U.S. DISTRICT COURT
DISTRICT OF VERMONT
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UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF VERMONT

GLENDA JIMMO, et al.,	)	
	)	
Plaintiff,	)	
	)	
v.	)	Case No. 5:11-cv-17
	)	
KATHLEEN SEBELIUS, Secretary of Health and Human Services,	)	
	)	
Defendant.	)	

ORDER DENYING PARTIAL RECONSIDERATION OF OPINION AND ORDER OF OCTOBER 25, 2011
(Doc. 57)

This matter comes before the court on Plaintiffs' motion for partial reconsideration of the court's Opinion and Order of October 25, 2011 (Doc. 57). In its October 25th Opinion and Order, the court granted in part and denied in part Defendant's motion to dismiss. Plaintiffs seek reconsideration of that part of the Opinion and Order dismissing plaintiff Edith Masterman's claim for lack of subject matter jurisdiction based upon her failure to exhaust her administrative remedies. Defendant opposes reconsideration.

I. Factual and Procedural Background.

Plaintiffs' motion for partial reconsideration seeks reconsideration of the following portion of the court's October 25th Opinion and Order:

> Although this case presents a close question, the court cannot conclude, based upon the record before it, that judicial review is unavailable to Ms. Masterman as a practical matter. As the Secretary points out, Ms. Masterman can force her HHA [Home Health Agency] to submit a claim through a procedure known as "demand billing." A "demand bill" is a "claim submitted by an HHA to [CMS] for services or items that the HHA believes are not covered but which the HHA must submit to [CMS] at the request of the beneficiary[.]" *Lutwin v. Thompson*, 361 F.3d 146, 149 (2d

> Cir. 2004) (internal quotation marks and alterations omitted). To require submission of a demand bill, the beneficiary must agree to pay the HHA for services that CMS determines are not covered by Medicare. *See id.* A beneficiary has this option when an HHA "prospectively decline[s] to provide . . . services . . . when it conclude[s]," as Ms. Masterman's HHA did here, "that [CMS] would not cover those services. *Id.*[1] This would "trigger the administrative process, at the end of which is judicial review of the Secretary's final decision." *Am. Chiropractic Ass'n*, 431 F.3d at 817. Some potential difficulty or financial hardship is generally not enough. *See Ringer*, 466 U.S. at 622, 625 (holding that Ringer's claim arose under the Medicare Act and required presentment even though "some . . . surgeons may well decline to perform the requested surgery because of fear that the Secretary will not find the surgery 'reasonable and necessary' and thus will refuse to reimburse them.").
>
> Here, Ms. Masterman has not established that she is financially unable to reimburse her HHA in the event services are not covered or that demand billing is not available to her. She has thus not established that applying § 405(h) to her claims renders judicial review unavailable. Accordingly, Ms. Masterman is required to present her claims to the Secretary, and jurisdiction under both § 405(g) and § 1331 is not available.

(Doc. 56 at 8-9).

With regard to Ms. Masterman, Plaintiffs' Amended Complaint alleges the following:

> 71. An infection occurred after the skin graft and she remained hospitalized until October 14, 2009. Upon her release from the hospital, she was admitted to a skilled nursing facility from October 14, 2009 to January 18, 2010. When she finally returned home in January 2010 her physician ordered home health care, but AHCH refused to accept her back as a patient on the grounds that it "cannot accept Edith because her Medicare will not pay for a chronic problem" and she needs long term care. AHCH informed Ms. Masterman that Medicare would not cover the wound care her doctor ordered because Medicare does not pay for care when a wound is chronic and never expected to heal.

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[1] When an HHA declines to provide services because it believes that such services will not be covered by Medicare, CMS requires it to provide the beneficiary with a "Home Health Advance Beneficiary Notice." On this notice, the beneficiary may trigger demand billing by selecting the following option: "I want the items and/or services . . . and I agree to pay for the items and/or services myself if Medicare or my other insurance doesn't pay."

> 72. Her doctors have been and are willing to order home health care.
>
> 73. Prior to her hospitalization, Medicare covered the services provided by an AHCH nurse who came to Ms. Masterman's home every other day. After her hospitalization and because she could not obtain Medicare coverage of her home health care, Ms. Masterman originally made weekly visits to the wound care clinic at the hospital. She now visits the wound care clinic once every four weeks.
>
> 74. She receives some home care services from Elder Independence of Maine, paid for by Medicaid, which includes home health aides three times daily for about 1-1/2 to 2 hours per visit from Home Care of Maine and a once weekly skilled nursing visit from Care and Comfort.
>
> 75. AHCH is the only Medicare certified home health agency in her area. Medicare-covered home health care from AHCH would be more frequent than the care she now receives and would free her from the taxing effort and discomfort of having to go to the wound care clinic.

(Doc. 13 at ¶¶ 71-75).

In seeking reconsideration, Plaintiffs present two arguments. First, they contend they did not have an adequate opportunity to address the Secretary's demand billing argument as it arose late in the briefing on the motion to dismiss. And second, they argue that demand billing was not available to Ms. Masterman because her HHA refused to accept her as a patient and thus she never had a patient-provider relationship that could give rise to demand billing. *See* Doc. 60 at 3 ("Here, the HHA did not enter a patient-provider relationship with Ms. Masterman.").

The Secretary counters that reconsideration is unavailable because Plaintiffs present no new evidence or law for the court's consideration, and because Plaintiffs do not allege that the HHA refused Ms. Masterman services even if she agreed to be personally financially responsible for them.

II. Conclusions of Law and Analysis.

A. Standard of Review

In the Second Circuit, the standard for reconsideration is "strict" and reconsideration "will generally be denied unless the moving party can point to controlling decisions or data that the court overlooked—matters, in other words, that might reasonably be expected to alter the conclusion reached by the court." *Shrader v. CSX Transp., Inc.*, 70 F.3d 255, 257 (2d Cir. 1995). "The major grounds justifying reconsideration are an intervening change of controlling law, the availability of new evidence, or the need to correct a clear error or prevent manifest injustice." *Virgin Atlantic Airways, Ltd. v. Nat'l Mediation Bd.*, 956 F.2d 1245, 1255 (2d Cir. 1992). It is in accordance with this exacting standard that Plaintiffs' partial motion must be considered.

B. Whether Plaintiffs had an Adequate Opportunity to Address Demand Billing.

Plaintiffs first argue that they lacked an adequate opportunity to respond to the Secretary's demand billing argument because it was raised for the first time in Defendant's reply memorandum. This argument is unavailing. Plaintiffs bear the burden of establishing the court's subject matter jurisdiction. *See Aurecchione v. Schoolman Transp. System, Inc.*, 426 F.3d 635, 638 (2d Cir. 2005). The motion to dismiss was extensively briefed by both parties and the issue of demand billing was squarely before the court.

Plaintiffs allege that Ms. Masterman cannot present her claims to the Secretary as required by the Medicare Act, 42 U.S.C. § 405(h) and thus the requirement to do so should be excused. Having made this argument, the burden was and is on Plaintiffs to make the requisite factual showing to support it. There can be no reasonable argument that they did not have an incentive and opportunity to do so. Accordingly, as an initial observation, the court notes that the demand billing issue should and could have been addressed by Plaintiffs previously.

C. Whether Plaintiffs Have Established that Demand Billing is Unavailable.

More importantly, the facts before the court remain unchanged. Plaintiffs argue that demand billing was not available to Ms. Masterman because the only HHA reasonably available to her refused to enter into a provider-patient relationship with her on any terms. Their Amended Complaint, however, supports a contrary conclusion. It *does not* allege, as Plaintiffs contend, that "the sole HHA in Ms. Masterman's geographic area denied admission to Ms. Masterman and refused to accept her as a patient." (Doc. 60 at 2). Rather, it alleges that Ms. Masterman was an *existing* patient of the HHA which had provided services to her in the past but which refused to provide services for a chronic condition only because Medicare would not pay for them and she required long term care. There is nothing in the Amended Complaint that would allow the court to conclude or even infer that the HHA would have refused to provide services to Ms. Masterman even had she agreed to pay for them herself. Moreover, Plaintiffs do not allege she was financially incapable of doing so. Accordingly, Plaintiffs have identified no new evidence which the court overlooked in determining whether Plaintiffs had established the court's subject matter jurisdiction over Ms. Masterman's claims.

For the foregoing reasons, partial reconsideration is hereby DENIED.

SO ORDERED.

Dated at Rutland, in the District of Vermont, this 23rd day of December, 2011.

/s/ Christina Reiss

Christina Reiss, Chief Judge
United States District Court