IN THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

NO. 16-4062

GLORIA L. TROSTLE, Individually and as Administratrix of the ESTATE OF DAVID A. TROSTLE, deceased,

Appellant

v.

CENTERS FOR MEDICARE AND MEDICAID SERVICES,

Appellee

BRIEF OF APPELLANT

APPEAL FROM THE ORDER AND OPINION OF THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF PENNSYLVANIA, NO. 1:16-CV-00156-WWC, DATED OCTOBER 17, 2016, GRANTING DEFENDANT'S MOTION TO DISMISS

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I. STATEMENT OF SUBJECT MATTER JURISDICTION AND APPELLATE JURISDICTION

Subject matter jurisdiction is the ultimate issue in this case and will be discussed more fully below. Ultimately, the District Court has subject matter jurisdiction under federal question jurisdiction, which recognizes that when an individual contracts with a federal agency, federal courts have jurisdiction. Alternatively, if this claim were under the Medicare Act, jurisdiction would be proper under 42 U.S.C. § 405(g), as a final decision has been made, as admitted by the Appellee in its arguments at the lower court.

Venue is Proper.

On the 17th day of October, 2016, District Judge William W. Caldwell issued the following Order:

1. Defendant's motion (Doc. 7) is GRANTED.
2. Plaintiffs' complaint, in its entirety, is DISMISSED with prejudice.
3. The Clerk of Court shall close this case.

a003, et seq.

Plaintiff filed a timely Notice of Appeal to your Court on November 4, 2016. **a001**

Your Honorable Court has jurisdiction over the instant matter pursuant to 28 U.S.C. § 1291.

II. STATEMENT OF THE ISSUES PRESENTED

1. Did the Trial Court err in determining that Plaintiff's Complaint arose out of the MCare Act instead of Contract law?

2. Did the Trial Court err in dismissing Plaintiff's Complaint with Prejudice?

III. STATEMENT OF RELATED CASES AND PROCEEDINGS

Plaintiff is unaware of any related cases or proceedings.

IV. STATEMENT OF THE CASE

On 7/8/11, a dialysis nurse at Fresenius Medical Care, called in a prescription for Lanthanum Phosphate (Fosrenal) into Bloomfield Pharmacy which incorrectly filled the prescription with Lithium Carbonate. Subsequently, after taking the medication, David A. Trostle, deceased, became ill and was hospitalized on 7/15/11 for lithium toxicity treatment, then transferred to a nursing home for further care. Mr. Trostle ultimately spent sixty-six (66) days in various hospitals and two (2) weeks in a coma as a result of this incident.

Following Mr. Trostle's ordeal, he brought an action against Bloomfield Pharmacy which went to a mediation on May 21, 2014. While the case did not settle at mediation, it did eventually settle in July, 2014 for $225,000. This settlement was premised upon the Trostles' knowledge of their liens, which at the time were reported to be $40,586.37 to Tricare Health Insurance and $1,212.32 from the Centers for Medicare and Medicaid Services ("CMS" or "Defendant"). The Trostles' attorney was successful in getting the Tricare lien reduced to $26,809.54 prior to settlement which led to the Trostles accepting the $225,000 offer.

After the case settled for $225,000 in July of 2014, CMS demanded on August 14, 2015, $53,295.14 to satisfy its lien. This led to an untenable situation wherein Mr. Trostle received less money than did his attorneys, and less money

than was either paid towards a lien or held in escrow for a potential lien. Had CMS asserted its higher lien amount prior to settlement Plaintiffs would not have settled for $225,000.

Following receipt of the claimed $53,295.14 lien, Trostle's attorney attempted to negotiate their lien with CMS to reduce it to a more manageable number. CMS refused to reduce its lien or even pay a pro-rata share of the attorney's fees and costs. Mr. Trostle died. Ultimately, Plaintiff Gloria L. Trostle, Individually and as Administratrix of the Estate of David A. Trostle, deceased, ("Plaintiff" or "Appellant") filed the present suit.

Plaintiff averred in the Complaint (**a021**) that it would be contrary to law and justice to allow CMS to ex post facto increase its lien amount over fifty-thousand dollars. The stated lien amount at the time of settlement induced the acceptance of an offer which would have been wholly unacceptable had a lien of over fifty-thousand dollars been asserted by CMS.

Plaintiff further averred that the modifications from $725.17 to $1,212.32 evidenced CMS's knowledge of the lien and continued treatment of Mr. Trostle, and the CMS's decision to raise the lien to $53,295.14 was unconscionable. Plaintiff also averred that CMS has waived any right to recovery over the amount of $1,212.32 by not asserting it at an appropriate time, and that the doctrine of

equitable estoppel prevents CMS from recovering more than it claimed to be owed at the time of settlement.

Plaintiff also averred that the administrative process had rendered a final decision and that there was no appeal available through the administrative process.

V. STANDARD OF REVIEW

The present case is before the Court on a motion to dismiss under F.R.C.P. 12(b)(1). There are two possible standards of review for such motions, "facial attack" and "factual attack," and both will be discussed herein.

In the present action, it would be proper to consider CMS's motion as a facial attack, under which:

> *[T]he court may consider only the allegations contained in the complaint and the exhibits attached to the complaint, matters of public record such as court records, letter decisions of government agencies and published reports of administrative bodies, and "indisputably authentic" documents which the plaintiff has identified as a basis of his claims and which the defendant has attached as exhibits to his motion to dismiss.*

John G. v. Northeastern Educational Intermediate Unit 19, 490 F. Supp.2d 565 (M.D. Pa. 2007) at 575.

This type of attack requires that the allegations of the complaint be considered as true.

The District Court applied a "factual attack" standard which only occurs when the motion factually challenges the court's subject matter jurisdiction. In this

case, there is no presumption of truthfulness and the plaintiff bears the burden of demonstrating jurisdiction. *Mortensen v. First Fed. Sav. & Loan Ass'n*, 549 F.2d 884, 891 (3d Cir. 1977). While the District Court relied on the evidence supplied and determined that CMS was making a factual attack, this ignores Plaintiff's contract claims, where there was no evidence supplied by CMS, which should have created a facial attack review.

VI. ARGUMENT

A. The District Court Should Not Have Granted CMS's Motion to Dismiss Because Plaintiff's Claims Do Not Arise Out of the MCARE Act, They Arise Out of Contract Law.

The District Court casts an exceptionally wide net in determining that Appellant's claims arise under the MCARE Act. While they are correct in the assertion that the Supreme Court has cast a wide net in determining whether or not a claim arises under the Medicare Act, they proceed to impermissibly expand the already broad test put forth in *Heckler v. Ringer*, 466 U.S. 602 (1984). The District Court focused on "both the standing and substantive basis for the presentation," and read that so broadly that any lawsuit against Medicare or CMS would ultimately have to be brought under the MCARE Act. It also would create a system wherein CMS not only decides whether or not to follow its contracts but also one where its administrative system determines if it did so properly. This would be contrary to logic and justice.

In the present action, Mr. Trostle's attorneys were able to get statements from CMS, both in the form of conditional payment letters and the Medicare website, which is updated more regularly than the letters. These sources are accepted as reliable and are then used to determine what CMS lien exists. However, in this case, despite the nearly two years between his injury and

settlement, CMS never bothered to change its numbers to reflect that Mr. Trostle's injuries were indeed from ingestion. The burden in that instance is on CMS, as it is its job to determine the amount owed and it has shown no case law which allows it to so dramatically change its quoted number after a settlement.

CMS here attempts to shift the blame to Mr. Trostle for not notifying them that his claim was one "involving ingestion" but that is counter to the truth. By no later than April 16 2013, when Mr. Trostle's attorney was authorized to use the MyMedicare.gov website, CMS was on notice that Mr. Trostle's injuries were related to the ingestion of the wrong prescription. It knew this because on the forms which must be submitted to Medicare in order to gain access to this website one is required to list the nature of the injury. When CMS did not update its system over the 14 months between the initial conditional payment letter and settlement of Mr. Trostle's claims, CMS created a situation where it encouraged the Trostles and their attorney to rely upon its representations in his settlement negotiations. This inducement and reliance is indicative of estoppel, and therefore is governed by contract law and not by the Medicare Act.

In the instant case, CMS did not look into Mr. Trostle's case, despite their notice that it was for ingesting the wrong medicine, until after settlement. This settlement figure was determined so that all liens could be paid in full, and so that Mr. Trostle could be compensated for his pain and suffering. By relying upon the

representations of CMS, the figure of $225,000 was accepted. Had the lien information changed prior to settlement, the settlement figure would have changed accordingly.

CMS has never explained how it suddenly knew that the case revolved around an ingestion issue and was able to add over $50,000 to Mr. Trostle's lien, and in the ineffective administrative system it will never have to. If CMS truly never received notice that this was an ingestion issue prior to the settlement it certainly did not receive notice of the condition after settlement. In the paperwork CMS was sent it was told only of what the settlement was and how it was broken down. To then determine it was an ingestion shows one of two things: either CMS had previously been on notice and chose not to update its numbers, or CMS had the ability to determine Mr. Trostle's injury in advance of settlement but simply chose not to until it saw the size of the settlement. Neither of those two options place the burden on the Plaintiffs nor are they courses of action which should be supported by this Court.

The principle of subrogation is grounded in equity. This Court should follow the Pennsylvania Supreme Court in deciding this case. In a 2007 case where a subrogation was not asserted until after settlement, the Pennsylvania Supreme Court held:

> [T]his Court and intermediate courts have made clear that a subrogation claim, in substance, is equitable in nature, and

> therefore does not sound in assumpsit. ... ("[T]he doctrine of subrogation is based on considerations of equity and good conscience ... to promote justice ... [and] is granted as a means of placing the ultimate burden of the debt on the person who should bear it. It is not a matter of contract or privity").
> ***
> A right to subrogation, then, may arise as a result of a contractual reservation or as a matter of equity, if no such specific reservation exists. When the subrogation claim arises out of a contract, Pennsylvania courts have long held that equitable principles even though the right thereto as authorized by statute and respective policies of insurances contractually declared.
>
> Notably, the majority of high courts in other jurisdictions that have squarely addressed the issue in the past two decades likewise have held that equitable principles apply to instances involving contractual rights of subrogation.

Valora v. Pennsylvania Employees Benefit Trust Fund, 939 A.2d 312 at 319-321 (Pa. 2007).

Ultimately, while the issue of whether or not there should be any lien does arise under the Medicare Act, the inducement to settlement was a contractual decision by CMS. Just because CMS exists as a result of the Medicare Act should not be enough to force all disputes with it to "arise" under the Medicare Act. This is a broader reading of the law than should be implemented, especially given the facts outlined above which clearly show that Appellant's case against CMS does not come from its ownership of a lien but rather from its conduct in failing to adequately update the lien which fraudulently induced the Plaintiffs into a contract they never would have signed otherwise.

B. Even if Plaintiff's Claims Arise Under the MCARE Act, CMS Acknowledges That She Has No Recourse Through the Administrative Process and Therefore a Final Decision Has Been Reached, Leaving Appellant With No Recourse But to File This Action.

CMS acknowledged in its lower court brief that "Plaintiff, the Trostle Estate, **has not and can no longer** exhaust administrative remedies....", Defendant brief, p. 17. This statement clearly demonstrates that in CMS's view, a final determination has been made as to Plaintiff's claims and a lawsuit is the final recourse.

While the District Court raises the issue that if this appeal were to be granted it would open the door for others to simply intentionally miss deadlines so that they can escalate the case to the District Court level, this ignores historical precedent wherein it is allowable if there are no facts in dispute. In *Mathews v. Diaz*, the Supreme Court held that it can be inferred that the Secretary of the Department of Health, Education and Welfare has waived any requirements to exhaust an administrative process when there are no factual disputes to be addressed during the process. *Mathews v. Diaz*, 426 U.S. 67, 75-76 (1976).

In the instant case, Appellee has never disputed any facts raised by Appellant as to the amount of the lien. The lien amount has changed, CMS admits

that it has changed, and the only dispute is over whether or not this change was proper. That is not a question of fact but rather one of law. In *Mathews*, "[a]lthough the Secretary moved to dismiss for failure to exhaust administrative remedies, at the hearing on the motion he stipulated that no facts were in dispute...." *Id.* at 76. While there is no stipulation, or even a hearing, in the present case, the lack of any factual dispute, other than whether or not there was a final determination reached, should be inferred as such a stipulation which would allow this case to be heard by the Courts.

If the Court is unwilling to infer that there is a stipulation of no factual dispute, there still is not enough evidence provided by CMS to show that there is a factual dispute. Without a hearing it is impossible for the District Court to definitively say that there was a factual dispute. If nothing else, the Court should overrule the dismissal and order a hearing at the lower court as to the motions.

Appellee's acknowledgement that there can be no further resolution through the administrative process, coupled with their lack of disputed facts and the Supreme Court precedent shows that even if this case does arise under the Medicare Act, subject matter jurisdiction still exists.

VII. CONCLUSION

This may be the first to reach Your Court dealing with the issue of CMS's ability to contract through their setting of lien amounts and whether or not that is under the Medicare Act. Even if it is under the Medicare Act, and Appellant denies that it is, then the Court should follow precedent dealing with Social Security cases. Reversal is Required.

Respectfully submitted,

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by:_____

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Date: December 19, 2016

CERTIFICATE OF BAR MEMBERSHIP

I, Richard C. Angino, Esquire, hereby certify that I have been admitted before the bar of the United States Court of Appeals for the Third Circuit Court of Appeals for the Third Circuit and that I am a member in good standing of the Court.

/s/ Richard C. Angino
Richard C. Angino, Esquire
Attorney for Appellants

CERTIFICATE OF COMPLIANCE WITH RULE 32(a)

Certificate of Compliance with Type-Volume Limitations, Typeface Requirements, and Type Style Requirements

I, Richard C. Angino, Esquire, hereby certify that:

1. This brief complies with type-volume limitation of Fed. R. App. P. 32(a)(7)(B), because this brief contains exactly 2,500 words, excluding the parts of the brief exempted by Fed. R. App. P. 32 (a)(7)(B)(III). This number was determined by using the Microsoft Word selection word count.

2. This brief complies with the typeface 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 proportional font/faces, using Microsoft Word 2010, with size-14 Times New Roman font.

/s/ Richard C. Angino
Richard C. Angino, Esquire
Attorney for Appellants

CERTIFICATE OF SERVICE

I, Richard C. Angino, Esquire, hereby certify that I have this 20th day of December, 2016, served a true and correct copy of the foregoing Brief and Appendix of Appellants upon counsel of record via postage pre-paid, first class mail United States mail addressed as follows:

D. Brian Simpson, Esquire
U.S. Attorney's Office, MDPA
228 Walnut Street
Harrisburg, PA 17108

I also hereby certify that I, Richard C. Angino, Esquire, have this 20th day of December, 2016, forwarded via first-class mail United States mail, (7) copies of Brief of Appellants and (4) copies of the Appendix to The United States Court of Appeals for the Third Circuit.

/s/ Richard C. Angino
Richard C. Angino, Esquire
Attorney for Appellants

CERTIFICATE OF AUTHENTICITY

Appellants hereby certify that the electronic version of Appellant's Brief file via ECF with the Court on December 20th, 2016, is identical to the paper copies forwarded to the Court.

/s/ Richard C. Angino
Richard C. Angino, Esquire
Attorney for Appellants

CERTIFICATION OF VIRUS DETECTION SOFTWARE

Appellants hereby certify that the offices of Angino Law Firm, P.C. has a sophisticated layered approach to antivirus protection, including:

1. all PCs have local AVG that scans files as they are created;

2. the exchange serve has AVG for email; and

3. Postini scans all outbound email.

This virus detection system was in operation in our offices at the time the electronic version of Appellants' Brief was created and filed.

/s/ Richard C. Angino
Richard C. Angino, Esquire
Attorney for Appellants

IN THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 16-4062

GLORIA L. TROSTLE, Individually and as Administratrix of the ESTATE OF DAVID A. TROSTLE, deceased,
Appellant

v.

CENTERS FOR MEDICARE AND MEDICAID SERVICES,
Appellee

APPENDIX
Volume I
a001 – a017

Appeal from the Order and Opinion of the United States District Court for the Middle District of Pennsylvania, No. 1:16-CV-00156-WWC, dated October 17, 2016, granting Defendant's Motion to Dismiss

Respectfully submitted,

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IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

GLORIA L. TROSTLE, Individually and as Administratrix of and the ESTATE OF DAVID A. TROSTLE, deceased Plaintiffs v. CENTERS FOR MEDICARE AND MEDICAID SERVICES Defendant	CIVIL ACTION - LAW JUDGE WILLIAM W. CALDWELL NO. 1:16-CV-00156-WWC JURY TRIAL DEMANDED ELECTRONICALLY FILED

NOTICE OF APPEAL TO A COURT OF APPEALS FROM AN ORDER OF DISTRICT COURT

Notice is hereby given that Gloria L. Trostle, Individually and as Administratrix of the Estate of David A. Trostle, deceased, Plaintiff in the above-named case, hereby appeals to the United States Court of Appeals for the Third

577890

~~Circuit from an Order dated October 17, 2016, Granting Defendant's Motion to~~ Dismiss Plaintiff's Complaint with prejudice.

Respectfully submitted,

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Dated: November 4, 2016

577890

UNITED STATES DISTRICT COURT FOR THE
MIDDLE DISTRICT OF PENNSYLVANIA

GLORIA L. TROSTLE, Individually and as Administratrix of the ESTATE OF DAVID A TROSTLE, deceased, Plaintiffs	:	
v.	:	CASE NO. 1:16-CV-156
CENTERS FOR MEDICARE AND MEDICAID SERVICES, Defendant	:	

ORDER

AND NOW, this 17th day of October, 2016, upon consideration of Defendant's motion to dismiss (Doc. 7), and pursuant to the accompanying Memorandum, it is ORDERED that:

(1) Defendant's motion (Doc. 7) is GRANTED.

(2) Plaintiffs' complaint, in its entirety, is DISMISSED with prejudice.

(3) The Clerk of Court shall close this case.

/s/ William W. Caldwell
William W. Caldwell
United States District Judge

UNITED STATES DISTRICT COURT FOR THE
MIDDLE DISTRICT OF PENNSYLVANIA

GLORIA L. TROSTLE, Individually and as Administratrix of the ESTATE OF DAVID A TROSTLE, deceased, Plaintiffs	:	
v.	:	CASE NO. 1:16-CV-156
CENTERS FOR MEDICARE AND MEDICAID SERVICES, Defendant	:	

MEMORANDUM

I. Introduction

On January 29, 2016, Gloria L. Trostle, individually and as administratrix of the estate of David A. Trostle ("Plaintiffs"), filed a complaint alleging that Defendant, Centers for Medicare and Medicaid Services ("CMS"), unfairly and unjustly increased the amount Mr. Trostle owed Medicare following the settlement of a tort liability lawsuit. (Doc. 1). Plaintiffs assert that CMS's actions should be equitably estopped, that CMS would be unjustly enriched if Plaintiffs were to pay the increased amount claimed ($53,295.14), that CMS waived its right to the increased amount based on prior communications, and that Plaintiffs' complaint is an appeal from an administrative body. (Id. ¶¶ 24-46). CMS moved to dismiss the complaint on multiple grounds under Federal Rule of Civil Procedure 12(b). (Doc. 7). For the following reasons, the court will grant CMS's motion and will dismiss Plaintiffs' claims with prejudice.

II. Background[1]

On July 8, 2011, Bloomfield Pharmacy ("Bloomfield") incorrectly filled a prescription for David Trostle, giving him Lithium Carbonate instead of his prescribed Fosrenal. (Doc. 1 ¶ 6). As a result, Mr. Trostle fell seriously ill and was hospitalized for lithium toxicity, spending sixty-six days in various medical facilities for treatment. (Id. ¶¶ 6-7). One of Mr. Trostle's health insurers, Medicare, helped to cover a substantial portion of the nearly $100,000 worth of medical expenses incurred for these medical and rehabilitative treatments. (Id. ¶ 8).

Mr. Trostle brought a personal injury claim grounded in negligence against Bloomfield, and reported this tort claim to CMS on March 28, 2013. (Doc. 1 at 12; Doc. 11-3). CMS, through its Medicare Secondary Payer Recovery Contractor ("MSPRC"), initially asserted a lien of $725.17 against any recovery Mr. Trostle might obtain from his personal injury claim. (Doc. 1 ¶ 9; Doc. 11-1 at 1). Approximately one year later, CMS increased this lien amount to $1,212.32, and on May 22, 2014, informed Mr. Trostle and his attorney of the increase. (Doc. 1 ¶ 11; Doc. 11-2 at 1, 7).

Believing that $1,212.32 was an accurate statement of the lien owed to CMS, Mr. Trostle settled his personal injury claim with Bloomfield for $225,000 on July 9, 2014. (Doc. 1 ¶ 14; Doc. 11-5 at 2). After the settlement was consummated, Mr. Trostle's attorney notified CMS and offered to reimburse CMS the lien amount of $1,212.32. (Doc. 1 ¶ 15; Doc. 11-5 at 2). On August 14, 2014, CMS informed Mr. Trostle that the lien amount had increased to $53,295.14. (Id. ¶ 16; Doc. 11-4 at 1).

[1] The following facts are taken from Plaintiffs' complaint and documents attached thereto, as well as from undisputed documentary evidence CMS appended to its motion to dismiss. Because the court decides the instant motion to dismiss solely on subject matter jurisdiction, evidence regarding lack of subject matter jurisdiction presented by CMS is properly considered. See Infra Section III.

In a letter to CMS dated August 26, 2014, counsel for Mr. Trostle appealed the lien determination of $53,295.14, claiming that Mr. Trostle had relied on the May 22, 2014 lien figure of $1,212.32 when he agreed to settle his personal injury claim for $225,000, and therefore he did "not have a legal obligation to pay [CMS] $53,295.14." (Doc. 1 at 12; Doc. 11-5). On October 15, 2014, in what appears to be a stock denial letter[2] (officially titled a "redetermination notice"), CMS denied Mr. Trostle's appeal and upheld its lien claim of $53,295.14. (Doc. 11-6 at 1). In this October 15, 2014 redetermination notice, CMS also explained that within 180 days of its decision, Mr. Trostle could request a "reconsideration," whereby a "new and impartial review" would be performed by a Qualified Independent Contractor ("QIC"). (Id. at 1-2). The redetermination notice further explained how to request a QIC reconsideration, and included a blank request form. (Id. at 2, 4).

Mr. Trostle's counsel requested QIC reconsideration by filling out the request form, attaching a typewritten appeal, and sending the request to the appropriate CMS contractor—Maximus Federal Services ("Maximus"). (Doc. 11-7). This request was dated June 10, 2015, and marked by Maximus with a "received" date of June 22, 2015. (Id. at 1, 4).

On August 24, 2015, CMS, through Maximus, informed Mr. Trostle and his attorney that because the request for QIC reconsideration had been received well after the 180-day filing deadline (calculated by CMS as April 18, 2015), the request for QIC reconsideration was dismissed pursuant to the relevant Code of Federal Regulations provisions that govern the appeal process and timing. (Doc. 11-8 at 2). This August 24,

[2] CMS's October 15, 2014 redetermination notice to Mr. Trostle states, "In your appeal request you stated that there are claims on the payment summary form unrelated to your case." (Doc. 11-6 at 1). Mr. Trostle's initial appeal, however, makes no such claim. (See Doc. 11-5).

2015 CMS dismissal also included instructions on how to seek an extension for late filing of a reconsideration request for good cause, or how to appeal a dismissal through an Administrative Law Judge if a claimant believed the dismissal to be incorrect. (Id. at 2-3). Neither appears to have been done.

At some point Mr. Trostle passed away, and Mrs. Trostle—both in her individual capacity and as the administratrix of Mr. Trostle's estate—filed the instant complaint on January 29, 2016. CMS now moves to dismiss Plaintiffs' claims pursuant to Federal Rules of Civil Procedure 12(b)(1), 12(b)(2), and 12(b)(6).

III. Standard of Review

When a Rule 12 motion is based on more than one ground, "the court should consider the Rule 12(b)(1) challenge first, because if the court must dismiss the complaint for lack of subject-matter jurisdiction, all other defenses and objections become moot." In re Corestates Trust Fee Litig., 837 F. Supp. 104, 105 (E.D. Pa. 1993), aff'd, 39 F.3d 61 (3d Cir. 1994). On a motion to dismiss for lack of subject matter jurisdiction, the plaintiff ordinarily bears the burden of persuasion that jurisdiction exists. Gould Elecs., Inc. v. United States, 220 F.3d 169, 178 (3d Cir. 2000).

A dismissal under Federal Rule of Civil Procedure 12(b)(1) is not a judgment on the merits of a case; rather, it is a determination that the court lacks the power to hear a case. Mortensen v. First Fed. Sav. & Loan Ass'n, 549 F.2d 884, 891 (3d Cir. 1977). A Rule 12(b)(1) motion may be treated in one of two ways: "either as a facial or a factual challenge to the court's subject matter jurisdiction." John G. v. Northeastern Educ. Intermediate Unit 19, 490 F. Supp. 2d 565, 575 (M.D. Pa. 2007) (citing Gould Elecs., Inc., 220 F.3d at 178).

Should the motion be presented or construed as a facial attack, the court may only consider "the allegations contained in the complaint," exhibits attached thereto, "matters of public record . . . , and 'indisputably authentic' documents which the plaintiff has identified as a basis of his claims and which the defendant has attached as exhibits to his motion to dismiss." Id. (citation omitted). The facial attack "offers a safeguard to the plaintiff similar to a 12(b)(6) motion; the allegations of the complaint are considered to be true." Mortensen, 549 F.2d at 891.

The second type of Rule 12(b)(1) motion—the factual attack—permits the defendant to submit, and the court to consider, "evidence that controverts the plaintiff's allegations." Gould Elecs., Inc., 220 F.3d at 178. If the motion factually challenges the court's subject matter jurisdiction, no presumption of truthfulness attaches to the allegations in the plaintiff's complaint, and the plaintiff bears the burden of establishing jurisdiction. Mortensen, 549 F.2d at 891. In such a case, the plaintiff must be permitted to respond to the defendant's evidence with his or her own evidence supporting jurisdiction. Id. Only when it is clear from the record that the plaintiff is unable to prove the existence of subject matter jurisdiction may a court properly dismiss the claim pursuant to a Rule 12(b)(1) factual attack. Id.

In the instant case, CMS has submitted substantial evidence with its motion to dismiss to establish that Plaintiffs have failed to exhaust their administrative remedies, and that such failure is fatal to Plaintiffs' ability to prove subject matter jurisdiction. Accordingly, the court will treat CMS's Rule 12(b)(1) motion to dismiss as a factual attack on subject matter jurisdiction.

IV. Discussion

CMS asserts that this court does not have subject matter jurisdiction over Plaintiffs' claims for several interrelated reasons. First, CMS maintains that Congress has provided for very limited federal judicial review (i.e., subject matter jurisdiction) over claims "arising under" the Medicare Act, requiring a claimant to fully exhaust his administrative remedies and receive a final decision from the Secretary of Health and Human Services ("Secretary") before taking his claim to the district court. (See Doc. 11 at 17-22). Second, if a claim arises under the Medicare Act, Congress has specifically mandated that such a claim cannot be brought in federal court under federal question jurisdiction, 28 U.S.C. § 1331. (Id. at 14-17). Finally, CMS insists that even if Plaintiffs' equitable claims were found not to arise under the Medicare Act, Plaintiffs have failed to show that the federal government waived sovereign immunity to allow such claims to be brought against one of its agencies.[3] (Id. at 12-14).

Plaintiffs counter that subject matter jurisdiction exists because the United States has expressly waived sovereign immunity over final decisions of CMS under the Medicare Act, and Mr. Trostle's dismissal by Maximus operates as a "final decision." (Doc. 12 at 6-7). Alternatively, Plaintiffs maintain that because their equitable claims are not "arising under" the Medicare Act but rather are grounded in contract law, subject

[3] CMS asserts that Plaintiffs' failure to establish waiver of sovereign immunity requires dismissal pursuant to Federal Rule of Civil Procedure 12(b)(2) for lack of personal jurisdiction. However, whether sovereign immunity exists or, conversely, the United States has consented to be sued, is an issue of subject matter jurisdiction, not personal jurisdiction. See United States v. Bein, 214 F.3d 408, 412 (3d Cir. 2000) ("It is a fundamental principle of sovereign immunity that federal courts *do not have jurisdiction over suits* against the United States unless Congress, via a statute, expressly and unequivocally waives the United States' immunity to suit.") (emphasis added) (citation omitted); Richards v. United States, 176 F.3d 652, 654 (3d Cir. 1999) ("Sovereign immunity not only protects the United States from liability, it deprives a court of subject matter jurisdiction over claims against the United States.") (citing United States v. Mitchell, 463 U.S. 206, 212 (1983)).

matter jurisdiction exists because Plaintiffs are suing "a federal governmental entity." (Id. at 7-9; Doc. 1 ¶ 2).

A. Plaintiffs' Claims Arise Under the Medicare Act

In 42 U.S.C. § 405(g), Congress set out how claims or disputes regarding Medicare may reach the federal district courts. Although the language concerns the Social Security Act, it is made applicable to the Medicare Act via 42 U.S.C. § 1395ii. See Heckler v. Ringer, 466 U.S. 602, 614 (1984); 42 U.S.C. § 1395ii. Section 405(g) mandates that a claimant may only seek judicial review in the district court after he receives a "final decision" from the Secretary of Health and Human Services. 42 U.S.C. § 405(g). "[A] final decision is rendered on a Medicare claim only after the individual claimant has pressed his claim through all designated levels of administrative review." Heckler, 466 U.S. at 606.

When a claim or dispute arises under the Medicare Act, and the Secretary makes a final decision, section 405(h) explicitly precludes review by "any person, tribunal, or governmental agency" except as provided by section 405(g). 42 U.S.C. § 405(h). Furthermore, section 405(h) explicitly bars the use of federal question jurisdiction—28 U.S.C. § 1331—for such "arising under" claims. Id. ("No action against the United States, the [Secretary], or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim *arising under* this subchapter." (emphasis added)).

Therefore, whether a claimant is required to navigate the administrative review process and obtain a final decision from the Secretary before seeking district court review turns on whether his claim "aris[es] under" the Medicare Act. See St. Francis Med.

Ctr. v. Shalala, 32 F.3d 805, 809-10 (3d Cir. 1994). If the claim arises under the Medicare Act, sections 405(g) and (h) set out the claimant's "sole avenue for judicial review." Heckler, 466 U.S. at 614-15. If, however, the claim does not arise under the Act, it follows that the claimant may pursue his claim in the district court so long as subject matter jurisdiction exists and the other prerequisites for federal filing are met.

The Supreme Court of the United States has broadly interpreted the "arising under" language of the Medicare Act. Id. at 615. A claim arises under the Medicare Act if "both the standing and the substantive basis for the presentation" of the claim is the Act, id., or if the claim is "inextricably intertwined" with a claim for benefits, id. at 614. In assessing whether a claim falls into either of these categories, the court "must discount any 'creative pleading' which may transform Medicare disputes into mere state law claims, and painstakingly determine whether such claims are ultimately Medicare disputes." Reg'l Med. Transp., Inc. v. Highmark, Inc., 541 F. Supp. 2d 718, 728 (E.D. Pa. 2008) (quoting Wilson v. Chestnut Hill Healthcare, No. 99-CV-1468, 2000 WL 204368, at *4 (E.D. Pa. Feb. 22, 2000)).

Plaintiffs contend that their claims do not arise under the Medicare Act, but rather are grounded in contract law. Plaintiffs do not dispute that all of the conditional payments made by Medicare and listed on its August 14, 2014 determination are properly related to treatment for Mr. Trostle's tort-claim injuries. They also do not dispute that the final lien amount of $53,295.14—asserted by CMS shortly after learning of the personal injury settlement—is an accurate figure for the extensive treatment Mr. Trostle received.

Rather, Plaintiffs' equitable claims of unjust enrichment, estoppel, and waiver are grounded on the theory that CMS failed to properly update its conditional payment

letters and its website portal to reflect the more accurate $53,295.14 lien amount. This failure, Plaintiffs assert, led Mr. Trostle and his attorney to believe that only $1,212.32 was owed to Medicare, causing them to rely on that mistaken belief when engaging in settlement negotiations. Plaintiffs further allege that even though CMS was on notice about the nature of Mr. Trostle's tort claim and the dates of the related injuries, and had nearly two years to adjust its conditional payment amount to accurately reflect the true amount owed to Medicare, CMS failed to take appropriate action until after it learned of Mr. Trostle's $225,000 settlement.

Plaintiffs' theory, while unique, fails to remove their claims from beneath the broad umbrella of "arising under" the Medicare Act. Plaintiffs' assertions, though styled as state law equitable claims, essentially argue that CMS's procedures and practices regarding its conditional payment letters and website portal management were deficient and unfair. Because such procedures and practices are part of the Medicare Act itself, however, Plaintiffs' claims necessarily arise under the Act.

The Medicare Secondary Payer ("MSP") provisions, added to the Medicare Act in 1980 to curb rising healthcare costs, allow Medicare (through CMS) to seek reimbursement from a "primary payer" (or an entity that receives payment from a primary payer) for "conditional" payments Medicare has made that should have been made by the primary payer. Fanning v. United States, 346 F.3d 386, 388-89 (3d Cir. 2003); see also 42 U.S.C. § 1395y(b)(2)(B)(ii); 42 C.F.R. § 411.22. In particular, Medicare is authorized to seek reimbursement from a person who received payment from a primary payer, such as a beneficiary or attorney who received settlement funds from a tortfeasor or a tortfeasor's insurer. See 42 C.F.R. §§ 411.22(a), 411.24(g), 411.37.

The processes governing CMS's notification to primary payers of conditional payments, its subrogation rights, its recovery calculations when a settlement is involved, and its MSP "Web portal" are fully set out in the Code of Federal Regulations. See 42 C.F.R. §§ 411.25, 411.26, 411.37, 411.39. Particularly relevant to the instant case is section 411.39, which provides detailed rules for the MSP Web portal, whereby a plaintiff or his attorney can create an account and access conditional payment information online. Notably, subsection (c) of section 411.39 provides step-by-step instructions for obtaining a *final* conditional payment amount through the web portal in the event that settlement is imminent. See 42 C.F.R. § 411.39(c).

Plaintiffs' claims, which challenge CMS's procedures and policies regarding conditional payment communication, settlement notification to CMS, and the MSP Web portal, essentially challenge the Medicare Act and its corresponding regulations. As a result, there is no question that the Medicare Act provides the standing and substantive basis for Plaintiffs' claims, Heckler, 466 U.S. at 614, and therefore such claims arise under the Act.

B. Plaintiffs Fatally Failed to Exhaust Their Administrative Remedies

Because Plaintiffs' claims arise under the Medicare Act, Congress has provided only one avenue for district court review: Plaintiffs must have exhausted their administrative remedies and received a final decision from the Secretary. See 42 U.S.C. § 405(g); Heckler, 466 U.S. at 614-15. Because Plaintiffs failed to follow the course mandated by Congress and detailed within the corresponding federal regulations, this court is without the power to address the merits of Plaintiffs' claims.

The administrative process for disputing a Medicare claim is clearly set out in the Code of Federal Regulations. After CMS makes an initial determination, a beneficiary who is "dissatisfied with the initial determination may request that the contractor perform a redetermination if the requirements for obtaining a redetermination are met." 42 C.F.R. § 405.904(a)(2). Requests for redeterminations must be filed within 120 calendar days from the date that the beneficiary receives notice of the initial determination. Id. § 405.942(a). After the redetermination, if the beneficiary is still dissatisfied, he or she may request a reconsideration of the claim by a Qualified Independent Contractor ("QIC"). Id. § 405.904(a)(2). Requests for reconsiderations must be filed within 180 calendar days from the date the beneficiary receives notice of the redetermination. Id. § 405.962(a). Following the reconsideration, the beneficiary may request a hearing conducted by an Administrative Law Judge ("ALJ"). Id. § 405.904(a)(2). Requests for an ALJ hearing must be filed within 60 calendar days after the beneficiary receives notice of the QIC's reconsideration. Id. § 405.1014(b)(1). Should the beneficiary wish to appeal the decision of the ALJ, he or she may request a review conducted by the Medicare Appeals Council ("MAC"). Id. § 405.904(a)(2). The beneficiary must file a request for a MAC review within 60 calendar days after receipt of the ALJ's decision or dismissal. Id. § 405.1102. It is only after receiving a decision from the MAC that a dissatisfied beneficiary may file a complaint in federal district court. Id. § 405.904(a)(2). In other words, after receiving a MAC decision, the "claimant has pressed his claim through all designated levels of administrative review" and has received a "final decision" from the Secretary that is reviewable by a district court. Heckler, 466 U.S. at 606.

Plaintiffs argue that Mr. Trostle exhausted his administrative remedies because, after he failed to timely request QIC reconsideration, his claim was dismissed and CMS's redetermination became binding. Plaintiffs contend, "At this time, the decision from CMS became final because Plaintiffs had no further appeal options through the administrative process." (Doc. 12 at 1).

This argument is misguided, however, because Plaintiffs conflate "final" decision with "binding" decision. If a claimant fails to follow the explicit administrative process to appeal an unfavorable decision, that decision generally becomes binding. See, e.g., 42 C.F.R. § 405.958 ("The redetermination is binding upon all parties unless . . . a reconsideration is completed . . . ."). A "final" decision, on the other hand, "is rendered on a Medicare claim only after the individual claimant has pressed his claim through *all* designated levels of administrative review." Heckler, 466 U.S. at 606 (emphasis added).

Under Plaintiffs' reasoning, any missed deadline in the administrative review process would create a "final" decision, thereby permitting district court review. If this theory were correct, however, claimants could abort the carefully constructed administrative review process whenever they pleased in order to take their claims directly to the district court. Such a theory contravenes the express language of the Medicare Act and its regulations, as well as the policy behind the administrative review process. See Wilson ex rel. Estate of Wilson v. United States, 405 F.3d 1002, 1015 (Fed. Cir. 2005) (explaining that to allow a claimant—who failed to properly exhaust her administrative remedies—to bring an action in federal district court would "substantially . . . undercut Congress'[s] carefully crafted scheme for administering the Medicare Act." (citation and internal quotation marks omitted)). Accordingly, the court rejects Plaintiffs' argument.

The exhibits provided by Plaintiffs and CMS indisputably demonstrate that Mr. Trostle failed to exhaust his administrative remedies. Mr. Trostle received an unfavorable redetermination from CMS on October 15, 2014, but did not request reconsideration until June 22, 2015, more than two months after such a request was due. See 42 C.F.R. § 405.962(a). No extension for filing a late reconsideration request or ALJ review of the dismissal appears to have been sought by Mr. Trostle or his attorney. Consequently, CMS's October 15, 2014 redetermination became binding upon all parties. Id. § 405.958.

Due to Plaintiffs' procedural default, they have not obtained—nor can they obtain—a final decision from the Secretary that would allow them to bring an action in this court. Thus, it is clear from the record that Plaintiffs have not, and cannot, prove the existence of subject matter jurisdiction. Consequently, this court lacks the power to entertain Plaintiffs' claims.[4]

V. Conclusion

Based on the foregoing analysis, this court is without subject matter jurisdiction to entertain Plaintiffs' claims of unjust enrichment (Count I), estoppel (Count 2), and waiver (Count III), which are, in fact, claims arising under the Medicare Act. Furthermore, Plaintiffs' claim that the instant case is an appeal from an administrative body (Count IV) also lacks subject matter jurisdiction because this case is not an appeal from a final decision issued by the Secretary of Health and Human Services, as required by Congress.

[4] Because subject matter jurisdiction is lacking for all claims, there is no need to address CMS's motion to dismiss pursuant to Rule 12(b)(6).

Accordingly, CMS's motion (Doc. 7) to dismiss pursuant to Federal Rule of Civil Procedure 12(b)(1) must be granted. This dismissal will be with prejudice, as no amendment to Plaintiffs' complaint could infuse subject matter jurisdiction into any of Plaintiffs' claims. An appropriate order will follow.

/s/ William W. Caldwell
William W. Caldwell
United States District Judge