Case No. 12-5903

IN THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

SOUTHERN REHABILITATION GROUP, *et al.*,
Plaintiffs/Appellants,

vs.

SECRETARY OF HEALTH AND HUMAN SERVICES, *et al.*,
Defendants/Appellees.

Appeal from the United States District Court
For the Eastern District of Tennessee

BRIEF *AMICI CURIAE* OF AMERICAN MEDICAL ASSOCIATION, TENNESSEE MEDICAL ASSOCIATION, KENTUCKY MEDICAL ASSOCIATION, MICHIGAN STATE MEDICAL SOCIETY, AND OHIO STATE MEDICAL ASSOCIATION SUBMITTED IN SUPPORT OF PLAINTIFFS/APPELLANTS AND URGING REVERSAL

Jon N. Ekdahl
Leonard A. Nelson
American Medical Association
Office of General Counsel
515 N. State St., 14th Floor
(312) 464-5532
Of Counsel

David L. Steed
Cornelius & Collins
Nashville City Center, Suite 1500
511 Union Street
Nashville, Tennessee 37219
(615) 244-1440
Counsel of Record

Attorneys for *Amici Curiae*

Certificate of Interested Persons and Corporate Disclosure Statement

Amici certify that, to the best of their knowledge, the Certificate of Interested Persons in the Brief of Plaintiffs/Appellants is complete.

Pursuant to Federal Rule of Appellate Procedure 26.1, *amici* state that they have no parent corporation and there is no corporation, publicly held or otherwise, that owns 10% or more of any of their stock.

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Statement of Identity and Interest of *Amici* and of Source of Authority to File Brief

Amici, all non-profit corporations, are professional associations of physicians, residents and medical students. *Amicus* the American Medical Association (AMA) is the largest such association in the United States. The remaining *amici* are the state medical societies representing the physicians, residents, and medical students who live or practice in the states that bear their respective names.

All *amici* have members who provide services to patients covered under the Federal Health Insurance for the Aged (Medicare) Act, 42 U.S.C. §§1395, *et seq*. Thus, all *amici* have members who are affected by whether the Department of Health and Human Services (HHS) promptly pays claims submitted for medical services provided to Medicare patients. Likewise, all *amici* have members affected by whether HHS honors its obligation to pay interest on delayed payments under 42 U.S.C. §1395u(c)(2).

As will be explained more fully in this brief, HHS has not only violated its obligation to pay the late payment interest it owes to the plaintiffs in this specific case, but HHS has a written policy, contrary to statute, which infringes that obligation. It is important to *amici* and the physicians they represent that this Court make clear that the written HHS policy is invalid and the statute means what it says.

Amici submit this brief in their own persons and also as representatives of the Litigation Center of the AMA and the State Medical Societies. The Litigation Center is an association among the AMA and the state medical societies, including the named *amici*, the purpose of which is to represent the interests of organized medicine in the federal and state court systems, in accordance with AMA policies.

Amici have sought leave to file this brief in accordance with Fed. R. App. P. 29(a).

FRAP Rule 29(c)(5) Statement

No party's counsel authored this brief in whole or in part, no party or party's counsel contributed money that was intended to fund preparing or submitting this brief, and no person other than *amici* contributed money that was intended to fund preparing or submitting this brief.

Issue Addressed in This Brief

This brief addresses one issue:

Whether there is a genuine issue of material fact regarding the plaintiffs' claim for interest under 42 U.S.C. §1395u(c)(2), arising from the delay of HHS in payment of the plaintiffs' "clean claims."

Amici note, however, that they support the principal arguments in the plaintiffs' brief, which address questions of jurisdiction. Many of *amici*'s

members have confronted similar obstructions to just payment from within the Medicare bureaucracy, but, as the plaintiffs have correctly asserted, few of them have the resources or commitment to fight against those obstructions. *Amici* have limited the scope of this brief because the plaintiffs' brief thoroughly covers these jurisdictional points, and *amici* have nothing to add to the plaintiffs' arguments on these issues.

Nature of the Case and the Proceedings Below, as Relevant to This Brief

The plaintiffs provide rehabilitation services in Kingsport, Tennessee. Approximately 70% of their patients are covered by Medicare, and they generate about 10,000 Medicare claims per year. The plaintiffs billed the services pertinent to this case to a Part B Medicare contractor, CIGNA. (Doc. [1] 63-1, Order of 5/21/12, p. 2).

The plaintiffs took issue with the way CIGNA processed their reimbursement claims, asserting that such claims were improperly downcoded or denied. (Doc. 63-1, Order of 5/21/12, p. 2). This was "[d]espite consistent documentation supporting each claim." (Doc. 7, Amended Complaint, p.23, ¶ 65). Following prosecution of their claims at the administrative level, which took several years (Doc. 7, Amended Complaint, p. 7, ¶ 22; Doc. 63-1, Order of 5/21/12, pp. 2-3), on October 13,

[1] The abbreviation "Doc." stands for the trial court docket number.

2009, the plaintiffs sued the Secretary of HHS and CIGNA[2] in the United States District Court for the Eastern District of Tennessee. (Doc. 1, Complaint). The plaintiffs raised a number of legal theories, and as part of their claim for relief they sought "[i]nterest on the unreimbursed claims pursuant to applicable law, including 42 U.S.C. §1395(u)(c)(1)(C) (allowing interest if payments are not made within approximately 17 days after a clean claim is received)." (Doc. 7, Amended Complaint, p. 50).[3]

On November 16, 2010, following several requests of defendants for extensions of time, the defendants moved to dismiss the amended complaint "in part," based on Fed. R. Civ. P. 12(b)(1) (lack of subject-matter jurisdiction) and 12(b)(6) (failure to state a claim). (Doc. 23, Motion to Dismiss Amended Complaint, in Part, p. 1). Both the defendants' motion (Doc. 23, Motion to Dismiss Amended Complaint, in Part, ¶ 5) and their supporting memorandum (Doc. 24, Memorandum in Support of Motion to

[2] In addition to the Secretary of HHS, the plaintiffs sued CIGNA Government Services, LLC, CIGNA Healthcare of Tennessee, Inc., Computer Sciences Corporation dba AdvanceMed, and Q2 Administrators, LLC. All of these private companies were involved in some aspect of administering plaintiffs' claims for reimbursement of Medicare services. The claims against CIGNA and the other private defendants are irrelevant to this brief, as it is HHS that owes interest on the late payments.

[3] Plaintiffs may have slightly miscited the statute. *Amici* believe the correct citation is 42 U.S.C. §1395u(c)(2)(C). Also, *amici* believe the time for paying interest on clean claims begins to run 30 days after receipt, 42 U.S.C. §1395u(c)(2)(B)(ii)(V), rather than 17 days.

Dismiss Amended Complaint, in Part, p. 2) acknowledged that "portions of the Amended Complaint are properly before the Court." Neither the motion nor the supporting memorandum suggested that the claim for late payment interest might be improper.

On October 13, 2011, exactly two years after the plaintiffs had filed their lawsuit, the defendants moved to have certain of the plaintiffs' payment claims remanded for further consideration at the administrative level. (Doc. 46, Motion to Remand Pursuant to Sentence Six of 42 U.S.C. §405(g) (Partial)). The motion stated, at p.4: "Upon remand, [HHS] will voluntarily pay the difference between the rate of payment that Plaintiffs received on the approximately 6,000 Medicare claims in question and the rate of payment that Plaintiffs seek for those claims." The motion made clear that HHS intended to pay $107,171.07, which was the previously disputed principal amount owed on the claims to be remanded. *Compare* (Doc. 46, Motion to Remand Pursuant to Sentence Six of 42 U.S.C. §405(g) (Partial) n. 4), *with* (Doc. 7, Amended Complaint, p. 22, ¶ 62; p. 50, ¶ 6(a)(i)-(iii)).

The trial court granted this motion (Doc. 47, Order of 10/18/12, although Plaintiffs pointed out that HHS should not be allowed to use the remand as a device to avoid production of the administrative record, as "that record is vital to establishing grounds for additional damages and the other

claims raised in the Amended complaint." (Doc. 49, Motion for Reconsideration and Motion to Alter or Amend Order on Partial Remand, p. 1). On February 24, 2012, HHS paid the approximately 6,000 remanded claims. The defendants, however, only paid the principal balance of $107,171.07 – not the late payment interest – on the remanded claims. (Doc. 62, Notice of Payment on Remand). The administrative record was never filed with the trial court.

On May 21, 2012, the trial court *sua sponte* notified the parties that it intended to convert the motion for partial dismissal into a motion for summary judgment and enter judgment on all issues for the defendants. (Doc. 63-1, Order). In its proposed denial of the claim for late payment interest, the trial court reasoned that the federal government is not required to pay interest except when Congress has expressly authorized it, and 42 U.S.C. §1395u(c)(2)(C)[4] was not such an express authorization. (Doc. 63-1, Order, p. 16). In further support of this conclusion, the trial court quoted language from §80.2.2.1.C of the Medicare Claims Processing Manual (the Claims Manual), to the effect that the late payment interest provision does not apply if a claim for Medicare benefits is resolved as the result of an administrative appeal. (Doc. 63-1, Order, pp. 16-17).

[4] The trial court cited the applicable statute correctly.

The plaintiffs objected to the proposed order of summary judgment on a number of grounds, including that the summary judgment improperly denied their claim for late payment interest. (Doc. 64, Response to Motion). On July 2, 2012, the trial court, after noting that the plaintiffs had not tendered additional evidence in support of their objection,[5] adopted its earlier proposed order and entered summary judgment on all issues for the defendants. (Doc. 67, Judgment on Decision by the Court).

This appeal followed. (Doc. 68, Notice of Appeal).

[5] HHS did not itself submit evidence, either before or after the trial court indicated that it would convert the motion for partial dismissal into one for summary judgment.

Summary of the Argument

42 U.S.C. §1395u(c)(2) requires HHS to pay interest on "clean claims" (defined in the statute as claims that have "no defect or impropriety … or particular circumstance requiring special treatment that prevents timely payment from being made)." Although HHS had delayed payment on thousands of the plaintiffs' claims for several years, the trial court, through a *sua sponte* order of summary judgment, denied plaintiffs their right to late payment interest. This was notwithstanding that HHS had never, either in its arguments or through a proffer of evidence, challenged the cleanliness of the remanded claims, and the trial court had no basis for questioning such cleanliness on its own.

To justify its ruling, the trial judge relied upon a section from the Claims Manual, which imposed conditions on payment of interest for clean claims contrary to those established under the statute. In other words, the Claims Manual misstated the law, and yet the trial court based its ruling on it. In so doing, the trial court gave weight to an unjustifiable practice of HHS, making it likely that HHS will continue to rely erroneously on the Claims Manual. It is, however, Congress that determines when and whether HHS is required to pay late payment interest – not HHS itself.

Argument and Citations of Authority

There is a Genuine Factual Dispute on the Plaintiffs' Claim for Interest Arising from the Delay in Payment of the Plaintiffs' Charges for Medical Services.

Summary judgment is to be granted only if both of the following conditions have been met: first, the movant must have established a basis for determining that no genuine issues of material fact are in dispute, and second, if the movant has met that initial burden, the party opposing the motion must have failed to show that there really are genuinely disputed issues of material fact. *See* Fed. R. Civ. P. 56(a) and (c)(1) and *Celotex Corp. v. Catrett*, 477 U.S. 317 (1986); *Moldowan v. City of Warren*, 578 F.3d 351 (6th Cir. 2009); *Morales v. American Honda Motor Co.*, 71 F.3d 531 (6th Cir. 1995), *cert. denied*, 130 S.Ct. (2010). Neither of these conditions were satisfied here. HHS proffered (and the trial court adopted) only specious arguments as to why plaintiffs should fail on their claim for statutorily mandated interest. Furthermore, the record is replete with an ample, affirmative showing of why interest should be allowed.

I. Neither HHS nor the Trial Court Demonstrated the Absence of A Genuinely Disputed Issue of Material Fact.

The statutory scheme for late payment interest is set forth in 42 U.S.C. §§1395u(c)(2)(B) and (C), which state, in applicable part, as follows:

> (B)(i) The term "clean claim" means a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this part.
>
> (ii) The term 'applicable number of calendar days' means …
>
> * * * *
>
> (V) 30 calendar days.
>
> (C) If payment is not issued, mailed, or otherwise transmitted within the applicable number of calendar days … after a clean claim … is received, interest shall be paid [at a rate determined by the Secretary of the Treasury and published in the Federal Register].

HHS did not contend in the trial court, and the trial court did not find, that the approximately 6,000 remanded claims were unclean. There was neither a contention nor a finding that payment on those claims was timely. Certainly, there was no attempt to follow the mandate of Fed. R. Civ. P. 56(c), which requires a summary judgment movant to cite specific portions of the court record to establish that a fact is not genuinely disputed.

Rather, HHS asserted that 42 U.S.C. §1395u(c)(2)(C) was inapplicable, because (a) "Congress has authorized the payment of interest only in certain, very limited and very specific circumstances in which payment is obtained through a successful Medicare reimbursement appeal," (Doc. 51, Response to Motion for Reconsideration and Motion to Alter or Amend Order on Partial Remand, p. 4) and (b) per the Claims Manual, "[t]he 'clean claims' provision does not apply to a situation in which a

Medicare claim, initially denied by the Medicare program, subsequently gets approved for payment at some level of the Medicare claims appeals process." (Doc. 51, Response to Motion for Reconsideration and Motion to Alter or Amend Order on Partial Remand, p. 3). The problem with these arguments, which the trial court adopted (Doc. 63-1, Order of 5/21/12, pp. 16-18), is that they are 180 degrees at odds with both the wording and the manifest purposes of the statute.

What Congress authorized was interest on any and all clean claims that are not paid within a defined time limit. Nothing in the statute suggests that it is any less applicable if payment was secured as the result of an administrative appeal. Furthermore, there is no logic in a scheme under which physicians would lose their right to late payment interest if Medicare not only processed the physicians' payment claims in an untimely manner but then compounded the problem by wrongfully denying the payment claims and necessitating an appeal. Manifestly, the purposes of 42 U.S.C. §1395u(c)(2)(C) are to incentivize HHS to pay Medicare claims promptly and then to compensate physicians (and other claimants) when it fails to do so, not to let HHS off the hook when it has misplaced documentation or otherwise made an unfounded claim denial.

The cases HHS and the trial court cited are off point. *Library of Congress v. Shaw*, 478 U.S. 310 (1986) (employment discrimination), *United States v. Louisiana*, 446 U.S. 253 (1980) (allocation of payments on mineral leases in the Gulf of Mexico), *Rimmel v. Mercantile Trust Co.*, 774 F.2d 279 (8th Cir. 1985) (recovery of payments improperly made to HUD), and *Lifeline Ambulance Service, Inc. v. Leavitt*, 2006 WL 626177 (W.D.Va. 2006) (upholding administrative denial of Medicare-based payment claims for ambulance services), all stand for the unremarkable proposition that the federal government is not liable for interest on late payments unless such right is specifically set forth in a statute or in a contract with a government agency. None of those cases discussed 42 U.S.C. §1395u(c)(2), which, of course, does establish a specific obligation of the federal government for interest on late payments.

Similarly, the trial court cited 42 U.S.C. §1395oo(f)(1) and 42 U.S.C. §1395ff(b)(2)(A), which authorize the payment of interest in certain situations that involve Medicare claims but in no way nullify the obligation to pay interest for clean claims under 42 U.S.C. §1395u(c)(2). In fact, the trial court observed: "The above-referenced limited circumstances do not apply to this case." (Doc. 63-1, Order of 5/21/12, p. 17). That is right; they do not apply.

Section §80.2.2.1.C of the Claims Manual, referred to at Doc. 63-1, Order of 5/21/12, pp. 16-17 and Doc. 51, Response to Motion for Reconsideration and Motion to Alter or Amend Order on Partial Remand, pp. 3-4, states as follows:

> Interest payments are not payable on clean claims initially processed to denial and on which payment is made subsequent to the initial decision as a result of an appeal request. This applies to appeals where more than the applicable number of days elapsed before an initial determination, but the claim was later paid upon appeal.

Inasmuch as the Claims Manual was adopted without the notice to the public or opportunity for public comment under 5 U.S.C. §553, it lacks the full weight of a regulation. *Shalala v. Guernsey Memorial Hospital*, 514 U.S. 87, 109 (1995) (O'Connor, J., dissenting). Moreover, even if it had been adopted as a formal regulation, it would still be without force.

As stated in *Chevron, U.S.A., Inc. v. Natural Resource Defense Council*, 467 U.S. 837, 842-843 (1989), the first question a court must address when reviewing an agency's construction of a statute is "whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." Here, Congress has directly spoken to the precise question at issue: Clean claims are always entitled to interest if they are not paid in a

timely fashion. Because the Claims Manual says to the contrary, it is to that extent invalid. That is the end of the matter.

II. The Court Record Amply Demonstrates a Genuine Dispute as to Whether the Remanded Claims Were Clean.

When reviewing a summary judgment, all reasonable inferences of fact are to be drawn in favor of the party against whom the motion was granted. *Hunt v. Cromartie*, 526 U.S. 541, 552 (1989). Moreover, the party who opposed the motion need not have proffered evidence that would have qualified for admissibility in an actual trial in order to show the existence of a genuine factual dispute. *Celotex Corp. v. Catrett*, 477 U.S. 317, 324 (1986).

As explained *supra*, the trial court made clear that evidence in support of the plaintiffs' prayer for late payment interest would be unavailing. Under its view, the mere denial by HHS of the plaintiffs' claims, without more, obviated any right to interest. This position was manifestly erroneous, and, because the trial court never reached that issue, it is not necessary that this Court examine the evidentiary support for late payment interest. Nevertheless, the record in this case amply demonstrates a more than reasonable basis for believing that the remanded claims were clean within the meaning of 42 U.S.C. §1395u(c)(2)(B). This issue was material to

plaintiffs' prayer for interest on those claims, and it provides an alternative ground for reversing the summary judgment.

HHS delayed payment for years on those claims that it later remanded. Then, without explanation, it decided to pay them. This was notwithstanding its obligation to refuse payment on claims that it deemed improper. Absent evidence to the contrary, government agencies are presumed to discharge their duties properly. *E.g.*, *United States v. Armstrong*, 517 U.S. 456 (1996). Because HHS paid the remanded claims with no suggestion of a change of circumstance following their initial submission, it can – and therefore should – be inferred that the payment was proper when made and that such payment would always have been proper. Thus, it should be inferred that those claims were facially legitimate and complete when first submitted -- hence, clean.

Furthermore, HHS had possession of the remanded claims, and plaintiffs could but guess as to whether HHS might have had any basis for finding some of them unclean. Under these circumstances, HHS had the burden of explaining whether it had a basis for denying the claims. *Thomas v. George, Hartz, Lundeen, Fulmer, Johnstone, King and Stevens, P.A.*, 525 F.3d 1107, 1110 (11th Cir. 2008) (party not required to establish facts peculiarly within the knowledge of his adversary); *United States v. One*

Parcel of Property, 85 F.3d 985, 990 (2d Cir. 1996), *cert. denied*, 519 U.S. 932 (1996) (burden of proof falls on party with superior access to evidence). Based on its superior access to the claims data and its knowledge of the decisional processes of its own agents, the failure of HHS to demonstrate affirmatively that the remanded claims were unclean by itself created a factual dispute.

Moreover, Plaintiffs here informed the trial court that they lacked access to the administrative record, which would have allowed them to demonstrate the cleanliness of their claims more meticulously. (Doc. 49, p. 1) Motion for Reconsideration. Yet, the trial court entered summary judgment without an opportunity for the necessary discovery. Summary judgment should be considered only after a reasonable opportunity for discovery. *Celotex Corp. v. Catrett*, 477 U.S. 317, 324 (1986). Since no such opportunity was extended here, the precipitate ruling of the trial court unfairly deprived plaintiffs of their ability to prove their case.

Conclusion

The reason given for denying late payment interest – that Congress did not authorize it – is specious. 42 U.S.C. §1395u(c)(2)(C) requires such interest for clean Medicare claims, and there is no ambiguity regarding the force of this requirement. To the extent the Medicare Claims Processing

Manual says something different, the Claims Manual is simply wrong and therefore invalid.

Moreover, the record in the trial court clearly shows a substantial factual dispute. The remanded claims should be deemed clean. Accordingly, the order of summary judgment, at least to the extent it applies to the claim for late payment interest, should be reversed and the case should be remanded.

Date: February 7, 2013

/s/ David L. Steed
David L. Steed
Cornelius & Collins, LLP
Nashville City Center, Suite 1500
511 Union Street
Nashville, Tennessee 37219
(615) 244-1440
Counsel of Record

Jon N. Ekdahl
Leonard A. Nelson
American Medical Association
Office of General Counsel
515 N. State St., 14th Floor
Chicago, Illinois 60654
(312) 464-5532
Of Counsel

Attorneys for *Amici Curiae*

Certificate of Compliance with FRAP 32(a)(7)

This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because this brief contains 3,534 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii). and complies with the requirements of Fed. R. App. P 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally typeface in 14-point Times New Roman font.

Date: February 7, 2013

/s/ David L. Steed
David L. Steed
Attorney for *Amici Curiae*

Certificate of Service

I hereby certify that a copy of the foregoing was filed electronically on this 7th day of February, 2011. Notice of this filing will be sent by operation of the Court's electronic filing system to all parties listed below. Parties may access this filing through the Court's electronic filing system.

Wynne du M. Caffey
5616 Kingston Pike, Suite 301
Knoxville, TN 37919
Counsel for Plaintiffs/Appellants

Robert C. McConkey III, AUSA
Office of the United States Attorney
800 Market Street, Suite 211
Knoxville, TN 37902
Counsel for Defendants/Appellees

Date: February 7, 2013

/s/ David L. Steed
David L. Steed
Attorney for *Amici Curiae*