The Law Offices of
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Health Care Provider
Legal Alert

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Palomar Medical Center v. Sebelius and its Impact on Challenging Medicare Reopening Decisions

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When Medicare contractors reopen an initial payment determination on a claim and change that determination more than a year later, health care providers lose the finality of the original determination and, often times, all or part of the Medicare reimbursement associated with the claim. The regulations require that the Medicare contractor have "good cause" to reopen the claim after one year. Health care providers have been quick to raise this rule as a defense to recoupment or repayment on the claim. But a recent decision by the United States Court of Appeals for the Ninth Circuit (the "Ninth Circuit") will make it more difficult to raise this procedural argument on appeal. In *Palomar Medical Center v. Sebelius*,[1] the court held that a provider may not challenge a lack of good cause for reopening a claim determination under the Recovery Audit Contractor (RAC) program.

Please feel free to reach us at the phone number or email address to the left if you have questions about the *Palomar* decision or challenges to reopenings of Medicare claim determinations.

Background. Medicare regulations define a "reopening" as "a remedial action taken to change a binding determination or decision that resulted in either an overpayment or underpayment, even though the binding determination or decision may have been correct at the time it was made based on the evidence of record."[2] A reopening may be undertaken by:

- a contractor (*e.g.*, FI, carrier or MAC) to revise the initial determination or redetermination;
- a Qualified Independent Contractor (QIC) to revise the reconsideration;
- an Administrative Law Judge (ALJ) to revise the hearing decision; or
- the DAB Medicare Appeals Council to revise the hearing or review decision.[3]

Taken together, the above provides Medicare contractors and appeal-related reviewing entities the authority to reopen earlier determinations under a broad set of circumstances.

Prior to Congressional authorization of Medicare reopenings in 2000, reopenings were governed under existing Social Security Administration

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(SSA) regulations. Under the SSA regulations, providers often challenged reopenings on the basis that the decision to reopen was not for good cause. It wasn't until 2005 that CMS promulgated the above reopening regulations specific to the Medicare program.[4] The Medicare regulations also have a good cause provision. It states that a Medicare contractor may reopen a determination or redetermination for any reason within one year, or for "good cause" within four years.[5] "Good cause" may be established when "(1) [t]here is new and material evidence" that "[w]as not available or known at the time of the determination" and "[m]ay result in a different conclusion," or "(2) [t]he evidence that was considered in making the determination or decision clearly shows on its face that an obvious error was made at the time of the determination or decision."[6]

A contractor's or reviewing entity's decision on *whether or not to reopen* is not appealable.[7] However, the regulations permit appeals from a *revised determination or decision* that *results from a reopening*.[8] "Only the portion of the initial determination . . . revised by the reopening may be subsequently appealed."[9]

Ninth Circuit's Decision in *Palomar Medical Center v. Sebelius*. The facts of the case before the Ninth Circuit Court of Appeals are not uncommon. In June 2005, Palomar Medical Center ("Palomar" or "Provider"), a Medicare-participating inpatient rehabilitation facility (IRF) located in California, provided rehabilitation services to a 79-year-old patient who had undergone a right total hip arthroplasty.[10] The next month, the FI paid Palomar's Medicare claim for $7,992.92 for the rehabilitation services provided.[11] In April 2007, Palomar's claim was selected for complex review as part of the RAC demonstration program. Palomar submitted to the RAC the patient's medical records and other documentation supporting the medical necessity of the IRF stay. Three months later, Palomar was notified of the RAC's revised determination of overpayment.[12] According to the RAC, the patient's rehabilitation in the IRF setting was not reasonable and necessary and could have been provided in a less intensive setting, such as a skilled nursing facility. As a result, Palomar was found liable for the entire overpayment amount.[13] Palomar appealed.

An ALJ agreed with the RAC that the IRF services were not reasonable and necessary, but reversed the overpayment determination on the basis that the RAC lacked good cause to reopen the claim.[14] The DAB Medicare Appeals Council then reversed the ALJ decision, concluding that the ALJ did not have jurisdiction to consider good cause for the reopening because the RAC's decision to reopen is not subject to appeal.[15]

Palomar filed for judicial review with the district court. Its primary argument was that, although a provider may not appeal the denial of a request to reopen or the reopening of a claim that is not revised, when a claim *is* reopened *and* revised, the provider can appeal both the portion of the redetermination or decision that is revised and the validity of the underlying reopening.[16] In other words, a valid appeal should allow the provider to

argue that a revised determination or decision is erroneous on the merits and raise procedural or jurisdictional issues. The district court was not persuaded. It held that, based on the plain language of the regulations and CMS's consistent interpretation, it did not have jurisdiction to hear the reopening challenge.[17]

Palomar appealed to the Ninth Circuit, again contesting that the RAC lacked good cause to reopen the initial determination. To further support its position, Palomar pointed out that CMS has permitted procedural challenges to reopenings in four situations: (1) SSA reopenings; (2) pre-2005 Medicare claim reopenings; (3) post-2008 Medicare cost report reopenings; and (4) a separate RAC reopening that was the subject of a different appeal by Palomar.[18] CMS countered that only the Medicare regulation at 42 C.F.R. § 405.980 is relevant here and it clearly establishes that the decision to reopen is not appealable. Therefore, the agency's interpretation is entitled to substantial deference, according to CMS.[19] CMS added that, as it explained in the rulemaking record, a contractor's failure to comply with the good cause requirement in the reopening regulation is only enforced by CMS itself, when it evaluates contractors' performance.[20]

The Ninth Circuit affirmed, ruling in favor of CMS. First, the court found the contested regulations to be sufficiently clear on their face as to justify CMS's interpretation.[21] The court reasoned that the repeated use of phrases like "not appealable" and "final" were indicative of the plain language meaning of the regulations.[22] Second, the Ninth Circuit dismissed Palomar's argument that other CMS reopening regulations and adjudications conflicted with the interpretation CMS had taken in this case.[23] Strictly framing the issue in terms of RAC reopenings, the court emphasized the fact that the contested reopening regulations[24] were promulgated around the same time as the development of the RAC program.[25] The court also disagreed with Palomar's arguments that the reopening regulation violates the Administrative Procedure Act and that the federal courts have other jurisdiction to review the issue.[26]

Impact on Provider Challenges. The Ninth Circuit decision in *Palomar* will make it more difficult for health care providers to challenge Medicare claim reopenings on procedural grounds, namely, for a lack of good cause to reopen. Although the facts of *Palomar* ostensibly limit the reach of the court's holding to RAC reopenings, and the holding is only binding precedent in the Ninth Circuit, the Ninth Circuit's rationale and conclusion will almost certainly be repeated in other Medicare claim reopening cases.

Providers whose Medicare claims are reopened one to four years after the initial determination should consider the following points when raising the lack of good cause as a defense. First, because the good cause requirement applies to the contractor performing the reopening, it should be raised directly with the contractor as early as possible. This not only creates an opportunity to have the issue addressed by the appropriate entity, it also documents for the record on appeal that the issue was presented to the

agency (via its contractor). Second, if a RAC is not the contactor that reopened the claim determination, *Palomar* is not binding authority. Third, similar to the last point, if the provider is located outside of the Ninth Circuit's jurisdiction, *Palomar* is not binding authority. Finally, providers should understand that the bar for Medicare contractors to establish good cause is relatively low, so any language in the contractor's revised determination that explains why the claim was selected for review upon reopening may be sufficient to withstand further scrutiny on appeal.

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[1] *Palomar Med. Ctr. v. Sebelius*, 10-56529, ___ F.3d _____, 2012 WL 3937269 (9th Cir. Sept. 11, 2012).
[2] 42 C.F.R. § 405.980(a)(1).
[3] *See id.* § 405.980(a)(1)(i)-(iv).
[4] 70 Fed. Reg. 11,420, 11,450-53 (Mar. 8, 2005).
[5] 42 C.F.R. § 405.980(b)(1)-(2),(c)(1)-(2).
[6] *Id.* § 405.986(a).
[7] *Id.* §§ 405.980(a)(5),405.926(l).
[8] 42 C.F.R. § 405.984(a),(g).
[9] *Id.* § 405.984(f).
[10] *See Palomar* at *5.
[11] *See id.*
[12] *See id.*
[13] *See id.*
[14] *See id.*
[15] *See id.*
[16] *See id.* at *7.
[17] *See id.* at *6.
[18] *See id.* at *9. In a separate appeal of a different RAC reopening, *In re Palomar Medical Center (Palomar I)* (M.A.C. Jan. 11, 2008), the DAB MAC ruled in favor of Palomar and remanded to the ALJ to allow the parties to present evidence on the basis for reopening, as the ALJ had raised that issue in the first instance. *See id*. at *8.
[19] *See id.* at *6-7.
[20] *See id.* at *3.
[21] *See id.* at *7.
[22] *Id*. at *7.
[23] *See id.* at *9.
[24] 42 C.F.R. §§ 405.926(l), 405.980(a)(5).
[25] *See Palomar* at *9.
[26] *See id.* at *10-*13.

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The Law Offices of Jason M. Healy PLLC is a Washington, D.C. based law firm serving national and local clients. We focus primarily on legal issues affecting health care providers and welfare benefit plans. We help health care providers and their trade associations understand Medicare and Medicaid laws and regulations, and address compliance matters. We also represent health care providers in reimbursement audits, appeals, litigation, and transactions. We

help sponsors of welfare benefit plans understand and comply with federal and state laws and prepare plan documents. Located in Washington, DC, just minutes from the Department of Health and Human Services, Congressional offices, and the White House, we are well positioned to provide legal support for advocacy efforts. Our Principal, Jason M. Healy, is a health care lawyer with over 14 years of experience with the array of legal issues facing health care providers.