No. 19-2085

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

SANDRA PETERS,

Plaintiff-Appellant,

v.

AETNA INCORPORATED, AETNA LIFE INSURANCE COMPANY, OPTUMHEALTH CARE SOLUTIONS, INC.,

Defendants-Appellees.

On Appeal from the United States District Court
for the Western District of North Carolina (No. 1:15-cv-00109-MR)
The Honorable Martin K. Reidinger, District Judge

BRIEF OF *AMICI CURIAE* AMERICAN MEDICAL ASSOCIATION, NORTH CAROLINA MEDICAL SOCIETY, MARYLAND STATE MEDICAL SOCIETY, SOUTH CAROLINA MEDICAL ASSOCIATION, AND MEDICAL SOCIETY OF VIRGINIA IN SUPPORT OF PLAINTIFF-APPELLANT

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DISCLOSURE OF CORPORATE AFFILIATIONS AND OTHER INTERESTS

Pursuant to FRAP 26.1 and Local Rule 26.1, the American Medical Association, North Carolina Medical Society, Maryland State Medical Society, South Carolina Medical Association, and Medical Society of Virginia, who are *amici curiae*, hereby disclose that they have no parent corporations and that no corporation holds 10% or more of an ownership interest in any of the *amici*.

December 27, 2019

s/ Kyle A. Palazzolo
Kyle A. Palazzolo

Counsel for Amici Curiae

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INTEREST OF *AMICI CURIAE*

Amici, the American Medical Association (AMA), North Carolina Medical Society (NCMS), Maryland State Medical Society (MedChi), South Carolina Medical Association (SCMA), and Medical Society of Virginia (MSV), submit this brief in support of Plaintiff-Appellant Sandra Peters.[1] *Amici* are also identified in their motion for leave to file this brief.

The AMA is the author and copyright holder of *Current Professional Terminology* (CPT®),[2] whose use and misuse underlie this case. The CPT code set is maintained and updated regularly by the CPT Editorial Panel, which is a panel consisting of 17 medical and allied health professionals representing a broad range of the health care industry, including health insurance companies, and with dedicated staff support from AMA personnel.

The AMA opposes the misuse of CPT content. *See* AMA policies H-70.954, *Improper Use of AMA-CPT by Carriers/Software Programs*, and H-70.982, *Primary Health Care Reimbursement Coding*.[3] More broadly, *amici* oppose systemic

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[1] *Amici* hereby certify that no party's counsel authored this brief in whole or in part, no party or party's counsel contributed money intended to fund preparation or submission of this brief, and no person other than *amici* and their counsel contributed money intended to fund preparation or submission of the brief.

[2] CPT is a registered trademark of the AMA.

[3] *Available at* AMA PolicyFinder, https://policysearch.ama-assn.org/policyfinder/detail/H-70.954?uri=%2FAMADoc%2FHOD.xml-0-

misrepresentations by health care companies, as has apparently occurred in this case. Such misrepresentations undermine public confidence in those who provide health care services, such as *amici*'s members, and make it even more difficult to obtain consensus around whether and how the health care system should be reformed.

SUMMARY OF ARGUMENT

The district court's order granting summary judgment on liability, Dkt. 242, shows a misunderstanding of the CPT code set and of medical billing generally. The summary judgment excused clearly improper and misleading CPT coding practices, perpetrated by two of the largest health care companies in the United States, which systematically harmed the employers who paid for their services and the patients who relied on those companies to administer their insurance benefits. Further, the district court protected these wrongful actions by sealing much of the court record, thus preventing the public from examining the defendants' misdeeds and evaluating the judicial response to those misdeeds.

This brief does the following:

1. It explains the methodologies and purposes of CPT;
2. It identifies the various players in this matter, including the employer-sponsored health plan of Ms. Peters' spouse, the insurance company

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5168.xml; https://policysearch.ama-assn.org/policyfinder/detail/H-70.982?uri=%2FAMADoc%2FHOD.xml-0-5196.xml.

(Aetna), and the Optum-contracted providers who participated in the Aetna network;

3. It showcases the defendants' misuse of CPT to conceal their conduct from Ms. Peters and her insurance plan in order to receive payment for administrative charges under the guise of charges for health care;
4. It highlights some of the trial court's numerous errors in its summary judgment decision; and
5. It explains why the large number of sealed documents in this case disserves the American people.

Amici urge this Court to reverse the district court's grant of summary judgment on liability and remand with an instruction to unseal court filings that do not protect patient information or, at least, take a hard look at whether such sealing is in the interests of justice.

ARGUMENT

I. The CPT code set, the most widely used system of medical nomenclature in the United States, is designed and maintained to create a common language for medical services.

CPT content provides a uniform language that accurately describes medical, surgical, and diagnostic services, and provides an effective means for reliable, nationwide communication among health care professionals, patients, and third

parties. *See* AMA, *Current Procedural Terminology* (4th ed. 2019).[4] Spanning thousands of codes across numerous types of health care procedures, the CPT code set is the definitive resource to ensure that people and organizations are using the same language when referring to health care services.[5] The AMA owns the copyright in CPT. *See Practice Mgmt. Info. Corp. v. AMA*, 121 F.3d 516 (9th Cir. 1997) (recognizing the AMA's copyright).

The federal government has repeatedly embraced the CPT code set as the definitive code set for medical terminology. Thus, beginning in 1977, the AMA has licensed CPT content to the federal government as authorized nomenclature to be used in identifying physicians' services for purposes of Medicare and Medicaid claim forms. *See* 42 U.S.C. § 1395w-4(c)(5) (authorizing such action). Again, in 2000, the Department of Health and Human Services designated CPT as a national coding standard for physician and other health care professional services and procedures under the Health Insurance Portability and Accountability Act. *See* 45 CFR § 162.1002 – Medical data code sets. Accordingly, federal law authorizes the

[4] *See* CPT Purpose and Mission, https://www.ama-assn.org/about/cpt-editorial-panel/cpt-purpose-mission; *see also* CPT Professional, https://commerce.ama-assn.org/store/ui/catalog/productDetail?product_id=prod2950002&navAction=push.

[5] This case involves transactions from several years prior to the preparation of this brief. The relevant CPT codes, 98940 and 97039, have not changed since the time of those transactions.

use of the CPT code set for financial and administrative health care transactions sent electronically.

Critically, CPT codes *only* describe health care procedures and services. The *Current Procedural Terminology* book ("*CPT Book*") states:

> Current Procedural Terminology (CPT®) . . . is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and other qualified health care professionals.

CPT Book at v. Thus, CPT codes are not properly used to identify or facilitate the billing of insurance companies' overhead charges, separate from health care service providers' charges.

The CPT guidelines instruct the user on the proper use of the CPT code set:

> Select the name of the procedure or service that accurately identifies the service performed. Do not select a CPT code that merely approximates the service provided. If no such specific code exists, then report the service using the appropriate unlisted procedure or service code. . . . When necessary, any modifying or extenuating circumstances are added. Any service or procedure should be adequately documented in the medical record.

All of this had to be well known to the defendants. Not only are they large companies in the health care industry, but they have each previously signed CPT license agreements with the AMA. CPT codes are used thousands of times a day in processing claims, and thus, understanding CPT codes and using them properly is critical.

II. The defendants misused CPT codes to conceal their conduct from Ms. Peters and her plan and pass on administrative charges under the guise of medical care.

The defendants' conduct in this case was contrary to the purpose of the CPT code set in creating precision and a common language for medical services and procedures. Regardless of what they agreed to in their contracts with each other, the CPT code set simply does not contemplate the use of CPT codes for procedures or services which are not actually delivered to a patient and accurately described in the medical record. This includes the use of the "non-specific CPT Codes" for administrative charges that are at issue in this case. Dkt. 242 at 8, n.2. CPT does not have "catch-all" or "miscellaneous" codes that can serve as a label for whatever the defendants elect to charge a member and their plan. Again, the defendants knew, or at least should have known, this. The defendants searched for a CPT code that would be difficult for laymen to understand in order to "bury" (their word) their administrative fees so that they could assert an unjustified, uncontracted charge against Ms. Peters and her employer-funded health insurance plan. *See* Dkt. 233-14 at Optum-Peters-14072. They assumed no one would understand and, because the charge looked official, no one would challenge it. But, Ms. Peters did.

A. The defendants misrepresented the entries in Ms. Peters's September 4, 2014 EOB.

Ms. Peters's September 4, 2014 statement from Aetna, commonly known as an explanation of benefits (EOB) form, evidences the defendants'

misrepresentations. *See* Dkt. No. 233-25. It is a prime example of both how the CPT code set should be used and how the defendants misused it.

On page 2 of the September 4, 2014 EOB, Ms. Peters received a listing of care she received during her July 16, 2014 visit to her chiropractor, who was a health care provider in the Optum network:

Your payment summary

		Your plan paid			You owe or already paid
Patient	**Provider**	**Amount**	**Sent to**	**Date**	**Amount**
Sandra (self)	Chiro-Optumhealth Care Sol	$56.71	Chiro-Optumhealth Care Sol	8/28/14	$14.18
Total:		$56.71			**$14.18**

Your claims up close

Claim for Sandra (self)

Claim ID: EXJLGMVSR00 Received on 8/26/14	Amount billed	Member rate	Pending or not payable (Remarks)	Applied to deductible	Your copay	Amount remaining	Plan pays	Your coinsurance	You may owe C+D+E+H=I
CHIROPRACTIC MANIPULATION on 7/16/14 98940	40.00		40.00 (1)						
UNLISTED MODALITY (SPECIFY) on 7/16/14 97039	70.89					70.89	56.71 (80%)	14.18 (20%)	14.18
Chiro-Optumhealth Care Sol									
Refer to Remarks Section			(2)						
Totals:	110.89		40.00			70.89	56.71	14.18	**$14.18**
	A	B	C	D	E	F	G	H	I

Id. at Aetna-Peters-256. Aetna first cites CPT code 98940, which is listed in the CPT code set as "chiropractic manipulation treatment (CMT); spinal, 1-2 regions." *CPT Book* at 733. Ms. Peters did not contest the legitimacy of this charge. She knew that she had received the service, and she understood that line item on her EOB. The EOB represented the amount she was required to pay for the service. She could then

decide for herself whether she was getting her money's worth for her chiropractor services and for her health insurance premiums. The CPT code set is designed to bring transparency to the health care billing process and allow all parties to understand what services were provided.

What Ms. Peters did not understand, and with good reason, is the next line item, "Unlisted Modality (Specify)" and the CPT code 97039. The CPT code set defines a "modality" as "any physical agent applied to produce therapeutic changes to biologic tissue; includes but not limited to thermal, acoustic, light, mechanical, or electric energy." *Id.* at 728. Within physical medicine and rehabilitation, which is what Ms. Peters was receiving, the modalities are divided into two categories: supervised attendance and constant attendance. *Id.*

A supervised modality is a modality that does not require direct patient contact. *Id.* For example, supervised modalities include: hot or cold packs; traction; electrical stimulation; or a whirlpool bath. *Id.* A constant attendance modality is a modality that does require patient contact. Constant attendance modalities include: iontrophoresis (a process of transdermal drug delivery through the use of a voltage gradient on the skim), contrast baths, and ultrasounds. *Id.* Constant attendance modalities are also limited to specific periods of time, in this case, 15 minutes each. *Id.*

The CPT code set provides information on how this code should be used. When a chiropractor employs a procedure designed to provide therapeutic benefits and that procedure does not fit into any other enumerated CPT codes, the chiropractor can then use 97039 and provide an additional description of the procedure. *Id*. at 729. The parenthetical "(specify)" is not meant to be shown on the EOB. A claims administrator should then use the information derived from the physician's or other health care professional's patient records to provide information that allows the patient and the patient's health insurance plan to understand what specific modality was used, and, if relevant, how long it was used. This helps the patient and the health insurance plan understand what was charged, why it was charged, whether the charge was proper, and whether the plan is paying its fair share.

An "unlisted modality" is only to be used to describe a medical service. Perhaps the defendants did not know all the intricacies of the 97039 code (although they should have known), but they had to know that CPT codes should be used only to describe medical services and procedures. They certainly knew that they should not assign a CPT code to an EOB line item if they did not know whether such assignment was proper. Ms. Peters did not receive a 97039 service, and the defendants' use of that code misled her.

B. The defendants used CPT content improperly in order to obscure their unjustified billing.

The inclusion of the unlisted modality entry on Ms. Peters' EOB was no happenstance. Rather, this was the defendants' attempt to pass on their administrative charges to Ms. Peters and her insurance plan under the guise of superficially legitimate CPT codes. Though *amici* are limited in their access to the record, as a number of exhibits were filed in the district court under seal, there is ample evidence that the defendants knew that what they were doing was inconsistent with CPT code usage and, as a result, misled patients and their insurance plans. Part of this evidence for the defendants' knowledge, as already discussed, arose from the circumstance of the defendants' being large companies in the health care industry and part arose from their being CPT licensees. This circumstantial evidence is, alone, enough to establish a triable issue on *scienter*. *See Malone v. Microdyne Corp.*, 26 F.3d 471, 478 (4th Cir. 1994) (reversing judgment, while finding that "proof of scienter need not be direct, but may be inferred from circumstantial evidence").

There is also direct evidence. For example, in November 2012, Aetna and Optum personnel devised a scheme to pass on administrative fees to patients and their insurance plans. *See* Dkt. 233-16. As part of their contract negotiations, Aetna and Optum searched for a CPT code, which they felt was of a cryptic nature. They sought to use this code to hide their administrative fees within the patients' bills, so

that the patients and their insurance plans would pay those fees without having contracted to do so. *Id*.

In emails produced by defendants, Theresa Eichten of Optum and Cyndy Kilpinen of Aetna discussed possible CPT codes that could be used to hide the administrative fee in billing records. *Id.* Eichten proposed the 97039 code, the unlisted modality, because according to Eichten, if it was billed by a chiropractor, Optum would not typically make an additional payment, as it was separately identified in their fee schedule. *Id.* at Optum-Peters-2887. Kilpinen then asked if they should use code 97110, which is for a "therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility." *Id.* at Optum-Peters-2885. Amy Wright of Optum responded further in the chain that she would not recommend using 97110 because that is a code that is frequently used by chiropractors, and it would not be a good "dummy code." *Id.* at Optum-Peters-2883. Wright then stated that "[d]ummy code use is 'frowned upon' by AMA/CPT." *Id.* Wright was exactly right. There are no "dummy" codes in the CPT code set, and each code is specifically tied to a medical service or procedure. The fact that some codes are explained in terminology that may be difficult for laymen to understand is no reason to use them as a front for other charges that Aetna and Optum wanted to conceal.

Yet, the defendants did just that. In December 2012, after the discussion about which code to select, Aetna's records show that Aetna and Optum agreed that their so-called "dummy" code:

> should never be referenced to the member or another PT/OT Provider outside of OptumHealth. This is just a code we use in regards to contracting. All other codes on the claim are what was billed to OptumHealth from the actual Provider of Service.

Dkt. 228-14 at Aetna-Peters-3057. Aetna told its own employees that they were to pass on administrative charges to members and they did not want outsiders to know what they were doing. Again, this was to conceal the nature of the charges and the basis for charging members (*i.e.*, beneficiaries) and their insurance plans.

Ms. Peters's EOB of September 4, 2014 specifically misrepresented the care she had received and thus, the amount owed by her and her plan. As Optum's David Elton testified, these problems persisted for months, and not just for Ms. Peters. Dkt. 189-16 at 31:17-32:23.

III. The summary judgment denying liability is rife with error.

A. The district court misunderstood medical billing, and it misinterpreted the EOB statement.

The summary judgment decision states:

> Since Optum is the provider of the network, the EOB identifies Optum as the "provider" for the service and reports a total "amount billed," which includes the flat-rate contractual fee to Optum and the CPT code required by the Aetna-Optum contracts. . . . Under the Aetna-Optum relationship, Optum receives payments only from Aetna itself, never from an Aetna member or plan sponsor.

Dkt. 242 at 10. This passage has multiple errors.

First, within the health care industry, a "provider" is one who performs a service (such as a physician) or who maintains a health care facility (such as a hospital). *See, e.g.*, 29 CFR § 825.125 (defining health care provider). Mere contracting with those who perform services or maintain facilities is not the provision of health care, and companies, such as Optum, who maintain these contracts are not deemed the "provider" of the service (even though they may provide the network). Second, as discussed *supra*, the defendants could not legitimately select a CPT code by contract. CPT code usage is determined by the performance of medical procedures, not by an *ex ante* contractual agreement. Third, the EOB states that the employer-funded plan had paid $56.71 for the "unlisted modality (specify)" service. Based on this information, a reasonable plan participant would have no way to know that this was a flat-rate contractually agreed administrative fee that had nothing to do with an unlisted modality service. Fourth, the EOB indicated that Ms. Peters was to pay, as part of her co-insurance, $14.18 for the "unlisted modality (specify)" service, which of course was never performed. The "payment summary" at the top of the EOB indicates that Ms. Peters and the plan had paid or were to pay their respective percentages to "Chiro-Optumhealth Care Sol" – presumably an entity associated with Optum, one of the defendants. This contradicts the district court's finding that Optum never received payments from an Aetna

member or a plan. Perhaps there are other explanations for these EOB entries, but at the summary judgment stage the defendants are not entitled to the benefit of any doubts. *See, e.g.*, *Gordon v. Schilling*, 937 F.3d 348, 356 (4th Cir. 2019) (reversing district court's grant of summary judgment to defendants).

Similarly, the district court found that "Optum's DTPs are not the 'Network Provider' in this context; Optum is." Dkt. 242 at 18. That is also wrong. A network provider is an entity that performs health care services (or maintains health care facilities) and is under contract to charge favorable rates to health insurance beneficiaries. *See* Glossary, "in-network," healthinsurance.org, *available at* https://www.healthinsurance.org/glossary/in-network/; *see also Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 332 (2003) (describing health care providers as those who perform health care services). An entity that assembles a network of providers is not the "network provider." Again, because this comes at the summary judgement stage, ambiguities, if there are any, should be construed against the defendants.

B. The district court wrongly excused the defendants' misrepresentations.

1. A jury could reject the defendants' theory of damages.

The district court concluded that "the undisputed forecast of evidence . . . shows that the Aetna-Optum contractual arrangement saved both Aetna plan sponsors and members millions of dollars." Dkt. 242 at 19-21. This conclusion,

however, presupposes that the plan or plan members would have used the Optum network providers if they had known the actual amount they were paying to use those providers. Had the EOBs been accurate, the plan or plan members might have chosen to stick with the original Aetna provider network, and there would not have been a savings. The defendants' contractual arrangement (known, in the industry, as a "rental network") may have allowed the insureds a greater choice of providers, but it would only have saved money if the expanded network was actually utilized—something that might not have been done if the EOBs had been transparent.

More generally, though, if the defendants were actually saving the plan and its members millions of dollars, then they did not have to misrepresent their charges. They could have been transparent, but they were not. The mere existence of their obfuscation, with nothing more, casts doubt on their theories of "injury," particularly at the summary judgment stage. A fact-finder is not bound to accept an expert report, even an unrebutted expert report, if there is reason to question its credibility. *See* 9C Charles Alan Wright & Arthur R. Miller, Federal Practice & Procedure § 2586 (3d ed. 2004) ("The court need not accept even uncontradicted and unimpeached testimony if it is from an interested party or is inherently improbable."); *EEOC v. Freeman*, 778 F.3d 463, 466 (4th Cir. 2015) (in determining the reliability of an expert, "a district court exercises a special gatekeeping obligation"). The district court erred in not allowing this issue to be presented to a jury.

2. The defendants should not gain a windfall from their own misconduct.

The district court's suggestion that Ms. Peters did not suffer harm because she had reached her out-of-pocket maximum is wrong. *See* Dkt. 242 at 11. This was a self-funded insurance plan. That means that if Ms. Peters had reached her out-of-pocket maximum, the employer-funded plan still had to pay the additional health care claims that she would otherwise have had to pay. So, Ms. Peters's derivative claim on behalf of the plan was viable.

Moreover, the defendants have no legal right to assert a windfall benefit on account of the collateral source payments from the health insurance plan. RESTATEMENT (SECOND) OF TORTS (1979), § 920A(2) states the basic rule:

> Payments made to or benefits conferred on the injured party from other sources are not credited against the tortfeasor's liability, although they cover all or a part of the harm for which the tortfeasor is liable.

Courts have consistently recognized that "compensation from a collateral source should be disregarded in assessing tort damages," and thus the district court should not have limited Ms. Peters's claims because she reached her out-of-pocket maximum and her plan was forced to make up the rest. *Sloas v. CSX Transp. Inc.*, 616 F.3d 380, 389 (4th Cir. 2010). Maybe, at the end of this case, the defendants will be found liable only for the $56.71 (the health plan) and the $14.18 (Ms. Peters) payments arising from the bogus 97039 "unlisted modality (specify)" charge on

7/16/14. So be it. Nevertheless, the district court erred when it granted summary judgment to the defendants.

IV. Because of the public interest in this case, the district court file should be unsealed.

This case evidences systemic misrepresentations on the part of two health company giants, which administer benefits for millions of Americans. Yet many of the documents produced and testimony provided are currently under seal and hidden from public view. The sealing of these documents is even more troubling as this occurrence is by no means singular for these defendants or for the health insurance industry generally. For example, in 2009, the New York Attorney General found these defendants (technically, Aetna and the Optum parent company, UnitedHealth Group) liable for fraud in their payment methodology of provider charges. *See* Am. Med. News, *United agrees to pay $350 million, scrap system that undercut fees* (Jan. 26, 2009).[6] Further, *Wit v. United Behavioral Health*, No. 14-cv-02346, 2019 WL 1033730 (N.D. Cal. Mar. 5, 2019), found that a company within the same corporate umbrella as Optum systematically denied mental health and substance abuse treatment benefits, in violation of federal and state law. More recently, the Department of Health and Human Services Office of Inspector General has reported that insurance companies, through manipulation of medical records, may have

[6] *Available at* https://amednews.com/article/20090126/business/301269997/1/.

overcharged the federal government by billions of dollars. *See* U.S. Dept. of Health and Human Services, Office of Inspector General, *Billions in Estimated Medicare Advantage Payments from Chart Reviews Raise Concerns* (Dec. 2019).[7]

Should these transgressions be chalked up to inherent human failings, which can be excused by the size and complexity of the health care industry? Do they result from the aberrant behavior of a few rogue employees? Or, do they represent something more? These are questions of public interest.

The district court weighed the public interest in this case against the defendants' claims of confidentiality. It decided to preserve the defendants' business secrets, and it entered a series of orders that allowed that allowed Aetna and Optum to keep a large amount of the documents and information about their practices permanently under seal. *Amici* believe the court went too far to protect the defendants. Perhaps at one point, the defendants' documents included confidential business information, but even if so, that point has long since passed. When, as here, wrongdoing has been uncovered, the public deserves transparency in the judicial system, and thus, the documents that do not contain protected patient information should be unsealed. *See, e.g.*, *Doe v. Public Citizen*, 749 F.3d 246, 265 (4th Cir. 2014) (discussing the public interest in access to judicial records).

[7] *Available at* https://oig.hhs.gov/oei/reports/oei-03-17-00470.pdf.

CONCLUSION

For the foregoing reasons, *amici* respectfully urge this Court to reverse the summary judgment on liability and instruct the district court to unseal the court file or at least reconsider whether a more limited protective order should be entered.

December 27, 2019

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE WITH TYPE-VOLUME LIMIT

This brief complies with the type-volume limits because, excluding the parts of the brief exempted by Fed. R. App. P. 32(f) (cover page, disclosure statement, table of contents, table of citations, statement regarding oral argument, signature block, certificates of counsel, addendum, attachments), this brief contains 4,113 words, based on the "Word Count" feature of Microsoft Word.

This brief complies with the typeface and type style requirements because this brief has been prepared in a proportionally-spaced typeface using Microsoft Office Word in 14-point Times New Roman.

December 27, 2019

s/ Kyle A. Palazzolo
Kyle A. Palazzolo

Counsel for Amici Curiae

CERTIFICATE OF SERVICE

I hereby certify that on December 27, 2019, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Fourth Circuit by using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

December 27, 2019

s/ Kyle A. Palazzolo
Kyle A. Palazzolo

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