Logic Loses Its Luster In Recent Eleventh Circuit False Claims Act Decision

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For those engaged in defending False Claims Act ("FCA") cases, it has become all too clear that the Department of Justice's focus on the healthcare industry shows no sign of waning. Unfortunately, a recent decision out of the Eleventh Circuit could make the defense of FCA allegations against healthcare providers more difficult. In *United States v. AseraCare Inc.*, No. 2:12-CV-245-KOB, 2014 U.S. Dist. LEXIS 167970 (N.D. Ala. Dec. 4, 2014), the Northern District of Alabama declined to follow a recent district court decision out of the Northern District of Illinois which found, under very similar facts, that a simple difference of opinion between healthcare providers was insufficient to support a FCA claim. *U.S. ex rel. Geschrey v. Generations Healthcare, LLC*, 922 F. Supp. 2d 695, 695 (N.D. Ill. 2012). Instead, and while acknowledging that the standard in Geschrey was appealing and logical, the *AseraCare* court allowed the government's claims to proceed despite the requirement under the FCA that the government prove objective falsehood with respect to the claims at issue. *U.S. ex rel. Parato v. Unadilla Health Care Ctr., Inc.*, 787 F. Supp. 2d 1329, 1339 (M.D. Ga. 2011) (quoting *U.S. ex rel. Roby v. Boeing Co.*, 100 F. Supp. 2d 619, 625 (S.D. Ohio 2000)).

The Hospice Care Benefit Under Medicare Part A

The Aseracare case involved hospice care, a benefit under Medicare Part A. The Medicare Hospice Benefit is administered by the Centers for Medicare & Medicaid Services ("CMS") on behalf of the Department of Health and Human Services. The Medicare Hospice Benefit pays a predetermined fee, based on the type of care provided by the hospice provider, for each day an eligible patient receives hospice care. To be eligible for hospice care under Medicare, "an individual must be . . . (a) [e]ntitled to Part A of Medicare; and (b) [c]ertified as being terminally ill in accordance with § 418.22." 42 C.F.R. § 418.20.

Per the regulations, patients must be certified as terminally ill before CMS will pay the provider for hospice care. To qualify for the Medicare Hospice Benefit, "the individual's attending physician . . . and . . . the medical director . . . of the hospice program providing . . . the care, each certify in writing at the beginning of the period, that the individual is terminally ill . . . based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness." 42 U.S.C. § 1395f(a)(7)(A)(i). A patient is considered to be 'terminally ill' if the patient has a medical prognosis of life expectancy of six months or less. 42 U.S.C. § 1395x.

After the patient is certified as eligible and has received hospice care, the provider submits a claim for the hospice services it provided the patient to CMS through the Medicare Administrative Contractor ("MAC"). The MAC processes Medicare Hospice Benefit claims for CMS and determines whether to pay or deny the claim for the Medicare Hospice Benefit.

U.S. ex rel. Geschrey v. Generations Healthcare

In *Geschrey*, the Relators (a nurse and a social worker) alleged that Generations Healthcare ("Generations") committed three types of fraud against the government related to hospice admissions: improper enrollment and fraudulent certifications, submission of false documents, and improper billing for services not provided. *U.S. ex rel. Geschrey*, 922 F. Supp. 2d at 703. The Relators claimed that Generations recruited and certified patients that it knew were ineligible for

hospice care because they were not terminally ill, and then fraudulently billed Medicare and/or Medicaid for the patients' care. *Id.* at 700. The Relators allege that they were involved in the decisions to certify patients for hospice care because they were part of an "interdisciplinary team" assigned to each patient. *Id.* A nurse and members of the interdisciplinary team would visit the patient, evaluate the patient's condition, and meet to report their findings. *Id.* Based on the interdisciplinary team's findings, a written certification of eligibility for hospice care was prepared and the notice of hospice election was filed on the patient's behalf. *Id.* The Relators alleged that Generations' medical director would sign off on the written certification without having seen the patient. *Id.*

With respect to the false certification claim, the Relators alleged that certain patients were not appropriate for hospice because they did not satisfy specific clinical criteria. *Id.* at 703. The Defendants argued that the Relators' allegations amounted to nothing more than a disagreement with the conclusion by the medical director that the patients were hospice appropriate. *Id.* The court held that the Relators' difference of opinion with the medical director did not support the claim that the certifying physician did not or could not have believed, based on the physician's clinical judgment, that the patient was eligible for hospice care. Id. As a result, the court found that a mere difference of opinion within the "interdisciplinary team," i.e., the Relators and the Medical Director, was not evidence of fraud and, therefore, insufficient to support a FCA violation. *Id.*

United States v. AseraCare Inc.

In *AseraCare*, patients referred for hospice care were initially evaluated and certified by their attending physician and AseraCare's hospice medical director. *United States v. AseraCare Inc.*, No. 2:12-CV-245-KOB, 2014 U.S. Dist. LEXIS 167970, at *7 (N.D. Ala. Dec. 4, 2014). Just as in *Geschrey*, the AseraCare medical director often relied on nurses and other staff for initial and recertification eligibility determinations, sometimes making the initial certifications by telephone based upon patient information verbally communicated by AseraCare nurses instead of the physical medical file. *Id.*

The Relators alleged that AseraCare schemed to defraud Medicare by coercing its employees to interpret medical records liberally so that AseraCare could submit hospice claims for borderline patients. *Id.* at *1-2. Specifically, the government alleged, among other things, that the certification of terminal illness for many patients signed by AseraCare's medical director was unsupported, and that the submission of those claims for payment satisfied the falsity element under the FCA. *Id.* at *14. To support those allegations, the Relators and the government pointed to purportedly objective information in patient medical records, as well as testimony from the government's paid expert. Id. at *14-15. Notably, the court acknowledged that the government expert's testimony regarding his review of the medical records in question was the only evidence of the falsity element, and that it was undisputed the expert could not say any physicians were wrong when they certified patients as terminally ill. *Id.* at *14.

AseraCare urged the court to adopt the standard and reasoning in *Geschrey* and grant summary judgment as to the government's claims based on the purported false certifications. AseraCare argued that because the government failed to provide evidence that its medical director did not or could not believe, based on his clinical judgment, that the certifications in question were appropriate, the government had failed to meet its evidentiary burden. *Id.* at *15. The court recognized that the *Geschrey* standard was "appealing and logical," noted that the FCA required "proof of an objective falsehood" to show falsity, and implied that the evidence presented by the government was of doubtful credibility. Id. Nonetheless, the court declined to follow the *Geschrey* standard and instead denied AseraCare's motion, ruling that the mere difference of opinion between the medical director and the government's expert provided the basis for the government's otherwise dubious claims to proceed. *Id.*

The court's decision in *AseraCare* not to follow what it acknowledges is a logical standard illustrates the difficulty in defending FCA cases. Courts are often wary of dismissing claims; unfortunately, in so ruling, courts perpetuate the hardship these cases have on providers – particularly in those cases where the only evidence is a difference of clinical opinion.

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