**IN THE UNITED STATES DISTRICT COURT**

**FOR THE DISTRICT OF SOUTH CAROLINA**

**ANDERSON DIVISION**

AnMed Health, Abbeville Area Medical Center, Aiken Regional Medical Centers, Bamberg County Memorial Hospital, Barnwell County Hospital, Bon Secours St. Francis Health System, Cannon Memorial Hospital, Carolina Pines Regional Medical Center, Chester Regional Medical Center, Conway Medical Center, Georgetown Memorial Hospital, Clarendon Memorial Hospital, Greenville Hospital System, Greenwood Regional Rehabilitation Hospital, Hampton Regional Medical Center, Kershaw County Medical Center, Lake City Community Hospital, Laurens County Health Care System, Loris Healthcare System, Marion County Medical Center, Medical University of South Carolina Medical Center, Newberry County Memorial Hospital, Oconee Memorial Hospital, Palmetto Health, Self Regional Healthcare, Sisters of Charity Providence Hospitals, Sisters of Charity Providence Hospitals NE, TRMC of Orangeburg and Calhoun Counties, Tuomey Healthcare System, Upstate Carolina Medical Center, Waccamaw Community Hospital, and Williamsburg Regional Hospital,

Plaintiffs,

vs.

Michael O. Leavitt, Secretary of the United States Department of Health and Human Services; and Kerry Weems, Acting Administrator of the Centers for Medicare and Medicaid Services,

Defendants.

Case No.

**COMPLAINT FOR DECLARATORY JUDGMENT, INJUNCTION AND MANDAMUS**

Plaintiff-hospitals hereby bring this action against Michael O. Leavitt, as

Secretary, United States Department of Health and Human Services, and Kerry Weems, Acting Administrator of the Centers for Medicare and Medicaid Services, state as follows:

## INTRODUCTION

1. This is a civil action for a Declaratory Judgment that the Secretary, U.S. Department of Health and Human Services, the Acting Administrator of the Centers of Medicare & Medicaid Services ("CMS"), acting through their agents and administrators of the Medicare program in South Carolina, Palmetto GBA, LLC, and Wisconsin Physicians Service Insurance Corporation, have unlawfully recouped alleged Medicare overpayments, thereby denying the Plaintiff Hospitals payments to which they are entitled for covered Medicare services, contrary to the requirements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 ("MMA"). Plaintiffs are also seeking repayment of the unlawful recoupments already made, plus interest and attorneys' fees, and an injunction preventing future recoupments inconsistent with CMS's statutory obligations.

2. In particular, Section 935(a) of the MMA, codified at 42 U.S.C. § 1395ddd(f)(2), precludes recoupment of alleged overpayments prior to a "reconsideration," which is the second level of appeal available to a Medicare provider of an alleged overpayment. In February, 2008, CMS, acting on determinations made by HealthDataInsights, Inc. ("HDI"), a Recovery Audit Contractor, sent notice letters to Medicare providers throughout South Carolina, including the Plaintiffs, most of which stated that CMS had determined that the hospitals had or should have had knowledge that certain services "were not medically necessary and reasonable," that the hospitals

had billed for those services incorrectly, and that the hospitals would receive remittance notices from their “fiscal intermediary,” Palmetto GBA. See **Exhibit 1**, 2/6/08 letter to Plaintiff Sisters of Charity Providence Hospitals. Although in its notice letters CMS outlined a process for contesting CMS’s determination, and mentioned that the hospitals could appeal the determination, CMS nowhere indicated that by statute neither the Secretary nor CMS can take any action to recoup the alleged overpayment until either a decision on the hospitals’ request for reconsideration had been rendered, or until the time period in which the hospital had the right to request an appeal had expired and the hospital did not request an appeal.

3. Plaintiffs have appealed CMS’s overpayment determinations. Nevertheless, without any statutory authority, CMS recouped approximately $30,000,000.00 from hospitals in South Carolina for alleged overpayments. The majority of this money was recouped because the RAC determined hospital inpatient services were not medically necessary and that patients who received these services should have been treated as outpatients and sent home. CMS requires hospitals to use written standards approved by CMS for determining whether patients should be admitted, but CMS allowed the RAC to apply different standards when reviewing claims.

4. The Defendants' recoupment of alleged overpayments either prior to the time allowed under the statute to appeal, and/or while the overpayments are the subject of pending appeals proceedings, violates the statute, and injunctive relief is appropriate to compel compliance with the Defendants' non-discretionary duties under the statute. No administrative remedy exists to challenge and stop the unlawful recoupment. Thus, Plaintiffs’ only remedy and recourse is in this Court. Relief is sought pursuant to 28

U.S.C. § 2201 providing for a declaratory injunction, or alternatively pursuant to 28 U.S.C. § 1361, to enforce the Secretary's non-discretionary duty to comply with the mandate of the MMA.

## PARTIES

5. Plaintiffs are thirty-two hospitals or hospital systems located throughout South Carolina. Each Plaintiff hospital is a provider of services to Medicare patients.

6. Defendant Michael O. Leavitt, Secretary of the United Statement Department of Health and Human Service ("HHS"), the federal agency charged with overseeing the operation of the Medicare program. Secretary Leavitt is sued in his official capacity only.

7. Defendant Kerry Weems, the Acting Administrator of CMS (the "Administrator"), is sued in his official capacity only.

## JURISDICTION AND VENUE

8. This case arises under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 and the Medicare Act, codified at 42 U.S.C. § 1395 *et seq.* Jurisdiction is founded upon 28 U.S.C. § 1331. While Section 1331 is inapplicable to most Medicare cases, this case presents a recognized exception to the rule, because this case is a statutory challenge to regulations and policies promulgated by the Secretary, and otherwise no judicial review or remedy would exist. *See, Bowen v. Michigan Academy of Family Physicians,* 476 U.S. 667, 678-680, 106 S. Ct. 2133, 2140-2141 (1986); *Shalala v. Illinois Council on Long term Care, Inc.,* 529 U.S. 1, 19, 120 S. Ct. 1084, 1096-1097(2000).

9. Jurisdiction also lies under 28 U.S.C. § 1361, which provides that "[t]he district courts shall have original jurisdiction of any action in the nature of mandamus to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the plaintiff." In this case, the Secretary has a non-discretionary statutory duty to discontinue recoupment of alleged Medicare overpayments while those alleged overpayments are being challenged through appropriate administrative channels. In addition, this Court has jurisdiction to review a final decision to the Secretary, through its agents, pursuant to 28 U.S.C. § 405(g).

10. Venue is proper in this District under 28 U.S.C. § 1391(e), because the Secretary, Department of Health and Human Services is an officer of a federal agency, and is amenable to suit in this District, where Plaintiffs are located. Venue is also proper in this District under 28 U.S.C. § 1391(b), because a substantial part of the events or omissions giving rise to the claim occurred in this District. Further, Plaintiffs AnMed Health and Oconee Memorial Hospital are both located within the Anderson Division.

## **FACTS**

## **STATUTORY AND REGULATORY FRAMEWORK CONCERNING RECOUPMENT**

11. Medicare is a federal health insurance program for the aged and disabled, governed by the Medicare Act, 28 U.S.C. §§ 1395 *et seq.* Administered by the CMS, a division of the Department of Health and Human Services, Medicare Part A provides benefits for "hospital, related post-hospital, home health services, and hospice services, and hospice care." 28 U.S.C. § 1395c. These are the costs associated with an

overnight stay in a hospital, skilled nursing facility, or psychiatric hospital, including charges for the hospital room, meals, and nursing services.

12. A hospital that elects to participate in the Medicare Part A program is known as a "provider." *See*, 28 U.S.C. § 400.202. The provider enters into a contract with CMS, in which the provider agrees to conform to the provisions of Title XVIII of the Social Security Act (i.e., the Medicare Act) and applicable sections of the Code of Federal Regulations during its participation in the program.

13. Each Plaintiff is a Medicare Part A provider.

14. In administering the Medicare program, CMS acts through fiscal intermediaries, now also known as Medicare administrative contractors in some regions. *See*, the MMA, § 911(d), Pub.L. No. 108-173, 117 Stat. 2066 (codified at 28 U.S.C. § 1395kk-1 (2003)). Palmetto GBA and Wisconsin Physician Services are fiscal intermediaries in South Carolina.

15. For reasons of administrative efficiency, initial payment for services under Medicare is ordinarily made as long as the claim on its face does not contain obvious irregularities. *See Hecker v. Ringer*, 466 U.S. 602, 627 (1984). The initial payment for services is referred to as an “initial determination.” *See* 42 U.S.C. §1395ff (a). CMS, through its contractors or “fiscal intermediaries,” then conducts a limited number of post-payment audits to ensure that payments are made in accordance with applicable Medicare payment criteria.

16. When an audit determines that a payment was made erroneously, an "overpayment" is assessed and "recouped" from subsequent payments due the provider. Recoupment is "[t]he recovery by Medicare of any outstanding Medicare debt

by reducing present or future Medicare payments and applying the amount withheld to the indebtedness."  42. C.F.R. 405.370; *see also* 28 U.S.C. § 1395ddd(f) (Medicare Integrity Program, Recovery of overpayments).

17.  Current regulations provide for two ways to refute an overpayment determination:  rebuttal and appeal.  The current regulations on rebuttals are found at 42 C.F.R. §§ 405.374-375.  These regulations allow providers an opportunity for rebuttal after receiving a notice of recoupment of an overpayment.  The provider has 15 days to submit the rebuttal statement.  The fiscal intermediary then must consider any rebuttal statement, along with other pertinent evidence, to determine whether the facts justify a recoupment of an alleged overcharge.  42 C.F.R.§ 405.374(a).  The recoupment is "not delayed beyond the date stated in the notice in order to review the statement."  Id.  In effect, these regulations generally allow Medicare contractors to initiate recoupment of alleged overpayments 15 days after notice to the provider.

18.  Apart from the rebuttal process, a provider may also appeal an alleged overpayment decision, pursuant to applicable statutes and regulations setting forth an administrative appeal process.  *See* 28 U.S.C. § 1395ff; 42 C.F.R. § 405.370 - § 405.375.  The initial stage of the appeal is known as redetermination; the second stage of the appeal is known as reconsideration.

19.  The provider has 120 days from the date it receives notice of the initial determination to request a redetermination by the fiscal intermediary.  42 U.S.C. § 1395ff (a)(3)(A) and (C)(i).  Redeterminations shall be concluded not later than 60 days from the date that the fiscal intermediary receives a request for redetermination.  42 U.S.C. § 1395 ff(a)(3)(C)(ii).  A provider cannot have an initial determination

"reconsidered," the second stage of the appeal process, until a redetermination has been concluded. 42 U.S.C. § 1395 ff(a)(3)(B)(i). The provider has 180 days from the date it receives notice of the redetermination to file a notice for reconsideration with the Secretary. 42 U.S.C. § 1395 ff(b)(1)(D)(i). Reconsiderations are decided by a "qualified independent contractor," and shall be concluded not later than 60 days from the date that a request for reconsideration was timely filed. 42 U.S.C. § 1395 ff(c)(3)(C)(i).

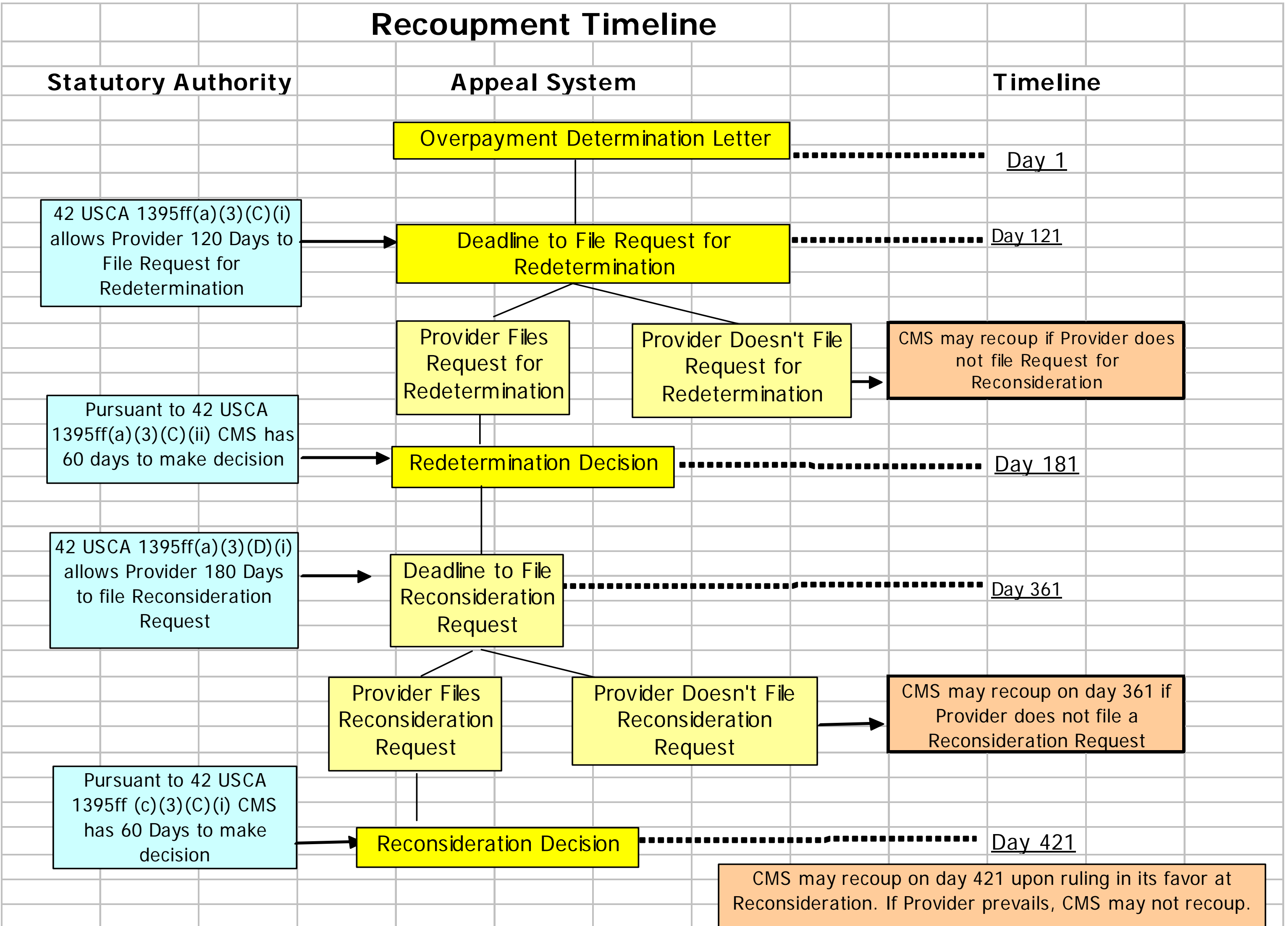
20. The MMA included a new provision, Section 935(a), which amended 42 U.S.C. § 1395ddd(f)(2) by adding language which precludes the Secretary from proceeding with a recoupment while a provider appeals an overpayment determination, as follows:

> **(2) Limitation on recoupment**
>
> **(A) In General**
> In the case of a provider of services or supplier that is determined to have received an overpayment under this subchapter and that seeks a reconsideration by a qualified independent contractor on such determination under Section 1935ff (b)(1) of this title, ***the Secretary may not take any action (or authorize any other person, including any medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered***…If the provisions of Section 1395ff (b)(1) of this title (providing for such a reconsideration by a qualified independent contractor) are not in effect, in applying the previous sentence any reference to such a reconsideration shall be treated as a reference to a redetermination by the fiscal intermediary or carrier involved.
>
> **(B) Collection with interest**
> Insofar as the determination on such appeal is against the provider of services or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment. Insofar as such determination against the provider of services or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest at the same rate as would apply

> under the previous sentence for the period in which the amount was recouped.
>
> **(C) Medicare contractor defined**
> For purposes of this subsection, the term "Medicare contractor" has the meaning given such term in Section 1395zz (g) of this title.

(emphasis added.)

21. The statutory framework thus prevents recoupment of an alleged overpayment as follows: (a) if the provider does not file a request for redetermination, then there can be no recoupment until 121 days from the date notice of overpayment received; (b) if the provider files a request for redetermination, but after the decision does not file a request for reconsideration, then there can be no recoupment until 181 days from the date of the redetermination; and (c) if the provider files a request for reconsideration, then there can be no recoupment until the reconsideration decision. Thus, depending on the amount of time taken for filing requests for redetermination and reconsideration, and on the amount of time taken to decide those requests, by law CMS potentially must not recoup an alleged overpayment for up to 421 days after notice of the alleged overpayment is received by the provider. A summary of this "recoupment timeline" required under the MMA is set forth below:




22. The legislative history is clear that Congress intended that CMS would not recoup alleged overcharges until a provider had the opportunity to appeal through the redetermination and reconsideration phase of the administrative appeal process. The Conference Report concerning the recoupment process noted that "[t]he Secretary is prohibited from recouping any overpayments until a reconsideration-level appeal (or a redetermination by the fiscal intermediary or carrier if the QICs are not yet in place) was decided, if a reconsideration was requested." See House Report 108-391 on the

23. Since the enactment of the MMA in 2003, CMS has continually and consistently failed to adhere to the statutory language in recouping alleged overpayments. First, in a June 3, 2004 Memorandum (Joint Signature Memorandum #255), CMS's Director of Financial Services Group, Director, Health Plan Policy Group, and Acting Director, Medicare Contractor Management Group, advised CMS contractors to stop recoupment of any overpayment when a provider or supplier had "*appealed*." The Memorandum provided, in pertinent part:

> Section 935(f)(2) of the MMA directs the Centers for Medicare 7 Medicaid Services (CMS) to ***stop recoupment of an overpayment where a provider or supplier has appealed***…Effective with the date of this memorandum, you ***should cease any ongoing recoupment*** as a result of a demand if (a) the first recoupment action occurred after December 8, 2003, and (b) a first-level appeal has been received. First-level appeal means the Fiscal Intermediary reconsideration for Part A overpayments…

This Memorandum, however, would allow recoupment prior to a first-level appeal being *received* by the fiscal intermediary. Thus, prior to the full 120 day period allowed by statute to appeal via a request for redetermination, a fiscal intermediary was allowed by CMS to recoup alleged overpayments. This interpretation by CMS is flatly inconsistent with the statute and clearly articulated legislative intent.

24. Subsequently, in September, 2006, CMS published proposed rules acknowledging that MMA required CMS to change the recoupment process, and purporting to implement the above-quoted provision of the MMA. **Exhibit 2**, 71 Fed.

Reg. 55404-55415. Although these proposed rules accurately set forth in chart form the administrative appellate process (Exhibit 2 at 55406), CMS once again took the position that "to the extent that the statutory language affords any discretion in implementation" (Exhibit 4 at 55407), it could recoup an alleged overpayment if the fiscal intermediary had not yet received the request for redetermination within *thirty days* of a provider receiving notice:

> This proposed rule would implement a new provision of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 that prohibits recouping Medicare overpayments ***when an appeal is received*** from a provider or supplier until a decision is rendered by a Qualified Independent Contractor (QIC). The QIC is the second level of appeal in the Medicare claims appeal process…

Exhibit 2 at 55404 (emphasis added). This "thirty day" rule is nowhere found in the statute.

25. In the "Background" section of the proposed rules, the Secretary readily acknowledged that it was the intent of Congress that there would be no recoupment during the entire appeal process. Exhibit 2 at 55407 (noting that it was the "Congressional intent that providers and suppliers be given expedited access to an objective party (independent from the originating contractor) to review the overpayment determination, prior to recouping, in the interest of fairness…").

26. The Secretary further stated in the "Background" to the proposed rules that Congress' language (*i.e.* the use of the term "reconsideration," rather than "redetermination") should not be applied to permit recoupment during the redetermination (or first) stage of the appeal process, but rather recoupment may not

occur during both the first *and* second stage of the appeal of an overpayment determination:

> Based on the statutory language, we could recoup during the period in which the provider is actively pursuing an appeal at this first level. This approach would reduce the administrative complexity of implementing this new statutory provision. Also, it would shorten the period of deferred recoupment under the Act thereby minimizing risk to the Medicare trust funds. However, this approach would mean, in many instances, we would have recouped the overpayment before a provider could request a reconsideration and thereby invoke the benefit of the limitation on recoupment. Although legally permissible, we believe this is ***inconsistent with Congressional intent.*** Instead, we propose in this rule to cease recoupment when a valid first level appeal is received. If the provider loses at the first level, ***we would then proceed to recoup 30 days after giving notice to the provider unless the provider appeals*** to the QIC in the interim. ***A provider who acts in a timely fashion can preclude any recoupment until the QIC decision is rendered as contemplated under the MMA.***

Exhibit 2 at 55407 (emphasis added). Again, although CMS did acknowledge that Congress did not intend for recoupment to take place until after the reconsideration phase of the appeal process, it took the position, contrary to the statute, that it can recoup alleged overpayments before the full 120 time period allowed for a provider to file a request for redetermination has expired.

27. The "Provisions" section of the proposed rules states that "Providers and suppliers can take advantage of the limitation on recoupment by not paying during the redetermination ***and*** reconsideration levels of appeal…"). Exhibit 2 at 55409 (emphasis added); *see also* Subsection E (regarding Proposed Rule 405.379) (Exhibit 2 at 55410) ("Recoupment of an overpayment once initiated will be stopped at the first two levels of the appeals process (the redetermination and the reconsideration) upon receipt of a

timely and valid appeal request applicable to that level. The provider or supplier does not have to take any affirmative action to invoke the limitation on recoupment beyond the act of appealing.")

28. CMS requested and received comments concerning the proposed rules. Those comments clearly articulate that CMS's proposed rules fly in the face of the statutory language of the MMA. **Exhibit 3**, Letter of the American Health Care Association, 11/21/2006; **Exhibit 4**, Letter of the National Association for Home Care & Hospice, 11/21/2006; **Exhibit 5**, Letter from the Federation of American Hospitals, 11/20/2006. For example, the American Health Care Association reviewed in detail the statutory and regulatory framework for recoupment of overcharges, and stated that "CMS can and should amend the regulations, consistent with the intent of the MMA, to provide that a timely request for redetermination and a timely request for reconsideration will prevent recoupment from being initiated." Exhibit 3 at page 5. Further, the National Association of Home Care & Hospice noted that "ignoring the plain language of Congress, CMS proposes regulations which permit CMS to start recoupment before a provider has time to request a redetermination of the overpayment, and yet not obligate CMS to pay the provider interest from the date of this recoupment if the overpayment is reversed in the redetermination decision or the reconsideration decision. This is not what Congress told CMS to do." Exhibit 4 at page 3. CMS has not adopted the proposed rules. In addition, the Federation of American Hospitals stated that the MMA "clearly provides that the earliest date upon which recoupment may commence is the date a reconsideration has been rendered. The statute contemplates that recoupment cannot take place before the reconsideration

process, or, as the proposed rule recognizes, the new law would be meaningless." Exhibit 5 at page 2.

## RECOUPMENT FROM SOUTH CAROLINA HOSPITALS BASED ON "RAC" AUDIT

29. In February, 2008, Plaintiffs were notified by HDI, a Recovery Audit Contractor paid on a contingency basis from all claims recouped, that certain of their Medicare claims were "not medically necessary and reasonable," and that therefore Medicare had made overpayments to the Plaintiffs. HDI's letter stated that the Plaintiffs "will receive a remittance notice from your fiscal intermediary reflecting the exact amount of the overpayment and withhold," that the Plaintiffs could submit a statement as to why they disagreed with the "withhold," and that Plaintiffs could appeal the overpayment decision by filing a "request for redetermination within 120 days of the date your receive the remittance notice from your fiscal intermediary." See Exhibit 1.

30. In many, if not most instances, the fiscal intermediary, Palmetto GBA and Wisconsin Physician Services, recouped these alleged overpayments from Plaintiffs either at or before the time that its notice letters were received by the Plaintiffs. The Plaintiffs effectively had no time at all to file a request for redetermination before recoupment, despite the statutory appeal framework that allows 120 days to file such requests, and despite CMS's prior acknowledgement that this recoupment process was "inconsistent with Congressional intent."

31. Plaintiffs have provided notice to the Secretary, through its agents, of their request for redetermination of the alleged overpayments, invoking their appeal rights and their rights under the MMA to stay any recoupment until the date the decision on the reconsideration was rendered.

32. By early March, 2008, Palmetto GBA and Wisconsin Physician Services had recouped approximately twenty million dollars from the Plaintiffs in alleged overpayments, and several millions more from other South Carolina providers.

33. On March 5, 2008, CMS published "Pub 100-20 One Time Notification, Transmittal 322," once again addressing the recoupment process. In that publication, CMS acknowledged again that the MMA, adopted in 2003, requires:

> CMS to change the way Medicare recoups certain overpayments. Before the MMA was enacted, if a provider or supplier elected to appeal an overpayment determination, there was no effect on Medicare's ability to recover the debt. This MMA provision requires that if a provider of services or a supplier seeks a reconsideration by a qualified independent contractor (QIC) on an overpayment determination, CMS and its Medicare contractors may not recoup the overpayment until the date the decision on the reconsideration has been rendered. . . . .
>
> On September 22, 2006, CMS published for public comment a proposed rule to implement Section 1893(f)(2). This proposed rule is not in effect and may be modified based on public comments received. **However, certain features of the current claims adjustment process are incompatible with the limitation on recoupment and need to be changed to bring CMS into compliance with the final rule once published and in effect**. Maximizing efficient adjustment processing of Medicare claims, the fiscal intermediary standard system (FISS) currently adjusts a claim and if there are claims in the system, immediately recoups. Recovered amounts are included in the remittance advice to providers. **For those Part A overpayments determined by a Medicare contractor and subject to 1893(f)(2), an alternate process is required which would enable the claims to be adjusted without immediate recoupment to allow the provider time to submit an appeal.** In addition, to the extent it is feasible and cost-effective to do so, certain new or revised overpayment recovery processes required to fully implement the limitation on recoupment should be automated. For planning and system design purposes, these changes should reflect the following approach. For Part A overpayments subject to 1893(f)(2), receipt of a timely and valid request for appeal (the contractor redetermination) triggers the limitation on recoupment. **Once the contractor has determined the overpayment and adjusted the claim in the FISS system,**

> **the withholding of the overpayment will automatically be set to begin withholding 40 days from the determination date**. When that day is current the withholding shall begin if the provider has not submitted an appeal for redetermination (first level of appeal). If an appeal was submitted by the provider within those 40 days the withholding will not begin. If the contractor redetermination results in a full or partial affirmation of the overpayment, contractors can begin or resume recoupment starting 60 days and no later than 75 day days after giving notice unless the provider appeals to the QIC in the interim. The contractor should cease or not begin recoupment if the QIC notifies the contractor that a valid and timely request for a reconsideration (second level of appeal) has been received. Following final action by the QIC, the contractor can initiate or resume recoupment whether or not the provider subsequently appeals to the administrative law judge (ALJ) (third level of appeal). For a period of up to 60 days following final action by the QIC and resumption of recoupment, Medicare contractors should not issue a second demand letter, the intent to refer letter, nor proceed with referral to the Department of Treasury. Interest will continue to accrue under current policies but will not be assessed when recoupment is stopped at either the redetermination or reconsideration (first and second level of appeals).

See **Exhibit** 6, Transmittal 322, Pub. 100-20 (Background) (emphasis added). Thus, immediately after CMS allowed its South Carolina fiscal intermediaries, Palmetto GBA and Wisconsin Physician Services, to recoup over thirty million dollars worth of alleged overpayments from South Carolina providers prior to those providers having *any* opportunity to appeal, CMS proposed allowing providers a forty day "grace period" to appeal prior to recoupment, all the while acknowledging that the immediate recoupment process violated (or, in CMS's words, was "incompatible with") a five year old statute.

34. This new forty day grace period proposed by CMS still falls eighty days short of the MMA's requirement that a provider has 120 days to request a redetermination of an alleged overpayment.

35. In April, 2008, South Carolina Congressional representatives, including Senators Lindsey Graham and James DeMint and Representatives Henry Brown, Joe Wilson, Gresham Barrett, Bob Inglis, and John Spratt, along with representatives of the South Carolina Hospital Association, met with Defendant Weems and other CMS employees, to discuss CMS's recoupment process in light of the provisions of the MMA discussed above. During that meeting, CMS acknowledged that it relied on existing regulations (42 C.F.R. §404.370 *et. seq.*), enacted before the MMA in 2003, for recouping alleged overpayments from South Carolina providers as part of its RAC program. CMS noted that it would revise its recoupment procedures to conform to the MMA no later than October, 2008. CMS also admitted that there was no way for any South Carolina hospital to have appealed in such a way as to toll recoupment of overpayments during the RAC demonstration project, given that the fiscal intermediaries, Palmetto GBA and Wisconsin Physician Services, had immediately recouped the alleged overpayments. Senator Graham asked CMS to apply its new recoupment procedures to South Carolina and the other RAC demonstration states, and CMS agreed to consider that request. See **Exhibit 7**, letter of South Carolina Hospital Association, dated April 25, 2008.

36. To date, CMS has not agreed to apply its new recoupment procedures to the alleged overpayments incurred against the Plaintiffs in February and March, 2008, nor has it agreed to apply the statutory time limits set forth in the MMA before recouping any alleged overpayments from February and March, 2008, or from future alleged overpayments.

37. This action does not challenge the correctness of any overpayment determination, as that is a question to be determined in the pending administrative appeal process. This action seeks judicial enforcement of the 2003 MMA barring the Secretary and his agents from effectuating a recoupment of alleged overpayments while those overpayments are being challenged by the provider in an administrative appeal and prior to a final determination of that challenge.

38. The Secretary has refused to reimburse Plaintiffs for the unlawful recoupment of the alleged overpayments and has refused to discontinue the recoupment from pending and future claims. That action (or inaction, however it is viewed), is contrary to the plain statutory language, contrary to acknowledged Congressional intent, contrary to the CMS June 3, 2004 Joint Signature Memorandum #255, in which CMS acknowledged the requirements of the statute, and contrary to the Secretary's construction of the statute, as reflected in the proposed rules and subsequent changes to those rules, as discussed herein.

## **CLAIM FOR RELIEF**

39. The allegations of paragraphs 1 through 37 are realleged and incorporated as if fully set forth herein.

40. The actions of the Secretary, through CMS, its agents and fiscal intermediaries, in recouping the contested alleged overpayments while Plaintiffs' appeals of the initial overpayment determination are pending, violates the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

41. The Defendants have a non-discretionary duty to comply with the Medicare, Prescription Drug, Improvement, and Modernization Act of 2003, which

precludes recoupment of the alleged overpayments prior to the time period allowed to request administrative review, and during the time period of that administrative review. The Defendants' actions as described herein are arbitrary, capricious, and contrary to law.

42. Plaintiffs have no administrative remedy to halt the unlawful recoupment, or to seek immediate repayment of the wrongfully recouped payments pending administrative review.

43. Defendants' consistent refusal to abide by the terms of the MMA violates Plaintiffs' rights to due process under law pursuant to the Fifth and Fourteenth Amendment to the Constitution of the United States.

44. The Secretary's refusal to comply with the term of the statute compels the conclusion that the parties have an actual and present controversy about their rights and obligations under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which is ripe for resolution and which can only be resolved through a declaratory judgment by this Court.

45. Title 28 U.S.C. § 1395ddd(f)(2) does not grant the Secretary or its agents the discretion to continue with recoupment of an alleged overpayment, while that determination is the subject of a valid and timely appeal by the provider during the redetermination and reconsideration phases of the appeal process. Thus, injunctive relief and/or the remedy of mandamus are required to compel the Secretary to exercise his duty to halt recoupment while Plaintiff's appeals of alleged overpayment determinations are pending.

## PRAYER FOR RELIEF

WHEREFORE, the Plaintiffs respectfully request that this Court:

(a) Assume jurisdiction over this case;

(b) Declare that Section 935 of the Medicare Prescription Drug Improvement and Modernization Act of 2003, codified at 42 U.S.C. § 1395ddd(f)(2), precludes recoupment prior to 120 days from the date a provider receives notice of an initial overpayment determination, and also precludes recoupment during the redetermination and reconsideration stages of the appeal of an initial overpayment determination (*i.e.,* both the first and second stages of the appeal process);

(c) Declare that Defendants' past and ongoing recoupment of alleged overpayments for Medicare covered services provided by Plaintiffs, while those alleged overpayments are being appealed, violates the Medicare Prescription Drug Improvement and Modernization Act of 2003;

(d) Direct the Defendants to comply with their mandatory and non-discretionary duties under 42 U.S.C. § 1395ddd(f)(2), to discontinue the challenged recoupments, and to pay back (with interest at the applicable rate) Plaintiffs' pending and future Medicare claims in full, until the conclusion of both the first and second stages of the administrative appeal process;

(e) Enter judgment in Plaintiffs' favor;

(f) Award Plaintiffs' costs as allowable by 28 U.S.C. § 1920, and attorney's fees pursuant to the Equal Access to Justice Act, 28 U.S.C. § 2412(d)(1)(A), based upon a finding that the Defendants' position is not substantially justified.

(g) Award such other and further relief as may be just and proper.

s/ Russell T. Burke

| | |
|---|---|
| Thomas L. Stephenson | Fed ID No. 4299 |
| Russell T. Burke | Fed ID No. 1604 |

NEXSEN PRUET, LLC
201 West McBee Avenue, Fourth Floor
Post Office Drawer 10648
Greenville, SC  29603
PHONE:  864.370.2211
TStevenson@nexsenpruet.com
RBurke@nexsenpruet.com

*Attorneys for Plaintiffs*

July 3, 2008
Columbia, South Carolina