No. 10-56529

IN THE
UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

PALOMAR MEDICAL CENTER,
Plaintiff-Appellant,

vs.

KATHLEEN SEBELIUS, SECRETARY OF THE UNITED STATES
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Defendant-Appellee.

AMICUS CURIAE BRIEF OF THE FEDERATION OF AMERICAN HOSPITALS, AMERICAN HOSPITAL ASSOCIATION, AND AMERICAN HEALTH CARE ASSOCIATION IN SUPPORT OF APPELLANT'S REQUEST FOR REVERSAL OF JUDGMENT

On Appeal From August 2, 2010 Judgment of the
United States District Court for the Southern District of California

The Honorable Roger T. Benitez, United States District Judge
U.S. District Court Case No. 09-cv-0605-BEN (NLS)

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AMICUS CURIAE DISCLOSURE STATEMENTS

Pursuant to Federal Rules of Appellate Procedure 26.1 and 29, the undersigned counsel for *amicus curiae* the Federation of American Hospitals ("FAH"), the American Hospital Association ("AHA"), and the American Health Care Association ("AHCA") hereby certifies that (a) the FAH, AHA, and AHCA are non-profit corporations that have no issued stock and have no parent corporation or owners; and (b) a party's counsel did not author *amicus curiae*'s brief in whole or in part; a party or a party's counsel did not contribute money that was intended to fund preparing or submitting *amicus curiae*'s brief; and no person – other than the FAH, AHA, AHCA, their members, or their counsel – contributed money that was intended to fund preparing or submitting *amicus curiae*'s brief.

DATED: January 26, 2010

Respectfully submitted,

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I. INTRODUCTION

By their instant *amicus curiae* brief, the Federation of American Hospitals ("FAH"),[1] the American Hospital Association ("AHA"),[2] and the American Health Care Association ("AHCA"),[3] support the reversal of the district court's ruling that a Medicare Administrative Law Judge ("ALJ") and the federal courts have no jurisdiction to determine whether a Centers for Medicare and Medicaid Services ("CMS") contractor had the "good cause," expressly required by agency regulations (*see* 42 C.F.R. § 405.980(b)(2) (2007)), to reopen and deny Medicare claims more than a year after they were paid.

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[1] FAH is the national representative of investor-owned or managed community hospitals and health systems. FAH has nearly 1,000 member hospitals in 46 states and the District of Columbia. These members include rural and urban teaching and non-teaching hospitals and provide a wide range of acute, post-acute, and ambulatory services.

[2] The AHA is a national not-for-profit association that represents the interests of approximately 5,000 hospitals, health care systems, networks, and other health care providers, as well as 37,000 individual members. It is the largest organization representing the interests of the nation's hospitals. The members of the AHA are committed to finding innovative and effective ways of improving the health of the communities they serve. The AHA educates its members on health care issues and trends, and it advocates on their behalf in legislative, regulatory, and judicial forums to ensure that their perspectives and needs are understood and addressed.

[3] As the nation's largest association of long term and post-acute care providers, the AHCA represents the long term care community to the nation at large and advocates for quality care and services for frail, elderly and disabled Americans. Its members provide essential care to approximately one million individuals in 11,000 not-for-profit and proprietary member facilities.

For Medicare providers, enforcement of the regulatory good cause prerequisite to reopening a payment determination is critically important because it prevents arbitrary reopening by private contractors and assures some reasonable administrative finality to paid Medicare claims. Because Medicare providers file millions of Medicare claims each day, the finality of payment determinations is important to providers and the Medicare program. The good cause requirement strikes a necessary balance between the government's need, for a limited time period, to reopen and revise paid Medicare claims and the need for finality of payment determinations.

If CMS or its contractors are not subject to enforcement of the regulation setting forth the conditions for and timing of reopening paid claims, then Medicare providers can never reasonably expect administrative finality to be achieved. Denying jurisdiction to a provider seeking enforcement of the government's regulation is tantamount to a total evisceration of the administrative finality doctrine.

Limiting reopening through a good cause standard is even more important to preserving hospital resources given the significant number of Medicare contractors that now have the authority to reopen claims. CMS has recently engaged new types of private contractors – including Medicare Administrative Contractors ("MACs"), Recovery Audit Contractors ("RACs") and Zone Program Integrity Contractors ("ZPICs") – that are authorized to

search for Medicare billing errors by hospitals, skilled nursing facilities and other providers and recover any resulting overpayments. During the three-year RAC demonstration project at issue here, CMS authorized RACs to identify, reopen, and deny old claims that had been mistakenly paid in exchange for being paid a bounty of approximately 20% of recovered overpayments even if their claim denials were later overturned on appeal. However, like any CMS contractor, RACs were expressly required by regulation to show "good cause" for reopening and denying more than a half a million Medicare claims that had been previously paid more than a year before.

Under these circumstances, *amicus curiae* are alarmed by a district court ruling that erroneously eliminates the long-standing right of Medicare providers to enforce private contractors' compliance with CMS's own regulatory "good cause" limitation on the reopening and denial of old claims through administrative appeals and judicial review. Such a ruling is not only contrary to the controlling Medicare regulations and case law, but also means that a provider's only remedy to a contractor's improper fishing expedition is to incur the often massive logistical and financial burden of administratively appealing each individual claim denial to show – usually, through medical records, expert testimony and the participation of the responsible physician at an ALJ hearing – that the billed services were provided as documented, covered and properly paid. Allowing this erroneous ruling to stand will also

encourage Medicare contractors to engage in random "bounty hunting" because many providers will simply repay improperly denied claims, rather than incur the high cost of filing Medicare administrative appeals. This process requires two levels of appeal to even obtain a hearing before an ALJ and burdens facility physicians with taking a day out of a busy practice to testify at the hearing.[4]

For these reasons, the *amicus curiae* strongly support Appellant's request that the district court's ruling be reversed and the case remanded to determine whether the Medicare RAC contractor had the requisite "good cause" to reopen Appellant's old Medicare claim. Such a reversal is mandated by the applicable Medicare regulations and the black letter rule of administrative law that a federal court always has jurisdiction to enforce a federal agency's compliance with regulations that regulate the rights and interests of others.

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[4] This is not a fanciful concern. CMS recently reported that Medicare providers only appealed 12.7% of RAC overpayment determinations during the demonstration project, but that an astonishing 64.4% of such determinations were reversed during appeal. *See* CMS, *The Medicare Recovery Audit Contractor (RAC) Program: Update to the Evaluation of the 3-Year Demonstration*, 2 (June 2010) ("CMS 2010 RAC Update") (available at https://www.cms.gov/RAC/Downloads/ DemoAppealsUpdate61410.pdf.) CMS is also further expanding its use of private contractors to review the Medicaid claims of hospitals and skilled nursing facilities, *see* 75 Fed. Reg. 9037 (November 10, 2010) (proposed rule), and Medicare Part C claims, *see* 75 Fed. Reg. 81278 (Dec. 27, 2010) (proposed rule). This will further increase the burden on providers of challenging improper claim denials if CMS's good cause requirement cannot be enforced.

II. FACTUAL BACKGROUND

The Medicare Program processes "more than 1.2 billion claims per year (the equivalent of 4.5 million claims per work day) . . . ." *See* U.S. GAO Report (March 2010), Medicare *Recovery Audit Contracting: Weaknesses Remain in Addressing Vulnerabilities to Improper Payments, Although Improvements Made to Contractor Oversight*, 9 (Publication No. GAO-10-143) ("GAO Report"). Beginning in 2005, CMS unleashed a flood of new Medicare private auditors, all of whom are tasked, in whole or in part, with searching for current and past billing errors by Medicare providers.

These new auditors included RACs, who were supposed to use automated and complex review processes to identify Medicare paid claims more than one year old that were improperly paid based on Medicare policies and regulations. GAO Report at 11. Likewise, ZPICs were tasked with helping MACs process claims by using data analysis programs to identify provider billing practices and services posing the greatest financial risk to the Medicare program, including billing error categories, high volume or high cost services being widely over-utilized, and program areas or specific providers involving possible fraud.

While these new private contractors were authorized to reopen and deny previously paid Medicare claims, CMS regulations required them to show "good cause" if a claim had been paid between one and four years earlier.

CMS even defined the applicable good cause standard by requiring a showing of (1) new and material evidence that might make the claim non-reimbursable that was unavailable or not known at the time of payment, or (2) evidence considered at the time of payment that clearly showed on its face that an obvious error was made. *See* 42 C.F.R. §§ 405.980(b)(2), 405.986 (2007). As explained by CMS and the courts, the purpose of Section 405.986's "good cause" reopening limitation was "to pay claims appropriately, subject to considerations of administrative finality," including, wherever possible for health care providers a "reasonable expectation as to the administrative finality of a decision on a claim or claims in question." *Medicare Program: Changes to the Medicare Claims Appeal Procedures; Interim Final Rule*, 70 Fed. Reg. 11419, 11420, 11451, 11453 (Mar. 8, 2005).

As became quickly apparent during the RAC demonstration project, enforcement of the regulatory policy of administrative finality embodied in Section 405.986's "good cause" reopening limitation was of particular importance to the Medicare provider community because "the contingency fee payment structure created an incentive for RACs to be aggressive in determining that paid claims were improper" and because CMS was "not holding the RACs accountable for the accuracy of their decisions." *See* GAO Report at 4, 29. Moreover, unless RACs complied with this "good cause" limitation <u>before</u> reopening claims, Appellant and other providers were faced

with the significant burden of administratively appealing each new overpayment determination on a claim-by-claim basis to establish coverage through a five-level Medicare appeals process that could last up to two years. *See id*. at 4 n.11, 13.[5]

Finally, Medicare providers were also very concerned that CMS would only judge the incidence of inaccurate contractor claim denials based on the number of successful provider administrative appeals, even though many providers might reasonably "choose not to appeal a RAC determination if the effort and cost involved in filing the appeal outweighs the benefit of recouping the money originally lost by the RAC's determination." *Id*. at 31 n. 51. This provider concern appeared legitimate in light of the high reversal rate during the Medicare administrative appeal process. *See* CMS 2010 RAC Update at 2.

In Appellant's case, as with many other California providers, it administratively appealed RAC PRG-Schultz's 2007 reopening and denial of a 2005 Medicare claim for inpatient rehabilitation services based on a lack of

[5] Specifically, a Medicare provider must exhaust its administrative remedies by filing its administrative appeal with its MAC, a Medicare Qualified Independent Contractor ("QIC"), a Medicare ALJ, and, finally, the Medicare Appeals Council. *See* 42 C.F.R. §§ 405.942(a), 405.950(a), 405.962(a), 405.970(a), 405.1004(a)(1), 405.1016(a), 405.1100(c), 405.1102(a)(1) (2007).

medical necessity.[6] Specifically, Appellant claimed that the services were necessary and that the RAC had failed to show the "good cause" required by Section 405.986 before reopening the claim, which had initially been paid by the Medicare fiscal intermediary more than a year earlier.

The Medicare ALJ ruled that the RAC had improperly reopened the claim without showing the "good cause" required by Section 405.986. However, the district court agreed with the Secretary of the Department of Health and Human Services ("the Secretary") that the ALJ and federal courts had no jurisdiction to review and enforce a RAC's compliance with her own non-discretionary regulatory limitation on a contractor's reopening and revision of old paid claims. As further detailed below, this ruling is incorrect as a matter of law. No Medicare regulation bars review of whether a contractor complied with Section 405.986's "good cause" requirement. Furthermore, a Medicare provider's undisputed right to appeal the denial of a previously paid Medicare claim necessarily includes jurisdiction to review whether the process of reopening and denying such claim complied with this non-discretionary regulatory requirement.

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[6] For more details of the specific problems with RAC PRG-Schultz's audits of California hospitals, see the *Amicus Curiae* Brief of the California Hospital Association.

III. ARGUMENT

A. CMS'S REGULATORY "GOOD CAUSE" LIMITATION ON A CONTRACTOR'S REOPENING AND DENIAL OF OLD PAID MEDICARE CLAIMS IS ENFORCEABLE THROUGH THE ADMINISTRATIVE APPEAL PROCESS

In ruling that the Medicare ALJ and federal courts have no jurisdiction to enforce CMS's regulatory "good cause" requirement for the reopening, the district court relied entirely on its conclusion that such review was unambiguously barred by two Medicare regulations. These two regulations provide: (1) "[a]ctions 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) (2007), and (2) "contractor's, QIC's, ALJ's, or MAC's decision on whether to reopen is final and not subject to appeal." 42 C.F.R. § 405.980(a)(5) (2007).[7]

However, as a matter of law, the district court's interpretation of Sections 405.926(l) and 405.980(a)(5) is unsupportable and contrary to the current legal

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[7] Three other district courts have also concluded (equally erroneously) that Sections 405.926(l) and 405.980(a)(5) strip an ALJ or a federal court of jurisdiction to enforce a RAC's compliance with Section's 405.986's mandatory "good cause" requirement. *See Morton Plant Hosp. Ass'n, Inc. v. Sebelius*, ___ F.Supp.2d ___, 2010 WL 3943687 (M.D. Fla. 2010); *Trustees of Mease Hosp., Inc. v. Sebelius*, 2010 WL 3222088 (M.D. Fla. 2010); *Hospital*

landscape surrounding the concept of administrative finality. The plain language of these two Medicare regulations only states that the decision of a contractor as to whether or not a previously paid claim should be reopened is not reviewable by an ALJ or the federal courts. That is, a contractor has the discretion to decide whether an initial determination should be reopened and that discretionary decision may not be challenged. These two regulations are consistent with uniform Supreme Court and federal court rulings that, absent a constitutional claim or constructive reopening, an agency's decision not to reopen a claim determination is unreviewable because such decision is discretionary and not appropriate for subsequent review. *Califano v. Sanders*, 430 U.S. 99, 107-109 (1977); *Your Home Visiting Nurse Services, Inc. v. Shalala*, 525 U.S. 449 (1999); *Udd v. Massanari*, 245 F.3d 1096, 1099 (9th Cir. 2001); *Michael Reese Hosp. and Medical Center v. Thompson*, 427 F.3d 436, 443 (7th Cir. 2005).

By contrast, Sections 405.926(l) and 405.980(a)(5) are silent on whether a Medicare ALJ and the federal courts have jurisdiction to review and enforce a contractor's compliance with Section 405.986's non-discretionary "good cause" limitation. *See* 42 C.F.R. § 405.984 (2007) ("The revision of an initial determination is binding upon all parties unless a party files a written request for a redetermination that is accepted and processed in accordance with 405.940

Committee for the Livermore-Pleasanton Areas v. Johnson, 2010 WL 1222764 (N.D. Cal. 2010).

through 405.958.") Put another way, Medicare regulations stating that the discretionary reopening decision is not appealable do not facially bar a provider's right to appeal the denial of a reopened claim on the ground that a contractor did not comply with another Medicare regulation's non-discretionary "good cause" limitation that led to such denial.

In its order, the district court nevertheless insisted that permitting Appellant to appeal the contractor's compliance with Section 405.986's "good cause" limitation would contradict the plain language of Sections 405.926(l) and 405.980(a)(5) that reopening decisions are not appealable. Again, however, the district court's expansive reading of Sections 405.926(l) and 405.980(a)(5) finds no support in the plain language of these regulations.

On the contrary, in the analogous context of Social Security Administration ("SSA") reopening regulations,[8] the Fifth Circuit in *Cieutat v. Bowen*, 824 F.2d 348, 353 (5th Cir. 1987) ruled that there was a crucial difference between a court's jurisdiction to review an agency's compliance with

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[8] The SSA reopening regulation provides, in relevant part, that an initial determination may be reopened "[w]ithin four years of the date of the notice of the initial determination if we find good cause, as defined in 20 C.F.R. § 404.989, to reopen the case." 20 C.F.R. § 404.988(b) (2007). In turn, the SSA regulatory definition of "good cause" is virtually identical to that of 42 C.F.R. § 405.986. *See* 20 C.F.R. § 404.989 (2007). Given this similar regulatory scheme, cases interpreting the SSA's "good cause" limitation on the reopening and denial of benefits are persuasive authority in the Medicare setting. Indeed, the Supreme Court has treated Medicare disputes as largely

a "good cause" limitation as part of an undisputed right to appeal a denial of benefits after reopening, and its lack of jurisdiction to hear an appeal of the reopening decision itself. In particular, the Fifth Circuit explained that its jurisdiction to review the agency's compliance with its own "good cause" limitation as part of the claimant's appeal of a denial of benefits was not inconsistent with the Supreme Court's ruling in *Califano* that a reopening decision is not appealable:

> Unlike the situation in [*Califano*], however, here the basis for judicial review is not the decision respecting reopening, but rather the admittedly reviewable decision denying benefits. We note that without making explicit reference to the basis for jurisdiction, courts in several circuits, including this one, have reviewed similar challenges to Appeals Council decisions to review or reopen ALJ decisions . . . . Thus, assuming a federal court can review an Appeals Council's decision to reopen consistently with the [*Califano*] holding, this Court should have jurisdiction over [claimant's] challenge to the Appeals Council's reopening of his case inasmuch as the reopening forms the basis for the denial of benefits of which [claimant] complains.

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indistinguishable from Social Security ones. *See Heckler v. Ringer*, 466 U.S. 602, 614-617 (1984).

Cieutat, 824 F.2d at 358 n.15 (citations omitted); *see Cole ex rel. Cole v. Barnhart*, 288 F.3d 149, 150 (5th Cir. 2002) (same).

The reasoning of the Fifth Circuit is persuasive and equally applicable in this case. No deference to the Secretary's interpretation of Sections 405.926(l) and 405.980(a)(5) is required "'if 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.'" *Thomas Jefferson University v. Shalala*, 512 U.S. 504, 512 (1994) (quoting *Gardebring v. Jenkins*, 485 U.S. 415, 430 (1988)). Here, the plain language of the Medicare regulations does not preclude ALJ and judicial review of a contractor's compliance with Section 405.986's mandatory "good cause" limitation on the reopening <u>and</u> revision of an old paid Medicare claim. Rather, the Medicare regulations specifically allow such an appeal.

The Medicare regulations make it clear that there is a distinction between a reopening and a revision of an initial determination. The time limits in Section 405.980(b) apply to both the reopening and revision of an initial determination by a contractor, providing that a contractor "may *reopen and revise* its initial determination or redetermination" within four years for good cause. 42 C.F.R. § 405.980(b) (2007) (emphasis added). In contrast, the restrictions on administrative review in Sections 405.926(l) and 405.980(a)(5) apply only to a contractor's decision to reopen an initial determination. They

do not apply to a contractor's revision of an initial determination. Instead, Section 405.984(a) unambiguously states that a revision of an initial determination may be appealed. *See* 42 C.F.R. § 405.984 (2007) ("The revision of an initial determination is binding upon all parties unless a party files a written request for a redetermination . . . .") Further, an initial determination may be revised after one year and within four years only for good cause and there is no limitation on a provider's ability to appeal the revision of an initial determination. As a result, it follows that a Medicare provider is entitled to challenge a revision on the ground that it was made after one year and within four years without a showing of good cause.[9]

In addition, the Secretary's commentary at the time that Sections 405.926(l) and 405.980(a)(5) were promulgated reveals no intent to overrule the long line of prior administrative and court decisions recognizing a Medicare provider's right to appeal CMS's failure to show "good cause" for the reopening and denial of old paid Medicare claims.[10] *See* 70 Fed. Reg. at

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[9] In 2009, the Secretary removed the words "and revise" from the introductory clause of Section 405.980(b) to reflect CMS's "longstanding policy that the timeframes for reopening a determination or decision are measured by the date of the reopening not the date of the revision of the determinations or decisions." *See Medicare Program: Changes to the Medicare Claims Appeal Procedures*, 74 Fed. Reg. 65296, 65314 (Dec. 9, 2009).

[10] *See e.g., Texas Medical Ass'n v. Sullivan*, 875 F.2d 1160, 1168 (5th Cir.), (Secretary's Medicare Part B reopening regulations required Medicare hearing officer to determine the "the merits of any such reopening … . includ[ing] the

11453. In particular, contrary to the district court's claim, the Secretary did not state "the good cause standard would be enforced on the contractors through audits and evaluations of the contractor's performance." Rather, the Secretary stated that her monitoring of CMS contractors and her proposed regulations were sufficient to enforce such standard:

> The regulations require that contractors abide by the good cause standard for reopening actions after one year from the date of the initial or revised determination. CMS assesses a contractor's compliance with Federal laws, regulations and manual instructions during audits and evaluations of the contractors' performance. Thus, the necessary monitoring and enforcement mechanisms are already in place.

70 Fed. Reg. at 11453. Similarly, the Secretary's commentary elsewhere reiterated her view that the proposed regulations were sufficient to enforce the

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question of whether the reopening was timely since initial payment determinations can only be reopened 12-48 months later if 'good cause' exists for the reopening"), *cert. denied*, 493 U.S. 1011 (1989); *Mark Twain Saint Joseph's Hospital (San Andreas, Cal.) v. BlueCross BlueShield Association/ United Government Services*, PRRB Dec. No. 2002-D30 (Aug. 2, 2002) ("Applying the reopening criteria at 42 C.F.R. § 405.1885, the Board majority finds that the Intermediary's attempt to reopen the 1992 and 1993 Medicare cost reports in 1998 was beyond the allowable time period for reopening"), *reprinted in*, [2003-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 80,889.

"good cause" standard because the parties had the right to administratively appeal any resulting new determination:

> For reopenings after that time, the rules we proposed are sufficient; that is, contractors must have good cause for reopening claims within 4 years and must have obtained reliable evidence for reopening at any time for fraud or similar fault. No matter what the outcome of a reopened and revised determination, parties retain the right to challenge the new determination at the appropriate appeal level.

70 Fed. Reg. at 11453. In sum, the Secretary's contemporaneous interpretation of Section 405.986's "good cause" requirement further confirms that she only intended Sections 405.926(l) and 405.980(a)(5) to insulate a contractor's reopening decision from review when the decision did <u>not</u> result in a revised claim determination. *See* 42 C.F.R. § 405.984 (2007).

The Secretary imposed Section 405.986's good cause limitation for a reason. While a contractor is free to reopen a claim within a year for any reason, some limitations on that discretion apply thereafter. Once that year has passed, good cause is the permit that limits the size of the fishing expedition. Once four years pass, fraud or similar fault must be demonstrated before a claim can be reopened. Under the district court's ruling, however, none of

Section 405.986's limitations are enforceable and any notion of administrative finality of paid claims is effectively eviscerated.

Finally, the conclusion that the plain language of Sections 405.926(l) and 405.980(a)(5) and the Secretary's contemporaneous interpretation of Section 405.986 unambiguously establish that an ALJ and federal courts have jurisdiction to review and enforce the "good cause" requirement is also consistent with the presumption that Congress intends judicial review of administrative action absent clear and convincing evidence to the contrary. *See Kucana v. Holder*, __ U. S. ___, 130 S. Ct. 827, 839 (2010); *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986). Consequently, the district court's ruling in this case should be reversed.

B. CMS CANNOT DEPRIVE THE FEDERAL COURTS OF JURISDICTION TO ENFORCE THE AGENCY'S COMPLIANCE WITH ITS OWN REGULATORY "GOOD CAUSE" LIMITATION

The district court also ignored the black letter rule of administrative law that a federal court always has jurisdiction to enforce a federal agency's compliance with its own regulations when they "regulate the rights and interests of others."[11] *Montilla v. I.N.S.*, 926 F.2d 162, 167 (2nd Cir. 1991), citing *U.S. ex*

[11] Appellant repeatedly argued to the district court that "it is beyond dispute that federal agencies must obey their own regulations" and that the Secretary cannot "shield the unlawful actions of her contractors from administrative and judicial review." *See e.g.*, Plaintiff's Memorandum of Law in Opposition to Defendant's Motion for Summary Judgment and Plaintiff's Reply in Support of

rel. Accardi v. Shaughnessy, 347 U.S. 260 (1954); *U.S. v. Ramos*, 623 F.3d 672, 683 (9th Cir. 2010) ("'It is a well-known maxim that agencies must comply with their own regulations'"); *Clemente v. U.S.*, 766 F.2d 1358, 1365 (9th Cir. 1985) (recognizing "well-settled rule that regulations validly prescribed by an agency are binding upon it"), *cert. denied*, 474 U.S. 1101 (1986); *Patel v. I.N.S.*, 790 F.2d 786, 788 (9th Cir. 1986) ("agency's violation of its own regulations is subject to judicial review"); *Kohli v. Gonzales*, 473 F.3d 1061, 1066 (9th Cir. 2007) (same)[12]

"The *Accardi* doctrine is premised on fundamental notions of fair play underlying the concept of due process." *Montilla*, 926 F.2d at 167. In a series of cases relying on *Accardi*, the Supreme Court has recognized a rule of federal administrative law that requires an agency to follow its own procedures or

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Its Motion for Summary Judgment, 1, 16 (CR 26). Appellant also cited cases holding that an agency's violation of its own regulations is subject to judicial review. *Id*. at 16, citing *Service v. Dulles*, 354 U.S. 363, 388 (1957) ("It being clear that [regulation] was not complied with by the Secretary in this instance, it follows that under the *Accardi* doctrine petitioner's dismissal cannot stand") and *Black v. I.C.C.*, 737 F.2d 643 (7th Cir.1984) ("If an agency in its proceedings violates its rules and prejudice results, any action taken as a result of the proceedings cannot stand.") Nevertheless, the district court's ruling entirely ignored this argument premised on an accepted rule of administrative law.

[12] In *Patel*, this Court recognized that it has not been consistent regarding the source of its jurisdiction, variously describing the *Accardi* doctrine as a portion of its supervisory powers, *Carnation Co. v. Secretary of Labor*, 641 F.2d 801, 804-05 (9th Cir. 1981) (per curiam), or as a rule of administrative law, *U.S. v.*

regulations if they affect an individual's rights or benefits. *See, e.g., United States v. Caceres*, 440 U.S. 741, 751 n. 14 (1979) (even if violation of agency regulations did not raise constitutional questions, "[i]t does not necessarily follow, however, as a matter of either logic or law, that the agency had no duty to obey them"); *Morton v. Ruiz*, 415 U.S. 199, 235 (1974) ("Where the rights of individuals are affected, it is incumbent upon agencies to follow their own procedures"); *Dulles*, 354 U.S. at 372 ("regulations validly prescribed by a government administrator are binding upon him as well as the citizen, and . . . this principle holds even when the administrative action under review is discretionary in nature.")

As a result, independent of any alleged constitutional violation, a district court always has jurisdiction to order appropriate relief based on "agency deviation from its own regulations and procedures . . . in a case otherwise properly before the court." *Haitian Refugee Center v. Smith*, 676 F.2d 1023, 1041 n.48 (11th Cir. 1982), citing *Accardi*, 347 U.S. at 267; *United States v. Nixon*, 418 U.S. 683, 695-96 (1974); *Mendez v. INS*, 563 F.2d 956, 959 (9th Cir. 1977); *Yee Dai Shek v. INS*, 541 F.2d 1067, 1069 (4th Cir. 1976). The *Accardi* doctrine is properly invoked when "violation of the regulation prejudiced the party involved," *Carnation Co.*, 641 F.2d at 804 n.4; *Kohli*, 473 F.3d at 1066,

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Calderon-Medina, 591 F.2d 529, 531 (9th Cir. 1979). *See Patel*, 790 F.2d at 788.

and the "appropriate remedy for the refusal of an agency to follow its own regulations may be injunctive relief, reversal of the agency action, or reversal and remand with an order requiring the agency to follow its own procedures." *Clemente*, 766 F.2d at 1365 n.10.

In this case, the Secretary cannot legally promulgate Section 405.980, a regulation imposing a mandatory "good cause" limitation on the reopening and denial of old Medicare claims, but then violate, or permit a private contractor to violate, such regulation without consequence. Rather, since Section 405.980 plainly affects a Medicare provider's right to retain previous claim payments by CMS for services, the *Accardi* doctrine requires the Secretary and the private contractor to comply with this regulation and permits Appellant and other providers to seek administrative and judicial relief to enforce the regulation's "good cause" limitation on a RAC's denial of old paid Medicare claims after reopening.[13]

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[13] For the same reason, even if Sections 405.926(l) and 405.980(a)(5) were intended to eliminate ALJ and federal court review of CMS's compliance with Section 405.980, the Secretary lacked the authority to deprive a federal court of such jurisdiction in this manner because Section 405.980's "good cause" limitation is a non-discretionary rule that is still in force and plainly affects the right of Medicare providers to retain claim payments. *See Flores v. Bowen*, 790 F.2d 740, 742 (9th Cir. 1986) (applying "the black-letter principle that properly enacted regulations have the force of law and are binding on the government until properly repealed.")

IV. CONCLUSION

For the foregoing reasons, the district court's ruling that a Medicare ALJ and a federal court lacked jurisdiction to review and enforce Section 405.986's "good cause" limitation on the reopening and denial of Appellant's previously paid Medicare claim should be reversed.

DATED: January 26, 2010

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Ninth Circuit Rule 32(e)(4), I certify that the answering brief is proportionately spaced, has a typeface of 14 points or more, and contains 4,890 words.

DATED: January 26, 2010

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