PALOMAR MEDICAL CENTER, Plaintiff, v. KATHLEEN SEBELIUS, Secretary of the United States Department of Health and Human Services, Defendant.

Civil No. 09cv605 BEN (NLS)

UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF CALIFORNIA

2010 U.S. Dist. LEXIS 76089

May 11, 2010, Decided
May 11, 2010, Filed

SUBSEQUENT HISTORY: Stay denied by *Palomar Med. Ctr. v. Sebelius, 2010 U.S. Dist. LEXIS 76086 (S.D. Cal., July 28, 2010)*
Adopted by, Summary judgment denied by, Summary judgment granted by *Palomar Med. Ctr. v. Sebelius, 2010 U.S. Dist. LEXIS 76093 (S.D. Cal., July 28, 2010)*

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For Secretary of HHS Kathleen Sebelius, Defendant: Joshua Wilkenfeld, LEAD ATTORNEY, United States Department of Justice, Washington, DC; Thomas B Reeve, Jr, LEAD ATTORNEY, U S Attorneys Office Southern District of California, San Diego, CA.

JUDGES: Hon. Nita L. Stormes, United States District Court Magistrate Judge.

OPINION BY: Nita L. Stormes

OPINION

REPORT AND RECOMMENDATION FOR ORDER:

(1) DENYING PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT [Doc. No. 19]; and

(2) GRANTING DEFENDANT'S CROSS MOTION FOR SUMMARY JUDGMENT [Doc. No. 24].

INTRODUCTION

Under the Medicare program, plaintiff Palomar Medical Center (Plaintiff), was reimbursed for medical services provided to John Doe. [1] Under the Medicare Recovery Audit Contractor program, defendant Kathleen Sebelius, as Secretary **[*2]** for the Department of Health and Human Services (Secretary or Defendant), reopened Plaintiff's Medicare claim for John Doe, and subsequently determined the claim was overpaid. Plaintiff filed suit against the Secretary, asserting that the reopening was procedurally invalid because the Secretary failed to show good cause to reopen the claim.

> 1 John Doe is an alias for the patient whose care is at issue. He is not a party to this action and his identity is not relevant to the instant claims. He has been de-identified in compliance with Title II of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Pub. L. No. 104-191, 110 Stat, 1936, 1991.

The Secretary disagrees and asserts that under the Medicare regulations, a decision whether to reopen a claim is not appealable. The Secretary also argues that if the court finds the decision to reopen is appealable, Plaintiff did not exhaust its administrative remedies as to whether there was good cause to reopen the claim, and

thus the issue should be remanded to the Medicare Appeals Council.

Judge Benitez referred the case to Judge Stormes for report and recommendation. The parties filed these cross summary judgment motions. Having [*3] considered all the papers submitted, the Court **RECOMMENDS** that Plaintiff's Motion for Summary Judgment be **DENIED** and Defendant's Motion for Summary Judgment be **GRANTED.**

BACKGROUND

1. The Medicare Program.

The Medicare program, as established by Title XVIII of the Social Security Act, *42 U.S.C. §§ 1395 et seq.,* reimburses health care providers for medical care provided to eligible aged and disabled persons. The Medicare program is administrated by the Centers of Medicare and Medicaid Services (CMS) on behalf of the Secretary. The CMS contracts with entities known as "fiscal intermediaries" (FIs) to act as the Secretary's agents in administering the program. *See 42 U.S.C. § 1395h.* Generally, FIs are private insurance companies. *Cedars-Sinai Medical Center v. Shalala, 939 F. Supp. 1457, 1460 (C.D. Cal. 1996).*

After providing a medical service, hospitals or other institutional health care providers can request payment from CMS through an FI. The FI will then issue an "initial determination" to decide whether the claims are for covered services, and if so, the appropriate amount for reimbursement. *42 U.S.C. § 1395ff(a); 42 C.F.R. § 405.920.* A provider dissatisfied with an initial determination [*4] may seek a "redetermination" from the FI. *42 C.F.R. § 405.940.* A provider dissatisfied with a redetermination may seek a "reconsideration" from a separate Medicare contractor, a Qualified Independent Contractor (QIC). *42 C.F.R. § 405.960.* A provider dissatisfied with a reconsideration may appeal to an Administrative Law Judge (ALJ), and thereafter, to the Medicare Appeals Council (MAC). 42 C.F.R. § 405.100 *et seq.; 42 C.F.R. § 405.1100 et seq.* "MAC decisions constitute the final decision of the Secretary and can be appealed to a Federal court." *70 Fed. Reg. 11421 (Mar. 8, 2005).*

2. Reopening of a Claim Under the Recovery Audit Contractor Program.

Congress enacted a three-year demonstration program (from March 2005 to March 2008) "to detect and correct improper payments [*i.e.,* overpayments or underpayments]." [2] CMS, RAC Demonstration, *available at* http://www.cms.hhs.gov/RAC/02_ExpansionStrategy.asp (last visited 4/22/2010). On April 27, 2007, PRG-Schultz, the Medicare Recovery Audit Contractor (RAC) in California, initiated an audit of Medicare claims reimbursed to Plaintiff for services rendered to John Doe in 2005. (AR pp. 3-4, 276-278.) On July 10, 2007, PRG-Schultz reopened Plaintiff's [*5] claim and notified Plaintiff that it had been overpaid $ 7,992.92, and that it must reimburse the overpayment. [3] (AR p. 4, 24, 273-274.) On September 29, 2007, Plaintiff appealed the overpayment determination and requested a redetermination. (AR pp. 24, 43.) On December 18, 2007, the FI issued an unfavorable redetermination, stating the medical services provided were not medically necessary. (AR p. 43.) On January 31, 2008, Plaintiff requested a reconsideration. (AR p. 43.) The QIC upheld the denial in a reconsideration decision. (AR p. 4.)

2 The RAC program has since been made permanent. *See 42 U.S.C. § 1395ddd(h).*

3 A reopening is defined as a remedial action taken to change a final determination or decision that resulted in either an overpayment or underpayment, even though the determination or decision was correct based on the evidence in the record. *See 42 C.F.R. § 405.980(a)(1).*

3. The ALJ Decision.

On May 27, 2008, Plaintiff requested an ALJ hearing. (AR p. 44.) On August 12, 2008, a telephonic hearing was held. (AR p. 44.) The ALJ agreed with the FI and QIC that the services Plaintiff rendered to John Doe were not medically necessary. (AR p. 57.) The ALJ, however, reinstated the [*6] initial determination and reversed the overpayment on the sole basis that he found "the RAC . . . failed to establish good cause for reopening [the] decision" and therefore ". . . failed to satisfy regulatory requirements . . ." (AR pp. 54, 57.) The ALJ held that (i) good cause was required to reopen the claim; (ii) the ALJ had jurisdiction to consider whether the reopening was supported by good cause; and (iii) PRG-Schultz had not sufficiently asserted such good cause. (AR pp. 43-58.)

The ALJ reasoned he had jurisdiction to consider whether a contractor complied with the Medicare regulations in reopening the claim because without such a review, "there would be no process by which a provider could challenge the legality of a specific contractor reopening" and ". . . would leave an individual provider . . . with no opportunity to challenge the lawfulness of [that] particular reopening." (AR p. 54.) According to the ALJ, providers should not be denied "the right to challenge the lawfulness of a reopening, particularly where there are extant regulations that list very specific timeliness and procedural requirements." (AR p. 55.) According to the ALJ, "only the discretionary decision whether [*7] or not to reopen is shielded from review by *42 C.F.R. §*

405.980(a)(5)." (AR p.55.) Therefore, the ALJ held that the reopening was procedurally invalid and reinstated the pre-RAC initial determination to pay in full Plaintiff's request for reimbursement. (AR pp. 58-59.)

4. The Medicare Appeals Council Decision.

The Medicare Appeals Council (MAC), on its own motion, decided to review the ALJ's decision. It determined that "the ALJ erred by concluding that [Plaintiff] was entitled to payment for services rendered in that the RAC failed to show good cause for reopening the claim." (AR p. 10.) The MAC determined that "neither the ALJ nor [the MAC] [had] jurisdiction to review" the legality of the reopening because the decision to reopen "is final and not subject to appeal." (AR p. 7.) The MAC also affirmed the overpayment due to lack of medical necessity. (AR p. 14.)

The MAC explained that under *42 C.F.R. §§ 405.980(a)(5)* and *405.926(l)*, ". **[*8]** . . the ALJ did not properly have jurisdiction to address the issue of the RAC's reopening of the claim, [and therefore,] it was not appropriate for the ALJ to address the issue of whether or not the RAC had good cause to reopen the initial determination." (AR p. 10.) Further, ". . . the RAC's decision to reopen the claim is not subject to the administrative appeals process." (AR p. 10.) Also, "CMS has expressly stated that the enforcement mechanism for good cause standards lies within its evaluation and monitoring of contractor performance, not the administrative appeals process." (AR p. 7 citing *70 Fed. Reg. 11419, 11453 (Mar. 8, 2005)*.)

Accordingly, the MAC (1) reversed the ALJ's finding that he had jurisdiction to address the issue of good cause to reopen the claim; (2) affirmed the ALJ's finding that Plaintiff provided services that were not reasonable and necessary; and (3) reversed the ALJ's finding that Plaintiff is entitled to payment for services provided to the beneficiary because the RAC failed to show good cause to reopen the claim. (AR pp. 13-14.)

DISCUSSION

Plaintiff appeals the MAC's determination that the RAC's failure to show good cause for reopening a claim more than **[*9]** one year and less than four years old is not appealable. Plaintiff argues that the MAC's decision was arbitrary, capricious, and an abuse of discretion, and contends the reopening should be reversed because it was procedurally invalid. Plaintiff also asserts that the Secretary has deprived it "due process by failing to provide any forum in which [Plaintiff] may contest the legality of the reopening." (Pl.'s Mot. for Summ. J. 2:7-8.) Further, Plaintiff argues that this Court has jurisdiction to determine whether in fact there was good cause to reopen the claim.

Defendant argues that Plaintiff cannot contest the basis for reopening the claim because under *42 C.F.R. § 405.980(a)(5)* "the decision on whether to reopen is final and not subject to appeal." **[*10]** Because Plaintiff cannot appeal the lack of good cause for the reopening, Defendant argues it can only contest the subsequent decision rendered after the reopening. If the Court vacates the MAC's decision regarding appealability of the reopening of the claim, Defendant argues that Plaintiff has not exhausted its administrative remedies with regard to whether the RAC had good cause to reopen the claim because the MAC did not review the issue.

A. Standard of Review

The parties disagree on the standard of review and deference this court should afford to the Secretary's interpretation of her own regulations. Plaintiff argues the Secretary has limited discretion in construing her regulations. Specifically, Plaintiff argues that the agency's interpretation should be evaluated under *Skidmore v. Swift & Co., 323 U.S. 134, 140, 65 S. Ct. 161, 89 L. Ed. 124 (1944)*, and should be given "weight to the extent that it has the 'power to persuade, if lacking power to control.'" (Plaintiff's MSJ 8:19-22.) Plaintiff argues that "where adversarial proceedings expose ambiguity, conflict, or outright silence in the applicable regulatory framework, the Secretary's discretion in construing provisions is, quite simply and of necessity, **[*11]** limited by considerations of fairness." (Plaintiff's MSJ 8:2-9:2 (citing *Powell v. Heckler, 789 F.2d 176, 180 (3rd Cir. 1986)*). Plaintiff also argues that the agency's decision should be afforded little to no deference because the reopening of claims involves procedural considerations usually assigned to a judiciary's field of expertise, and is not within the agency's expertise. (Plaintiff's MSJ 8:23-24.) The Secretary argues that her interpretation of her regulations should be afforded substantial deference in accordance with *Thomas Jefferson University v. Shalala, 512 U.S. 504, 512, 114 S. Ct. 2381, 129 L. Ed. 2d 405 (1994)*.

Courts must defer to an agency's interpretation and application of its own rules when Congress delegates such rule-making authority to that agency. *Gonzales v. Oregon, 546 U.S. 243, 255-256, 126 S. Ct. 904, 163 L. Ed. 2d 748 (2006)*; *see Chevron, U.S.A., Inc. v. Nat'l Resources Defense Council, Inc., 467 U.S. 837, 842-844, 104 S. Ct. 2778, 81 L. Ed. 2d 694 (1984)*. Under *Chevron,*

> [i]f Congress has explicitly left a gap for the agency to fill [in a congressionally created program], there is an express delegation of authority to the agency to elu-

> cidate a specific provision of the statute by regulation. Such legislative regulations are given controlling weight unless they **[*12]** are arbitrary, capricious, or manifestly contrary to the statute.

467 U.S. at 843-844. If "the legislative delegation to an agency on a particular question is implicit rather than explicit, . . . a court may not substitute its own construction of a statutory provision for a reasonable interpretation made by the administrator of an agency." *Id. at 844*. Therefore, an agency's interpretation of a statute must be affirmed if Congress made an express delegation to the agency and the agency's construction is not arbitrary, capricious or manifestly contrary to the statute. *See Johnson v. Buckley, 356 F.3d 1067, 1073 (9th Cir. 2004)*.

Moreover, an agency's interpretation of its own regulations must be given substantial deference:

> We must give substantial deference to an agency's interpretation of its own regulations. [Citation.] . . . [T]he agency's interpretation must be given "controlling weight unless it is plainly erroneous or inconsistent with the regulation." [Citation.] In other words, we must defer to the Secretary's interpretation unless an "alternative reading is compelled by the regulation's plain language or by other indications of the Secretary's intent at the time of the regulation's **[*13]** promulgation."

Thomas Jefferson University v. Shalala, 512 U.S. 504, 512, 114 S. Ct. 2381, 129 L. Ed. 2d 405 (1994).

Here, the regulations at issue are not ambiguous because they specifically state in two different subsections that a decision to reopen is not appealable:

> 1. "Actions that are not initial determinations and are not appealable under this subpart include . . . [a] contractor's, QIC's, ALJ's, or MAC's determination or decision to reopen or not to reopen an initial determination, redetermination, reconsideration, hearing decision, or review decision" (*42 C.F.R. § 405.926(l)*); and
>
> 2. "The contractor's, QIC's, ALJ's, or MAC's decision on whether to reopen is binding and not subject to appeal." (*42 C.F.R. § 405.980(a)(5)*).

This language is clear and unambiguous. The Court, therefore, adopts the *Chevron* standard, because the *Skidmore* standard only applies when regulations are ambiguous. Further, an agency can interpret a regulation regarding the reopening of claims, as such a matter is not expressly assigned to the judiciary. *See, e.g., Your Home Visiting Nurse Servs., Inc. v. Shalala, 525 U.S. 449, 119 S. Ct. 930, 142 L. Ed. 2d 919 (1999)* (the Supreme Court deferred to an agency's interpretation of a *federal* statute regarding reopenings even though **[*14]** it did not appear that any agency expertise was involved in making the interpretation).

Based on the relevant case law, this Court will afford the Secretary's interpretation of the Medicare regulations regarding reopenings substantial deference under the *Thomas Jefferson* standard, and not greater scrutiny.

B. Whether Reopening of a Claim is Subject to Appeal.

Congress delegated authority with respect to reopening claims to the Secretary: "The Secretary may reopen or revise any initial determination or reconsidered determination . . . under guidelines established by the Secretary in regulations." *42 U.S.C. § 1395ff(b)(1)(G)*. Using that authority, the Secretary promulgated regulations that allow a contractor to "reopen and revise its initial determination or redetermination on its own motion: (1) Within 1 year from the date of the initial determination or redetermination for any reason; and (2) Within 4 years from the date of the initial determination or redetermination for good cause as defined in *§ 405.986*." *42 C.F.R. § 405.980(b)*. The decision to reopen is binding and not subject to appeal. *42 C.F.R. § 405.926(l)*; *42 C.F.R. § 405.980(a)(5)*.

Once a claim is reopened and revised, the revised **[*15]** decision is a "'separate and distinct determination or decision,'" subject to the normal administrative appeal procedures. *Anaheim Memorial Hosp. v. Shalala, 130 F.3d 845, 848 (9th Cir. 1997)*; *42 C.F.R. § 405.1889*. The right of appeal, therefore, attaches only to the scope of the revision, and not to the threshold basis for reopening a claim.

While Plaintiff challenges the reopening of the Medicare claim at issue here, it agrees that the Medicare regulations "shield from review the discretionary decision to reopen or not to reopen." (Plaintiff's MSJ 9:26.) Instead, Plaintiff argues that "[t]he regulations do not shield the *legality* of an opening from review because ALJ's have authority to adjudicate all 'issues' having a material impact on the appeal." (Plaintiff's MSJ 9:28-10:1 (emphasis added).) [4]

4 Plaintiff cites *Wyatt v. Barnhart, 349 F.3d 983 (7th Cir. 2003)* as an example of a court that held a reopening to be unlawful because the grounds for the reopening failed to satisfy the Medicare regulations. That case in inapposite for several reasons. First, the decision is not binding on this Court. Second, *Wyatt* involved social security disability benefits while this case involves Medicare **[*16]** claims. Third, *Wyatt* involved a Medicare reimbursement that had been overpaid to a beneficiary rather than to a medical provider. Because the payment was to a beneficiary, the court factored in the "considerable hardship" that the miscalculation could cause on the individual beneficiary, and decided to construe the regulations more liberally in favor of the individual beneficiary. *349 F.3d at 986.*

Medicare regulations preclude a medical provider or ALJ from contesting a contractor's discretionary decision to reopen a claim. This court finds that there is essentially no distinction, as Plaintiff argues, from challenging the discretionary decision to reopen as opposed to challenging the legality of the reopening, because the fact of the reopening is not appealable. *See 42 C.F.R. §§ 405.980(a)(5)* ("[t]he contractor's . . . decision on whether to reopen is binding and not subject to appeal") and *405.926(l)* ("[a]ctions that . . . are not appealable . . . include, but are not limited to . . . [a] contractor's . . . determination or decision to reopen or not to reopen an initial determination, redetermination, reconsideration, hearing decision, or review decision").

Further, the regulation **[*17]** states on its face that a decision on *whether* to reopen is not appealable. *42 C.F.R. § 405.980(a)(5).* This restriction on a provider's right to appeal a reopening encompasses not only a decision not to reopen, but also a decision to reopen. Moreover, *42 C.F.R. § 405.926(l)* makes it doubly explicit that "[a]ctions that are not initial determinations and are not appealable" include a "decision to reopen or not to reopen an initial determination [or] redetermination." *See Hosp. Comm. for Livermore-Pleasanton Areas v. Johnson, No. C-09-1786, 2010 U.S. Dist. LEXIS 27821, 2010 WL 1222764, at 7 (N.D. Cal. Mar. 24, 2010.)*

Under the *Thomas Jefferson* standard, this Court must "defer to the Secretary's interpretation [of a regulation] unless an alternative reading is compelled by the regulation's plain language or by other indications of the Secretary's intent at the time of the regulation's promulgation." *512 U.S. at 512.* Plaintiff's interpretation of the Medicare regulations, while perhaps not unreasonable, is not compelled by the plain language of *42 C.F.R. § 405.980(a)(5).* That regulation states that the decision on "whether to reopen is *binding* (emphasis added)," which indicates that the decision may not be reconsidered **[*18]** even after the revised determination has been made. Further, the plain language of *42 C.F.R. §§ 405.980(a)(5)* and *405.926(l)* would be rendered meaningless if the Court were to adopt Plaintiff's interpretation of these statutes and allow them to appeal the legality of the reopening.

Under *Thomas Jefferson,* the next step is to determine whether "an alternative reading is compelled by the regulation's plain language or by other indications of the Secretary's intent at the time of the regulation's promulgation." *512 U.S. at 512.* At the time the regulations were promulgated, the agency commented in response to a concern about how the agency would enforce the good cause provision. *70 Fed. Reg. 11420, 11453 (Mar. 8, 2005).* The agency stated that it would enforce the good cause standard through its own internal procedures, and not through private action via an appeal. *See id.* The Secretary takes a consistent position with this appeal.

Plaintiff finally argues that the Secretary's interpretation of the Medicare regulations leaves medical providers without due process of law, because it does not allow for any sort of real enforcement of the good cause standard, and thus providers are left without **[*19]** recourse. But a provider who is not satisfied with the reopening of a claim has the option to appeal the substantive result of the reopening on both administrative and judicial review. While the provider cannot contest directly the legality or fact that the claim was reopened, it is not left without due process because it can appeal the substantive portion of the "initial determination, redetermination, reconsideration, or hearing decision revised by the reopening." *42 C.F.R. § 405.984(f).*

This Court finds that Plaintiff cannot challenge the decision to reopen the claim. While Plaintiff's position is not unreasonable and its effort to enforce the good cause requirement is understandable, when this court applies both prongs of *Thomas Jefferson,* it must give credence to the Secretary's interpretation of the Medicare regulations. Further, under *Chevron,* this Court must accept that interpretation. Thus, this Court will not evaluate whether there was actual good cause to reopen the claim because that issue is not appealable. Plaintiff can only challenge the substantive decision finding that the claim was overpaid, and here, Plaintiff does not appeal that decision.

CONCLUSION

For the foregoing **[*20]** reasons, this Court **RECOMMENDS** that:

1. Plaintiff's Motion for Summary Judgment be **DENIED with prejudice; and**

2. Defendant's Motion for Summary Judgment be **GRANTED.**

This report and recommendation is submitted to the United States District Judge assigned to this case pursuant to *28 U.S.C. § 636(b)(1).*

IT IS ORDERED that no later than **May 26, 2010,** any party to this action may file written objections with the Court and serve a copy on all parties. The document should be captioned "Objections to Report and Recommendation."

IT IS FURTHER ORDERED that any reply to the objections shall be filed with the Court and served on all parties no later than **June 2, 2010.** The parties are advised that failure to file objections within the specified time may waive the right to raise those objections on appeal of the Court's order. *Turner v. Duncan, 158 F.3d 449, 455 (9th Cir. 1998)*; *Martinez v. Ylst, 951 F.2d 1153 (9th Cir. 1991).*

DATED: May 11, 2010

/s/ Nita L. Stormes

Hon. Nita L. Stormes

U.S. Magistrate Judge

United States District Court