medicare Act, 42 U.S.C. § 1395, et seq.

130. Defendants committed willful and wrongful misconduct in their actions as set forth herein.

131. In addition to other actions, Defendants initiated a post-payment review on the Plaintiffs for claims previously submitted and paid from 2004 to 2006. Defendants then applied a statistical extrapolation formula to their review findings, despite the requirements not being met to do so, in violation of 42 U.S.C. § 1395ddd(f)(3) (§1893(f)(3) of the Act).

132. Defendants were also willful and wanton in initiating the post-payment review of the Plaintiffs claims, when the requirements for this were not met.

133. Defendants had a duty or duties to the Plaintiffs as set forth, in part, in the statutes and regulations governing the Medicare Program and the Medicare Appeals Process.

134. Defendants willfully and wantonly breached their duty or duties to the Plaintiffs in one or more ways as set forth herein.

135. Plaintiffs were harmed as a direct result of their breaches.

136. Defendants' wrongful and improper actions as stated above directly caused or resulted in Plaintiffs' damages as set forth in detail in Paragraphs 115 through 122 above, incorporated herein by reference.

WHEREFORE, for the purposes of this Count, Plaintiffs request the Court enter judgment in their favor against the Defendants, jointly, severally and in individually for:

A. Pre-judgment interest on all liquidated amounts.

B. Monetary damages for all past and future losses.

C. Their attorney's fees and costs.

D. Post-judgment interest.

E. Any other relief the Court finds to be fair and equitable.

COUNT V
TORTIOUS INTERFERENCE WITH BUSINESS RELATIONSHIPS AND EXPECTANCIES
(Against All Defendants)

137. This is a cause of action for tortious interference with business relationships and expectancies, arising under Michigan law, for

monetary damages within the jurisdiction of this Court, by the Plaintiffs against all three (3) Defendants.

138. This Count is pleaded in the alternative to and in addition to all other Counts in this Complaint.

139. Paragraphs 1 through 60 and 89 through 113 above are incorporated herein by reference.

140. At all times relevant hereto Defendants were acting outside the course and scope of their contracts with CMS, were not acting with due care, and were knowingly violating applicable laws and regulations.

141. Plaintiffs presented the claims stated in this Count to the relevant government agency and to the Defendants named herein and such claims were administratively litigated to finality as shown, in part by Exhibit "1." Plaintiffs have exhausted their administrative remedies for the claims stated in this Count.

142. Alternatively, it is alleged that the wrongful actions taken by the Defendants as stated herein and the claims made by the Plaintiffs in this Count did not arise under the Medicare Act, 42 U.S.C. § 1395, et seq.

143. New Vision had profitable business relationships with third parties.

144. New Vision also had the expectancy of additional profitable business relationships with third parties.

145. The third parties referred to above include, but were not limited to:

a. Its clients and patients;

b. Physicians who referred patients to New Vision for services and wrote orders (or prescriptions) for its services;

c. Hospitals and health systems, including but not limited to, Detroit Medical Center, Beaumont, Henry Ford, Hurley, McLaren;

d. Assisted living facilities and skilled nursing facilities which referred patients/clients to New Vision.

146. New Vision had a robust network of referring providers including physicians and physician groups and discharge planners in hospitals and other health facilities.

147. In 2006, during the time of the pre-payment review, New Vision had established business relationships with over 150 referring providers.

148. The Defendants had actual knowledge of the business relationships and expectations stated above.

149. All of New Vision's business came through its business relationships stated above.

150. By virtue of TrustSolutions's and NGS's roles as Medicare Integrity Program (MIP) contractors, Defendants were aware that New Vision had a relationship and continued business expectancy with CMS as an enrolled provider of Medicare services. Additionally, by virtue of TrustSolutions's and NGS's roles as MIP contractors, Defendants were aware of New Vision's relationship and continued business expectancy with its Medicare patients and extensive network of referring providers.

151. Despite their knowledge of these relationships and business expectancies, Defendants knowingly, intentionally and improperly interfered with these relationships and business expectancies, inducing and causing a disruption and termination in these relationships and business expectancies.

152. Acts by the Defendants included, but are not limited to:

a. "Fraud Investigators" from TrustSolutions sought out existing patients of Plaintiffs and informed them that New Vision had committed Medicare fraud. This alarmed and disturbed these patients who then obtained services

elsewhere.[11]

b. "Fraud Investigators" from TrustSolutions went to physicians offices who were existing referral sources for New Vision and informed physicians and their employees that New Vision had committed Medicare fraud. This caused those physicians and physician groups to stop referring patients to New Vision.

c. "Fraud Investigators" from TrustSolutions went to healthcare facilities that referred patients to New Vision and informed their employees that New Vision had committed Medicare fraud. This caused those facilities to stop referring patients to New Vision.

d. One of TrustSolutions' managers, B.S., while speaking with the Director of Nursing of New Vision, T.W., its employee, told the Director of Nursing in a number of different telephone conferences from March through August 2007, that New Vision had committed Medicare fraud and "We are shutting you down." This upset that employee, caused panic among New Vision's employees, and employees left

---

[11] *See*, for example, GAO, Medicare Program Integrity: Contractors Reported Generated Savings, but CMS Could Improve Oversight (Oct. 23, 2013), available at http://www.gao.gov/assets/660/658565.pdf, pg. 33, Appendix II (In 2012, ZPICs conducted 3,658 patient interviews).

and caused employees to leave and find jobs elsewhere.

153. Defendants also:

a. Knew that wrongfully asserting an overpayment for the extrapolated amount of $4,155,239.00 and wrongfully upholding the denial of claims on appeal at the redetermination level against New Vision would interfere with New Vision's business relationships and expectancies with CMS, referring providers and Medicare patients.

b. Persisted in their post-payment audit, statistical extrapolation and review on appeal, which were undertaken with the purpose of unlawfully interfering in New Vision's business relationships and expectancies with CMS, with their referring providers and with their Medicare beneficiaries (patients), with the self-serving, improper, unethical and fraudulent purpose of securing future CMS contracts, including as future RACs, MACs and ZPICs.

154. Defendants' intentional, improper and wrongful interference resulted in New Vision's damages.

155. As shown by the allegations set forth above:

a. The Defendants intentionally and improperly interfered with the business relationships and expectancies of the Plaintiffs.

b. The Defendants induced and caused breaches, disruptions and terminations of the business relationships and expectancies of the Plaintiffs.

c. The wrongful actions of the Defendants resulted in damages to the Plaintiffs from the breaches, disruptions and terminations of the business relationships and expectancies stated above.

156. Defendants' wrongful and improper actions as stated above directly caused or resulted in Plaintiffs' damages as set forth in detail in Paragraphs 115 through 122 above, incorporated herein by reference.

WHEREFORE, for the purposes of this Count, Plaintiffs request the Court enter judgment in their favor against the three (3) Defendants, jointly, severally and in individually for:

A. Pre-judgment interest on all liquidated amounts.

B. Monetary damages for all past and future losses.

C. Their attorney's fees and costs.

D. Post-judgment interest.

E. Any other relief the Court finds to be fair and equitable.

COUNT VI
VIOLATION OF RIGHT TO PROCEDURAL DUE PROCESS

157. This is a cause of action for violation of the Plaintiffs' right to due process of law pursuant to the Fifth Amendment of the U.S. Constitution and Article I, Section 17 of the Constitution of Michigan. It is a claim for monetary damages within the jurisdiction of this Court, by the Plaintiffs against all three (3) Defendants.

158. This Count is pleaded in the alternative to and in addition to all other Counts in this Complaint.

159. Paragraphs 1 through 60 and 89 through 113 above are incorporated herein by reference.

160. At all times relevant hereto Defendants were acting outside the course and scope of their contracts with CMS, were not acting with due care, and were knowingly violating applicable laws and regulations.

161. Plaintiffs presented the claims stated in this Count to the relevant government agency and to the Defendants named herein and such claims were administratively litigated to finality as shown, in part by Exhibit "1." Plaintiffs have exhausted their administrative remedies for the claims stated in this Count.

162. Alternatively, it is alleged that the wrongful actions taken by the Defendants as stated herein and the claims made by the Plaintiffs in this Count did not arise under the Medicare Act, 42 U.S.C. § 1395, et seq.

163. The Fifth Amendment to the U.S. Constitution states:

> No person shall be . . . deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

164. Article I, Section 17, of the Constitution of Michigan states, in relevant part:

> No person shall be . . . deprived of . . . property, without due process of law. The right of all individuals, firms, corporations and voluntary associations to fair and just treatment in the course of legislative and executive investigations and hearings shall not be infringed.

165. Plaintiffs had a protected property interest in reimbursement from Medicare for its home health services at the duly promulgated reimbursement rate.

166. Plaintiffs were entitled to the funds it was paid by Medicare for the services they had

rendered to Medicare beneficiaries.

167. By law, Plaintiffs were entitled to due process of law before such property could be taken from them.

168. By law, Plaintiffs were entitled to fair proceedings which met all standards of fairness and other statutory requirements for the Medicare Appeals Process, before such property could be taken from them.

169. To satisfy the requirements of due process, among other obligations:

a. TrustSolutions was required to provide Plaintiffs with the reasons for the post-payment review for the claims from 2004 to 2006, which it started after New Vision had successfully appealed the pre-payment review;

b. TrustSolutions was required to provide Plaintiffs with notice that the audit would involve statistical sampling, as well as providing them identification of the universe of claims subject to the post-payment audit;

c. TrustSolutions was required to utilize a qualified statistical expert to calculate the overpayment amount prior to issuance of the overpayment notice to the provider; and

d. TrustSolutions was required to

maintain and provide to Plaintiffs the information necessary to allow New Vision to review and replicate the statistical sampling and extrapolation to be able to defend itself; and

e. TrustSolutions was required to provide Plaintiffs a meaningful opportunity to review and respond to the adverse determinations and extrapolated overpayment findings asserted against it.

170. To satisfy the requirements of due process, among other obligations:

a. NGS was required to provide to Plaintiffs the information necessary to allow them to review and replicate the statistical sampling and extrapolation;

b. NGS was required to provide Plaintiffs with a meaningful opportunity to review and respond to the adverse determinations and extrapolated overpayment findings asserted against them.

171. Both TrustSolutions and NGS failed to take any of the actions set forth in Paragraphs 169 and 170 above.

172. The most basic due process protections require that a party subject to a proceeding, such as that set forth in the Medicare Appeals Process, have access to the evidence used to support a decision adverse to it.

173. CMS requires that a PSC such as TrustSolutions maintain complete documentation of the sampling methodology followed in calculating overpayment amounts, to allow for re-creation should the methodology be challenged. (CMS, Medicare Program Integrity Manual, CMS Pub. 100-08, Ch. 8, § 8.4.4.4.) Both TrustSolutions and NGS failed to do this.

174. By regulation, a contractor that issues a redetermination decision, such as NGS, must include "as appropriate, a summary of the clinical or scientific evidence used in making the redetermination." 42 C.F.R. § 405.956(b)(2). NGS failed to do this.

175. As found by Judge O'Leary in his Decision, Exhibit "1":

> The lack of timely responses from [TrustSolutions and NGS to Plaintiffs] guaranteed the impossibility of presenting a meaningful challenge to the validity of the statistical sampling herein by the Appellant and its statistical experts prior to reconsideration, which denied New Vision its right to a "true appeal."

(Exhibit "1," pp. 14 & 303).

176. TrustSolutions's and NGS's willful disregard of their legal obligations deprived New Vision of its ability to meaningfully challenge the

validity of the statistical sampling and extrapolation and thus, deprived New Vision of a fair and impartial review at the redetermination level (Step 1 of the Medicare Appeals Process) and at the reconsideration level (Step 2 of the Medicare Appeals Process).

177. Once the reconsideration decision was rendered in late July 2010, NGS began recouping on the alleged statistically extrapolated overpayment amount of $4,155,239.00.

178. NGS started recoupment on the statistically extrapolated overpayment amount ($4,155,239.00) without first providing New Vision with a meaningful opportunity to challenge the validity of the statistical sampling and alleged overpayment deprived New Vision of both its property interests and liberty interests without due process of law.

179. TrustSolutions and NGS had no legitimate interest in wrongfully withholding and ignoring the Plaintiffs' requests for the statistical information and other documents and information they required.

180. The actions of the Defendants stated above violated Plaintiffs' rights to both substantive and procedural due process of law.

181. Defendants' wrongful and improper actions as stated above directly caused or resulted in Plaintiffs' damages as set forth in detail in Paragraphs

115 through 122 above, incorporated herein by reference.

WHEREFORE, for the purposes of this Count, Plaintiffs request the Court enter judgment in their favor against the three (3) Defendants, jointly, severally and in individually for:

A. Pre-judgment interest on all liquidated amounts.

B. Monetary damages for all past and future losses.

C. Their attorney's fees and costs.

D. Post-judgment interest.

E. Any other relief the Court finds to be fair and equitable.

COUNT VII
DECLARATORY JUDGMENT

182. This is a cause of action for a declaratory judgment pursuant to 28 U.S.C. § 2201 and Rule 57, Federal Rules of Civil Procedure, within the jurisdiction of this Court, by the Plaintiffs against all three (3) Defendants.

183. This Count is pleaded in the alternative to and in addition to all other Counts in this Complaint.

184. Since this Count does not seek to impose civil liability on the Defendants, immunity from civil liability does not bar the Court from entering the relief sought.

185. Paragraphs 1 through 60 and 89 through 122 above are incorporated herein by reference.

186. At all times relevant hereto Defendants were acting outside the course and scope of their contracts with CMS, were not acting with due care, and were knowingly violating applicable laws and regulations.

187. Alternatively, Plaintiffs presented the claims stated in this Count to the relevant government agency and to the Defendants named herein and such claims were administratively litigated to finality as shown, in part by Exhibit "1." Plaintiffs have exhausted their administrative remedies for the claims stated in this Count.

188. Alternatively, it is alleged that the wrongful actions taken by the Defendants as stated herein and the claims made by the Plaintiffs in this Count did not arise under the Medicare Act, 42 U.S.C. § 1395, et seq.

189. Additionally, Paragraphs 143 through 155 and 163 through 178 above are incorporated herein by reference.

190. Plaintiffs request that the Court interpret

the provisions of the Administrative Law Judge's Decision, Exhibit "1," and provide the Parties with a declaration as to their rights thereunder.

191. An actual justiciable controversy exists between the parties.

192. A declaratory judgment is required so as to guide the Parties in their future relationships and to preserve the Plaintiffs' legal rights.

193. A bona fide, actual, present practical need for a declaration exists.

194. The declaration requested concerns a present, ascertained or ascertainable state of facts or present controversy as to a state of facts.

195. A privilege or right of the Plaintiffs is dependent upon the facts or the law applicable to the facts.

196. The Plaintiffs and the Defendants have an actual, present, adverse and antagonistic interest in the subject matter, both in law or in fact.

197. Declaratory relief will avoid future conflicts between the Parties in related actions.

198. The relief sought by the Plaintiffs is not merely giving of legal advice or the answer to questions propounded for curiosity.

WHEREFORE, Plaintiffs request this Court to enter a declaratory judgment declaring Plaintiffs' rights, including but not limited to the following:

A. Whether Defendants are required to comply with the Administra-tive Law Judge's Decision, Exhibit "1."

B. What amount is owed back to Plaintiffs by Defendants pursuant to Exhibit "1."

C. Whether or not Defendants have complied with U.S. government auditing standards in conducting their reviews of Plaintiffs.

D. Whether Defendants have complied with applicable professional standards for similar organizations in the actions they have taken with regard to the Plaintiffs.

E. Whether Plaintiffs have complied with contractual provisions contained in their contracts (sometimes referred to as "offers for work," "work performance standards," "responses to requests for proposal," "work orders"or other similar terms).

F. Whether Defendants have complied with applicable Medicare statutes, federal regulations applicable to the Medicare Program, and Medicare guidelines,

policies and manuals issued by the Medicare Program in the Defendants' activities involving these Plaintiffs.

G. Whether Defendants have exercised due care in their reviews, audits hearings, appeals and other actions taken in relation to these Plaintiffs.

COUNT VIII
INJUNCTION

199. This is a cause of action for injunctive relief pursuant to Rule 65, Federal Rules of Civil Procedure, within the jurisdiction of this Court, by the Plaintiffs against all three (3) Defendants.

200. This Count is pleaded in the alternative to and in addition to all other Counts in this Complaint.

201. Since this Count does not seek to impose civil liability on the Defendants, immunity from civil liability does not bar the Court from entering the relief sought.

202. Paragraphs 1 through 60, and 89 through 122 above are incorporated herein by reference.

203. At all times relevant hereto Defendants were acting outside the course and scope of their contracts with CMS, were not acting with due care, and were knowingly violating applicable laws and

regulations.

204. Alternatively, Plaintiffs presented the claims stated in this Count to the relevant government agency and to the Defendants named herein and such claims were administratively litigated to finality as shown, in part by Exhibit "1." Plaintiffs have exhausted their administrative remedies for the claims stated in this Count.

205. Alternatively, it is alleged that the wrongful actions taken by the Defendants as stated herein and the claims made by the Plaintiffs in this Count did not arise under the Medicare Act, 42 U.S.C. § 1395, et seq.

206. For purposes of this Count, regardless of any other allegations, Plaintiffs plead that they have no adequate remedy at law.

207. Additionally, Paragraphs 143 through 155 and 163 through 178 above are incorporated herein by reference.

208. Without and injunction, Defendants will continue their injurious acts, continue to interfere in the business relationships of the Plaintiffs, and continue to damage the professional reputations of the Plaintiffs.

209. Plaintiffs have a substantial likelihood of success on the merits.

210. Plaintiffs will suffer irreparable harm from the acts of the Defendants unless injunctive relief is granted. Such harm is real and imminent.

211. The harm the Plaintiffs will suffer outweighs any harm the Defendants will suffer if an injunction is entered.

212. An injunction will serve the public interest.

213. The interests of third persons and of the public will be served by the entry of a permanent injunction.

214. An injunction can be practically and adequately framed and enforced.

215. Justice requires the Court to enter an injunction.

WHEREFORE, Plaintiff requests the Court enter an injunction against the three (3) Defendants, ordering them each:

A. To comply in all respects with the Administrative Law Judge's Decision, Exhibit "1."

B. Remove the Plaintiffs from any ongoing prepayment reviews.

C. Terminate any ongoing audits, reviews or

investigations they are conducting of the Plaintiffs for any Medicare claims submitted at any time prior to 2013.

D. Comply in the future with all applicable Medicare Program laws, regulations, and guidance and contracts they have with CMS, with respect to these Plaintiffs.

JURY DEMAND

216. Plaintiffs demand a trial by jury for all issues so triable.

REQUEST FOR RELIEF

WHEREFORE, Plaintiffs respectfully requests that this Court grant the following relief against Defendants, jointly, severally and individually, as follows:

A. A ruling that Anthem unlawfully used TrustSolutions and NGS as mere instrumentalities and as its alter egos, and piercing the corporate/company veils of TrustSolutions and NGS;

B. Issuance of a writ of mandamus to enforce the ALJ Decision, Exhibit "1," as requested in Counts I and II;

C. Monetary damages, both general and special;

D. Pre-judgment interest on all liquidated damages;

E. A Declaratory Judgment as requested in Count VII;

F. An injunction as requested in Count VIII;

G. Attorney's fees and costs;

H. Post-judgment interest; and

I. All other relief to which Plaintiffs are entitled at law or equity.

CERTIFICATE OF SERVICE

I hereby certify that I filed the foregoing electronically via the Clerk of Court's CM/ECF system, which automatically serves a copy on all parties who have appeared; that I have also mailed a copy via U.S. mail, postage prepaid, to the following non-CM/ECF Defendants:

Service List:

TrustSolutions, LLC, via its
Registered Agent: CT Corp System
8020 Excelsior Drive, Ste. 200
Madison, WI 53717

Anthem, Inc., via its
Registered Agent: Kathleen S. Kiefer
120 Monument Circle
Indianapolis, IN 46204

National Government Services, Inc.,
via its Registered Agent: CT Corp System
150 West Market Street
Indianapolis, IN 46204

Additionally, I certify that I have served a copy of this Second Amended Complaint on each of the foregoing via U.S. certified mail, return receipt requested, postage pre-paid. I further certify that I have served a copy of the foregoing via e-mail on the following CM/ECF participant who has filed an appearance on behalf of Defendants Anthem, Inc., TrustSolutions, LLC, and National Government Services, Inc.:

BARBARA L. McQUADE
United States Attorney
Zak Toomey (MO61618)
Assistant U.S. Attorney
211 W. Fort Street, Suite 2001
Detroit, Michigan 48226
Phone: (313) 226-9617
E-mail: Zak.toomey@usdoj.gov

this 11th day of March 2017.

/s/ George F. Indest III

GEORGE F. INDEST III, J.D., M.P.A., LL.M.

Board Certified in Health Law
by The Florida Bar

Florida Bar No. 382426
CAROLE C. SCHRIEFER, R.N., J.D.
Florida Bar No. 835293
THE HEALTH LAW FIRM
Attorney for Plaintiffs
1101 Douglas Avenue
Altamonte Springs, Florida 32714
Phone: (407) 331-6620
Fax: (407) 331-3030
E-mail: GIndest@TheHealthLawFirm.com
Secondary e-mail:
CourtFilings@TheHealthLawFirm.com
ATTORNEYS FOR PLAINTIFFS NEW VISION HOME HEALTH CARE, INC., AND SALEEM SHAKOOR

APPENDIX G

Case: 17-2165 Document: 22 Filed: 02/02/2018

No.: 17-2165

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

NEW VISION HOME
HEALTH CARE, INC., *et al.*,

Plaintiffs-Appellants,

- v. -

ANTHEM, INC., *et al.*,

Defendants-Appellees.

On Appeal from the United States District Court
for the Eastern District of Michigan
Case No.: 2:16-cv-13173-VAR-RSW

BRIEF OF PLAINTIFFS-APPELLANTS
NEW VISION HOME HEALTH CARE, INC., et al.

GEORGE F. INDEST III
Fla. Bar No. 382426
LANCE O. LEIDER

Fla. Bar No. 96408
THE HEALTH LAW FIRM
1101 Douglas Avenue
Altamonte Springs, Florida 32714
Phone: (407) 331-6620
Counsel for Plaintiffs-Appellants

ORAL ARGUMENT REQUESTED

CORPORATE DISCLOSURE STATEMENT

Pursuant to Rule 26.1, Federal Rules of Appellate Procedure, and Rule 26.1, Sixth Circuit Rules, appellants state:

1. Is said party a subsidiary or affiliate of a publicly owned corporation?

Appellants are New Vision Home Health Care, Inc., a closely held, Michigan corporation and Medicare provider, and its owner, a citizen and natural person. Appellants certify that no Appellant is a subsidiary or affiliate of a publicly owned corporation.

2. Does any publicly owned corporation that is not a party to this appeal have a financial interest in the outcome?

The Appellants are not aware of any publicly owned corporation that is not a party to this appeal having any financial interest in its outcome.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Federal Cases

Federal Statutes

Federal Regulations

Other Authority

STATEMENT IN SUPPORT OF ORAL ARGUMENT

Pursuant to the Federal Rules of Appellate Procedure and Sixth Circuit Rule 34(a), Plaintiffs-Appellants respectfully request the Court grant oral arguments in this case.

This appeal raises important issues relating to: Appellants' constitutional due process rights and, by extension, the rights of other similarly situated Medicare providers; the fundamental fairness of the Medicare appeals process; and the accountability of private government contractors for their conduct while administering the Medicare program.

Medicare laws, regulations, guidelines and the Medicare appeals process are voluminous and confusing.[1] The facts of this case are complex with the

---

[1] Justice (then Judge) Gorsuch, in an opinion he authored in the Tenth Circuit Court of Appeals, stated:

> . . . Medicare is, to say the least, a complicated program. The Centers for Medicare & Medicaid Services (CMS) estimates that it issues literally thousands of new or revised guidance documents (not pages) every single year, guidance providers must follow exactingly if they wish to provide health care services to the elderly and disabled under Medicare's umbrella. Currently, about

Appellants' having appealed through the Medicare appeals process at least two complete times.[2] Oral argument will help to clarify issues and facts in the case below and answer any question which the Court may have.

> 37,000 separate guidance documents can be found on CMS's website — and even that doesn't purport to be a complete inventory. . . .

Caring Hearts Pers. Home Servs. v. Burwell, 824 F.3d 968, 970, 2016 U.S. App. LEXIS 9790 (10th Cir. 2016) (citation omitted).

[2] The ALJ decision which the Appellants are seeking to enforce was 305 single-spaced pages, without counting the lengthy attached appendices and schedules. *New Vision Home Health Care, Inc.*, ALJ Appeal No. 1-909 525621 (Dep't Health & Human Serv., Ofc. of Medicare App. Hearings, Sept. 4, 2013). A copy of this decision is Exhibit 1 of the Second Amended Complaint, R.18.

JURISDICTIONAL STATEMENT

The United States District Court had subject matter jurisdiction over Appellants' mandamus counts pursuant to 28 U.S.C. § 1361, the declaratory relief claim under 28 U.S.C. § 2201, and diversity of citizenship and federal question jurisdiction (28 U.S.C. § 1331) over the remaining claims.

The Sixth Circuit Court of Appeals has subject matter jurisdiction over this case pursuant to 28 U.S.C. § 1291.

On August 28, 2017, the District Court issued an Opinion and Order Granting Appellees' Motion for Reconsideration and Motion to Dismiss which dismissed all claims then pending. There were no hearings so there is no transcript.

On September 26, 2017, Appellants filed a timely Notice of Appeal with the District Court which forwarded it to this Court on the same day.

STATEMENT OF ISSUES

I. Whether the District Court erred in dismissing Counts I and II of the Second Amended Complaint on the grounds that:

   A. Appellants failed to exhaust their administrative remedies related to amounts Appellees withheld beginning after 2006; and

   B. The Administrative Law Judge did not impose a clear nondiscretionary duty on Appellees to pay Appellants funds Appellees withheld beginning after 2006.

II. Whether the District Court erred in dismissing Counts III through VIII on the sole ground that Appellants failed to exhaust their administrative remedies through the Medicare appeals process.

STATEMENT OF THE CASE

This appeal, despite the underlying case's sordid procedural history at the U.S. Department of Health and Human Services, is solely about jurisdiction.

The underlying case at the District Court level involved the Appellants' seeking to enforce a final decision by an Administrative Law Judge (ALJ) which the Appellee contractors[3] had ignored, as well as other causes of action.

In their Second Amended Complaint, Appellants asserted claims for: mandamus to enforce the final ALJ decision, binding on all parties under 42 C.F.R. § 405.1048 (Counts I and II), and other additional causes of action (or claims) made under state and federal law (Counts III through VIII). [Sec. Am. Compl., R. 18, Page ID ## 1-52]. Appellants raised the additional claims or causes of action through the administrative process and have exhausted all administrative remedies in this matter through an ALJ decision in their favor which was not further appealed by the Appellees.

Appellees Anthem, Inc., TrustSolutions, LLC (Trust Solutions), and National Government Services, Inc. (NGS), in their Motion to Dismiss [Mtn. to

---

[3] Appellees are for-profit government contractors retained by the government, specifically the Centers for Medicare and Medicaid Services (CMS), a subdivision of the U.S. Department of Health and Human Services (HHS), to assist in carrying out its duties under the Medicare Act.

Dismiss, R. 20] and Motion for Reconsideration [Mtn. for Recon., R. 32] filed below, claim the District Court did not have jurisdiction to adjudicate Appellants' claims.

A. Medicare Appeals Process

Medicare statutes and regulations set forth a comprehensive administrative process which must generally be exhausted before an aggrieved provider may bring suit in federal court for claims arising under the Medicare statute. See 42 U.S.C. § 1395ff.

After notice of a denied claim is received by the provider, in this case Appellants, the first level of Medicare appeal is to request a "redetermination" by the fiscal intermediary or carrier. 42 U.S.C. § 1395ff(a)(3); 42 C.F.R. § 405.940.

A party who is not satisfied with the redetermination can seek "reconsideration" by a Qualified Independent Contractor ("QIC"). 42 U.S.C. § 1395ff(b)(1)(A); 42 C.F.R. § 405.960.

A party not satisfied with the decision of the QIC may request a hearing before an Administrative Law Judge. 42 U.S.C. § 1395ff(b)(1)(A); 42 C.F.R. §§ 405.1002, 405.1006, 405.1014(b), 405.1016. The ALJ conducts an evidentiary hearing and issues a decision. Id. at §§ 405.1016, 405.1020, 405.1046(d).

If any party is dissatisfied with the decision, the party may request that the Medicare Appeals Council

review the ALJ decision. 42 U.S.C. § 1395ff(d)(2); 42 C.F.R. § 405.1100. If no appeal to the Council is filed, the ALJ's decision is final and binding on all parties. 42 C.F.R. § 405.1048.

If a party requests review by the Medicare Appeals Council, the Council reviews the case and issues a final agency decision. 42 U.S.C. § 1395ff(d)(2); 42 C.F.R. § 405.1100.

The fifth and final level of appeal is to file suit in federal district court. 42 U.S.C. § 1395ff(b)(1)(A); 42 C.F.R. § 405.1136.

In the instant case, no party filed an appeal of the September 4, 2013, ALJ decision. The Appellants found the decision to be in their favor, since the ALJ ruled they were entitled to payment for in excess of ninety-nine percent (99%) of the claims that had been denied below; therefore, there was no reason for Appellants to appeal any further. Thus, it became the final decision of the Secretary and binding on the parties. Heckler v. Ringer, 466 U.S. 602, 606 (1984); 42 C.F.R. § 405.1048.

The lengthy chronology of the Medicare appeals process, fully showing that the Appellants had exhausted their administrative remedies, is attached as Appendix C of the ALJ's decision, and is incorporated herein by reference. [Opp. to Mtn. to Dismiss, R. 24, Exhibit 3, Page ID ## 988-93].

B. Facts Leading to Filing Suit in District Court

A thorough understanding of the parties and their varying responsibilities under the Medicare statute is necessary to resolve this appeal. However, in the interest of economy of space, Appellants adopt and incorporate by reference the portion of their Second Amended Complaint offering a more detailed description. [Sec. Am. Compl., R. 18, Page ID ## 385-88].

Appellants are a home health agency (a Medicare health care provider) and its owner who provided home health services to Medicare beneficiaries. [Sec. Am. Compl., R. 18, Page ID # 385]. The basis of this dispute arose when, in 2007, Appellee Trust Solutions initiated an audit of Appellants' claims for dates of service in 2003-2006. [Sec. Am. Compl., R. 18, Page ID # 390]. These were claims the Appellants had already submitted and had been approved and paid by the Appellees. Appellants submitted documents supporting their claims for the audit by the Appellee Trust Solutions. In August 2008, Appellee Trust Solutions denied approximately ninety percent (90%) of the claims previously paid. [Sec. Am. Compl., R. 18, Page ID ## 390-91].

Appellee Trust Solutions then used a statistical extrapolation formula and reached an estimated overpayment of more than $4,000,000. [Sec. Am. Compl., R. 18, Page ID # 391]. Appellants appealed through the first, second, and third levels of the

Medicare appeals process and were wholly denied by Appellees at each level. Appellants timely filed for an ALJ hearing which was first held in July 2011.[4] The ALJ's decision was wholly favorable to Appellants. New Vision Home Health Care, Inc., ALJ Appeal No. 1-737870647 (Dep't Health & Human Serv., Ofc. of Medicare App. Hearings, Oct. 18, 2011).

Appellees, however, were unsatisfied with the loss and appealed the decision to the Medicare Appeals Council. The Council then remanded the case for yet another ALJ hearing. That hearing occurred in 2012 and resulted in the final decision dated September 4, 2013.[5] Appellees declined to appeal the 2013 ALJ decision. In accordance with 42 C.F.R. § 405.1048, the decision of the ALJ then became binding on all parties.

In 2008, and while the audit case was working its way through the Medicare appeals process, Appellants filed suit in the District Court seeking injunctive relief and various other claims against the

---

[4] There was actually an even earlier ALJ hearing, before 2011, from which the ALJ remanded the case back to the lower Qualified Independent Contractor (QIC) for another redetermination, which took place before the 2011 ALJ hearing. For purposes of this appeal, Appellants are only discussing the last two ALJ hearings in this case, hearings which resulted in formal ALJ decisions.

[5] *See supra*, N.2. The hearing date was June 7, 2012. A copy of this 305 page decision, entered in 2013, is Exhibit 1 of the Second Amended Complaint, R.18.

Secretary of HHS.[6] The purpose of that suit was to attempt to halt the recovery efforts of Appellants while the case moved through the Medicare appeals process.

The District Court ultimately dismissed Appellants' case for lack of subject matter jurisdiction because it found Appellants' claims arose under the Medicare statute and could not be entertained at that early stage of the Medicare appeals process. *Id.* Thus, the District Court concluded it did not have jurisdiction to hear Appellants' claims until all administrative remedies under the Medicare statute were exhausted. *Id.* Following the dismissal of the previous federal court case, Appellants worked diligently through the lengthy administrative process as described above until the last favorable 2013 ALJ decision.

Appellants brought the action presently under appeal for two primary reasons, to seek enforcement of the 2013 ALJ order and for redress of gross violations of its due process rights and other rights.

While Appellants worked through the Medicare appeals process from approximately 2007 through 2016, with the expenditure of tremendous amounts of time and attorney's fees, Appellees went ahead and recouped and withheld over $200,000 in Medicare

---

[6] *New Vision Home Health Care, Inc. v. Leavitt*, 581 F. Supp. 2d 802 (E.D. Mich. 2008).

claims payments[7] that had been approved and owed to Appellants to repay the $4,000,000 the Appellees claimed they were owed. [Opp. to Mtn. to Dismiss, R. 24, Page ID # 913].

This offset of money owed to Appellants was in direct violation of the 2013 final ALJ order which ordered Appellees as follows:

> The Medicare contractors are hereby DIRECTED to process the claims and claim lines at issue in accordance with this decision. Any amounts recouped or otherwise recovered from the Provider based upon the invalid overpayment demands herein shall be returned to the Appellant.

[Sec. Am. Compl., R. 18, Page ID # 740].

Since Appellees never provided any notice to Appellants that they were subject to any other audits, the withholding of payments on approved claims submitted between 2007 and 2016 has no reasonable explanation other than as an attempt by Appellees to wrongfully continue to recover the amount allegedly

---

[7] The exact amount is uncertain at this point in time because no discovery has occurred.

owed from the audit of the 2003 through 2006 claims. This is consistent with the policies of Appellees by which they withhold future payments on approved claims to offset a past overpayment determination. Appellants' position is further supported by electronic remittance advices provided to them by Appellees which show payments were withheld and applied to an undisclosed outstanding balance. [App., pp. 1-4].

Counts I and II of the Second Amended Complaint are counts seeking mandamus to enforce the final decision of the ALJ, specifically the release of all improperly retained funds owed to Appellants. [Sec. Am. Compl., R. 18, page ID ## 396-400]. Appellees have ignored the ALJ's decision. Appellees were and are in violation of the ALJ's Order and continue to withhold payments as offsets against the invalidated overpayment demand. The mandamus action requested that the District Court order Appellees to either release the payments or justify their continued withholding.

Counts III through VIII of the Second Amended Complaint state claims for negligence, tortious interference and other state and federal claims related to the destruction of Appellants' business by Appellees. Appellants contend the grounds underlying these claims were raised by them during the Medicare Appeals Process and are reflected in specific findings that were made by the ALJ in his final 2013 decision.

The ALJ expressly found that Appellees repeatedly violated Appellants' due process rights,

federal law, state law, and federal regulations. The violations committed by Appellees are too numerous to list here, but were stated at length in the ALJ's decision, and summarized by Appellants in their Opposition to the Motion to Dismiss, incorporated herein by reference. [Opp. Mtn. to Dismiss, R. 24, Page ID ##926-29]

The ultimate result of Appellees' bad faith audit and illegal practices was the collapse of Appellants' business under the combined weight of providing services to Medicare beneficiaries without receiving payment wrongfully withheld by Appellees and the legal fees required to fight the case for over a decade. Counts III through VIII of the Second Amended Complaint addressed these violations.

C. District Court Proceedings

The procedural history in the District Court parallels to some degree that of the Medicare appeals process. Appellees filed a Motion to Dismiss the Second Amended Complaint on April 26, 2017. [Mtn. to Dismiss, R. 20, Page ID ## 841-94]. Appellees raised only jurisdictional grounds for dismissal in their motion. [*Id.*].

Appellants filed a Response in Opposition to the Motion to Dismiss on May 25, 2017, which included affidavits addressing the issues. [Resp. in Opp., R. 24, Page ID ## 904-93]. In response, Appellees filed a Reply. [Reply to Resp., R. 26, Page ID ## 996-1031]. Then, with leave of court, Appellants filed a Sur-Reply

on June 22, 2017. [Sur-Reply, R. 27, Page ID ## 1032-60].

On July 12, 2017, the District Court entered an order ruling in favor of Appellants and denying Appellees' Motion to Dismiss. [Order Dny. Mtn. to Dismiss, R. 30, Page ID ## 1068-73]. Appellee contractors then filed a Motion for Reconsideration raising no truly new grounds for relief. [Mtn. for Recon., R. 32, Page ID ## 1078-91]. The District Court ordered Appellants to file a response to the Motion for Reconsideration, which they did on August 4, 2017. [Resp. to Mtn. for Recon., R. 36, Page ID ## 1135-65].

Once the matter was fully briefed, the District Court completely and inexplicably reversed its previous decision and entered an Order Granting Defendants' Motion to Dismiss as to all counts. [Ord. Grt. Mtn. to Dismiss, R. 38, Page ID ## 1194-1209]. That is the Order that is the subject of this appeal. No hearings were held.

The District Court dismissed the mandamus counts (Counts I and II) on two primary grounds. First, it found Appellants had not exhausted their administrative remedies on the allegation that the monies withheld by Appellees beginning in 2006 were related to the 2003-2006 overpayment. Second, it found that the 2013 ALJ decision did not impose a clear nondiscretionary duty on Appellees to repay the Appellants payments that the Appellees had wrongfully recouped and withheld beginning in 2006.

The District Court dismissed the remaining counts (Counts II through VIII) on the sole basis that Appellants had not exhausted their administrative remedies with respect to them.

D. Additional Facts Supporting Reversal of the District Court

With respect to the mandamus relief in Counts I and II of the Second Amended Complaint, Appellants believe the 2013 ALJ order unambiguously directed Appellees to return to Appellants: "Any amounts recouped or otherwise recovered from the Provider based upon the invalid overpayment demands. . . ." [Sec. Am. Compl., R. 18, Page ID # 740].

According to Appellees, in December 2013, at the conclusion of the administrative process, Appellee contractors sent Appellants an account balance letter, claiming Appellants still owed $41,675.65. [Mtn. to Dismiss, R. 20, Page ID # 894]. Appellees also adopted, without any supporting evidence, the position that they did not collect any of the alleged $4,000,000 overpayment from Appellant New Vision during the administrative process, with the exception of $7,508.62 in interest payments. [*Id.*] Appellants argued below, submitting supporting affidavits, that Appellees were incorrect about their recoupment. [*See, generally* Opp. to Mtn. to Dismiss, R. 24].

Since 2011 Appellees withheld a minimum of $201,175.02, of Medicare payments they owed to

Appellants.[8] In contrast, the 2013 ALJ decision only found $35,872.28 in total, was paid to Appellants in error. By the time of the ALJ decision in 2013, Appellees had already withheld hundreds of thousands of dollars more than what Appellants owed and still have not refunded any of it.

The affidavit of Appellant Shakoor, attached to the Response in Opposition to the Motion to Dismiss, attests to the alleged inaccuracy of Appellee's position regarding compliance with the 2013 ALJ order and the primary factual basis for the Motion to Dismiss. [Resp. in Opp. to Mtn. to Dismiss, R. 24,Page ID ## 950-77].

Appellants provided the court below with substantial evidence that the Appellee contractors did not comply with the 2013 ALJ order by continuing to withhold payments due to Appellants as if the alleged $4,000,000 overpayment was validated by the decision.

The mandamus relief sought by the Appellants included a simple accounting for amounts Appellants paid and Appellees withheld and payment to

---

[8] Appellants suspect the amount is far greater; however, due to going out of business because of the acts of the Appellees, the records are not available. That is, in part, why mandamus relief is necessary. Appellees do have the records, the only available proof of exactly what was owed and what was paid to Appellants, but have failed to provide this to Appellants. Appellees have been requested to, at the very least, disclose this information and documentation to Appellants and have not. By dismissing the case prior to any discovery, the District Court let Appellees off on nothing more then their word.

Appellants of any money that was incorrectly withheld, in accordance with the ALJ decision. The affidavits and evidence produced by the Appellants in opposition to the Appellees' motion to dismiss was adequate to defeat a motion for summary judgment, much less a motion to dismiss. The Court should not have dismissed the case on a preliminary motion to dismiss.

With respect to Counts III through VIII of the Second Amended Complaint, Appellants presented supporting evidence that due process and tort related claims were presented during the Medicare appeals process, were presented to the ALJ and were considered by the ALJ at the hearing. The ALJ's decision contains findings related to these. [Resp. in Opp. to Mtn. to Dismiss, R. 24, Page ID ## 922-30].

Specifically, the ALJ made findings that Appellee contractors "exhibited disregard for the CMS instructions to auditors"; that their processes were "unacceptable"; that Appellees "did not use care"; "did not demonstrate even substantial compliance"; their methods lacked "legitimacy, integrity, and credibility"; "failed to comply with . . . generally accepted government auditing standards"; provided "evasive responses" to FOIA requests; that Appellees did not "faithfully execute" their responsibility to protect Appellants' due process rights; and that their breach of the rules "undermined the appeal process." The fact that Appellee government contractors ignored with impunity statutes, regulations and federal agency guidelines, violating the Appellants' rights and

violating fundamental fairness and due process of law, was clearly presented to the ALJ and considered by him. A reading of the exceptionally thorough, 305-page decision by the ALJ shows this.

The ALJ's conclusions and statements in his 2013 order are evidence that the violations of Appellants' due process and other rights, as stated in Counts III through VIII of the Second Amended Complaint, were actually before the ALJ, and were at least partially the basis for his decision.

The fact that the ALJ does not have authority to grant relief for the causes of action pleaded in Counts III through VIII is irrelevant. This is not required by law. And this is why federal court relief is required on these.

SUMMARY OF THE ARGUMENT

I. Mandamus Should Have Issued Because Appellants had No Alternative Remedies Available and Counts I and II Related to a Nondiscretionary Duty

The District Court's Order dismissing Appellants' Second Amended Complaint should be reversed. The lower court erred in both its finding that Appellants failed to exhaust their administrative remedies with respect to payments undisputably withheld by Appellees; and that the Administrative Law Judge did not issue an order that imposed a clear non-discretionary duty on Appellees to pay the withheld sums.

The District Court failed to appreciate the relief sought by Appellants with respect to Counts I and II. Specifically, Appellants showed the Court unrebutted evidence Appellees did not pay claims submitted by Appellants from 2006 through 2016. Appellants also showed, again without rebuttal, that those amounts were withheld and applied to recoup an alleged overpayment made by Appellees to Appellants. Appellants provided testimony alleging there were no overpayments or audits other than the one which is the basis of this entire dispute. None of Appellants' contentions were rebutted or even disputed by Appellee.

The crucial error made by the District Court was that it failed to take note Appellants already

exhausted their administrative remedies when they received a favorable ALJ decision in 2013, and that Appellant only sought enforcement of that order. The District Court compounded that error by failing to recognize the scope and intent of the ALJ's order. Specifically, the ALJ ordered Appellees to pay any amounts withheld by them as a result of the invalidated overpayment. The amounts withheld by Appellees beginning in 2006 were withheld to satisfy the overpayment that was reversed. By not connecting the withheld sums to the ALJ's order, or at least requiring that Appellees offer an alternative explanation, the District Court failed to appreciate that payment of withheld funds was itself the very non-discretionary duty imposed by the order. The order did not draw a distinction between funds withheld prior to its issuance, and those withheld thereafter. The District Court read a temporal requirement into the order which was simply not there.

The District Court should have issued an Order to Show Cause requiring Appellees to demonstrate compliance with the ALJ's order and that they have no nondiscretionary duty.

II. Counts III through VIII were Presented to the ALJ and Administrative Remedies were Exhausted

The District Court erred in holding that Counts III through VIII of the Second Amended Complaint were not presented to the ALJ. The 2013 ALJ

decision, which is the final decision of the government and binding on all parties, discussed at length the numerous egregious due process violations, willful negligence, and intentional misconduct of Appellee contractors. The ALJ's ultimate decision in favor of Appellants was in large part based upon the misconduct of Appellees.

Under established law, administrative remedies for tort claims can be exhausted when those claims are used to support a final decision in favor of the claimant on the administrative matter at issue. The District Court failed to recognize that the law does not require a claimant file a tort claim directly against an agency in the administrative process. The parties agree that Medicare ALJs do not have the authority to grant monetary relief. Nor does the ALJ have authority to grant injunctive relief. Requiring a party to file a tort claim would be tantamount to requiring it to perform a knowingly futile act. Instead, the law considers a tort claim "presented" for exhaustion purposes when it is used as a basis for relief which the agency is able to grant.

Here, Appellants raised the issues of violation of due process, negligence, and intentional misconduct during the auditing and Medicare appeals process. The ALJ found that Appellee contractors committed specific due process violations, acts of negligence, and acts of intentional misconduct. Appellees' misdeeds then formed the basis of the final agency decision in favor of Appellants.

In the alternative, courts have held that tort claims of the kind brought by Appellants do not "arise under" Medicare, and they can be brought directly in federal courts. Further, Appellee contractors' acts of misconduct are outside their authority as government Medicare contractors and the bounds of the discretion granted to them by the federal government. As such, their conduct is personal to them and suit can be brought directly in federal court under 28 U.S.C. §§ 1331 or 1332.

STANDARD OF REVIEW

This appeal is a review of a District Court's findings as to whether or not it had subject matter jurisdiction. Review of such a determination by the Circuit Court is *de novo*. *Durand v. Hanover Ins. Grp., Inc.*, 806 F.3d 367, 374 (6th Cir. 2015); *Carson v. U.S. Office of Special Counsel*, 633 F.3d 487, 491 (6th Cir. 2011)(citing *Willis v. Sullivan*, 931 F.2d 390, 395 (6th Cir. 1991)); *Sanderson v. HCA-The Healthcare Co.*, 447 F.3d 873, 876 (6th Cir. 2006). This standard is applicable to all issues in this appeal.

ARGUMENT

I. The District Court Erred in Finding that Appellants Failed to Exhaust their Administrative Remedies and that Appellee Contractors Did Not Owe a Nondiscretionary Duty to Appellants

Counts I and II of the Second Amended Complaint seek mandamus relief under 28 U.S.C. § 1361, to enforce the 2013 ALJ decision in favor of Appellants against Appellees. The question must be asked that if mandamus relief does not exist in such circumstances, then how can an Administrative Law Judge's decision that is ignored ever be enforced.

The background for this relief is that beginning in 2006, Appellees stopped disbursing funds to Appellant on claims that had been submitted by Appellants **and reviewed and approved for payment by the Appellee contractors**. However, instead of actually paying the Appellants, the Appellee contractors withheld the amounts that had been approved for payment. To add insult to injury, the Appellee contractors also issued IRS Forms 1099 to the Appellants each year showing these amounts as though they had actually been delivered to the Appellants, when they had not been.

Since Appellants owed no other debt to Appellee contractors or to the federal government, the only reasonable conclusion Appellants can draw is that Appellees withheld those funds and applied them to

the overpayment that was invalidated by the ALJ's 2013 decision.

Where much of the confusion arises seems to be in the precise nature of the mandamus relief sought by Appellants. Appellants do not contest any denied claims. Appellants do not ask for review of any part of the 2013 Medicare ALJ decision. Appellants only seek enforcement of that decision, a decision that the Appellee contractors have ignored.

The time at which the apparent confusion arose is somewhat unknown, because the District Court seemed to understand Appellants' position quite clearly when it first denied Appellees' Motion to Dismiss. [Ord. Deny. Mtn. to Dismiss, R. 30]. There the court said:

> [I]t does not matter if the plaintiff was partially or fully successful; what matters is whether a final decision was rendered in the administrative process on the claims plaintiff brings to the court for enforcement purposes only. Here, the ALJ reached a final decision that Defendants owed New Vision; New Vision only seeks enforcement of the final decision by the ALJ.

[Order Den. Mtn. to Dismiss, R. 30, Page ID # 1073].

Appellee contractors, and the District Court after its change of heart, seem to now be of the opinion that Appellants have some sort of dispute over the treatment of claims they submitted to the Appellee contractors beginning in 2006 that must somehow be resolved through the Medicare appeals process, again. That is simply not the case and has not been alleged in the Second Amended Complaint. **There is no such dispute**. Appellee contractors reviewed the claims submitted after 2006 by Appellants and agreed to pay them. Appellee contractors issued Electronic Remittance Advices (RAs) to that effect and provided IRS Forms 1099 each fiscal year attributing the claims as income to Appellants. The problem is, Appellee contractors never actually paid the money to Appellants. They simply withheld it.

A. The District Court Incorrectly Applied the Legal Standard for Rule 12(b)(1) Dismissal

The standard for a motion to dismiss under Rule 12(b)(1), Fed R. Civ. P., which presents a facial jurisdictional attack **requires** the plaintiff's allegations be accepted as true. *Bracken v. Dasco Home Med. Equip., Inc.*, 2013 U.S. Dist. LEXIS 90628 *5 (S.D. Ohio June 27, 2013)(quoting *DLX, Inc. v. Kentucky*, 381 F.3d 511, 516 (6th Cir. 2004)).

Further, as the District Court noted, subject matter jurisdiction challenges permit the court to look

beyond the jurisdictional allegations and "consider whatever evidence the parties submit." [Order Grt. Mtn. to Dismiss, R-38, Page ID # 1199 (quoting *Fairport Int'l Exploration, Inc. v. Shipwrecked Vessel Known as THE CAPTAIN LAWRENCE*, 105 F.3d 1078, 1081 (6th Cir. 1997))].

Based on the standard cited above, the District Court was **required** to accept Appellants' allegations that Appellees withheld post-2006 payments in order to pay back the $4,000,000 overpayment that was invalidated by the ALJ. Appellees presented no conflicting argument, documents, affidavits, or evidence of any kind that Appellants' position was wrong in any respect. On the other hand, being required to do so by the District Court, Appellants produced affidavits and documents in opposition to the motion to dismiss which proved their allegations.

Without any challenge, the facts alleged in the Second Amended Complaint showed a *per se* violation of the ALJ's order. Those allegations should have flowed through to the District Court's decision and left the court no choice but to deny the motion to dismiss and grant mandamus relief. In the alternative, the District Court could have issued an order requiring Appellee contractors to show cause as to why the mandamus should not be granted or could have reserved judgment through discovery and entertained motions for summary judgment at that time.

Appellee contractors' challenge may have been valid if, and only if, Appellees had shown that they had

completely complied with the ALJ's 2013 decision. *See Carson v. U.S. Office of Special Counsel*, 633 F.3d 487, 496 (6th Cir. 2011)(holding mandamus is not appropriate where a state actor already performed nondiscretionary duty). Since Appellee contractors failed to present any evidence of their compliance, their jurisdictional attack should have failed.

B. Appellants were Entitled to Mandamus Relief

While the Social Security Act bars many different types of relief, it does not preclude mandamus relief. *See* 42 U.S.C. § 405(h); *Ganem v. Heckler*, 746 F.2d 844, 845-46 (D.C. Cir. 1984). In fact, this Court specifically acknowledged mandamus relief is not expressly barred by statute or the U.S. Supreme Court. *See BP Care, Inc. v. Thompson*, 398 F.3d 503, 515 (6th Cir. 2005).

Federal mandamus relief is intended to provide a remedy to a party once it has exhausted all other avenues of relief and the action sought is performance of a nondiscretionary duty. *See Kerr v. U.S. Dist. Ct.*, 426 U.S. 394, 402-03 (1976); *U.S. ex rel. Girard Trust Co. v. Helvering*, 301 U.S. 540, 543-44 (1937).

Mandamus lies in Medicare cases where the actions of the Secretary of Health and Human Services constitute an abrogation of the Secretary's statutory duties. *Pritchett v. Comm'r of Soc. Sec.*, 2005 U.S. Dist. LEXIS 46965, *12 (E.D. Mich. Jun. 22, 2005)(quoting *Ganem*).

In order to justify mandamus jurisdiction, a plaintiff must show it exhausted all other avenues of relief, and that the defendant owes it a clear nondiscretionary duty. *Heckler*, 466 U.S. at 616.

Appellee contractors' employer, the U.S. Department of Health and Human Services, is no stranger to grants of mandamus relief. In *Wolcott v. Sebelius*, 635 F.3d 757 (5th Cir. 2011), a writ of mandamus was issued under 28 U.S.C. § 1361 ordering the Secretary of HHS to release payment on approved claims it had yet to pay. In that case, Wolcott was a health care provider who successfully challenged denied claims through the Medicare appeals process. *Wolcott, 635 F.3d* at 761. Specifically, Wolcott disputed denials of claims for wound debridement and eventually won an ALJ decision in its favor. *Id.* The problem arose when, as in this case, the government's contractors refused to pay Wolcott for the claims that they had denied and Wolcott had successfully challenged. *Id.* at 768-771. The Fifth Circuit determined Wolcott was entitled to mandamus relief because the contractors owed a clear nondiscretionary duty to pay the claims at issue in the appeal.

The instant case is on all fours with *Wolcott* and should have been decided similarly by the District Court. The only notable, albeit ultimately inconsequential, difference between the cases is the manner in which the government failed to pay the claims. In *Wolcott*, the government contractors directly ignored their obligations and refused to pay

the claims for which their denials were reversed by the ALJ. *Id.* at 770.

By contrast, the misconduct of the Appellee contractors in this case is slightly more nuanced. Appellees, rather than directly refusing to pay the overturned claims, decided to indirectly refuse to pay by withholding **future** payments and instead applying them to the overpayment as if it was never reversed by the ALJ. Nevertheless, whether refusal to pay was direct, as in *Wolcott*, or indirect, as it was in the present case, it had the same ultimate effect, valid claims were not paid as the law requires. Courts have long held that one cannot do indirectly that which one is prohibited to do directly. *Mugler v. Kansas*, 123 U.S. 623 (1887).

C. Appellees Failed to Perform a Nondiscretionary Duty and Pay Valid Claims

The primary basis for the District Court's ruling with respect to the mandamus counts was that it believed the ALJ's order did not compel the Appellee contractors to pay monies withheld beginning in 2006. To a certain extent, the court was correct. Withholdings for claims submitted beginning in 2006 was not the subject of the appeal before the ALJ during the 2013 hearing. However, where that reasoning falters is in its misapprehension of the scope and application of the ALJ's ruling. The money that was withheld by Appellees beginning in or after 2006 was withheld to cover the alleged $4,000,000

overpayment on the 2003-2006 claims.

The claims submitted after 2006 were adjudicated by Appellee contractors, found to be valid and payable, and documents were issued by Appellee contractors (including IRS Forms 1099) showing that these claims were paid by them. Therefore, there was no adverse claims decision for the Appellants to appeal after 2006. The only problem was, the Appellees did not actually deliver the payments to the Appellants, Appellees withheld them.

A nondiscretionary duty is a mandatory ministerial obligation. "Mandamus issues to compel an officer to perform a purely ministerial duty. It cannot be used to compel or control a duty in the discharge of which by law [an official] is given discretion." *Work v. U.S. ex rel. Rives*, 267 U.S. 175, 177 (1925). Essentially, "If a duty is discretionary or directory, the duty is not owed." *Mackzo v. Joyce*, 814 F.2d 308, 310 (6th Cir. 1987)(quoting *Short v. Murphy*, 512 F.2d 374, 377 (6th Cir. 1975)).

At its core, Appellants' claim for mandamus relief is an assertion of a right to payment. In this case, that right is bolstered by a final order of the Secretary of the U.S. Department of Health and Human Services. There is no real argument between the parties that the law requires Appellee to pay Appellants for bonafide claims. Likewise, there is no argument that Appellees have a non-discretionary duty to pay a successfully appealed claim. In fact, the agency has admitted as much in past litigation.

Wolcott, 635 F.3d 769)("The defendants concede that Trailblazer [a government Medicare contractor] has a non-discretionary duty to pay a successfully appealed claim. . . ."). The issue then becomes a determination as to whether Appellees' offsetting future payments to satisfy denials of claims that were successfully appealed is a violation of its nondiscretionary duty of payment.

i. Payment was a Nondiscretionary Duty Under 42 C.F.R. § 405.920

Appellee contractors, as fiscal intermediaries for the U.S. Department of Health and Human Services, are subject to the requirements imposed by the regulations promulgated by the agency. In this case, Appellees had a clear nondiscretionary duty to pay under the plain language of 42 C.F.R. § 405.920. That regulation outlines some of the basic requirements of a Medicare contractor.

Of particular relevance to this case is 42 C.F.R. § 405.920(b) which states that after a contractor determines whether the items or services furnished by the provider are covered and otherwise reimbursable, it is to determine how much the payment should be and "make payment accordingly." Whether a claim is payable, and how much to pay, are discretionary determinations. Whether to actually disperse payment after a claim is approved is not subject to debate. It is no longer discretionary.

The Federal Regulation could not have made a more clear statement. The contractor is to make payment on approved claims. Appellants provided undisputed documentary evidence that Appellee contractors failed in their duty under 42 C.F.R. § 405.920(b). When a "plainly defined and peremptory" obligation is not performed, it is ripe for mandamus. *U.S. v. Battisti*, 486 F.2d 961, 964 (6th Cir. 1973).

ii. The ALJ Order Imposed a Nondiscretionary Duty

Even if the Court finds that 42 C.F.R. § 405.920(b) did not independently impose a nondiscretionary duty on Appellee contractors to pay the post-2006 claims reviewed and approved for payment, the 2013 ALJ order certainly did. The operative portion of the order stated:

> The Medicare contractors are hereby DIRECTED to process the claims and claim lines at issue in accordance with this decision. Any amounts recouped or otherwise recovered from the provider based on the invalid overpayment demands shall be returned to [Appellants].

[Order Granting Mtn. to Dismiss, R-38, Page ID # 1197].

What the District Court failed to recognize is that even though the ALJ approved nearly all of the claims subject to the audit and appeal, Appellee contractors had been withholding payment of all the claims submitted by Appellants after the audit period. Appellees took the otherwise approved payments, and, instead of disbursing them, withheld them. Then Appellees applied the amounts to the approximately $4,000,000 "overpayment" that was before the ALJ.

The fact that this was occurring was before the ALJ and considered by him. Hence the language in the decision: "Any amounts recouped or otherwise recovered from the provider based on the invalid overpayment demands shall be returned to [Appellants]."

However, the Appellant contractors ignored the ALJ's decision and continued to wrongfully withhold approved payments, despite the ALJ's order, until Appellants could not survive financially any longer. In accounting parlance, as far as Appellee contractors were concerned, the Appellants "had a negative on the balance sheet" and future payments were being applied to settle it.

Generally, that is how Appellee contractors do business. Once an overpayment is finalized, Appellees then apply any future reimbursement to the overpayment. Medicare regulations even permit Appellees to do so while the provider is challenging the overpayment, as in this case. *See* 42 U.S.C. § 1395ddd.

Following its standard process, Appellees continued to withhold and apply payments they owed to Appellants for claims Appellants submitted between 2006 and the cessation of business operations in 2016. The payments were unlawfully held back and retained by Appellee contractors to satisfy the overpayment which was vacated by the ALJ.

As far as Appellants can tell from the remittance advices and IRS Forms 1099 they received, Appellees' must believe Appellants owe them well in excess of the $35,872.28 remaining under the final ALJ decision. Appellants reached this conclusion because Appellees have, to date, withheld a minimum of $165,302.74 in payments for valid, approved claims. [Resp. in Opp., R-24, Page ID ## 950-51].

Based on the above, Appellee contractors breached the nondiscretionary duty they owed to Appellants in two material respects. First, they continued to collect an overpayment that was invalidated. Second, they did not pay claims that they approved and credited to Appellants.

In support of its opinion that Appellees' duty was discretionary and not clearly defined, the District Court relied on *Mackzo v. Joyce*. In *Mackzo*, the plaintiff received a favorable order directing her employment be reinstated with reasonable accommodations, back pay and benefits, and seniority. *Mackzo*, 814 F.2d at 309. When the plaintiff did not receive the benefits, she sought a writ of mandamus. This Court reasoned mandamus was not appropriate

because the terms of the original order were not "readily ascertainable" because the parties disagreed over their meaning. *Id.* The primary point of disagreement for the *Mackzo* court was that the plaintiff sought enforcement of what amounted to nonliquidated damages. *Id.* at 310-11.

Mackzo is distinguishable for several reasons, not the least of which was that the parties in *Mackzo* had a *bone fide* dispute over the interpretation of the EEOC order. Here, there is no argument as to what the ALJ ordered Appellees to do: pay back all the money withheld in satisfaction of the vacated overpayment. This Court can read the ALJ's decision and it is doubtful that this Court will have find any confusion.

When the ALJ's directive is coupled with Appellees' obligation to pay approved claims under 42 C.F.R. 405.920(b), there is no colorable dispute as to the substance of the Appellee contractors' duty as set forth in the ALJ's order.

The amounts owed to Appellants by Appellees are not "unliquidated"; they are, instead, readily foreseeable and calculable. The ALJ himself was able to easily calculate the exact amount of the claims Appellants had submitted from 2003 through 2006 and exactly calculate the amount of any overpayment due.

There is only a perspicuous universe of claims that was billed by Appellants. Those claims were either: denied; actually paid; or payment was

approved and the funds withheld and applied to an overpayment. They were not denied. Documents sent by Appellee contractors showed they were reviewed and approved for payment. If they were actually paid (which they were not), then Appellees have a record of the electronic transfer of funds to Appellants' bank account. If the claims were approved but payment withheld, then Appellees have a record of where and to what the withheld amounts were applied.

This is precisely the type of calculation the court made in *Pritchett v. Comm'r of Soc. Sec.*, 2005 U.S. Dist. LEXIS 46965 (E.D. Mich. June 22, 2005). *Pritchett* involved a social security income (SSI) determination dispute that resulted in an ALJ ordering the agency to reinstate and pay back benefits. *Id.* at *3-7. The agency failed to abide by the order and Mr. Pritchett filed suit in federal court seeking, and ultimately receiving, mandamus relief. *Id.* at *24.

The Court ultimately granted mandamus and required the parties to determine exactly what benefits were owed (i.e., which payments were not made), and whether deductions for overpayments were appropriately made. *Id.* at *3-8. The same calculations are necessary here.

We know the claims which were billed by Appellants to Appellees. Appellees have a record of whether those claims were paid, and where those payments went. [*See, e.g.,* Appx., pp. 1-4]. To resolve the matter, the parties need only to review Appellees' records and reconcile the payments. There is no

interpretation necessary.

D. Appellants Had No Other Available Remedy

The second prong of the mandamus test requires the party seeking relief must have no other available remedy. *Kerr*, 426 U.S. at 402-03. As a preliminary matter, Appellants believe they have no remedy under the Medicare statutes or regulations which offers them an avenue other than mandamus down which they can pursue relief. Consequently, the District Court's and Appellees' references to the five-stage Medicare appeal process was wholly inapposite. This avenue has been thoroughly trod by the Appellants. These procedures have previously been exhausted.

The District Court's first error was to treat Appellees' unlawful application of post-2006 payments to the invalidated overpayment as a brand new claim which needed to be adjudicated in the administrative process. Specifically, the Court stated:

> There were no findings of fact or conclusions of law that pertain to the funds [Appellees] withheld from New Vision beginning in 2006, nor was there a finding that [Appellees] withheld funds beginning in 2006 to continue to collect on the Disputed Amount.

[R-38, Page ID # 1202].

The reasoning went, if the failure to pay post-2006 claims was not the subject of the ALJ's order, and no other final agency order covered them, then *ipso facto*, Appellants did not exhaust their administrative remedies. This line of reasoning by the District Court suffers from two fatal flaws. First, the Medicare appeal process is a method through which providers can appeal **denied** claims for reimbursement and adverse benefit determinations. It is not for pursuit of payments for reviewed and approved claims. Second, the ALJ order is intended to cover any action of Appellee, whether past, present, or future, as those actions related to the invalidated overpayment. The District Court seemed to view the order's application as exclusively retroactive. However, this view ignores the ALJ's clear language in 2013: "Any amounts recouped or otherwise recovered from the provider based on the invalid overpayment demands shall be returned to [Appellants]."

i. Triggering the Medicare Appeals Process

As outlined in detail above, the Medicare appeals process is a multi-step process through which providers can appeal denied claims. According to 42 U.S.C. § 1395ff and 42 C.F.R. § 405.904 the appeals process is for two types of initial determinations: entitlement appeals; and claim appeals.

Entitlement appeals relate to initial

determinations as to whether a beneficiary is entitled to receive Medicare benefits of a certain type. *See* 42 C.F.R. § 405.904(a)(1). Claim appeals relate to initial determinations as to whether a particular claim for benefits under Part A or Part B is payable under Medicare. 42 C.F.R. § 405.904(a)(2). Neither entitlement, nor claim appeals have anything to do with disputes over payment of already approved claims.

This position finds further support in 42 C.F.R. § 405.920, which states:

> After a claim is filed with the appropriate contractor in the manner and form described in subpart C of part 424 of this chapter, the contractor must -
>
> (a) determine if the items and services furnished are covered or otherwise reimbursable under title XVIII of the Act;
>
> (b) Determine any amounts payable and make payment accordingly; and
>
> (c) Notify the parties to

> the initial determination of the determination in accordance with § 405.921.

Section 405.920 clearly says there are only two types of initial determinations, whether something is payable, and if so, how much. Meaning, once the post-2006 claims were approved for payment at the full Medicare amount, there was nothing for Appellants to appeal. The process did not offer them an entry point.

The District Court's Order mentions these facts but seems to take no notice of the conflicting language. In discussing the administrative appeal process, the District Court described entry into the administrative process as follows:

> After a party receives a **denial of its claim**, the first level of appeal is invoked by requesting a redetermination by the fiscal intermediary carriers.

[Ord. Grt. Mtn. to Dismiss, R-38, Page ID # 1201 (emphasis added)].

Essentially, the District Court's interpretation of the law placed Appellants squarely within a "Catch 22." In order to seek mandamus relief, Appellants first needed to enter and exhaust the administrative

process. However, Appellants are barred from so entering the administrative process because they lack the requisite predicate, namely a denied claim.

Considering there was no administrative means of addressing the unlawfully withheld payments, Appellants argued that *Pritchett v. Comm'r of Soc. Sec.*, 2005 U.S. Dist. LEXIS 46965 (E.D. Mich. June 22, 2005) should control.

The District Court, however, distinguished *Pritchett* by stating Mr. Pritchett had exhausted his administrative remedies, but Appellants had not. That line of reasoning is clearly erroneous. Appellants, as stated above, had no administrative means of addressing Appellees' misconduct.

When the Court considers the purpose and nature of the Medicare appeals process, it must find that *Pritchett* is apposite and controlling authority. In both *Pritchett* and this case, there was an agency determination that it overpaid benefits. Both plaintiffs successfully challenged the determination before an ALJ. Both plaintiffs received orders requiring the agency to pay any back benefits withheld. Both times the agencies failed to comply. Both plaintiffs filed for mandamus relief. The only difference is that the Eastern District of Michigan granted mandamus in *Pritchett*, but denied it in this case.

ii. The ALJ's Order Contemplated Future

Application

The District Court's error in reasoning is further belied by the plain language of the ALJ's Order. ALJ O'Leary ordered Appellees to return or repay all funds "recouped or otherwise recovered from the provider based upon the invalid overpayment." [Ord. Grt. Mtn. to Dismiss, R-38, Page ID # 1201]. The District Court impermissibly read a temporal limitation into the order which is simply not there.

The order's language is straightforward. Appellees were ordered to pay back any money they recovered or withheld as a result of the overpayment.[9] Inherent in the order was the supposition that Appellees would follow the directives therein. The ALJ could not reasonably foresee that not only would Appellees not release funds as required, but would instead continue to recoup them until Appellants became insolvent and stopped submitting them.

The following excerpt from the ruling below elucidates the error:

> Neither the ALJ nor MAC rendered a final agency decision on whether

[9] Necessarily, this requirement was related only to those amounts over and above the $41,675.65 (as contrasted with the $4,000,000 amount originally demanded by Appellee contractors), the amount of the actual overpayment that remained after the 2013 ALJ hearing. Meaning Appellees could permissibly offset that amount from post-2006 claims, but no more.

> [Appellees] withheld funds beginning in 2006 to collect on the Disputed Amount, and whether [Appellees] were required to reimburse [Appellants].

[R-38, Page ID # 1205].

The problem with this reasoning is that the ALJ's order clearly acknowledged that funds had been recouped or withheld and may be in the future. After all, the final decision was issued nearly seven (7) years after the designated audit period, so it stood to reason the agency would have tried to recover some of the roughly $4,000,000 it alleged Appellants owed.[10] Had the ALJ not considered possible offsets, there was no reason to order Appellees to return "recouped or otherwise recovered" funds.

From a temporal perspective, the ALJ's order does not distinguish between money recouped before the order issued and that which may be recouped in the future. What the order **does** say is that Appellees were to return or otherwise repay all funds "recouped or otherwise recovered from the provider based upon the invalid overpayment." [R-38, Page ID # 1197]. The only condition in the ruling is that it applies to amounts recouped based on the 2003-2006 audit. [*Id.*].

---

[10] The audit period was from January 1, 2003, through December 31, 2006. The final decision of the ALJ issued on September 4, 2013.

II. The District Court Erred in Finding Appellants Had Not Exhausted Their Administrative Remedies for Counts III through VIII

The District Court's sole basis for dismissing Counts III through VIII of the Second Amended Complaint was that it believed Appellants did not exhaust their administrative remedies prior to filing suit in the District Court. [R-38, Page ID ## 1206-08].

There are two primary errors in the District Court's decision. First, Appellants did present their case on these claims or causes of action to the agency, and the presiding ALJ made specific findings relative to each of the causes of action in those counts. Second, Appellants seek relief for claims that do not "arise under" the Medicare Act. As such, Appellants do not need to proceed through the administrative process, and Appellees are not entitled to the protections of 42 U.S.C. §§ 405(g) & (h).

The District Court had jurisdiction under 28 U.S.C. §§ 1331 & 1332 and should have allowed the case to proceed.

A. Appellants Presented Their Claims to the ALJ

Presentment of claims, as required by 42 U.S.C. § 405(g), is satisfied where a party presents its claim theories through the administrative process. *See Bodimetric Health Servs., Inc. v. Aetna Life & Cas.*,

903 F.2d 480, 486 (7th Cir. 1990)(holding a plaintiff could present underlying allegations and common law theories against the Medicare contractors in the Medicare appeals process in order to obtain a favorable outcome); *accord*, *Southern Rehab. Grp., P.L.L.C. v. Sec'y of Health & Human Servs.*, 732 F.3d 670, 678 (6th Cir. 2013).

In *Bodimetric* an operator of home health agencies brought suit seeking damages from a fiscal intermediary based upon its claims handling activities. *Bodimetric*, 903 F.2d at 481-83. Specifically, Bodimetric alleged the fiscal intermediary adopted several "hide-the-ball" and unjustly restrictive policies toward claim adjudication and issued wholesale denials of reimbursement. *Id.* at 482-83. Bodimetric alleged those denials, while almost unanimously overturned in the appeal process, resulted in the collapse of its business. *Id.*

The court rejected Bodimetric's contention that it could not raise its challenges to government contractor Aetna's unlawful behavior in the administrative process **because the agency could not award damages for them**. In reaching its conclusion, the court held that while an ALJ could not award damages, Bodimetric could use the contractors' misdeeds as grounds to challenge the individual benefit determinations. *Id.* at 486.

Appellants followed the blueprint set forth in the *Bodimetric* decision and raised the facts underlying the tort and due process causes of action to

the ALJ. *Id.* at 486-87. Indeed, that method was successful as the 2013 ALJ order is replete with findings of misconduct and violations against Appellees upon which the decision was based. [Resp. in Opp., R-24, Page ID ## 922-29].

The District Court, however, quixotically found those statements by the ALJ to be "at best . . . dicta, and not part of or the basis for the final decision." [Ord. Grt. Mtn. to Dismiss, R-38, Page ID # 1208]. Appellants ask this Court to find that characterization meritless.

The case before the ALJ was Appellants' challenge of the Medicare Qualified Independent Contractor's (QIC) redetermination decision. That decision included individual claim determinations and a statistical extrapolation which bloated the alleged overpayment amount to an amount in excess of $4,000,000. The ALJ order included some of the following as section headings in bold type face:

- "Problems both large and small, both technical and substantive";
- "Claim lines at issue not clearly defined . . . ";
- "Claim lines clearly omitted from QIC review . . .";
- "Substantive and evidentiary issues with the reconsideration

decisions";

- "Citations to evidence not in the appeal record";
- "Citations to data files not in record and withheld from [Appellants] despite FOIA requests";
- "False or misleading characterizations in the Maximus [another government contractor] reconsideration decisions";
- "Intentional misrepresentations"; and
- "Fallacies of logic"

Each of those headings were substantiated by the ALJ in detail in the written decision. When considered in context, the District Court's conclusion that the ALJ's findings like the following made against the Appellee contractors were "mere dicta" is incredible:

- failure to include mandatory elements;
- "did not use care";
- "did not demonstrate even

substantial compliance";

- "the documents lack the legitimacy, integrity, and credibility to prove a sizable debt";
- "failed to comply with CMS guidance in the MFMM and with the generally accepted government auditing standards";
- "far less than forthcoming";
- provided evasive FOIA [Freedom of Information Act] responses;
- "failed to comply with the ethical guidelines and with generally accepted statistical practice and procedures";
- failed to "faithfully execute" its obligation to safeguard Appellants' due process rights;
- undermined the "integrity of the appellate process" and violated the "principles of fairness";
- knowingly committed breaches of the Medicare Program Integrity (MPIM) rules;

- Did not respond to FOIA requests;
- "flagrantly disregarded MPIM guidance as well as generally accepted government auditing standards as well as statistical practice and procedures"; and
- demonstrated a "lack of adherence to CMS guidance and professional standards."

[Resp. in Opp., R-24, Page ID ## 922-928].

The ALJ best summed up his findings by saying:

> the lack of responsiveness of various Medicare entities documented herein paint a picture of bureaucratic delay and obstruction, which is prejudicial to providers with millions of dollars at stake who have to meet fixed deadlines for filing appeals, despite being deprived of an accounting sufficient to show the accuracy of the calculated overpayment.

[R-18, Page ID # 735].

Findings made by an administrative law judge like those above do not, under any reasonable interpretation, constitute "mere dicta." Instead, they are substantive determinations by the ALJ based on Appellants' presentation of the fraud, deceit, and gross bureaucratic negligence perpetrated by Appellees. Unfortunately for these Appellants, the ALJ does not have authority to provide a remedy for that misconduct. Appellants have no remedy except from the District Court.

Where Appellants believe the District Court went wrong is that it failed to realize that the case before the ALJ was not just about claim denials of Medicare claims for health services provided. True, the claim adjudications were a major part of the decision itself, but they only represent a small part of the amount the Appellee contractors sought to recover.

The lion's share of the alleged overpayment came from Appellees' use of a statistical extrapolation formula to take an alleged overpayment in the tens of thousands of dollars and exaggerate it to abn alleged debt of millions of dollars.

So, when the District Court finds the statements above to be mere dicta, that may have been true only if the case was just about whether the claims were reimbursable under Medicare. Since the extrapolation was an equally important part of the case before the ALJ, Appellees' procedural misconduct and tortious actions relative to the extrapolation are certainly more than "mere dicta."

Based on the above, Appellants have certainly satisfied the type of presentment discussed by the *Bodimetric* and *Southern Rehab.* courts.

B. Appellants' Claims Do Not "Arise Under" Medicare and Are Not Barred by 42 U.S.C. § 405(h)

Even if the Court were to find that Appellants did not sufficiently present the claims underlying Counts III through VIII in the Medicare proceedings below, administrative exhaustion is not a prerequisite to filing in the District Court because the claims to do not "arise under" Medicare.

In most cases where plaintiffs brought tort or other business-related claims against Medicare contractors the reviewing courts found 42 U.S.C. § 405(h) & (g) barred the action because it arose under Medicare and, therefore, must be presented in the administrative process. *See Bodimetric*, 903 F.2d at 482-83; *Heckler*, 466 U.S. at 610; *Do Sung Uhm v. Humana, Inc.*, 620 F.3d 1134, 1140-43 (9th Cir. 2010)(unjust enrichment claim for withheld prescription coverage "arises under"); *Livingston Care Center, Inc. v. United States*, 934 F.2d 719, 721-22 (6th Cir. 1991).

The key distinction of this case and *Bodimetric* and others reaching the same or similar conclusion is that Appellants did not bring suit for unlawful or unjust practices in making benefit determinations. *See Bodimetric*, 903 F.2d at 482-83 (provider brought

suit for pattern of arbitrary denials); *Heckler*, 466 U.S. at 608-10 (suit brought for denial of previously covered surgical procedure); *U.S. v. Erika, Inc.*, 456 U.S. 201, 204-05 (1982)(suit brought for amount of reimbursement paid); *Kurtizky v. Blue Shield*, 850 F.2d 126 (2d Cir. 1988)(suit brought related to amount of reimbursement); *Ass'n of Seat Lift Mfrs. v. Bowen*, 858 F.2d 308 (6th Cir. 1988)(challenge to reimbursement decision for medical devices). Instead, Appellants bought suit for violations of their due process rights committed by Appellees during the audit process and the subsequent Medicare appeals process.

Since the Supreme Court decided *Bowen v. Mich. Academy of Family Physicians*, 476 U.S. 667 (1986)(superseded by statute on other grounds), the courts' primary focus in answering jurisdictional questions related to Medicare suits rested on the distinction between challenges to the application of Medicare regulations *vis-a-vis* claim adjudication, and constitutional challenges to the actual regulations themselves. *Bodimetric,* 903 F.2d at 485-86.

The Seventh Circuit succinctly stated its reasoning in *Bodimetric* by saying: "Whether its complaint is with Aetna's rejection of one claim or a thousand claims, Bodimetric's grievance is, at bottom, a challenge to Aetna's approach to processing claims." *Id.* at 486.

However, in the present case Appellants' primary purpose in bringing suit was not to recover

damages related to the Appellee contractors' claim processing procedures. Rather, Appellants herein sought compensation for Appellees' wilful and wanton violations of Medicare statutes, regulations, guidelines and Appellants' due process rights, as well as their abandonment of all sense of fair play in the audit and appeals process.

Bodimetric, *Michigan Academy*, *Erika*, and their progeny only exist to safeguard Medicare's jurisdictional bar because:

> [i]f litigants who have been denied benefits could routinely obtain judicial review of these decisions by recharacterizing their claims under state and federal causes of action, the Medicare Act's goal of limited judicial review for a substantial number of claims would be severely undermined.

Bodimetric, 903 F.2d at487. That is not this case.

Counts III through VIII of Appellants' Second Amended Complaint do not offend the principle quoted above. Unlike the plaintiffs in the above-cited cases, Appellants' claims are not "inextricably intertwined" with benefits determinations under the Medicare Act. *Heckler*, 466 U.S. at 622-24. Likewise, Appellants'

claims are not "at bottom" a challenge to Appellees claims processing habits.

The wrongs committed by Appellee contractors can be reviewed and adjudicated absent any reference to the underlying claims for reimbursement. **Where a reviewing court does not necessarily have to examine the claims themselves to determine whether the defendant harmed the plaintiff, the cause of action does not "arise under" the Medicare Act.** *See Fin. Advisors & Consultants v. Cooperativa de Seguros de Vida*, 106 F. Supp. 2d 244, 252 (Dist. P.R. June 27, 2000)(holding bribery allegations under RICO act sufficiently separate from the underlying claims for jurisdictional bar to apply); *Zanecki v. Health Alliance Plan*, 2013 U.S. Dist. LEXIS 82732 (E.D. Mich. May 20, 2013)(tort for wrongful death not likely to "arise under"); *Rochester Methodist Hospital v. Travelers Ins. Co.*, 728 F.2d 1006 (8th Cir. 1984)(jurisdiction found in case against contractor that committed tortious action); *Ardary v. Aetna Health Plans of S. Cal.*, 98 F.3d 496 (9th Cir. 1996)(claim for wrongful death did not "arise under"); *but see Kaiser v. Blue Cross*, 347 F.3d 1107, 1114-15 (9th Cir. 2003)(finding case arose under the Medicare Act because it followed a finding of a valid overpayment). In the present case, the Court does not have to "examine the claims themselves to determine whether the defendant harmed the plaintiff" in ruling on Counts III through VIII. Medicare claims (as in claims submitted for services provided) are not at issue in Counts III through VIII.

Building on the arguments in the preceding section, Appellants seek redress for injuries caused by Appellees, not in the claim review process, but in their wrongful conduct during the audit and appeal process. Appellants do not charge that the later-overturned claim denials were the principal cause of their losses because those claims were paid to Appellants when they were initially submitted.

Appellants do, however, allege Appellees' flaunting of Appellants' due process rights, refusal to abide by generally accepted auditing principles, intentional disregard for Medicare rules in preparing the statistical extrapolation, and generally obfuscatory conduct in the appeal process had the effect of damaging their business and reputation beyond repair and dragging them through nearly a decade of still as yet unresolved litigation.

Following the reasoning in *Fin. Advisors & Consultants*, *Ardary*, *Ellis v. Blum*, 943 F.2d 68, 75-76 (2d Cir. 1996), and others, Appellants' claims do not "arise under" Medicare because they do not "at bottom" seek reimbursement for Medicare claims. *Fin. Advisors & Consultants*, 106 F. Supp. 2d at 252 (quoting *Heckler*, 466 U.S. at 614). They seek compensation for damages, for actual harm caused by the Appellee contractors to the Appellants.

CONCLUSION

This case should not have been dismissed on a motion to dismiss. At the very least, discovery should have occurred. Based on the facts and arguments above, Appellants respectfully request the Court reverse the District Court's order dismissal of Counts I through VIII of the Second Amended Complaint and remanding the case for further proceedings.

Respectfully submitted this 2nd day of February 2018, by:

/s/ George F. Indest III

GEORGE F. INDEST III
Fla. Bar No. 382426
LANCE O. LEIDER
Fla. Bar No. 96408
THE HEALTH LAW FIRM
1101 Douglas Avenue
Altamonte Springs, Florida 32714
Phone: (407) 331-6620
Fax: (407) 331-3030
ATTORNEYS FOR APPELLANTS NEW VISION HOME HEALTH CARE, INC., AND SALEEM BIN SHAKOOR

CERTIFICATE OF COMPLIANCE

1. This brief complies with the word limit set forth in Fed. R. App. P. 32(a)(7)(B)(i) because, according to the word-count feature of Corel WordPerfect X7, it contains 10,616 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

2. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared in a proportionally spaced typeface using Corel WordPerfect X7 in Times New Roman 14-point font.

/s/ George F. Indest III

GEORGE F. INDEST III
Fla. Bar No. 382426
LANCE O. LEIDER
Fla. Bar No. 96408
THE HEALTH LAW FIRM
1101 Douglas Avenue
Altamonte Springs, Florida 32714
Phone: (407) 331-6620
Fax: (407) 331-3030
ATTORNEYS FOR APPELLANTS NEW VISION HOME HEALTH CARE, INC., AND SALEEM BIN SHAKOOR

CERTIFICATE OF SERVICE

I certify that I electronically filed this Initial Brief of Appellants New Vision Home Health Care, Inc., and Saleem Bin Shakoor with the Clerk of the Court using the CM/ECF system, which sends electronic notification to all counsel of record.

Done this 2nd day of February 2018, by:

/s/ George F. Indest III

GEORGE F. INDEST III
Fla. Bar No. 382426
LANCE O. LEIDER
Fla. Bar No. 96408
THE HEALTH LAW FIRM
1101 Douglas Avenue
Altamonte Springs, Florida 32714
Phone: (407) 331-6620
Fax: (407) 331-3030
ATTORNEYS FOR APPELLANTS NEW VISION HOME HEALTH CARE, INC., AND SALEEM BIN SHAKOOR

ADDENDUM

Designation of Relevant District Court Documents

RECORD ENTRY NUMBER	DESCRIPTION	DATE DOCKETED	Page ID # Range
18	Second Amended Complaint	3/11/2017	181-837
18-1	Exhibit 1 to Second Amended Complaint	3/11/2017	436-837
20	Defendants' Motion to Dismiss	4/26/2017	841-894
21	Order to Show Cause	4/28/2017	895-897
22	Plaintiffs' Response and Brief in Opposition to Defendants' Motion to Dismiss	5/25/2017	904-993

23	Defendants' Reply in Support of Their Motion to Dismiss	6/8/2017	996-1031
27	Plaintiffs' Unopposed Motion for Leave to File Sur-Reply in Opposition to Defendants' Reply in Support of Their Motion to Dismiss	6/22/2017	1032-1060
27*	Order Granting Motion to File Sur-Reply	7/6/2017	n/a
30	Order Denying Motion to Dismiss	7/12/2017	1068-1073
32	Defendants' Motion for Reconsideration	7/26/2017	1078-1091
32*	Order Setting date for Response to Motion for Reconsideration	7/27/2017	n/a

33	Defendants' Answer and Affirmative Defenses	7/26/2017	1092-1119
36	Plaintiffs' Response to Defendants' Motion for Reconsideration	8/4/2017	1135-1165
37	Plaintiffs' Verified Motion to Remove or Disqualify U.S. Attorney as Counsel for Defendants	8/23/2017	1166-1193
38	Order Granting Defendants' Motion to Dismiss	8/28/2017	1194-1209
39	Notice of Appeal	9/26/2017	1210-1228
40	Certificate of Service	9/26/2017	1229

* denotes docket entry by the District Court - no document number or page # ID assigned

APPENDIX H

Case: 17-2165 Document: 51 Filed: 11/19/2018

No.: 17-2165

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

NEW VISION HOME HEALTH CARE, INC., et al.,

Plaintiffs-Appellants,

- v. -

ANTHEM, INC., et al.,

Defendants-Appellees.

On Appeal from the United States District Court
for the Eastern District of Michigan
Case No.: 2:16-cv-13173-VAR-RSW

AMENDED PETITION FOR REHEARING EN BANC FOR PLAINTIFFS-APPELLANTS NEW VISION HOME HEALTH CARE, INC., et al.

GEORGE F. INDEST III
Fla. Bar No. 382426
LANCE O. LEIDER
Fla. Bar No. 96408
THE HEALTH LAW FIRM
1101 Douglas Avenue
Altamonte Springs, Florida 32714
Phone: (407) 331-6620
Counsel for Plaintiffs-Appellants

STATEMENT REGARDING NECESSITY OF EN BANC REHEARING

Rehearing is necessary to correct a decision that is a substantial departure from established law and precedent which, if left uncorrected, will deprive Appellants and thousands of other Medicare providers of due process rights and recompense for violations of those rights. A copy of the Court's Opinion is attached.

Pursuant to Rule 35(b)(1)(B), Federal Rules of Appellate Procedure, Appellants state that the panel decision rendered on October 3, 2018, in this case conflicts with the decisions of the United States Court of Appeals for the Fifth Circuit in *Family Rehab., Inc. v. Azar*, 886 F.3d 496 (5th Cir. 2018), and *Affiliated Prof'l Home Health Care Agency v. Shalala*, 164 F.3d 282 (5th Cir. 1999), and warrants rehearing en banc because it creates a question of exceptional importance.

The Court's decision creates a split among the federal appellate circuits by taking a position that where a clear non-discretionary duty is owed to a plaintiff to be paid according to an ALJ's ruling, mandamus does not lie. Further, a split is created by this Court's decision to the extent it stands for the proposition that the District Court does not have jurisdiction over a collateral claim related to a Medicare overpayment action.

This Petition is timely filed as the real party in interest on the side of Appellee is the United States.

Meaning, under Rules 35(c) and 40(a)(1)(A)-(C), Federal Rules of Appellate Procedure, this Petition must be filed within forty-five (45) days of the entry of judgment.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Federal Cases

Federal Statutes

Federal Rules

ARGUMENT

A. Summary of Issues

i. The Panel created a circuit split by taking the position that mandamus does not lie where enforcement of a clear non-discretionary duty to pay a provider issues from an ALJ's order.

In its Second Amended Complaint and on appeal, Appellants argued that the Medicare ALJ issued an order directing Appellees to pay all claims that were previously denied. Appellants further argued such a directive is fodder for mandamus relief should the government and its contractors fail to comply. After all, 28 U.S.C. § 1361 grants mandamus jurisdiction to the district courts. The federal appellate circuits have further held that § 1361 jurisdiction is not precluded by 42 U.S.C. § 405(h). *See Family Rehab., Inc.*, 886 F.3d at 505; *Wolcott v. Sebelius*, 635 F.3d 757, 764-65 (5th Cir. 2011).

The Panel's opinion inexplicably held that mandamus jurisdiction did not exist because Appellants had not yet exhausted their administrative remedies. [Op. at p. 8]. The reasoning for that conclusion being primarily that the ALJ decision was not the "Secretary's final decision" and was, instead, only "binding on the parties". [*Id.*, at p. 9]. It strains credulity to think that an ALJ, who is employed by the

agency, can render a decision that is "binding" but not "final." Such a line of reasoning is akin to saying the District Court (or this Circuit's) ruling is not final until the U.S. Supreme Court passes on it.

The Panel's decision on the merits is in direct conflict with the Fifth Circuit in *Family Rehab., Inc.*, finding explicitly that exhaustion is not a prerequisite for mandamus relief. There the court held, "To say that exhaustion is a jurisdictional requirement would only further conflate jurisdiction with the merits." *Family Rehab., Inc.*, 886 F.3d at 506. The law in the Fifth Circuit cleaves cleanly from the apparent law in this Circuit when the Fifth Circuit opined that "mandamus jurisdiction lies wherever a plaintiff seeks to 'compel an officer . . . to perform an allegedly non-discretionary duty owed to the plaintiff.'" *Id.* (quoting *Wolcott*, 635 F.3d at 763).

ii. The Panel created a circuit split to the extent its opinion stands for the proposition that the District Court does not have jurisdiction over a collateral claim related to a Medicare overpayment action.

Collateral claims are those that do not require the reviewing court to "immerse itself" in the substance of the underlying claims for reimbursement from the Medicare program, nor do they portend a "factual determination" related to the applicable provisions of the Medicare Act. *Affiliated Prof'l*, 164 F.3d at 285-86.

Collateral claims are not claims that request administrative relief, i.e. the payment of denied claims. *Id.* at 286. "Instead, the [collateral] claim must seek some form of relief that would be unavailable through the administrative process." *Family Rehab., Inc.*, 886 F.3d at 501-02 (citing *Mathews v. Eldridge*, 424 U.S. 319, 330-32 (1976)).

Under the rationale of *Family Rehab., Inc.* and *Affiliated Prof'l*, Appellants' claims in Counts III-VIII are plainly collateral. Like the plaintiffs in *Family Rehab., Inc.*, Appellants brought state law and procedural due process claims as well as alleged that they suffered damages based on the *ultra vires* actions of Appellees. Finding those claims were not properly exhausted or presented is contradictory to the holdings in the Fifth Circuit and warrant review *en banc*.

B. The Panel Mischaracterized Plaintiffs-Appellants' Case in the Panel's Opinion

The Panel mischaracterized Appellants' case in its October 3, 2018, Opinion when it stated "On Counts I and II of the complaint, which sought a writ of mandamus **ordering an Administrative Law Judge ("ALJ") to enforce its 2013 order**." [Op. at p. 1] (emphasis added). Appellants sought a writ of mandamus to order the Appellees to comply with ALJ James S. O'Leary's 2013 Decision, not to order the ALJ to enforce its own order.

In addition, the Panel found that Appellants had not demonstrated that Appellee Contractors were

under a clear nondiscretionary duty to make payments on New Vision's post-2006 reimbursement claims and that the district court was correct in finding that it lacked subject matter jurisdiction to grant mandamus relief on the claims based on ALJ O'Leary's 2013 decision. [Op. at p. 12]. However, ALJ O'Leary's 2013 decision states:

> The Medicare contractors are hereby **DIRECTED** [sic] to process the claims and claim lines at issue in accordance with this decision. **Any amounts recouped or otherwise recovered from the Provider based upon the invalid overpayment demands herein shall be returned to the Appellant**.

[ALJ O'Leary's 2013 Decision, at p. 305] (emphasis added).

On the face of ALJ O'Leary's 2013 Decision it is clear that Appellee Contractors had a clear nondiscretionary duty to provide Appellants with the amounts that Appellee Contractors had recouped, whether prior or after to ALJ O'Leary's 2013 Decision.

The Panel also agreed with the district court, "that New Vision was required to pursue its tort and constitutional claims through the four-step Medicare

appeals process." [Op. at p. 12]. This logic is counter-intuitive and mischaracterizes what Appellants are seeking. Essentially, the Panel is suggesting that even though New Vision obtained a favorable decision, New Vision should have appealed its favorable decision to the Medicare Appeals Council ("MAC").

The panel was also incorrect and created a circuit split when it refused to find the tort and constitutional claims to not be collateral to exempt from the exhaustion requirement. *See Family Rehab,* 886 F.3d at 501-502 (collateral claims are those that seek relief not available through the administrative process).

C. The Panel Has Created a Circuit Split Regarding the Issue of Mandamus

In *Family Rehab., Inc.,* the Fifth Circuit decided a case where a Medicare provider, Family Rehabilitation, Incorporated, had gone through the first two (2) stages of the Medicare appeals process to prevent the Medicare contractor from recouping $7.6 million. However, when Family Rehab requested *de novo* review of its reconsideration, it discovered that there was a massive backlog in Medicare appeals and that it would likely not receive an ALJ hearing for at least three (3) years. This immense backlog and extended delay for an ALJ hearing would force Family Rehab into bankruptcy as the Medicare contractor continued to recoup payments.

Family Rehab did not complete all four stages of the Medicare administrative appeal process, nor did it escalate its claim to the MAC and wait 180 days for the MAC to take action. Instead, Family Rehab invoked recognized exceptions to the channeling requirements of § 405 as their bases for jurisdiction. Family Rehab claimed that its procedural due process and *ultra vires* claims were collateral to the agency's appellate process, thereby invoking *Mathews v. Eldridge*, 424 U.S. at 326-32. It insisted that § 405 "would not simply channel review through the agency, but would mean no review at all," thereby arguing that jurisdiction was proper under 28 U.S.C. § 1331. *Family Rehab., Inc.*, 886 F.3d at 501 (citing *Shalala v. Ill. Council on Long Term Care, Inc.,* 529 U.S. 1, at 19 (2000)). In addition, Family Rehab claimed that the court had mandamus jurisdiction.

The Panel splits from the Fifth Circuit over the issue of mandamus in stating:

> To satisfy the Supreme Court's test for mandamus jurisdiction under 28 U.S.C. § 1361, New Vision must show both that it has "exhausted all other avenues of relief" and that Contractors "owe [New Vision] a clear nondiscretionary duty." *Heckler v. Ringer*, 466 U.S. 602, 616 (1984); accord *BP*

> *Care, Inc. v. Thompson*, 398 F.3d 503, 514–15 (6th Cir. 2005).

[Op. at p. 7]. The Panel determined that because New Vision did not appeal its 2013 ALJ decision to the MAC, New Vision had not exhausted all of its administrative remedies.

The Fifth Circuit, on the other hand, analyzed the Department of Health and Human Services' ("DHHS") argument, which cited *Jones v. Alexander*, 609 F.2d 778 (5th Cir. 1980), and acknowledged, "[t]he government insists that exhaustion is a prerequisite to mandamus jurisdiction." *Family Rehab., Inc.*, 886 F.3d at 506. The Fifth Circuit went on to say, "one element of mandamus relief is the lack of other adequate means," and that the government therefore reasoned that exhaustion was necessary for mandamus jurisdiction. *Id.* (quoting *Jones,* 609 F.2d at 781). However, the Fifth Circuit stated:

> Although the government's reading of *Jones* is not implausible, we disagree. We have cautioned to 'avoid tackling the merits under the ruse of assessing jurisdiction.' To say that exhaustion is a jurisdictional requirement would only further conflate jurisdiction with the merits.

Id. The Fifth Circuit went on to conclude:

> [n]or does *Jones* compel such a result—it is consistent with *Jones* to relegate exhaustion to the merits and hold that mandamus jurisdiction lies wherever a plaintiff seeks "to compel an officer . . . to perform an allegedly nondiscretionary duty owed to the plaintiff." *See Wolcott*, 635 F.3d at 763. For such requests, mandamus is plainly the "appropriate means of relief," and jurisdiction may obtain. *See Jones*, 609 F.2d at 781.

Id.

The reason the Fifth Circuit did not provide Family Rehab with mandamus relief is because Family Rehab did not request mandamus relief in its complaint and only requested injunctive relief. However, New Vision requested mandamus relief in its complaint in order to have ALJ O'Leary's 2013 Decision enforced against a Medicare contractor. New Vision lacks other adequate remedies to obtain the money that is owed to it by Appellee contractors since it does not seek to appeal ALJ O'Leary's 2013 Decision.

New Vision sought and continues to seek to compel an officer or agent to perform a nondiscretionary duty owed to it, which is the return of money collected by Appellee contractors during recoupment.

Given the same circumstances, the Sixth Circuit Panel would deny mandamus relief that the Fifth Circuit would grant.

Another issue that is left unaddressed is the Panel's treatment of a Medicare ALJ's order. The Panel states, "[t]he decision of the ALJ or attorney adjudicator on a request for hearing is binding on all parties;" however, the Panel states that only the MAC's decision is final and binding. [Op. at p. 6]. The Panel is suggesting that an order or decision from an ALJ is binding, but not final. Following this logic, no Medicare contractor would comply with an adverse decision from an ALJ since it is not final. Additionally, no Medicare contractor would appeal the ALJ's decision and risk having the MAC issue a final and binding decision. Conversely, a Medicare provider cannot appeal a favorable ALJ decision because there is no basis for review. This would allow Medicare contractors to avoid appropriately paying Medicare providers for their services by essentially gaming the "binding but not final" system.

D. The Panel Has Created a Circuit Split Regarding the Issue of Collateral Claims

The second circuit split has to do with collateral claims and *ultra vires* actions. Appellants' Counts III-

VIII are collateral claims that have been brought about by Appellee's *ultra vires* actions. The Panel found in its Opinion that Appellants' claims for negligence, gross negligence, tortious interference with business relationships and expectancies, violation of right to procedural due process, declaratory judgment, and injunction should have been brought before ALJ O'Leary and carried forward until Appellants exhausted all administrative avenues for relief. Specifically, the Panel states:

> Under *Southern Rehabilitation*, therefore, New Vision was required to exhaust its administrative remedies with regard to all of its claims in Counts III-VIII arising under the Medicare statute.

[Op. at p. 12-13]. The Panel continues its analysis of *Southern Rehabilitation* and states:

> we found that the state-law and federal constitutional claims were 'inextricably intertwined with the claim for review of the Secretary's decision' and must, like claims for review, 'be presented to the agency.'

[Op. at p. 13] (quoting *Southern Rehab. Group,*

P.L.L.C. v. Sec'y of HHS, 732 F.3d 670, 680 (6th Cir. 2013).

The Fifth Circuit, however, came to a different conclusion when assessing collateral claims. The Fifth Circuit based its analysis on *Mathews v. Eldridge* and stated:

> There, the Court held that jurisdiction may lie over claims (a) that are 'entirely collateral' to a substantive agency decision and (b) for which 'full relief cannot be obtained at a postdeprivation hearing.'

Family Rehab, Inc., 886 F.3d at 501 (quoting *Mathews v. Eldridge*, 424 U.S. 319, at 330 (1976)). The Fifth Circuit continued by stating:

> 'when a plaintiff asserts a collateral challenge that cannot be remedied after the exhaustion of administrative review,' courts shall deem exhaustion waived.

Id. (quoting *Affiliated Prof'l Home Health Care Agency v. Shalala*, 164 F.3d 282, 285 (5th Cir. 1999)).

As stated above, the Fifth Circuit found that

collateral claims are those that do not require the reviewing court to "immerse itself" in the substance of the underlying claims for reimbursement from the Medicare program, nor do they portend a "factual determination" related to the applicable provisions of the Medicare Act. *Affiliated Prof'l*, 164 F.3d at 285-86. In addition, the claim cannot request relief that would be "administrative," meaning it cannot be substantive, permanent relief that the plaintiff seeks or should seek through the agency appeals process. As determined in *Matthews*, the claim must seek some form of relief that would be unavailable through the administrative process. *Matthews v. Eldridge*, 424 U.S. at 330-32.

In this context, the Fifth Circuit analyzed *Heckler v. Ringer* and found that in *Heckler* the plaintiffs:

> sought a declaration that HHS's [sic] policy was unlawful and that certain claims were reimbursable under the Medicare Act. That, the Court reasoned, was nothing more than 'a claim that they should be paid' for certain procedures; as such, the claim was "inextricably intertwined' with [their] claims for benefits' under the administrative process. Even though the plaintiffs

> had alleged certain procedural claims, the relief they sought from those claims was still substantive.

Family Rehab, Inc., 886 F.3d at 502 (quoting *Heckler v. Ringer*, 466 U.S. 602, 610 (1984)). The Fifth Circuit summarized these findings by saying:

> If the court must examine the merits of the underlying dispute, delve into the statute and regulations, or make independent judgments as to plaintiffs' eligibility under a statute, the claim is not collateral. [...] And if plaintiffs request relief that is proper under the organic statute—by requesting that benefits or a provider status be permanently reinstated—the claim is not collateral

Id.

Just like in *Family Rehab., Inc.*, New Vision's procedural due process and *ultra vires* claims do not require the court "to wade into the Medicare Act or regulations." *Id.* at 11. Unlike in *Family Rehab., Inc.*,

New Vision has already been forced to cease its business operations and was forced to put its employees and patients through the detrimental effects of having to shut down, qualifying as an irreparable injury. As the Fifth Circuit has said, "[t]he combined threats of going out of business and disruption to Medicare patients are sufficient for irreparable injury." *Id.*

Due to the nature of Family Rehab's collateral claims and threat of irreparable injury, the Fifth Circuit determined that the court had jurisdiction to hear Family Rehab's collateral claims. Given that New Vision's circumstances closely mirror Family Rehab's circumstances, it stands to reason that the Fifth Circuit would have granted New Vision mandamus relief where the Panel did not.

New Vision's claims in Counts III-VIII are entirely collateral to its claims for payment. Medicare is not authorized to issue damages, it can only approve or deny claims for reimbursement. As such New Vision's claims in Counts III-VIII cannot be brought in front of a Medicare ALJ. In addition, New Vision's claims in Counts III-VIII have nothing to do with payment of a Medicare claim and are only concerned with the actions taken by Appellee contractors.

In *Family Rehab, Inc.,*The Fifth Circuit found that due process claims are collateral, "because [Family Rehab] raises claims unrelated to the merits of the recoupment, its claims are collateral." *Family Rehab., Inc.,* 886 F.3d at 503. Similarly, New Vision's

claims in Counts III-VIII for negligence, gross negligence, tortious interference with business relationships and expectancies, violation of right to procedural due process, declaratory judgment, and injunction are due process claims and, therefore, are collateral claims.

In addition, New Vision's claims in Counts III-VIII are entirely separate from the adjudication of the Medicare claims in the underlying audit. Counts III-VIII only have to do with Appellee contractors' bad faith conduct during the process of the audit. Counts III-VIII do not arise out of the adjudication of the Medicare claims and would still be ripe for review even if the ALJ issued an adverse decision against New Vision. These claims do not arise under the Medicare Act. Instead, they stand separately and apart from New Vision's claim for payment. As such, and according to the Fifth Circuit, New Vision's claims in Counts III-VIII are collateral claims.

CONCLUSION

Appellants request the Court identify the circuit split the Panel's decision created and grant a rehearing *en banc*.

CERTIFICATE OF COMPLIANCE

This petition complies with the word limit set forth in Fed. R. App. P. 35(b)(2)(A) because, according to the word-count feature of Corel WordPerfect X7, it contains 3,048 words, excluding the parts of the

petition exempted by Fed. R. App. P. 32(f).

This petition complies with the typeface requirements of Fed. R. App. P. 40(b) and 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared in a proportionally spaced typeface using Corel WordPerfect X7 in Times New Roman 14-point font.

CERTIFICATE OF SERVICE

I certify that I electronically filed this Petition for Rehearing En Banc with the Clerk of Court of the U.S. Sixth Circuit Court of Appeals, using the CM/ECF system, which automatically electronically serves all counsel of record, this 19th day of November 2018.

/s/ Lance O. Leider

GEORGE F. INDEST III
Fla. Bar No. 382426
LANCE O. LEIDER
Fla. Bar No. 96408
THE HEALTH LAW FIRM
1101 Douglas Avenue
Altamonte Springs, Florida 32714
Phone: (407) 331-6620
Fax: (407) 331-3030
ATTORNEYS FOR APPELLANTS NEW VISION HOME HEALTH CARE, INC., AND SALEEM BIN SHAKOOR

Attachment: Opinion, dated October 3, 2018