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

GENERAL MEDICINE, P.C.,
A Michigan professional corporation,

Plaintiff,

-vs-

Case No.
MAC Docket No. M-17-2922
ALJ Appeal No. 1-1056003206

XAVIER BECERRA, in his official capacity as Secretary of the U.S. Department of Health and Human Services,

Defendant.
_____/

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_____/

COMPLAINT

NOW COMES Plaintiff General Medicine, P.C., by and through its attorneys, Seyburn, Kahn, P.C., and states the following:

1. Plaintiff General Medicine, P.C. is a Michigan professional corporation with its principal office located in the City of Novi, County of Oakland, in the Eastern District of Michigan of the United States District Court.

2. Defendant Xavier Becerra is the current Secretary of the Department of Health and Human Services.

3. Jurisdiction is based upon 42 U.S.C. §405(g) providing for judicial review of the final decision of the Secretary made after a hearing.

4. Venue is based upon 42 C.F.R. §405.1136(b) because Plaintiff has its principal place of business in the Eastern District of Michigan.

5. The amount in controversy exceeds the sum of $800,000.00.

6. The review is sought from a final decision of the Medicare Appeals Council ("MAC") dated May 7, 2021 and received on May 22, 2021; a copy of which is attached hereto as Exhibit A.

7. Plaintiff is a post-hospitalist company that employs board-certified physicians and nurse practitioners who specialize in the care of patients residing in post-acute, long-term care and assisted living facilities.

8. In 2010, the Centers for Medicare and Medicaid Services (CMS) conducted a post-payment audit of claims submitted by Plaintiff to Medicare for payment for services rendered to patients covered by Medicare.

9. The services were rendered to residents of long-term care facilities located in Louisiana in 2004-2006.

10. Most of the services were rendered in the months before, during and immediately after the disaster of Hurricane Katrina that devastated parts of

Louisiana.

11. CMS selected 90 claims at random and determined that Plaintiff had been overpaid on most of the claims.

12. CMS then extrapolated the statistical sampling of the overpaid claims which resulted in an overpayment demand amount of $804,653.00.

13. Plaintiff, in its own right and not on behalf of any beneficiary, appealed the overpayment determination through the Medicare administrative appeal process, culminating in a Request for Hearing before an Administrative Law Judge (ALJ) filed on November 11, 2010.

14. One of Plaintiff's primary defenses to the overpayment determination was that payment for the services rendered prior to and during Hurricane Katrina should not have been denied under a CMS policy that relaxed normal Medicare requirements for payments, due to the destruction caused by the storm to facilities and records kept therein.

15. On September 1, 2011, the ALJ conducted a hearing on Plaintiff's appeal of the overpayment determination, as to 73 of the claims that were still unfavorable to Plaintiff.

16. The ALJ discovered that not all of the claims had been reviewed by the CMS Medicare Qualified Independent Contractor (QIC), so those claims were remanded to the QIC and no further testimony or argument was presented to the

ALJ pending the QIC's decision on the remand order.

17. On December 5, 2013, more than two years after the remand, the ALJ notified Plaintiff in writing that its Request for Hearing was defective because Plaintiff had failed to send a copy of the Request for Hearing to each of the seventy-three (73) residents of the facilities to whom Plaintiff had rendered medical services some seven to nine years earlier.

18. The ALJ stated that 42 C.F.R. §405.1014(b)(2) required Plaintiff to send copies of the Request to all of the other "parties" to the appeal, and that the 73 beneficiaries were "parties" to the appeal.

19. The ALJ ordered Plaintiff to present proof that each of the 73 beneficiaries was sent a copy of the Request within 60 days or the appeal may be dismissed (See Exhibit B attached hereto).

20. On December 13, 2013, Plaintiff sent a letter to the ALJ arguing that the beneficiaries were not "parties" to the appeal under the definitions provided in the Medicare regulations, and citing a prior decision of the Medicare Appeals Council which supported Plaintiff's position, as well as the fact that CMS had not treated the beneficiaries as "parties" in the earlier appeals (See Exhibit C attached hereto).

21. In Plaintiff's response, Plaintiff also requested that that ALJ advise Plaintiff if it disagreed with Plaintiff's position.

22. On September 28, 2016, nearly three years later, and more than five years from the date that Plaintiff filed its Request for Hearing, and 10 to 12 years after the services were rendered, the ALJ dismissed Plaintiff's appeal for failure to serve the 73 beneficiaries (See Exhibit D attached hereto).

23. On November 29, 2016, Plaintiff filed a timely appeal of the ALJ's dismissal to the Medicare Appeals Council (MAC).

24. In its appeal, Plaintiff argued the following:

a. the beneficiaries are not "parties" to the appeal as defined by the Medicare regulations because Plaintiff was appealing on its own behalf as the provider and not on behalf of the beneficiaries, and they were not required to be served with the Request for Hearing to the ALJ;

b. if the beneficiaries were "parties", then the QIC would have been required to serve them with its decision, which it did not do;

c. the MAC had previously held in an unrelated case that a failure to notify beneficiaries who have no interest in overpayment cases is not a basis for dismissal; and

d. any notice, even if required by the regulations, was rendered meaningless by the delay of seven to nine years between the

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