No. _____

In The

Supreme Court of the United States

GERTRUDE PARKER,

Petitioner,

v.

UNITED STATES OF AMERICA,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

WHETHER PARKER WAS DENIED EFFECTIVE ASSISTANCE OF COUNSEL GUARANTEED BY THE SIXTH AMENDMENT TO THE UNITED STATES CONSTITUTION AS A RESULT OF HER TRIAL COUNSEL'S FAILURE TO PRESENT EVIDENCE TO THE JURY, AND ACCOMPANYING ARGUMENT, THAT PARKER'S CONDUCT WAS NOT CRIMINAL BECAUSE SHE WAS OPERATING UNDER A REASONABLE INTERPRETATION OF THE MEDICARE STATUTES AND REGULATIONS AND PARKER WAS PREJUDICED WHEN THE JURY RETURNED A GENERAL GUILTY VERDICT BASED ON INSUFFICIENT EVIDENCE AS TO ONE OF THE THREE ALLEGED ALTERNATIVE MEANS OF THE CONSPIRACY.

LIST OF PARTIES

Gertrude Parker, Petitioner

United States of America, Respondent

STATEMENT OF RELATED CASES

- *United States of America v. Gertrude Parker*, No. 2:15-cr-152-CJB-JVM, U.S. District Court, Eastern District of Louisiana, New Orleans Division, judgment entered January 24, 2017
- *United States of America v. Gertrude Parker*, No. 2:19-cv-13616-CJB, U.S. District Court, Eastern District of Louisiana, New Orleans Division, judgment denying 2255 entered February 24, 2021
- *United States of America v. Gertrude Parker*, No. 21-30127, U.S. Court of Appeals, Fifth Circuit, motion for a certificate of appealability denied June 15, 2021

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The Petitioner, Gertrude Parker, respectfully prays that a writ of certiorari issue to review the decision of the United States Court of Appeals for the Fifth Circuit, entered in *United States of America v. Gertrude Parker*, in Fifth Circuit Case Number 21-30127, Filed June 15, 2021 denying Parker's request for a certificate of appealability of the denial of his petition filed under Title 28, United States Code § 2255. The order of the Fifth Circuit was unreported, but a true and correct copy is included in Appendix A, *infra*. The United States District Court for the Eastern District of

Louisiana had previously denied Parker's 2255 petition in an unpublished order entered February 24, 2021, a copy of which is included in Appendix B, *infra*.

OPINION BELOW

The decision and order of the Fifth Circuit was unreported. The decision of the district court on the merits of the 2255 petition was also unreported.

JURISDICTION

This Court has jurisdiction to review the decision of the United States Court of Appeals for the Fifth Circuit denying Parker's request for certificate of appealability pursuant to Title 28 U.S.C. § 1254(1).

CONSTITUTIONAL PROVISIONS INVOLVED

The Sixth Amendment to the United States Constitution provides:

> Amendment VI. Jury trials for crimes, and procedural rights
>
> In all criminal prosecutions, the accused shall enjoy the right to a speedy and public trial, by an impartial jury of the State and district wherein the crime shall have been committed, which district shall have been previously ascertained by law, and to be informed of the

> nature and cause of the accusation; to be confronted with the witnesses against him; to have compulsory process for obtaining witnesses in his favor, and to have the Assistance of Counsel for his defense.

STATEMENT OF THE CASE

Pursuant to Title 28, United States Code § 2253(c)(1)(B), and Rule 22(b), Federal Rules of Appellate Procedure, Gertrude Parker ("Parker") requested a Certificate of Appealability ("COA") from the Order dated and entered February 24, 2021 denying her petition filed under 28 U.S.C. § 2255. Rule 22(b) of the Federal Rules of Appellate Procedure and Title 28 U.S.C. § 2253 require issuance of a COA before an appeal may be heard of a denial of a petition for relief under 28 U.S.C. § 2255. Parker filed a timely notice of appeal. Thereafter the Fifth Circuit Court of Appeals denied the COA request by an unreported opinion June 15, 2021. This certiorari petition followed in a timely manner.

BACKGROUND FACTS AND ISSUE PRESENTED

A Federal grand jury in the Eastern District of Louisiana, by way of superseding indictment, charged Rodney Hesson, Gertrude Parker, Dr. Beverly Stubblefield, and Dr. John Teal in a conspiracy to commit

health care fraud spanning six and a half years, from January 1, 2009 through May 31, 2015. The Superseding Indictment charged each defendant with one count of conspiracy to commit health care fraud in violation of 18 U.S.C. § 1349 (Count One) and one count of conspiracy to make false statements related to health care matters in violation of 18 U.S.C. § 371 (Count Two).

Parker proceeded to trial and was convicted of both counts by a jury using a general verdict form. Parker was sentenced to 84 months of imprisonment. Parker filed a 179 page timely pro-se habeas petition pursuant to 28 U.S.C. § 2255 raising, among other claims, that she was denied effective assistance of counsel when her counsel failed to present evidence to the jury, and accompanying argument, that Parker's conduct was not criminal because she was operating under a reasonable interpretation of the Medicare statutes and regulations and Parker was prejudiced when the jury returned a general verdict based on insufficient evidence as to one of the three alleged alternative means of the conspiracy. The Government filed a thirty (30) page response, and Parker filed a twenty-four (24) page Reply on February 16, 2021. Eight days later, the District Court denied Parker's 2255 petition in a two-page order and ordered that a certificate of appealability not be issued. The District Court's Order held in pertinent part:

> After reviewing the evidence raised in this case, the Court is convinced that no jury

would find Defendant's conduct complied with any reasonable interpretation of the statute.

Appendix B.

ARGUMENT IN SUPPORT OF GRANTING THE WRIT

I. WHETHER PARKER WAS DENIED EFFECTIVE ASSISTANCE OF COUNSEL GUARANTEED BY THE SIXTH AMENDMENT TO THE UNITED STATES CONSTITUTION AS A RESULT OF HER TRIAL COUNSEL'S FAILURE TO PRESENT EVIDENCE TO THE JURY, AND ACCOMPANYING ARGUMENT, THAT PARKER'S CONDUCT WAS NOT CRIMINAL BECAUSE SHE WAS OPERATING UNDER A REASONABLE INTERPRETATION OF THE MEDICARE STATUTES AND REGULATIONS AND PARKER WAS PREJUDICED WHEN THE JURY RETURNED A GENERAL GUILTY VERDICT BASED ON INSUFFICIENT EVIDENCE AS TO ONE OF THE THREE ALLEGED ALTERNATIVE MEANS OF THE CONSPIRACY.

Under 28 U.S.C. § 2253(c)(2), a certificate of appealability may issue "only if the applicant has made a substantial showing of the denial of a constitutional right." 28 U.S.C. § 2253(c)(2). The term "constitutional right" in § 2253 includes "federal rights," because any attempt by Congress to enact a "wholesale strip of

authority" for federal appellate courts to review decisions is of "questionable constitutionality" and requires a "clear statement" of intent to divest jurisdiction that § 2253 lacks. *Gomez v. Dretke*, 422 F.3d 264 (5th Cir. 2005). A petitioner satisfies the "substantial showing" standard by demonstrating that reasonable jurists would find that an assessment of his claims is debatable. *Miller-El v. Cockrell*, 537 U.S. 322, 338 (2003). A petitioner is not required to show that any jurist would agree with him. *Id*. The issues need only be "adequate to deserve encouragement to proceed further." *Id*. at 338.

Parker's petition and request for certificate of appealability presents a claim of ineffective assistance of counsel which is far more than debatable. The claim was summarily rejected by the District Court without an evidentiary hearing. Parker argued in her 2255 and her Reply to the Government's response that her counsel failed to present argument and argue to the jury that Parker's conduct was not criminal because she was operating under a reasonable interpretation of the Medicare statutes and regulations and she was prejudiced when the jury returned a general verdict based on insufficient evidence as to one of the three alleged alternative means of the conspiracy. The Government's response to Parker's 2255 primarily argued that any deficient performance was harmless.[1] The District Court denied Parker's claim as follows:

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[1] An analytical error which permeated the Government's response to Parker and Hesson's 2255 is the confusion and

> After reviewing the evidence raised in this case, the Court is convinced that no jury would find Defendant's conduct complied with any reasonable interpretation of the statute.

Appendix B. The order fails to identify the basis for this ruling, and the facts of the case do not support it. As explained below, Parker and Hesson's interpretation of the Medicare regulations was reasonable, and had their counsel shown this to the jury, there is a reasonable probability that the jury would have found Parker and Hesson not guilty.

The Government charged Parker and Hesson with Medicare fraud, arguing that the fraud was committed in any one of three ways, over-billing, billing for medically unnecessary services, or not providing the billed-for services at all. The trial court gave the jury a

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misapplication of the concept of legally sufficient evidence (a direct appeal standard) to uphold a conviction versus the *Brecht v. Abrahamson* habeas standard. Before *Brecht v. Abrahamson*, 507 U.S. 619 (1993), the courts applied the same harmless error rule on direct appeal and in federal habeas corpus. Under that rule, embraced for constitutional errors in *Chapman v. California*, 386 U.S. 18 (1967), a conviction tainted by a constitutional error susceptible to harmless error analysis could be upheld only if the state demonstrated that the error was harmless beyond a reasonable doubt. After *Brecht*, the venerable *Chapman* rule still applies to constitutional errors identified and reviewed on direct appeal, but an ostensibly "less onerous" standard applies to constitutional errors identified and reviewed on federal habeas corpus. Under this standard, derived from *Kotteakos v. United States*, 328 U.S. 750 (1946), and once used only for nonconstitutional errors, a conviction tainted by constitutional error "requires reversal only if it 'had substantial and injurious effect or influence in determining the jury's verdict.' "

unanimity theory instruction, instructing the jury that it did not have to find the defendants guilty of all three objects, any one would suffice, and indeed in closing argument, the government emphasized this, telling the jury that once they reached unanimity on any object, they could cease deliberations and return a guilty verdict. This has implications for the convictions which will be discussed below.

The focus of the Government's case was over-billing. Whether what was done constituted over-billing or not, really does depend, despite the Government's arguing to the contrary, on whether Dr. Hesson's system for billing *locum tenens*, and billing for incident to services, and billing for the work of assistants, and then aggregating billing, was either consistent with governing Medicare regulations *or a reasonable interpretation* of governing regulations or not.

The law is well settled in the Fifth and Eleventh Circuits, that in a criminal fraud case based on legally false statements, such as that charged in this indictment, the Government has the burden of proving beyond a reasonable doubt that the *defendant's interpretation* of the governing regulation was not simply wrong, but entirely *unreasonable*. *United States v. Jones*, 664 F.3d 966 (5th Cir. 2011), citing and relying upon *United States v. Whiteside*, 285 F.3d 1345 (11th Cir. 2002).

At the beginning of the case, the trial court candidly confessed that it was unfamiliar with this area of law, and sought guidance from the Government as to

what was required, and frankly, the Government, no doubt quite innocently, misadvised the trial court, because the Government never explained this burden of proof to the court and indeed led the court into evidentiary rulings which further prevented the defense from doing its job. However, fundamentally it was incumbent on the defense, in the absence of effective assistance of prosecution, so to speak, to brief the court on the Government's burden. That was not done. Instead, the Government closed the case with no argument to the jury that Dr. Hesson's and Parker's interpretations of the governing regulations were *unreasonable*, simply that they were wrong. This effort was legally insufficient. In fact, on cross-examination, Hesson stated that he believed he was using a "reasonable interpretation" of the Medicare regulations. The prosecutor responded: "Sir, I'm not asking about a reasonable interpretation."

The theory of defense was simple, that Dr. Hesson and Parker interpreted the governing regulations to permit the billing he did. This was the defense.

Given this indisputable fact, it is incomprehensible that the defense did not request the trial court to instruct the jury on the governing regulations. Even if the exact language of the proposed jury instructions included in Parker's *pro se* 2255 petition were incorrect, some version of an instruction on the governing regulations would have been given had it been requested—and if not, the failure would have been reversible error on appeal—even if it were only to instruct the jury on the express code provisions, which

the court had announced at one point it was ready to do. With the pertinent and governing instructions not before the jury, there was no way it can be said that the jury reached a sustainable verdict under the governing Fifth Circuit law, that is, that the Government had proved that Hesson and Parker's interpretation of the Medicare regulations were not simply wrong, but unreasonable.[2]

The Government repeatedly argued in its response to Parker and Hesson's 2255 petition that the resolution of the improper billing object of the conspiracy charges is unnecessary because the jury alternatively convicted the defendants of conspiracy to provide medically unnecessary services. Not only is this not an answer to the improper billing argument, but it discloses the fundamental flaw in the convictions as a whole.

The Fundamental Flaw in the Prosecution—The General Verdict

The Government proceeded under an indictment which as to both counts one and two alleged three alternative means by which the conspiracy to commit

[2] The presumption the law gives the Government on direct appeal in a case in which the defendant testifies, and is then convicted, that the jury rejected the defendant's testimony does not apply as a matter of law to a habeas proceeding, and in any event does not apply to this case, because the jury was not properly instructed that it was not a matter of whether Dr. Hesson and Parker's interpretation of the governing regulations were wrong, but whether their interpretation were wrong, but not unreasonable.

health care fraud and conspiracy to make false statements was executed: (1) by improper billing, (2) by performing medically unnecessary services, or (3) by not providing billed medical services at all.

The defense requested, the government objected, and the court denied a special verdict by which it could be determined that the jury had reached a unanimous verdict as to which of the alternative means.

Lack of a special verdict in a conspiracy with multiple objects ordinarily will not matter but it matters greatly if, as was the case here, the evidence turns out to be legally insufficient as to one of the alternative objects. Then in that case, the lack of the special verdict proves fatal to the conspiracy charges as a whole. In other words, it is the Government's argument in reverse. Because the conspiracy convictions on both counts may have rested on an alternative object as to which we have no special verdict but as to which the evidence was legally insufficient, the convictions must be vacated.

The evidence was legally insufficient to establish that Hesson and Parker over-billed, because determination of that charge required the Government to prove that Hesson and Parker's interpretation of the governing regulations which served as the basis for their billings was unreasonable, which the Government failed to do.

Therefore, the Government cannot rely upon its assumption that the jury alternatively convicted the defendants of conspiracy to provide medically

unnecessary services. This conclusion, however, does not simply return us to a reexamination of the defendants' billing arguments. Instead, it leads us to the larger conclusion that the verdicts as a whole must be vacated on both counts.

This is because the law is well settled that absent a saving special verdict, when a conspiracy is charged with multiple objects, and the evidence is legally insufficient as to one such object, then the verdict as a whole is infirm. *United States v. DeLuca*, 692 F.2d 1277, 1281 (9th Cir. 1982); *United States v. Carman*, 577 F.2d 556, 566-68 (9th Cir. 1978) (a conspiracy conviction must be reversed if the trial court instructs the jury that it need find only one of the multiple objects alleged in order to convict of conspiracy in a case in which the reviewing court holds any one of the supporting counts legally insufficient); *see also Van Liew v. United States*, 321 F.2d 664 (5th Cir. 1963). Here, absent a special verdict, it is impossible to know if the jury found Parker guilty based exclusively on the over-billing object of the conspiracy, which she had a defense to, that her counsel failed to present.

The Government's Erroneous Impossible Hours Argument

As noted above, at the heart of the Government's case against Dr. Hesson and Ms. Parker was the Government's theory that Hesson and Parker's Medicare billing had to be fraudulent based purely on the number of hours that individual psychologists were billing

over a specified period of time. The Government's case agent, Jennifer Terry, was called as the first witness against Hesson and Parker and presented what seemed to be damning testimony against both of them regarding time billed under individual psychologists:

> There was a pattern of billing in the time studies where a large number, a majority of the doctors were billing more hours than were possible. They were billing impossible hours and more hours than the universe even allots us to have.

This was the thrust of the Government's case against Hesson and Parker, yet their counsel did next to nothing to present their numerous defenses to it as alleged in Hesson and Parker's 2255 petitions. In response to Hesson and Parker's 2255 petitions, the Government again raised their impossible hours argument. This theory of prosecution was demonstrated at trial primarily through two charts that Agent Terry created, both of which were deeply flawed and ignored the billing practices that were employed by Hesson and Parker, which they believed to be consistent with governing Medicare regulations or a reasonable interpretation of those regulations.

Government Exhibit 1027

The Government's first exhibit introduced at trial to show impossible billing was Exhibit 1027. Appended hereto as Appendix C. Exhibit 1027 was created by Agent Terry and was entered into evidence with no

objection from the Defense. It is titled "Hesson's Average Hours Worked Per Calendar Day and Per Date of Service (96101) Only," yet it does not accurately represent either metric. The chart purports to calculate the average hours billed by Hesson under Medicare billing Code 96101 per calendar day and per date of service to exceed 24 hours per day, with the natural implication to the jury being that Hesson had to have been overbilling Medicare by billing so many hours. Hesson's lawyer made no attempt to discredit the chart which in no way represented the time Hesson was billing for his personal services. Agent Terry was not cross-examined at all on the source of the numbers in the chart, the calculations in it, or the false implications it created. Some of the problems with the chart and the Agent's testimony about it—ripe for cross-examination—are as follows:

A. Hesson's Billing Under Medicare Billing Code 96101 Does Not Represent Actual Hours Personally Spent by Hesson with Patients

The Government throughout the trial implied that billing of units under Medicare Code 96101 equated to face-to-face hours spent by the psychologist with the patient. This was false. Under Hesson's reasonable interpretation of the Medicare regulations, Hesson billed Code 96101 under his provider number for a number of other psychologists under the Medicare accepted practice of "*locum tenens*" billing. Hesson interpreted Medicare's conditions of payment to permit billing for

locum tenens services under his provider number even when he was busy evaluating other beneficiaries. Indeed, no Medicare regulation or other authority exists to indicate that Hesson's interpretation of Medicare's conditions of payment was unreasonable, and background information giving examples of some reasons for *locum tenens* coverage—"for reasons such as illness, pregnancy, vacation, or continuing medical education"—does not purport to represent an exhaustive list. Given Agent Terry's failure to account for *locum tenens* billing, the hours totaled in her chart, Government Exhibit 1027 are overinflated and meaningless.

Further inflating the numbers in Agent Terry's Exhibit 1027 is the fact that Hesson billed under his provider number as Code 96101 a substantial amount of time spent by clinical assistants pursuant to Medicare's "incident to" provisions. This also was consistent with his understanding of the Medicare regulations. According to the CPT code book, Code 96101 "is also used in those circumstances when additional time is necessary to integrate other sources of clinical data. . . ." Current Procedural Terminology Manual, p.484, American Medical Association (2010). Relevant here, Hesson interpreted the regulations to mean that he was permitted to bill for the time it took his clinical assistants ("incident to" his professional services, and under his general supervision from outside the facility) to (a) review the clinical record at the nursing home and copy the relevant portions for integration into NHPS's clinical record (a Medicare requirement); (b) conduct collateral interviews of family members and

staff at the nursing home; and (c) have this clinical information available for the psychologist on the day when he/she actually meets face-to-face with the patient for assessment and testing (i.e., the official "billing date of service"). Furthermore, under Hesson's interpretation of the Medicare regulations, these "incident to" services could be performed under the general supervision of the psychologist rather than under direct supervision. Agent Terry read during her testimony at trial the exception identified in the Medicare Benefit Policy Manual (Section 80.2) which allows a clinical psychologist to bill Medicare under CPT Code 96101 for generally supervised "incident to" services provided by staff assistants. As Parker detailed in her 2255 petition, general supervision does not require that psychologists be at a facility with clinical assistants when they work. As such, he did not need to be at the nursing home when the clinical assistant went there—in advance of the psychologist's actual face-to-face contact with the Medicare beneficiary—to integrate (i.e. review, copy and incorporate) the relevant clinical information in the medical record into the NHPS template ("packet") in preparation for the psychologist's upcoming face-to-face interaction.

Because Agent Terry's chart did not account for any amount of "*locum tenens*" billing nor the large amount of time billed for clinical assistants providing "incident to" services under the general supervision of Hesson, the chart's numbers and its calculations are meaningless and the implications that they conveyed to the jury significantly prejudiced Hesson and Parker

when their attorneys failed to object to the chart or bring out its failings on cross-examination.

B. Medicare Billing Units Do Not Equate to Actual Hours

An unfortunate theme throughout the trial was the Government's attempts to synonymize Medicare billing units with hours in the minds of the jurors. Government Exhibit 1027's hour total calculations were apparently a simple one to one conversion with Medicare units billed. As explained by Agent Terry later in her direct examination, a Medicare unit is often far less than an hour. Even ignoring the fact that *locum tenens* billing and incident to billing occurred under Hesson's provider number, the failure to account for the discrepancy between Medicare units and actual hours greatly exaggerated the numbers in the Government's Exhibit.

C. Service Days is Not Representative of Days Hesson Worked

Another misleading feature of Government Exhibit 1027 is the inclusion of the columns labeled "Service days" and "Average Hours per Date of Service." Service days describe only the day the patient was initially seen by the psychologist. Naturally, not all services for any particular patient were completed on the initial date of service, but to simplify billing to Medicare, it was Medicare's preference that a single cumulative bill be sent to Medicare that captured all of the

services provided to a particular patient. This was Hesson and Parker's billing policy which is termed "cumulative billing." Neither the Government in its response nor its witnesses at trial refuted the legality of cumulative billing and in some cases attempted to account for it. This did not happen with Government Exhibit 1027 which included a total of service days per year for Hesson, but failed to account for the reality that he worked billable hours on many days that would not be labeled as service days because they did not involve initial patient contact. This failure in Agent Terry's chart prejudiced Hesson when she divided the total hours billed to Medicare by the service days which resulted in extremely high numbers which furthered the implication to the jury that Hesson was dramatically overbilling. This point was not raised by Hesson's counsel through objection or in cross-examination.

The prejudice from Government Exhibit 1027 was amplified when a graph form of the chart was admitted into evidence, again without defense objection, which merely depicted the extremely inflated and misleading numbers calculated in the chart.

Government Exhibit 1038

In the Government's Response to Parker's 2255, the Government argued that even if *locum tenens* could account for Hesson's billing in Government Exhibit 1027, Hesson was "still billing too many hours." To further their argument that Hesson was personally

billing too many hours, the Government's case agent picked a single date of service and compiled a chart by cross-referencing the visitor log at Hattiesburg Health and Rehab on 6/29/2011 which shows which patients Hesson saw, with the internal billing sheets for those patients which were ultimately provided to Hesson's accountant for billing to Medicare. This exercise created a compelling looking, but ultimately meaningless and highly prejudicial chart which was admitted as Government Exhibit 1038B without any objection from Hesson's counsel. Appended hereto as Appendix D. The chart is titled "Patients seen by Rodney Hesson at Hattiesburg Health and Rehab on 6/29/2011." The chart's ultimate conclusion, as explained by Agent Terry, was that Hesson billed for 29 hours and 30 minutes of "face-to-face" time for that day at the nursing home. This is false and is based on numerous incorrect assumptions by Agent Terry. Nevertheless, this chart was presented and explained to the jury without any challenge from Hesson's lawyer on cross-examination. Exhibit 1038B was highly prejudicial to Hesson and was extraordinarily misleading.

Agent Terry's calculation of "face-to-face" time is flawed and extremely misleading. The purpose of the chart she created was to demonstrate to the jury that Hesson had to be overbilling because the total hours of "face-to-face" time needed to complete the services billed for the June 29, 2011 date of service exceeded 24 hours. Agent Terry testified that she calculated "face-to-face" time required to justify the time billed to Medicare by adding the Intake Units, Interview Units,

Record Review Units, and Testing Units together for each patient and then totaling the time required for all patients at the bottom of the chart. This method of calculation is flawed in several ways:

First, as described above, based upon Hesson's reasonable interpretation of the Medicare regulations, he was billing Code 96101 for services that were performed incident to his services under his general supervision.

Second, as discussed above, Medicare preferred cumulative billing, which involved services performed for a patient over a period of several days being submitted on one bill to Medicare. Government Exhibit 1038B improperly accounts for this as Agent Terry assumed that the only portion of the billed time, which could have been performed on a day other than the date of service was the Report Writing units. In reality, the Collateral Interview units, Record Review units, and Report Writing units were all services that could be performed on different days than the Intake, Interview, and Testing Units and be billed cumulatively and therefore cannot be considered in attempting to establish the face-to-face time with patients required of Dr. Hesson with his patients on June 29, 2011.

The only portion of the units billed to Medicare for Hesson's visit to Hattiesburg Health and Rehab on June 29, 2011 which required Hesson to be face-to-face with the patients were the Intake units and portions of the Testing units. If one eliminates the units which were performed incident to his services and the units

which, under cumulative billing, did not necessarily occur on that day, you are left with the following which demonstrates the reasonableness of the hours billed:

Hesson billed one unit (a minimum of 31 minutes) to each of six patients for 90801 Intake services performed on June 29, 2011. This represents a minimum of 186 minutes (6 patients x 31 minutes/patient) of work, which converts to 3.1 hours. Hesson was present and supervised portions of the testing of patients for the remainder of the time he was at Hattiesburg Health and Rehab that day.

Without any objection by the defense or cross-examination of Agent Terry who created it, Government's Exhibit 1038B was submitted to the jury and told the jury that Hesson billed for 29 hours and 30 minutes of his time on June 29, 2011. Had Hesson and Parker's lawyers been prepared to dispute Agent Terry's chart, they could have presented a table like the following, which would have helped to visualize for the jury the portions of the billing which actually required Hesson and Henley to be face-to-face with patients on June 29, 2011.

Patients seen by Rodney Hesson at Hattiesburg Health and Rehab on 6/29/2011							
Patient Initials	90801 Intake Units	96101 Interview Units	96101 Record review Units	96101 Testing Units	96101 Report Writing Units	Total Units billed	Total Units Which Had to Occur on 6/29/2011
L.C.	1	1	1	1.5	2	6.5	2.5
J.M.	1	1	1	1.5	2	6.5	2.5
B.S.	1	1	1	2	2	7	3
J. S.	1	1	1	1.5	2	6.5	2.5
W.W.	1	1	1	2	2	7	3
H. W.	1	1	1	1.5	2	6.5	2.5
D. A.		0.5	0.5	0.5	1	2.5	0.5
S. B.		0.5	0.5	0.5	2	3.5	0.5
L. B.		0.5	0.5	0.5	2	3.5	0.5
D. C.		0.5	0.5	0.5	1	2.5	0.5
J. C.		0.5	0.5	0.5	2	3.5	0.5
J. D.		0.5	0.5	0.5	1	2.5	0.5
A. F.		0.5	0.5	1	2	4	1
D.G.		0.5	0.5	0.5	1	2.5	0.5
C.M.		0.5	0.5	0.5	2	3.5	0.5
G.M.		0.5	0.5	0.5	1	2.5	0.5
J.R.		0.5	0.5	0.5	1	2.5	0.5
N.S.		0.5	0.5	0.5	2	3.5	0.5

Total patients seen on this day which required Hesson's physical presence	6	Units highlighted in yellow represent units that were partially performed by Hesson
Total units billed for this day which required Hesson's physical presence	6	Units highlighted in red represent units that were exclusively performed by Hesson
Hesson's Minimum face to face time in minutes	186	Units highlighted in green represent units that were not necessarily performed on June 29, 2011
Total Units which had to occur on 6/29/2011 between Hesson and Henley	22.5	

Between Government Exhibit 1027 and Government Exhibit 1038B, the jury was bombarded with "evidence" that Hesson was continuously billing Medicare for more hours per day than there are hours in the day. As demonstrated above, reasonably competent counsel could have easily discredited the Government's charts through basic cross-examination, but completely failed to do so. Had Hesson or Parker's counsel discredited the charts demonstrating the Government's theory of impossible billing, there is a reasonable probability that the jury would have found Hesson and Parker not guilty.

The Government's Flawed Medical Necessity Theory of Fraud

The Government's response also argued that Hesson and Parker "repeatedly billed for tests that were not necessary, helpful, or warranted." To support this theory, the Government repeated the testimony of their expert witness, Dr. Daniel Marson. Ironically, their reliance on expert testimony highlights the ineffective assistance of counsel that Hesson and Parker received when their lawyers failed to find an expert to testify on their behalf at trial that the judge would permit. Had their lawyer's found an expert, they would have explained the numerous misrepresentations of fact that were told to the jury through the Government's expert. First, they would have clarified that an unresponsive patient (comatose or obtunded) is not the same thing as a patient who provides non-responsive answers during psychological diagnostic testing.

Specifically, valid testing results cannot be obtained from the former, but they can be obtained from the latter. Second, they would have testified that neither NHPS nor PCS ever administered formal psychological diagnostic testing to an unresponsive patient and instead marked the patient's file with "unable to obtain valid results" or "unable to test." Third, they would have clarified that all referrals to NHPS and PCS were based on a physician's order which identified the symptoms or behavior's that needed to be better managed. In some cases, a request for re-evaluation was for the purpose of helping a physician with the management of psychoactive medications with substantial negative side effects. 42 U.S.C. § 1320c-5(a) and 42 C.F.R. § 410.32 specifically allow Medicare claims that charge for assisting in the patient's management. Fourth, the expert would have explained that when NHPS and PCS psychologists were asked to evaluate or re-evaluate Medicare beneficiaries who could not be formally tested—whether due to the severity of the mental illness or the side effects of medication—the clinical psychologist assigned to the case would still conduct a psychodiagnostic assessment based on, among other things, behavioral observations. Fifth, they would have corrected the Government's unfounded assumption that units listed on the billing sheet as "96101 Psychological testing and interpretation" referred exclusively to formal testing time, as opposed to the time it took to conduct a psychodiagnostic assessment which may or may not have included formal testing. The Government's misunderstanding of this led the jury to believe that any time listed as "96101 Psychological testing

and interpretation" for patients who could not be tested was fraud. Had Parker and Hesson's attorneys obtained an admissible expert to testify to these facts and correct the government expert's misunderstandings, there is a reasonable probability that the jury would not have convicted Hesson and Parker.

CONCLUSION

Based on the foregoing, Petitioner Parker respectfully submits that she has made a substantial showing of the denial of a constitutional right as to the above issue and is entitled to the issuance of a certificate of appealability.

Respectfully submitted,

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