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SUPERIOR COURT OF ARIZONA

MARICOPA COUNTY

AMBER WINTERS, et al., on behalf of themselves and all others similarly situated, Plaintiffs, vs. BANNER HEALTH NETWORK, et al., Defendants.	**Case No. CV2012-007665** **PLAINTIFFS' RESPONSE TO DEFENDANTS' MOTION FOR NEW TRIAL** **(The Honorable J. Richard Gama)**

Plaintiffs hereby respectfully respond to Defendants' Motion for a New Trial pursuant to Rule 59(a)(8), Ariz.R.Civ.Proc. (the "Motion"). As explained herein and throughout these proceedings, the Court's rulings–specifically, the rulings complained of in Defendants' Motion on the merits and on the award of attorneys' fees–are not contrary to law. Defendants' Motion should be summarily denied.

I. The "Merits Ruling" Is Not Contrary to Law.

Defendants argue the Court's "merits ruling" in this case—in particular, the Court's ruling that "A.R.S. § 36-2903.01(G)(4) is preempted because it violates federal Medicaid law prohibiting a health care provider from collecting the balance of its bill from the Medicaid patient"—is "contrary to law." *See* Minute Entry (filed 1/21/2014) ("Merits Minute Entry").

In furtherance of this, Defendants rehash the same unavailing arguments this Court previously rejected while continuing, once again, to selectively "quote mine" various out-of-context "attachments" which neither support Defendants' position nor relate to the pending dispute. This Court correctly rejected Defendants' arguments, just as every other court in every other jurisdiction–including Arizona–has done for the last 31 years when considering the same issues and the same arguments made by other hospitals.

A. There is a clear conflict between Arizona law and Federal law.

As one Arizona Court of Appeals judge already stated, there is "no question" Arizona law and Federal law are in conflict. Case-after-case in jurisdiction-after-jurisdiction makes that conclusion inescapably clear.

Federal law states payment from Medicaid is "payment in full" to the Medicaid provider. *E.g.*, 42 U.S.C. §1396a(a)(25)(c) and 42 C.F.R. § 447.15. Congress has stated, "[a]s a matter of public policy, it would be best for all concerned . . . if the reimbursement made by the State" to the Medicaid providers constituted **all** the compensation received by Medicaid providers. *E.g.* SENATE REPORT No. 744, 90th Cong., 1st Sess., at 187-188 (1967). This directly conflicts with A.R.S. § 36-2903.01(G)(4), which purports to authorize "balance billing" by hospitals for the care of Medicaid patients.

Defendants' arguments—*i.e.*, that healthcare provider liens are not in conflict with federal law and that *Lizer* was wrongly decided—are contrary to the avalanche of unwavering and unanimous authority holding such liens *do* violate and *are* preempted by federal law. To be sure, on the pending Rule 54(b) appeal for the "Closed Lien Plaintiffs," Defendants' counsel was repeatedly asked at oral argument by the Arizona Court of Appeals to identify a single case upholding a state lien statute and concluding it was not preempted by federal law. After Defendants' repeatedly dodged the question, an impatient Judge Kessler said the following:

> Judge Kessler: But [is] there **any** case that's [concluded that] a lien statute . . . was not preempted by the federal law?
>
> Mr. Artigue: Certainly not from Arizona.
>
> Judge Kessler: But [is] there . . . **anywhere**?
>
> Mr. Artigue: No. That's – my candid answer is no, but it's . . . not on me to say there's a statute that says I can do this and here's a case that says I can do this. The burden is on them – you know.

Transcript of *Abbott v. Banner Health Network*, Case No. 1 CA-CV 13-0259 (April 10, 2014) ("Transcript") at 25:2-14 attached hereto as **Exhibit 1** (emphasis added).

And, if there was any doubt a conflict exists, Judge Norris laid it to rest when she observed there is "**no question**" A.R.S. § 36-2903.01(G)(4) permits "balance billing," but that "the federal Medicaid regulation . . . bars balance billing [and] has been in existence since at least 1983, and perhaps even earlier." Transcript at 28:9-21. In fact, Judge Norris concluded:

> [B]y 2010, the law in the federal system was . . . unanimous that hospitals or healthcare providers are not entitled to collect against third-party payers [or] tortfeasors on lien claims. Once they've accepted a Medicaid dollar, they can't go back. If they've accepted a Medicaid dollar, they have been paid in full and they cannot either go against the lien claim and they can't retract and say, "Oh, too bad; I'd like to now give you back that Medicaid dollar."

Transcript at 29:5-13.

For Defendants to continue to argue there is "no conflict" between Arizona law and Federal law, when they cannot point to a single case anywhere that supports their position, surely tests the boundaries of Rule 11.

B. Federal law prohibits the Defendant hospitals from accepting Medicaid and "balance billing" anyone – especially Medicaid patients.

Defendants argue 1) "payment in full" should be construed as "payment in full from some sources but not from tortfeasors" and 2) it "is an indisputable point of Arizona law" that Defendants' collections using healthcare provider liens are collections from third party tortfeasors, not Medicaid patients, under *Andrews v. Samaritan Health*, 36 P.3d 57 (App. 2001), *disapproved by Blankenbaker v. Jonovich*, 71 P.3d 910, 913-14, 205 Ariz. 383 (Ariz. 2003). This is incorrect.

First, Defendants' proposed construction of the phrase "payment in full" goes against the plain meaning of the phrase and the stated intent of Congress. "Payment in full" means what it says – namely, any payment from Medicaid extinguishes any rights by the healthcare provider to demand additional payment for services rendered. As the Court in *Taylor v. Louisiana DHH*, 7 F.Supp.3d 641 (M.D. La. 2013), recently explained:

> Congress did **not** intend for providers to receive Medicaid reimbursement for patient care and then intercept funds that the patient would otherwise receive. Once a health care provider has received Medicaid coverage for a patient, it is precluded from recovering more than the program's reimbursement rates for care.

But secondly, even if one was to accept Defendants' construction just for argument's sake, collecting proceeds from Medicaid patients' recoveries using healthcare provider liens is not "collecting from tortfeasors." *E.g.*, Merits Minute Entry at 3 ("This contention was rejected in *Lizer v. Eagle Air Med Corp.*, 308 F. Supp. 2d 1006 (D. Ariz. 2004)."). To be sure, no healthcare provider lien at issue herein was ever filed against

any tortfeasor, they were all filed against the named lead Plaintiffs and the class they represent. This is because the hospital Defendants have no privity or legal claim against tortfeasors. Defendants' only claim is through A.R.S. § 36-2903.01(G)(4) against *Plaintiff Medicaid-patients'* money—and this species of state law claim is prohibited by federal law.

Defendants' argument also lacks a logical basis, which was specifically recognized by this Court as well as the Court of Appeals. This Court's Merits Minute Entry, for example, cited *Spectrum Health Continuing Care Group v. Anna Marie Bowling Irrevocable Trust Dated June 27, 2002*, 410 F.3d 304, 317 (6th Cir. 2005), and explained: "The Court agrees with the Sixth Circuit . . . [O]nce the settlement has been approved, the settlement proceeds are no longer the property of the tortfeasor . . . Instead, the entirety of the settlement, regardless of how it is allocated, ***belongs to [the Medicaid patient]***; [the health care provider's] lien is merely an encumbrance upon that property." Merits Minute Entry at 5 (emphasis added).

This Court's reasoning mirrors Judge Norris' thinking just a few months later when Defendants attempted to make the same argument in the Court of Appeals. Judge Norris stated that, "when we look at a lien claim, when . . . a tortfeasor or his or her carrier pays in, that money goes to the patient or the patient's counsel, and that money no longer belongs to the tortfeasor or the carrier***. It belongs to the patient. . . . . that money now is the property of the patient."*** Transcript at 30:9-16 (emphasis added).

This is also consistent with the holding of every other court that has ever considered the issue. *E.g., Olszewski v. Scripps Health*, 135 Cal.Rptr.2d 1, 22, 69 P.3d 927 (Cal. 2003), *Evanston Hosp. v. Hauck*, 1 F.3d 540, 542-43 (7th Cir. 1993), *Taylor v. Louisiana DHH*, 7 F.Supp.3d 641 (M.D. La. 2013), *Wright v. Smith*, 641 F.Supp.2d 536,

541 (W.D. Va. 2009), *Mallo v. Public Health Trust of Dade Cty.*, 88 F.Supp.2d 1376, 1387 (S.D. Fl. 2000), *Public Health Trust v. Dade Cty. Sch.*, 693 So.2d 562, 566 (Fla.App. 1996), *West v. Shelby Cty. Healthcare Corp.*, 2013 WL 500777 (Tenn.App. 2013), *Parnell v. Adventist Health Sys./West*, 26 Cal.Rptr.3d 569, 574-580, 109 P.3d 69 (Cal. 2005), *Smallwood v. Central Pen. Gen.*, 151 P.3d 319, 320-21 (Alaska 2006), *Bynum v. Magno*, 101 P.3d 1149, 1152 (Hi. 2004), *Via Christi Reg. Med. Center, Inc. v. Reed*, 276 Kan. 539, 543-44, 78 P.3d 798 (Kan. 2013), *MCG Health, Inc. v. Owners Ins. Co.*, 707 S.E.2d 349, 353 (Ga. 2011), *Palumbo v. Myers*, 197 Cal.Rptr. 214, 149 Cal.App.3d 1020, 1021-30 (Cal. App. 1983).

For example, the California Supreme Court observed:

> [A] provider does not have a direct cause of action against a third party tortfeasor and may not independently recover any amount from that tortfeasor. Consequently, a [healthcare provider] lien . . . does not attach until after the judgment, compromise, or settlement becomes the ***property of the Medicaid beneficiary***.

Olszewski, 135 Cal.Rptr.2d at 22 (emphasis added); *see also Lizer v. Eagle Air Med. Corp.*, 308 F.Supp.2d 1006, 1009 (D.Ariz. 2004) (noting "the . . . [federal] regulation was passed in order to ensure that this purpose was carried out by preventing providers from intercepting funds on the way to a patient.").

Defendants are clearly wrong and their arguments have been rejected by every court in every jurisdiction that has ever considered these issues. Namely, Defendants' collections using healthcare provider liens: 1) violate Medicaid's "payment in full" prohibition; and 2) are illegal collections from the patient, not the tortfeasor.

Defendants' reliance on the disapproved-*Andrews* case is unavailing. *See Blankenbaker v. Jonovich*, 205 Ariz. 383, 71 P.3d 910, 913-14 (2003) (disapproving *Andrews*). *Andrews* did not involve AHCCCS patients and did not consider 42 C.F.R. §

447.15 or federal law, so it never addressed the "payment in full" prohibition. And, for the secondary argument that this is not a collection from the Medicaid patient, Defendants stretch *dicta* well beyond the breaking point and from a case that did not even concern Medicaid. Two years after *Andrews*, the Arizona District Court in *Lizer, supra*, was urged to accept the construction Defendants are urging here and declined to do so (as have five subsequent other courts) because collections through healthcare provider liens obviously involve collections from the Medicaid patient, not the tortfeasor.

C. Defendants have made repeated admissions that collections for medical care via healthcare provider liens are collections from patients.

As the Court observed, Defendants have made statements and arguments inconsistent with their contention that healthcare provider lien collections are from tortfeasors rather than Medicaid patients. As shown below, this is quite right and has continued.

First, as the Court already noticed, Defendants attempt to have it both ways. They previously argued the payment made by Medicaid patients for a release of a healthcare provider lien constituted an "accord and satisfaction" between the Medicaid patient and the Defendant hospitals which was binding upon the billed Medicaid *patient* who was forced to pay for the release. Defendants now try to back out of this admission, arguing the healthcare provider liens are really just collections from third parties who "delegated" the right to settle their claims to Plaintiffs.

The "delegation" argument is a desperate invention of the last two weeks and there is not a shred of fact evidence to support the assertion that any actual delegation ever took place. More importantly, this contradicts what Defendants were saying at the time, for example:

- "These 15 plaintiffs voluntarily settled their disputes with the hospitals," Motion to Dismiss at 8:6-7 (filed 7/13/12);
- "These 15 plaintiffs already settled their lien claims," Reply to Motion to Dismiss at 8:7-8 (filed 8/17/12);
- "Both sides performed the settlement agreement: plaintiffs tendered the agreed upon amounts, and the hospitals released their liens upon receiving payment." *Id.* at 2:14-16;
- "The fifteen plaintiffs could have challenged their liens . . . " *Id.* at 5:1; and
- "Plaintiffs cannot back out of their own voluntary settlement agreements . . ." *Id.* at 1:19.

Again and again, Defendants admitted these healthcare provider liens were claims against Medicaid patients and settled by those same Medicaid patients. It would be spectacularly unjust and inconsistent to:

1) rule against Medicaid patients who paid off these illegal healthcare provider liens, on the theory the liens were collections against Medicaid patients which "the patient chose to settle;" and

2) then to rule against Medicaid patients who chose not to pay off these illegal healthcare provider liens, on the theory the liens were never collections against Medicaid patients in the first place.

But this is exactly what Defendants are asking the Court to do.

Second, it bears mentioning that during the pendency of this class action, a second class action was filed against many of the same Defendants who were unlawfully using healthcare provider liens to "balance bill" patients enrolled in Medicare Advantage. *See Aycock v. Scottsdale Healthcare Corp, et al.*, Case No. CV2014-006882 (removed to the United States District Court, District of Arizona, Case No. 2:14-cv-01483). While Defendants initially made the same argument—*i.e.*, healthcare provider liens are not collections from the patients—Defendant Dignity Health, represented by the same

lawyers, ultimately entered into a Consent Judgment precluding the use of healthcare provider liens against Medicare Advantage enrollees, except to collect "cost sharing (as defined by 42 C.F.R. § 422.2 or other applicable Medicare Advantage statutes and regulations) ("cost sharing") **owed by that enrollee**." See Consent Judgment (filed 12/10/14) attached hereto as **Exhibit 2** (emphasis added). In other words, Defendant Dignity Health stipulated to reserve the right to use **healthcare provider liens** to collect deductibles and co-payments "**owed by the patient**." This is yet another clear and unequivocal admission that healthcare provider liens are vehicles to collect money from **patients**—not tortfeasors.

D. Congress has adopted a policy to protect the indigent.

Defendants next argue that "across 50 years of Medicaid laws, Congress has never said that it cared about the tort recoveries of Medicaid beneficiaries." Motion at 5:10-13 (emphasis in original). As with so many of Defendants' assertions, this one is made with no authority and, in this case, with complete ignorance of the historical record.

In ordering the Department of Health, Education and Welfare to enact 45 C.F.R. § 249.31, which became 42 C.F.R. § 447.15, Congress stated "[a]s a matter of public policy, it would be best for all concerned . . . if the reimbursement made by the State" constituted all the compensation received by Medicaid providers. SENATE REPORT No. 744, 90th Cong., 1st Sess., at pp. 187-188 (1967). Congress went further, stating it would pass a statute to this effect, unless regulations were enacted requiring providers in all but a few states to stop attempting to bill Medicaid and then to collect additional monies from the patient, their family or friends by January 1, 1971, with the remaining states phasing out the practice shortly thereafter. Congress ultimately did pass such a statute in 1985. *See* 42 U.S.C. § 1396a(a)(25)(C).

In examining congressional intent regarding 42 C.F.R. § 447.15, the 6th and 7th Circuits have observed "someone was bound to receive a windfall in these circumstances, and Congress decided it should be the recipient of medical care, **not the hospital**." *E.g.*, *Evanston Hosp.*, 1 F.3d 540, 543 (7th Cir. 1993) (emphasis added). Indeed, "to permit recovery [by the hospital] would be to transform Medicaid into 'an insurance program for hospitals rather than for indigent patients,'" which was not the intent of Congress. *Spectrum Health Continuing Care Group*, 410 F.3d 304, 314-315 (6th Cir. 2005) (quoting *Evanston Hosp.*). Congress has been quite clear that this prohibition is for the financial welfare of Medicaid patients.

E. Lacking any direct authority, Defendants misrepresent secondary materials that simply do not support Defendants' contentions.

In a series of related arguments, Defendants insist the law is not to be determined by the only reasonable construction of its plain language, *e.g.*, 42 C.F.R. § 447.15 ("payment in full"), clear statements of Congressional intent, *e.g.*, SENATE REPORT No. 744, 90th Cong., 1st Sess., at pp. 187-188 (1967)., the well-reasoned decisions of at least eleven courts, the written policy of AHCCCS or the policy of HHS, *Olszewski*, 135 Cal.Rptr.2d at 7. Rather, the law is to be determined by making strained constructions of small sections of a few administrative documents, all taken out of context. *See* Motion at 4 and 6-10.

Plaintiffs have comprehensively rebutted all of this before:

- **"1997 policy statement" from "CMS" (Motion at 4)**. Defendants continue to rely upon a 1997 letter. This letter is not a policy statement, it is a letter from the acting director of an internal bureau at the Health Care Financing Administration, a very low level official. *Spectrum Health Continuing Care Group*, 410 F.3d at 319 and *Taylor*, 7 F.Supp.3d at 643 held that this letter was not a policy statement, was entitled to no deference whatsoever and rejected it. *Olszewski*, 135 Cal.Rptr.2d at 20-21, made the more salient point that the letter itself expressly forbids what Defendants herein are doing. That is, the letter requires a waiver from HHS (which Defendants do not have) and a refund of the monies paid by AHCCCS (which Defendants are not doing). The

1997 letter is also inconsistent with more recent correspondence from CMS in 2011 that confirms that balance billing Medicaid patients is not permitted and that Arizona's Medicaid Plan does not contain a waiver of the prohibition. *E.g.*, Plaintiffs' Statement of Facts (filed 6/27/13), Exhibit 6.

- **Defendants' Statement of Facts Nos. 11-15, Exhibit F (Motion at 4)**. Defendants try to cut a path through clips of the Federal Register but ignore the most relevant point, as clearly stated in the follow-up entry at 55 Fed.Reg. 1423-02, p. 1428 (Defendants' Exhibit F), that a provider may not collect ***any amount*** from a patient outside of a copay, coinsurance or deductible. That is, Defendants ignore that "[t]his final rule prohibits the provider from seeking to collect from the Medicaid recipient any amount that exceeds the amount, if any, allowed" under 42 C.F.R. § 447.20. Section 447.20 concerns coinsurance, copayments and deductibles, which no one contends are at issue here.

- **42 C.F.R. § 433.136, 138 and 139 (Motion at 4, 7-10)**. Defendants brazenly attempt, on more than one occasion, to co-opt certain undisputed rights inuring to *AHCCCS* through various regulations as though they were rights belonging to the hospitals. But the purpose of these regulations are to allow for the "[a]ssignment to the State of an individual's rights to third party payments." 42 C.F.R. § 433.135. In other words, to help *AHCCCS* collect from third parties, thereby lowering the cost of Medicaid to the State of Arizona. It is spectacularly disingenuous to suggest these regulations are meant to compensate providers, rather than AHCCCS, thereby failing to lower the cost of Medicaid.

- **Attachment 4.19-A to the State Medicaid plan (Motion at 7-9)**. Defendants continue to argue that Attachment 4.19-A in the Arizona Medicaid Plan constitutes a waiver that allows balance billing Medicaid patients. But Attachment 4.19-A only concerns payments for "off reservation Indian Health Service members, Emergency Services only populations and special cases." It has nothing to do with personal injury settlements, healthcare provider liens, the healthcare provider lien statutes, balance billing or substitute billing, and is not an authorization of any kind. Indeed, the former General Counsel of HHS has offered unrebutted testimony that HHS' policy was that "nothing in the Arizona State Medicaid Plan, at Section 4.19, Attachment A or anywhere else, gives Arizona providers permission to 'supplement AHCCCS payments through lien recoveries.'" Plaintiffs' Statement of Facts (filed 6/27/13), Exhibit 2 at ¶¶ 7-10. Furthermore, CMS Notice No. 10130, 70 Fed.Reg. 24478, also establishes that Defendants' proposed construction of 4.19-A is wrong. *E.g.*, CMS 10130 ("Consistent with 42 CFR § 447.15, Medicaid payments will be considered payment in full . . . . ") attached to Plaintiffs' Statement of Facts (filed 9/6/13), Exhibit 7 at pg. 14.

- **Chapter 9 of AHCCCS Provider Manual (Motion at 8-10)**. Defendants do quite a job of trying to confuse the Court with an extended and misleading discussion of Chapter 9 of the AHCCCS Provider Manual. Defendants fail to cite Chapter 4, attached hereto as **Exhibit 3** (pgs. 4-5), however, which actually concerns the issue under discussion and plainly states providers "***must accept payment by AHCCCS as payment in full***" and notes that providers are prohibited "from billing [or collecting from] AHCCCS recipients."

Defendants have repeatedly cited to secondary materials and unnecessarily burdened the Plaintiffs and the Court with bold assertions that are simply not supported by the materials referenced. Faced with unanimous nationwide authority that they are wrong, Defendants have instead resorted to a war of attrition by repeatedly misdirecting and misrepresenting to this Court, or anyone who would listen, the veracity of these secondary materials. *See* Transcript at 24:20-24 ("[I]t's as complicated an issue of law as I've ever encountered . . . I'm digging into 35 year-old excerpts from the US Code, congressional and administrative news.").

While it has been no easy task running down each of Defendants' baseless claims, there has yet to be a single source anywhere supporting Defendants' claims or showing why a dozen other courts, including this one, were wrong. This matter was made unnecessarily complicated by shrewd attorneys who are seemingly capable of saying virtually anything to support their contention that collecting money from AHCCCS patients is not a violation of federal law. This Court's ruling on the merits is–quite obviously–not "contrary to law."

II. The "Fees Ruling" Is Not Contrary to Law.

Defendants next argue the Court's "fees ruling" in this case is "contrary to law." *See* Minute Entry (filed 10/15/2014) ("Fees Minute Entry"). Defendants do this by raising a new and meritless legal argument (the "reverse *Erie* doctrine") and rehashing a few others.

A. Arizona law governs the Arizona private attorney general doctrine.

Defendants argue that under the "reverse *Erie* doctrine," state courts must apply federal law to all attorneys' fee awards in state court cases that involve preemption and that federal law does not allow attorneys' fees under the private attorney general doctrine.

Motion at 11:5-13:3.

This argument is absurd. For starters, the "reverse *Erie* doctrine" applies only in admiralty and maritime cases. The Constitution vested admiralty jurisdiction in the federal courts. *See* Article III, Section 2, Clause 1. In the Judiciary Act of 1789 (now codified at 28 U.S.C. § 1333), Congress clarified that admiralty jurisdiction was exclusive to federal courts (subject to certain narrow exceptions enacted many years thereafter, such as the Jones Act, 46 U.S.C. § 688), but under a "savings to suitors" clause, certain state law causes of action could be heard in admiralty cases. *See*, 28 U.S.C. § 1333(1).

The "reverse *Erie* doctrine" provides that, when a state law cause of action is asserted in a federal admiralty or maritime case pursuant to 28 U.S.C. § 1333(1), the court must insure that state law substantive remedies are consistent with the federal admiralty and maritime law remedies provided by federal statute. *Offshore Logistics v. Tallentire*, 477 U.S. 207, 223 (1986). This makes sense because the federal courts were attempting to keep remedies consistent in this limited sphere.

Defendants make the spectacularly wrong and unsupportable assertion that the "reverse *Erie* doctrine" applies to: 1) all claims brought in state courts concerning preemption; and 2) prevents awards of attorneys' fees under state common law. No case in any jurisdiction at any time anywhere has stated or implied either of these incorrect assertions.

Apparently having figured this out, Defendants instead cite four cases which do not even mention the "reverse *Erie* doctrine" and focus entirely on 42 U.S.C. § 1988.[1] 42

[1] *Verdugo v. Pima Cnty.*, 135 Ariz. 401, 661 P.2d 665 (App. 1983); *Maine v. Thiboutot*, 448 U.S. 1, *Franklin Cty Sch. Bd. V. Page*, 540 So.2d 891 (Fla.App. 1989); and *Challenge Inc. v. State ex. Rel. Corbin*, 138 Ariz. 200, 673 P.2d 944 (App. 1983).

U.S.C. § 1988 is a federal statute which allows the prevailing party in a 42 U.S.C. § 1983 action to recover attorneys' fees, even if the 42 U.S.C. § 1983 action is brought in state court. *E.g., Maine,* 448 U.S. at 11. These four cases involved a cause of action under a federal statute (42 U.S.C. § 1983) and all sought attorneys' fees under a federal fees statute (42 U.S.C. § 1988). They have zero relevance to the case at bar, as does the "reverse *Erie* doctrine."

When a litigant has had a state law held preempted in state court and seeks attorneys' fees under the private attorney general doctrine, or any other state law attorneys' fees theory, as Plaintiffs did here, the state trial court applies state appellate case law, not federal case law, in determining whether to award fees. *E.g., Defenders of Wildlife v. Hull,* 199 Ariz. 411, 18 P.3d 722, 739 (App. 2001) (43 U.S.C. § 1301 *et. seq.* found to preempt A.R.S. § 37-1101(2) and attorneys' fees awarded under private attorney general doctrine); *Kerr v. Killian,* 197 Ariz. 213, 3 P.3d 1133, 1140 (App. 2000)(4 U.S.C. § 111 preempts Arizona state law treatment of federal employee retirement plans and attorneys' fees awarded under state law common fund theory); *American Cable TV v. APS*, 693 P.2d 928, 143 Ariz. 273, 280 (App. 1983) (Federal Communications Commission, not Arizona Corporation Commission, found to have jurisdiction to regulate pole attachments and awarded attorneys' fees under A.R.S. § 12-348); *Chaurasia v. General Motors*, 212 Ariz. 18, 126 P.3d 165 (App. 2006) (15 U.S.C. 2310(d)(2) found not to preempt attorneys' fees awarded under A.R.S. § 12-341.01).

This is because, if the prevailing party seeks attorneys' fees pursuant to an Arizona state law, as is the case here,[2] then the final arbiter of Arizona state law is the Arizona

[2] *Arnold v. Dept. of Health Services*, 160 Ariz. 593, 609, 775 P.2d 521 (1989) (private attorney general doctrine is a common law creation of the Arizona Supreme Court).

Supreme Court, not the federal courts. *Senor T's Rest. v. Ind. Comm'n,* 131 Ariz. 389, 392, 641 P.2d 877 (App. 1981). Defendants do not and indeed cannot cite anything suggesting otherwise and the "reverse *Erie* doctrine" is yet another of Defendants' bold, but ultimately hollow and meritless claims.

B. The underlying action required private enforcement because a state statute purported to legalize a practice which is prohibited by federal law.

To escape the private attorney general doctrine, Defendants argue private enforcement was not necessary in this case because Plaintiffs could have brought Defendants' illegal lien collections to the attention of AHCCCS. *See* Motion at 13:4.

Plaintiffs did bring Defendants' illegal lien collections to AHCCCS' attention, but that is wholly irrelevant. The "requires private enforcement" prong of the private attorney general doctrine test is met as a matter of law if the vindication of the right "required a direct challenge to a statute adopted by the Arizona Legislature," because public enforcement would then be impossible. *Arizona Center for Law v. Hassell*, 837 P.2d 158, 172 Ariz. 356, 371 (App. 1991); *see also, Kadish v. Arizona,* 868 P.2d 335, 177 Ariz. 322, 330 (App. 1993).

The fact that a plaintiff could complain to AHCCCS is irrelevant to the "requires private enforcement" prong of the test. AHCCCS is a creation of the Arizona legislature, A.R.S. § 36-2901, *et seq.*, and it has no authority to strike down or otherwise enjoin a duly passed statute of the Arizona legislature which purported to legalize this practice, such as A.R.S. § 36-2903.01(G)(4). That authority is reserved to the judicial branch of Arizona government under the Arizona Constitution, §6. Likewise, because the Arizona Attorney General is not in the business of striking down Arizona statutes, private enforcement was indeed required to bring A.R.S. § 36-2903.01(G)(4) before the judiciary

and the "requires private enforcement" prong is met as a matter of law. *E.g.*, *Hassell*, 172 Ariz. at 371.

C. The Court's fees ruling is well within the mainstream of private attorney general doctrine cases.

Defendants argue that the private attorney general doctrine has been unduly expanded because while the doctrine was applied for noble purposes in the past, "this case is about money, not lives." *See* Motion at 14:3. This argument demonstrates a lack of familiarity with the private attorney general doctrine case law.

In *Kadish v. Ariz. St. Land Dept.*, 747 P.2d 1183, 155 Ariz. 484 (1987), a teacher's union sued because the lease rates Arizona charged to miners on state trust land were not high enough and therefore, the schools were not receiving enough money from the lease revenue. *Id.* at 485-89. Private attorney general doctrine fees were awarded in that case. 177 Ariz. 322, 334.

Likewise, *Hassell, supra* and *Defenders of Wildlife, supra*, both concerned attempts to sell state trust land for money and were also a basis for private attorney general doctrine fees. Even in *Arnold, supra*, cited by Defendants, plaintiffs therein were already receiving government payments and government supplied housing and were suing for additional services. *Id.* at 596-98.

In this case, Congress has clearly stated for nearly fifty years that Medicaid, not the indigent patient, shall pay for health services covered by the Medicaid program. In violation of federal law, Arizona has authorized by statute certain collections of money from indigent Medicaid patients, in addition to Medicaid program payments. Discovery has established those illegal collections total several millions of dollars per year from Arizona's indigent. Particularly given the desperate needs of the class, this case is a lot more about "lives" than *Kadish*, *Hassell* or *Defenders of Wildlife* and equals *Arnold* in

that regard.

D. The Court did not improperly award fees for work done for the Closed Lien Plaintiffs.

Defendants' last argument is that the Court improperly awarded fees for work "solely done" for the Closed Lien Plaintiffs. *See* Motion at 15:1. Defendants do not break out and identify any specific time entries, however, so there is no way to evaluate their argument.

But addressing their argument with general principles, "'the test is whether relief sought on the unsuccessful claim is intended to remedy a *course of conduct* entirely distinct and separate from the course of conduct that gave rise to the injury upon which the relief granted is premised.'" *Odima v. Westin Tucson Hotel*, 53 F.3d 1484, 1499 (9th Cir. 1995) (quoting *Thorne v. City of El Segundo*, 802 F.2d 1131, 1141 (9th Cir. 1986)). If there is a "common core of facts" among claims, a fee award is appropriate. *Marsu v. Walt Disney Co.*, 185 F.3d 932, 939 (9th Cir. 1999); *Watson v. City of Riverside*, 300 F.3d 1092, 1096-97 (9th Cir. 2002).

In this case, it was impossible to segregate time between claims of the Open and Closed Lien Plaintiffs since the two groups' claims were identical, but for a single affirmative defense (accord and satisfaction) that the Court found applicable to one group. In fact, the distinction between "Open Lien Plaintiffs" and "Closed Lien Plaintiffs" was one made by Defendants–*not Plaintiffs*–and the substantive "course of illegal conduct" was the same for both groups.

For example, it would be impossible to segregate a nationwide search of all cases that applied 42 C.F.R. § 447.15 between Open and Closed Lien Plaintiffs. As far as either group was concerned, this all involved the same "course of conduct" and the work was all related to addressing this "course of conduct."

One affirmative defense does not render the Closed Lien Plaintiffs' claims "entirely distinct and separate" from the claim upon which the Open Lien Plaintiffs prevailed. *Odima, supra* at 1499. Obviously, there is a "common core of facts" with all of the claims, making an award of fees appropriate. *E.g., Marsu, supra; Watson, supra*. If Defendants had cited specific entries that clearly did not touch upon the Open Lien Plaintiffs' claims, this might be different, but they have not done so.

III. The Court should award attorneys' fees for the time to respond to this Motion and the Concurrently Filed Motion to Amend or Alter the Judgment.

In Order to respond to twelve arguments encompassing nineteen pages, counsel THE ENTREKIN LAW FIRM worked 22.6 billable hours and counsel LEVENBAUM TRACHTENBERG PLC worked 13.0 billable hours, as follows:

THE ENTREKIN LAW FIRM

12/3/14	BLE	Researched Lizer, Andrews, Olszewski and all other related cases (2.5); wrote first section (1.0)	3.5
2/4/14	BLE	Researched past pleadings for admissions (.9); wrote second section (.9); researched federal statutes and history (.6); wrote third section (1.5)	3.9
12/5/14	BLE	Researched all documents raised by Defendants (2.7); Wrote fourth section (1.9)	4.6
12/8/14	BLE	Researched "reverse Erie" and all Arizona cases regarding fee award for preemption (4.0); wrote fifth section (1.0); wrote eighth section (.7)	5.7
12/9/14	BLE	Researched and wrote sixth section (1.7); researched and wrote seventh section (1.2); researched and wrote response to Motion to Amend Judgment (2.0)	4.9

22.6 HOURS X $425.00 = $9,605.00

LEVENBAUM TRACHTENBERG PLC

12/12/14	GMT	Review motion for new trial (.8); review draft of response in opposition (.8); begin review of Arizona Court of Appeals transcript re preemption issues (.6); begin revising Part I of the response (2.2)	4.4
12/14/14	GMT	Continue revising Part I of the response and research regarding Taylor and the AHCCCS Provider Manual (3.5); revise Part II of the response and review Arizona preemption case law applying state law to fees (2.8)	6.3
12/15/14	GMT	Final review and revision of response and prep exhibits for filing (1.5)	1.5
12/16/14	GMT	Review and revise response to Motion to Amend Judgment (.8)	.8

13.0 HOURS X $425.00 = $5,525.00

The Entrekin Law Firm respectfully requests an award of $9,605.00 in attorneys' fees and Levenbaum Trachtenberg PLC respectfully requests $5,525.00 for attorneys' fees in responding to Defendants' Motion and Motion to Amend or Alter the Judgment.

IV. Conclusion

For the foregoing reasons, Plaintiffs respectfully request the Court to deny Defendants' Motion in its entirety and award attorneys' fees as requested herein.

/ / /

/ / /

RESPECTFULLY SUBMITTED this 23rd day of December, 2014.

LEVENBAUM TRACHTENBERG, PLC

/s/ Geoffrey M. Trachtenberg
Geoffrey Trachtenberg (#19338)

THE ENTREKIN LAW FIRM

/s/ B. Lance Entrekin
B. Lance Entrekin (#16172)

Attorneys for Plaintiffs

ORIGINAL of the forgoing e-filed via TurboCourt
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EXHIBIT 1

IN THE ARIZONA COURT OF APPEALS

JACKIE ABBOTT; ROBERT BERGANSKY; RAYMOND BROWN; NICHOLAS BIGLER; RICHARD CAMPUZANO; DALTON GORMEY; TRACY JAMES; JOHN JAMES; STEPHANTE KRUEGER; ZATNAB MOHAMED; ROBERT PIERSON; LUCAS SMTTH; ROBERT VAN STEENBURGH; AMBER WINTERS; CHRISTINA YERKEY; And STEVEN YOUNG, Plaintiffs/Appellants, v. BANNER HEALTH NETWORK fna Banner Health, Inc., an Arizona Corporation; DIGNITY HEALTH fka Catholic Healthcare West, a California corporation; SCOTTSDALE HEALTHCARE CORP., an Arizona Corporation; NORTHWEST HOSPITAL LLC, a Delaware corporation; NORTHERN ARIZONA HEALTHCARE CORP., an Arizona corporation; JOHN C. LINCOLN HEALTH NETWORK, an Arizona corporation; UNIVERSITY MEDICAL CENTER CORP., an Arizona corporation; CARONDELET HEALTH NETWORK, an Arizona corporation; TUCSON MEDICAL CENTER, an Arizona corporation; ORO VALLEY HOSPITAL, LLC, a Delaware Corporation, Defendants/Appellees.	Court of Appeals Division One No. 1 CA-CV 13-0259 Maricopa County Superior Court No. CV2012-007665

Phoenix, Arizona
April 10, 2014

BEFORE THE HONORABLE PATRICIA K. NORRIS
BEFORE THE HONORABLE DONN KESSLER
BEFORE THE HONORABLE MAURICE PORTLEY

TRANSCRIPT OF PROCEEDINGS

Oral Argument

Proceedings recorded by electronic sound recording; transcript produced by AVTranz.

J. MARIE MORAN
Transcriptionist
D-677

I N D E X

April 10, 2014

M I S C E L L A N E O U S

APPEARANCES

April 10, 2014

Justices: Patricia K. Norris

Donn Kessler

Maurice Portley

For the Plaintiffs/Appellants:

Geoffrey M. Trachtenberg

Witnesses:

None

For the Defendants/Appellees:

Cameron Artigue

Witnesses:

None

Also Appearing:

Lance Entrekin

David Abney

Chris Herring

Phoenix, Arizona

April 10, 2014

(The Honorable Patricia K. Norris, Donn Kessler and Maurice Portley Presiding)

ORAL ARGUMENT:

(Audio begins)

JUDGE KESSLER -- a few minutes for oral argument. If the Appellants who desire to reserve any time for rebuttal, you may do so. There's a clock on the podium, and the clock shows the amount of time you have remaining of the 20 minutes, including your rebuttal time.

So you need to manage your own time. If it shows have five minutes left, that includes your rebuttal time. If there are going to be more than one attorney arguing on either side, you only get 20 minutes per side, not per attorney.

To guide you somewhat in dealing with the oral argument, you should be aware that we have read the briefs; we've reviewed the record; we have conferenced this matter, so we're relatively familiar what the issues are, the facts are, and the procedural background. When you approach the podium, since we are audio recording this and video recording the argument, smile for the camera, and please state your name and who you're representing.

With that, counsel for the Appellants.

MR. TRACHTENBERG: Good morning, Your Honors. My

name is Geoff Trachtenberg. I am representing the putative class of Plaintiffs known as the closed-lien Plaintiffs in this litigation, and I'm pleased to be here today. I'd like to reserve about ten minutes of time, if that's possible.

Your Honor, the foundational issue in this case is the legality of the underlying conduct. You cannot have accord and satisfaction satisfaction if the underlying conduct is illegal or against public policy, and the Defendants, the Appellees admit this. They admit, you can't have accord and satisfaction for prostitution or a murder for hire.

JUDGE KESSLER: Well, wait. Wait. Those are malum in se types of agreements.

MR. TRACHTENBERG: Well, if we're going to go to malum in se, they're -- in other words, they're affirmatively prohibited, correct. As --

JUDGE KESSLER: Right.

MR. TRACHTENBERG: As is the conduct in this case under 42 CFR 447.15.

JUDGE KESSLER: But there's a -- but there's a state statute that expressly permitted this -- these liens, and no state court, no binding law -- actually, a binding decision of a court in Arizona at the time these agreements were entered into said that these liens were preempted.

MR. TRACHTENBERG: Well --

JUDGE KESSLER: So what do we do with that?

MR. TRACHTENBERG: Okay. What you do with that is, first off, I don't think you can look at a law. You have to look at the law. You don't get to just look at the state law and stick your head in the sand and ignore the rest of the law. You have to look at everything. What's more is, if we're going to pick state statutes and things like that, why not pick the state regulation? Why not pick Regulation R9-22-702?

That's a regulation that expressly prohibited this type of conduct, and it's a regulation that they agreed to comply with in their program participation provider agreements, which they all signed pursuant to federal law.

JUDGE NORRIS: Mr. Trachtenberg, let me raise something that has concerned me about this. The clause-lien Plaintiffs that have appealed were represented by counsel when they entered into a lease. I think 10 or 11 accord of satisfactions, and then the other three or four, it's a little slightly different documentation, but they all had counsel, and they all had, what I -- as best as I can tell, experienced counsel, and counsel entered into this with their advice these agreements.

So if all of this was so clear and understandable and we can't hide our head and ignore the law, how does that square with counsels' obligation to know the law and raise these issues?

MR. TRACHTENBERG: Thank you, Judge.

JUDGE NORRIS: Yeah.

MR. TRACHTENBERG: Judge Norris, how I would address that issue is, the reason for the illegality exception exists to protect vulnerable people from powerful people.

JUDGE NORRIS: Well, excuse me. That -- and I do appreciate that. My question has to do with in looking at the appropriateness of an accord and satisfaction, how do we then take -- should we be taken to account the fact that experienced counsel represented the closed-lien Plaintiffs, and I presume, should also know the law, and entered into these arrangements on behalf of their clients?

MR. TRACHTENBERG: Judge Norris, none of that is in the record, specifically with respect to the pleadings. We were dismissed on the pleadings. If we get into the facts, Your Honor, if we get into the facts, I can assure you, there's plenty of evidence that these people were under undue influence. These people were subject to the most extreme kind of poverty, which is functional because they're all part of Medicaid.

JUDGE NORRIS: Uh-huh.

MR. TRACHTENBERG: They have all their money held up because of ER1.5.

JUDGE NORRIS: So --

MR. TRACHTENBERG: Something their counsel is bound to follow.

JUDGE NORRIS: So let me make sure I have this, because I will tell you, this is something that I really thought long and hard about in this case. What you're saying is that, even though the record contains the correspondence exchanged between counsel in a number of the circumstances and situations that there are, perhaps, fact issues regarding duress or other reasons that would have motivated or informed the decision whether this would be in good faith.

MR. TRACHTENBERG: Yes, ma'am.

JUDGE NORRIS: Okay.

MR. TRACHTENBERG: That is absolutely the truth.

JUDGE NORRIS: Okay. Okay.

MR. TRACHTENBERG: We never got a chance to get that far because we were just judged on the pleadings. The simple fact is --

JUDGE KESSLER: So you're asking us to consider something that's outside the record to say there's a fact dispute?

MR. TRACHTENBERG: I'm saying that there are factual issues, but Your Honor had asked me about the fact that they were represented by counsel.

JUDGE KESSLER: Right. But --

MR. TRACHTENBERG: That's only -- that's only because these folks attached letters to their motion --

JUDGE KESSLER: But you could have -- you --

MR. TRACHTENBERG: -- which were considered.

JUDGE KESSLER: But you didn't -- in responding to the motions, did you start to argue, gee, these people were acting under duress?

MR. TRACHTENBERG: We did.

JUDGE KESSLER: That they --

MR. TRACHTENBERG: It's in our plead- -- our complaint is abuse of process. It's fraud.

JUDGE KESSLER: No, no, no. Have they -- that they were acting under duress and, therefore, shouldn't be bound by what their attorneys had agreed to?

MR. TRACHTENBERG: Well, the -- here's the thing I also take issue with. They didn't --

JUDGE KESSLER: Just answer.

MR. TRACHTENBERG: No.

JUDGE KESSLER: Before you say "in addition," just answer.

MR. TRACHTENBERG: Okay. No. No.

JUDGE KESSLER: Okay.

MR. TRACHTENBERG: They shouldn't be bound by it. They should be -- they --

JUDGE KESSLER: Did you make -- and you made that argument --

MR. TRACHTENBERG: Yeah, we made that argument.

JUDGE KESSLER: You said that they shouldn't be bound

by what their attorneys did because of --

MR. TRACHTENBERG: Well, we didn't get a -- it's in the papers. We didn't get oral argument. So yes, it is in the papers. I believe it is in the papers.

JUDGE KESSLER: And it's in your briefs on appeal?

MR. TRACHTENBERG: Absolutely it is.

JUDGE KESSLER: That they were acting under duress.

MR. TRACHTENBERG: Absolutely it is.

JUDGE KESSLER: And where is that in your argument?

MR. TRACHTENBERG: The word "duress" may not appear in there, but the -- we --

JUDGE KESSLER: Where is the argument that they were acting under --

MR. TRACHTENBERG: It comes in -- I know -- I know at a minimum, it's in the reply brief, and it is in the --

JUDGE KESSLER: In the opening --

MR. TRACHTENBERG: -- open- --

JUDGE KESSLER: In the opening brief, where is it?

MR. TRACHTENBERG: You know, it is in the context of the opening brief --

JUDGE KESSLER: Okay.

MR. TRACHTENBERG: -- where we talk about ER 1.15. I mean, you know --

JUDGE KESSLER: Okay.

MR. TRACHTENBERG: -- the simple fact is --

JUDGE KESSLER: Okay. Okay.

MR. TRACHTENBERG: -- we do talk about the fact that these folks had all of their money locked up. This is not -- I really want to say, this is not a case of somebody having changed their mind saying, "Well, if I had only known then what I knew now or saying they want to rewrite the deal." This is not that case, Your Honor.

This case is more like, and this is the best example I can come up with, it's like a mugger who says to you, "Give me all of the money in your wallet," and as you're emptying your wallet, they smile and they say, "Why don't you just keep 90 percent; I'll take the 10 percent and we'll call that an accord and satisfaction." The other things that you're doing is you're saying that this agreement that they entered into is -- this is -- the label that -- the accord and satisfaction label was something that the hospitals did.

They wrote that in their letters and they said, "Here you go. It's an accord and satisfaction."

JUDGE NORRIS: Well, Mr. Trachtenberg, I don't think the hospitals are now with just the muggers; that's the first thing, and secondly, I don't mean to beat this horse to death, but counsel for these individuals had correspondence in which they accepted those letters and didn't object, and I -- we've thrashed that now and we can move on, but I think that argument is -- is not -- it is not -- it undercuts the strength of your

case. Let me put it that way.

MR. TRACHTENBERG: I accept that, Judge.

JUDGE NORRIS: Okay?

MR. TRACHTENBERG: And I'm not necessarily saying they're analogous to muggers.

JUDGE NORRIS: Yes.

MR. TRACHTENBERG: But what I am saying is that the analogy of taking and demanding money when you're not entitled to demand it, there is just not many examples of that.

JUDGE NORRIS: Well, let me ask you about that. I've looked at all of the cases that you've cited in this, and we'll have a number of questions for your opposition here about this, nevertheless, we're in the situation where, at least in Arizona, there was, in fact, a statute that authorized this. There was -- we did not have any dispositive, binding precedent in Arizona.

No one raised the argument when this was going on at the time that these liens were in any way, form or fashion preempted by federal law, and so there was at least some uncertainty. And when there is uncertainty and there is controversy, that's normally considered an appropriate issue that can be settled through an accord and satisfaction.

MR. TRACHTENBERG: That is correct when there is uncertainty, and if you will hear me out --

JUDGE NORRIS: Yeah. Okay.

MR. TRACHTENBERG: -- there is not uncertainty here. I'm telling you, I'm sorry to offend Judge Kessler if I'm calling them muggers, but these folks knew, the knew that what they were doing was illegal. We have an affidavit of a lawmaker that's attached to the motion for summary judgment in the lower court, which we never got to present to you, saying they knew. They came in and they testified that this -- that they couldn't do this.

JUDGE NORRIS: Where is that in the record?

MR. TRACHTENBERG: It's -- it's in June 27, 2013. It's in the lower court.

JUDGE NORRIS: Oh, and what's it attached to?

MR. TRACHTENBERG: It's attached to a motion for summary judgment.

JUDGE NORRIS: Okay.

JUDGE KESSLER: This is on -- this is on your preemption -- this is on --

MR. TRACHTENBERG: Yes, sir.

JUDGE KESSLER: -- the argument on the preemption?

MR. TRACHTENBERG: Yes, sir, it is.

JUDGE KESSLER: Oh.

MR. TRACHTENBERG: We have -- that's direct evidence. We have circumstantial evidence that this was illegal. We have the fact that they routinely would assert these retail rates, full-retail rate liens --

JUDGE KESSLER: Well, of course, under Banner --

MR. TRACHTENBERG: -- and then --

JUDGE KESSLER: Under the Banner Health case, Baptist found -- Baptist Hospital case, I believe, they're allowed to file -- they're allowed to charge their filed rates. As much as I dissented in that case, they're allowed to --

MR. TRACHTENBERG: Not --

JUDGE KESSLER: -- file their charges or filed rates. That was right, too.

MR. TRACHTENBERG: That did not -- that did not involve Medicaid. So they filed it --

JUDGE KESSLER: No, it didn't. It didn't.

MR. TRACHTENBERG: This is the thing, you're dealing with sophisticated folks. I mean, here's my point, and this is the real point I really want to make before I sit down --

JUDGE KESSLER: Sure. Sure.

MR. TRACHTENBERG: -- and that is, they knew this was illegal. They do these liens, then they compromise them. They compromise them for ten cents on the dollar. They know what's going on. They're just shaving off because they know that these poor folks, the folks that are so poor that at or below the federal poverty level cannot survive. They have to make a choice. The choice is, "Do I feed my family Alpo tonight or do I give the hospital a little bit of money and get access to the

money I'm entitled to to make me whole?"

JUDGE KESSLER: Counsel, let me -- one question I had was: Sometimes there are statutes that say, this right is not waive-able. In the Landlord-Tenant Act, I think, has something that says this is a right that no one can ask you to waive. Is there any federal regulation or statute that said the right not to have a -- seek collection of the balance billing, we'll call it balance billing --

MR. TRACHTENBERG: Yes.

JUDGE KESSLER: -- or substituted billing, is not waive-able. No one can ask you -- can effectively say you have to waive your -- your protection from malice (sic) billing.

MR. TRACHTENBERG: There is. I mean, the first example would be the Spectrum case, Spectrum v. Bowling.

JUDGE KESSLER: No, I asked for a statute. Is there a case --

MR. TRACHTENBERG: Oh, a statute? No.

JUDGE KESSLER: Is there any statute or federal statute or regulation that says --

MR. TRACHTENBERG: Well, there's no statute that --

JUDGE KESSLER: -- you waive it?

MR. TRACHTENBERG: -- goes one way or the other.

JUDGE KESSLER: All right. And we've read Spectrum.

MR. TRACHTENBERG: Yeah, and so you can't waive it.

JUDGE KESSLER: I understand your argument in

Spectrum.

MR. TRACHTENBERG: And all of the cases say you can't waive it. And the fact is, this is designed --

JUDGE KESSLER: Right.

MR. TRACHTENBERG: Well, they did. They all say --

JUDGE KESSLER: Well, Spectrum --

MR. TRACHTENBERG: -- you can't waive it.

JUDGE KESSLER: Spectrum --

MR. TRACHTENBERG: Spectrum does, but Glengarriff (phonetic) does and Sarah Feeney (phonetic) does.

JUDGE KESSLER: Sure. But Spectrum, none of those cases had a state statute that says we are going to allow this lien.

MR. TRACHTENBERG: Well, but there were states with statutes that said we are going to allow liens. There's Kozlowski in California. You've got the Tennessee case. You've got Louisiana and Florida.

JUDGE KESSLER: Yeah.

MR. TRACHTENBERG: They have regulations saying -- and here, remember, we had a -- they may have a state statute, but there's a state regulation specifically that says you can't do this.

JUDGE KESSLER: So how do we deal with that? How do you deal with a state regulation that says you're not supposed to balance bill, and then you have a state statute that says

but you can file a lien; how do you deal with that? I mean --

MR. TRACHTENBERG: Well, you know, I recognize that there's a pecking order, okay, on the one hand, in terms of regulations and statute per se, but part of the overall, when I say you have to look at the law not a law, part of the overall gestalt of Medicare is, you have to agree. You have to abide by a plan entered into with the state, and the plan specifically, in this case, references the regulation. It doesn't in any way, shape or form. We've attached the PPAs to the complaint; it never references that statute.

I'd like to reserve the rest of my time.

JUDGE KESSLER: But we do have to read the statues into all contracts and agreements, don't we? I mean, Banner, the Baptist case, and there's plenty of case law that says if there's a statute out there, it's read into every contract, and the problem here is, is that you have statute and regulation that may be at odds with each other, and then the question is, there is this preemption issue that -- let me see if I can summarize something without call- -- without your -- without name-calling about muggers and --

MR. TRACHTENBERG: I don't mean --

JUDGE KESSLER: -- stealing from --

MR. TRACHTENBERG: I'm trying to use it as an analogy.

JUDGE KESSLER: But in essence, putting it in legal

terms, you're saying there can't be a good-faith dispute about the legitimacy of the lien because the liens were preempted by every federal case out there and the federal statute and regulations?

MR. TRACHTENBERG: The liens were clearly unlawful, and I mean, I have -- there is more evidence -- I mean, the -- you know, that the liens were clearly unlawful, and I'll point to the fact that 120 attorneys signed affidavits to support the class-action certification motion, but to answer -- to answer your question, yes. And both Shelton (phonetic), both the one-and-a-half pages of Shelton and the two-and-a-half pages of Brett (phonetic) both say twice, not once, but twice, that it has to be good faith, or it has to be in other -- he says -- they say in Brett, it was an honest difference of opinion.

This was not an honest difference of opinion. The other thing is, there were lawsuits in these cases. Lawsuits that were filed. In one case, there was a judgment entered, and in another case, they -- they had it dismissed. In this case, they're saying, "Ah, we're going to use this ethical rule to hold up all of your money until you agree to give us some," and that's, by the way, why the Supreme Court has now changed the ethical rule effective January 1st of this year to avoid this type of misconduct.

Thank you.

JUDGE KESSLER: Thank you.

MR. ARTIGUE: Good morning. Cameron Artigue on behalf of the Appellees. The issue for today is not preemption. It's not the merits. The issue for today is whether a lien claim can be settled.

JUDGE NORRIS: You know, I know that's your position, but I will tell you, I found it less than helpful for the Appellees not to engage in a discussion of the federal law here, because that goes to the heart of whether this settle -- or these accords of -- these alleged accord and satisfaction were taken in good case -- case for adequate consideration. It made our job difficult. So I just want you to know, I understand that the avoidance of an engagement on those issues was not helpful to Judge Kessler.

MR. ARTIGUE: Your Honor, I appreciate that.

JUDGE NORRIS: Okay.

MR. ARTIGUE: And I appreciate that we're here on 12(b) motion, and for that purpose, we assume the allegations of the Complainant are correct.

JUDGE NORRIS: Uh-huh.

MR. ARTIGUE: To get back to the point of procedure that you and Judge Kessler addressed. The complaint alleges that there was a settlement, that the settlement was illegal and we'd like our money back. The motion to dismiss attaches the settlement correspondence. That's not going outside the pleadings. That's staying within the pleadings. There's no

objection to that correspondence. In 13 of the 15 Plaintiffs, that correspondence is with Mr. Trachtenberg himself.

So what exactly is going through his mind when he writes a letter to hospital's counsel and says, "I am -- I have authority to bind my client to a settlement, and I intend to bind my client to a settlement and I hereby bind my client to a settlement." That is how these claims are settled, and if as he now contends these claims are absolutely without merit, then the client, frankly, has to ask some questions of Mr. Trachtenberg and say, "Why did you advise me to pay money in settlement of a lien claim that was no good?"

That's a fair question. If he's like -- and he's put himself in this dilemma, because you cannot go out and tell opposing counsel, "I am going to settle this claim. Yeah, we've got a deal." It's a binding settlement, and in private, reserve the right to a month later, a year later say, "Oh, never mind. That was never binding."

Now, what was incumbent on Mr. Trachtenberg, if his client was under -- was poor or needed the money, is to do exactly what he did with the open-lien Plaintiffs, which is to say, you know, "I think there is a legal issue here and I'm going to go to the Superior Court and file a declaratory judgment action." We know he could have done that because he did. What you cannot do is settle the claim, manifest an intention to settle, and then come back later and say, "Oh,

never mind. It's illegal."

JUDGE KESSLER: How -- how can we -- the Arizona Supreme Court case that talks about achieving the underlying dispute, underlying agreement is invalid or is a good-faith dispute.

MR. ARTIGUE: Yes.

JUDGE KESSLER: How can we -- what's your position on how we can say as a matter of law there is no good-faith dispute when, one, there doesn't appear to be any federal -- any case that holds that this statute is -- is enforceable. In other words, that these -- you can file liens to get balance billing or substitute billing in case -- some cases, and two, it seems to be the tension, at least the tension, between that statute, lien statute, and the regulation, which is read into the provider agreements?

How can we say as a matter of law that these agreements, that the dispute it was in good -- the dispute about the liens was in good faith?

MR. ARTIGUE: I think you can say that it was a good-faith dispute because the statute has been on the books for 30 years. The statute is presumptively constitutional. The case law that existed reflected positively on the statute, one could say, and try as you might, Judge Kessler, you cannot put the merits of this dispute on the far side of Shelton versus Scrubs (phonetic). You just can't do it.

In this case, you have a state law that says hospitals, you have a lien claim. In Shelton versus Scrubs, the statute says to the unlicensed contractor, you do not have any claim. You do not have any claim, and he took that statute and parlayed it into an enforceable settlement.

Now, that -- you know, this case just -- you can debate, well, the federal case and the Louisiana case and the Florida case, and those aren't reasons why you can't settle; those are reasons why you can. Uncertainty about the law is why public policy favors settlement. You don't say, "Oh, well, there's a case out there from some other jurisdiction and there's some legal arguments, so we're not going to let lawyers settle those kind of claims."

JUDGE KESSLER: But there's -- yeah, but is this a -- is there any federal case -- I know there's no binding federal case or state case on this issue on the lien, the forcible (sic) lien, but was there any -- at the time these agreements were entered into, were there -- was there any reported decision upholding a lien?

MR. ARTIGUE: Yes. I mean, I'm going to incur Judge Norris's wrath here, but, yes.

JUDGE NORRIS: No, you won't. No, you won't.

MR. ARTIGUE: There's a case from out of Chicago called -- not Olshevsky --

JUDGE KESSLER: Right. I think the --

MR. ARTIGUE: No, you're thinking of Spectrum Health. There's another one --

JUDGE KESSLER: They cite -- they cite -- Spectrum Health cites --

MR. ARTIGUE: Yeah.

JUDGE KESSLER: -- the -- but I didn't think there was a lien statute in place.

JUDGE NORRIS: Aren't you thinking of the California case?

MR. ARTIGUE: No, but what you get into -- and look, the briefing we submitted to Judge Gama on the merits, frankly, and one reason -- and we're not trying to hide anything from the Court --

JUDGE KESSLER: Right.

MR. ARTIGUE: -- but it was like 100 pages --

JUDGE KESSLER: You couldn't anyway. And you wouldn't --

MR. ARTIGUE: -- of briefing.

JUDGE KESSLER: And you wouldn't and you couldn't.

MR. ARTIGUE: Okay. Well, and if and when that issue comes up, we may file oversized briefs. I don't know, but it's as complicated an issue of law as I have ever encountered. It's really complicated, and I'm digging into 35-year-old excerpts from US Code, congressional and administrative news.

JUDGE KESSLER: Sure, but was there any --

MR. ARTIGUE: So --

JUDGE KESSLER: But was there any case that's --

MR. ARTIGUE: Yes. Yes.

JUDGE KESSLER: -- supported that a lien statute was preempted by state -- by the federal law -- that was not -- that was not preempted by the federal law?

MR. ARTIGUE: Certainly not from Arizona.

JUDGE KESSLER: But was there -- was there anywhere?

MR. ARTIGUE: But you know, it's, again, the --

JUDGE KESSLER: Was there anywhere?

MR. ARTIGUE: No. That's -- my candid answer is no, but it's -- the burden is not on me to say there's a statute that says I can do this and here's a case that says I can do this. The burden is on them --

JUDGE KESSLER: Sure. Sure.

MR. ARTIGUE: -- you know.

JUDGE KESSLER: But if -- but if we're looking at a good-faith dispute and saying --

MR. ARTIGUE: Right.

JUDGE KESSLER: You can see what I'm getting at is, is there a good-faith dispute, and they say, "Gee, we don't have any federal case or state case that says these lien statutes are valid, but we presume it's valid, and therefore, we think there's a good-faith dispute."

MR. ARTIGUE: Right.

JUDGE KESSLER: As a matter of law. Not as a matter of fact, as a matter of law.

MR. ARTIGUE: As a matter of law, there is also an AHCCCS reg that says that hospitals have to copy the AHCCCS Administration on all of the liens that they file. So as a matter of law, AHCCCS is aware of this lien enforcement. AHCCCS gets -- stands in line ahead of the hospitals. They have first priority.

JUDGE KESSLER: That doesn't seem to have been raised as an issue in this case.

MR. ARTIGUE: It's a 12(b) motion.

JUDGE KESSLER: We're AHCCCS --

MR. ARTIGUE: That's exactly right.

JUDGE KESSLER: We're AHCCCS -- what's AHCCCS's role in all of this? I mean, does any of this affect AHCCCS's rights to reimbursement?

MR. ARTIGUE: Because they have a senior lien, no, but as a practical matter, they're in on the same -- they're attending the same settlement conferences at superior court as the hospitals are. This is not a secret. This is --

JUDGE KESSLER: But AHCCCS isn't here.

MR. ARTIGUE: AHCCCS is not here, but, you know, if you -- if we got to the -- the factual phase of the case, you would see at a 25-year ordinary course of business of, this is how lien claims are settled. This is -- this is -- the case

is -- this is like the guilty pleas that -- that -- you know, the routine business, and you can't -- just like you can't challenge a guilty plea by saying, "Well, I'm innocent, you know, so therefore, my sentence is illegal. Never mind that I pled guilty on the advice of counsel." You can't come here and say, "I settled my civil dispute on the advice of counsel, but, in fact, the claim had no merit."

JUDGE NORRIS: Let me ask you on this, and don't get me wrong, I don't mean to sound like I'm dumping on your or the other side. I find this a very difficult case, and I confess, I am really struggling with this. Just on the points you just raised, you know, normally when I do commercial litigation, I would say accord and satisfaction is a issue of law, we don't need the facts.

It's straightforward summary judgment or a motion to dismiss lend (sic). Here, based on what you're saying about how this was really the course of business; this is what was going on in Arizona at the time, are there issues of fact that shouldn't be resolved as to whether then, in fact, these liens were enforced and settled through accord and satisfactions in good faith?

MR. ARTIGUE: No. I think if you ask any lawyer is it sufficient to exchange correspondence that says we have offered to settle this case for $6,000; is that acceptable? Responding lawyer says we agree. Enclosed is a check for

$6,000. This is a settlement. This is the end of the story. Close file. I think the answer is, no.

The second answer to your question, Judge Norris, if there were anything more to the story, you should have -- it was incumbent on the Appellants to say there's something here we want to add, Rule 56(f). We need some kind of further factual development, and no such argument or objection was ever made, okay?

JUDGE NORRIS: Let me raise one other point, and this gets to the reason why I am struggling with this. There is no question that by Arizona statutes in 36-290301 that the hospitals were entitled to or authorized to collect unpaid portions from hospital liens. There's just no question about that, and there's also no question that provision has been in our statutes for a long, long time.

Okay. The federal Medicaid regulation that basically bars balance billing has been in existence since at least 1983, and perhaps even earlier. The federal statute has been around for a long time as well. I then turn to the provider contracts that are with AHCCCS, and I just picked on the Banner one because that was Exhibit 1, it says in paragraph 15,

> "The provider agrees to abide by Arizona Administrative Code R9-22-702, prohibiting the provider from charging, collecting or attempting to collect payment from an AHCCCS eligible person."

Then I look at the closed-lien Plaintiffs and the record we have, and with the exception of Mr. Abbott, who I believe settled or resolved his matter in 2008, everyone is from 2010 and 2011. And clearly by, I think, 2008, but unquestionably by 2010, the law in the federal system was, as far as I can tell, unanimous that hospitals or other healthcare providers are not entitled to collect against third-party payers, tortfeasors, on lien claims.

Once they've accepted a Medicaid dollar, they can't go back. If they've accepted a Medicaid dollar, they have been paid in full and they cannot either go against the lien claim and they can't retract and say, "Oh, too bad; I'd like to now give you back that Medicaid dollar." So my concern here, and I'm sorry for the long question, but when you have all of that, that history, that set of circumstances, can we then say that these accords and satisfaction were in good faith for consideration?

MR. ARTIGUE: Yes.

JUDGE NORRIS: Okay.

MR. ARTIGUE: And here's why. The Arizona lien statute, unlike the lien statutes in the federal cases you described, is only enforceable against third-party tortfeasors and their liability carriers. Okay, that's the -- the Blankenbaker versus Jonovitch case from the Arizona Supreme Court. There's a case called Maricopa County versus Barfield,

from this court. There is no recourse whatsoever, even in theory, against the patient --

JUDGE NORRIS: But the problem I have with -- yeah.

MR. ARTIGUE: -- and that's what's different.

JUDGE NORRIS: Well --

MR. ARTIGUE: That's --

JUDGE NORRIS: -- but --

MR. ARTIGUE: You know --

JUDGE NORRIS: But when we look at a lien claim, when there -- a tort feasor or his/her carrier pays in, that money goes to the patient or patient's counsel, and that money no longer belongs to the tort feasor or the carrier. It belongs to the patient. Now, then we get into the issue of the lien claim, but that money now is the property of the patient, and that's why those prior cases, in light of the history of what was going on here and the law, is different.

MR. ARTIGUE: I think that you might be getting ahead of the facts there --

JUDGE NORRIS: Okay.

MR. ARTIGUE: -- with respect, Your Honor. I think that the money might be paid over on the condition that you take care of lien claims, and that's -- you know, but this is -- this is why, honestly, I felt like it was -- on a 12(b) motion from accord and satisfaction, I felt like it was too much to spend four-fifths of our appeals brief discussing

issues that are not on appeal.

The provider-agreement issues you raise are briefed and pending before Judge Gama right now. I mean, he hasn't even looked at this stuff yet. This is a 54(b) on the accord and satisfaction. There is one other exchange you had, Judge Kessler, about illegality, and I want to point out the kind of broader sense in which the Appellants are using that word.

If you look in a contract-law treatise or the restatement of contracts under the heading of illegality, what they're talking about in the old-fashioned sense is prostitution, gambling, bootleg rum. You know, it's sort of where the primary conduct is illegal. That's not what's going on here.

JUDGE KESSLER: Well, the --

MR. ARTIGUE: And --

JUDGE KESSLER: I mean, you -- I think I understand where you're going on this, and that is, the difference between that's malum in se.

MR. ARTIGUE: Right.

JUDGE KESSLER: Yeah. Yeah. Recognize that no one's -- no court's going to enforce a contract for prostitution or murder --

MR. ARTIGUE: Right.

JUDGE KESSLER: -- or arson, but the question then becomes -- and that's the distinction between that and saying,

even though there's this federal law out there, we have a state statute that says we can have these liens --

MR. ARTIGUE: Right.

JUDGE KESSLER: -- so it's not malum in se.

MR. ARTIGUE: Right.

JUDGE NORRIS: Arguably, preemption is just not the same as classic illegality.

JUDGE KESSLER: Right.

MR. ARTIGUE: Classic illegality is where the primary conduct violates the law. What -- what -- the sense in which they're using the word is that this claim lacks merit because of some statute. You know, because of --

JUDGE KESSLER: As of which -- which --

MR. ARTIGUE: -- the notice of claims statute --

JUDGE KESSLER: Which claim, the liens?

MR. ARTIGUE: Yeah. They're saying that the lien claim lacks merit because of the involvement of some other statute, and a creative lawyer can make that sort of "illegality argument" with a lot of cases, I pointed out in the briefs the taxation context.

You know, if you push the Appellants' argument to its logical conclusion, you can't have a binding closing agreement with the Department of Revenue, because you're resolving an illegal -- you know, you're resolving a question of legality, and the taxpayer could always come back and say, oh, those were

illegal taxes. The closing agreement is not binding.

Here, I think the -- my favorite proves too much point. If you take the Appellants' position to its conclusion, you could not settle this lawsuit today. If -- and I don't know what the lien claim was versus Jackie Abbott, but let's say it was $5,000. If I could save the hospital right here and now, I'll pay Jackie Abbott $4,000. Count it out right here at the lectern and hand it to her, we'll settle her personal claim, and Mr. Trachtenberg says "Deal" and I say "Deal" and the Court says "Deal," that's not a binding settlement.

We couldn't do it, try as we might. Even if we had full, informed, voluntary consent of all of the lawyers and all of the courts in the land, because according to their theory, oh, it's just an illegal claim, and even if we did it here and now today, it would still be as void and illegal a settlement a transaction as what we had before, because what we had before, we didn't have a lawsuit, but we had a lawyer for both sides exchanging correspondence in a voluntary transaction, and something is wrong when they're advocating a view of the law that says you cannot settle.

That when there is an issue of legality, you just you can't settle it.

JUDGE KESSLER: So if I were going to summarize your argument --

MR. ARTIGUE: Yes.

JUDGE KESSLER: -- would it be a fair summary to say that the hospitals had a right to rely on the lien statute to believe that their liens were maybe valid, and therefore, entered into a good-faith accord and satisfaction with the Plaintiffs, with the patients, based on that, regardless of the lack of any federal case that's -- that --

MR. ARTIGUE: Yes.

JUDGE KESSLER: -- that said these -- the lien was enforceable. Is that a fair -- is that a fair summary?

MR. ARTIGUE: Yeah. Yeah. A right to rely is a little bit of a equitable flavor. I might say that the presumption of constitutionality is not just a slogan; it's a real thing, you know.

JUDGE NORRIS: But based -- but based -- our Arizona statute is not unconstitutional. In my view at least, preemption is a different type of doctrine. Well, there's nothing wrong with the statute, it's just arguably preemptive, and in my view, you're making a persuasive case, and I hope you'll respond to it, that preemption is not the same thing as illegality.

MR. ARTIGUE: Right. Right. It's just -- it's another -- well, it's -- in the broad sense of illegality, of, well, there's a statute. You know, some statutes you can -- you can create an affirmative defense or a procedural bar or -- you know, statutes interplay with legal claims in countless

ways, and the only kind of illegality the Appellants are asserting is that, you know, preemption is just part of that path full of arguments, that -- you know, that this is -- this is something that can be settled.

Unless there is a question, I --

JUDGE KESSLER: Well, I was going to say, it brings you back to probably where you started is there was a dispute; we had settlement; that should be it, because there was a remedy at that point in time, to the extent that there was, but it wasn't pursued.

MR. ARTIGUE: That is correct, Your Honor.

JUDGE KESSLER: Okay.

MR. ARTIGUE: Thank you.

JUDGE KESSLER: Thank you, counselor.

MR. TRACHTENBERG: Thank you. I will address, first, Judge Norris's concern. Judge Norris, it's not fair to say preemption is different from classic illegality. There's different kinds of preemption. I mean, if there was a federal law that made it illegal to steal children, okay, they made it affirmatively illegal to steal children, you -- and there was a state law that said you could, but you wouldn't say that, well, that's just a -- that's just mere preemption; it's not illegality.

What happened in Brecht, was completely different, and I, unfortunately, don't -- I mean, I don't have a ton of

time to go into it, but the bottom line is this, in Brecht, you've got the state constitution that says you've got authority to go collect money, and you've got the conclusion that, well, after all, the state didn't have the authority to impose that on a pre-territorial bank.

So it is not fair to say a preemption is just candidly different from illegality; that's number one. Number two, this idea that, well, we couldn't possibly settle is nonsense. They could settle. They could drop the lien, and by the way, in terms of, well, look at the open-lien Plaintiff --

JUDGE KESSLER: That's a heck of a settlement.

MR. TRACHTENBERG: But they're not entitled to -- they're -- it's -- this is --

JUDGE KESSLER: I mean, you're -- what you're basically saying is -- I mean, I understand your point.

MR. TRACHTENBERG: Yeah. Yeah.

JUDGE KESSLER: But your point is, settle by just waiving your lien --

MR. TRACHTENBERG: That's what they did in this case --

JUDGE KESSLER: -- by not having a lien.

MR. TRACHTENBERG: -- to a number of people. They did offer us a judgment in this case for a number of people, and by the way, you know, this is the -- the illegality of demanding this money. I mean, I'm sorry. I'm just going to

use the mugger because it's easy for me to understand, not for you. I'm the one who is dense.

JUDGE NORRIS: No, you're not.

MR. TRACHTENBERG: You know, look, if you mug somebody and then -- and then they turn around and sue you, and you let them keep a little bit of money and they turn around and sue you, you obviously can't say, "Well, you know, we entered this agreement." It's illegal to do that. You weren't entitled to keep and demand the money in the first place, and so I think that that is important. They weren't entitled to keep and demand -- to demand this money.

That made it -- by the way, makes it very different from Shelton. Shelton talks about -- talks about the statute that says you can't sue, but this Court, this Court held in -- while I'm making good use of this limited time. This Court held in Bentigvegna v Power Steel, which is 206 Ariz. 581, at paragraph 20. That the statute doesn't prevent the contractor from keeping the money. The statute prevents the contractor from filing the lawsuit.

This case involves somebody who is collecting money who it's illegal to do it under federal law. There is no uncertainty in the law. There is -- we didn't get a chance to develop the facts. The fact that there were attorneys involved is a non sequitur. The fact is, there are clients who needed money. During this case, he points to the fact that, well, we

know they could have filed a lawsuit. After all, that's what they did with the open-lien Plaintiffs.

JUDGE NORRIS: Well, I have --

MR. TRACHTENBERG: The jury in this case, people said, I give up. I give up. I can't hold on any longer. I need AHCCCS.

JUDGE NORRIS: Well, and the point you make about counsel of Spectrum, that agreement was negotiated with counsel involvement.

MR. TRACHTENBERG: Indeed it was, and it was blessed by the court --

JUDGE NORRIS: Right.

MR. TRACHTENBERG: -- in addition to that.

JUDGE NORRIS: Yeah. Yeah.

JUDGE KESSLER: But there wasn't a lien statute there, right?

MR. TRACHTENBERG: There was a lien statute in the State of -- in the State of -- in that state?

JUDGE KESSLER: Where did -- I read that case, and it seemed to me that in Spectrum, they indicated there wasn't a statute allowing the lien.

MR. TRACHTENBERG: I believe what they were saying was there was a state statute prohibiting the conduct, but there was a -- there is a -- there exists in that state a traditional healthcare provider lien statute. I don't believe

there's many states without them. They're pretty standard.

JUDGE NORRIS: We'll check Spectrum.

MR. TRACHTENBERG: And by the way, the -- if you read Blankenbaker, you'll see that the purpose of those lien statutes isn't to fill some gap. It's not -- you know, it's not to do anything like that. It's the purpose. As the Supreme Court said in Blankenbaker, it is to protect medical providers against "non-paying persons." People who don't pay at all. It's not to add to the coffers.

We did say, you asked about the opening brief during my comments, and you said, "Well, did you bring up these undue influence in your opening brief?" We did at page two, where we discussed ER 1.15, and how as soon as there is a lien on ER 1.15, you're hosed. We also brought up the fact that there is fraud. That the AHCCCS website calls this fraud for them to do this.

AHCCCS calls it fraud. We put in the record, subsequently, the affidavit of Jim Botsko, the former AHCCCS general who said, I wasn't aware this was going on and this is not right. This is illegal.

Your Honors, I'm not going to drone on, but I will say this: The other -- fact I want to mention is 447.15, it wasn't just invoked or came into power -- came into existence after the state enacted this law. 447.15 has been the law since 1968, for 40 -- for 40-some years, 46 years in one form

or another. It was de-labeled (sic).

JUDGE NORRIS: That's the regulation; that's one that came in?

MR. TRACHTENBERG: Yes. That's the federal --

JUDGE NORRIS: Okay.

MR. TRACHTENBERG: -- regulation in one form or another. And a number of other states, as I said, tried passing laws at the urging of the hospitals, the hospitals lobbied to get regulations passed in Florida and Louisiana, and then state's -- the hospitals repeatedly tried in California, and time after time the Court said no, you cannot do this.

I won't even try to say something in ten seconds. Thank you very much.

JUDGE KESSLER: Thank you, counsel, for your arguments and thank you for your briefs. Let me add a personal note on the briefs. Go ahead and have a seat.

The briefs were -- substantively, were very helpful, and I know -- and so I don't want to make this a big deal, but I notice that in both sets of briefs, you dropped almost all of your authorities in footnotes and not the case record. I don't care about that.

JUDGE NORRIS: Well, I do care about that when it's on the footnotes.

JUDGE KESSLER: But I -- which we do, we're talking about footnotes. And I'll tell you, I know there is a theory

out there that, oh, drop all of your authorities in the footnotes, and I'll tell you that almost every judge I've talked to has the same reaction I do. Please don't do that, and spread the word to others.

JUDGE NORRIS: And there's actually a practical reason, and the reason is that now that everyone is -- has everything on either an iPad or on Ultrabook or something like that, you have to scroll up and down, up and down, up and down to be able to get to the citations in the footnote.

MR. TRACHTENBERG: You will be pleased to know that this was something we've talked about and we debated --

JUDGE NORRIS: I bet you lost an hour --

MR. TRACHTENBERG: -- and so a couple --

JUDGE NORRIS: -- so there --

JUDGE KESSLER: And again, it's --

MR. TRACHTENBERG: No, I appreciate that.

JUDGE KESSLER: -- it's a side note.

JUDGE PORTLEY: Well, you know what blind gardeners say. Stop it.

JUDGE KESSLER: Right. Right. It's more important the substance of the briefs were very well done and we appreciate that, so I didn't want the opportunity to go by without at least raising this issue of the footnotes.

MR. TRACHTENBERG: Thank you.

MR. ARTIGUE: Thank you.

JUDGE KESSLER: So thank you, counsel. We will take this matter under advisement and issue a decision in due course.

We stand adjourned.

JUDGE NORRIS: Thank you.

(Proceedings concluded)

CERTIFICATE

AVTranz has a current transcription contract with the Maricopa County Superior Court under contract # 13010-RFP, as such, AVTranz is an "authorized Transcriber".

I, Harold Ferguson, a court-approved proofreader, do hereby certify that the foregoing is a correct transcript from the official electronic sound recording of the proceedings in the above-entitled matter, to the best of my professional skills and abilities.

TRANSCRIPTIONIST: J. MARIE MORAN

/s/
Harold Ferguson December 11, 2014
Proofreader

EXHIBIT 2

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF ARIZONA

Bobby Aycock, et al., Plaintiffs, v. Scottsdale Healthcare Corporation, et al., Defendants.	No. CV-14-01483-PHX-DLR **ORDER**

This matter having come before the Court on a Stipulation for Entry of a Consent Judgment (Doc. 47), and the Court having reviewed the matter and finding good cause,

IT IS HEREBY ORDERED, ADJUDGED AND DECREED that:

1. From the date of this Consent Judgment forward, Defendant Dignity Health ("Dignity") is permanently enjoined from enforcing or asserting health care provider liens, pursuant to A.R.S. § 33-931 *et seq.*, against a Medicare Advantage enrollee's personal injury recovery, settlement or judgment proceeds after having received any payment from their Medicare Advantage Organization (as defined by 42 C.F.R. § 422.2 or other applicable Medicare Advantage statutes and regulations) for their medical care; *except however*, that Dignity may enforce or assert such health care provider liens for the purpose of collecting unpaid cost sharing (as defined by 42 C.F.R. § 422.2 or other applicable Medicare Advantage statutes and regulations) ("cost sharing") owed by that enrollee. Dignity shall not shall not seek or demand any payment, pursuant to A.R.S. § 33-931 *et seq.*, from a Medicare Advantage enrollee's personal injury recovery,

settlement or judgment proceeds that is in excess of unpaid cost sharing owed by that enrollee.

2. Dignity shall not be required to identify and release any pending liens recorded prior to the date of this Consent Judgment. If, however, a Medicare Advantage enrollee, or their representative, submits a written request (including a request by e-mail) after the date of this Consent Judgment that a lien be released pursuant to Paragraph 1 of this Consent Judgment, Dignity shall record a release within seven (7) calendar days of the request. Such requests may be emailed to pgill@gblaw.com.

3. From the date of this Consent Judgment forward, if Dignity inadvertently accepts money to satisfy a health care provider lien in violation of Paragraph 1 of this Consent Judgment, then Dignity shall return any excess monies paid to satisfy the lien within fourteen (14) calendar days of a written request (including a request by e-mail) by the Medicare Advantage enrollee (or their representative) to do so. Such requests may be sent in the same manner as provided in Paragraph 2. This Paragraph 3 shall not apply to any monies paid to Dignity before the date of this Consent Judgment.

4. In the event the Medicare Advantage statutes or regulations are subsequently amended, or the Arizona Court of Appeals, the Arizona Supreme Court, the Arizona District Court, the Ninth Circuit or the United States Supreme Court enters a decision allowing a healthcare provider to record and/or enforce healthcare provider liens against liability settlement proceeds, judgment proceeds, third party liabilities and/or recoveries from third parties, or for any other equitable reason under Rule 60 of the Federal Rules of Civil Procedure, Dignity may move this Court to vacate this Consent Judgment by stipulation of the parties, pursuant to Federal Rule of Civil Procedure 60 or by other available remedy.

5. Plaintiffs' claims in this action against Dignity, including, but not limited to, breach of contract, declaratory relief and injunctive relief are hereby dismissed with prejudice.

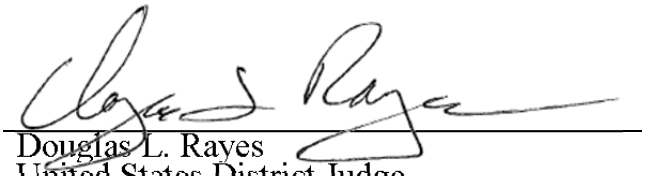
6. Dignity's Motion to Dismiss for Lack of Jurisdiction and Alternative

Motion to Deny Class Certification (Doc. 39) is denied as moot.

7. Plaintiffs and Dignity agree that each shall bear their own attorneys' fees and costs in connection with this Consent Judgment and the disposition of claims against Dignity only.

8. The Court hereby directs that this Consent Judgment be entered by the Clerk of the Court forthwith as a final judgment.

Dated this 10th day of December, 2014.

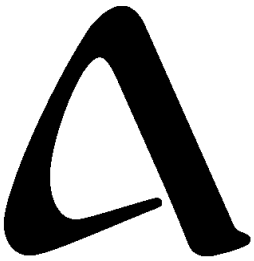


Douglas L. Rayes
United States District Judge

EXHIBIT 3

Chapter 4

Fee-for-Service General Billing Rules



AHCCCS

GENERAL INFORMATION

This chapter contains general information related to AHCCCS billing rules and requirements. Policies regarding submission and processing of fee-for-service claims are communicated to providers via such channels as this AHCCCS Fee-For-Service Provider Billing Manual and the Claims Clues.

Claims must meet AHCCCS requirements for claims submission. In the absence of specific policies, AHCCCS endeavors to follow Medicare policy guidelines as closely as possible.

In addition to Medicare requirements, AHCCCS follows the coding standards described in the UB-04 Manual; International Classification of Diseases, 9th and 10th Revisions (ICD-9, ICD-10) Manual; Physicians' Current Procedural Terminology (CPT) Manual; Health Care Procedure Coding System (HCPCS) Manual; the CDT Manual for dental (Current Dental Terminology) as well as the First Data Bank Blue Book for pharmacy information.

CLAIM SUBMISSION REQUIREMENTS

Claims for services must be legible and submitted on the correct form for the type of service billed. Claims that are not legible or are not submitted on the correct form will be returned to providers without being processed. If a claim is returned, you must refile a legible copy of the claim on the correct type of claim form and submit it within the required time frame.

AHCCCS retains a permanent electronic image of all paper claims submitted, requiring providers to file clear and legible claim forms.

Claims or copies that contain highlighter or color marks, copy overexposure marks, or dark edges are not legible on the imaging system. Liquid paper correction fluid ("White Out") may not be used. Permanent self-adhesive correction tape must be used to cover information that should not appear on the claim.

Any documentation submitted with a claim or subsequent to the submission of a claim also is imaged and linked to the claim image. Documentation is not required when resubmitting claims if the required documentation was submitted with an earlier version of the claim and the claim number is referenced on the resubmitted claim.

All paper claims should be mailed, with adequate postage, to:

AHCCCS Claims
P.O. Box 1700
Phoenix, AZ 85002-1700

AHCCCS also accepts HIPAA-compliant 837 electronic fee-for-service claims from all certified submitters. Providers and clearinghouses must successfully complete testing to be certified to submit 837 transactions. For EDI inquiries, roster issues or to become an AHCCCS Trading Partner, please email to EDICustomerSupport@azahcccs.gov

Claims may also be submitted through the AHCCCS on-line claim submission process.

CLAIM SUBMISSION TIME FRAMES

In accordance with ARS §36-2904 (H), an initial claim for services provided to an AHCCCS recipient must be received by AHCCCS not later than 6 months from the date of service, unless the claim involves retro-eligibility. For hospital inpatient claims, "date of service" means the date of discharge of the patient.

Claims initially received beyond the 6-month time frame, except claims involving retro-eligibility, will be denied.

If a claim is originally received within the 6-month time frame, you have up to 12 months from the date of service to correctly resubmit the claim in order to achieve clean claim status or to adjust a previously processed claim, unless the claim involves retro-eligibility. If a claim does not achieve clean claim status or is not adjusted correctly within 12 months, AHCCCS is not liable for payment.

As defined by ARS §36-2904 (H)(1) a "clean claim" is:

> A claim that may be processed without obtaining additional information from the provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

PRIOR QUARTER COVERAGE ELIGIBLE

Effective 1/1/2014 AHCCCS is required to expand the time period AHCCCS pays for covered services for an eligible individual, to include the three months prior to the month the individual applied for AHCCCS, if the individual met the eligibility requirements during the month when the Medicaid service was provided.

Federal requirements provide that an applicant may be eligible for covered services during any of the three months prior to the Medicaid application date if the applicant:

1. received one or more AHCCCS covered services during the month and

2. would have qualified for AHCCCS at the time services were received if the person had applied for Medicaid.

The AHCCCS Administration will determine whether or not an applicant meets prior quarter coverage criteria.

If the applicant meets the prior quarter coverage criteria, providers will be required to bill the AHCCCS Administration for services provided during a prior quarter eligibility period upon verification of eligibility or upon notification from the recipient of prior quarter coverage eligibility.

Upon notification of prior quarter coverage eligibility, R9-22-703 ***requires*** the provider to promptly refund to the recipient any payments that have been received for services in an approved prior quarter period and must accept payment by AHCCCS as payment in full. Providers failing to reimburse a recipient for any payments made by the recipient will be referred to the AHCCCS Office of Inspector General for investigation and action.

For covered services received during the prior quarter which have not yet been reimbursed or billed the provider must submit a claim to the AHCCCS Administration.

AHCCCS Managed Care Contractors are ***not*** responsible for determining prior quarter coverage or for payment for covered services received during the prior quarter. Claims submitted to AHCCCS Managed Care Contractors for prior quarter coverage will be denied.

Providers may submit prior quarter coverage claims for payment to AHCCCS in one of the following ways:

1. the HIPAA compliant 837 transaction, or

2. through the AHCCCS on-line claim submission process, or

3. by submitting a paper claim form.

All providers, including RHBA and TRHBA providers must submit a claim directly to the AHCCCS Administration. Pharmacy point of sale claims must be submitted to the Pharmacy Benefits Manager, Med Impact.

RETRO-ELIGIBILITY

Retro-eligibility affects a claim when no eligibility was entered in the AHCCCS system for the date(s) of service but at a later date eligibility was posted retroactively to cover the date(s) of service.

Fee-for-service claims are considered timely if the initial claim is received by AHCCCS not later than 6 months from the AHCCCS date of eligibility posting. Claims must attain clean claim status no later than 12 months from the AHCCCS date of eligibility posting.

Adjustments to paid claims must be received no later than 12 months from the AHCCCS date of eligibility posting. This time limit does not apply to adjustments which would decrease the original AHCCCS payment due to collections from third party payers.

BILLING AHCCCS RECIPIENTS

Arizona Revised Statute §36-2903.01(K) prohibits providers from billing AHCCCS recipients, including QMB Only recipients, for AHCCCS-covered services:

> Upon oral or written notice from the patient that the patient believes the claims to be covered by the system [AHCCCS], a provider or nonprovider of health and medical services prescribed in §36-2907 shall not do either of the following unless the provider or nonprovider has verified through the administration that the person has been determined ineligible, has not yet been determined eligible or was not, at the time services were rendered, eligible or enrolled:
>
> 1. Charge, submit a claim to, or demand or otherwise collect payment from a member or person who has been determined eligible unless specifically authorized by this article or rules adopted pursuant to this article.
> 2. Refer or report a member or person who has been determined eligible to a collection agency or credit reporting agency for the failure of the member or person who has been determined eligible to pay charges for system covered care or services unless specifically authorized by this article or rules adopted pursuant to this article.

Note: "QMB Only" is a Qualified Medicare Beneficiary under the federal program but does not qualify for Medicaid. Under A.A.C. R9-29-301 AHCCCS shall only reimburse the provider for the Medicare deductible/copay/coinsurance amount when Medicare pays first. (refer to Chapter 9)

RESUBMISSIONS, REPLACEMENTS, AND VOIDS

The AHCCCS Claims Processing system will deny claims with errors that are identified during the editing process. These errors will be reported to you on the AHCCCS Remittance Advice. You should correct claim errors and resubmit claims to AHCCCS for processing within the 12-month clean claim time frame (See Chapter 26, Correcting Claim Errors).

When **resubmitting a denied claim**, you must submit a new claim form containing all previously submitted lines. The original AHCCCS Claim Reference Number (CRN) must be included on the claim to enable the AHCCCS system to identify the claim being resubmitted. Otherwise, the claim will be entered as a new claim and may be denied for being received beyond the initial submission time frame.

You do ***not*** need to resubmit documentation unless specifically requested to do so.

You will **resubmit** a corrected claim when the original claim was denied or partially denied.

To **resubmit** a denied CMS 1500 claim:

Enter "A" in Field 22 (Medicaid Resubmission Code) and the CRN of the denied claim in the field labeled "Original Ref. No."

Resubmit the claim in its entirety, including all original lines if the claim contained more than one line.

Note: Failure to include all lines of a multiple-line claim will result in recoupment of any paid lines that are not accounted for on the resubmitted claim.

Example:

You submit a three-line claim to AHCCCS. Lines 1 and 3 are paid, but Line 2 is denied.

When resubmitting the claim, you should resubmit all three lines. If only Line 2 is resubmitted, the AHCCCS system will recoup payment for Lines 1 and 3.

To **resubmit** a denied UB-04 claim:

Write the word "Resubmission" and the CRN of the denied claim in the "Remarks" field (Field 84).

If Field 84 is used for other purposes, write the word "Resubmission" and the CRN at the top of the claim form.

To **resubmit** a denied ADA 2006 claim enter the CRN of the denied claim in Field 2 (Predetermination/Preauthorization Number).

After a claim has been paid by AHCCCS, errors may be discovered in the amounts or services that were billed. These errors may require submission of an **replacement to the paid claim**. For example, you may discover that additional services should be billed for a service span or that incorrect charges were entered on a claim paid by AHCCCS.

When adjusting a paid claim, you must submit a new claim **replacement** containing all previously submitted lines. If any previously paid lines are blanked out, the AHCCCS system will assume that those lines should not be considered for reimbursement, and payment will be recouped.

The original CRN must be included on the **replacement** claim to enable the AHCCCS system to identify the claim to be adjusted. Otherwise, the claim will be entered as a new claim and may be denied for being received beyond the initial submission time frame or for being a duplicate of a previously paid claim.

Every field can be changed on the **replacement** claim except the service and billing provider ID number and tax ID number. If these must be changed, you must void the claim and submit a new claim.

To **replace** a paid CMS 1500 claim:

Enter “A” in Field 22 and the CRN of the claim to be adjusted in the field labeled "Original Ref. No."

Resubmit the claim in its entirety, including all original lines if the claim contained more than one line.

Note: Failure to include all lines of a multiple-line claim will result in recoupment of any paid lines that are not accounted for on the resubmitted claim.

Example:

You submit a three-line claim to AHCCCS. All three lines are paid.

You discover an error in the number of units billed on Line 3 and submit an adjustment.

When submitting the adjustment, you should resubmit all three lines. If only Line 3 is resubmitted, the AHCCCS system will recoup payment for Lines 1 and 2.

An adjustment for additional charges to a paid claim must include all charges -- the original billed charges plus additional charges.

Example:

You bill for two units of a service with a unit charge of $50.00 and are reimbursed $100.00. After receiving payment, you discover that three units of the service should have been billed.

When adjusting the claim, you should bill for three units and total billed charges of $150.00 (3 units X $50.00/unit). The AHCCCS system will pay the claim as follows:

Allowed Amount (3 units)	$150.00
Previously Paid to Provider	<$100.00>
Reimbursement	$ 50.00

If you billed for the one additional unit at $50.00, the AHCCCS system would recoup $50.00 as shown below:

Allowed Amount (1 unit)	$50.00
Previously Paid to Provider	<$100.00>
Reimbursement (Amount recouped)	<$ 50.00>

To **replace** a paid UB-04 claim:

Write the word "Adjustment" and the CRN of the claim to be adjusted in the "Remarks" field (Field 84).

If Field 84 is used for other purposes, write the word "Adjustment" and CRN at the top of the claim form.

To **replace** a paid ADA 2006 claim enter the CRN of the denied claim in Field 2 (Predetermination/Preauthorization Number).

When **voiding a claim**, you should submit documentation stating the reason for the void. Only the provider who submitted the original claim may void the claim. When a claim is voided, all payment is recouped. This process should only be used when there is no other alternative.

Unlike resubmissions and adjustments, you should submit only the line(s) to be voided. Lines that should be not be voided should be blanked out to avoid recoupment of payment for those lines.

To **void** a paid CMS 1500 claim enter "V" in Field 22 (Medicaid Resubmission Code) and the CRN of the claim to be voided in the "Original Ref. No." field.

To **void** a paid UB-04 claim:

Use bill type XX7 (for example 117, 727, etc.) and enter the CRN of the claim to be voided in the "Remarks" field (Field 84).

If Field 84 is used for other purposes, write the CRN at the top of the claim form.

To **void** a paid ADA 2006 claim write the word "VOID" and enter the CRN of the paid claim to be voided in Field 2 (Predetermination/Preauthorization Number).

OVERPAYMENTS

A provider must notify AHCCCS of an overpayment on a claim by submitting an adjustment to the paid claim. Providers should attach documentation substantiating the overpayment, such as an EOB if the overpayment was due to payment received from a third party payer.

The claim will appear in the Adjusted Claims section of the Remittance Advice showing the original allowed amount and the new (adjusted) allowed amount.

Do NOT send a check for the overpayment amount. The claim must be adjusted and the overpaid amount will be recouped.

GENERAL AHCCCS BILLING RULES

Most of the rules for billing AHCCCS follow those observed by Medicare and other third party payers. However, the following requirements are emphasized by AHCCCS.

Billing must follow completion of service delivery. A claim may cover a time span over which service was provided, but the last date of service billed must be prior to or the same date that the claim is signed.

Billing multiple units:

If the same procedure is provided multiple times on the same date of service, the procedure code must be entered once on the claim form.

The units field is used to specify the number of times the procedure was performed on the date of service.

The total billed charge is the unit charge multiplied by the number of units.

Medicare and third party payments

By law, AHCCCS has liability for payment of benefits after all other third party payers, including Medicare.

You must determine the extent of third party coverage and bill all third party payers prior to billing AHCCCS.

NOTE: See Chapter 9, Medicare/Other Insurance Liability.

Age, gender and frequency-based service limitations:

AHCCCS imposes some limitations on services based on recipient age and/or gender.

Some procedures have a limit on the number of units that can be provided to a recipient during a given time span.

AHCCCS may revise these limits as appropriate.

All claims are considered non-emergent and subject to applicable prior requirements unless the provider clearly identifies the service billed on the claim form as an emergency.

On the UB-04 claim form, the Admit Type (Field 19) must be "1" (emergency) or "4" (newborn) on all emergency inpatient and outpatient claims.

All other Admit Types, including a "2" for urgent, designate the claim as non-emergent.

On the CMS 1500 claim form, Field 24 C must be marked to indicate that the service billed on a particular claim line was an emergency.

AHCCCS staff will review ADA 2006 dental claims for adults to determine if the service provided was emergent. Note: Adults are eligible for emergency dental services only. (refer to Chapter 10 Dental Services for coverage limitations.)

Recoupment

A.R.S. §36-2903.01 L. requires AHCCCS to conduct post-payment review of all claims and recoup any monies erroneously paid.

Under certain circumstances, AHCCCS may find it necessary to recoup or take back money previously paid to a provider.

Overpayments and erroneous payments are identified through reports, medical review, grievance and appeal decisions, internal audit review, and provider-initiated recoupments.

Upon completion of the recoupment, the Remittance Advice Adjusted Claims will detail the action taken.

If payment is recouped for a reason other than third party recovery (e.g., no medical documentation to substantiate services rendered), you will be afforded additional time to provide justification for re-payment as outlined below.

In the case of recoupments, the time frame for submission of a clean claim differs from the time frames described earlier in this chapter.

The time span allowed for submission of a clean claim will be the *greatest* of:

- ☒ Twelve months from the date of service, or
- ☒ Twelve months from the date of eligibility posting for a retro-eligibility claim, or
- ☒ Sixty days from the date of the adverse action.

If recoupment is initiated by the AHCCCS Office of Inspector General (OIG) as a result of identified misrepresentation, you will not be afforded additional time to resubmit a clean claim. (refer to Chapter 28 Claim Disputes)

Additional billing rules

Do not submit double-sided multiple-page claims. Each claim page must be on a separate piece of paper with the pages numbered (e.g., 1 of 3, 2 of 3, 3 of 3).

To ensure that all pages of a multiple-page UB-04 claim are processed as a single claim the pages should be numbered (e.g., 1 of 3, 2 of 3, 3 of 3). All pages should be clipped or rubber-banded together (do not staple). Totals should not be carried forward onto each page. The "001" total should be entered on the last page only.

AHCCCS will key revenue and procedure codes billed with zero charges. However, revenue codes with zero charges will not be considered for reimbursement.

Mothers and newborns

Newborns whose mothers are AHCCCS recipients are eligible for AHCCCS services from the time of delivery.

Newborns receive separate AHCCCS identification numbers, and services for a newborn must be billed separately using the newborn's AHCCCS ID.

Services for the newborn that are included on the mother's claim will be denied.

Contact the AHCCCS Verification Unit for newborn eligibility and enrollment information (See Chapter 2, Eligibility).

Change in recipient eligibility

If the recipient is ineligible for any portion of a service span, those periods should not be billed to AHCCCS.

If a recipient’s eligibility changes, each eligible period should be billed separately to avoid processing delays.

Change in reimbursement rate

It is not necessary to split bill an inpatient hospital claim when the claim dates of service span a change in the inpatient hospital reimbursement rates.

Reimbursement of inpatient claims is based on the rate in effect on the admission date.

When a hospital outpatient claim is submitted with dates of service that span a change in the hospital outpatient reimbursement rate, the claim must be split.

DOCUMENTATION REQUIREMENTS

Medical review is a function of the AHCCCS Claims Department and is performed to determine if services are provided according to AHCCCS policy related to medical necessity and emergency services. Medical review also is performed to audit appropriateness, utilization, and quality of the service provided

In order for this medical review to take place, providers may be asked to submit additional documentation for fee-for-service CMS 1500 claims identified in the AHCCCS claims processing system as near duplicate claims. The documentation is necessary to allow the AHCCCS Medical Review staff to determine whether it is appropriate to reimburse multiple providers for the same service on the same day.

Near duplicate claims are claims for the same procedure, same day, same recipient, and different providers.

Near duplicate claims for certain evaluation and management (E&M) codes (e.g., emergency room visits, critical care visits, newborn care, and hospital visits) may pend for review. If the documentation substantiates the services, Medical Review staff will release the claim for payment, assuming that the claim has not failed any other edits.

If no medical documentation is submitted, Medical Review staff will deny the claim with a denial reason specifying what documentation is required. For example, a claim may be denied with Medical Review denial code "MD008 - Resubmit with progress notes." Providers will not receive a letter requesting documentation because the denial codes are very specific as to what is required.

It is expected that certain E&M codes such as 90491 (Critical care, evaluation and management) and 90431-90433 (Subsequent hospital care) will frequently fail the near duplicate edit because it is feasible that a recipient could be seen by more than one provider on the same day. However, each provider must submit documentation substantiating the necessity for his or her services.

Example:

Provider A, a pulmonologist, and Provider B, a cardiologist, both see Mr. Jones in ICU on April 22. Both providers bill AHCCCS for CPT Code 90491 for April 22 for Mr. Jones.

Either claim may fail the near duplicate edit and pend to Medical Review. The Medical Review nurse will review the documentation submitted with the claim. In this case, the nurse would expect to find a critical care progress note from the provider.

If no medical documentation is provided, the Medical Review nurse will deny the claim with denial code "MD008 - Resubmit with progress notes."

While it is impossible to offer specific guidelines for each situation, the following table is designed to give providers some general guidance regarding submission of documentation. Also, not all fee-for-service claims submitted to AHCCCS are subject to Medical Review.

CMS 1500 Claims		
Billing For	**Documents Required**	**Comments**
Surgical procedures	History and physical, operative report	
Missed abortion/ Incomplete abortion Procedures (all CPT codes)	History and physical, ultrasound report, operative report, pathology report	Information must substantiate fetal demise.
Emergency room visits	Emergency room record	Billing physician's signature must be on ER record
Anesthesia	Anesthesia records	Include begin and end time
Pathology	Pathology reports	
E&M services	Progress notes, history and physical, office records, discharge summary, consult reports	Documentation should be specific to code billed
Radiology	X-ray/Scan reports	
Medical procedures	Procedure report, history and physical	Examples: Cardiac catheterizations, Doppler studies, etc.
UB-04 Claims		
Billing for	**Documents Required**	**Comments**
Observation	All documents required by statute and observation records	If labor and delivery, send labor and delivery records
Missed abortion/Incomplete abortion	All documents required by statute, ultrasound report, operative report, pathology report	Information must substantiate fetal demise
NICU/ICU tier claims	All documents required by statute	MD orders and MD progress notes to substantiate level of care billed
Outlier	All documents required by statute	

Note: AHCCCS requires all claims related to hysterectomy and sterilization procedures be submitted with the respective consent forms. See Chapter 10 for specific information in the respective sections Hysterectomy and Family Planning.

DOCUMENTATION REQUIREMENTS (CONT.)

Providers should *not* submit the following unless specifically requested to do so:

Emergency admission authorization forms

Patient follow-up care instructions

Nurses notes

Blank medical documentation forms

Consents for treatment forms

Operative consent forms (Exception: bilateral tubal ligation and hysterectomy)

Ultrasound/X-ray films

Medifax information

Nursing care plans

Medication administration records (MAR)

DRG/Coding forms

Medical documentation on prior authorized procedures/hospital stays

Entire medical records

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