No. 10-56529

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

PALOMAR MEDICAL CENTER,
Plaintiff-Appellant,

v.

KATHLEEN SEBELIUS, Secretary of Health and Human Services,
***Defendant-Appellee*.**

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF CALIFORNIA

APPELLEE'S OPPOSITION TO PETITION FOR REHEARING *EN BANC*

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INTRODUCTION AND SUMMARY

Appellant Palomar Medical Center ("Palomar") has failed to satisfy the Court's stringent standards for rehearing *en banc*. Palomar does not – and could not – argue that the panel's unanimous decision conflicts with another decision of this Court or any decision of any other court of appeals. See Fed. R. App. P. 35(b); Cir. R. 35-1. Instead, Palomar contends that a matter of "exceptional importance" is involved here for three reasons. None of Palomar's arguments warrants *en banc* review, and, in any event, all are meritless.

First, Palomar complains that the panel erroneously upheld an interpretation by the Department of Health and Human Services ("HHS" or "the agency") of its own Medicare reopening regulations "based on what the panel perceived as the needs of a single type of Medicare contractor, the Recovery Audit Contractor ('RAC')," when the reopening regulations apply to all contractors. Pet. 1, 5. Palomar's objection falls of its own weight. That the reopening regulations "apply across the board, not just to RACs," Pet. 1, means that HHS's interpretation of those regulations is supported *not only* by the congressionally-mandated RAC program, but also by multiple Medicare audit programs designed to uncover incorrect payments. Moreover, inasmuch as a RAC reopened the particular claim at issue in this appeal, and the numerous briefs of the parties and *amici* contain

substantial discussion of the RAC program, the panel cannot reasonably be faulted for referring to that program.

Second, Palomar erroneously contends that HHS "claims authority to divest federal courts of jurisdiction to review [its] unlawful acts." *Ibid*. But, as the panel explained, "[t]he *Medicare statute limits judicial review of [HHS's] decisions* to 'final decision[s] * * * made after a hearing.' * * * The decision to reopen a paid Medicare claim, however, is discretionary and does not constitute a 'final decision' for purposes of § 405(g)." Op. 11033 (quoting 42 U.S.C. §§ 405(g)-(h), 1395ff(b)(1)(A)) (emphasis added). That is because "no hearing on a reopening decision is required by statute." Op. 11034. The panel therefore correctly held, based on the Medicare statute's jurisdictional provisions and established Circuit and Supreme Court precedent, that it lacked power to review the RAC's decision whether to reopen the claim at issue. Op. 11035.

Third, Palomar contends that HHS has unlawfully "subdelegated unreviewable authority to Medicare contractors to enforce the reopening regulations." Pet. 1. Palomar concedes that it did not previously raise this issue, but claims that the Court can nonetheless consider this argument because HHS "did not reveal [this position] until after oral argument." Pet. 1. That is patently incorrect. Palomar's argument is based on its inexplicable misreading of a statement in HHS's supplemental brief – a statement that was *also* contained in

HHS's appellee brief and *is directly based on the agency's regulations*. More important, as HHS's regulations, accompanying preamble, and briefs in this litigation make unequivocally clear, the agency itself enforces contractor compliance with the reopening regulations through "audits and evaluations of the contractors' performance." 70 Fed. Reg. 11,420, 11,453 (Mar. 8, 2005). HHS has not unlawfully subdelegated its authority, and the issue that Palomar attempts to raise here for the first time is a red herring.

The panel's decision is correct, and the Court should therefore deny Palomar's petition.

STATEMENT

1. Medicare reimburses only expenses that are "reasonable and necessary for the diagnosis or treatment of illness or injury." 42 U.S.C. § 1395y(a)(1)(A). HHS administers the Medicare program through its Centers for Medicare and Medicaid Services ("CMS"), which, in turn, uses contractors to process claims and perform related functions on behalf of the agency. See S*chweiker v. McClure*, 456 U.S. 188 (1982) (upholding constitutionality of use of private insurance carriers for hearings on disputed Medicare claims).

As the panel's decision explains, Op. 11014, a provider dissatisfied with a Medicare contractor's initial determination respecting an individual's claim for Medicare benefits can challenge that determination through four levels of

administrative appeal. It may seek a redetermination from the Medicare contractor that made the initial determination; reconsideration from a Qualified Independent Contractor; and a hearing before an administrative law judge ("ALJ"). 42 C.F.R. §§ 405.940, 405.960, 405.1000 (2007).[1] The Medicare Appeals Council ("the Council") renders the fourth and final decision on behalf of HHS, *id*. § 405.1130, and that decision may be appealed to a federal district court, see 42 U.S.C. §§ 405(g), 1395ff(b)(1)(A).

Initial claim determinations may also be "reopened" by Medicare contractors. 42 C.F.R. § 405.980(a)(1)(i). In contrast to the four levels of administrative appeal concerning an initial claim determination, a reopening is "a remedial action" that is intended to ensure that Medicare has paid the correct amount. 67 Fed. Reg. 69,312, 69,327 (Nov. 15, 2002); see also 70 Fed. Reg. at 11,450-51. Thus, reopenings of initial determinations are an audit function.

The Medicare statute does not require reopenings; "reopening exists only by grace of [HHS]." *Your Home Visiting Nurse Servs., Inc. v. Shalala*, 525 U.S. 449, 454 (1999). Congress has also given HHS wide discretion to establish "guidelines * * * in regulations" for reopening and revising claim determinations. 42 U.S.C. § 1395ff(b)(1)(G). Pursuant to that authority and after notice-and-comment

[1] The 2007 edition of C.F.R. is cited here because that is the version in effect at the time of the events in question.

rulemaking, HHS issued regulations in 2005, clarifying the agency's discretionary procedures for reopening and revising claim determinations. See 67 Fed. Reg. 69,312 (proposed rules); 70 Fed. Reg. 11,420 (interim final rules).

The regulations permit a Medicare contractor to reopen a claim determination on its own initiative or at a party's request. 42 C.F.R. § 405.980(b), (c). As pertinent here, contractors may reopen and revise initial determinations or redeterminations on their own motion "[w]ithin 4 years from the date of the initial determination or redetermination for good cause as defined in § 405.986." *Id*. § 405.980(b)(2). Good cause "may" be found when there is "new and material evidence" not previously "available or known at the time of the determination" or an "obvious error" was made. *Id*. § 405.986(a).

A provider may appeal "[o]nly the portion of the initial determination * * * revised by the reopening." *Id*. § 405.984(f). The provider may also seek judicial review of the final revised payment determination.

The regulations state further that "[a] contractor's * * * determination or decision to reopen or not to reopen an initial determination" is an action that is "not [an] initial determination[]" and is "not appealable" under the regulations, *id*. § 405.926(*l*), and a contractor's "decision on *whether to reopen* is final and not subject to appeal," *id*. § 405.980(a)(5) (emphasis added). In response to a comment in the rulemaking suggesting that the agency "create enforcement

provisions for the good cause standard when contractors reopen claims," HHS declined to provide such a procedure, explaining that it "assesses a contractor's compliance with Federal laws, regulations and manual instructions during audits and evaluations of the contractors' performance." 70 Fed. Reg. at 11,453. Thus, compliance with the "good cause" standard for reopening is enforced directly by HHS through audits of its own contractors' performance, rather than through the administrative appeals process.

2. In 2007, a Recovery Audit Contractor reopened a claim for Medicare reimbursement submitted by Palomar in 2005.[2] The RAC determined that Palomar had been overpaid on that claim by almost $8000, because the services provided to the beneficiary were not reasonable and necessary. Palomar challenged that overpayment determination through four levels of administrative review, and each HHS decisionmaker agreed with the RAC that the services were not reasonable and necessary and thus, were not covered by Medicare. Op. 11019-20.

However, notwithstanding the regulations explicitly precluding appeal from the contractor's decision whether to reopen, the ALJ entertained Palomar's challenge on that issue and concluded that the contractor did not have good cause

[2] Congress created RACs in 2003. See Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA"), Pub. L. No. 108-173, § 306(a), 117 Stat. 2066, 2256. In light of their success in correcting over $1 billion in improper payments, Congress subsequently made RACs a permanent part of the Medicare Integrity Program. 42 U.S.C. § 1395ddd(h).

to reopen the claim. He therefore set aside the overpayment determination. The Council reversed that ruling, holding that neither the ALJ nor the Council had jurisdiction to assess whether the RAC had good cause to reopen, because that threshold decision was not subject to administrative appeal under HHS regulations. Op. 11020.

3. Palomar filed suit in federal district court, challenging only the Council's ruling that the RAC's decision to reopen the claim determination was not subject to administrative appeal. The district court granted summary judgment to HHS, deferring to the agency's interpretation of the plain language of its regulations and concluding that the RAC's decision to reopen Palomar's claim was not subject to administrative or judicial review.

This Court unanimously affirmed. First, the panel concluded that "the regulations mean what they say: reopening decisions are final, and final means they cannot be challenged after an audit and revised determination." Op. 11025. In the panel's view, Palomar's position "would lead to a bizarre and inefficient system of recovery audits and appeals" that would "tilt the focus from the reasonableness and necessity of providing medical services to the strength of the RAC's grounds for reopening." Op. 11025. The panel also rejected Palomar's reliance on HHS's alleged previous interpretation of regulations governing Social Security and other kinds of Medicare reopenings, noting that the agency's

interpretation of "two newly promulgated regulations on the reopening of Medicare claim determinations" is at issue here, not other regulations for other programs. Op. 11029.

Next, the panel held that the reopening regulations are consistent with the Medicare statute, which gives HHS the discretion to reopen and revise initial determinations "under guidelines established by the [agency] in regulations." 42 U.S.C. § 1395ff(b)(1)(G). The panel found "nothing arbitrary or capricious" about HHS's decision to enforce the "good cause" reopening standard internally, rather than through provider appeals: "This enforcement scheme sensibly balances providers' interests in fairness and finality against Congress's and the public's interests in paying Medicare claims accurately and preserving funds for future Medicare beneficiaries." Op. 11032.

Lastly, in response to Palomar's contention that the courts nevertheless have jurisdiction to consider a provider's objection that a contractor did not have good cause to reopen a claim determination, the panel explained that "[t]he Medicare statute limits judicial review of [HHS's] decisions to 'final decision[s] * * * made after a hearing.'" Op. 11033; see 42 U.S.C. §§ 405(g), (h), 1395ff(b)(1)(A). Because the decision to reopen a claim "is not a 'final decision of the [Secretary] made after a hearing,' the district court and this court lack jurisdiction to review it." Op. 11035.

ARGUMENT

I. The Panel's References To The RAC Program Are Appropriate

Palomar first alleges that "[t]he panel erred by treating the regulations at 42 C.F.R. § 405.980(a)(5) and § 405.926(*l*) as specific to RACs," when those regulations actually "govern a wide array of Medicare audit contractors and agency appellate bodies," "[i]n addition to RACs." Pet. 7, 8; see also Pet. 1 ("[The] regulations apply across the board, not just to RACs."). According to Palomar, "[HHS's] interpretation of the regulations cannot be upheld, therefore, based upon the specific needs of the RAC program." Pet. 8.

Palomar's argument is illogical. To be sure, the regulations plainly refer to reopenings by a "contractor" and do not limit their application to any particular type of contractor reopening. See, e.g., 42 C.F.R. §§ 405.926(*l*), 405.980(a)(1)(i), (2)-(5), (b). Contrary to Palomar's suggestion, the Court's opinion shows that the panel understood that. See, e.g., Op. 11014-16, 11023-25. More important, however, if the needs of one audit program provide a basis for those regulations and HHS's interpretation thereof, the fact that the regulations apply to reopenings under other circumstances as well simply provides *additional* support for the agency's regulations and the panel's decision.

The panel's discussion of the RAC program is also not surprising. A RAC reopened the claim at issue in this case. Op. 11019. Palomar's opening brief

mentioned the "Recovery Audit Contractor" program and "RACs" over 50 times. See Palomar Br. (Docket Entry 9-1). And, a substantial portion of the first of two *amicus* briefs filed by the California Hospital Association ("CHA") was devoted to criticism of the RAC program. See CHA Br. (Docket Entry 18-2). Indeed, the bulk of the *amicus* brief filed by the American Medical Association ("AMA") in support of the rehearing petition consists of essentially policy-type complaints about the congressionally-created RAC program. See AMA Br. (Docket Entry 69-1). Had the panel failed to discuss the RAC program, Palomar and its *amici* undoubtedly would have raised *that* as a point of error.

In any event, if "audits" or "contractors" were substituted for the unanimous decision's references to the RAC program, it would not alter or undermine the panel's reasoning. All Medicare audit programs share the same goals of ensuring that payments are made properly and efficiently. It was entirely appropriate for the panel to take those reasonable goals into consideration in upholding HHS's interpretation and application of the agency's own regulations governing reopenings of claim determinations.

Palomar also complains that HHS "has proffered inconsistent interpretations" of "nearly identical language applicable to reopening Social Security claims and Medicare cost reports." Pet. 9. The panel, however, correctly rejected that argument, emphasizing that the issue here "is [HHS's] interpretation

of two newly promulgated regulations on the reopening of Medicare claim determinations, not [its] interpretation of other regulations governing [Social Security] reopenings or Medicare cost report reopenings." Op. 11029. The panel explained that the "independent Medicare reopening regulations" here at issue "nowhere exist in [Social Security] regulations" and "are similarly distinct from the Medicare cost report reopening regulations." Op. 11029.

Moreover, as the panel pointed out, neither HHS's "prior conduct of [Social Security] reopenings nor [its] subsequent conduct of cost report reopenings make[s the agency's] interpretation of 42 C.F.R. §§ 405.926(*l*) and 405.980(a)(5) 'plainly erroneous or inconsistent with the regulation[s].'" Op. 11029 (quoting *Auer v. Robbins*, 519 U.S. 452, 461 (1997)). Indeed, in 1995, the Social Security Administration became independent of HHS, and, in 2003, in the same statute that created the RAC program, Congress directed HHS to establish regulations specifically to govern Medicare claims, as distinct from Social Security claims. See MMA, *supra* note 2, § 931(a)(2)(D), 117 Stat. 2397. Finally, as the panel noted, HHS "has consistently held that these regulations bar administrative review of RACs' compliance with the time limits and standards for reopening." Op. 11029-30 (citing examples). Thus, HHS's interpretation and application of the regulations *involved in this case* have been consistent.

II. The Panel Correctly Held That Federal Courts Lack Jurisdiction Under The Medicare Statute To Review Contractors' Compliance With The Good Cause Standard For Reopening

The Medicare statute provides that a person dissatisfied with "any initial determination" is entitled to (i) "reconsideration of the determination" and (subject to certain conditions not relevant here) "a hearing thereon"; and (ii) "judicial review of [HHS's] final decision after such hearing as is provided in [42 U.S.C. § 405(g)]." 42 U.S.C. § 1395ff(b)(1)(A). Section 405(g), in turn, provides for judicial review in a federal district court of "any final decision * * * made after a hearing." *Id*. § 405(g). Thus, in order to obtain judicial review, there must be an initial determination respecting a claim for Medicare benefits, followed by HHS's final decision after a hearing.

Palomar claims that "[t]he panel has granted [HHS] vast new powers over the federal courts" by holding that HHS "may close the courthouse doors simply by defining an 'initial determination' as not encompassing review of whether [HHS] has complied with [its] regulations." Pet. 10. Palomar is mistaken. The panel has not given HHS any "new" or "vast" powers; it is the Medicare statute that forecloses review of a contractor's threshold decision whether to reopen a claim determination.

As the panel correctly explained, "[t]he decision to reopen a paid Medicare claim * * * is discretionary." Op. 11033. The Medicare statute does not provide

for reopenings; rather, "reopening exists only by grace of the Secretary." *Your Home*, 525 U.S. at 454. See also *Califano v. Sanders*, 430 U.S. 99, 108 (1977). In addition, Congress gave HHS discretion to fashion reopening regulations, as the agency sees fit: HHS "may reopen or revise any initial determination * * * under guidelines established by the [agency] in regulations." 42 U.S.C. § 1395ff(b)(1)(G).[3] Pursuant to that broad authority, HHS adopted the regulations at issue, which specify that a contractor's threshold decision to reopen or not to reopen an initial claim determination is not itself an initial determination and is not appealable. 42 C.F.R. §§ 405.926(*l*), 405.980(a)(5).

The panel explained that "the standards governing reopenings 'are afforded by [HHS's] regulations and not by the [Medicare] Act' and no hearing on a reopening decision is required by statute." Op. 11034 (quoting *Sanders*, 430 U.S. at 108). Because Congress gave HHS the "discretion to set guidelines governing the reopening and revision of claim determinations and to structure the means of enforcing such guidelines so as to achieve efficiency and accuracy in the administration of the Medicare program," HHS "permissibl[y]" placed reopening decisions beyond review. Op. 11034. The panel therefore correctly held that the decision to reopen is not "a 'final decision' for purposes of [42 U.S.C.] § 405(g),"

[3] Thus, HHS could adopt a regulation that permits reopening of a claim at any time, for any reason.

Op. 11033, and "the district court and this court lack jurisdiction to review it," Op. 11035.

The panel's decision is consistent with this Court's precedents, as well as those of other courts. See Op. 11034-35 (citing cases). For example, in *Matlock v. Sullivan*, 908 F.2d 492, 493 (9th Cir. 1990), plaintiff sought review of the dismissal of his untimely request for review of the denial of his application for supplemental Social Security benefits. The Court held that "whether jurisdiction exists depends on whether the action by [HHS] constitutes a final decision under section 405(g)." *Ibid*. (citing, *inter alia*, *Sanders*, 430 U.S. at 108). The agency's refusal to consider plaintiff's untimely request for review was a matter of discretion under the statute and agency regulations, and, thus, it was not a final decision made after a hearing, subject to judicial review under section 405(g). *Id*. at 493-94. The same is true here: the entirely discretionary decision whether to reopen a claim determination is not a final decision made after a hearing, and, accordingly, the courts have no jurisdiction to review it. See also *Your Home*, 525 U.S. at 454.

Contrary to Palomar's contention, HHS's regulation specifying that a "decision to reopen or not to reopen an initial determination" is not itself an initial determination subject to appeal, see 42 C.F.R. § 405.926(*l*), is fully consistent with the Medicare statute. Nothing in the provision cited by Palomar, 42 U.S.C. § 1395ff(a)(1), suggests otherwise. In fact, the section that gives HHS discretion

to "reopen or revise any initial determination" shows, on its face, that Congress understood that the decision to "reopen" is distinct from the "initial determination" itself. *Id*. § 1395ff(b)(1)(G).

Finally, Palomar and its *amici* mistakenly rely on authority holding that agencies must comply with their own regulations. Pet. 11. While generally true, that principle does not establish that a court will always have jurisdiction to review any challenge to an agency's alleged noncompliance with its regulations. Here, as discussed above, the Medicare statute confers jurisdiction on federal courts to review only final orders made after a hearing; the threshold decision whether to reopen a claim determination is not such an order. In any event, Palomar's complaint here is, in effect, that HHS *complied* with its reopening regulations that foreclose appeal of the decision to reopen a claim.

III. HHS Has Not Unlawfully Subdelegated Unreviewable Authority To Medicare Contractors

Palomar contends that HHS has "unconstitutionally subdelegated to Medicare contractors unreviewable discretion to comply with the reopening regulations." Pet. 12. Palomar admits that it did not previously raise this issue at any time during this litigation, but argues that there are "'extraordinary circumstances'" for allowing it to do so. Pet. 14 n.4. According to Palomar, "[a]fter oral argument, [HHS] revealed for the first time, in a supplemental brief, that [it] interprets the reopening regulations to forbid even [the agency] from

correcting [its] contractors' specific reopening errors." Pet. 13-14. That is patently wrong.

Palomar quotes the following statement in HHS's supplemental brief – *a brief to which Palomar responded*: "Thus, neither a provider nor [CMS] may challenge a contractor's decision to reopen." HHS Supp. Br. (Docket Entry 50-1) 4. That statement immediately follows a discussion of HHS's regulations stating that the threshold decision whether to reopen a claim "'is not subject to appeal.'" *Ibid.*; see 42 C.F.R. §§ 405.926(*l*), 405.980(a)(5). Virtually the same statement appears, in the same context, in HHS's appellee brief (to which Palomar also replied): "Thus, if a provider requests and obtains reopening of an initial determination, CMS cannot challenge the decision to reopen." HHS Br. (Docket Entry 25-1) 31 n.16. The point of those statements, as is evident from both the context in which they appear and the plain language of the regulations themselves, is that *the regulations foreclosing administrative appeal from the decision whether to reopen apply evenhandedly to providers and CMS alike*.

Nothing in those statements contradicts or undermines the fact that HHS *itself* monitors and enforces contractors' compliance with the "good cause" standard for reopening. In fact, the very next page of HHS's supplemental brief states:

> As for contractor compliance with the regulations, HHS explained that "[t]he regulations require that contractors

> abide by the good cause standard for reopening actions after one year," and *the agency "assesses a contractor's compliance with Federal laws, regulation and manual instructions during audits and evaluation of the contractors' performance.* Thus, the necessary monitoring and enforcement mechanisms are already in place." [70 Fed. Reg. at 11,453.] HHS reiterated that position in a subsequent rulemaking. 74 Fed. Reg. 65,296, 65,312 (Dec. 9, 2009).

HHS Supp. Br. (Docket Entry 50-1) 5 (emphasis added).[4]

Thus, the statement to which Palomar belatedly objects was *not* made for the first time in HHS's supplemental brief, and it does *not* say what Palomar inexplicably claims that it says. HHS has *not* "subdelegated" its authority to ensure contractor compliance with its regulations to the Medicare contractors themselves. The Court should reject Palomar's eleventh hour attempt to fashion an entirely new issue out of whole cloth.

IV. The Court Should Disregard *Amici's* Various Other Complaints

The *amici* briefs in support of Palomar's rehearing petition (like their several earlier briefs) repeat generalized complaints about audits and reopened claim determinations. Such complaints are both unsurprising and unfounded. And, in any event, they provide no basis for rehearing this case *en banc*.

[4] It also bears noting that, in the second of its two *amicus* briefs, the AMA made the same argument to the panel that Palomar attempts to raise here, AMA Br. (Docket Entry 44) 5, and HHS's supplemental brief (at 8-9) addressed it. Thus, the panel had an opportunity to address this non-issue and properly chose not to do so.

For example, the AMA complains about hypothetical reopenings of claim determinations many years after payment, by which time memories will have faded. However, given the size and scope of the Medicare program, CMS has as much interest in an efficiently run program and administrative finality of claim determinations as providers do. CMS therefore instructs RACs not to reopen claims (absent evidence of fraud) more than 3 years later.[5] Moreover, reopening a claim determination routinely involves review of existing *records* documenting the nature of and need for a beneficiary's medical treatment, not witness testimony.[6] Hospitals are required to retain medical records for at least five years, 42 C.F.R. § 482.24(b)(1), and often longer under state law. Physicians also generally retain patient medical records for five years or longer, as required by state law. And CMS requires contractors to retain claims records (which include the documentation used to support Medicare payments) for six years and three months and often much longer. Medicare Manual, Pub. 100-01, ch. 7, § 30.30.2,

[5] See *Statement of Work for the Recovery Audit Program* (2011) 9-10, 10-11, http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/090111RACFinSOW.pdf; see also 42 C.F.R. § 405.350(c) (provider is "deemed to be without fault" if overpayment determination is made more than three years after claim was paid).

[6] Witness testimony can be important in fraud cases. But in such cases – which may be reopened at any time, see 42 C.F.R. § 405.980(b)(3) – HHS has an incentive to act as promptly as possible.

http://www.cms.hhs.gov/manuals/downloads/ge101c07.pdf. Thus, the AMA's complaints are not grounded in reality.

Amici also complain about the "bounty" paid to RACs. However, Congress mandated that RACs be compensated on a contingency fee basis, 42 U.S.C. § 1395ddd(h)(1), which is the same way in which auditors of private health care plans are typically paid. See GAO-10-143, *Medicare Recovery Audit Contracting* 8 (March 2010), http://www.gao.gov/assets/310/302559.pdf. Moreover, RAC contingency fees are publicly disclosed, and, if a RAC's overpayment determination is reversed at any level of appeal, the RAC must return the fee for that case. GAO-10-864T, *Medicare Recovery Audit Contracting* 8 (July 2010), http://www.gao.gov/assets/130/124986.pdf. Thus, while RACs have a financial incentive to uncover overpayments, they also have an incentive to make accurate determinations.

CONCLUSION

For the foregoing reasons, the Court should deny Palomar's petition for rehearing *en banc*.

Respectfully submitted,

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JANUARY 2013

CERTIFICATE OF COMPLIANCE

This brief complies with the format requirements of Fed. R. App. P. 32(c)(2) and Cir. R. 35-4(a) and 40-1(a), because it was prepared using Microsoft Word 2010, Times New Roman proportional font, 14-point, and it contains 4,199 words.

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9th Circuit Case Number(s) 10-56529

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